EXPERIMENTAL FUTURES

TECHNOLOGICAL LIVES, SCIENTIFIC ARTS, ANTHROPOLOGICAL VOICES

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P. Sean Brotherton

REVOLUTIONARY MEDICINE

HEALTH AND THE BODY IN POST-SOVIET CUBA

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PROLOGUE

Walking along the streets of the formerly posh suburbs of Havana, I am always struck by the contrast between the old and new, now fused together. The streets resemble a bricolage of different centuries, and each house I pass seems to reveal a new style, era, or simply an invention born of necessity. Romanesque pillars painted in soothing pastel colors, now faded, complement large windows and crumbling balconies that contrast with decorative rusting ironwork and gardens in disarray. It is not uncommon to find a bust of the Cuban independence fighter José Martí standing proudly in the center of many of these gardens, an image of his head and a revolutionary slogan engraved on a small plaque partly shrouded by encroaching weeds.

In contrast to this serene image is the blaring sound of American pop music coming out of 1950s-model Fords and Chevrolets with large Sony or Panasonic speakers from the U.S.-dollar store placed strategically in the cars' rear windows. The booming, repetitive bass and synthesized voices remind me that, despite appearances, we are in the new millennium. Laundry hanging out of ornate colonial windows and the buzzing sound of pressure cookers softening the daily fare of frijoles negros *(black beans) are accompanied by the shrill laughter of brightly uniformed children on their way home from school. People standing in a winding queue in front of the local* bodega *(ration store) converse, laugh, and share a collective sigh, as most of the daily rations fail to arrive or simply run out. Unbothered by a river of water flowing from a broken pipe in the street, people smile obligingly as a passing tourist snaps a photo of what is, for him, a novelty: Cubans lining up for bread. These are the participants in the making of history, as it passes by in a series of rhythmic beats.*

PREFACE

ETHNOGRAPHY OF CONTRADICTIONS

In a crowded theater in Havana in the summer of 2000, as I sat watching the Cuban-directed and Cuban-produced movie of the year, *Un Paraíso bajo las estrellas* (A paradise under the stars)—incidentally, this is also the motto of the Tropicana, the infamous Cuban cabaret that features voluptuous dancing girls—the audience roared with laughter and shouted comments about the unfolding drama. One part of the movie that generated a particularly vociferous response was the demise of one of the secondary characters, who, while arguing with his neighbors, slipped off a bridge and fell to his death, standard fare in a Cuban soap opera. What was most remarkable about this death, however, was the character's rebirth.

During his funeral, his ex-wife, a Cuban living in Spain, arrived with her arms weighed down with shopping bags and boxes and dressed in the latest designer wear. The center of attention immediately shifted from the deceased to the newly arrived *cubana de afuera* (Cuban living abroad) and her declaration that she had brought *regalitos* (little presents) for everybody. While the mourners surrounded her, the deceased, not to be left out of the general mayhem of gift distribution, suddenly awoke.

The mourners, stunned into disbelief, began to question him. "What happened?," they cried out. Responding quite matter-of-factly he stated, "When I got to Heaven, they wouldn't let me in because the entrance fee was in *divisa* [U.S. dollars]." Rejoicing in his rebirth, the mourners silently accepted the reality that the afterlife is merely an extension of everyday life, in which access to divisa shapes lives and experiences differentially. The audience in the theater screamed out in jest, *"Vaya, no es fácil!"* (It is not easy!). A woman sitting next to me shook her head and grumbled, "This

country is shit." A man yelled out, "*Oye* [listen], there is nothing left in this country that isn't in divisa!"

In Cuba today a deep discontent runs beneath the reiteration of revolutionary catechisms. In myriad ways Cubans are beginning both to voice serious concerns and to poke fun at the situation in which they find themselves. Whereas once official state rhetoric served as a political summons to rally the population, even if superficially, the conspicuous reemergence of haves and have-nots, defying the socialist discourse of egalitarianism, leaves the government exposed to widespread criticism at unprecedented levels, often in public forums. As the state continues to defend its socialist aspirations, individual citizens, long accustomed to the basic necessities and the few extra luxuries furnished by the revolution, are starting to feel the effects of a prolonged economic crisis now that this material well-being is no longer guaranteed. More important, citizens are beginning to question and challenge the rebirth of a class-stratified economy in which possession of divisa indexes differential access to basic goods and services and to rampant consumerism by the privileged few who reside in the upper layer of this multitiered economy.

Like other spheres of Cuban society, the health care system has been at the center of recent macroeconomic transformations, such as the socialist government's pursuit of a dual economy using Cuban pesos and U.S. dollars (now substituted by *pesos convertibles*).[1] This book examines how these reforms characterize some of the implicit contradictions of everyday life and, importantly, shape individuals' experiences with institutions of the state. Nowhere are these contradictions more evident than in Cuba's socialist health policies, which are currently undergoing revisions, experiencing constraints, and meeting obstacles as the country's current financial woes pose serious challenges to the state's ability to keep the underlying principles of the socialist government intact.

While many social scientists have examined public health care in Cuba, none have ethnographically explored how health reform might be analyzed in terms of larger economic and political considerations, many of them external to Cuba, as well as in terms of changing practices in the everyday lives of citizens. To address these concerns, I ground this book in what I call an ethnography of contradictions, and, in order to map such an ethnography, I advocate a theoretically promiscuous approach, one that is wedded not to a single theoretical camp or framework, but to an engagement with a diverse body of

recent scholarship on the anthropology of the state, critical-interpretive medical anthropology, and postcolonial and postsocialist studies. Such an approach is necessary in order to analyze an ethnographic context—contemporary Cuba—that has occupied multiple positions throughout history: from Spanish colony (1493–1899) to capitalist democracy under the tutelage of U.S. domination (1902–59) to socialist state (1959–present).

Shortly after arriving in Havana in July 2000 to begin my formal field research, I set off early one morning to meet a professor named Liliana Menendez from the Ministerio de Salud Pública (Ministry of Public Health, MINSAP). I had met Menendez a year earlier while visiting a close friend of mine who worked in her office. I was pleasantly surprised to find out that she was an avid reader of medical anthropology literature, and she immediately expressed an interest in my research. Having sent my proposal earlier for her review, I was eager to get feedback. She agreed to meet me in her small office, located in a crumbling building in the city center that also served as a residence for students. After we exchanged formal greetings and sat down she pulled out a copy of my proposal.

Before launching into her discussion, she stated, "These are only suggestions, but I think you should strongly consider them." She circled the phrase "governable subjects" in the opening paragraph. "My dear," she said, laughing playfully, "this language is simply too strong." Switching to a more serious tone, she queried what exactly I meant by such a phrase. "Are you suggesting Cubans are manipulated like objects by the state?" she asked pointedly. She was skeptical of my references to various theorists, in particular, Michel Foucault, and said one could interpret my research intentions in Cuba as being overly critical of the socialist government. The state review board, she stated, shaking her head, would never approve such a study.

She pulled out a scrap of paper and began to draft a new proposal, one which, she stated, would be of "greater scientific interest" and, importantly for state reviewers, appropriate in the Cuban context: a comparison of the "cultural models of health care" in the United States, Canada, and Cuba. Excitedly, she sketched out a chart with three columns: on the left was Capitalism–United States; on the extreme right of the page was Socialism–Cuba; and in the middle was a Mixed–Model–Canada. She seemed impressed by the new "culturally appropriate" project she had drafted and once again stressed that the new project was only a suggestion. As I maintained an expressionless face throughout her frenzied sketching and exclamations that

the project was of "vast interest," she finally looked up at me and gauged that I was not terribly enthusiastic. "You are aware that several social scientists have been removed from Cuba, aren't you?" she queried. Her comments had a ring to them that made me feel I was privy to some kind of secret information. After forty minutes of explaining the importance of a sound methodology, as opposed to anthropological methods, which she disparagingly referred to as "simply hanging out," she finished drafting the new proposal. By her account, it followed the grant guidelines set out by the Pan American Health Organization, a format, she indicated, that state reviewers responded to well. Handing me several sheets of paper, a draft of my "new project," she wished me good luck. After thanking her for her help, I left her office with the clear sense that I had my work cut out for me.

Several days after my encounter with the professor from the MINSAP I spoke with a close friend of mine, a Cuban physician, who was completing a master's degree in biostatics. He offered to work with me to make my proposal acceptable to the officials of the MINSAP. "Your language is too theoretical," he complained. The physician worked with me for two days to help me transform my original proposal into a project infused with positivist language that harkened back to my second-year university organic chemistry lab reports. After reading over the proposal, the physician was convinced it was "scientifically solid" and, in his view, could actually say something beyond a limited context; that is to say, he proudly concluded, it was "statistically significant." The revised proposal would have had me working in eight *consultorios* (family doctor's offices), randomly selected across the city, and carrying out extensive survey-like research with, at a minimum, several hundred people. Moreover, the new project was devoid of the hallmarks of anthropological research methods—extensive participant observation and semistructured interviews—and purposefully avoided political issues.

Unwilling and unable to carry out such a large-scale project, I decided to seek out a social science research institution. I had a lucky break when, after repeatedly being told by various government officials that any study of medicine in Cuba, social or otherwise, is the sole responsibility of the MINSAP, I finally got an appointment with a social science professor who was recommended to me by a friend of a friend. I sat down with the professor, who I later found out was a high-ranking member of the Communist Party. He examined my original proposal and my curriculum vitae and, to my surprise, expressed great interest in my project. "It is obvious that the MINSAP will not understand the kind of research you are doing," he stated. "You are not studying medicine per se but examining the practice of medicine as your object of study." "At this institution," he continued amicably, "I am sure you will find we are very open-minded." He offered me numerous references and contacts with medical professionals and personally took on the responsibility of calling the people who could secure my student research visa. In less than a week a local ethnological research institution officially sponsored my field research, with no changes to my original proposal.

In a country beleaguered by bureaucratic red tape, matched by a population conditioned by years of having to possess multiple layers of documentation, the mere existence of a Cuban form of identification made things easier for me in certain respects. My "Temporary Foreign Resident in Cuba" identification booklet, which listed biographical information, citizenship, parents' names, address in Cuba, and institutional affiliation, served as a point of reference of sorts, flagging that a state entity was essentially responsible for me. In effect, the booklet granted me access to a plethora of institutions, including libraries, research centers, hospitals, and clinics, and authorized me, as a person living in the country, to socialize and interact with Cubans in ways that normally arouse the suspicion of authorities, who often treat such interactions as signs of prostitution, hustling, or general illegality.

However, as a foreign researcher, I was also aware that the socialist government had demanded over the years that various social scientists, among other researchers, leave Cuba for carrying out what government officials believed was "questionable research practices."[2] As if reading from the pages of George Orwell's novel *1984*, I did have fleeting thoughts of the omniscient Big Brother state watching and controlling my every move and action and that of the populace. For the most part, this was not my personal experience of Cuba, although some individuals did interact with me in ways that reinforced the rumors that the populace was being watched and followed by a ubiquitous state. For example, a small percentage of people I interviewed whispered, refused to be taped, or went to great lengths to arrange interviews in out-of-the-way places.

My most troubling experience involved several interviews I conducted with family physicians in Havana, all of whom were recommended to me through my Cuban host research institution. This experience made me rethink my methodological approach and wonder whether I had dismissed the notion of Big Brother too quickly. During several of the interviews with

family physicians, I was surprised to find a striking similarity among their responses to my questions. They were reminiscent in both cadence and content of Fidel Castro's popular speeches, and I thought I had fallen prey to the official harangue of prescribed state discourse—what many Cubans refer to as *el teque* (literally, a spinning top).[3] The physicians' responses, replete with discussions of the successes reflected in Cuba's vital health statistics and peppered with accolades for the country's family physician and nurse program, which is popularly understood as being the product of Castro's innovative thinking, shared critiques of what was to blame for recent changes to the Cuban health care system: the withdrawal of Soviet aid and the U.S. embargo against Cuba, popularly known as *el bloqueo*.

I wondered whether my affiliation with my host institution, which in theory was a nongovernmental organization (NGO) but for all intents and purposes was managed and run by the Ministry of Culture, had cast me in a specific light. I could well have been perceived as an official of the state. It was clear that several of the interviews, previously arranged through my Cuban advisors, had set the stage for a particular kind of interaction. In effect, any effort to secure my informants' anonymity was impossible. Having carried out extensive preliminary fieldwork in Havana since 1998, I had, by the time my formal research began in 2000, already built up a large informal network of friends and acquaintances, many of whom were family physicians. I was well aware, from attending many gatherings with this eclectic group of people, that heated debates and discussions on numerous topics, political and otherwise, were commonplace in certain situations. The physicians I encountered who were toeing the party line in formal interviews were the exception rather than the rule.

Having carried out extensive formal and informal interviews among the general public, I encountered a diverse range of opinions and experiences, particularly in regard to the public health system. Were these physicians, who had been recommended to me by my host institution, just feeding me state rhetoric? A close Cuban friend of mine made an astute point that helped shed light on my dilemma. As he put it, two kinds of people typically flock to Cuba. The first group, the idealists, come to Cuba in search of the image of Ernesto "Che" Guevara, and they have a romanticized vision of Castro and socialism. The second group, he suggested, are the critics, who arrive in Cuba in droves to point fingers, cast doubt, and castigate the socialist government. Unfortunately, as my friend further pointed out, while

some individual citizens may happily bare their souls without thinking twice, many state professionals, especially physicians, are in a different position. They are more conscious, he suggested, of the way in which open dissent may have negative consequences for their careers, particularly as they work so closely with the government. This is a risk, he added, that many physicians are unwilling to take with people who have not demonstrated themselves to be *de confianza* (trustworthy).

My final decision to branch out and pursue interviews with physicians recommended through informal contacts, rather than through my sponsoring institution, was prompted by one event in particular. Marisol Domínguez, a forty-eight-year-old family physician recommended to me by a Cuban professor at my host institution, had agreed to do a series of interviews with me and offered to let me visit her consultorio. Arranging to meet her at her house for our first interview, I found the experience to be revealing in many ways. Domínguez responded to all of my questions in monosyllables, and I had decided that the interview was a complete failure. Toward the end of our conversation, I asked her to tell me about some of the challenges she faced in her work as a family physician. I also asked her to comment on any improvements she felt were needed in the current primary health care system.

Looking noticeably uncomfortable, Domínguez asked, "You do know our Comandante is the mastermind behind this current program, don't you?" She paused and then added, "I believe the program is ideal, and no changes are needed." Upon further questioning about how her consultorio was affected by the recent shortages of food and medicine in Cuba, she became visibly disturbed and adamantly stated, "Nobody in Cuba is without adequate food or medicines. If people are telling you that, they are absolute lies." Taken a little aback by her hostile response, I inquired about the general shortages that many of the ordinary citizens I had interviewed complained of. "Well, yes," she admitted, "we have some shortages, but they are getting better. Surely you do not want to focus on this topic when we have accomplished so much in Cuba." I made it clear I was not on a fact-finding mission to identify only the faults in the system or to criticize the government, but to put in context recent changes in the health care system caused by social and political shifts in Cuba. Seemingly unimpressed by my explanation, Domínguez concluded, "Cubans are prone to exaggerate things, especially with foreigners."

My formal meeting with Domínguez was similar to several others I had with people I refer to as low-level bureaucrats—social workers, MINSAP officials, and so on—who were recommended to me through my host institution. Rather than dismiss these interviews as mere rhetoric, I include them alongside other interviews, many of which involved informants with whom I had developed long-term relationships, such as those I met in 1998 or 1999. Others warmed up to me only after repeated interviews and extensive participant observation. I do acknowledge, though, that Domínguez's comments about the questionable interaction between foreign researchers and exaggerating Cubans have a certain ring of truth, however limited.

Throughout my fieldwork it was not uncommon for some informants to drop by my house or to call on me, often to complain extensively about their various experiences with the primary health care system or about one physician in particular. For example, one woman I had interviewed insisted that I put on a doctor's lab coat and sneak into the maternity hospital where her niece had been admitted in order to witness firsthand the abhorrent conditions. I declined. Several people unmistakably had an agenda, one which they believed matched what they thought was my own: to identify faults in Cuba's health care system in order to undermine the socialist government. When these individuals had positive experiences with their family physician or state officials, I was not called upon to chronicle those events. Not attempting to censor the experiences of my informants, I nevertheless had to use my own strategies and tactics sometimes in order to tease out the underlying and multiple truths in people's everyday experiences.

For example, several individuals painted images of starvation and at times complained that the state had not provided basic monthly rations, such as meat or fish. When I asked to see their state ration books (*libreta*), which I justified by stating that I was merely curious, meat and fish products were indeed provided.[4] I asked people to explain the discrepancies in their stories. "But those are not the choice parts of the meat," many of them would claim, or "Yes, we got fish last week, but it was in a can." The notion of starvation, in this context, was the inability to eat culturally appropriate foods. Moreover, other individuals complained of having no access to U.S. dollars yet smoked a particular brand of cigarettes that was sold only in this currency. When I asked them how often they smoked, on average, several individuals indicated they smoked a pack a day. The popular brands of cigarettes for sale in U.S. dollars sell for anywhere between fifty cents and one dollar per pack.

Therefore, some people were smoking from fifteen to thirty dollars' worth of cigarettes per month. Yet by their own accounts they did not have access to U.S. dollars. These are only some of the many discrepancies among the multiple realities of people's lived experience. Ethnographic research, in this context, is the best way to address the many nuances and contradictions of contemporary Cuban life.

Introduction

BODIES IN STATES OF CRISIS

Tracing the deep, furrowed lines that branched out from slightly under her nose and created a crease on either side of her mouth, María Luisa laughed apprehensively. The permanent frown of etched lines temporarily transformed.

"They appeared right at the height of the *período especial*," she remarked. These were not mere signs of age or the vain complaints of a woman of a certain age who no longer looked the way she used to, she commented. Instead, "these *cicatrices* [scars]" were the embodied proof of living through the worst years of Cuba's economic crisis of the early 1990s. Shuffling through her bag, she quickly produced her *carné de identidad* (state identification card). "This is what I looked like at the beginning of the crisis," she proudly exclaimed. The card was issued in 1988. She was thirty-five then. The face that stared back from the crumbled blue carné had little resemblance to the frail figure that sat before me.

Looking around suspiciously, she continued in a barely audible tone: "El Barba"—she rubbed her chin to indicate the beard of El Comandante, Fidel Castro—"doesn't like people to tell things the way they are. But I can't lie. People here are going through a terrible crisis." The crisis had changed everything, she lamented: "My body is still suffering from the effects of the período especial. Since then, things have never been the same."

Using her body as a diagnostic map, María Luisa walked me through her many ailments: a case of optic neuropathy in 1993, which resulted in a prolonged period of temporary blindness. She found out circuitously from a friend who had access to the international media that foreign presses were reporting severe nutritional deficiencies as the cause.[1] Only later did her doctor intimate that this was, indeed, the cause. Shortly thereafter she

started experiencing flare-ups of gastritis, severe migraines, body aches, and fatigue, all of which she medicated through a combination of prescription pills. To make matters worse, she added, because the local state pharmacies were increasingly unable to fill prescriptions, even for aspirin, she was often forced to rely or impose on her friends, friends of friends, and the *bolsa negra* (black market) to fill the void.

As an accountant affiliated with the Institute of Cuban Radio and Television prior to the crisis, María Luisa had lived what she described as "a privileged existence." She had traveled to Moscow on several occasions as a student during the Soviet period. Fluent in Russian and French, she had also worked part-time as a translator, which sometimes allowed her to tour the island with foreign dignitaries. Recognized for her involvement in revolutionary activities, including her work with the Federation for Cuban Women, the government awarded her an apartment in a beautiful colonial building in the Santos Suárez neighborhood of Havana, well known for its striking architecture.

However, within Cuba's supposed new social order, everyday life was now inverted, María Luisa conceded. The frequent blackouts, crumbling local transportation system, empty pharmacies, massive lineups for the few basic necessities (those still provided), and the politics of passively watching foreigners enjoy the now-popular socialist resort island and not being able to participate were simply too much for the average person. In an exasperated tone she added that Cubans had come to expect a certain standard of living, similar to that of people in other economically developed countries: "Is this not what *la Revolución* was for?"[2]

This book charts diverse narratives, such as María Luisa's, that relate to the body and health in order to explore the Cuban government's changing policies and objectives in the primary health care sector. These narratives speak to the myriad ways in which the specter of the Soviet past and the uncertainty of the island's political future have served as potent signifiers of the nation's vulnerability, particularly as the withdrawal of Soviet aid and the magnified effects of the U.S. embargo manifest at the level of individual bodies and reverberate through the multiple spheres of quotidian life.

In 1991 the government declared, "Socialism is under siege" and formally announced the beginning of the Período Especial en Tiempos de Paz (Special period in time of peace, hereafter, período especial). The logic of everyday life in post-Soviet Cuba was radically transformed under the rubric of

"wartime measures in times of peace." Operating in many ways as a "state of exception,"[3] government policies institutionalized corrective measures by creating new and refining older policies (migration laws, banking practices, employment categories, and access to basic needs and services, to name a few) as part and parcel of a general program of economic recovery and revival.[4] In 1991 Julio A. García, the former head of the Cuban Chamber of Commerce, described the Communist Party's logic behind these changes: "We have to think like capitalists but continue being socialists."[5] As implied by García's statement, the island started charting a new course for the social, political, and economic survival of the country's socialist revolution.

Over the past decade scholars and political commentators have continued to debate whether the período especial, as a transitory phase, has officially ended in light of the country's improving economic indicators in the late 1990s. Yet the rush to demarcate a beginning and an end obscures the lasting affective and corporeal dimensions of how this period was imprinted on people's bodies; in particular, how it was embodied through physical and mental ailments, palpably and materially experienced through deep senses of loss, betrayal, disillusion, and longing. The redefining of the socialist state through the lens of crisis directly influences the multifaceted ways in which individual Cubans in Cuba construct narratives about bodily and psychological health through the vagaries of social, economic, and political change.

Such narratives form an active part of people's imagination and circulate in multiple registers: real, imagined, symbolic, material, state-sponsored, and personal. They are also mobilized to variously construct notions of victimhood, social suffering, martyrdom, patriotism, resilience, resistance, and physical pain. These narratives serve as an Archimedean point for broader debates and discussions, often invested with great emotional intensity, on bodily health, the health of the nation, and the role of the political in defining both. The crisis narrative, therefore, becomes a way to discuss the complex dynamics that have historically influenced Cuban culture and shaped the construction of *cubanidad* (Cuban national identity).[6]

Based on more than a decade of field research (1998–2010) conducted in the city of Havana, this book chronicles the experiences of family physicians, everyday citizens, public health officials, and research scientists participating in the country's primary health program, central to what is known as the Programa del Médico y la Enfermera de la Familia (MEF, Family physician

and nurse program).[7] This program calls for family physician-and-nurse teams to live and work in small clinics known as *consultorios* on the city block or in the rural community they serve.[8] Through an ethnographic exploration of the relationship between health policy (of which the MEF program is an example) and individual experiences, I explore two central themes.[9] First, I focus on how state policy, enacted through the government's public health campaigns, has affected individual lives and changed the relationship among citizens, government institutions, public associations, and the state. Second, I look at how the collapse of the Soviet bloc and the strengthening of the U.S. embargo are changing the relationship between socialist health policies and individual practices; specifically, I discuss how these changes have redefined the way in which state power becomes enacted through and upon individual bodies.

Combining historical, epistemological, and ethnographic modes of analyses, this book is divided into three parts. Part I explores how, in a context of growing economic scarcity in the health sector, individual citizens, who have highly medicalized understandings of their body, negotiate the role of the state in providing health and social welfare and their own personal desires to seek comprehensive health care, increasingly at their own expense. Part II takes up a historical examination of the mechanisms and practices through which power relations operate in the primary health care system. Through a discussion of various public health campaigns, with their emphasis on treating both the individual and social body, I explore the relationship between health ideology as an explicit discourse and as lived experience. Finally, part III considers how the country's shifting state policies and external global factors have interacted with each other to change the course and practice of health and medicine in the island nation.

A GENEALOGY OF INDIVIDUAL BODILY PRACTICES

The analysis presented throughout this book is informed and shaped by what I call a *genealogy of individual bodily practices*. For the purposes of this book, I define individual practices as the complex ways in which individuals communicate, improvise, enact, and revise ideology.[10] Yet the task of genealogy, according to Michel Foucault, is to expose a body totally imprinted by history.[11] Genealogy provides an empirical methodology by which to explore the truth claims individuals make regarding the knowledge they have of themselves, their bodies, and society at large, while at the same time

understanding such knowledge as a relation of power.[12] By unraveling the multiple historical layers that contribute to bodily formations, both culturally and materially, a genealogy of individual bodily practices offers an analytical lens through which to examine the lived experience of bodies. This approach addresses three interrelated ethnographic and theoretical concerns.

First, it reveals how individuals embody the past in creating and re-creating the present. This makes legible how bodies operate in particular fields, or *doxas*; that is, sentient bodies are products of embodied knowledge that are shaped by historical events, unconscious beliefs, and learned behavior and values. Ultimately, this influences people's actions and thoughts. Second, my approach emphasizes that while we cannot take for granted that self-directed agency is everywhere, neither can we assume that subjects do not try to modify, manipulate, or escape the effects of those forces that construct them.[13] In this way, it draws attention to multivalent individual and group responses to the changing nature of state power. These responses are complex, blurred, and fractured and at times function in the form of pragmatic behavior, bodily reform, or the quotidian practices of routine actions.[14] Finally, a genealogy of individual bodily practices offers a theoretical lexicon to examine the sometimes contradictory and overlapping relationships among the individual practices of everyday citizens, economic reform, and state power.[15] In this way, it reworks the customary model for understanding state power as imposing itself on the subject who, weakened by its force, comes to internalize or accept its terms.[16] My approach, rather, stresses that state power "can only achieve an effective command over the entire life of a population when it becomes an integral, vital function that every individual embraces and reactivates on his or her own accord."[17] This approach, then, seeks to create a "history of the present" or "to create a history of the different modes by which, in our culture, human beings are made subjects."[18] It advocates that comprehending how bodies are being imagined and reimagined in Cuba's post-Soviet context is to treat them as a palimpsest by situating the present and its pasts side by side so that they can be seen and interpreted simultaneously.[19]

Since the revolution in 1959, many of the practices employed by the state and by individual Cubans, particularly during the período especial, have obvious continuities with the past. In this respect I argue that the revolution was in fact not revolutionary in the sense of provoking a dramatic shift in

ideas and practice. Rather, I suggest that one must understand the contemporary interaction and competition among different ideological principles as the ongoing expression of years of political struggle, which has historically existed between sectors within the island's population.[20] In an attempt to address this approach, I have integrated the narratives of several of my interlocutors throughout the text as a way of presenting their personal lived experiences and accounts of historical and current events in Cuba.[21] Each personal account, I argue, represents a separate genealogy that reflects a complex web of values, ideas, and, ultimately, lived experience before and since the Cuban revolution.

Cuba's socialist revolutionary period, also known as the Período Revolucionario Socialista (1959–present), has used health as a defining characteristic of its reform. Underpinning this commitment was the notion that the health of the individual is a metaphor for that of the body politic, effectively linking the bodies of individuals to the political project of socialism and its governmental apparatuses. Since 1959 the country's socialist health ideology, in part predicated on the idea that health care is a basic human right, has been successful both at the level of ideology and in practice. This health ideology operated as a form of biopower that regulated "social life from its interior, following it, interpreting it, absorbing it, and rearticulating it."[22] These all-encompassing health campaigns effectively produced a new kind of medicalized subjectivity in Cuba, one in which a prolific network of health professionals has encouraged the citizenry to become increasingly attuned to biomedical understandings of what constitutes bodily health and physical well-being.[23] One of the results of embracing this subjectivity has been the increasing reliance on biomedical intervention and innovation. Physicians and their patients, particularly those who are ill, became much more invested in a politics of hope, whereby the power of biomedicine, infused with a millenarian quality, takes center stage as the primary therapeutic answer.[24] The socialist health care doxa has saturated people's everyday lives and mundane practices, producing state-fostered expectations and feelings of entitlement to a particular form of biomedical health care.

With the advent of the período especial, the state embarked on a new kind of biopolitical endeavor that sought to divert the moral expectations, assumptions, and entitlements of the citizenry away from the cradle-to-grave social welfare model so painstakingly cultivated over three decades to be more in line with the forces of market capitalism. The state's slow withdrawal from certain sectors in the political economy of health care demanded that individuals engage in a complex web of practices to mitigate the increasing pressures of daily life.[25] These practices, often classified as *lo informal*, depend on a network of client-based relations with individuals known as *socios* (informal partner or affiliate), or an "economy of favors."[26] These activities include, but are not limited to, the bolsa negra, which trades in goods stolen from state enterprises; involvement in legal and illegal small private businesses for profit (known as *cuenta propia* and *el bisne*); and hustling and prostitution (commonly referred to as *jineterismo*).

Under a system characterized by *sociolismo*, as opposed to *socialismo*, social relationships are no longer strictly defined by state politics or affiliations, but by personal contacts and socios framed by access to material resources like medicine, food items, and luxury goods and to specialized services, including unofficial access to health care services and supplies. Sociolismo was exacerbated by the legalization and circulation of the U.S. dollar shortly after the crisis began, a step which has effectively destabilized the state's ability to control wealth and income disparity within the population.[27] In terms of health care, people increasingly engage in lo informal to obtain foreign currency (*divisa*) or, more recently, its equivalent, *pesos convertibles*, often as proactive strategies to seek out therapeutic recourses that the state can no longer provide for. On the one hand, I argue that individual citizens with access to foreign currency are increasingly (and ironically) becoming active health consumers in a climate of ever more scarce resources. On the other, I argue that individual bodily practices reflect an expanding "therapeutic itinerary" in which individuals seek out diverse avenues, both state sponsored and informal, in biomedical, spiritual, and alternative medicine to achieve personal fulfillment of their notions of health and well-being.[28]

STATES OF CRISIS

While significant social and politico-economic changes in the country's biopolitical project have led to the proliferation of individual practices, including those in the health sector, I argue that this does not signify an outright withering of state power. The political flurry surrounding the announcement in 2006 of Castro's undisclosed health crisis best exemplifies this, albeit in the abstract. The crisis led to renewed speculation about the future of Cuba after Castro, particularly as international media outlets and

political and cultural theorists alike metonymically linked the survival of the Cuban state to the aging socialist leader.[29]

This discursive imaginary of the state, however, feeds into a specific kind of moral economy that adheres to the dyadic model of the transition from the strong state to the weak state.[30] To this end, Castro's bodily health became a metaphorical battleground for the staging of a visceral politics of the withering state. From the early 1960s to the present, analysts have imagined the reified strong state in Cuba as a static entity in which the visibility of state power is often linked to a form of authoritarian governmentality. This exertion of power is enacted on decidedly nonliberal subjects, for example, through the jailing of political dissidents and the systematic surveillance and harassment of those people deemed *la lumpen*, or the underclass.[31] Contrary to this depiction, an emerging body of literature in Cuban studies has argued that ordinary Cubans have increasingly engaged in informal practices to mitigate the escalating pressures on daily life and that this development has largely weakened state power and eroded the government's political order.[32] Ethnographically, then, how can one reconcile and account for these competing state imaginaries?

To address this question, I draw a distinction between state power and state regulatory authority.[33] This differentiation "seems a more precise manner of taking on the state as an anthropological object, and . . . accounts, in some respects, for the contradiction between the expansion of unregulated activities, which seems to indicate a loss of state control, and the continuity of state power in spite of it all."[34] The very contradiction of states makes them ethnographically productive objects of analysis.[35] This book addresses state power not as a monolithic function, but as a proliferation of strategies that shape individual experiences.[36] Such an approach allows one to explore how everyday practices in the health sector culturally constitute the state as a dispersive network of multiple actors, institutions, and bureaucratic processes.

Recent studies of the state have suggested that "when practices that violate laws are accepted as the norm and have a legitimacy that is not the state's, they are often called 'informal practices.' "[37] Equally important, though, is how one theorizes an understanding of a state that actually creates spaces of informality in which such practices thrive. Moreover, through what theoretical framework can one analyze these spaces when they are used as state-sponsored economic strategies to tap into individual wealth accumulation? For example, the divestment in state-sponsored services and social welfare to private corporations speaks to Marxist theories of "accumulation through dispossession."[38] But what are the microdynamics of these marginalized or dispossessed spaces? How can these spaces also be theorized as generative or as "productivity in the margins," whereby individuals' lives are not strictly determined by an all-powerful capital or lack thereof, but are also manipulated in ways that become important for the formation of new fiscal subjects?[39] Within this analytical framework, individual bodily practices "are fundamentally linked to the state and are even essential to the very recomposition of state power in present conditions of extreme austerity."[40]

This book challenges the popular perception that lo informal, as constituted through individual bodily practices in the health sector, is a kind of Achilles heel of Cuban socialism. This belief assumes that lo informal is a subversive element percolating through and chipping away at the artifice of socialism and, in the process, exposing a linear movement toward a predetermined end: liberal capitalism and democratic politics.[41] These practices are not a political index of the demise of the state, occupying the shadows or margins of everyday life. Rather, they are an integral and vital part of the basic subsistence patterns for many Cubans. Furthermore, this is a reality the state can neither deny nor compete with. To a certain degree, individuals must rely on the informal economy to fill in the gaps that have resulted from the deterioration of government social welfare programs. Within this context, individual bodily practices that effectively integrate formal and informal economies play an important role in the maintenance of Cuba's health care system and, more generally, contribute to the daily functioning of the country's modern welfare state.[42]

STATISTICAL FETISHISM AND DOCILE BODIES

As one walks along the waterfront or tours the hospitals, schools, and monuments in the neighborhoods of Havana, one sees billboards advertising the successes of the revolution, as if, in the words of the fiction writer Cristina García, "they were selling a new brand of cigarettes."[43] Covering the sides of buildings and erected on movie-sized screens, these enormous signs contain such various aphorisms as "Millions of children in the world die of curable diseases, none of them are Cuban"; "The weapons of the Revolution are our ideas"; "We believe in socialism now more than ever before"; or "Hey Imperialist. We have absolutely no fear of you." The messages conveyed by these clever forms of political rhetoric are open to multiple interpretations. One

message, deeply rooted in the demarcation between Cuba's past and present, suggests the power of "political will" to reinvent history. Another, perhaps less subtle, expresses the socialist government's anxiety over convincing the Cuban citizenry and the rest of the world that the revolutionary project is working. In the case of Cuba's primary public health system this is particularly true.

In 2000 the widely circulated Health Report of the World Health Organization (WHO) ranked the world's health care systems according to an overall index of performance and responsiveness based on, among other things, vital health statistics. The WHO Health Report ranks Cuba 39th among 191 countries surveyed, whereas the United States is ranked 37th, suggesting that there is no link between gross domestic product (or health expenditures) and health outcomes. The report's ranking of the small island nation with a socialist-based economy, rare in today's global capitalism, is of great theoretical and practical relevance.

In one respect Cuba's success in the field of health reform, most celebrated in international development circles, helps boost the egos of Cuban Communist Party officials, who find moral solace in these tangible results of years of revolutionary fervor and sacrifice. Hinging on the success of their public health reforms and corroborated by concrete health outcomes, as evidenced in their health statistics, Cuba became, as Castro made clear, "a bulwark of medicine in the Third World."[44] In this way Cuba has gained the status of a kind of antimodel for the development logic that fuels the top-down structural adjustment policies so common in contemporary Latin America and the Caribbean. Several of Cuba's best-known public health successes, such as the island's low HIV/AIDS transmission rates, low infant mortality rate, and longer life expectancies at birth, have led a vast number of scholars to conclude that even in the face of scarce material resources the country has managed to achieve First World health outcomes through strong political will.[45] This argument is an important one. For example, in many countries of Latin America and the Caribbean, structural adjustment policies, for the most part funded and implemented through international bodies such as the World Bank and the International Monetary Fund, have spelled financial ruin and deepening poverty, leaving large segments of the population without basic health care.

Nonetheless, scholars who follow this line of thinking are blinded by what I call a kind of statistical fetishism, a heightened focus on ideological models and measures of health in place of more nuanced accounts of the complex interrelationships among the individual practices of health care professionals and ordinary people, health policies, and state power.[46] Ultimately, this form of fetishism serves a specific purpose: Cuba's health care statistics provide a "model of" and a "model for" reality, to borrow the famous dictum of the anthropologist Clifford Geertz, but do not constitute a critical examination of what those numbers reflect or, more important, how they are produced. In one respect, scholars have analyzed Cuba's health statistics as models of the health of the body politic, while others have used Cuba's health statistics as models for or alternatives to the status quo in international development circles.[47]

For purely heuristic purposes, I would organize the abundant studies of Cuba's public health system in two groups: the first generally describes the relationship between the individual and the state as one characterized by "hyper-vigilant medical police" who exercise control on "over-observed and over-disciplined bodies."[48] Interpreting Cuba's public health system through the lens of the social control thesis, the studies cast the Cuban citizenry as unwitting actors in an unfolding play of disciplinary technologies.[49] This approach suggests that state health policies such as increased health surveillance of the population inevitably shape, regulate, and control people's everyday practices and experiences. The second group, hoping to breathe life into Che Guevara's original project of "exporting revolution," promotes the Cuban model for health reform on an international scale.[50] In doing so, these studies fail to address how the conditions of the Cuban revolution are materially, culturally, and historically situated.

In the end, both groups reify an uncritical statistical approach in which individuals are perceived as passive subjects of state rule; in short, individuals become a caricature of Foucault's idea of "docile bodies," bodies manipulated and controlled in the management of the population. This process is further driven by international governing bodies such as the WHO, which explicitly link global agendas to local practices and circulate health statistics as a means to rank and classify the countries of the world on a scale from developed and First World, on one extreme, to underdeveloped and Third World on the other. Cuba, when viewed through such a polarized lens, becomes an enticing case study. But what do the statistics actually reflect? More important, what light can the numbers shed on the so-called anomaly of Cuba, a country in which, to quote a popular Cuban saying, "people live

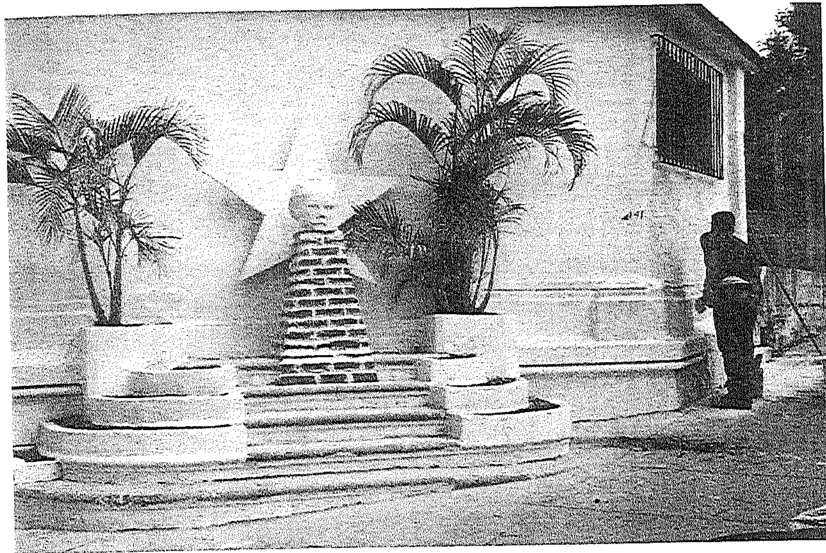
like the poor, but die like the rich." I believe the answers to these questions can be found by exploring how "statistics tell stories. They are techno-representations endowed with complex political and cultural histories. . . . One should be able to analyze counting in terms of its political consequences, the way in which it reflects the crafting of subjectivities, the shaping of culture, and the construction of power—including what these figures say about surplus material and symbolic consumption in those parts of the world that think of themselves as developed."[51]

Only by examining the interrelation of economic, ideological, and geopolitical discourses in the development of Cuba's contemporary public health system can one address the ways in which these discourses articulate and construct an image of a healthy nation. Specifically, one can see how Cuba's vital health statistics, as a reflection of the success of the country's socialist project, have become part of a larger web of power relations. These relations feed into the geohistorical categories of First, Second, and Third World, whereby Cuba attains the status of a celebrated anomaly: "the Third World country with First World health indicators." Embedded within this "development discourse," to borrow Arturo Escobar's (1995) terminology, Cuba's health statistics become trapped in an epistemological conundrum, one that not only discursively but also materially constructs certain realities, while simultaneously excluding others.

This book draws attention to the individuals and animate social processes, or "social life," to which these health statistics refer.[52] In it, I shift the analytical gaze away from docile bodies—individuals who are acted upon through regimens of discipline—to an account that examines how individuals are active subjects operating in specific sociopolitical and historical contexts. In breaking from the "avalanche of printed numbers," the analysis that unfolds in each chapter begins the important task of interrogating how Cuba's health statistics are in fact part of a broader social and political project.[53] This project has its historical roots in Cuba's socialist health ideology, in epistemological changes to their approach to public health, and in the governing of the population.

Part I

BIOPOLITICS IN THE SPECIAL PERIOD



The sculpted head of the Cuban independence fighter José Martí being refurbished in a neighborhood of Havana for the 26th of July celebrations. Brotherton © 2002.

1 THE BIOPOLITICS OF HEALTH

In Cuba, health care is free. But when you go to the family doctor, the clinics, or the hospitals there are generally no medications, no disinfectants, no cotton, and sometimes no needles. If you need to be admitted to the hospital, you have to bring your own sheets, a towel, and a fan because there is no air conditioner, or it is broken. For the most part, you have to find a way to get the medications you need if they are not available, which is often the case, even the most basic drugs, such as aspirin. But, yes, health care is free. . . . In this country, the government goes on and on about how "nobody is without access to health care from the most advanced to most basic." But, really, if it were not for the people *luchando* [struggling] you would really see what our health care system actually provides. We are the ones, *el pueblo* [the people], that make the sacrifices so Fidel can give his grandiose speeches about how wonderful our health care system is!

Marianna Díaz Rodríguez, accounting assistant,
born in Havana in 1951

Since the crumbling of the Soviet bloc in 1989, Cuba's socialist health care system has been affected by market-based reforms and the government's pursuit of a dual economy in U.S. dollars and Cuban pesos. These new economic reforms, complicated by the U.S. government's tightening of economic sanctions against Cuba, have undermined individual health by affecting the availability of food, medicines, and equipment.[1] For example, the term *la lucha* (the struggle) joined a legion of other terms in the early 1990s within a growing body of idiomatic phrases known as *cubanismo*, specialized terms or phrases either invented or commonly used that have taken on new meanings in the post-Soviet context. The term *la lucha* addresses the multiple ways in which individuals are dealing with the widening gap between

their current standard of living and the formal state apparatus aimed at addressing the material well-being of the populace. Often used in response to "How are things?," "Estoy en la lucha" (I'm struggling) has become a way of describing the personal hardships of everyday life. Díaz Rodríguez, bitterly ironic, expresses her frustration with the Cuban state's increasing problems in providing adequate health and social services. Rather than focus on Cuba's health accomplishments as defined through the widely published vital health statistics, I want to critically examine the role of individual Cubans and professionals who are luchando to achieve their health care goals and who generate these statistics. This approach requires a shift from the macro- to the micropolitics of health, which necessarily moves the discussion away from an examination of the state as an entity that acts on individual bodies toward an examination of the multiple on-the-ground social processes that shape and influence Cuba's contemporary primary health care system.

MACROECONOMIC CHANGE

One of the major differences I have noticed after the *período especial* is the health situation of our country. While, generally, I think things have gotten better in terms of overall health after 1993, there have been major shortages in medicines, distribution of medicine, and basic medical supplies. However, I still maintain that health, on an individual level, is still better in the 1990s, despite the economic crisis, than in the 1980s. If you look at the basic health statistics you see that individual health has actually improved, with the average life expectancy increasing. These are indicators of the health of our country. I also strongly believe these numbers are a reflection of the work of our health care professionals and their effectiveness, despite many hardships. I think one of our strongest programs in Cuba has been the maternal-infant health program. The education for maternal and infant health care has been growing steadily over the past forty years. Our infant mortality figures nationally are seven or eight [per ten thousand live births], generally below seven. This is a reflection of the strength of our primary public health programs.

In my hospital, for example, we have the majority of necessary medicines and almost all of the antibiotics, or at the least the necessary primary materials to produce them in Cuba. We receive the primary materials mainly from Europe. However, as you know, there are some lines of antibiotics that are very expensive for us to produce. If possible, we usually get some of these medicines through donation. For example, I am treating a patient now for whom I managed to get a treatment that lasts fourteen days, and the antibiotic cost U.S. $100. Now this is just one case, but you know that such an expense for the average Cuban is impossible. However, through international-donations and working through *socios*, you can find solutions.

Javier Valdéz, Director of Primary Health Care Research in Plaza of the Revolution City Hospital, born in Havana in 1963

As Valdéz notes, physicians, like individual citizens, are not immune to the struggles of everyday life in the período especial, and many of the strategies and tactics health professionals employ, such as working through socios and transnational connections, suggest that the revolutionary work ethic is now merged with a pragmatic engagement in the informal economy. With the advent of the período especial in the early 1990s, the structural reforms implemented in the face of mounting macroeconomic changes directly affected the political economy of the health sector. Buffered for over three decades by highly favorable terms of trade with the former Soviet Union and the countries of the Council for Mutual Economic Assistance, or COMECON, that had been major catalysts in the country's social development, Cuba was now faced with a severe economic crisis.[2] This crisis was triggered and compounded by Cuba's nearly complete dependence on the Soviet Union and by the economic embargo the U.S. government had imposed on Cuba more than forty years earlier. Between 1984 and 1989, 77 percent of Cuba's export trade was attributable to sugar, and nearly 70 percent of its import–export trade was with a single country, the Soviet Union.[3] As a result of the Soviet collapse and the U.S. embargo, between 1989 and 1993 the country's gross domestic product fell 35 percent, and exports declined by 75 percent.[4]

In the aftermath of the Soviet withdrawal from Cuba a complicating factor was the U.S. government's tightening of economic sanctions against Cuba in the 1990s. The so-called Torricelli-Graham Act of 1992,[5] also known as the Cuban Democracy Act, and then the Helms-Burton bill[6] of 1996 made clear that the intent of U.S. foreign policy toward Cuba was to foster the socialist government's defeat through what U.S. Sen. Jesse Helms called "a final push over the brink."[7] In late December 1997 Vice President Carlos Lage of Cuba estimated that the U.S. embargo and other political factors cost the Cuban economy U.S. $800 million a year, equivalent to about 20 percent of Cuba's current import bill.[8] The economic crisis threatened the survival of the Cuban revolution, particularly in regard to its continued commitment to basic human needs. However, the economic crisis also undermined health by

affecting the availability of food, medicines, and equipment, and this subsequently challenged the developments achieved in public health.[9]

The MINSAP reports that between 1989 and 1993 the total expenditures in hard currency in the health sector went from U.S. $227 million to $56 million. In 1990 the country imported approximately U.S. $55 million in medical and pharmaceutical products, while by 1996 this figure had dropped to U.S. $18 million, a decrease of around 67 percent. An agricultural and nutritional crisis also affected the health of the population, as a critical shortage of petroleum and the growing scarcity of replacement parts for antiquated Soviet technology brought the agricultural industry to a grinding halt in the early 1990s. Food production plummeted.

An often-cited case of the nutritional crisis was the outbreak in 1993 of an epidemic of neuropathy, which caused thousands of people to temporarily lose their vision (see introduction). This outbreak was due in part to nutritional deficiencies resulting from the dropping per-capita daily food consumption, which fell from 3,100 calories in 1989 to fewer than 1,800 in 1993.[10] In the early 1990s a decline in medical and pharmaceutical imports seriously compromised many physicians' treatment options. As a result of a reduction in therapeutic options, increasing numbers of nonfunctioning medical devices, and equipment shortages in the country's hospitals, the capacity of secondary and tertiary institutions to undertake high-technology procedures decreased markedly. For instance, the political scientist Thad Dunning (2001) studied the effects of the período especial on the ability of hospitals in the city of Santiago de Cuba to perform major surgeries. He found that between 1989 and 2000 the number of surgeries decreased by 46 percent in selected hospitals. Dunning hypothesized that this trend was reflective of the overall decrease in high-tech procedures being performed in other hospitals throughout the country.

The withdrawal of Soviet aid and the deleterious effects of the U.S. *bloqueo* have been linked to such negative trends as massive shortages in pharmaceutical drugs and medical supplies.[11] In 1997 the American Association for World Health sponsored a study of the impact of the embargo on health and nutrition in Cuba. The study suggested that while 1,297 medications were available in Cuba in 1991, physicians in 1997 had access to only about 889 of them, many of which were available only intermittently.[12] The strengthening of the embargo in the mid-1990s resulted in drastic changes in Cuba's ability to trade with foreign countries. Despite the U.S. Department of State's contention that the embargo against Cuba did not prohibit U.S. companies and their subsidiaries from selling medicines and medical supplies to the Cuban people, the same report failed to address the almost insuperable bureaucratic barriers imposed by U.S. legislation.[13] Laws imposed by the U.S. government, which require multiple levels of bureaucratic approval to export goods to Cuba, result in inordinate delays, increased costs, and limited access to some of the most important medicines and medical products. The added expense of imports for public health due to the embargo cost the Cuban government an estimated U.S. $45 million in 1993.[14] From this perspective, the bureaucratic obstacles put in place by the U.S. government amount to a de facto embargo on important medicines and medical supplies.[15]

Strangely, despite the significant macroeconomic changes affecting Cuba's health sector, the country's basic health indicators continued to increase over the course of the período especial. For example, between 1990 and 2001 the infant mortality rate declined from approximately 11 to 6 deaths per 1,000 live births, and life expectancy improved slightly between 1990 and 2001, from 75.22 to 76.3. Given this seeming paradox in Cuba's health care system, I reiterate Dunning's question: "How did the health-care system, which was deeply compromised by economic contraction, nonetheless produce an improvement of basic health indicators?" (2001, 1). Dunning provides one of the most compelling attempts to explain health care outcomes by examining patterns of resource allocations in the context of state spending and Cuba's dual monetary economy. He argues that from 1989 to 1999, the quantitative success in basic health indicators can be attributed to the state's concentration on resources for "health care within the internal, Cuban-peso dominated sector" and "the expansion of the family doctor system, primary care and other low-tech but human-capital intensive investments" (2001, 1). This idea resonates with the opinions of several health professionals I interviewed, who suggested that Cuba's vital health statistics, the infant mortality rate being the most widely referenced, was an embodiment of their hard work and daily sacrifices. However, while persuasive, this argument has several limitations. The focus on resource allocation in the form of human capital is one aspect of a much more complex series of processes. The MEF program is dependent on salaried family physicians working within the peso economy, who are essentially clinicians and who in

most cases have very little equipment or medicine at their disposal. The MEF physicians' primary goals are health promotion and disease prevention, and their role is to identify health problems that can be referred to more specialized institutions. In this respect, the expansion of the MEF program at best played an influential role in maintaining Cuba's basic primary health statistics, if only because of these physicians' efforts to mobilize communities around health education (for example, the education campaigns geared toward infant and maternal health).

The relationship between the increasing role of medical intervention (or between the level of expenditures in health care) and mortality and morbidity rates are questionable.[16] Vital health statistics are influenced by several factors, including, but not limited to, nutrition, sanitation, the general standard of living, and medical care.[17] In this respect, an analysis of Cuba's resource allocation and funding patterns neglects other important factors that occurred in Cuba from 1989 until the present, namely, the role of individual Cubans in negotiating their own health and well-being. Rather than falling prey to statistical fetishism or an analysis of the achievements of the health sector as if they existed in a vacuum, one must look beyond the raw numbers achieved in Cuba's population health profile. The período especial called into question the moral legitimacy of the state, and it had indelible social and political consequences for both the revolutionary government and the popular support citizens and health professionals gave it.

One area among many that could considerably influence the health sector was the everyday practices of individual Cubans who, during the same period, were ingeniously maneuvering through other sectors of the economy that were undergoing state reform; for example, the legalized circulation of dollars, changes in U.S. legislation allowing remittances to be sent to the island, the opening of U.S.-dollar stores, the expansion of pharmacies and international clinics that catered to tourists and Cubans alike, and changes in laws allowing Cubans who lived abroad, especially Cuban Americans, to visit their friends and families on the island.[18] Within this broader context it becomes apparent that the very fabric of Cuban society, including the practice of medicine, was undergoing broad social and political changes.

In the following vignettes, I examine the various ways in which individual Cubans and primary health care physicians are negotiating macroeconomic changes in their everyday lives. I present the experiences of individuals in their designated health area (*área de salud*) that is attended to by MEF physician-and-nurse teams stationed in small clinics known as *consultorios del médico de la familia.* The vignettes reflect a growing reality among a number of people whose access, or lack thereof, to foreign currency has shaped their everyday experiences in the city of Havana.

CONSULTORIO SAN LÁZARO

Living in a small two-bedroom apartment with her mother, husband, and son in a rundown area of central Havana, Isabella Esparza discussed how her daily struggles with the primary health care system resulted from the massive changes brought about by recent macroeconomic problems and the widespread corruption that had ensued. Her mother, Adelfa Castillo Esparza, was paralyzed on the left side of her body and in need of regular checkups and medication. Castillo was unable to walk, so the family physician had to visit her house on his local afternoon rounds. As Esparza stated,

> I can't take my mother to the consultorio because she cannot walk, and to carry her there I have to bring the wheelchair down three flights of stairs. Then, I would have to carry my mother down. Of course, for whatever emergency, I call the consultorio. Sometimes they come. Other times, they tell me they cannot come. More often than not, they do not actually come. When they arrive, they often do not have a stethoscope or equipment to take blood pressure. It is like, why come then? I understand, though, there is no motivation to do the work they are supposed to do. Imagine, they make four hundred pesos per month. That is about twenty dollars in *divisa,* which is not enough to buy anything. The médicos work with nothing. The conditions they work in are horrendous. They often do not have papers to write out prescriptions, worse yet, they know the drugs are not available, and so they cannot solve the most basic problems that physicians should be able to solve. I have never solved any of my mother's health problems at the médico de la familia. The médicos are just like us; they have to take the *camello* [a long bus mounted on a flatbed truck] and make a living. There is no incentive to go door to door anymore.
>
> If it wasn't for my friend Robercito, who works at one of the major hospitals and basically works out everything, you know, from behind—that is how things work now—what would I do with my mother? My aunt in Miami is really the one who sends my mom the money to buy the foods for her special diet, and the drugs and sterilized needles I need to inject her medication. I

> have learned to administer the drugs myself. That is what things have come to these days. Do you understand me? I think when the médico de la familia was started up, it was able to do its job because at that time the equipment for sterilization and the basic medical tools were readily available for physicians to do their jobs effectively. However, you have to remember in 1984, when the program started, there was not an economic crisis. The year the economic crisis began in 1990, things started to fall apart. After the período especial, the médico de la familia couldn't do injections because there were no sterilized needles; there was no alcohol for disinfection; if you needed cotton or bandages you had to bring your own. Slowly, the médico de la familia no longer solves our problems.

Esparza's narrative reflects the concerns of several of the citizens I interviewed, including the family physicians themselves. As several family doctors made clear, they are forced to work with severe limitations and, at times, feel that their role is more that of a social worker than a health care provider. As one physician in Esparza's neighborhood said, "People do not respect us like they did before. Now, we cannot solve even the most basic problems. I have to look into patients' eyes and say, 'Sorry, I do not have needles,' or 'Maybe you can get a relative who lives abroad to send you this certain kind of medication.' For me, these are hard things to say. Basically, you have to learn to invent something out of nothing." This physician, however, was blunter than several other physicians I interviewed, who evaded the topic by choosing to use oblique phrases like, "We make do" or "Things are tough, but Cubans are notoriously inventive."

Rather than passively accept the massive shortages of important medications and supplies, however, Esparza was very methodological in her ability to ensure her mother's health care. Having given up her job as a factory worker several years earlier to take care of her mother full-time, Esparza has been fastidious in making contacts at various institutions and pharmacies in order to help facilitate her mother's care. Esparza had created a socio in strategic places. She would take coffee to a local pharmacist, who in return would save her the essential drugs that she needed, when available, to be purchased in Cuban pesos. As an anthropologist, I was not exempt from being part of Esparza's network of contacts. She often called on me to purchase prescription drugs at international pharmacies by using my passport (see chapter 6). In addition, when I was in Canada Esparza managed to write me through her son's university e-mail address, asking me to bring a range of medicines and medical supplies, several of which I was unable to obtain without a prescription. Instead of consulting with her designated family doctor for regular checkups, as stipulated in the MEF program, Esparza would call her friend, a physician in a large hospital in the city center, and get him to attend to her mother personally.

Subsidized peso taxis, historically designated for taking patients to the hospital for their health appointments, were now involved in the thriving private informal economy and operated as *boteros* (illegal taxis that charge ten to twenty pesos to go between specific locations), so Esparza relied strictly on tourist taxis that charged in U.S. dollars to pick her and her mother up from her house, take them to the hospital, and then drop them back at home. For a small tip (*propina*), the tourist taxi drivers would often help her mother up and down the stairs of her apartment building. Dependent on the monthly remittance from her aunt in Miami, who sent anywhere from eighty to one hundred dollars a month, Esparza washed clothes and cleaned apartments for people in her building to earn extra money to meet her mother's health care needs. Esparza's husband, a *militante* (Communist Party member) and a former member of the Fuerzas Armadas Revolucionarias (FAR), was unhappy that his wife was working, essentially as a maid, and constantly reminded her that the government had worked years to overcome such class-based inequalities.

Frustrated, Esparza argued that despite her informal activities she was still a *revolucionaria*, but her mother's health came before politics. On the various occasions that I spoke with Esparza, she would always respond to my standard greeting, "How are you?" with her characteristic phrase, "I am still here, my dear, luchando." Esparza's son was in his last year of university and was studying immunology. Legally, he could not work while registered in school, and he, too, was dependent on the remittances sent from Miami to buy his school clothes, books, and meals at school. The end of every month, when Esparza's son picked up the Western Union money transfer from her aunt in Miami, was always fraught with tension for Esparza. As she remarked, her son demanded more and more money to purchase brand-name clothes and shoes, now sold at the dollar stores (*shopin*). While critical of her son for trying to "live like a capitalist," Esparza was upset that the state was selling overpriced consumer goods in U.S. dollars to a population that was, for the most part, officially paid in Cuban pesos. As she said, the state has

created unreasonable and in many cases unobtainable desires among young people. Esparza remarked that young people, in addition to a growing number of adults, wanted the consumer goods that were increasingly visible in contemporary Cuban society. "In the 1970s and 1980s," she said, "everybody basically had the same kinds of things with little variation. People had Soviet-style boots, the same kind of pants and shirts, and so on. But now, we have kids with brand-name clothes sent from their relatives abroad and American movies every weekend on TV, with the latest stuff. These things have an influence on el pueblo."

Esparza's husband, Ramón Crespo, a fifty-five-year-old retired military lieutenant, despite his assertion that he did not want to be formally interviewed because he did not have much experience with the health care system, often participated indirectly by offering a sort of armchair commentary while, on one occasion, he sat watching a baseball game on television. Asking to speak to me one day, Crespo offered me a glass of aged whiskey, sat down with me, and explained why people in general, particularly young people, should value *la Revolución*. Crespo, who had no relatives living outside of Cuba—something he was proud of—had great disdain for his wife's extended family that had fled Cuba to the United States in the early 1960s and often referred to his wife's relatives in Miami as the *gusanera* (worms).[19] Crespo made it clear that the remittances his wife's aunt sent were strictly for his mother-in-law's health care needs, and he saw none of that money. In fact, he refused to allow his wife's family to come to his home when they visited from the United States, and he refused even to greet them on the phone when they called. Crespo argued that although the Cuban government was going through a hard time, in recent years things were slowly changing for the better.

Unable to live on his state pension, Crespo, with the help of the FAR, had recently returned to work as a manager of a distribution warehouse for a popular chain of state-run stores. His company regularly awarded him vouchers—material incentives to reward him for his good work. The vouchers could be redeemed in dollar shops and allowed him to purchase electronic goods, bedroom furniture, and, more recently, a new washing machine, all for Cuban pesos at one-for-one U.S.-dollar prices. For example, his new washing machine, valued at two hundred dollars, was purchased with a voucher for two hundred Cuban pesos (ten dollars). The government cared, he argued, for those who worked well and were dedicated *revolucionarios*. Crespo was involved in several of the mass organizations and regularly participated in voluntary labor campaigns. Throughout the years, the local Comité de Defensa de la Revolución had presented him with various medals and certificates of accomplishment for his revolutionary activities. The problem with the health care system, Crespo noted, was the deteriorating values of health professionals, who were tempted by desires for material wealth and had fallen into the trap of making money on the side through informal practices.

Esparza, whom I interviewed on several occasions without her husband present, felt that her husband was out of touch with the reality of el pueblo. She said the state was taking care of select people, especially Communist Party members and people in the military. However, as she said, while she was fortunate to have some material luxuries provided through her husband's job, the rest of el pueblo was left to fend for itself. In prerevolutionary times, Esparza remarked, her mother was an associate of the Spanish insurance scheme known as *mutualistas* (see chapter 3).

> In those days, my mother was attended to by La Covadonga Hospital, which la Revolución renamed Salvador Allende Hospital after the assassinated Chilean president of the same name. I recall when I was six or seven my mother had a uterine infection and was treated there. Everything was beautiful and the staff provided you with everything, including well-cooked meals and clean linen. I am not a racist, but blacks were not allowed in specific sections of the La Covadonga, and there were certain standards of hygiene. Now, if you go to the same hospital you need to bring a bottle of bleach to clean the floor and you see roaches everywhere. My mother went there two years ago and the service was horrible! I would never go back.[20]

Esparza's discussion reflects her critical stance on the state's current inability to provide equitable social and health welfare; however, she is also nostalgic and optimistic about the semiprivatized health care system that existed in the prerevolutionary period, in which, as she stated, "You got what you paid for."

Esparza's and her husband's experiences reflect the challenges faced by individual citizens in the context of massive social and economic changes. Esparza is torn between her commitment to la Revolución and her firsthand experiences with a health care system that is rife with massive shortages and that has required her to become increasingly vigilant in working through

socios to secure services and resources in a system overrun by informal practices. However, although Crespo has less direct experience with the health care system, his narrative is equally important. The ideas and values he discusses reflect sectors of the Cuban population that, despite tremendous social upheaval, hold steadfast to the objectives of la Revolución and see the recent turn of events as a temporary product of the effects of U.S. influence—an influence, Crespo argues, facilitated by the return of Cubans living abroad and the money they send to promote capitalist values in an attempt to subtly undermine la Revolución.

CONSULTORIO LAS VEGAS

María Menendez, a family physician in her late thirties working in a neighborhood in the municipality of Plaza of the Revolution, was assigned to a relatively affluent área de salud (health area). Popularly known as Las Vegas, Menendez's área de salud was made up of about six hundred people, the majority of whom were involved either directly or indirectly with the tourist economy. Menendez remarked that a large percentage of her patients have family members living abroad, which made her job easier. As she stated, "Cuban people always have a socio who can resolve their problems in one way or another, so really my job is to identify the problem and let them work to find the solution. Really, that is all I can do." I was in a privileged position for carrying out research in the consultorio Las Vegas because I lived in close proximity to many of Menendez's patients and encountered them daily in the market, at the local dollar store, or, more often than not, buying prized food items from the same vendors in the private informal economy.

The neighborhood of Las Vegas had a high concentration of people with access to U.S. dollars, perhaps because it is was home to foreigners who live in state-licensed housing; it also had many wealthy apartment owners who earned as much as four hundred to six hundred dollars a month renting out their homes. For these reasons the area was a prime target of various vendors in the private informal economy. A regular topic of discussion in Las Vegas was the availability of various foods and medicines from informal contacts recommended by word of mouth to different clientele. In the building where I lived, for instance, several of my neighbors had put vendors at ease in my presence by informing them that *"está en confianza"* (he can be trusted). Although I was a stranger and a foreigner, they knew I was not going to report them to the authorities.

As word spread to other vendors in the area, I ended up purchasing the majority of the food I consumed at my front door, from men and women selling everything from first-grade beef, lobster, and shrimp to milk powder, cheese, and eggs. All of these products were sold at prices considerably cheaper than at the local dollar stores, although in many instances the items being sold, for example, state-regulated lobster and beef, would bring jail sentences should the vendor be caught. At first I was uncomfortable making these transactions, but I quickly got over any conflicts of conscience, especially seeing that the local shopin carried a selection of liver, gizzards, chicken backs and legs, canned goods, milk, beverages (alcoholic and otherwise), and other packaged consumer goods that were often overpriced and, according to the labels, already expired. The other option, the diplomatic store (*diplotiendas*), was a considerable distance away, and the prices there were often exorbitant. While I was less concerned with purchasing medicine and medical supplies, as a *persona de confianza* I quickly tapped into the reality that Las Vegas was also home to a large-scale informal economy of people selling *pastillas* (pills), which were often stolen from the local pharmacies or were sent from abroad in their original packaging. These medications were usually sold per pastilla, with the foreign-produced drugs and nongeneric brands being sold at significantly higher prices.[21]

In one local pharmacy, a forty-five-year-old woman I interviewed, Margarita Pérez, who lived in my building, tried to buy vitamins without the required prescription and was told they were sold out. However, the pharmacist added, there was another brand of vitamins available for ten pesos, if she was interested. Pérez, knowing full well that the normally subsidized vitamins and drugs, which rarely cost more than one to two pesos, were being appreciably hiked in price, decided it was the best way for the pharmacist to turn a blind eye to the fact that she had no prescription. I regularly bought cold and flu medicine and antihistamines, several of which theoretically needed prescriptions, directly from the peso pharmacies. I often simply asked for what I wanted and, if asked for a prescription, made up some excuse about not going to the doctor; I usually paid anywhere from ten to forty pesos, depending on the pharmacist.

This routine, Pérez claimed, was common. However, she argued, it also undermined centrally planned resource distribution. As people seek out drugs, medical supplies, and other health-related supplies and services in other health areas, the local pharmacies, clinics, and hospitals find them-

selves burdened with heavy caseloads and dwindling supplies that are often funneled into black market networks and not to those individuals who follow official channels. Pérez later stated, "I do not understand how the state can say drugs are not available when some of these very drugs are made in Cuba. It is like you go to the local pharmacy with the prescription, and they say sorry, we do not have that in stock. Then you walk one block and people are selling the very same drugs, made in Cuba, on the street! Where are they getting the drugs? You understand, people are stealing the stuff and everybody knows."

Several of the individuals I interviewed in Menendez's área de salud were regularly both buyers and sellers of pharmaceutical products and medical equipment. Often bringing the doctor *regalitos* (little presents), many of these patients stressed that the gifts were tokens of appreciation because Menendez often prescribed medicines that she knew were not available in local Cuban pharmacies—at least, not for sale in pesos. Meybol Tomas, a sixty-five-year-old diabetic who lived in Menendez's área de salud, for example, made frequent visits to consultorio Las Vegas with her foreign-purchased medications. Tomas wanted Menendez to translate the complicated instructions and warnings on the package from English into Spanish. Furthermore, she wanted Menendez to advise her on the other medications her overzealous relatives in Miami had sent her, which, they indicated, "were also good for diabetes." Tomas, unlike many of the other residents I interviewed for this book, was cautious before taking too many drugs based on word-of-mouth advice. Menendez used these visits to stress the importance of diet and exercise in Tomas's daily routines. As Menendez indicated, "My consultorio is packed, and it is often to give people advice on how to use the drugs they already have in their possession. I always warn them of the dangers of self-medicating, but historically, Cubans have been known for their obsession with taking pills for everything."

Many of the physicians were well aware of the proliferation of informal trading in pharmaceutical drugs and medical supplies. This situation, they noted, resulted in increased self-diagnosis and self-medication. For example, a large percentage of the individuals I interviewed bought their medications without a medical prescription, directly from the black market (*bolsa negra*), many without consulting a family physician. This is not to suggest, however, that this process of self-diagnosis and self-medication does not have serious consequences. For example, the dangerous misuse of antibiotics or the reality that a serious medical problem may go undetected and untreated was troubling. Surprisingly, though, many of the interviewees stated that they felt comfortable with this way of doing things and saw themselves as active consumers in addressing their individual and family health needs. The family physicians of many of these people were used as a means to an end in a complex network of contacts, often reduced to writing prescriptions and advising people on the correct usage of various medications.

Several of the physicians also used consultations to admonish their patients for naively self-medicating without the physician's direct instructions. The physician's admonishments, for the most part, fell on deaf ears, as individuals increasingly claim control of their own health care needs. For instance, the health expenses of those people I interviewed who had access to U.S. dollars ranged from ten to eighty dollars per month for the purchase of medication, vitamins, and other health-related products. Those individuals who tended to spend more money on health care expenses also tended to suffer from chronic illnesses such as asthma, diabetes, or cardiovascular-related problems. These individual health care expenses are significant when put in the context of the average official state salary of a Cuban, which in 2001 was approximately 180 to 200 Cuban pesos per month ($8 to $10). Individuals I interviewed made it clear that they were increasingly forced to seek out U.S. dollars, whether through remittances or the informal economy, to meet individual and family health care expenses. This practice is supported by national studies of Cubans in the diaspora that examined their intended purposes for sending remittances to the island. They were found to be, in declining order of importance, health care needs, consumer goods purchases, home improvements, and small-scale business ventures.[22]

It would be unfair to suggest that individual Cubans do not have health care options in the Cuban peso economy and must instead resort to private informal activities. To lose sight of some of the health care system's achievements would be misleading. One woman I interviewed, Eva Castañeda, a fifty-four-year-old woman who lived in a remote rural area an hour outside of Havana, had undergone a heart-valve replacement two years earlier. Having no access to U.S. dollars, she expressed little interest in politics and stated that, despite being poor, she still had access to health care, from the most basic to the most advanced. She added, "The kind of surgery I got would have cost nearly $20,000 in the States." She mentioned this several times, repeating what her doctors had told her at the Cardiology Surgical Hospital

in Havana, where her surgery was performed. While relatively apathetic toward la Revolución, she openly criticized the U.S. government and was convinced—on the basis of images from documentaries, frequent on Cuban television, that feature the U.S. government's problems with drugs, racism, illiteracy, and health care—that a person like her was better off in Cuba. In the more than one hundred interviews I carried out in various municipalities, all the individuals expressed respect and admiration for a health care system that did not have barriers based on gender, race, income level, occupational status, religious affiliation, or sexual orientation. What upset people was the disintegration of the quality of services provided, including the sporadic availability of important drugs and medical supplies, compounded by long waits and increasingly unsympathetic health professionals.

My personal experiences of Cuba's local health care system, as opposed to an international clinic, provides a good example of the severity of complaints being expressed by individual citizens. One evening, suffering from a severe allergic reaction to a strange mildew that emerged from an old Russian air conditioner in my bedroom, I arrived in the emergency room at the local Calixto Garcia Hospital and went directly to the ear, nose, and throat specialist. Despite the insistence of a friend who had accompanied me that I invent a more Spanish-sounding name so that, as a foreigner, I would not be charged the U.S. consultation fee, I resisted. The Cuban government offered free medical and dental assistance to students who are classified as temporary foreign residents, which I was at the time. Clearly, the deteriorating appearance of the hospital and the dismal-looking examination room paled in comparison to the ultra modern U.S dollar international clinics. Appearances aside, the specialist attending me conducted the physical exam with great care, writing extensive notes on a piece of scrap paper and determined that I had inflamed sinuses. She prescribed antihistamine nasal drops and sent me on my way. I picked up the medication, manufactured in Cuba, at the hospital pharmacy for seventy-five *centavos* (less than five U.S. cents) and left the hospital less than fifteen minutes after entering. My symptoms were gone within three days.

While my Cuban friend profusely apologized for the conditions of the hospitals and recommended that I go to the international clinic for more personalized and friendly attention, I told him I could only dream of being attended to in an emergency room in a hospital or even a doctor's office in Canada in such record time. While my experience is anecdotal, it is nonetheless important to stress that, despite some of the changes brought about by the período especial, the health care infrastructure and human resources remain in place. Furthermore, those individuals with no access to U.S. dollars are not simply left without basic health services. The circulation of foreign currency, however, has meant that individuals who have access to dollars can now strategically exploit the two-tiered health care systems: one in dollars and the other in pesos.

PRAGMATIC STRATEGIES AND NEW AND OLD SUBJECTIVITIES

In this period of the building of socialism, we can see the *hombre nuevo* [new man] being born. **Ernesto "Che" Guevara,** *Man and Socialism*

The Cuban ethnologist Miguel Barnet has recently bemoaned the arrival of a "new type of Cuban . . . a sort of anachronism," resulting in people "who want to be capitalists but don't know what a capitalist is. [They] want to imitate the Cuban of the 1940s and 1950s, but with the achievements of socialism" (1995, 30). Barnet's pronouncement is clear: the birth of this hombre nuevo in Cuba's current social and political milieu is a step backward. I argue the opposite. The emergence of these new subjectivities, what I call *pragmatic subjectivities*, is expressed by individuals negotiating and, in some cases, manipulating the very contradictions of the state itself. In this respect, the recent economic crisis has served as a catalyst for the emergence of new subjectivities and the reemergence of old ones in the island's changing social and political landscape. Despite this shifting terrain, the Cuban government has been adamantly opposed to describing the current sociopolitical climate in the country as late socialism, let alone as postsocialist.

The increasing reliance on social relations, or *sociolismo*, has redefined and challenged the historic relationship between the individual, the family, and the state. Individual citizens forging social relationships based on material interests have reformulated some of the informal values of Cuba's prerevolutionary past, as Barnet notes above, and have combined them with a pragmatic twist to confront the new challenges of everyday life. The rise of such pragmatic subjectivities, maneuvering through the vicissitudes of the state's crumbling welfare system, are shaped by gender, local classifications of race, and local and translational ties to relatives and friends, both on and off the island. They are also, most certainly, historical narratives of the intimate

and corporeal ways in which the past is embodied and rearticulated in the present.

Prior to 1989, 94 percent of the workforce in Cuba was employed in state enterprises; workers were divided into about twenty salary categories with fixed remuneration matched by subsidized consumer goods. By 1996 the percentage had shrunk to 78, and a significant portion of the population had moved into the private, mixed, and cooperative sectors. Relatively high amounts of market-based wealth and power began to be concentrated in the hands of a small group of people, especially in economically expanding regions such as those catering to tourists. Cuba's economy of remittances also contributed notably to the growing income disparity among groups in the population.[23] Official figures estimate that remittances increased from a reported fifty million dollars in 1990 to over nine hundred million in 2005, representing a large infusion of foreign currency circulating in the hands of individual Cubans during the período especial.[24]

In spite of the government's assurances that socialism was still intact, the unintended consequences of the new reforms in the health sector and beyond have created a situation wherein Cubans without regular access to dollars now look with envy at the minority, who can enjoy the fruits of the dollar economy.[25] The reality created by this situation leaves many individuals bitter, especially those who have dedicated their lives to la Revolución and have now witnessed the removal of barriers to the development of economic inequality. Such disparities have threatened to resurrect the social divisions between different ethnic groups in Cuba. Cubans of color are not only less likely to have relatives who have emigrated, a source of dollars through remittances, but are also, owing to a resurgence of racial discrimination and prejudice, less likely to be hired in many of the joint-venture businesses operating in Cuba, backed by foreign investors.[26]

It would be impossible to discuss these events without addressing the way in which la lucha of everyday life is increasingly and disproportionately gendered. As the state slowly receded as the sole provider of the political economy of health care, women have been increasingly forced to fill this role in their homes. Historically, state public health campaigns of the past, infused with paternalist language, comforted expectant mothers and their families with phrases such as "For This Child That Is To Be Born. We are all caregivers."[27] At that time the message was clear. The state would assume the primary responsibility for the welfare of the citizenry as a right to which they were guaranteed. The moral character of past state campaigns carries considerably less material and rhetorical authority in the present day, particularly as women are forced to navigate formal and informal networks in pursuit of their families' basic needs. The gendering of la lucha speaks to the limitations of the socialist government's policies concerning gender equality in the workplace and at home. Historically, the vestiges of entrenched gendered practices and gender inequality in Cuban society were at the forefront of the country's mandate for socioeconomic development. While the country made considerable headway in ameliorating many of these inequalities, many undoubtedly remained, if only under the radar.[28] They are now more pronounced and solidified.

The population, which had grown accustomed to the privileges provided by the cradle-to-grave health and social welfare system, which was intimately tied to social and economic equality, is now witnessing a chipping away of the foundations of that system. As a result, individuals are becoming active in addressing and administering their own health care needs and, despite the state's disapproval of these practices, they pragmatically rationalize their actions by drawing on the state's socialist discourse of access to health care as a basic human right. People view themselves as filling in the gaps created between the state's rhetoric of health and social welfare and its inability to actually provide these services. In many instances, *lo informal* in the health sector, as constituted through individual bodily practices, operates in parallel with the objectives of the state's health care programs: for example, in seeking necessary medications and medical supplies through remittances and socios. In other instances, individuals undermine the institutions of the state by siphoning limited resources away from official channels to informal networks, which leads to increases in self-medication and autonomous practices.

The state's withdrawal from various sectors of the economy, not simply health care, has encouraged the development of informal practices and alternative forms of social networking, which are gradually replacing the state as the sole means of addressing the problems of everyday life.[29] These sinuous ties that weave diverse groups of people together, crosscutting personal, institutional, familial, state-sponsored, and private spheres, constitute the micropolitics of health. They have become part and parcel of the so-called normal functioning of Cuba's socialist health care system. In recent years Castro's pronouncement that "socialism is under siege" and his calls for

the population to luchar, have been effective in the health sector, although the results have not unfolded in a teleological fashion. It has become increasingly difficult to disentangle practice from ideology as individuals, physicians, and health officials juggle multiple subjectivities in the pursuit of positive health outcomes. While it is self-evident that many individuals luchan for their own bodily health and physical well-being and for those of their family members, what is less evident is the way in which these practices contribute to the perception that Cuba's primary health care system is a success.

2 EXPANDING THERAPEUTIC ITINERARIES

At the very beginning of my formal research in Cuba in July 2000 I rented a small apartment in a quiet residential area of Havana. The owner of the apartment, Trinidad López, a sixty-year-old retired nurse, was eager to rent to me, although she did not have a state license to legally rent to foreigners. Hoping to avoid paying the high rental tax to the state, she explained to her inquisitive neighbors that I was her *sobrino* (nephew) from the countryside. Packing up a few of her things, she left me a set of keys and instructed me not to open the heavily barred front door to strangers. In the event that I absolutely had to open the door, for instance, to pay the electricity or water bill brought by the door-to-door state collectors, she told me to speak as little as possible and direct the collectors to her neighbor's apartment. Her neighbor, whose outdoor patio was adjacent to my own, was aware that I was a foreigner, despite López's claims that I was related to her. Her neighbor went along with the act and politely turned a blind eye to the holes in her story.

As if to test López's explicit instructions not to open the front door, her neighbor and persistent friends always came knocking in hopes of getting her advice or a chance to discuss the eight-foot Santería altar built into the closet of my bedroom. The altar, always full of offerings and holding over fifteen round ceramic jars, each representing a particular *orisha* (syncretic Yoruba-Catholic saint), required frequent propitiation and maintenance. While I had initially thought of the ritual objects in my closet as not being relevant to my research into the primary health care system, it was obvious from the visitors to my apartment, who often gave detailed explanations of what they were hoping to obtain by consulting with López, that, for them, issues of health and well-being were intimately interconnected with spir-

itual and material well-being. It was not until several weeks later, when I acquired my state research visa and moved into a new apartment building that was registered with the state housing authorities, that López's altar in the closet took on greater meaning. Again, I saw people coming in and out of my new building to consult with one of my neighbors, Angela Ulloa, a *santera*, or practitioner of Santería, to solve both health-related and spiritual problems.

MAMÁ OCHÚN

I met Angela Ulloa in an unconventional manner.[1] One day, as she was washing sheets on her back terrace, which was parallel to my own, we struck up a conversation on the nuisance of the people selling black market goods at our doors. An older woman, Ulloa was vivacious and used crude body language to express her points, often punctuating her rough street Spanish with English phrases for my benefit. She was born in Santiago de Cuba in 1938 and in 1960 moved to Havana with her husband, who was a former rebel fighter in the M-26-7 (the 26th of July Movement), also known as a *combatiente*. The revolutionary government had awarded Ulloa and her husband an apartment in the fashionable Havana municipality of El Vedado, one of the many apartments vacated by wealthy urbanites in the mass departure shortly after *la Revolución*.

Although she had little formal education beyond high school, Ulloa had little difficulty after moving to Havana, she told me, in integrating her life into the revolutionary movement and taking advantage of the many benefits such integration entailed, including retraining and adult education. Shortly after her arrival in the city she started working as the director of the janitorial staff at a local hospital. She kept one secret, though: she and her husband were both active practitioners of Santería. Being a believer, or *creyente*, in Santería meant that she and her husband had to be discreet about their faith in certain circles. Ulloa made clear that during the first thirty-five years of the revolution, that is, until the mid-1990s, one could not readily admit in public to being both a creyente and a *militante*. If discovered, such practices would be strongly frowned upon by the socialist revolutionary government and ultimately would result in some form of sanction by the party, if not the outright revocation of one's membership.

In the early 1960s, in line with scientific atheism—as part of the transition to communism—the government declared Cuba to be an atheist state and began a gradual program of repression of religious groups. For example, the Roman Catholic Church and other religious institutions were severely marginalized, and practitioners were forced to worship in private, often secretly. A rare collection of ethnographic studies by the anthropologist Oscar Lewis and his team of researchers details the everyday experiences of life in a Havana shantytown, providing one of the most personal accounts of life before and after the revolution.[2] The individual oral histories presented in these studies reflect the vibrancy and importance of religious forms, such as Santería, also known as the Rule of Orisha, or La Regla de Ocha, a syncretic complex of African beliefs and traditions and Roman Catholicism.[3] Since many slaves from Africa arrived in Cuba as late as the mid-nineteenth century, their African past was only a generation old at the time of independence. The Lewis studies chronicle how individuals, marginalized by the poor physical conditions of their squatter settlements, confronted the harshness of family life as well as the integral role Santería played in shaping their life experiences. The oral life histories also reveal the high levels of racial discrimination that prevailed in the prerevolutionary era. For example, the shantytown Lewis studied was believed to be a stronghold of *santeros* and perceived by many wealthier city dwellers to be associated with high levels of criminality, filth, and disease. This association was, in part, a colonial legacy that linked the terms *Africa* and *blackness* with inferiority, degeneration, disease, and contagion.[4]

Shortly after the revolution, Santería was dismissed as a folkloric practice and an impediment to the project of modernity and was valued only for its redeeming qualities in the form of public cultural performances. Santería, however, never required the institutional infrastructure of Catholicism and continued to exist in private throughout the revolutionary period. For example, Ulloa and her husband, like López, had a small hidden altar in one of the closets of their apartment. Despite the difficulties involved, they tried to maintain a close relationship with their orishas (pantheon of gods). The orishas, Ulloa noted, were very demanding and needed to be propitiated frequently. Meanwhile, life grew increasingly difficult for Ulloa. Her marriage became shaky because of her husband's alcoholism and the physical abuse she suffered as a result of it. Ulloa also discovered during that time that she was unable to have children, and she felt increasingly separated from her family in Oriente.

As an active member of the Federación de Mujeres Cubanas (Federation

of Cuban women, or FMC) and a local delegate of the Comité de Defensa de la Revolución (CDR) in her municipality, Ulloa stated that she became less dependent on having a man around the house for economic security, companionship, and so on. If anything, she noted, la Revolución was liberating in many respects because it gave people, particularly women, options. The majority of men, she argued, remained set in their ways, despite the revolutionary teachings that stipulated the egalitarian delegation of tasks, both inside and outside of the home. Women still carried the burden of domestic chores, in addition to revolutionary commitments, and this situation only made her marriage worse. As she stated, she did not want to be a housewife. More specifically, she had no children, and she was not going to be like her mother and be defined solely by her husband. Rather, Ulloa asserted, she would live her life alone and in the way she deemed appropriate, without the added burden of living with a domineering husband.

Divorcing her husband after twenty years of marriage, Ulloa sought a *permuta* (exchange) to switch her two-bedroom apartment for two separate one-bedroom apartments to enable her to start her life independently.[5] Securing a small one-bedroom apartment a block away from her former home, she began seriously dedicating her life to the secret worship of her orishas. She had lived the double life of a *revolucionaria* and creyente for many years, but the economic crisis of the 1990s marked a turning point in her life: "I could no longer live the hypocrisy of what it meant to be a revolucionaria." The economic crisis, she stressed, had forced creyentes, who often worshiped in secret, to become bolder in their desire to worship openly. Ulloa further noted that during the height of the economic crisis in 1993, the rhythmic sound of *batá* drums, the sacred drums used in Afro-Cuban rituals, could often be heard in the late afternoons before the sun set on her normally sedate residential community. The rhythmic Afro-Cuban drumming was luring the orishas to the mundane world, where santeros were asking their patron saints for help and guidance.[6] Also noticeable during the height of the economic crisis, she said, was a growing number of santeros in public places, both new and old adherents, often decorated in bright beaded bracelets and wearing necklaces that were visible outside their state uniforms. Seeking out protection to ensure their well-being from their respective orishas, individuals brazenly appeared in the streets of Havana, Ulloa said, adorned in the consecrated white- and blue-beaded chains for Yemayá or the red and white beads for Changó. Creyentes, she noted, were slowly beginning to openly proclaim their faith.

El Estado (the state), Ulloa stressed, appeared to react complacently to the reappearance of blatant religious accoutrements. Ulloa and several other santeros I interviewed agreed that it was a widely held belief that Castro was the son of Changó (*el hijo de Changó*), an orisha known for being a fierce warrior and the embodiment of virility.[7] In fact, Ulloa noted, police, physicians, and well-known party members, among other state officials, were regular participants at various Santería gatherings from the very beginning of la Revolución. The practice of Santería, Ulloa remarked, could not simply be explained away as the superstitious beliefs of an ignorant group of poor Afro-Cubans. The practitioners, she stressed, were from all walks of life. As was evident from the many gatherings Ulloa held that I personally attended, there was no clear sociodemographic profile that could accurately describe the diverse group of participants I encountered regularly in her living room.

In 1993 Ulloa retired and started to collect her state pension. Suffering from severe asthma and diagnosed with hepatic cirrhosis, she found that her health was rapidly deteriorating. The state, she declared, had failed her. Food items for her special diet, normally provided through her ration card, were increasingly unavailable for longer periods of time. Crucial things like an inhaler to control her asthma and vitamins and medicines to help alleviate the effects of her deteriorating liver function were quickly disappearing from local peso pharmacies—only to reappear, she added, at exorbitant prices in the *bolsa negra*. "People were becoming desperate and things were becoming critical for many people," she said. "People were drinking sugar water at the height of the special period, in 1993. That was one of the worst years of my life. If you wanted anything of value, you had to start buying it in *divisa*," she said. "I remember my doctor asking me if I had any friends abroad who could send me the important medicines I needed. I asked the doctor why—the government is supposed to provide these things. Everything was changing and the poor like myself, who had nobody abroad, were suffering."

Ulloa had always relied on the orishas for spiritual guidance. However, now she was looking to them for something more concrete: to meet her material needs. She recalled the day she asked her orishas for help: "When I stood in front of my beautiful Ochún, I said, Mamá Ochún, I need help

because I earn 127.40 Cuban pesos a month [U.S. $6], and with the special diet I have, and the drugs I need to buy, the money I have won't suffice. I don't have kids, and I can only ask my brother for money for so long before he says, 'Sorry, my sister, I don't have any more money to give you.' " Asking the *carcacoles* (a form of divination) to predict her future, Ulloa was comforted that Ochún would protect her. Help for Ulloa, she believed, came two months later in the form of an *extranjero* (foreigner) from Brazil. Rolando, an elderly man, had arrived in Cuba to become initiated into the religion of Santería. Angela met Rolando at his initiation ceremony.

In Rolando's ceremony it was determined he was a son of Ochún (also known as the Virgen de la Caridad del Cobre), the Yoruba and Santería goddess of sweet waters (river), love, and money, and the patron saint of Cuba. Naturally, Ulloa declared, they were drawn to one another because they shared the same patron saint, but, as she made clear, there was nothing sexual between them. Immediately after their friendship began, Rolando, a former federal judge in a small province of Brazil, started sending Ulloa from fifty to one hundred dollars a month, in addition to sending all her necessary medications and vitamins. With the influx of money, Ulloa grew fiercely religious. As she remarked, she was no longer willing to hide her faith in the closet and instead built an altar in her living room and started to worship her orishas openly. As she stated, she wanted to dedicate her life to Ochún and the other orishas.

Recalling another critical time in her life when she fell ill, Ulloa explained that she went to the hospital first but also consulted with her *padrino* (godfather or spiritual advisor in Santería), who looked after her spiritual well-being. Her padrino, in turn, used caracoles to diagnose and provide her with a spiritual therapeutic recourse. "I had faith that Ochún would not abandon me," she noted. She still believed in the "hard sciences," that is, biomedicine, but she also believed strongly that one could follow the treatment regimen for each tradition without any internal contradiction. "One system of belief is as important as the other," Ulloa stated, adding, "My doctor is aware that I am a santera. She is aware that I also seek out the advice of my padrino, and there is nothing she can do about it. The government cannot tell me what to believe. Take a look outside. How many people do you see at work, or more generally walking around the streets, dressed all in white with the beads openly around their necks? These are new initiates to Santería, and there are many, and the number of creyentes is growing. Before, when the Russians were here, this would be unheard of. Now, people need something to believe in. The *santos* will answer our prayers." This is because the state, Ulloa added, had stopped fulfilling its function, which she defined as providing citizens with the basic material necessities for life.

I visited the homes of several individuals who claimed to be atheist, and it was evident that some were uncomfortable discussing their religious beliefs; often they had small glasses of water, a typical offering to the saints, with flowers and candles strategically placed behind doors or on high shelves in their apartments. Moreover, when I attended several *fiestas de santos* (a party celebrating the day one became initiated into Santería), many of my apparently atheist friends, who claimed they were only there for the food and drink, danced correctly in step to the various Afro-Cuban rhythms and spoke with specialized knowledge with other santeros on the various ways one could appease a specific orisha. When I finally asked several of these supposed nonbelievers why, if they were not creyentes, they were interested in learning about these things, they admitted that they did not want to "tempt fate." Several people pointed out that it couldn't hurt if an orisha would help give them an edge when confronting the problems of everyday life.

Several of these same individuals stated that, informally, they were "pragmatic religious practitioners"; in other words, there was no harm in drawing on religion in times of crisis, as people the world over do. "It works," stressed a close friend of mine, a young physician and Communist Party member who aggressively defended la Revolución at every opportunity. He argued that Santería was another option for seeking out personal health and well-being. The inspiration for his renewed faith, he later revealed, was his mother's recent bout with cancer, which he believed was cured after she was initiated into Santería. At the time of his mother's illness hospitals did not have the proper drugs to administer chemotherapy, despite the physician's desperate attempts to work through *socios* to guarantee her stay in one of the best hospitals in Havana. His family members, who lived three hours outside of Havana, had not been creyentes before, but turned to Santería as an alternative.

In 2007, when I paid a visit to Trinidad López, who acted as a *madrina* (godmother) to a large network of younger santeros, she said she was a little surprised to find an increasing number of people turning to Santería in hopes of finding quick solutions to their problems, like asking the saints to help them "get papers to get out of Cuba." "The orishas," she remarked

ironically, "do not work in immigration." Although she spoke reservedly, López was nonetheless adamant that Santería could not be strictly reduced to a religion of give and take, in which people conducted magic spells to produce positive results. Building a relationship between oneself and las orishas, she stressed, is only possible with time. While an increasing number of people were becoming santeros, she noted, there was unfortunately no quick fix to their problems. López was a little disturbed by the apparently causal relationship between the recent economic crisis and the visible presence of creyentes.

This link between the increasing numbers of people being initiated into Santería and the crumbling of the state's provision of social and material welfare has been recognized before. The ethnomusicologist Katherine Hagedorn, who examined the aesthetic and ritual significance of Afro-Cuban Santería, argues that "the chance to *resolver* one's material problems is directly related to the swelling ranks of Santeros and Santeras in Cuba" (2001, 220). The term *resolver*, Hagedorn contends, implies relying on an informal network of people, both living and deceased, who may help resolve everyday problems. In this way, individuals from the spiritual world are added to one's network of socios. Beyond material necessity, however, which is not necessarily considered profane, as I was informed by various participants in Santería, one repeatedly propitiates the orishas in order to seek guidance and protection and to find solutions to everyday problems in the here and now, as well as for spiritual assistance in the future. I was told repeatedly in numerous interviews that increasing numbers of individuals are proclaiming a faith in Santería because it provides a tangible means to seek out immediate physical and spiritual well-being. The ability to change one's current life conditions is in opposition to clerical religions such as Catholicism or, increasingly in Latin America and the Caribbean, evangelical Christianity, both of which focus more on spiritual redemption and the afterlife.[8]

As was evident after Pope John Paul II's visit to Cuba in 1997, during which he publicly condemned both the socialist government for curtailing religious expression in Cuba and the United States for its embargo against the island, religious spiritualism has been gaining ground in recent years.[9] The Roman Catholic Church began to experience a resurgence of followers. The Cuban government previously espoused a militant atheism and embodied Marx's dictum that "religion is the sigh of the oppressed creature, the feeling of a heartless world, and the soul of soulless circumstances. It is the

FIGURE 1. Medicina tradicional y natural (MTN) pharmacy in Havana. Brotherton © 2006.

[opiate] of the people."[10] The state now turns a blind eye to open religious worship. I interviewed several physicians and one MINSAP official who were skeptical of religious healing and viewed people's return to *curanderos*, or what they termed *brujeros* (witch doctors), with disdain; however, I suspect that given the current climate of scarce resources in Cuba, they thought that spiritualism could also divert people's attention from growing economic inequalities. Yet one could equally argue that many of the individuals seeking out Santería for health and well-being would have done so previously, if the state had not carried out a passive campaign to eradicate this religious practice as "witchcraft." Given that Santería existed as an informal practice both before and after la Revolución, it is difficult to discern a single underlying motive behind the recent visible reemergence of santeros.[11] To date, no published study has systematically addressed medical pluralism in Cuba and, in particular, the role of Santería in people's health-seeking behavior in the *período especial*.[12]

The state's reluctance to denounce the return to religious practices is directly related to the ease and openness with which individuals are now exploring the health options available to them, without fear of state reprisal. In the following case study I explore how, in the context of the período especial, the socialist state, rather than individual citizens, is actively promoting the use of *Medicina tradicional y natural* (natural and traditional medicine, MTN) as part of a strategy, presented as benevolent, to offer the population more health care options (see figure 1).

While modernization campaigns throughout the world, including in Cuba, have resulted in the preeminence of scientific medicine, most commonly associated with biomedicine and also known as cosmopolitan medicine, the eradication of natural and traditional approaches to medicine in

many parts of the globe has proven difficult: "Economic necessity has, of course, been a driving force in sustaining this situation."[13] But in Cuba the revolutionary government has attempted, with partial success, to eliminate the class-based inequalities that denied people access to cosmopolitan medicine—irrespective of individual cultural beliefs toward different medical traditions—and has carried out various campaigns to marginalize medical traditions like herbal medicine, for example, that diverge from what the government believes is evidence-based medicine.

PRACTICING *"MEDICINA VERDE"* (HERBAL MEDICINE)

Miguel Nuñez, a thirty-four-year-old physician who pursued his medical training through the FAR, was stationed in various posts for the FAR as a military physician until the late 1990s, when he asked to be discharged. At that time, Nuñez wanted to pursue his research interests in the study of medicinal plants. This interest, he stated, was stimulated in part by a study he conducted for the FAR in the mid-1990s on the knowledge of medicinal plants among curanderos and santeros throughout the island. His study received a warm welcome among FAR scientists, although the general scientific community in Cuba still looks upon these practices as a form of quackery. However, Nuñez noted that FAR scientists had been carrying out clinical investigations of medicinal plants since the mid-1980s as a strategy to prepare the country for the possibility of war.[14]

Finding his role in the FAR limiting, Nuñez, who had worked closely as a personal physician for several high-ranking military officials and Communist Party members, requested to be transferred to one of the many state research facilities. Several weeks after his request, the FAR coordinated a research position for him at a research institute run by the Ministry of Science, Technology, and the Environment (CITMA), formed in 1994. Nuñez stated that the FAR had been very good to him, even awarding him an apartment in a prized area of the city center overlooking the waterfront. Nuñez's tastefully decorated apartment was formerly the home of another well-known research scientist who had defected while at a scientific conference in Mexico, eventually making his way to Miami. "I am a *revolucionario*," Nuñez told me, making it clear that, unlike the apartment's former owner, he was dedicated to la Revolución and for this reason deserved the luxuries afforded him by the state. Nuñez believes that the FAR was being especially generous to him in view of his relatively young age, perhaps in

recognition of his unique credentials: his title as a physician of MTN. He completed a master's degree in this specialty in 1996. At the time, he was one of few people who specialized in this area and was trained in Cuba, as opposed to abroad, where this form of specialization is more common.

In 1991 Nuñez was part of a unique group of physicians who benefited from the MINSAP's broadening of a narrower vision of science and medicine to incorporate the use of herbal remedies and therapeutic regimes into the biomedical model. This was accomplished under the newly devised Programa para el Desarrollo y la Generalización de la Medicina Tradicional y Natural (Program for the development and generalization of natural and traditional medicine). An executive report issued by the MINSAP in 1996, "Analysis of the Health Sector in Cuba," outlines the rationale for the newly devised program:

> The strategic objective of the National Health System is to give priority to the development of natural and traditional medicine. The "Program of Development," initiated in 1991, includes the search for active medicinal principals of plants, their clinical testing, and the subsequent generalization of the results so that they can be progressively incorporated into the techniques and procedures of the East Asian medical tradition. For the development of these activities, we have created a multisector commission that is presided over by the MINSAP and that integrates the Ministry of Agriculture and the Ministry of Science, Technology and the Environment, among others.[15]

While the MINSAP's strategic rationale behind the development of Cuba's program for MTN focused strictly on scientific inquiry, a report produced by the MINSAP in 1999 puts the recent developments in a more historical and socioeconomic context:

> Among recent trends in the practice of contemporary medicine around the world, one especially stands out: the inclusion of natural and traditional medicine [MTN]. The professional practice of MTN is not an alternative based on simple economic necessity, a solution to, say, a shortage of medical supplies. It is a true scientific discipline. We must study to perfect MTN and develop a lasting tradition by demonstrating its ethical and scientific advantages. This medical tradition can help correct the inequalities between poor countries and highly industrialized countries that have produced a worldwide pharmaceutical monopoly.[16]

The MINSAP reports show that natural and traditional medicine, which was previously marginalized by the state as an "occult science," is now being strategically pursued. However, conspicuously absent from the MINSAP reports was any mention of the reality of massive shortages in pharmaceutical drugs and medical supplies that resulted from the cessation of Soviet aid after 1989 and the strengthening of the U.S. blockade. The strategic pursuit of MTN is discussed in terms of the scientific efficacy of these practices, with no mention of the state's inability to provide pharmaceutical products, as it had previously done. As what constitutes scientific medicine in the global scientific community has changed, contributing to a new regime of truth, MTN in Cuba has become an acceptable and justifiable therapeutic avenue. As the MINSAP report further indicates, "MTN **does not constitute a form of alternative or complementary** therapy developed in response to economic problems. Rather, it is a discipline of scientific medicine."[17]

However, despite MINSAP's disclaimers, it is important to examine, from a historic perspective, the shift in the MINSAP's official policy. Nuñez provides a more detailed explanation of the reasons underlying the MINSAP's changed approach to MTN:

> I will say this, but I believe it needs to be said responsibly. The período especial was definitely a catalyst for self-reflection within MINSAP and other institutions of the state. Cuba is a poor, Third World country and without a financial backer such as the Soviet Union, we have to face certain realities that are characteristic of our kind of economy. When the MINSAP started to develop programs based on natural and traditional medicine in 1991, only a small percentage of people actually believed in it. I don't think it was difficult to convince people over time, since these traditions existed before la Revolución. Meanwhile, the international scientific community evolved over time, and I think MINSAP started to realize, in the decade of the 1990s, that well-respected institutions such as the WHO had approved thousands of projects for investigation with respect to natural and traditional medicine.
>
> Before 1959 *el pueblo* was syncretic and actively used natural and traditional remedies. But for certain reasons—I guess we can say errors committed by la Revolución—these practices were denounced as "primitive." La Revolución saw these practices as a kind of witchcraft [*oscurantismo*]. What happened in 1959, 1960, and 1961, at the beginning of la Revolución, was that all of the pharmacies with medicinal plants disappeared or were eradicated.

> Beyond that, all of the traditional healers such as curanderos and brujeros, who had a poor scientific reputation in the eyes of the state, were pushed underground. Of course, you could never say that the popular uses of these kinds of treatments stopped. Doctors and professionals are quite familiar with grandmother's home remedies. But at the institutional level, the direct actions of MINSAP, which controlled all levels of medical care and practice, including control of research within the country, effectively eradicated what we call popular medicine at the institutional level. If health professionals were found to be engaging in unorthodox medical practices, such as recommending herbal remedies to their patients, MINSAP would not take away their degrees, but it would sanction them. You also have to remember that, at that time, Cuba had significant ties with countries in the Soviet bloc. Our pharmacies were chock full of pharmaceutical products from these countries.
>
> I am sure that there are still health professionals in the upper levels of the MINSAP—people above the age of forty or fifty—who during the past thirty or so years were prohibited from using "popular medicine" and were never trained in it. I think these are the doctors, trained at the height of la Revolución, who are most disappointed to see a return to these forms of medical practice. However, the newer generations, trained in the late 1980s and 1990s, have confidence in these medical traditions. And you can see the older generations welcoming these practices because, quite frankly, they never stopped using them in private.

As Nuñez attests, he was convinced that the resurgence in MTN practices was, in part, associated with the country's decline in foreign pharmaceutical imports. While the knowledge of natural and traditional medicine is increasingly widespread among primary health physicians in Cuba, Nuñez was the only physician I interviewed for this book who had specialized in MTN. In the early 1990s, in an attempt to promote the use of MTN, the MINSAP distributed a national formulary and educational materials on "green [that is, herbal] medicine," compiled by seventeen scientists in medicine and biology, which was sent to practitioners throughout the country. Among other things, these documents discussed the pharmacological basis of traditional herbal remedies. Similar MINSAP materials were also directed at the general population. Local pharmacies featured colorful illustrated posters with the plants' popular medicinal names, their scientific names, and a description of their medicinal properties. In addition, all of the local pharmacies started to carry a

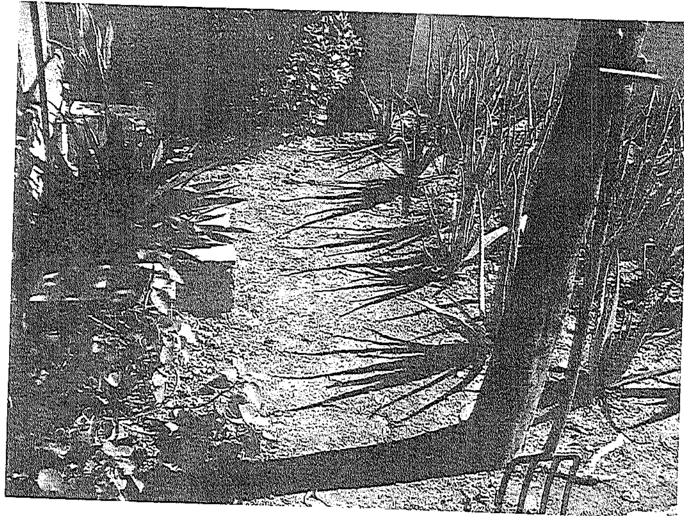


FIGURE 2. *Huerto* (garden) of medicinal plants. Adriana Premat © 2001. Reprinted by permission.

limited selection of bottled herbal remedies for sale in Cuban pesos. Not surprisingly, while the majority of the pharmacies I visited had a limited selection of pharmaceutical medicines, they carried a wide selection of herbal remedies for a variety of ailments, including treatments for colds, upset stomachs, and some antiparasitic lotions for external application.

The state's promotion of MTN has been mixed. While several of the citizens and medical practitioners openly embraced the integration of MTN, the majority I interviewed saw the medicina verde as a clear sign that the state was trying to cover up for a lack of pharmaceutical products it had been promoting zealously for over forty years. For example, when I visited a physician named Louis Pérez in his *consultorio*, known as Los Molinos, he had a dwindling supply of allopathic treatments, which meant he often had to send his patients directly to the local polyclinics for routine injections because, at times, he didn't have even the necessary needles. According to the MINSAP, the consultorio should have approximately twenty-six types of medicine on-site.[18] Pérez's consultorio had less than half of the medicines on the stipulated list. A small, unkempt plot of land on the side of the consultorio was used to grow a sparse garden of medicinal plants (such as that shown in figure 2). These herbal remedies, Pérez explained, supplemented and in some cases supplanted the dwindling supply of drugs he had at his disposal.

"Some are actually quite useful," he offered sardonically. He claimed that with the right knowledge of medicina verde, a physician could make efficacious treatments.

Unfortunately, the majority of the doctor's patients were proving hard to convince when it came to taking the herbal remedies. "When they come to *el médico* they want pills and needles. Generally speaking, if they want to use medicina verde they do not need to come and see me. I believe most Cubans are aware of herbal remedies either through word of mouth or from older family members," the doctor said. A patient I interviewed was frustrated after a visit with Pérez: "I go to the doctor for antibiotics to treat an infection and he gives me aloe vera or some kind of herbal calming tea. What on earth am I suppose to do with this? Yet I go home and watch Fidel on TV sending our doctors all around the world and providing free medical care. You can bet those doctors have the necessary drugs and equipment to take care of their patients. But what about us, *los cubanos*? All of these sacrifices? And for what, I ask?" A large percentage of the individuals I interviewed, while not against MTN, would not substitute them for the apparent wonders of pharmaceutically based medicine. Not surprisingly, many of the interviewees who were born and raised in the sixties, seventies, and eighties and were trained under the revolutionary pedagogy were forthrightly resistant to MTN. However, several older people I interviewed, including several santeros, had always incorporated herbal remedies into their religious practices and were convinced of the efficacy of MTN and even of acupuncture. A more systematic study would be necessary to identify specific trends that might throw light on the relationship between an individual's perceptions of MTN, on the one hand, and age and religious beliefs, on the other.

All the primary health care physicians I interviewed had a basic knowledge of MTN, in part because all medical graduates, including nurses and dentists, are required to attend training courses in MTN. Among the family physicians I worked with, several had to tend to small medicinal gardens, if grudgingly, that were located alongside their consultorios (figure 2). While few of the primary health care physicians were thrilled about their added responsibility as gardeners, in several instances community members, as part of the popular participation of the community in health-related affairs, had organized collectives to tend the herbal gardens. Nuñez elaborated on some of the challenges the new MTN program has faced from physicians and the wider community:

> The problem with the MEF program is that some of the médicos are not convinced of the use of medicinal plants, despite the fact that they have been well educated on them and understand their correct usage. There are other médicos, on the other hand, who do not know how to properly use medicinal plants. For example, some doctors believe that the popular use of medicinal plants sets a dangerous precedent. For example, people who do not know how to use these medications may take toxic dosages or experience secondary side effects because they don't understand the correct dosage and the specific ways in which MTN must be taken. In this respect, we have our work cut out for us. We still need to educate el pueblo more. These are traditions that have existed for years, but in Cuba we can't expect to learn them overnight.
>
> We don't have the experience of the Chinese, who have over five thousand years of practice. But while people still see a certain degree of conflict between Western medicine and traditional medicine, I don't doubt that they could coexist in Cuba. I believe that traditional medicine can actually be complementary to Western medicine. If you approach the matter intelligently, you can seek out both traditional and Western medicine and basically exploit the positive characteristics of each. In this way, individuals can ultimately obtain the same final results. We have had help from advisors in Cuba over the past ten or twelve years—Chinese, Vietnamese, Koreans, and some Canadians—who are very well known.
>
> Look at acupuncture, which arrived in Cuba around the 1960s. It was not very strong at that time, but slowly it has gained momentum. By the 1990s, acupuncture had become a strong tradition in Cuba. In my opinion, it is because it was a Chinese tradition and people could more easily believe in a tradition that was backed by history. There is a popular saying in Cuba, "If a Chinese doctor can't save you, nobody can." This saying emerged because Cubans believe the Chinese to have a very strong history in the development of medicine. However, medicinal plants have a unique history in Cuba. In Cuba, herbal remedies are associated with the black curanderos of Africa, and so you can see that people question the competency of those practitioners because of their racial origin. How could black Africans know anything about medicine, is what people think in the general population.

Nuñez provides a historical context in which to trace the influences on individuals' perceptions of various medical traditions. Several individuals I interviewed, while willing to try acupuncture because of its proven history as

a form of Chinese traditional medicine, were more skeptical of Cuba's fledgling herbal medicine program. The fact that herbal medicine in Cuba has been associated with the historic practices of the Afro-Cuban population has added to people's unwillingness to embrace it. Although the MTN program is being marketed to the population as the evolution of Cuba's health sector, the reality that the state's ideological shift in approach to basic medicine occurred just as the island was undergoing massive shortages in medicines and medical supplies seriously calls into question whether this strategic move was not a form of economic pragmatism. A more systematic study is needed to arrive at a definitive conclusion.

MEDICAL PLURALISM AND STATE-SANCTIONED SOCIAL WELFARE

Alberto Guerrero, a fifty-four-year-old physician and a former research scientist specializing in drug-transport mechanisms, worked as a family physician in a local polyclinic in a municipality of Havana. Suffering from stress, insomnia, and body aches and pains, Guerrero had been unable to get an accurate diagnosis for his medical problems. He was frustrated by the regular battery of tests he was subjected to and was recommended by another physician to an MTN and alternative-health clinic in Havana. He described his experience as follows:

> The doctor looked me over and used her hand to get a feel for my energy. She concluded that I was a violet person. Yes, violet, the *color*. The doctor asked me if I would think in violet. Of course I was a little taken aback. Another physician then entered the room, and he immediately stated he could feel my negative aura. He massaged the aura that was apparently emanating from my body and declared that I needed to be spiritually cleansed. When the consultation was over, the doctor very officiously wrote out a prescription for several herbal remedies, and another page outlining the specific uses, and dosages to be taken, and what I should do to cleanse my spirit. When I got the hell out of there, I thought, "Is this what medicine has been reduced to in Cuba?"
>
> The recent trend in using such questionable treatments in Cuba, similar to the trends occurring in other industrial countries, in one respect is disheartening, but also refreshing. The average Cuban out there has no access to U.S. dollars and has limited options when it comes to buying the drugs at the international pharmacies or getting them sent from abroad. These alternative

and herbal clinics are there to make these people feel better. Some people swear on their life that they actually work. The government, of course, likes this because it means people are not complaining about what it is not providing. The government is supposedly giving el pueblo options for medical treatments, when really what it is doing is hiding the fact that it does not have the financial resources to provide the population with pharmaceuticals or, worse, is selling them on the international market.

On a positive note—and I say this as a former research scientist—the recent crisis has opened the door to all kinds of innovative medical research, which the government previously did not permit. For example, I know a scientist—a good friend of mine—who is studying the effects of healing the body through positive thinking. Imagine! Of course, don't think the older established scientific community in Cuba is happy about all of this. Like me, they think all this MTN and alternative therapy stuff is rubbish.

While Guerrero is fairly critical of the recent promotion of MTN in the health sector, he views this recent trend as a kind of opiate of the masses, meant to appease the population when the state has nothing else to offer. In this sense, the state's promotion of MTN and its loosening of restrictions on religious practice, whether seen as positive or negative developments, must also be viewed as a pragmatic strategy employed by the state. It has emerged in part from the necessity of providing the population with health options and, ultimately, of shifting some of the responsibility for health and social welfare from the state onto the individual. For example, the anthropologist Steve Ferzacca, who examined health governance in the changing political context of Indonesia, argued that medical pluralism was employed as a form of state rule "disguised as state-sanctioned social welfare."[19] Extrapolating on Ferzacca, I argue that one must question the degree to which the promotion of MTN and alternative medicine, as Guerrero points out, is offered as a means to placate a health-conscious population that is slowly realizing that the state can no longer provide the same level of health care services as it did in the past.

The período especial has created a climate that allows individuals greater freedom to pursue natural, traditional, and alternative (and spiritual) therapy. However, as is clear in other highly visible spheres of the health sector, the state has been reluctant to relinquish control of some health policies. For example, maternal and infant care programs still mandate institutional childbirth and do not recognize traditional birth attendants, or midwives.

The Cuban government has made choices that are not all visibly driven by economic pragmatism, though this is not to suggest that a strategy is not involved. Since the early 1960s Cuban leaders have envisioned physicians as being akin to soldiers, though armed differently, in the island's historic battle against disease and suffering. For example, in an address to the nation in 2002, Castro argued, "Health care is one of the most sensitive areas through which our enemies tried to hurt our people. It is very logical that we Cubans aspire to lowering infant mortality; to extending the average life expectancy of every citizen; to combating disease; and combating death. There is no aspiration more legitimate than this one."[20] The implementation of public health programs provided the state with quantifiable means, like the infant mortality rate and increasing life expectancies at birth, by which to measure success and bolster domestic and international recognition of the revolutionary achievements of the state. In the process, the government expended considerable capital—financial, social, political, and symbolic—in strategically defining the terms and parameters of what constituted bodily health and physical well-being.

Part II

SOCIALIST GOVERNMENTALITY, PUBLIC HEALTH, AND RISK

Use me. . . . Cooperate with me to keep the city clean and healthy. Source: *Bohemia*, 26 February 1965: 108.

3 MEDICALIZED SUBJECTIVITIES

During my research I was regularly struck by the descriptive language people used to speak about their bodies and health. I met countless individuals, of different educational backgrounds and ages, who could discuss with a relatively advanced biomedical vocabulary the etiology and treatment of various illnesses; for example, the various kinds of parasites one can be exposed to, the symptoms one exhibits, and the specific drugs and dosages required to treat such infestations. Most people knew the names of drugs, either by their generic or brand name, the class of drug they belonged to (e.g., whether an antibiotic, anti-inflammatory, or hypertensive), and the corresponding treatment regimen. Moreover, many people were equally literate in translating the drug names of North American brands, mostly sent by relatives in the United States, to the equivalent drugs manufactured in Spain, Italy, or France and in mastering a dizzying array of treatment plans and dosages.

Many of the individuals I worked with throughout the course of my research had large collections of pharmaceutical drugs and medical supplies that far exceeded the contents of the average first-aid kit (figure 3). A woman who I interviewed at her home proudly pulled out her medicine drawer to show me how well equipped she was for any unexpected illnesses. Her collection included an array of *pastillas* (pills), including different classes of prescription drugs such as hypertensives, antibiotics, diuretics, and painkillers as well as ointments, needles, sterile water, and gauze. This type of collection was not uncommon in the building where I lived. If I so much as coughed or complained of a headache I was offered a spectrum of medications and subjected to ad hoc medical diagnoses from my neighbors, all of whom had a small pharmacopoeia in their homes. One of my neighbors, a nurse at a local hospital, was unhappy with how skinny I looked and con-

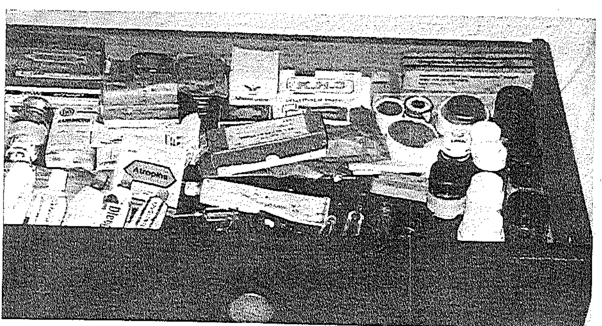


FIGURE 3. A personal collection of medicine, ointments, needles, and gauze of one of my informants. Brotherton © 2002.

vinced herself that I needed Vitamin B-12 injections to give me more energy and, hopefully, a more robust appetite. In her attempts to convince me she would often appear unannounced at my door with a disposable needle and packaged vitamin in hand. Since I was a foreigner and presumably flush with dollars, "there was no excuse to be thin in Cuba," she regularly complained. Cubans, she often playfully noted, "like people with meat on their bones." Rather than changing my diet and lifestyle, medical intervention in the forms of injections or vitamins was, according to her, the answer to my apparent problem.

Beyond skillfully negotiating pharmaceutical prophylaxis and therapeutic options, many people I interviewed were equally invested in a biomedical culture in which medicalized understandings of the body were concomitantly couched within larger conceptual framings of scientific advancement and socialist modernity. Years of state-sponsored public campaigns, policies, and practices had resulted in highly medicalized understandings of what constitutes health and physical well-being. The creation of these medicalized subjectivities is the product of a historically, socially, and politically contingent way of seeing the individual and social body as populations in need of management. For instance, the early revolutionary period, characterized by a large population that had been historically dispossessed of basic medical and health services, made it possible for the revolutionary government to incorporate large masses of individuals into health-reform campaigns. These reforms, which were synonymous with the betterment of all in the socioeconomic transformation of Cuban society, were increasingly linked to the construction of a socialist society. However, consistent with the vision of socialist society was the increasing focus on science and medicine as rational means of developing the country.

It is impossible to speak of the Cuban revolution as being external to the revolution in the health sector. To consider the two phenomena as separate events would fail to address "the confrontation between real people, armed with ideas and politics, and the concrete problems that are thrust upon them by history."[1] A brief genealogy of Cuba's public health revolution will serve to draw attention to changing governmental apparatuses involved in delivering postrevolutionary health services and, in turn, to the changing relationships among citizens, government institutions, public associations, and the state. This changing individual-society-state dynamic represented a distinctive shift in the art of governing the island's population, requiring the mobilization of a new armature of techniques and practices that set out to craft a socialist citizenry that was as explicitly political as it was corporeal. The body figured prominently as the battleground for the deployment of strategies and policies to develop and expand an efficient public health system, one that required an increasing degree of state intervention, management, and protection and that reinforced the infrastructure and institutions necessary to create, regulate, and produce "governable subjects."[2]

RECONCILING HISTORY (1902–1958)

A cursory review of the public health services in the prerevolutionary context, the *período burgués*, or bourgeois period (1902–58), serves as an important counterpoint for subsequent analysis. My concern here is not to enter into a semantic and statistical tug-of-war to reconcile descriptions of Cuba's prerevolutionary health services, or what Quiroga calls "two distinct memories of the process," the "official" and the "dissident."[3] My objective, rather, is to highlight how a particular political discourse was mobilized to create and transform subjectivities. Comprehending the history of the public health system requires placing specific events, people, and experiences in context. The postrevolutionary government's strategy to create healthy bodies, which entailed broadening the definition of individual health to integrate health care into the overall socioeconomic development of the country, has served as an important source of political legitimacy in official public health discourses.

Located ninety miles south of Miami, lodged between the Gulf of Mexico and the Caribbean Sea, Cuba was settled by Spain in 1493 and used primarily as a naval base. Following the introduction in the seventeenth century of sugar plantations worked by African slave labor, as occurred in many of its

Caribbean neighbor countries, Cuba's monoculture export economy prospered; the United States, the dominant economic power in the region, was its main trading partner. However, strained relations between Spain and the United States culminated in the U.S. government's occupation of Cuba after the second war of independence (1894–98). The United States imposed a military government on the island from 1899 until 1902. Under the Platt Amendment to the new Cuban constitution of 1902, the United States retained the right to intervene in the Republic's affairs, and it exercised this right on several occasions, namely, in 1906–9, 1917, and 1921.

A series of administrations characterized by instability, authoritarianism, and gangsterism marked the period from independence in 1899 up until the 1930s. Although Cuba abolished slavery and gained its independence, the cultural underpinnings of colonialism remained important factors in the postcolonial subjugation of the island nation under U.S. tutelage. In 1933 a rebellion by students and army officers brought Fulgencio Batista Zaldívar, who was backed by the U.S. government, to power. From 1934 until 1936 Cubans lived under a virtual military dictatorship.[4] The Batista government, aided in part by U.S. corporate interests in Cuba, did little to reduce the problems of structural violence associated with the highly class-stratified Cuban society. For example, the pervading social injustice and material inequalities that characterized the período burgués were best depicted in the various social and political actors who were involved in Cuba's sugar cane industry: the military, the bourgeoisie, domestic and foreign corporate interests, and the exploited worker. As other scholars have noted, the place of the sugar industry in Cuba's history reveals the profound local and global interactions that shaped the production, extraction, and consumption of this commodity and helped determine the social and political trajectory of the inhabitants of the island.[5]

Given the widespread poverty that prevailed in the período burgués, in 1959 the revolutionary government inherited what Fidel Castro called an "overdeveloped capital in a completely underdeveloped country."[6] Public health services during the período burgués reveal a system characterized by uneven distribution of and access to medical services, determined by social class, urban and rural locations, and ethnic differentiation. An abundance of literature on the prerevolutionary period describes a health care system that was profit-oriented and focused on the diagnosis and treatment of diseases

rather than on their prevention through education and other services essential for the long-term improvement of health.[7] The diversity in health care access and quality resulted in a high concentration of privately owned clinics that provided health care services for the few people who lived in the cities and who could afford it. Consequently, physicians in private practices tended to serve only the upper-middle and upper classes.

In addition, a system called the mutual benefit societies, also known as *mutualistas*, consisted of exclusive hospital plans organized to serve the descendants of people from specific geographic regions of Spain, who paid monthly membership dues similar to medical insurance collectives. In 1948 this self-financed system served about 20 percent of the population and had about 242 clinics and hospitals. The mutualista system incorporated approximately 1.4 million associates and had an annual budget of 40 million pesos, twice that of the state budget, admitting only those members enrolled in their health programs.[8] Except for the program's exclusionary politics, the mutualista system represented one of clearest antecedents for what was later to become Cuba's socialized health care system.[9] Perhaps owing to the relative success of the mutualista system before 1959, Cuba's health profile and its health care delivery system were fairly good when compared to the health statistics of other developing countries in the region.[10] Cuban health statistics from the late 1940s and early 1960s indicate that it "appears to have been (in terms of health and sanitation) a healthier place in the Batista years than most contemporary representations of this period imply."[11]

However, the aggregate statistics masked enormous regional, racial, and class inequalities.[12] For instance, in 1959 more than 60 percent of Cuba's population of 6.5 million had virtually no access to health care. Given that more than 50 percent of the doctors and 70 percent of hospital facilities were in the capital province of Havana, where costly services catered to the fortunate few, the people of rural Cuba and the majority of the urban poor went unserved. This segment of the population depended on the few state-run services,[13] which were so corrupt, as suggested by interviews I conducted with people who experienced this period firsthand, that even admissions to hospitals were bestowed in exchange for favors or bribes to politicians.[14]

All of the above factors resulted in high morbidity and mortality rates for curable and preventable diseases such as polio, malaria, tuberculosis, and intestinal parasitism.[15] The general state of public health care for many

Cuban citizens in the período burgués is described in Castro's speech "History Will Absolve Me," given in his defense of 1953 before the Batista government's magistrate, where he stated the following:[16]

> Only death can liberate one from so much misery. . . . Ninety per cent of rural children are consumed by parasites, which filter through their bare feet from the earth. Society is moved to compassion when it hears of the kidnapping or murder of one child, but it is criminally indifferent to the mass murder of so many thousands of children who die every year from lack of facilities, agonizing in pain. . . . They will grow up with rickets, with not a single tooth in their mouths by the time they reach thirty; . . . and will finally die of misery and deception. Public hospitals, which are always full, accept only patients recommended by some powerful politician who, in turn, demands the electoral votes of the unfortunate one and his family so that Cuba may continue forever in the same or worse conditions.[17]

While undoubtedly serving as an evocative and highly stylized performance, Castro's landmark speech, whether taken as political rhetoric or as a true reflection of on-the-ground realities, articulates how inequitable access to medical services and facilities in the período burgués was a pivotal theme in mobilizing popular support for his movement. This discourse resonated with many individuals who were on the margins of Cuban society and, as Castro suggests, were placed there as a result of a range of political and cultural factors that created difference according to ethnicity, social class, and geographical location.

THE BODY AS A BATTLEGROUND

Soon after the revolutionary army arrived in Havana, Castro and his supporters, most prominently his brother Raúl Castro and Che Guevara, transformed the Cuban economy from one of entrepreneurial capitalism to a centrally planned system. Castro united various political groups to form the Organizaciones Revolucionarias Integradas (ORI) to spearhead this transformation of Cuban society. These changes, including land reforms, the nationalization and socialization of private property,[18] and campaigns to reduce illiteracy sought to equalize the vast disparities of resources, wealth, and education in Cuban society.[19] Many Cubans who were against the government's initial changes fled to the United States, in particular many of the business and professional classes and those closely associated with the

former Batista government, known as *batistianos*. In 1960, in response to Cuba's new policies, the U.S. government quickly imposed a partial embargo on Cuban imports. Almost a year later, in January 1961, in response to the Cuban government's expropriation of assets worth over one billion dollars belonging to U.S. enterprises, the United States severed relations with Cuba and extended the partial embargo to all goods, including food and medicine. The severity of the embargo may be gauged from Cuba's trade figures for 1959, in which 74 percent of all trade was with the United States. Cuba, left with no viable economic alternative, turned to the Soviet Union for trade and military protection. This relationship was formalized in 1972, when Cuba became a member of the Council for Mutual Economic Assistance. Cuba entered a period of hostile relations with the United States, framed by the geopolitics of the Cold War.[20]

While Castro's revolutionary government had not professed an adherence to a particular ideological framework earlier, Cuba's alliance with the Soviet Union heralded the growing importance of the Soviet model of socialism in Cuba's politico-economic organization and political ideology. For instance, when, in the early 1960s, under the tutelage of the Soviet Union, the Castro government started to make advancements in implementing public health programs, increased education, and the reduction of economic disparities, the revolutionary government also began to affirm Marxist-Leninist principles. In 1964 the Castro government formed the Partido Comunista de Cuba (PCC).[21] A new constitution, approved by referendum in 1976, replaced the one suspended when Batista fled in 1948. The new constitution describes Cuba as a socialist workers' state in which the entire population owns the basic means of production. However, the socialist government went beyond the oft-quoted Sovietization of Cuba and sought to socialize the populace by creating the *hombre nuevo* (new man). These cadres of men and women were to work together with the revolution to realize the collective vision of Cuba as a state of the people.

In the late 1960s and particularly in the early 1970s official state discourse in Cuba was steeped in Marxist-Leninist and Guevarist principles. Castro, drawing on Marx, portrayed communism as the highest, most ideal stage of development surpassing the earlier stages of feudalism, capitalism, and socialism. Echoing Marxist thinking, Castro advocated that under communism people would contribute according to their capacity and be rewarded according to their need. Following Lenin, Castro envisioned that a "van-

guard party," the PCC, would facilitate this radical transition to communism.[22] For example, in the early 1960s Che Guevara strongly criticized the Soviet model of development for its bureaucratic and technocratic nature. Instead, Guevara advocated a strategy for economic, social, and political development to deepen and expand the role of the working people in Cuba. The ubiquitous revolutionary slogan of the time was *"¡Patria o Muerte!"* (Homeland or death!), which sought to implement the notion of heroic sacrifice (*numancia*) and the worker's dedication to the nation or the Cuban people (*el pueblo cubano*). In line with this vision, the worker was exhorted to labor for society rather than for personal gain.

Rather than work for material rewards, workers were to labor out of a sense of moral commitment. For their dedication, individuals were to be recognized with pennants, flags, and titles. During the Year of Solidarity in 1966, Castro stated, "If we want people to remove the dollar sign from their minds and from their hearts, we must have men who have gotten rid of their own mental dollar signs."[23] In line with these statements, the Castro government nationalized and expanded social services. Education, medical care, social security, day care, and most housing were provided free of charge, with access to them designed to be more equitable and need-based than ever before.[24] Seeking to dismantle the former class-based privilege and elitism of the prerevolutionary era, the new government drew on the utopian ideas of Marx and on Cuba's independence hero José Martí to break down barriers between manual, nonmanual, and intellectual labor. City dwellers and professionals were encouraged to voluntarily participate in seasonal agricultural labor, mainly in sugar production. Such activities, the government argued, would blur, if not eliminate, the contentious divide between consumer and producer, between bourgeoisie and proletariat, and help to create a communist consciousness (*conciencia*).

As part of the general initiative to incorporate the masses (*las masas*) into the revolutionary transformation, the Castro government created new organizations that brought people together on a territorial and functional interest-group basis. For example, the Comités de Defensa de la Revolución (CDRs),[25] the Cuban Women's Federation (FMC),[26] and the Cuban Labor Federation (CTC)[27] were just three of many organizations that encouraged the adult population to actively participate in revolutionary reform. Youth were organized into political groups during their schooling; primary school children formed the Cuban Pioneer's Union, and older students belonged to the Federation of Secondary School Students, the University Students' Federation, and the Union of Young Communists. The formative role of these organizations was, and still is, to instill the values of the revolution and, in turn, loyalty to the "vanguard party," that is, the PCC.[28] These organizations were officially recognized as the heart of "socialist civil society" and actually operated as "transmission belts" to solidify the relationship between the state and the party.[29] This relationship is reflected "in their [the mass organizations'] negligible autonomy evident in their public stances on a variety of issues."[30]

Theoretically, more than 80 percent of the Cuban population belongs to one or more of the youth and adult organizations, representing one of the state's objectives: the active participation of the entire population in social and state activities. The pedagogical and social importance of mass organizations in Cuba's social transformation cannot be underestimated. Revolutionary campaigns like the fight against illiteracy and the programs for reeducation and job training were influential in the construction of active, productive members of the communities. As studies of that era make clear, las masas were also inspired to devotion by Castro's almost messianic status.[31]

Descending from the mountains with peasants-turned-rebels at his side, Castro symbolized the battle to free Cuba from what revolutionary pedagogy defined as the three evils of the Batista government: hunger, misery, and exploitation. As Damián Fernández notes, "Charisma, popular religiosity, and political religion . . . are keys to understanding the emotional force of the revolution in the early years and the issues of legitimacy, authority, political strategies, and violence. The revolution evoked feelings and also relied on those feelings to muster support and, in no small measure, to survive in power."[32] Narratives like that of a man named Rivera reflect these commitments: "I have always favored the Revolution and hated *gusanos* [worms]. . . . Those gusanos forget the miserable poverty in Machado's time. . . . People complain we're not free because we have no elections and are under Fidel's dictatorship. But there's more freedom now in every way. . . . And it was Fidel who gave the country back to the people! I feel patriotic for the first time, because now Cuba is *our* country."[33] The state's various mass organizations were an important mechanism that fed on this early revolutionary fervor and rallied support around revolutionary objectives and projects, in particular the project of building an egalitarian communist state.[34]

Shortly after the Cuban revolution, a plethora of state institutions, supported by an elaborate network of mass organizations, managed to exercise an unparalleled degree of authority in promoting various public health initiatives, such as decreasing infant mortality and detecting and containing infectious diseases. These initiatives, which reinforced the state's commitment to health care as a constitutional right and repudiated the evils associated with class-stratified, capitalist societies, were rooted in the underlying principles of the revolution. These principles suggested that attempts to restore the health of individuals, in the broadest sense, are also attempts to restore the health of the society as a whole. Consequently, the health, welfare, and accomplishments of the revolutionary government are "at heart, political; they are contingent on state priorities, on types of programs governments choose to finance, and the groups targeted."[35]

On January 1, 1959, when the Cuban rebel army marched victoriously into Havana, the emphasis of the new government was on dismantling discriminatory practices and making universal provisions for basic needs and health care.[36] Like other developing nations with socialist ideologies of that era, Cuba embraced a vision of modernity that entailed not only taking advantage of the scientific and technical revolution but also being part of it.[37] Incorporating science as an element of their strategy for the overall socioeconomic development of the island, the revolutionary government embraced the socialist vision of science as a means for achieving a rational and planned social transformation.[38] Public health and medicine were key areas in which considerable investments were made: research facilities, technology, research and development strategies, and human resources were amply funded. In the revolutionary context, health became an important index of the larger social transformations associated with the socioeconomic development of Cuba, including the elimination of hunger, inadequate housing, discrimination, and the reduction of exploitative labor practices.

At the onset of the revolution in 1960 influential figures like the Argentine-born doctor-turned-revolutionary Che Guevara assisted Castro in outlining a system of social medicine. Seeking to cure the social ills of society, Guevara believed disease prevention consisted not only of a detailed compilation and analysis of diseases, but also of a history of "what their [Cubans'] sufferings are . . . including their chronic miseries for years, and what has been the inheritance of centuries of repression and total submission."[39] Under Guevara's plan for "the creation of a robust body with the work of the entire collectivity upon the entire social collectivity," the revolutionary government invested considerable amounts of attention to expanding and democratizing access to the public health system.[40] The government created a model of health care that was informed by the revolutionaries' vision of a new social order, which in turn would help to create the hombre nuevo.

During the early 1960s roughly half of the country's doctors fled the island when the revolutionary government began expropriating and nationalizing all foreign-owned enterprises. As a result, the first priority in reforming public health care was to begin training an entirely new medical corps under the philosophy of the hombre nuevo. Moving against the trend occurring in other developing countries, the state focused on training fully qualified physicians to handle every level and aspect of curative medicine. The medical responsibilities given to paramedics and community health workers diminished. Drawing heavily on revolutionary metaphors, Guevara proclaimed, "Now the conditions are different, and the new armies which are being formed to defend the country must be armed with different tactics. The doctor will have an enormous importance within the plan of the new army."[41] Instead of the Hippocratic oath, medical graduates promised to abide by revolutionary principles: "They were asked to agree to serve the rural areas, not engage in private practice, promote preventive medicine and human welfare, strive for scientific excellence and political devotion, encourage proletarian internationalism, and to defend the revolution."[42] The first priority of the revolutionary government was the organization and development of an integrated national health system that would govern the health of the entire population, making it the full responsibility of the state.

Of the 6,300 physicians in Cuba in 1959, only 3,433 remained in 1967 after their exodus en masse, principally to the United States and Spain.[43] In addition, in 1960 only sixteen professors remained at the only medical school in the country, in Havana. Severely hampered by the paucity of medical professionals, the government initially encountered difficulties in extending health care to marginalized groups in urban and rural locations and in maintaining the existing state-run health services in Havana. However, Cuba's newfound relationship with the Soviet Union in 1961 was influential. The Soviet Union helped Cuba to enact its plan for a revolutionized health care system. For example, Soviet physicians and allied health professionals from other socialist countries compensated for the domestic shortage of doctors and professors. In 1964 the Havana Medical School graduated 394

physicians.[44] By 1971, 30 percent of all university students were studying medicine, and new medical schools were being built to accommodate the growing student body across the country.[45] In 1972, when the number of doctors reached 7,200, the quota was dropped to 20 percent.[46] To help address the shortage of physicians in marginalized areas, all new medical graduates were assigned to three years of rural service.[47]

In 1961 the first plan for a comprehensive national system of primary health service began to take form. After an initial purging of Batista supporters from the medical class (*la clase médica*), the administration of some hospitals and clinics was turned over to physicians who had served in the revolutionary army and to other physicians dedicated to revolutionary reform.[48] Following the Czechoslovakian model of health planning, which concentrated the administration of health care in one governing body with an administratively decentralized delivery system, Cuban public health officials formed the current Sistema Nacional de Salud (SNS, national health system). The SNS is organized at three levels: national, provincial, and municipal. The national level is represented by the MINSAP, which coordinates everything pertaining to health and health care and fulfills the methodological, regulatory, coordination, and control functions for the whole country.[49] Provincial and municipal levels are represented by public health offices, which are under the direct financial and administrative authority of their respective provincial and municipal councils. All levels integrate the basic functions of public health: treatment, health protection, long- and short-range planning, and scientific improvement of health workers.[50]

Under the direction of the SNS, the existing state-run services fell under the control of the revolutionary government and were subsequently restructured. The two remaining systems, the mutualista program and private health care, were left intact temporarily to handle the severe shortage of medical personnel. However, a new law introduced in August 1961, known as Law Number 949, indicated that the MINSAP was in charge of all the health activities in the country, including the private health and mutualista systems. The latter two were phased out by 1970 and were either closed or changed into public facilities and integrated into the SNS. In 1964 the integral polyclinic program (*policlínico integral*) was the first health services program that the new SNS embarked on.

POLICLÍNICO INTEGRAL

Representing the earliest stage of establishing primary health care in postrevolutionary Cuba, the integral polyclinic program offered outpatient care that sought to decentralize the services traditionally supplied by hospitals by targeting medically marginalized groups in both rural and urban areas.[51] The four founding principles of the new revolutionary primary health care system were (1) The health of all people is the full responsibility of the state; (2) Universal coverage is guaranteed to all persons without discrimination; (3) The people must participate actively to assure and maintain high health levels; (4) Preventive care is the primary goal of health care. The polyclinic system was designed to instill, integrate, and address these founding principles through the provision of four basic services in a specifically defined area and population: clinical services (for example, curative-preventive care); environmental services (hygiene and sanitation); community health services (health promotion campaigns); and related social services (social workers).[52]

Between 1962 and 1970 the number of polyclinics in the country steadily rose from 161 to 308, and by 1976 there were 344 fully staffed polyclinics operating in the country and an additional 140 rural medical posts.[53] The polyclinic's health coverage was subdivided on a regional basis into sectors, each with about thirty thousand inhabitants served by health teams that included preventive and curative wings. Polyclinics typically offered primary care specialists, including several internists, a pediatrician, an obstetrician-gynecologist, a dentist, a nurse, and a social worker. Polyclinics also offered clinical outpatient services designed to prevent illness and to improve the quality of public health.

The foremost objective of the integral polyclinic was to reduce morbidity and mortality from communicable diseases, which were a major health problem in Cuba in the 1960s. MINSAP officials believed that continuous care by the same health team promotes a better understanding of the patients and their environments on the part of staff. Such an understanding, health officials thought, would be effective in addressing the physical and social causes of the patients' illness. By 1970 the following health programs were being implemented, in elementary form, in every municipal polyclinic: comprehensive attention to women, comprehensive attention to children, comprehensive attention to adults, hygiene and epidemiological surveillance, dental care, and postgraduate training programs for medical staff.[54]

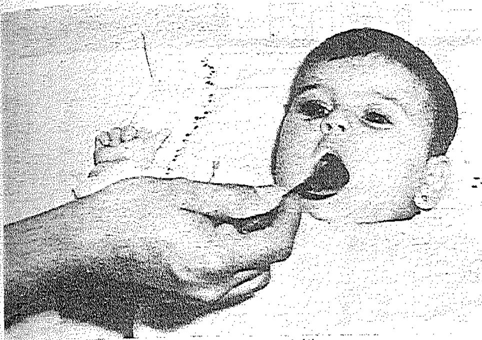
The policlínicos relied heavily on the popular participation of state-

promoted mass organizations in order to carry out various public health campaigns. During the October Missile Crisis in 1962, for example, the MINSAP needed to organize people to give blood so that the country would have a sufficient reserve in case of emergency. Within ten days the CDR had mobilized eight thousand Cubans to give blood.[55] Moreover, the mass organizations participated in health education, literacy training, and other social activities, all of which sought to incorporate the wider community in the state's various reform campaigns. These campaigns included mass immunization programs, blood donations, and disease-control campaigns such as hygiene and sanitation lessons.

A well-known example of widespread participation in disease control was the role played by mass organizations in the polio vaccination campaigns of the early 1960s (figure 4). These campaigns were carried out throughout the country in as little as seventy-two hours. As a result, polio was eliminated from Cuba by 1963, years before the United States succeeded in doing so. Campaigns were also carried out to vaccinate against tuberculosis (figure 5). These public campaigns were conducted in tandem with massive literacy campaigns and *brigadistas* (public health brigades) that explained the evolutionary cycle of parasitism and how poor sanitary conditions contributed to disease transmission. For instance, in an interview I conducted with Julio César Serra, born in 1955, he described his experience of several of these campaigns:

> When *la Revolución* arrived there was a great deal of ignorance. There were families that were afraid of the vaccines; there were people who thought they were diabolic things. You could hear any number of ridiculous theories and ideas about what was happening. The government immediately began educating the population, reading health education pamphlets on the television and the radio all over the country, trying to educate the population about boiling drinking water and about the importance of children using shoes to prevent parasites from entering through their feet. La Revolución informed families about all these problems and said, "Look, you can't have stagnant water because it can be a breeding ground for mosquitoes, and mosquitoes can transmit diseases."

Through the creation of mobile sanitary units that worked with mass organizations and traveled around the country to address environmental problems and implement health promotion and disease prevention, the



POLIOMIELITIS 1965

	Casos
Brasil	541
México	477
Perú	444
Colombia	330
Honduras	265
Ecuador	217
Chile	206
Estados Unidos	72
Venezuela	118
CUBA	0

¡TERRITORIO LIBRE DE POLIOMIELITIS!

Poliomielitis aguda en Cuba. Casos notificados y defunciones

Año	Casos	Defunciones
1959	288	32
1960	330	32
1961	342	26
1962	46 *	7 *
1963	1 **	0
1964	1 **	0
1965	0	0
1966	0	0
1967	0	0
1968	0	0
1969	0	0

* Casos ocurridos de enero-mayo antes de finalizar la I Campaña Nacional de Vacunación Antipolio.
** En personas que no habían sido vacunadas.
FUENTE: Dpto. de Estadísticas del MINSAP

FIGURE 4. Elimination of poliomyelitis in Cuba. Source: *Bohemia*, 6 February 1970: 65.

FIGURE 5. Vaccinations against BCG tuberculosis. Source: *Bohemia*, 23 April 1965: 107.

population was encouraged to become more attuned to bodily functions and to adopt practices that linked health, hygiene, and the environment (figures 6–9). With catch phrases such as "Hagamos de Cuba el País Más Saludable del Mundo" (Let's make Cuba the healthiest country in the world) and "Higiene es Salud" (Hygiene is health), these campaigns aimed at transforming the social body by targeting individual bodily practices. In effect, these campaigns trained the population to increasingly view their bodies through a specific biomedical framework. For example, campaigns strongly advised the population to avoid ad hoc home remedies and self-medication of undiagnosed problems, especially among infants and children. Instead, the campaigns emphasized the importance of the physician as the *only* person authorized to determine the cause of unexplained ailments (figure 10). At the same time, campaigns educated the population about the symptoms and etiology of infectious diseases such as hepatitis (figure 11) and the biological functions of nutrition (figure 12).

In spite of these exhaustive campaigns and the optimistic efforts of the integral polyclinic, the program was not entirely successful in dealing with the burgeoning health needs of the population, which had been without basic health services for many years. Cuban public health officials found problems with the system. For instance, a shortage of medical personnel specializing in primary health care meant that a different physician treated the same patient from one visit to another.[56] This reduced the chances that a particular doctor would be familiar with a patient's life history. Second, physicians did not work in health teams, as originally planned, and as a result the interdisciplinary component believed necessary to address health issues was absent. Third, health care tended to be primarily curative, and physicians lacked the appropriate doctor-patient-community relationship required for the new socialist society. The poor training of primary health care workers led to an increased number of patient cases referred to secondary specialists and to the appearance of more people in hospital emergency rooms.

The shortage of physicians entering primary health care was a result of the lack of opportunities to engage in advanced teaching and training at the primary health level. There was little incentive, therefore, for professionals and technicians to enter this specialty. In an attempt to address these weaknesses, a general restructuring of the polyclinics' operations occurred in 1976 under the heading of Medicina en la Comunidad (Medicine in the Community).

FIGURE 6. Listen to this friend . . . ! The Sanitation Inspector will periodically knock on your door. This person is responsible for making sure that you follow the campaigns to exterminate the *Aedes aegypti* mosquito, which transmits Yellow Fever. We will eradicate the mosquito that transmits Yellow Fever! Source: *Bohemia*, 19 February 1964: 82.

FIGURE 7. Parasitism: Measures of control: Wash your hands; Boil water and milk; Wash fruits and vegetables; Cook meats thoroughly. Source: *Bohemia*, 23 April 1965: 107.

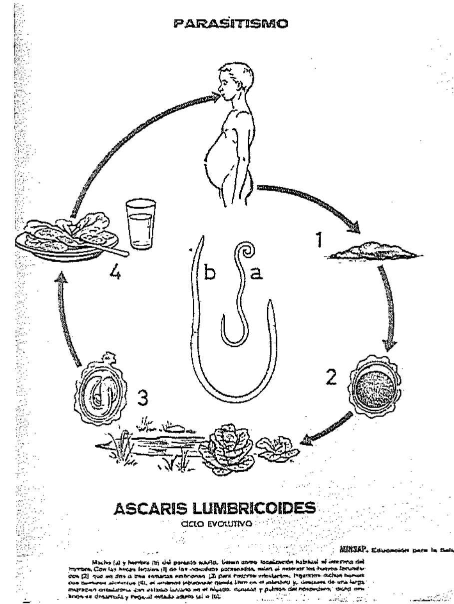


FIGURE 8. Parasitism: Life cycle of *Ascaris lumbricoides* (roundworm). Source: *Bohemia*, 26 February 1965: back cover.

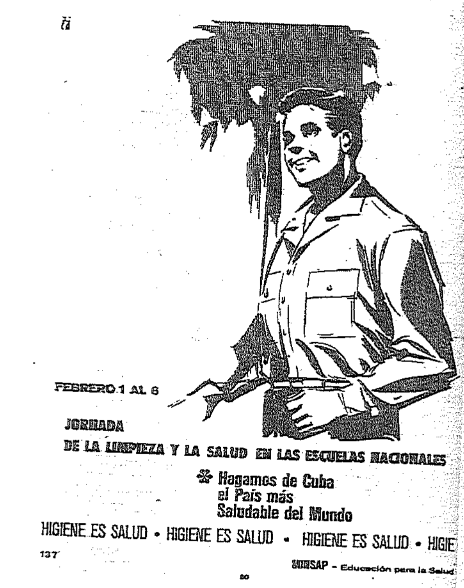


FIGURE 9. Hygiene Is Health. Let's Make Cuba the Healthiest Country in the World. Source: *Bohemia*, 5 February 1965: 80.

FIGURE 10. To a child with vomiting and diarrhea . . . Giving them the first home remedy recommended to you IS DANGEROUS! Taking lightly the use of informally procured medicine has caused a great number of infant deaths from GASTROENTERITIS. At the first signs of vomiting and diarrhea, GO TO THE DOCTOR! He is the only person authorized to decide the cause of those symptoms. Source: *Bohemia*, 5 March 1965: 91.

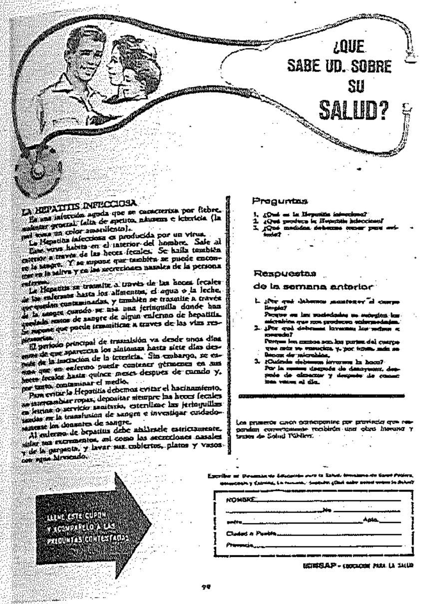


FIGURE 11. What do you know about your health? Infectious hepatitis. Source: *Bohemia*, 23 April 1965: 99.

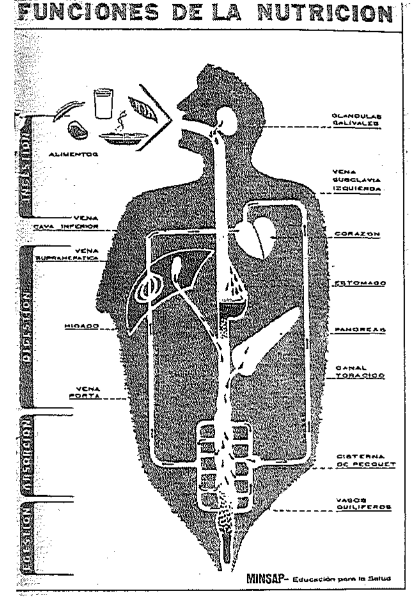


FIGURE 12. The functions of nutrition. Source: *Bohemia*, 2 February 1965: back cover.

This program was hailed as an improved model that viewed health as a function of the biological, environmental, and social well-being of individuals.

MEDICINA EN LA COMUNIDAD

The year 1970 marked a shift to a second, distinct stage in the development of the public health system. In 1969 the Ten-Year Health Plan, which sought to carry out various health initiatives from 1970 to 1980, was enacted. One of the priorities of the plan was screening for asymptomatic diseases. Health-related activities were directed at enriching and developing principles that aimed not only to provide therapy, but also to investigate hidden morbidity. The latter required the health teams to work on highlighting the social morbidity that contributed to nontransmissible chronic illnesses and their risk factors. This meant giving priority to the treatment of healthy people who exhibited risk factors for certain diseases or disorders over individuals who were healthy but exhibited low risk factors. For example, the public health campaigns of 1970, as evinced in health promotion advertisements, started targeting smoking and lifestyle, such as unhealthy diets and sedentarism.

The Medicine in the Community program, also known as the *policlínicos comunitarios,* was first tested in the Policlínico Alamar in 1974. It incorporated existing health programs from the policlínico integral system. Polyclinic teams were assigned to a sector of the population, such as infants or the elderly, that was defined by its high-risk assessment. This allowed medical services to be dispensed through a system known as *dispensarización,* which provided continuous assessment and risk evaluation. Each municipality had a defined number of health areas, and each urban health area with twenty-four thousand to thirty thousand inhabitants had a polyclinic, while rural areas were served by rural hospitals.

Prior to Medicine in the Community, people went to the polyclinic in their area and saw the appropriate primary care physician. In the new program, the community-based model of primary care provided integrated health programs carried out by a health team that sought "to discover the health status of the population, to select the at-risk population groups for various health programs, to define the environmental, biological, social, and psychological factors that interrelate as determining variables in the health-illness process, and to analyze the needs and resources available."[57]

"The physician-nurse teams attend[ed] patients in the polyclinic [and] also visited patients in their everyday environment: the home, school, day-care centre, and workplace."[58] During the 1970s, in collaboration with the WHO and the Pan American Health Organization (PAHO), Cuba elaborated a strategy to advance medical science, health services, and the health status of the population to the highest international levels. Relying heavily on criteria such as the infant mortality rate that had been set out by the WHO as standard health indicators, Cuba created a number of national public health campaigns targeted at lowering infant mortality and increasing infant life expectancy at birth. Understanding Cuba's infant mortality rate as a reflection of the success of the country's health care system, the revolutionary government placed a strong emphasis on health care programs for women, with priority given to maternal and infant care programs.

The development of maternal and infant health care programs was carried out against a background of broad socioeconomic changes that affected women's lives, such as the redefining of traditional female roles in a revolutionary context. In the spirit of egalitarianism and arguably also out of a shortage of workers, the Castro government sought out women's participation in the newly designed workforce. The government made a concerted effort to facilitate this transformation, which Castro referred to as a "revolution within a revolution." In 1976 the constitution codified women's equal rights in marriage, employment, wage equity, and education. Sex discrimination was punishable by a withholding of rations or by imprisonment. Moreover, the famous family code of 1976 noted that men were to share household duties when women were gainfully employed. These measures were complemented by the massive extension of public day care facilities and, in 1974, a maternity law that guaranteed women paid maternity leave and the right to take time off from work to attend to their children's health care needs. Under the new revolutionary system many women had become actively involved in juggling the roles of working mother and good *revolucionaria.* Women were incorporated into mass organizations and participated in such revolutionary projects as seasonal agricultural labor and health education campaigns.

The FMC was an extension of the state apparatus that gave women a collective voice and ensured their full and equal participation in the revolutionary movement. A well-known indicator of women's changing role in postrevolutionary Cuba was the birth rate in the first two decades after the revolution, which has steadily declined since 1963 and represents one of the lowest in Latin American. For example, by 1979 the birth rate had dropped to 18.0 per 1,000 inhabitants from 28.3 per 1,000 before the revolution. While the revolutionary government always provided birth control methods at low cost to women who wanted them, it did not conduct public campaigns to promote family planning. Such a remarkable decline in the birth rate in the absence of any governmental effort to bring it about, while other countries like Mexico have used high-pressure tactics without success, indicates that the socioeconomic pressures for having many children had been mitigated, and women were beginning to assess on their own accord the advantages of having smaller families.[59]

In 1977 the MINSAP established a series of objectives to be met by primary health care centers nationwide: "Early detection of pregnancy (before the third month); early consultation with the obstetrical health team (also before the third month); provision of at least nine prenatal examinations and consultations for women in urban areas and six for women in rural areas; education about hygiene, health during pregnancy, childbirth, and child care; special prenatal attention to women considered to be high obstetrical risk; psychological counseling with regard to childbirth; instruction in birth

exercises; and finally, a provision that all childbirth take place in hospitals."[60] Consistent with its objective to manage the country's infant mortality rate, the government also began targeting perinatal diseases and congenital problems, the main causes of infant death. Perinatal intensive care units were created in all maternal and infant hospitals, and therapeutic abortions were strongly advised for mothers found, through genetic screening, to be carrying babies with congenital abnormalities.[61]

Utilizing the extensive network of public organizations, specifically CDRs and the FMC, the MINSAP trained health brigade members (*brigadistas sanitarias*) to assist polyclinic staff in seeking out pregnant women. The aim was to target expectant mothers and discuss with them the need to go for medical consultation and to monitor those women who failed to appear for their scheduled appointments. This popular participation in health campaigns, which was described by PAHO as a critical strategy to achieve health for all by the year 2000, was crucial to the increased institutionalization of childbirth in Cuba in the early 1980s. In addition to basic health coverage, all women who were pregnant or breastfeeding were granted supplemental food rations and vitamins. Furthermore, measures were taken by the Cuban government to improve children's life expectancy from birth. For example, the use of such facilities as maternity homes guaranteed that nearly 100 percent of babies were born in hospitals with staffs trained to detect birth-related problems. Maternity homes, an integral part of the current primary health care system, are comprised of residential facilities with medical attendants where women go when they reached approximately thirty-seven weeks in their pregnancy. There, women await the birth in the company of other women and free of the responsibilities of maintaining a household. After delivery, new mothers and their babies generally go home on the first postpartum day and are seen in the home daily by a family doctor and nurse for the next ten days. Additionally, a doctor or nurse schedules a minimum of two monthly pediatric visits along with one home visit (figures 13, 14).

The successes of the Medicine in the Community health system, including the maternal and infant care health program, lent credence to MINSAP officials' claims that the individual could best be treated as a psychosocial being (that is, treated in both mind and body) in a specific environment. The new program was widely heralded by the government as an ideal social medicine program because it was designed to view health and medicine as integral to the overall socioeconomic development of Cuba. MINSAP officials

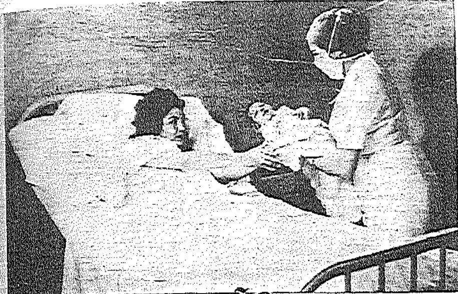


FIGURE 13. For this child, we are all caregivers: The pediatric identification card guarantees your child appropriate attention. Source: *Bohemia*, 15 January 1965: 71.

FIGURE 14. For this child who is to be born, we are all caregivers . . . and for you as well! Source: *Bohemia*, 8 January 1965: 91.

argued that the new health program would effectively provide health care to the country and reach the state's goal of making Cuba a world medical power (*potencia médica mundial*). Cuban leaders considered health indicators to be measures of the efficacy of the socialist revolutionary project. As a report from the MINSAP declared, "Infant mortality is one of the indicators internationally considered to be the greatest global measure for the health of a country. Before the triumph of the Revolution, infant mortality in Cuba was greater than 70 deaths per 1,000 live births, in 1987, we achieved a rate of 13.3. This rate is very similar to those exhibited in more developed countries, and the results of this and other indicators allow us to determine the state of health of our population."[62] The MINSAP's statements reflected the official public health discourse in Cuba, which cites the country's low infant mortality rate as a currency of symbolic exchange, whereby vital statistics index the success of socialist modernity. This increasing reliance on statistical fetishism, however, belies the increased role that women's reproductive labor plays in achieving these goals.

Despite Cuba's success in reaching a low infant mortality rate, the overall achievements of the primary health program quickly fell short of the objectives. Several studies have illustrated that the community health teams were not adequately trained to screen the population for certain ailments. Specifically, chronic illnesses like cancer and high blood pressure, along with related heart diseases, were not adequately detected and went untreated.[63] Cuban primary public health professionals commented that there were inequalities between the care offered at the training polyclinics—centers associated with teaching hospitals (less than 10 percent of those clinics in the country)—and that offered in nontraining polyclinics. In addition, health teams were unable to effectively address the behavioral determinants of ill health, including smoking, alcoholism, and promiscuity, that put people at risk. As a consequence, they failed to create health promotion campaigns aimed at high-risk groups and antismoking campaigns (figures 15 and 16). Some health care teams' lack of familiarity with the families and communities in which they worked meant that they were unable to identify other important social problems, which impeded a holistic, integrative approach to health care. The lack of personalized medical attention by the same health teams resulted in the persistence of symptomatic visits, which were treated as acute episodes, without an examination of the relationship between the illness and its broader biological, emotional, or social origins.

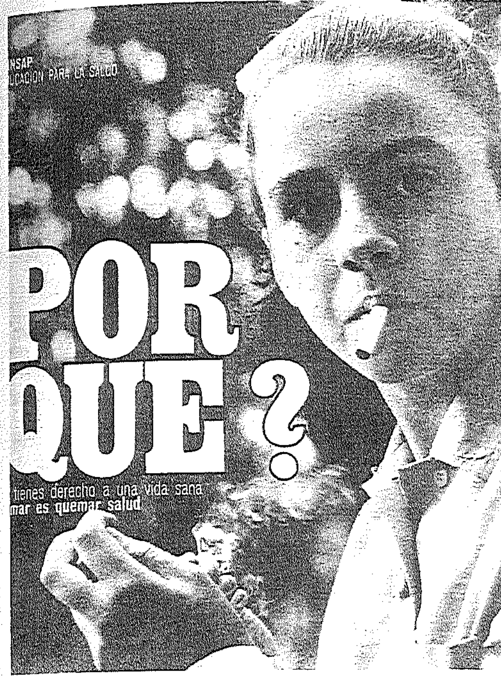


FIGURE 15. Why? You have a right to be healthy. Source: *Bohemia*, 13 November 1970: back cover.

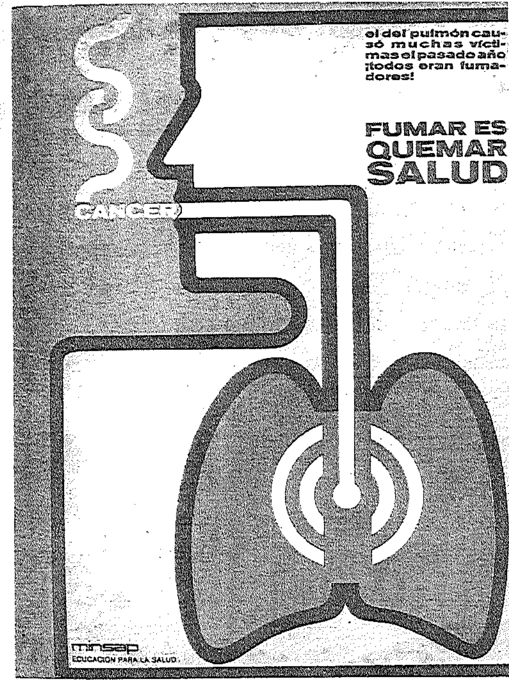


FIGURE 16. To smoke is to "burn" your health. (Lung cancer caused the death of many people in the past year. All were smokers!) Source: *Bohemia*, 16 January 1970: back cover.

In conclusion, public health officials determined that the community medicine program lacked the tools to provide an integrative evaluation that took into consideration all the factors affecting the well-being of patients. Doctors ended up having a passive role in the polyclinics and waiting for morbidity to arrive instead of seeking out, preventing, and controlling their patients' health problems after a careful analysis of the morbidity of the population. The excessive workload of the nontraining polyclinics contributed to the quality of care given, which was not the best in many instances. For example, many of the personnel at the polyclinics failed to make appropriate referrals to specialists at local hospitals. Often this resulted in patients preferring to go directly to the hospitals themselves (where the assistance was, at least, faster), bypassing the polyclinics altogether. As a result, the program did not achieve the objectives of an integrative, holistic medicine for the population and still had a technical-biological focus at the expense of attention to psychosocial and environmental variables.

Given the above conclusions, in the 1980s the Castro government became convinced that the structure of medical services and education in Cuba needed fundamental change. Castro formed the Carlos F. Finlay Medical Detachment in 1982 to restructure the profession of medicine. Given that the pattern of morbidity and mortality in Cuba had slowly changed from diseases of poverty, for example, parasitic and infectious diseases, to diseases of development, such as heart disease and cancer, Castro called for the training of better-equipped primary care family doctors to better address the changing populations' health needs. Under the newly formed detachment, Castro declared family medicine to be a new specialty in medical training, one that was subsequently designated as a new generalists' residency program termed Medicina General Integral (MGI), thereby eliminating the distinction between the practice of general medicine and specialization.

Medical education was extended from six to ten years when MINSAP instituted a new curriculum that required six years of undergraduate and predoctoral medical education and a four-year residency in MGI.[64] This new scheme meant that medical students would now graduate as *médicos generales básicos* (MGB). In order to integrate these new medical professionals into the SNS, the revolutionary government designated an interdisciplinary commission to "elaborate the conceptualization of community medicine within the Marxist–Leninist and socialist ideology and character of the health system."[65] Out of this process emerged the current primary health care system, MEF, created in 1984, that is central to it. As was evident shortly after the launch of the MEF program, Castro declared the participating physicians to be "symbols of the Revolution"[66] and focused on their roles as reinforcing the values of the revolution through their continual contact with the population.

nism? It was the utopia that Fidel knew could never be accomplished and that is why he abandoned it.

Dimitri Martínez, state newspaper editor, born in Havana in 1974

Communism is a beautiful idea, but in practice it cannot work, especially not in the tropics. In Cuba we are supposed to be a socialist country. But really, I don't know what we are.

María Luisa Rodríguez, accounting assistant, born in Havana in 1953

NOTES

PREFACE

1. In November 2004 Cuba's dual economy became further mired in controversy when Cuban authorities eliminated the circulation of U.S. dollars throughout the country. The Cuban Central Bank (BCC) issued a new currency, the Cuban *peso convertible*, popularly referred to as the *chavito*. This new currency is necessary, Castro argued in a speech in October 2004, because the United States has discouraged banks from sending U.S. cash to Cuba. Although those in possession of U.S. dollars are not penalized, only pesos convertibles are currently accepted in all establishments that formerly used the U.S. dollar. In an attempt to discourage use of dollars, which had been in free circulation for nearly ten years, the BCC issued resolution 80/2004, which established that from 8 November 2004 on the exchange of U.S. dollars for pesos convertibles would bear a 10 percent tax. In April 2005 the BCC further revalued the peso convertible by 8 percent in relation to the U.S. dollar, thereby levying a whopping 18 percent exchange rate (10 percent penalty plus 8 percent revaluation) on U.S. dollars. All other foreign currencies are exchanged according to the international currency market, taking into consideration the 8 percent revaluation of the peso convertible.

2. The plight of Oscar Lewis, the late American anthropologist, is one of the most noteworthy cases. The studies of Lewis, Lewis, and Rigdon (1977a, 1977b, 1978) were carried out in 1969–70. They were controversial and were terminated by the Cuban government in 1970. Raúl Castro, then minister of the Revolutionary Army, declared that the study "departed from the [agreed-upon research] proposals" and carried out counterrevolutionary activities with the aim of conducting "political, economic, social, cultural, and military espionage, making use of their progressivist facade" (cited in Lewis 1977a: xxii). Lewis and his research team denied these allegations. The full details of the events can be found in the foreword of volume 1 of their two-part anthology (1977a).

3. See Fernández (2000a) for a detailed description of this term.

4. Rationing of food began in March 1962. In principle, the system ensures equality of food consumption among the population since every Cuban is, in theory, legally permitted to buy the same amount of basic food products at the same prices. Ration cards (*libretas*) set limits on the quantities that one person can purchase at

subsidized prices, although rationing does not guarantee that those products will be available for purchase every month (Benjamin, Collins, and Scott, 1984). See, for example, Premat (1998) and Garth (1988) for an ethnographic account of the ways in which Cubans negotiated food shortages and rationing during the *período especial*.

INTRODUCTION

1. From 1991 to 1993 an epidemic of optic and peripheral neuropathy—commonly associated with a painful inflammation of nerves—affected more than fifty thousand people in Cuba. The number of new cases decreased after vitamin supplements were distributed through family doctors to every citizen.

2. In Cuban Spanish, all references to the Cuban revolution of 1959 are capitalized. The term conveys how individuals express feelings and ideas about *la Revolución* as an agent capable of acting on an individual.

3. In times of crisis, Agamben (2005, 5) asserts, the "state of exception" refers to the expansion of the powers of government to issue decrees that have the force of law. As the government engages in the process of claiming this power, questions of sovereignty, citizenship, and individual rights can be diminished, superseded, and rejected.

4. For instance, the government introduced reforms that sought to restore import capacity and stimulate domestic supply; increase the economy's responsiveness to the world market; search for foreign capital and technology; allow free-market sales of surplus produce, handcrafts, and some manufactured goods; increase the categories of self-employment allowed by the state to cover an additional one hundred freelance occupations; and permit the registration and taxation of private rental activity (Economist Intelligence Unit 1999).

5. Cited in Eckstein 1994, 103.

6. Crisis, as an isolated event or discursive category of a prolonged period of unrest, is hardly new in Cuba's revolutionary vernacular and arguably could be extended back to the country's formation as a republic in 1902. Since 1959 the island has experienced multiple crises: the Bay of Pigs invasion (1961), the Cuban Missile Crisis (1962), the era of *perestroika* and *glasnost* (mid-1980s), and the ongoing U.S. embargo (1962–present), among other notable events in the island's historical trajectory.

7. While I have traveled extensively throughout Cuba in the past decade, and much of the analysis I present in this book resonates with my experiences in other regions of the country, I am both cognizant of and careful about misrepresenting the experience of *habaneros* (residents of the city of Havana) as the general experience of all Cubans. "Working in Havana and talking about Cuba is paramount to working in Manhattan and generalizing about the United States," an independent scholar who worked in Santiago de Cuba in the eastern region of the island complained at a conference at which I presented a paper in 2007. The scholar was uncomfortable with the privileging of Havana as the benchmark of most of the research carried out on the island. Recognizing this regionalist divide and the scholarly bias in the pursuit of knowledge production, I argue that Havana, despite revolutionary efforts to change this fact, is still home to Cuba's prized hospitals, burgeoning research and biotechnology institutions, and a plethora of health tourist clinics and pharmacies. The capital city is a significant draw for Cubans from other provinces seeking out medical treatment and specialized medical services, both formally and informally. For the questions being explored in this book, the city of Havana is an ideal site for addressing changes to the country's health care system.

8. The bulk of my field research was carried out with residents within a regional division of the MEF program, which I will describe in detail in chapter 4.

9. To elicit a wide cross section of opinions and experiences of the health care sector every effort was made in this research to interview people who cut across the lines of professional status, class, gender, local categories of race, and sexuality. For example: informants ranged from twenty-one to seventy-five years of age; 65 percent of those interviewed were women; monthly official state salaries, for those who were employed, ranged from the equivalent of 7.50 to 30 U.S. dollars, with no access to other income; other individuals supplemented their state income or relied solely upon income generated from trading on the black market, renting rooms to tourists and Cubans, both legally and illegally, and receiving remittances from abroad (these individuals made between 20 to 400 U.S. dollars per month); educational levels ranged from university graduates to people with no formal education. All the names of the people and places—for example, the *consultorios* and the specific subdivision in which they are located—used in the book are pseudonyms to protect the identity of those who participated in the research. Moreover, published English translations of original Spanish texts have been used whenever available. Unless otherwise noted, the author translated all published texts and quotations from interviews.

10. Bourdieu's (1977, 1990) "theory of practice" is pivotal to this discussion, particularly the idea of practice as part of his broader argument on the relationship between belief and what he calls *habitus*, which he defines in terms of structures, or "systems of durable, transportable dispositions, structured structures" (1990, 53) that are internalized by the subject and that come to generate and organize social practices and representations. The habitus, then, is constituted through the past experiences, both individual and collective, of subjects within the world. Bourdieu argues that the habitus "is always oriented towards practical functions," since it regulates human practices and behavior (1990, 52). Individual bodily practices also build on earlier works on bodily techniques and *hexis* (Mauss 2006 [1934]); and the civilizing process (Elias 2000).

11. See Foucault 1991, 83.

12. This builds on Lacombe's (1996, 348) definition of the genealogical method.

13. See Abu-Lughod 1990.

14. As Farquhar (2002, 9) notes, Bourdieu's concept of habitus has been criticized as ahistorical and deterministic: "To be useful to social anthropology at all, it must be seen as open to history and many unexpected variations." Other scholars have examined this variation; see, for example, Lock and Kaufert 1998; Lock 1993b; Lock and Farquhar 2007; Boddy 1989; Comaroff 1985; Fassin 2007; Scott 1990; Lock and Schepher-Hughes 1987; and de Certeau 1988.

15. This book also contributes to recent literature on governmentality and subjec-

tivity in socialist and postsocialist contexts (see, for example, Palmié 2004; Philips 2005; Rigi 2005; and Yurchak 2005) as well as to studies that focus on science and medicine (see Petryna 2002; Farquhar 2002; Greenhalgh and Winckler 2005; Rivkin-Fish 2005; Hyde 2007; Ninetto 2005; and Reid-Henry 2003, 2007). It also contributes to emerging ethnographies of capital (see, for example, Elyachar 2005; Fisher and Downey 2006; Ong 2006; Roitman 2004a, 2004b; and Sunder Rajan 2006).

16. See Butler's (1997, 2) important discussion on the paradoxical nature of state power.

17. See Hardt and Negri 2000, 23.

18. Foucault 1983, 208. Also see Verdery's (1996) application of *étatization* to examine the regulation of time in European socialism. Similarly, Farquhar's discussion of how the Maoist past is embodied in the political and historical character of pleasure in modern-day China also speaks to variants of the genealogical method.

19. See José Quiroga (2005), *Cuban Palimpsests*.

20. Fernández (2000a), for example, identifies three major cultural paradigms that can be identified in Cuba's history: the liberal, the corporatist, and the informal (*lo informal*). Central to the liberalist project were the ideas that individual rationality and self-interest were to be wedded with the autonomy of social organization in a free market economy. Corporatism, Fernández argues, "endorsed the notion of law, order, stability, and elite leadership through a centralized bureaucratic authority—the state—that would rule over, and function in coordination with, sectoral groups hierarchically and organically integrated" (2000a, 27). Lo informal, on the other hand, subverted the institutions and regulation of daily life in order to satisfy the material and nonmaterial needs of the self, the family, and the community.

21. This book privileges the analysis of the way in which the creation and transformation of medicalized subjectivities are part and parcel of a broader matrix of socioeconomic and political changes. This is not to suggest that other factors, such as gender and local categories of racial classification, among others, are not equally important factors. Yet this form of finite analysis should be elaborated on in separate scholarly works: for example, gendering *la lucha* or discussions of race and the dual economy. I only briefly touch upon these latter themes in chapter 1.

22. See Hardt and Negri 2000, 23.

23. There are several notions of citizenship in relation to biomedicine and medical practice with which this work is in dialogue. See, for example, biological citizenship (Petryna 2002; Rose 2006; Rose and Novas 2004); and therapeutic citizenship (Nguyen 2010).

24. See DelVecchio Good's (2007) work on the "political economy of hope" and the "biotechnical embrace." This work demonstrates how biomedical intervention, in fields such as oncology, increasingly take on affective and imaginative dimensions, enveloping physicians, patients, and the public. She argues that analyzing the "multiple regimes of truth" circulating in high-technology medicine serves as a nexus for examining the subjective experiences of patients, clinical scientists, and the political economy of biomedicine.

25. This is not to suggest that the informal economy is a new phenomenon in Cuba. As many Cubans pointed out during interviews, a black and gray market had existed since the mid-1960s, before the advent of the período especial. However, as several informants also pointed out, the private informal economy tended to be in nonessential items (e.g., blue jeans and electronic equipment), not in basic medical provisions (e.g., medicine, medical supplies, and access to medical services). I highlight the qualitative differences in the informal economy from before and after 1989 in chapters 1 and 2.

26. See the work of Alena Ledeneva (1998).

27. One of the greatest sources of U.S. dollars before the law changed allowing Cubans to legally hold them was through remittance payments from Cubans abroad. The government had an official procedure by which the state would exchange these dollars at a one-to-one exchange for Cuban pesos.

28. I borrow the term from Augé and Herzlich 1983.

29. These speculations were made more complex when, in February 2008, Fidel Castro retired. Raúl Castro, Fidel's younger brother (younger by only a few years), was shortly thereafter officially recognized as the president of the Cuban Council of State. As recently as August 2010 Fidel's reappearance to give speeches, grant media interviews, and pose for public photos has only thickened the plot on the various speculations of the associations between his bodily health and the socialist state. This has led to a resurgence of questions about the longevity of both.

30. These categories not only take the meanings of terms such as *weak* and *strong* or *authoritarian* and *democratic* to be self-evident, but also are premised on a certain set of assumptions about the nature and function of states. In the end, scholars fall prey to a Eurocentric logic and take for granted that the so-called fully developed or ideal states are Western liberal democratic ones and that they are the norm by which other states are judged (see the work of Sharma and Gupta 2006).

31. For example, the state carries out periodic crackdowns on black market ringleaders (*macetas*, literally "flowerpots"), illegal renters, and *jineteros*, among others, who are publicly arrested and denounced for their activities. While these selective displays of sovereign state power are relatively ineffectual in curtailing the widespread existence of informal activities, they serve to keep them in check. In April 2003, for instance, the socialist government infiltrated several dissident movements operating in Cuba, which state security agents suggested were sponsored and funded by the U.S. government. All of the dissidents were sentenced to long jail terms, mostly ranging from fourteen to twenty-eight years. Shortly after this incident, three men who hijacked a passenger ferry and attempted to steer it to Florida before running out of fuel were sentenced with "very grave acts of terrorism" and were executed by firing squad. While there are clear differences between political repression and the control of the private informal economy in Cuba, several of my interlocutors in Cuba commented that the state's severe, brutal response to the dissidents and hijackers had temporarily resulted in a noticeable decrease in certain sectors of the private informal economy (namely, the black market trade in food items, electronics, and construction materials). As one Cuban I interviewed shortly after the

crackdown noted, the government's response was harkening back to the old days and the state's hard-line approach to illegal practices.

32. The gradual dismantling of prevailing forms of the state's social and political control has led to what some scholars argue is the gradual emergence of civil society (see Dilla 1999; Eckstein 1994; Fernández 1998; and León 1997). "Civil society," argues the Cuban sociologist Haroldo Dilla, provides "independent spaces for activities and debate" and "must be seen as the interaction—in words or deeds—among groups that form new power relations or affect existing ones, either by consolidating or chipping away at them" (1999, 32).

33. I take this lead from Roitman's (2004a; 2004b) work.

34. Roitman 2004b, 194.

35. See Aretxaga 2003; Bendix, Ollman, Sparrow, and Mitchell 1992; Coronil 1997; Das and Poole 2004; Gupta 1995; Masquelier 2001; Mitchell 1991a, 1991b; Montoya 2007; Sunder Rajan 2006; and Trouillot 2001.

36. See de Certeau 1988; Hacking 1986; and Pels 1997.

37. Elyachar 2005, 67. Much has been written (critically) about informal economies and shadow economies, and this scholarship informs my analysis (see Burawoy and Verdery 1999; Ferguson 2006; Ledeneva 1998, 2006; Nordstrom 2004; Roitman 1990, 2004b; Verdery 1996; Yang 1994; and Yurchak 1997, 2002, 2005).

38. See Harvey 2003.

39. See Roitman 2004b.

40. Ibid., 192.

41. This linear metanarrative that posits a progression for socialism to capitalism has been classified as a form of "transitology," and highlighted by several scholars who work in postsocialist studies (see, for example, Burawoy and Verdery 1999; Humphrey 2002; Humphrey and Mandel 2002; Verdery 1996, 2002; Yang 1994; Yurchak 1997, 2002; and Zhang 2001).

42. Lo informal in Cuba's health sector is in contrast to former Soviet bloc countries in which informal networks known as *blat* networks undermined the state (see, for example, Field 1995; Ledeneva 1998; Rivkin-Fish 2000, 2005; and Salmi 2003).

43. Garcia 1992, 215.

44. Cited in Constantín 1981, 1.

45. See, for example, Barberia and Castro 2003; Danielson 1979, 1981; Díaz-Briquets 1983; Feinsilver 1993; Farmer and Castro 2004; Huish 2008; Kath 2010; Perez 2008; Santana 1987, 1990; Whiteford and Branch 2008; and Ubell 1989.

46. For the purposes of this discussion, the best way to define *fetishism*, following the anthropologist Michael Taussig, is a state in which "definite social relationships are reduced to the magical matrix of things" (2002, 479). Taussig is building on Marx's discussion of the relationship between capital, workers, and social relations in capitalist nations.

47. Geertz's (1973) paradigm was primarily concerned with how religious symbols provide a representation of the way things are (the "model of") as well as guides and programs directing human activity (the "model for").

48. Scheper-Hughes 1994, 997.

49. See Dalton 1993; Werner 1983; and Hirschfeld 2008.

50. Ernesto "Che" Guevara was a strong proponent of "exporting revolution" to other Latin American countries. See Fidel Castro's speech of 4 February 1962 entitled "The Duty of a Revolutionary Is to Make Revolution: The Second Declaration of Havana," in which he stated, "The duty of every revolutionary is to make the revolution. It is known that the revolution will triumph in America and throughout the world, but it is not for revolutionaries to sit in the doorways of their houses waiting for the corpse of imperialism to pass by. The role of Job doesn't suit a revolutionary" (Castro Ruz 1969a, 104). Che was killed in 1967 while attempting to aid rebel fighters in "making revolution" in Bolivia.

51. Escobar 1995, 213.

52. This echoes Appadurai's (1988) discussion of the complex mechanisms that imbue meaning and value to things.

53. See the work of Hacking (1982) on the rise of statistics in governing society.

1. THE BIOPOLITICS OF HEALTH

1. See Brotherton 2008; Doyon and Brotherton 2008; and Spiegel and Yassi 2004.

2. The Council for Mutual Economic Assistance, 1949–91, was an organization composed of the countries of the Eastern bloc and a select number of socialist countries elsewhere in the world.

3. See Pastor and Zimbalist 1995, 8.

4. See Pan American Health Organization (PAHO) 2001.

5. The Torricelli Act forbids foreign subsidiaries of U.S. companies from trading with Cuba and places a six-month U.S. port ban on ships that have called at Cuban ports.

6. The Helms-Burton bill temporarily halted all direct flights and remittances to Cuba and allowed U.S. investors to take legal action in American courts against foreign companies that were utilizing their confiscated property in Cuba.

7. Brenner and Kornbluh 1995, 39

8. A number of other causal factors are responsible for the current crisis. These include what the policy analysts Ritter and Kirk (1995, 3) argue was the dysfunctional economic architecture, which was inadequate in dealing with a set of three interlinked crises as a result of the cessation of foreign exchange earnings. First, an energy crisis emerged with the reduction of petroleum. Second, an agricultural food-nutrition crisis resulted from reduced agricultural production, including the sugar harvest. Third, a general macroeconomic crisis was reflected in open unemployment, hidden "unemployment-on-the-job" (people being paid but not producing anything), high absenteeism, and a shift to legal or illegal economic activities.

9. See the work of the noted Cuban public health historian Delgado-García 1996c.

10. See PAHO 2001; see also A. Chomsky 2000.

11. See, for example, American Association for World Health (AAWH) 1997; Kirkpatrick 1996, 1997.

12. AAWH 1997, 2.

13. See, for example, Burns's statement of 1997 from the U.S. Department of State.

14. See Nayeri 1995, 326.

15. See also Kirkpatrick 1996, 1997; American Association for World Health 1997, for similar arguments.

16. See McKeown 1976a, 1976b; see also Navarro 2000.

17. It is important to distinguish between clinical medicine and public health. Clinical medicine (or intervention), such as pharmaceutical prophylaxis, may be effective in treating the prevalence of a condition (that is, the number of people who currently have the condition) but is relatively ineffective statistically at the population level. Whereas public health, composed of a spectrum of interventions aimed at the environment, human behavior and lifestyle, and medical care, is more effective at targeting the incidence of a particular condition (that is, the occurrence of new cases). Statistically speaking, public health efforts have been effective at controlling and preventing infectious diseases at the local and population levels, but there is still considerable debate over their impact on treating and preventing chronic illnesses (see Crabb 2001 for review of this debate, particularly in the context of Cuba).

18. In 1993 the government opened a series of Cadecas (that is, Casa de Cambio, S.A.), an operation designed specifically for currency exchange, where Cubans could legally exchange U.S. dollars into *moneda nacional*, or Cuban pesos (or vice versa), at a rate higher than that on the black market. Cuba thus entered into a state-approved dual economy.

19. This term is used in Cuba to refer to anyone who does not support the Cuban revolution. Often used in reference to Cubans who live in exile in Miami, it is also known as the Mafia of Miami.

20. Mutual benefit societies, known as *mutualistas*, consisted of medical insurance collectives; the members paid monthly dues (see chapter 3).

21. My research suggests that individuals tend to prefer products, including drugs, produced and manufactured abroad because they believe the quality of Cuban-made products is poor. While individuals discuss with admiration Cuba's scientific research community (*el pueblo científico*) (see chapter 6), they attribute the poor quality of drugs manufactured in Cuba to the widespread theft in state-run industries, which results in employees cutting corners to steal the basic ingredients to sell on the black market.

22. See Eckstein (2009, 190) for a detailed discussion of this subject.

23. See Dilla 2001.

24. This figure is reflective of the formal routes of sending money to Cuba, that is, the large and small money agencies that are dedicated to remittances to the island. Manuel Orozco (2002) notes that informal sources (for example, sending money via Canada, money provided to individuals by tourism, and money sent through friends and family members) may push this figure above one billion dollars. In 2002 over 90 percent of the reported remittances sent to Cuba originated from Cubans living in the United States. There is a growing body of literature that addresses the critical role of remittances in both the formal and informal economy in Cuba (see, for example, Díaz-Briquets and Pérez López 1997; Eckstein 2009; Kildergaard and Orro Fernández 2000).

25. Some scholars estimate that the proportion of the population that has access to dollars through various channels reached 62 percent in 1999 (Ritter and Rowe 2000, 11–12). This number is difficult to estimate, but I suspect the figure is much higher, especially given that in addition to remittances, many individuals are involved in *trabajo por cuenta propia*, or self-employment for private profit (see Henken 2008).

26. There is an ongoing debate over the use of the terms *Afro-Cuban* and *black* (see, for example, Pérez Sarduy and Stubbs 2000). Arguably, all Cubans are Afro-Cuban if one considers their shared African cultural heritage. On the other hand, the term *black* is contentious because it fails to address the mixed racial heritage of many Cubans with darker skin tones. Acknowledging the wider debate surrounding these terms, all references in this book to Cubans of color, or *Cubanos de color*, indicate blacks and people of mixed racial heritage (*mulattos*). The problem of race is complex in Cuba's postrevolutionary environment, which in official state discourse is extolled as a harmonious racial mosaic. Historically, the revolutionary government, informed by Marxist teachings, had emphasized issues of class over race in overcoming Cuba's highly stratified society. The state had hoped that once class-based inequalities were overcome, other forms of discrimination would be overcome as well. However, the concept of race must be situated in reference to the prerevolutionary past, in which a discriminatory social order shaped the lives and experiences of people of color in Cuba. Many Cubans of color have long been considered by many as the main beneficiaries of the postrevolutionary social order and therefore have been deemed a group from which the current government draws unconditional political support. No longer relegated to the discussion of Cuba's postrevolutionary racial harmony, issues of race, racism, and discrimination are now being considered seriously as topics of popular debate (see, for example, Castillo Bueno 2000; de La Fuente and Glasco 1997, 53; de la Fuente 2001; N. Fernández 2010; Pérez Sarduy and Stubbs 2000).

27. See the discussion of campaigns in chapter 3.

28. See, for example, Andaya 2007; Smith and Padula 1996.

29. See León's 1997 work on the rise of *sociolismo*.

2. EXPANDING THERAPEUTIC ITINERARIES

1. The case study of this section examines Santería because of the clear links that are drawn between the spiritual and material, particularly by those interviewed about their physical health and well-being. An examination of individuals returning to Evangelical churches, Catholicism, and other religious traditions is also relevant (cf. Hearn's 2008 discussion of the increasing role of religion in Havana's urban renewal projects). However, Santería was by far the most commonly followed religious tradition among those formally interviewed for this research.

2. See Lewis, Lewis, and Rigdon, *Living the Revolution* (1977a, 1977b): *Four Men* (vol. 1), and *Four Women* (vol. 2).

3. Cf. Barnet 1997.

4. Arnold 1988, 1992; Comaroff 1993; Gilman 1985.

5. Until a new law took effect on 10 November 2011, property sales were not permitted in Cuba, but Cubans can exchange apartments; for example, someone can trade a two-bedroom apartment for two separate one-bedroom apartments (and vice versa), in the case of divorce, family expansion, or to live in a better area or apartment. While simplistic, at least in theory, the practice of housing exchange, popularly known as *permuta*, is rife with illegality involving cash interactions above and beyond the trades. A growing number of informal real estate agents have emerged to facilitate these illegal acts, which people effectively use for profit by manipulating the laws regulating the terms and conditions of housing exchange. See Lewis, Lewis, and Rigdon's ethnography *Neighbors* (1978) for an examination of the politics of housing exchange in Cuba in the 1960s and 1970s.

6. Katherine Hagedorn notes, "The potential to negotiate with, and *resolver* [to solve one's problems] through the *orichas* is inherent in the philosophy of Santería. All of the *orichas* can be favorably influenced by offerings of water, flowers, candles, fruit, honey, candy, liquor, money, fish, birds, or, in serious situations, four-legged animals. . . . Santeria is not only a polytheistic religion with many *orichas*, but each *oricha* also has at least several (and sometimes several hundred) *caminos* [paths or roads to follow]. Each *oricha* is generally associated with certain colors, foods, natural phenomena, and sacred attributes, and these associations and preferences become more specific with each *camino* or avatar of the particular *oricha*" (2001, 213).

7. Castro enjoyed the popular support of *santeros*, practitioners of Santería. Known as *El Caballo* (the horse) in these circles, Castro was assumed to have mysterious qualities similar to those of santeros, who are also known as the horses for the saints. Moreover, the colors of the flag of the Movement of July 26th rebel army, which are red and black, symbolize the colors of Changó, the warrior god in Santería.

8. The work of the anthropologist Roger Lancaster (1988), who examined the rise of liberation theology (the fusion of folk Catholicism and Marxism) in Nicaragua in the early 1980s, is an exceptional example of the way in which religious beliefs can be framed and reinterpreted within the context of solving the material problems of daily life. Moreover, as the Cuban American anthropologist Mercedes Sandoval, who carried out research on the role of Santería as a mental health care system among Cuban refugees in Dade County, Florida, in the 1970s noted, "In an amoral, materialistic, present-oriented society, gods which are conceptualized in pragmatic terms are seen as more real and efficient than sublime deities. The reasoning appears to be that the supernatural powers must be as amoral and manipulative as society today is perceived to be. Consequently, there need be little concern about moral behavior, which is to be rewarded in the afterlife" (Sandoval 1979, 144).

9. Cf. Cabrera 1999.

10. Marx 1977, 64.

11. Neophytes in Santería often stand out because they are required to wear white clothes and coverings from head to toe during the first year as santeros. In downtown Havana countless individuals are dressed in this fashion. As my informant Angela Ulloa pointed out, this was not the case before the período especial.

12. Wedel (2003) focuses on the aesthetics of healing in Santería. The author does not examine the theme of medical pluralism in contemporary Cuba.

13. Nichter and Lock 2002, 3.

14. In this context, the word *war* does not necessarily correspond to any war in particular. Rather, in the mid-1980s, the FAR, under the banner "La Guerra de Todo El Pueblo" (The war of all the people), began investigating a number of alternative strategies for ensuring the survival of Cuban socialism in the event it was ever threatened. This included training the militia and individual citizens for combat, building underground tunnels and safe havens, and investigating MTN and methods for water and food conservation.

15. Ministerio de Salud Pública (MINSAP) 1996, 25.

16. MINSAP 1999, 7.

17. Ibid., 9.

18. See MINSAP 2001, 31.

19. Ferzacca 2002, 50.

20. See Castro Ruz 2002, 2.

3. MEDICALIZED SUBJECTIVITIES

1. Danielson 1979, 2.

2. Cf. Burchell, Gordon, and Miller 1991; Foucault 1991.

3. See Quiroga 2005, 22.

4. See Whitney 2001, 121.

5. See, for example, Ortiz 1995; Barnet 1980; McGillivray 2009; and Mintz 1985 for a historical discussion of the sugar industry.

6. Cited in Lockwood 1967, 104.

7. Gilpin 1989; Gilpin and Rodriguez-Trias 1978, 4; Nelson 1950.

8. See Danielson 1979, 127–63; Gilpin 1989; Díaz Novas and Fernández Sacasas 1989.

9. As several scholars have noted, those left without formalized health care in prerevolutionary Cuba were mostly drawn from the black and colored population (Danielson 1979). The racial and demographic composition of Cuba's social stratification during the *período republicano burgués* was parallel to the color and class hierarchy of the colonial period. Furthermore, as Danielson notes, blacks were excluded from many of the prepaid medical plans (mutualistas) during the prerevolutionary period (1979, 6).

10. Modest estimates at the time placed the infant mortality rate at sixty per one thousand live births and life expectancy at approximately sixty-one years (Díaz Novas and Fernández Sacasas 1989). In addition, in the 1940s Cuba had the highest ratio of hospital beds to population in the Caribbean, of which 80 percent were in the city of Havana (Benjamin, Collins, and Scott 1984).

11. Hirschfeld 2008, 212.

12. See A. Chomsky 2000, 332.

13. Many individuals also used the services of traditional healers (*curanderos*) or healers who were practitioners of Santería (*santería espiritualistas*). Traditional and religious healing services played an active role in the lives of poor rural and urban

Cubans in the prerevolutionary context (see, for example, Lewis, Lewis, and Rigdon 1977a, 1977b, 1978).

14. See also Gilpin 1989.

15. See Gilpin and Rodriguez-Trias 1978, 4.

16. On 26 July 1943 more than one hundred revolutionaries led by Fidel Castro attacked Batista's troops in the Moncada Barracks (Santiago de Cuba), the second most important garrison in Cuba. They were captured and imprisoned before being exiled. This speech formed part of his legal defense. The date, the 26th of July, became the defining symbol of Castro's revolutionary rebel army, which later became known as the 26th of July Movement.

17. Castro Ruz 1983, 72–73.

18. One of the first formalized processes of nationalization was the Agrarian Reform Law, adopted on 17 May 1959. This law prohibited private farms larger than four hundred hectares. The expropriated lands were to be distributed among former tenant farmers and sharecroppers, but during 1961 and 1962 most of the land was turned into state farms. In addition, in March 1968 approximately forty-four thousand small businesses, largely family owned and operated, were closed down by the government as part of a new so-called revolutionary offensive to avoid private ownership. These were small steps in the revolutionary government's greater plan to return the means of production to state ownership. The underlying logic of these reform policies, through the interpretive lens of a Marxist–Leninist framework espoused by the state, would reduce class stratification in Cuban society.

19. Fidel Castro declared the year 1961 the Year of Education, dedicated to eradicating illiteracy in Cuba. Schools were closed and one hundred thousand students from junior high to college level were mobilized as *brigadistas* (brigades), trained, and sent into rural and poor urban areas to teach reading and writing. The program was reported to be successful in reducing the illiteracy rate from 23 percent to approximately 3 percent (Lockwood 1967, 126). Other programs included the campaign to eliminate prostitution, which began in 1961 and lasted five or six years. In addition, the state ran a number of reeducation training programs, such as the Educación Obrera-Campesina (Worker peasant programs), offered to unskilled laborers to provide high school equivalency education in order to be eligible for university preparation programs.

20. There have been no formal diplomatic relations between the United States and Cuba since 1961, although both governments maintain Interest Sections in other embassies in each other's capitals.

21. The PCC is the only legal political party in Cuba, and it exercises de facto control over government policies.

22. Eckstein 1994, 33; Castro Ruz 1969a.

23. Castro Ruz 1969b, 199.

24. Eckstein 1994, 34.

25. The Comités de Defensa de la Revolución (CDRs) were founded in 1960. Organized as *frentes*, or fronts, CDRs are active in a broad range of programs, including recruiting volunteers to participate in public health campaigns, providing education, promoting urban reform, carrying out local administration as well as actively pursuing surveillance work against counterrevolutionary activities. CDR members are known as *cederistas*.

26. The Federación de Mujeres Cubanas (FMC) was founded primarily as a women's movement and played a major role in mobilizing women to pursue postsecondary education, join the labor force, and participate in community defense and surveillance.

27. The Central de Trabajadores de Cuba (CTC) brought together members of sixteen industry-based unions. This organization serves as a channel through which government directives affecting constituencies are disseminated to bolster support and participation (Eckstein 1994). In effect, the CTC is like a labor union organizing all employees at a workplace.

28. Given the selective nature of membership in the PCC, mass organizations often serve as a primary source for recruiting *militantes* (members of the PCC, also known as cadres).

29. See Dilla 1999.

30. Ibid., 32.

31. In addition to the religious and symbolic affiliation of Castro as a messiah (see Fernández 2000a for a more elaborate discussion), Castro enjoyed the popular support of santeros, practitioners of Santería, as I mentioned in the previous chapter.

32. Fernández 2000a, 64.

33. Cited in Lewis, Lewis, and Rigdon, 1977a, 218.

34. The early revolutionary years were not without casualties. While mass organizations grouped ordinary citizens into miniature polities, they also served as a prime means of surveillance and control of daily life. Under siege by both direct and indirect counterrevolutionary activities being carried out by the U.S. government and communities of Cuban Americans in exile, mass organizations responded by becoming active participants in weeding out certain ideas, values, and individuals who were believed to be opposed to the collective vision of a communist Cuba. In 1964, for example, a special program (now defunct), the notorious Military Units to Assist Production (UMAP), was created to reform, through hard labor, people deemed to be socially dangerous, antisocial, or antithetical to revolutionary principles. Interns in the UMAP included, among others, militant Catholics, artists, academics, and homosexuals, self-identified or not. All interns were subject to reform under Castro's vaguely worded pronouncement of the early 1960s: "Inside the Revolution, everything; against the Revolution, nothing." As a result of these repressive practices, the revolutionary government quickly earned an international reputation as a violator of human rights. Domestically, there was a conspicuous absence of dissenting voices, especially those who openly criticized government practices or polices. As Fernández notes, "The many benefits provided (education, health care, guaranteed employment, among others) came with a price attached: conformity to official dogma, and a dosage of control (closely resembling corporatism)" (2000b, 84).

35. Eckstein 1994, 128.

36. Fidel Castro identified health welfare as a basic human right. It was codified as such in the Cuban Constitution of 1976.

37. For example, China and the former USSR.

38. The state's narrowly defined vision of science and development in the health sector meant a disavowal of alternative perspectives and approaches to health care. For example, the role of midwives, curanderos (traditional healers), Santería, and herbal medicine, among other alternatives to biomedicine, were actively marginalized and effectively criminalized as occult sciences in the postrevolutionary environment. This situation changed in the período especial, as I noted in chapter 2.

39. Guevara 1968b, 114.

40. Ibid. This phrase is reflective of the overall philosophy of the revolutionary government, which emphasizes a materialist approach to health, viewing the individual as a social being (worker) in harmony with the physical environment.

41. Guevara 1968a, 119.

42. Eckstein 1994, 130.

43. Gilpin and Rodriguez-Trias 1978, 4.

44. Admissions to medical school were open to everybody in the country, and campaigns were organized to recruit medical students. This differed from the prerevolutionary context, in which the medical school tended to cater to students who could afford to attend. Under the revolutionary administration, free tuition and residential scholarships changed the socioeconomic makeup of the student body. The selection of medical students is based not only on good examination results from grade twelve, but also on the reference from the applicant's CDR. Macdonald, a health care specialist who has carried out extensive research on Cuba's education system, writes, "The CDR record of a person will show, for instance, to what extent a candidate's hobbies throughout his/her school life have been socially 'oriented'" (1999, 94–96). Moreover, as Dalton (1993) has noted, the selection process seeks to promote those students who have most actively participated in la Revolución and are more likely to espouse the values of the dominant state ideology.

45. The training of auxiliary medical personnel also increased during the early years of the revolution. By 1968 there were 17,084 graduates of basic training in nursing and the paramedical professions, and 1,470 of these had completed specialty training after two years of practice (Danielson 1979, 184).

46. Werner 1983, 24.

47. For example, in 1960 the revolutionary government introduced Law Number 723, El Servicio Médico Social Rural. The law required doctors to spend a set amount of time in rural areas, thereby guaranteeing medical and social services to the most marginalized areas of the country. See Gilpin and Rodriguez-Trias 1978; Danielson 1979.

48. See Danielson 1979.

49. MINSAP was created in 1949. It existed as various governing bodies before the revolution. For example, public health was under the direction of the Secretary of Sanitation in 1909, the Ministry of Health and Social Assistance in 1940, and the Ministry of Health and Hospital Assistance in the early months of 1949 (cf. ACIMED 1998).

50. Danielson 1979, 143–44.

51. Dalton 1993; Delgado García 1996a, 1996c; Eckstein 1994.

52. See Gilpin and Rodriguez-Trias 1978, 4; Danielson 1979, 168.

53. Gilpin and Rodriguez-Trias 1978, 4–6.

54. See Feinsilver 1993; Díaz Novas and Fernández Sacasas 1989, 446–64.

55. See Gilpin and Rodriguez-Trias 1978, 7–8.

56. See Díaz Novas and Fernández Sacasas 1989.

57. Ordóñez Carceller 1976, 12.

58. Feinsilver 1993, 37.

59. See Werner 1983.

60. See MINSAP, *Programas básicos* 1977, 79–84; Eckstein 1994, 136–37; Feinsilver 1989, 17.

61. See Eckstein 1994, 136–37; Feinsilver 1989: 17; Andaya 2007.

62. Delgado García 1996b: 11. Feinsilver (1993) has argued that Cuba's impressive health statistics have been the basis for the island's "global empowerment" and a significant source of Cuban nationalism (see also Eckstein 1994, 128, for a similar argument).

63. Díaz-Briquets 1983, 118–19; Santana 1987, 117.

64. See, for example, Cardelle 1994 for a detailed description of curriculum reform; see also *Granma Weekly Review* 1986, 4; Dalton 1993, 123.

65. Fernández Sacasas and López Benítez 1976, 1.

66. Cited in *Granma Weekly Review* 1986, 4.

4. CURING THE SOCIAL ILLS OF SOCIETY

1. MINSAP 2001, 10.

2. Ibid., 11.

3. According to the MINSAP, over 50 percent of Cuban physicians remain family practitioners.

4. In 2009 approximately 70 percent of Cuba's total health sector staff was made up of women; women also comprised about 50 percent of the island's family doctors. These figures are indicative of the feminization of medical labor and care giving on the island (MINSAP 2009).

5. My ethnographic field research suggests that, owing to a severe housing shortage in Havana, a significant number of physicians and nurses do not live in the communities they serve. Rather, the health teams commute daily to the *consultorios* in their respective neighborhoods. Only two physicians in the more than fifteen consultorios I researched extensively lived in the same complex, and all the nurses lived elsewhere.

6. Cited in Gilpin 1989, 470.

7. Central to the Alma Ata Declaration (1978) is a definition of health. The declaration asserts that "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and . . . the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector" (WHO 1978, 1).

8. See, for example, Rodríguez and Zayas 1997.

9. Historically the increasing participation of the citizenry in state health reforms