The Pragmatic State: Socialist Health Policy, State Power, and Individual Bodily Practices in Havana, Cuba

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Abbreviations

APS	Primary Health Care Attention
CARE	Continuous Assessment and Risk Evaluation
CDR	Committees for the Defence of the Revolution
CENESEX	National Centre for Sexual Education
CITMA	Ministry of Science, Technology and the Environment
CME	Council for Mutual Economic Assistance (formerly called COMECON)
CTC	Cuban Workers Union
FEU	Federation of University Students
FMC	Federation of Cuban Women
GBT	Basic Working Group
MEF	Family Physician and Nurse Program
MINAGR	Ministry of Agriculture
MINCULT	Ministry of Culture
MININT	Ministry of the Interior
MTN	Natural and Traditional Medicine
MINSAP	Ministry of Public Health
PAHO	Pan American Health Organization
PCC	Communist Party of Cuba
SNS	National Health System
SOCUPF	Cuban Society for Family Planning
UJC	Union of Communist Youth
WHO	World Health Organization

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Abstract

This thesis examines how the recent socio-economic and political arena in Cuba informs the relationship among the idea of population health, national statistics, and the everyday lives of individuals. Post-revolutionary Cuba has used measures of the health of individuals as a metaphor for the health of the body politic, effectively linking the efficacy of socialism and its governmental apparatus to the health conditions of the population. The creation of a model of health care that was informed by the revolutionaries' vision of a new social order, which in turn would help to create an '*hombre nuevo*' (new man and new woman), effectively shaped a model of citizenship that was associated with a particular notion of health, and in addition defined a system of socialist values and ideals. Thirty months of ethnographic field research in the city of Havana focused specifically on the Family Physician-and-Nurse Program — an innovative primary health care program in which family physician-and-nurse teams live and work on the city block or in the rural community they serve. Drawing on my ethnographic findings, I explore two key themes. First, I examine how state policy, enacted through the government's public health campaigns, has affected individual lives, changing the relationship among citizens, government institutions, public associations and the state. Secondly, I examine how the collapse of the Soviet bloc (post-1989) and the strengthening of the US embargo is changing the relationship between socialist health-policies and individual practices and how it has redefined how state power becomes enacted through and upon individual bodies. In particular, I examine how individual practices play an important role in the maintenance of Cuba's population-health profile, as individual citizens give priority to their own health care needs, both material (such as food, medicines and medical supplies) and spiritual (including the re-emergence of religious participants). I explore how citizens negotiate the gap between the role of the state in providing health and social welfare, and their individual desires to seek positive health outcomes, increasingly at their own expense.

Résumé

Cette thèse examine comment les enjeux politiques et socio-économiques ont reconfiguré la relation entre la santé populaire, les statistiques nationales, et la vie quotidienne à Cuba. L'État cubain post-révolutionnaire a utilisé les indicateurs sanitaires comme une métaphore de la santé du corps politique, liant l'efficacité du socialisme cubain et de son appareil gouvernemental aux conditions sanitaires de la population. La création d'un nouveau modèle de soins de santé a été guidée par la vision révolutionnaire d'un nouvel ordre social, qui permettrait la fabrication d'un « hombre nuevo » (homme nouveau), façonnant ainsi un modèle de citoyenneté qui est associé à une notion particulière de la santé et définissant un système d'idéaux et de valeurs socialistes. L'objet de cette enquête de 30 mois à la Havane fut le Programme de santé familiale, un programme innovateur de soins primaires dans lequel des équipes de médecins et d'infirmières vivent et travaillent dans la communauté qu'ils servent, que ce soit en milieu urbain ou rural. Cette enquête permet d'examiner deux thématiques. Premièrement, comment les politiques de l'État, mises en œuvre à travers les campagnes de santé publique, ont changé la relation entre les citoyens, le gouvernement, les associations politiques, et l'État. Deuxièmement, comment l'effondrement de l'URSS en 1989 et le renforcement de l'embargo américain transforment la relation entre les politiques sanitaires socialistes et les pratiques individuelles, et comment cela a redéfini la façon dont le pouvoir étatique se manifeste à travers et sur les corps. Plus particulièrement, j'examine comment les pratiques individuelles jouent un rôle capital dans le maintien du profil de santé publique du pays, car les individus donnent priorité à leurs propres besoins en matière de santé, autant matériels (tels que la nourriture, les médicaments et l'équipement médical) que spirituels (entre autres à travers la résurgence de pratiquants religieux). J'examine comment les citoyens négocient l'écart entre le rôle de l'État, pourvoyeur de la sécurité sanitaire et sociale, et leur quête personnelle d'une bonne santé, qui se fait de plus en plus à leurs dépens.

Preface
La Revolución Full Circle

One afternoon, I walked several miles to a small park in one of the formerly wealthy subdivisions in the city of Havana. My intentions that day were to catch a glimpse of Cuba's Commander-in-Chief, Fidel Castro (popularly known as *El Comandante)*. Several of my close Cuban friends scoffed that I would *actually* go out of my way to see the prodigious leader in person. "Just turn on the TV any day of the week," several of them sarcastically remarked. At the time, *El Comandante* was making regular appearances on the daily political program "Round Table" (*Mesa Rodunda*), which many Cubans I knew despised; they routinely turned off their TV's, tired, they exclaimed, of years of saturation with political rhetoric.

Rumour had it that *El Comandante* was going to make a public appearance to inaugurate, of all things, the new "John Lennon Park." The park featured a life-size bronze statue of the former Beatle sitting on a park bench. Arriving to the park a little late, I had to struggle for a space among several hundred other people, who had also gathered for the event. The anxious spectators included everybody from housewives with curlers still dangling from their hair; staid looking uniformed military officials; groups of teenagers with Bob Marley and popular American punk band T-shirts; elderly couples and uniformed school children; all of them were chanting, "Fi-del, Fi-del, Fi-del!" My camera in hand, I waited. I could not help but sense the irony of this event.

The long awaited moment finally arrived, when *El Comandante's* motorcade pulled up and he stepped out of his shiny black Mercedes. Affectionately raising his arms to the masses (*las masas)*, he was dressed in his characteristic olive green military fatigues and matching cap. His white beard was neatly trimmed. Two women standing next to me were chattering among themselves about how handsome *El Comandante* looked. The rumours of his ill health must have been just that: rumours, one woman remarked. People cheered, while others cried, I assumed, from excitement; a caustic friend of mine later joked, they cried because he was still alive. My attempt to get a clear photograph of Cuba's aging leader was subverted when the crowd began to jostle to get a closer inspection and, in the end, enveloped him completely. While burly guards stood by languidly, people asked for hugs and screamed out affectionate greetings. An intrepid reporter, close to the front of the group, playfully requested whether *El*

Comandante would indulge the audience by poising for a picture sitting alongside the pensive statue of John Lennon. He politely declined.

After more than 40 years of *la Revolución,* John Lennon was being memorialised. Only three decades earlier, he was considered a "longhaired knave" and seen as symbolising anti-social behaviour or, employing the rhetoric of the time, for being "an impediment to revolutionary progress." *La Revolución* had come full circle, I thought. The formerly linear progression toward a defined goal, socialism or communism (often clouded even within revolutionary discourse), had now taken a long circuitous path. The starting point and end points were seemingly merged or intertwined. As I shall examine in this dissertation, for this unpredictable revolutionary journey, a form of pragmatism had become the driving force. Individual Cubans, for their own part, are responding in kind, falling back on age-old tactics and strategies, now reworked to confront new challenges. One thing was clear: many individuals are still dedicated to the former leftist guerrilla-turned-political icon. An elderly woman I interviewed for this research, who was a former university professor, explained this phenomenon as follows, "Cubans are not stupid. They know for better or for worse, it if were not for Fidel we would be like any other third world country: poor and destitute. Fidel is like the family member whom you love to hate. But in the end, you know you can't live without him. Politics aside, people still love him. He is, in the end, what defines being Cuban: fierce, passionate and, at times, irrational."

* * * * * *

When I arrived home from my "sighting," several of my neighbours in the apartment building where I lived wanted to know how *El Comandante* looked. Did he look like he was on his last legs, as the rumours had suggested? Did he subject the audience to one his long-winded speeches? One woman in my building shook her head disappointingly. "You're crazy!" she declared. "What is wrong with you foreigners? You all come to Cuba and think this is fun and interesting to study us. Let me tell you, until you truly live the Cuban experience, you will never know the truth." The source of my neighbour's outburst was the recent departure of a young French couple, who had also been renting an apartment in our building. The couple had arrived in Cuba with an expressed desire to experience Cuban socialism *en vivo*, as they often stated it. They wanted to live with *las masas* and experience the life of average Cubans. With the exception of the rent they paid in US dollars, the couple had attempted to live in

Havana strictly with in the Cuban peso economy. Every opportunity they had, the young couple lectured Cubans who regularly complained about the increasing difficulties of everyday life, often remarking, "You should be grateful you live so well." This comment was often followed with a long tirade of what "real" poverty looked like in poor "developing countries" similar to Cuba. "This is Cuba, not Africa," several of my neighbours fiercely responded. "How dare they compare the two countries [sic]." Cuba was after all, "modern," several of them contended. Based on this privileged status, Cubans expected a certain standard of living, similar to people in other economically "developed countries." A close friend of mine rhetorically asked, "Is this not what *la Revolución* was for?"

Given the interpersonal dynamics of my building, the young couple were the source of much gossip, and were often called "cheapskates" (*tacaños)* and "ridiculous" (*ridiculos).* In a matter of months, the couple conceded, "Life was too hard." The frequent blackouts, crumbling local transportation system, massive line-ups for basic necessities and, importantly, the politics of passively watching other foreigners enjoy the now popular socialist resort island — while not being able to participate in the fun— was simply too much. The couple moved out of the building and were later spotted in US-dollar shops, tourist restaurants, and expensive hotel boutiques. Several of my neighbours relished in the young couple's defeat. "It is impossible to live in Cuba without access to US dollars (*divisa)*" several of my neighbours triumphantly concluded. Equally, however, their comments could be interpreted to suggest the improbability of experiencing Cuban socialism in an economy increasingly characterized by market-based economic reforms.

As many Cuban citizens have come to learn, living *la Revolucíon* after the collapse of the Soviet bloc has also meant accepting the very contradictions this political project has now come to represent: a rock star, formerly considered counterrevolutionary, is memorialised by the socialist government; the US dollar becomes pre-eminent in an economy in which the average person is paid in Cuban pesos. But these disparate events have a common theme. The clashing of the small island nation and the capitalist world economy has heralded a new beginning in Cuba's revolutionary historiography: that is, Cuban socialism is in what Stefan (2002) terms the "post-communist era."

* * * * * *

I arrived in Havana, Cuba for the first time in the summer of 1997, during the 14th Annual International Communist Youth Festival. At that time, I was hoping to take a break from fieldwork for my MA thesis on the politics of stigma in an HIV/AIDS Hospice in an inner city community in Kingston, Jamaica. Seeking out my friend, who was then conducting her MA research on urban agriculture in the city of Havana, I arrived on the island at a time of much fanfare. Students from across the globe swarmed the crumbling streets of the city-centre brandishing ideological slogans printed on signs, T-shirts, and banners, several read: "Socialism or Death!" or "Long Live Fidel!" My introduction to Cuba, then, rather, than being a benign tourist experience, was undeniably a political event. Unlike my fellow *compañeros* in Havana at the time, I was not adorned in a stylised Ernesto "Ché" Guevara beret, nor had I acquired the ideological vocabulary of Fidel Castro, Jose Martí, Karl Marx, or Vladimir Lenin. Having visited the former USSR in 1988 — right before the fall of European communism — as part of a three-week school trip, many of the images I encountered in Cuba were surprisingly familiar. I remember very clearly actively participating in the various parades and political marches, often drawn in by the sheer euphoria of the chants and being part of a greater collective.

When I arrived in Cuba, I was already interested in the broad theoretical issues concerning health, identity, the body, and the emerging literature on post-colonial studies. Growing up in Canada, with parents who refer to "home" as Jamaica, the island were they where raised and educated as British subjects in the 1940s and 1950s, from an early age I had been nourished on personal accounts of the wrongs of imperialism and colonial domination. Not surprisingly, Fidel Castro was an influential person in my childhood. Rather than being labelled pejoratively a "communist" or "dictator," as he had been in so many other households, he occupied a privileged position in my house. Fidel Castro's image, built on the collective ethos of so many people from the so-called "Third World," was a beacon of light, an exemplary model of anti-imperialism. Thus, my initial entry into Cuba, shaped by my parents stories, was sympathetic — perhaps naively — to what I had come to understand was Cuba's unique role in Latin American and the Caribbean, as symbolizing "hope;" that "small people" could have a voice in the context of the world political economy, where people of the "Third World" were often disadvantaged players. As my parents bluntly put it, "Castro kept the Americans out!"

In contrast to the conditions of poverty and poor health I found while doing my MA research in Kingston, Jamaica, when I arrived in Cuba, what I saw stood out as

an example that developing countries and positive health indicators are not mutually exclusive categories. When I made the decision to switch my dissertation research to Cuba, I was interested in carrying out a comparative study between the two islands on the management and control of infectious diseases. However, after serious contemplation, I decided to focus on Cuba alone, in order to do justice to the massive social and material changes that this island has undergone throughout the last 50 years. In May 1, 2001, after nearly a year of fieldwork in Havana, I recall, once again, marching down the streets of Havana, this time on the Avenue of the Presidents, famous for the *Primero de Mayo* Labour Day festivities. Alongside me were the *papier-mâché* heads of Prime Minister Jean Chrétien, President George W. Bush, and the former President Alberto Fujimori, who danced on top of poles as symbols of shame for their recent votes against Cuba at the UN for human rights violations. By that point, I had become more nuanced in my appreciation of the positive and negative aspects of Cuban socialism. Moreover, I had also grown accustomed, with the help Cubans on the island and abroad, to understanding the political nature of working and living in a country that has both spurred contempt and earned admiration the world over.

As of today, more than seventeen full pages of my passport are filled with entry and exit visas reading, "The Republic of Cuba." Since arriving home from my field research shortly after the unfortunate events of September 11, 2001, I find that customs officials at airports and border crossings always question me about my frequent travels to and from Cuba. One Canadian customs official responded to my complaints of harassment by saying, "What do you expect? You are working in a terrorist country." Her remarks echo the opinions of many, who are morally outraged that I "work in socialist state." As an invited guest at a dinner party in Rochester, New York earlier this year, a close friend of mine naively introduced me as "working in Cuba" to the other guests, which effectively put a damper on the entire evening. "But, do you actually support the Castro regime?" several guests angrily queried. Disturbed that I may actually be a "communist sympathizer," several of them lectured me on the atrocities of the Castro government. I dared not engage them in a Noam Chomsky version of US domestic and foreign policy that questions the politics of pointing fingers without critical self-reflection.

As a scholar working in Cuba, I inevitably have to broach the question of whether I support Cuba's revolutionary government and, by implication, the man-in-

charge, Fidel Castro. By answering this single question, I apparently position myself within the ongoing debates about democracy, human rights and, by extension, give people a lead as to how to read what I write and, situate what I think about Cuba. My frustration with this line of questioning is the reduction of research to an investigation of moral absolutes, by which I am forced to claim that "Cuba is bad" or "Cuba is good" based on an examination, in my case, of Cuba's health care system. I purposefully do not participate in this debate. I acknowledge that my research is informed in many ways by who I am as a person, but I also believe that my personal opinions of Castro's government are neither relevant to nor cogent in this discussion. Instead, what I offer is a critical examination of ongoing social processes from the standpoint of Cuba's primary health care system. In doing so, I chronicle the massive social and political changes occurring throughout the island through the lens of an ethnography of individuals' health practices and experiences of everyday life in contemporary Cuba.

Introduction

Living la Revolución[1]*: Disentangling Practice from Ideology*

As I walk along one of the many streets in the formerly posh suburbs of Havana, I am struck by the contrast between 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 invention born of necessity. Romanesque pillars bathed in soothing pastel colours, now faded, complement large windows and crumbling balconies that contrast with decorative rusting ironwork and gardens in disarray. It is not uncommon to find the bust of Cuban independence fighter Jose Martí standing proudly in the centre of many of these gardens, 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 US-dollar-store Sony or Panasonic speakers placed strategically in the rear windows of the car; the booming repetitive bass and synthesized voices remind me that, despite appearances, we are in the so-called new millennium. Laundry hanging out of ornate colonial windows and the buzzing sound of pressure cookers softening the daily fare of black beans (frijoles negros) is matched by the shrill laughter of brightly uniformed children on their way home from school. People forming a winding line-up in front of the local ration store (bodega) 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 forming 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[2]*.*

Cuba's primary health care system is a microcosm for the broad social, political and economic changes that characterize contemporary Cuban life. This dissertation explores how the recent socio-economic and political arena in Cuba shapes the relationship among population health, national statistics, and the

[1] In Cuban Spanish, all references to the 1959 Cuban revolution are capitalized. In the translation of all field interviews from Spanish to English, I have maintained this rule. In this way, I hope to convey how individuals express feelings and ideas about the *la Revolución* as an agent capable of acting on an individual. Equally, however, I recognize that I may also inadvertently reify *la Revolución* by making it stand out, both literally and conceptually. This is not my intent. Rather, I wish to draw critical attention to the mechanism by which ideology, in this context, becomes naturalized in everyday interactions.

[2] This passage is taken from my fieldnotes, dated January 10, 2001.

everyday lives of individuals. More specifically, I examine two key themes. First, I examine how state policy, enacted through the government's public health campaigns, has affected individual lives, changing the relationship among citizens, government institutions, public associations and the state. Second, I examine how the collapse of the Soviet bloc after 1989 and the strengthening of the US embargo is changing the relationship between socialist health-policies and individual practices and how it has redefined the way in which state power becomes enacted through and upon individual bodies. Similar to other spheres of Cuban society, the health-care system has been affected by the increasing market-based reforms, such as the socialist government's pursuit of a dual economy —— Cuban pesos and US dollars. These reforms characterise some of the implicit contradictions of the socialist state and, importantly, shape individuals' experiences with, and around, institutions of the state.

Cuba's primary health-care system, by definition, extends beyond treating health and illness as mere physiological states. The socialist government has made health a defining characteristic of its revolutionary reform. Underpinning this commitment to health is the notion that the health of the individual is a metaphor for the health of the body politic, effectively linking the bodies of individuals to the political project of socialism and its governmental apparatuses. For this reason, an ethnography of Cuba's primary health-care system must also be an ethnography of the roles of institutions, the state, and individuals in shaping public health policies, and an examination of the ways in which these polices affect the everyday experiences of individuals.

My study takes as its object of investigation Cuba's current Family Physician and Nurse Program — *Programa Médico y Enfermera de la Familia* (MEF) — an innovative primary health-care program in which family physician-and-nurse teams live and work on the city block or in the rural community they serve. Through an ethnographic exploration of the relationship between health policy (of which the MEF program is an example) and individual experiences, I examine how this relationship is influenced by such factors as age, gender, "race" and personal political and religious affiliations. How, I ask, have external factors, such as the US economic embargo and the collapse of the Soviet bloc affected individual health and medical practices in Cuba? More broadly, what is the

impact of these factors on health-care research and its application, and on the lives and health of individual Cubans?

Theoretical Perspectives and Organization of Text

While many social scientists have examined public health-care in Cuba, none have explored the interrelationships among the individual practices of health care professionals and ordinary people, health policies, and state power in Cuba. Most research on the Cuban health and welfare system lacks detailed ethnographic analysis and tends to reify post-revolutionary ideology as a major policy determinant while ignoring how health reform might also be grounded in larger economic and political considerations, many of them external to Cuba, as well as in changing practices in the everyday lives of citizens. My dissertation addresses this theoretical gap in the literature by directly exploring the relationship between Cuba's health ideology and individuals' experiences of it. In order to look at the multi-level dynamics of the relationship between the individual and the state in the context of Cuba's socialist health-care system, this dissertation draws on recent scholarship in anthropology, post-colonial studies, political sciences and sociology, as well as on research in the fields of health and development studies. I also draw on recent anthropological scholarship that has called for a critical interrogation both of the cultural production of biomedicine and of the knowledge and practices of biomedicine that are culturally constructed and situated within broader power relations (Lock 1993a; Young 1995).

Several recent studies of public health in Cuba have described 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" (Scheper-Hughes 1994: 997; see also Cortiñas 1993; Dalton 1993). These studies have cast the Cuban citizenry as unwitting actors in an unfolding play of disciplinary technologies, and have uncritically adopted the premise that state health policies such as increased health surveillance of the population inevitably shape, regulate and control people's everyday practices and experiences. These studies rely heavily on a state-centered approach in which individuals are perceived as passive subjects of state rule (cf. Horowitz 1995). Such interpretations of Cuban life suggest that the Cuban socialist government

is unchanging and unresponsive to political pressures both from within and without the country.

My dissertation distances itself from these studies, which posit the contemporary socialist government as a powerful state that dominates a fragile and weak civil society. Rather, I explore issues of state power, not as a monolithic function, but as a proliferation of strategies that shape individual experiences (cf. de Certeau 1988; Hacking 1986; Pels 1997; and, León 1997 for a critique of the totalitarian model of Cuba). Anthropologist Akhil Gupta argues that "studying the state ethnographically involves both the analysis of the *everyday practices* of local bureaucracies and the *discursive construction* of the state in public culture ... it allows the state to be disaggregated by focusing on different bureaucracies without prejudging their unity or coherence. It also enables one to problematize the relationship between the translocality of the 'state' and the necessarily localized offices, institutions, and practices in which it is instantiated" (Gupta 1995: 375-376, emphasis original; see also, Mitchell 1991a; 1991b; and Bendix *et al.* 1992 for critiques of state-centered approaches).

In the chapters that follow, I draw on Foucault's later work on governmentality[3], described below, to examine how the socialist state, as instantiated in state health policy, has contributed to the management of social and individual bodies in numerous ways. This process has in turn introduced new modes of surveillance, disciplinary techniques, and forms of self-governance into everyday life that both limit and, importantly, enable individual agency. Central to my study is an examination of the historical construction of the socialist state's primary health-care system during three critical periods: the Bourgeois Republic (*Período Republican Burguesa*, 1902-1958); the Socialist Revolution (*Período Revolucionario Socialista*, 1959-1989); and finally, the Special Period in a Time of Peace (*Período Especial en Tiempo de Paz*, 1990-present). I have divided my discussion into three parts (not necessarily in chronological order) that focus on specific ethnographic and theoretical themes in each of these time periods.

[3]See, for example, Foucault's three volumes on the *History of Sexuality* series (Foucault 1990a; 1990b; 1988) and his lectures on governmentality (Foucault 1991).

Part I "Rethinking Revolution:" Genealogies of the Cuban Republic

In *Part I*, I provide a genealogy[4] of the Cuban Republic's historical formation after the island's independence from Spain in 1902. I trace how the island's post-colonial victory was short lived, as it became a "virtual colony" of the United States until 1959. Post-revolutionary Cuba, therefore, is also post-colonial. As various post-colonial theorists have noted, the prefix "post" in "post-colonial" (or "post-revolutionary") is problematic, mainly because the "post" implies an aftermath in two senses —— temporal, as in coming after, and ideological, as in supplanting (Loomba 1998; Appiah 1996). The former, post-colonial critics argue, relies too heavily on a teleology of a Eurocentric history-as-progress framework (cf. Shohat 1993; McClintock 1995; Dirlik 1994; de Alva 1995), and elides the critical distinctions between the chronologies of what Franz Fanon (1959) has termed "de-colonization." The latter, Marxists would argue, disguise the fact that many aspects of neo-colonialism, neo-imperialism and other forms of economic oppression have been at work to different degrees until the present day. In other words, we must ask have the inequities of colonial rule been erased, and can we thus speak about the absolute demise of colonialism? I examine whether some of these theoretical insights are also applicable in an analysis of Cuba's post-revolutionary situation.

Part I is divided into two chapters. Chapter one serves as a historical introduction to Cuba and examines the ideological demarcation between the island's pre- and post-revolutionary eras. Through a brief review of the repressive economic modes of production in Cuba's *período burgés* (1902-1958), I shed light on the unequal power relations in the appropriation and exploitation of labor in the island's sugar harvest (*zafras*). This discussion provides a framework for explaining some of the pervasive social and material conditions that, in part, inspired Cuba's insurrection movement in the late 1950s. My intent in this chapter is to explore how Cuba's past and present are inextricably tied to the island's historic struggle for political emancipation. Part of Cuba's

[4] I use the term genealogy in the Foucauldian sense of a "method that takes seriously the truth claims people make regarding the knowledge they have of themselves while, at the same time, understanding such knowledge as a relation of power" (Lacombe 1996: 348). In an attempt to address this methodological approach, I have integrated the narratives of several informants throughout the text as a way of presenting their personal lived experiences and accounts of historical and current events in Cuba.

pre-revolutionary legacy is as an island where the powerful forces of colonialism brought together an ethnically heterogeneous population with entrenched socio-economic class divisions. Together, these factors contributed to competing visions of the island's future. As Cuban studies scholar Damían Fernández notes, "While aspiring to political modernity (namely, sovereignty, a rational state bureaucracy, and democracy either liberal or socialist variants) implied in *cubanidad* [Cuba as a nation-state], Cubans carry in their world-view alternative normative and instrumental standards — ontological and epistemological — originating in different political traditions that collide with modernity" (Fernández 2000b: 80). The 1959 Cuban revolution, therefore, marked a particular juncture in the trajectory of the island's history.

Shortly after the Kennedy administration came into power in the US in the early 1960s, the newly appointed director of the brand new Latin American mission, Arthur Schlesinger, declared that the problem of Cuba was "the spread of the Castro idea of taking matters into one's own hands" (cited in N. Chomsky 2000: 89). What was misleading in this statement was the very premise that the "Castro threat" was —— and is —— a new phenomenon. I argue that Cuba's revolutionary discourses reformulate and reframe ideological aspirations that have existed from the late eighteenth century. The revolutionary guerrilla struggle was only one battle, among many, to achieve sovereignty from foreign domination: first from Spain and later from the US. When the Castro government declared the Marxist-Leninist underpinnings of *la Revolución* in 1961, the island was duly thrust into the geo-politics of the Cold War and, effectively, the original anti-imperialist orientation of Castro's earlier revolutionary speeches took on a decidedly Bolshevik turn, due in part to the financial support of the Soviet Union.

Chapter two provides an introduction to contemporary Cuba and in particular to the nature of Cuban socialism as it has come to redefine itself after the fall of the Soviet Communist bloc in 1989. Since approximately 1990, largely as a result of the collapse of the Soviet Union — Cuba's major source of trade, credit and aid — the basic relations of production and distribution established in the first three decades of the revolution have been eroded and the social safety net left in tatters. This chapter provides an ethnographic account of the everyday experiences of individuals living *la Revolucón* in Cuba's *período especial*

(1991 to the present) and serves as a backdrop to situate my study of Cuba's current primary health-care system.

Part II Socialist Governmentality, Public Health, and Risk

In *Part II*, I move my discussion to an examination of Cuba's primary health-care system. In particular, I examine the interrelations among economic, ideological and geopolitical factors in the development of public health services in post-revolutionary Cuba. In addition, I focus on the ways in which these factors interact with the construction of an image of a healthy nation. Social scientists have argued that examining governance is important for revealing the underlying mechanisms and practices through which power relations operate. Many of the contemporary concerns with governance, for instance, have drawn on the concept of governmentality (Foucault 1991) in order to examine how a liberal mode of government, typified by a focus on the production of a community of autonomous individuals, is increasingly mediated through understandings of health risk. The notion of being at risk, researchers argue, has become a central feature of public health, especially health-promotion campaigns, and has both disciplinary and regulatory potential (Petersen and Lupton 1996).

In order to draw attention to the coercive and non-coercive strategies that the state and other institutions urge on individuals seemingly for their own benefit, studies of governmentality and public health have emphasized the strategies used to direct individual conduct. These studies have drawn attention to the changing notion of risk and, in particular, to the ways in which preventive strategies used to detect risk dissolve the notion of a subject or specific individual, and put in its place factors of risk. Such a transformation has led to a focus on collective risk, or on the identification of potential risk at a population level. Populations from the nineteenth century onward have been increasingly managed on the basis of profiles of factors such as individual age, social class, occupation and gender. The enumerative technologies and interventions used to identify these and many other factors add up to "epidemiological risk."

In other words, one of the dominant features of liberal governance and public health has been a concern with the health and behaviour of autonomous

individuals who are at the same time members of a population, in which issues of risk intersect with issues of national policy and power (cf. Gordon 1991: 4-5). Given these characterizations of liberal governance, how would one characterize *socialist governance?* If "socialism itself does not possess and has never possessed its own distinctive art of governing" (Gordon 1991: 6; cf. Hindess 1993), are conventional notions of *governmentality* applicable in the socialist context of post-revolutionary Cuba? I argue, following the work of Dean Mitchell (2001), that these notions are indeed applicable[5].

Part II addresses these theoretical concerns and is divided into three chapters. Chapter three examines Cuba's public health revolution historically, drawing attention to changing governmental apparatuses involved in delivering post-revolutionary health services and, in turn, to the changing relationship between the individual and the state. I describe the antecedents of Cuba's current primary health-care system, to which the "Family Physician-and-Nurse Program" (MEF) is central. I argue that the strategies and policies used to expand and develop an efficient public health system required an increasing degree of state intervention, management, and protection that reinforced the infrastructure and institutions necessary to create, regulate and produce "governable subjects" (cf. Burchell *et al.* 1991; Foucault 1991). For instance, the creation of a new model of health care that was informed by the revolutionaries' vision of a new social order, which in turn would help to create an *'hombre nuevo"* (new man), effectively shaped a new model of citizenship that was attached to a particular notion of health and in addition defined a system of socialist values and ideals.

Chapter four extends the discussion begun in chapter three, tracing the most recent phase in the development of Cuba's current primary health-care-and-prevention program, the MEF program, and placing it within the context of the *período especial* (1990-present). I argue that the state's gradual refinement of

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[5]A growing body of scholarship is critically examining whether a Foucauldian framework is at all applicable, or even relevant, to the study of resistance, authority relations, and power outside of non-Western contexts (see, for example, Gupta 1999; Mitchell 1991b; Mundimbe 1988; Spivak 1985; Stoler 1995; Thomas 1995; Vaughan 1994). Equally, some feminist scholars have further added that a Foucauldian approach runs the risk of failing to address the specific issues of gender inequality and the need to be sensitive to the ways in which power differentials are uniquely gendered (Harstock 1990; Sawicki 1991). My analysis is informed by these ongoing debates.

socialist health policies, with their emphasis on treating both the individual and social body, reshaped the individual citizen's sense of self. Drawing on ethnographic fieldwork, my central argument in this chapter is that Cuba's current public-health policies serve as a vehicle for introducing socialist rationalities of governance; that is to say, Cuba's health policies work to (re)produce socialist ideology in the institutions and practices of everyday life. Following the work of Shore and Wright (1997: 29), this chapter deals with health policy not so much as political discourse, but rather as a form of power that works upon the individual's sense of self (cf. Foucault 1991; Lupton 1995; Petersen and Lupton 1996).

In chapter five, I examine the health-promotion and disease-prevention campaigns carried out through the MEF program. I examine the notion of epidemiological-risk and governance to explore how health education and preventive strategies operate and how they may be taken up, negotiated or resisted by those for whom they are intended. My intent in this chapter is to move away from the social control thesis so prevalent in the literature on governmentality, public health, and risk. While superficial analyses of Cuba's socialist contexts may suggest that it provides an ideal model to study the exercise of disciplinary power *in situ*, I argue that individual citizens can and do critically respond to these strategies. Furthermore, there is an assumption, embedded in these studies of governmentality and risk, that suggests that epidemiological-risk strategies and health promotion campaigns effectively work to produce subjects who passively take up government imperatives. As Foucault has acknowledged, "the existence of strategies of power does not necessarily correspond with the successful exertion of power, and that intended outcomes often fail to materialise because disciplinary strategies break down or fail" (cited in Lupton 1997: 102).

While the accounts provided by Foucauldian scholars of risk and governmentality, in the context of public health, have drawn attention to the ways in which subjects are regulated via the apparatus of governmentality, they have not dedicated sufficient attention to how people respond, adapt to, or resist these discourses as part of their everyday lives. This over-reliance on discourse analysis, therefore, has created some unexamined areas in the literature. Scholars have tended, for instance, to represent the Foucauldian view

of the self as a universal category without recognizing the varying ways in which people of different age, gender, ethnicity, and so on may respond to discourses and strategies (cf. Lupton 1999). I would argue, therefore, that governmentality studies of risk need to be more richly integrated into ethnographic contexts with a stronger consideration for how ordinary people incorporate governmental health imperatives to suit their own ends (see, for example, Lock and Kaufert 1998, who review similar themes in relation to women and the use of biomedical technologies). This discussion leads me to the final section of the dissertation.

Part III Cuban Socialism and the Pragmatics of Everyday Life

In *Part III*, I take up an examination of everyday practices among Cubans with an emphasis on issues relating to the body and health. In particular, I examine how the recent *período especial* (1990 – present), characterized by an economy of scarcity and material constraints on everyday life, has seen the state and individual Cubans resort to different pragmatic strategies for survival (*sobrevivencia).* These different strategies — manifested for example, in the thriving informal economy and the state's recent changes in emphasis in medical research and practice — have had indelible social and political consequences for the revolutionary government. I follow the lead of Mona Rosendahl, who argues that "an anthropological study of ideology is not complete without examination of practice — the actions and reactions through which people communicate, enact, and revise ideology" (1997: 5). In this respect, I build on the work of other anthropologists who have demanded a critical reworking of the relationship "between ideology as explicit discourse and as lived experience" (Comaroff 1985: 5; see also Lock's 1993a discussion of menopause and local biologies)[6].

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[6] I use "ideology" in this study, following the work of Allan Young (1983), who makes a distinction between ideology, ideological knowledge and ideological practices. Young differentiates these terms as follows: "*Ideology* is a *process* through which socially significant facts and meanings are produced and valorized, circulated, and accumulated. . . *Ideological knowledge* refers to facts and meanings which have entered into the consciousness of a particular person and now affect that individual's choice of socially significant action. In other words, ideological knowledge mediates between ideology and social behaviour. *Ideological practices* are the means by which (a) people's facts are *materialized,* in the sense that they are made to occur and then given the degree of unity and transcendence needed for them to enter people's consciousness; and (b) these facts are appropriated, in the sense that they are collected and selectively distributed among the people engaged in the knowledge production process" (1983: 204, emphasis original).

My analysis in *Part III* draws on the recent ethnographic and theoretical work on practices. The work of Xin Liu (2000) and Judith Farquhar (2002) are exemplary in this respect. Drawing on ethnographic examinations of practices in post-reform China, the work of both scholars has provided a novel space for theorizing practices in the context of late-socialism (or post-socialism). For example, central to Farquhar's study is an examination of how "everyday life in post-reform China is still inhabited by the nation's Maoist past" (2002: 10). Farquhar's study examines how the ideological legacy of Mao is *lived* in people's mundane practices and embodied habits. The processes described by Farquahar can be applied in the context of Cuba. In recent years, Cuba has been undergoing market-based reforms similar to those in China, although in a limited and scaled-down version. The Cuban government, however, has been adamantly against describing the current socio-political climate in the country as late socialism, let alone as post-socialist. Nonetheless, the contradictions of market-based reforms in Cuba have produced mixed results.

Since the 1959 Cuban revolution, which I have intentionally italicised as *la Revolución* throughout my dissertation —— both to problematize this notion and to draw attention to its animate properties in everyday interactions —— the socialist state has encouraged the formation of a particular subjectivity, that is, of the revolutionary (*revolucionario*). For individual citizens, one result of embracing this revolutionary identity has been the internalisation of the underlying tenets of Cuban socialism. For example, shortly after the collapse of the communist bloc in Eastern Europe, Fidel Castro vehemently defended the continuing survival of Cuban socialism by stating that "ideas and ideology are the first trench in the defence of our country" (cited in *Granma*, December 30, 1989: 1). In this context, Castro invokes the role of Cuba's socialist ideology in shaping people's conceptions of the self and, importantly, the world around them in favour of Cuban socialism.

For example, Cuba's socialist health ideology, in part predicated on the idea that health care is a basic human right, has been successful for the past four decades in changing people's perceptions of the "way the world should work." In recent years, however, the citizenry has responded and internalised this dominant ideology as their justification for engaging in informal (*lo informal*) practices, in order to fill the growing gap between their current standard of

living and the state's crumbling provision of material and social welfare. Individual citizens justify these informal practices, for the most part non-political, by describing them as metaphors of struggle (*lucha*) and sacrifice (*sacrificio*). Ironically, however, the socialist government regularly employs these same metaphors in calls for the population to fight for the survival of Cuban socialism. I argue that rather than see the proliferation of informal health-care practices as critiques of socialism, the population is responding to the changing (and in many ways diminishing) role of the state, particularly in areas where individual citizens believe the state should remain strong.

While doing this research, I examined the practices —— enacted by both individuals and the state —— in Cuba's *periodo especial*, drawing on the theoretical work of Michel de Certeau, and to a lesser extent on that of Pierre Bourdieu (1990). Bourdieu (1977; 1990) has outlined a "theory of practice" in which he advocates the idea of practice as part of his broader argument on the relationship between belief and what he terms *habitus*. He defines the *habitus* in terms of structures, or "systems of durable, transportable dispositions, structured structures" (1999: 53) that are internalised by the subject and that come to generate and organise 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 behaviour (1990; 52). As Farquhar (2002) notes, this concept 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" (2002: 9).

De Certeau (1988) makes a useful distinction between tactics and strategies that is relevant for my study of practices. De Certeau argues that "tactics" are the essence of a theory of practice. The difference between strategies and tactics is key to his argument. Strategies require a subject from which to generate relations with an exterior. Strategic practices, therefore, become possible when a subject possessing will and power (a proprietor, an enterprise, a city, a scientific institution) can exert force over an exterior distinct from it (competitors, adversaries, "targets," or objects of research) (1990: xix). As he argues, "political, economic, and scientific rationality has been constructed on this strategic model" (1990: xix). Tactics, on the other hand, have no

"proper" localisation, and are not strongly separated from the "other." Tactics are opportunistic in application, always on the watch, and innovative. Tactics, therefore lend a "political dimension to everyday practices" (see also Scott 1985; 1990 for similar discussion).

Part III is divided into two chapters. In chapter six, I examine how individual practices play an important role in the maintenance of Cuba's population-health profile, as individual citizens give priority to their own health needs and negotiate the gap between the role of the state in providing health and social welfare, and their own personal desires to seek positive health outcomes, increasingly at their own expense. My hypothesis is that many individual citizens with access to US dollars are increasingly (and ironically) becoming active health consumers in a climate of increasingly scarce resources. In chapter seven, I examine how the socialist state itself, in view of its recent entry into the capitalist world economy, has been forced to adopt certain strategies in the health sphere in order to stay afloat.

Methodological Considerations

To address the theoretical questions above, this dissertation uses an analytic framework that encompasses both *micro* and *macro*-levels of analysis. Ethnographic research focused on participant-observation and interviews with over 80 people in three urban municipalities in the city of Havana and in one rural municipality in the Province of Havana. I lived in the city of Havana for a total of 30 months and my research was broken up into several stages: nine months of preliminary archival and library research from May 1999 to January 2000; sixteen months of dissertation field research from July 2000 to October 2001; and five months of follow-up research from June 2002 to August 2002 and from November 2002 to January 2003.

The bulk of my field research was carried out with residents within a regional division of the Family Physician and Nurse program (MEF), that is, a specific geographic area where a physician and nurse team is assigned to live and work. I will describe this program in detail in chapter four. I conducted participant-observation on the everyday practices and other more formal activities of residents, health-care professionals (medical doctors, nurses, and

social workers), as well as with public citizen groups participating in public health campaigns such as Committees for the Defence of the Revolution (CDRs) and the Federation for Cuban Woman (FMC) (to be described in more detail in chapter one). I observed the process by which individuals access and interact with various health services and professionals (for example at *consultorios* (family doctor offices), homes, public meetings, and so on). One of the primary aims of these activities was to observe how individual citizens, health-care professionals and public organizations (that is, CDRs, the FMC) talk about and participate in the achievement of the stipulated goals of the MEF program.

This research focused on individual experiences and the contexts in which they were situated. I used extensive unstructured and semi-structured interviews[7] to collect life-histories and individual narratives of people accessing health services. I conducted initial interviews with residents within a regional division of the Family Physician-and-Nurse Program[8]. I then carried out in-depth follow-up interviews and traced the life history of specific individuals in each region. I asked individuals to describe their experiences of the public-health system in Cuba and to recall moments or instances in which they felt the health initiatives of the MEF program addressed (or failed to address) their

[7] The majority of my formal interviews were taped. Some individuals, however, indicated they were uncomfortable with being recorded and in those cases, I wrote extensive notes. As a general rule of thumb, I carried out one or two taped formal interviews with an individual in tandem with repeated informal interviews with the same individual. It was my experience that taped formal interviews often created an awkward dynamic by which informants felt pressured to say something profound and, generally, were less likely to speak more freely about their experiences. As a result, I often ended up spending time with many informants on a daily basis — when possible — in an attempt to create less cumbersome interactions.

[8] Every effort was made in this research to interview people who cut across the lines of professional status, class, gender, ethnicity, and sexuality. For example: informants ranged from 21 to 70 years of age; 65 percent of those interviewed were women; monthly "official" state salaries, for those who were employed, ranged from 160 pesos ($7.50US) to 400 pesos ($20US) 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 for tourists and Cubans, both legally and illegally, and receiving remittances from abroad (these individuals made between $20US per month to $400 US per month); educational levels ranged from university graduates to people with no formal educational training. Informants reflected different ethnic backgrounds, and 15 percent identified themselves as gay or lesbian. All the names of the people and places — for example, *consultorios* and the specific subdivision in which they are located — used throughout this dissertation 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. All other translations of both published texts and informant quotations have been made by the author.

personal or community health needs. I also questioned people about what changes they believed could improve health educational campaigns and health services in Cuba in general. The aim of this activity was to ascertain the different paths by which people seek out different health resources (both official and unofficial) and why (cf. Janzen 1978 for a more detailed discussion of 'patterns of resort'). The overall aim of these inquiries was to explore the relationship between the discourses of public-health programs, medical practitioners, and government functionaries, and the everyday experiences of individuals who access health services. In particular, I was interested in understanding the perceptions and experiences of different citizens in relation to the state public-health programs in order to provide an in-depth ethnography of how people adopt, resist, and reflexively engage with health policy to effect changes in their lives and/or social environments.

The Politics of Fieldwork

Shortly after arriving in Havana in July 2000 to begin my formal field research, I set off early one morning to meet a professor from the Cuban Ministry of Public Health (MINSAP). I had met Dr. Liliana 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 earlier sent my proposal for her review, I was anxious to get feedback. She agreed to meet me in her small office, which was located in a crumbling office building in the city centre, which also served as a residence for students. We exchanging formal greetings and immediately sat down. She pulled out the Spanish-version of my proposal, which was now bathed in green ink.

Before launching into her discussion, she first stated, "These are only suggestions, but I think you should strongly consider them." She then looked up at me to circle the phrase "governable subjects" in the opening paragraph. "My dear," she laughed 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 sceptical of my references to various theorists (in particular, 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, which she stated, would be of "greater scientific interest" and, importantly for state reviewers, appropriate in the Cuban context: a comparison between the "cultural models of health care" in the USA, Canada, and Cuba. Excitedly, she sketched out a chart with three columns: one 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 that she had drafted up and once again stressed that the new project was *only* a suggestion. As I maintained a neutral face throughout the 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 that I was in privy to some kind of secret information. After 40 minutes of explaining the importance of a sound methodology, as opposed to anthropological methods, which she despairingly referred to as "simply hanging out," she finished drafting the new proposal. By her account, the new proposal followed the grant guidelines set out by the Pan American Health Organization (PAHO), 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 Masters degree in biostastics. He offered to work with me to make my proposal acceptable to the Ministry of Public Health officials. "Your language is too theoretical," he complained. His remarks were reminiscent of one of the anonymous reviewers of a research grant I was awarded for my dissertation research, who stated, "The project is feasible, despite the cloud-nine theory." Clearly, the presence of Foucault in Cuba was considered a product of my personal whims and, perhaps, not terribly relevant to an examination of the primary health care system. 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, for him, 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 8 MEF *consultorios,* randomly selected across the city, and carrying out extensive survey-like research with several hundred people, at a minimum. Moreover, the new project was devoid of the hallmarks of anthropological research methods —— extensive participant-observation and semi-structured 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 in Cuba. I had a lucky break when, after repeatedly being told by different 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 through a friend of a friend. I sat down with the professor, whom I later found out was also a high-ranking Communist Party member. He closely examined my original proposal and curriculum vitae, and, to my surprise, he expressed great interest in my project. The title of my MA thesis caught his attention: *"Contagious Bodies:" Multiple Narratives from a Jamaican AIDS Hospice.* "It is obvious that the MINSAP will not understand the kind of research that 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 said amicably, "I am sure you will find we are very open minded." He offered me countless number of references and contacts with Cuban medical professionals and personally took on the responsibility of calling the necessary people to make my student research visa[9] possible. In less than a week, with no changes to the original proposal, a local ethnological research institution officially sponsored my dissertation field research.

[9]A medical research institute in the city of Havana sponsored my preliminary visits to Cuba. In chapter seven, I will explain in more detail why I chose to change my sponsoring institution.

Towing the Party Line: Discerning Rhetoric from Reality

Throughout my research in Cuba, I was often disturbed when I compared my fieldwork experiences with those of several other foreign anthropologists who were also working in Havana at the time. As foreign researchers, we were clearly 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."[10] However, the descriptions I heard from these anthropologists had an ominous tone to them, as if they were reading from pages of George Orwell's novel *1984*; the omni-present "Big Brother" was watching and controlling us at all times. As anthropologists, the thought that one's informants' abilities to speak and act freely are compromised by the infiltration of state apparatus into everyday life is disturbing. For the most part, this was not my personal experience of Cuba, although some individuals did interact with me in ways that reinforced the rumours that the populace was being watched and followed by an 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. The most troubling experience involved several interviews I conducted with physicians in the city of Havana, all of whom were recommended to me through my Cuban host research institution. This latter 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 the physicians' responses to my questions. They were reminiscent in both cadence and content to 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)

[10] The plight of Oscar Lewis, the late American anthropologist, is one of the most noteworthy cases. Lewis *et al.'s* (1977a; 1977b; 1978) studies were carried out in 1969-70. These studies were controversial due to their termination by the Cuban government in 1970. Raúl Castro, Minister of the Revolutionary Army, declared that the study "departed from the [agreed upon research] proposals" and carried out counterrevolutionary activities with the aims 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 these events can be found in the Foreword of Volume One of their two-part anthology (1977a).

(cf. Fernández 2000a for detailed description of this term). The physicians' responses, replete with discussions of the successes reflected in Cuba's vital health statistics and peppered with accolades for the MEF program, which is popularly understood as being the product of Castro's innovative thinking, shared common critiques of what was to blame for recent changes to Cubans' health care system: the withdrawal of Soviet aid and, importantly, the US embargo against Cuba (popularly known as *el bloqueo*).

I seriously wondered whether my affiliation with my host institution, which in theory was a non-governmental 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 claims I made about their anonymity were moot. Having carried out extensive preliminary fieldwork in Havana since 1998, by the start of my formal research in 2000, I had already built up a large informal network of friends and acquaintances, many of who 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 "toeing-the-party-line" physicians I encountered in formal interviews were the exception to rather than the rule.

Having carrying out extensive formal and informal interviews among the general public, I encountered a diverse range of opinions and experiences, particularly with regards to the public health system. Is the contrast between individual citizens' comments and the formal interviews with physicians recommended to me by my host institution, an indication of these doctors feeding me state rhetoric? A close Cuban friend of mine made an astute point that help shed light on my dilemma. As he put it, there are typically two kinds of people who flock to Cuba. The first group, he said, are the "idealists." They come to Cuba in search of the image of Ernesto "Ché" Guevara, and with a romanticized vision of Fidel Castro and socialism. The second group, he suggested, are the "critics." They 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 socialist government. This is a risk, he added, that many physicians are unwilling to take with people who have not demonstrated themselves to be trustworthy (*de confianza*).

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. Dr. Marisol Domínguez, a 48-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, including a visit to her *consultorio*. Arranging to meet her at her house, I found the interview revealing in many ways. Throughout the interview, Dr. Domínguez answered all of my questions with monosyllabic responses, and I had decided that the interview was a complete failure. As I finished, 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 where needed in the current primary health care system.

Looking noticeably uncomfortable, Dr. Domíguez 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 work was affected by the recent shortages with food and medicine in Cuba in her *consultorio*, she became visibly disturbed and adamantly stated, "Nobody in Cuba is without adequate food or medicines. Such things are absolute lies if people tell you things are so." Taken a little aback by her hostile response, I inquired about the general shortages that were major complaints in my interviews with the ordinary citizens. "Well, yes," she admitted, "we have some shortages, but they are getting better. Clearly you do not want to focus on this topic when we have accomplished so much in Cuba." I made it clear that 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 that were due to social and political changes in Cuba. Seemingly unimpressed by my explanation,

Dr. Domínguez concluded, "Cubans are prone to exaggerate things, especially with foreigners."

This experience with Dr. Domíguez was similar to several other formal meetings I had with people I refer to as low-level bureaucrats (for example, social workers, MINSAP officials, and so on) who were recommended to me through my host institution. Rather than dismiss these interviews as "rhetoric," I include them alongside other interviews, many of which involve informants with whom I had developed long-term relationships, such as those I met in 1998 or 1999; others only warmed up to me through repeated interviews and extensive participant observation. It's important to acknowledge though, that Dr. Domínguez's comments of the questionable interaction between foreigner researchers and exaggerating Cubans has a certain, albeit limited, ring of truth.

Throughout my fieldwork, it was not uncommon for various 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 "first hand" the abhorrent conditions. I declined. It was obvious that several people clearly had an agenda, which they believed matched my own, to identify faults in Cuba's health-care system in order to undermine the socialist government. When these same individuals had positive experiences with their family physician or state officials, I was not called upon to chronicle those events. Thus, without attempting to censor the experiences of my informants, at times I had to use common sense and my own strategies and tactics in order to tease out the underlying truth(s) in people's everyday experiences.

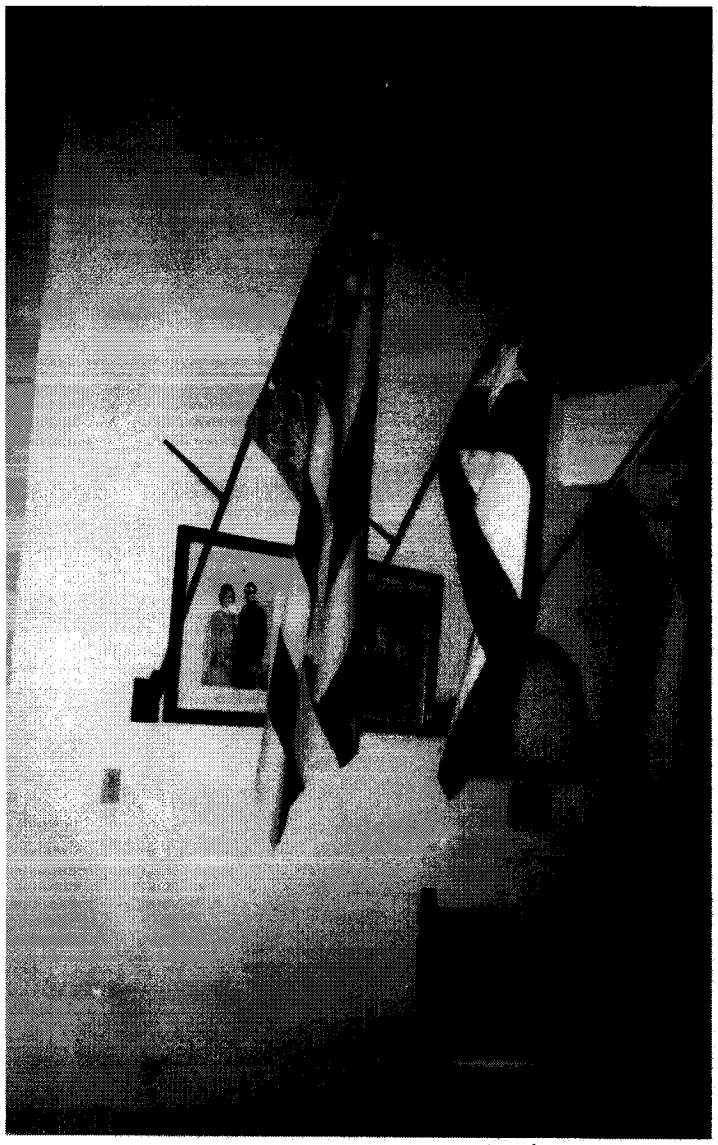
For example, several individuals painted images of starvation and at times complained that the state had not provided basic rations such as those for meat or fish administered through the monthly rations. When I asked to see their state ration books, which I justified by stating that I was merely inquisitive, meat and fish products were indeed provided. Always feigning ignorance —— a strategy I developed in order to appear non-confrontational —— 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 US dollars, yet smoked a particular brand of cigarettes, which were only sold 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 US dollars sell for anywhere between 50 cents to one US dollar per pack. Therefore, some people were smoking from $15 to $30 US a month in cigarettes, yet, by their own accounts, were without access to US dollars.

These are only some among many of the discrepancies between rhetoric and the multiple realities of people's lived experience. Survey research, in this context, would have been unable to address the many nuances —— and contradictions —— of contemporary Cuban life. The findings presented in my study are important and profound in their implications for on-the-ground examinations of everyday local practices and experiences. In the chapters that follow I offer a cross-section of the everyday realities of the people who participated in this research; these accounts provide a snapshot of their lives at particular moments and express their personal experiences, filtered through my interpretations, of living *la Revolución*.

Part I

"Rethinking Revolution:" Genealogies of the Cuban Republic



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The picture of Fidel Castro alongside a portrait of Spain's King Juan Carlos and Queen Sofia in the lobby of a restaurant in central Havana.

Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past. The tradition of all dead generations weighs like a nightmare on the brain of the living. And just when they seem engaged in revolutionising themselves and things, in creating something that has never yet existed, precisely in such periods of revolutionary crisis they anxiously conjure up the spirits of the past to their service and borrow from them names, battle-cries and costumes in order to present the new scene of world history in this time-honoured disguise and this borrowed language . . .

(Karl Marx [1852] 2003: 227)

Chapter One

Genealogies of The Cuban Republic[1]

> Throughout the nineteenth century Cubans appropriated and adapted as a means of national identity, principally to develop alternative forms to Spanish colonial claims, often consciously engaged in a process of self-definition as a means of self-determination. . . Much in this transformation involved Cubans in the appropriation of North American forms, adapting them to their needs, reshaping them in their own image, as imaginative — and, it should be added, effective — devices of national ascendancy. They were conscious of breaking with the colonial past and understood, too, that the point at which the break occurred represented a great divide that had to be crossed; this necessarily meant crossing new thresholds of consciousness of selfhood and nationhood.
>
> — Louis A. Pérez Jr., *On Becoming Cuban: Identity, Nationality and Culture*, 1999: 7.

1.1 Introduction

In the quote above, Louis A. Pérez Jr. reveals the manifest ways in which Cuba's historic relationship with the United States profoundly influenced Cubans identity, nationality, and sense of modernity from the early 1850s, when the island was still a Spanish colony, until the revolution that erupted in 1959. Almost 44 years after the 1959 Cuban revolution, history — as something that is both made and reinvented — has once again greatly influenced what it means to be Cuban. Cubans, whether "in Cuba," "in exile (*exilio*)," or the newest category to emerge, "living abroad" (as opposed to being in a self-declared state of exile), all construct narratives of the Cuban experience in a variety of ways; some are patriotic, bitter, angry, betrayed, or content — and so on. In this chapter, I seek to break down the seemingly neat temporal and ideological divide between pre–and-post-revolutionary Cuba: a divide that has significantly shaped the identities, bodies and experiences of Cubans in the small island nation and beyond.

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[1] I intentionally use the term 'Republic' because it denotes two specific time periods in Cuba: the pre-revolutionary Republic, from 1902 to 1958; and, the contemporary Socialist Cuban Republic, which began in 1959 until present day.

This chapter is situated theoretically within the recent body of scholarship emerging from the intersection of anthropology[2] and post-colonial studies[3], which has critiqued analyses that rely on a linear progress of history and the construction of master narratives. Instead, this emerging literature has emphasized the importance of examining the multiplicity of often conflicting and frequently parallel narratives that shape history and identity (cf. de Alva1995). As such, in this chapter I aim to move away from binary contrasts, or what JanMohammed (1985) has called the "Manichean allegory." "Manicheanism," JanMohammed argues, makes use of neatly bounded discursive oppositions that polarize conceptions: for example, "colonized" versus "colonizer," or in the case of contemporary Cuba, the presumed oppositions implied by the demarcation of pre-and-post-revolutionary eras. To uncritically apply such binary contrasts, JanMohammed suggests, elides nuanced understandings of the implicit complexities involved in these relations; they reduce the plural, multi-faceted and multi-vocal aspects to a unidirectional movement, expressed as a linear view of history, and, ultimately, to singularity. Throughout this chapter, and several others, I have interspersed my informant's narratives[4]. Each personal account, I argue, represents a separate genealogy, which reflects a complex web of different values, ideas, and, ultimately, lived experience before and since the 1959 revolution.

In the analysis that follows, I explore how Cuba's past and present are inextricably tied to the island's historic struggle for political modernity. Despite what may appear to be clear socio-political shifts in Cuba's history — that is, the

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[2]There is a vast and growing field of literature on the anthropology of colonialism (Dirks 1994; Stoler and Cooper 1997, and Taussig 1989), or anthropology and history (Comaroff & Comaroff 1992). Most notably the work of anthropologists' Jean Comaroff and John Comaroff (1991; 1992) has served as a particularly fertile source of theoretical input. The Comoroffs' analysis of colonialism and consciousness, especially with reference to the powerful ways in which the material and symbolic are incorporated into the global economy, have added greatly to the debates on the heterogeneous aspects of colonizing power and resistance.

[3] Many collections are dedicated to "post-colonial studies;" for example, Ashcroft *et al.* 1989, 1995, 1998; Cooper and Stoler 1997; Chamber and Curti 1996. Moreover, several anti-colonialists scholars noted, before the currency of the term "post-colonial," that the body has served as a crucial site for representation and control (Fanon 1959).

[4]Throughout this dissertation, all italicized excerpts are taken from field interviews.

island's transformation from a Spanish colony (1493 – 1899) to capitalist democracy under the tutelage of United States domination (1902 – 1959), and finally, to socialism (1959 –present) — Cuba's national aspirations, according to Cuban studies scholar Damián Fernández, " . . . have remained rather constant over time. They have been, and continue to be, primarily modern ones: sovereignty, democracy, economic growth through industrialization, and social welfare, in short, modernization" (2000a: 43; cf. Fernández and Cámara Betancourt 2000). In this chapter, I expand on Fernández's argument to examine how the ideological aspirations of the Cuban people have been shaped historically.

In the first section, I provide a very brief genealogy of three dominant cultural paradigms, outlined by Fernández (2000a), in Cuba's "Period of the Bourgeoisie Republic *(Período Republicano Burgués)*" (1902-1958). In the second, I provide a description of Cuba and elaborate on how these cultural paradigms took form in practice through a description of the historical, social and political-economic characteristics of everyday life in the *período burgués*. Finally, I shift my analytical gaze to a review of Cuba's "Socialist Revolutionary Period (*Período Revolucionario Socialista)*" (1959- present) and trace how the construction of the socialist state during the early revolutionary years was prefaced on resolving the Republic's historical problems, namely issues of national identity, the reduction of social and material inequalities, and, importantly, the goal of obtaining national sovereignty.

1.2 Political Modernity and The Politics of Passion

My father was a labourer and my mother was a housewife. In those days, we weren't rich but we had enough to live decently, or let's say, comfortably. My family moved to Havana from Cienfuegos when I was 9. My father was offered a position in the Electric Company, which was an American company back then. He was a good worker, and the company respected him. He was promoted several times. I can remember when I was about 19 or so, every year the Electric Company held exams to seek new employees and the children of "good workers" were always selected. It was a good system because there was a relationship of trust between the employers and the employees.

My sister and I were selected to work at the Electric Company when I was nineteen. Of course, the employers knew that you wouldn't disappoint your parents, so that guaranteed that you would work hard. In those days it was like 165 pesos/month. It was really a good wage, then. I had a car, which I had bought and I lived really well. I went on trips to Varadero, and ate in all the good restaurants of Havana. In those days, Cubans could go to Hotel Nacional or to the Hilton, now

Hotel Habana Libre, and stay in the rooms, or swim in the pools. I travelled to New York and Miami and shopped and always had the latest clothes. It was a really good life back then.

After the la Revolución everything changed. The company I worked for was nationalized and I was "let go" along with a couple hundred other workers. They said, it was because I was actively involved in the Roman Catholic Church, and they determined that I wasn't a person would could be trusted. This was because I wasn't involved in the revolutionary movement, you see. I was immediately re-assigned to a new work centre to help re-educate and train formerly marginal people. I had to be around prostitutes, and people who barely had any education. I had never been around these kinds of people in my life before. Of course, many members of my family left at the beginning of la Revolución. Two of my brothers fled to the United States. One lives in Miami and the other in Connecticut. I stayed in Cuba because I thought the la Revolución wouldn't last. Imagine, here I am still, waiting. After about two years of working in that Work Centre, all the people who were let go by the Electric Company were offered their positions again. I said no, could you imagine? After the fiasco that they had created earlier there was no way I was going to return to that old position. I choose instead to go into an administrative job. I was bright and I had graduated from a technical school for secretaries when I was eighteen, so I had training in this area. I worked as an administrator at a local Factory in Havana. I stayed there until my retirement about 15 or 16 years ago.

—Sra. Raquel Hernández, retired administrator, born in Cienfuegos, 1930.

Historian and anthropologist Nicholas Dirks (1994) suggests that the analysis of culture should be taken as a " . . . site of intervention, dislocation, and struggle . . . to identify and analyse a new set of issues and problems" (1994: 11). Perhaps no scholar of Cuban studies has so thoroughly documented the complex dynamics that have influenced Cuban culture and shaped the construction of Cuban identity (*cubanía*) as Cuban anthropologist Fernando Ortiz[5]. In 1939, Oritz introduced the *ajiaco* metaphor. *Ajiaco* is a traditional Cuban stew-like dish of Ameridian origin, which is cooked over a long period by continuously adding new ingredients — typically different root vegetables — to the simmering mixture. The ingredients of the stew, Ortiz argued, are similar to Creole culture: they maintain their original identity in varying degrees, with some dissolving and blending into the mixture, and others remaining distinct. The

[5] There is an ongoing debate of the terms to be used for Cuban national identity, which oscillate between the following terms: *lo cubano*, *cubanidad*, and *cubanía* (see, for example, Fernández and Cámara Belancourt 2000; Behar 1995). Following the work of Fernández and Cámara Belancourt, all references in this dissertation to these terms indicate the following: *cubanía*, meaning Cuban national identity; *cubanidad*, meaning Cuba as a political entity, a nation-state; and *lo cubano*, as a synonym for the two other terms (2000: 5)

result, Oritz argued, is a heterogeneous mixture that provides a novel way of conceptualising Cuban culture and identity.

In describing the complex appropriation and transformation mechanisms that make up the creolization process, Oritz coined the term "transculturation." This term, Ortiz argued, was to be an alternative to the conventional anthropological term "acculturation," which merely denoted the adaptation of cultural traits from a dominant culture (Ortiz 1995: 97). For Ortiz, Cuban national identity was about ". . . the subjective consciousness and will to be Cuban rather than such external features as national origin, citizenship, or race" (Duany 2000: 22) [6]. Ortiz's theme of "transculturation" has been advanced theoretically in recent literature on subjectivity, driven most-notably by post-colonial studies. The writings of Homi K. Bhabha, for example, have emphasized the failure of much of work in colonial and post-colonial studies to address the "ambivalence" and "hybridity" of identities produced within the dynamics of colonial encounters. Bhabha (1984) argues that scholars have relied too heavily on fixed and stable identities. Rather, he argues, we should be should be breaking down the "Manichean divide," and address how self-Other, that is colonized-colonizer, are necessarily co-produced.

The historiography of Cuba requires an examination of identity that traces the coexistence and confluence of multiple genealogies, similar to the ingredients of the *ajiaco*, each one constituting its own unique social history. 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*). Without subscribing to a model of historical determinism, or an approach that clumps history into easily identifiable patterns, I believe Fernández's work provides an effective analytical tool to deconstruct what may appear as complex and contradictory narratives in Cuba's socio-political history. In the following section, I provide a very brief description of each of the cultural paradigms, present important characteristics and issues, and focus on some of the essential debates in order to provide a greater sense of their interconnections and complexities.

[6] This echoed the earlier writings of Cuban independence fighter José Martí, who had argued a Cuban is more than mulatto, black, or white (Martí 1959).

1.2.1 The Three Cultural Paradigms

Liberal ideology, Fernández (2000a: 27) suggests, reached Cuba from Europe and United States in the eighteenth and nineteenth centuries. Liberalist ideas, he argues, were important in shaping the way in which elites spoke and thought about the future of Cuba. Democracy and national sovereignty were the hallmarks of liberal ideas that became fashionable in the late-eighteenth century. 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 (Fernández 2000a: 27). Ideally, the supporters of liberalist ideas sought to have their aspirations expressed by a sovereign state that reflected the rationalization of modern life. However, the liberalist ideas proved intractable in a country that was still intricately interwoven within the webs of Spanish colonialism, and later neo-colonialism under the domination of the United States. Cuba's quest, sovereignty, thus became an unobtainable goal well into the twentieth century.

Liberalist ideas, Fernández further notes, clashed with Cuba's colonial legacy, of which the second paradigm, corporatism, was a remnant. 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). Corporatism, Fernández argues, was influenced by high levels of economic paternalism and a reliance on the state for the provision of moral and material welfare. "Corporatist movements," notes Robert Whitney, a historian of Cuba, "were a response to the development of mass workforces and the creation of a new urban social class; corporatists wanted to work out ways to control and manage the process of rapid social class formation while guaranteeing capitalist development" (2001: 84-85). The corporatist paradigm was best characterized by the administration of President General Gerardo Machado (1925-1933), a reformist nationalist, who advocated *cooperativismo*. The presidency of Machado was marked by popular uproar as the state increasingly promised far more than it could deliver, both materially and spiritually. I will elaborate upon this theme in the discussion of Cuba's socialist period.

The last cultural paradigm, *lo informal*, Fernández argues, is "closer to a pattern of behaviour (with its own logic, norms, vocabulary, economic rationality, and emotional infrastructure) than to an explicitly articulated intellectual framework" (2000a: 29). Within this last paradigm, individuals subvert the institutions and regulation of daily life in order to satisfy the material and non-material needs of the self, the family and the community. Religious syncretism is an example of *lo informal*. The process by which African slaves came to worship Catholic saints in Cuba's colonial period denotes an outward conformity to the Spanish colonizers' worldview. Yet, privately and informally, these religious symbols took on new meanings to the growing Afro-Cuban population, such as the increasing association of Catholic saints with Yoruba deities. In this way, individuals were not simply receptors of knowledge, but also active agents in shaping that knowledge (cf. Comoroff 1985 for a similar argument in the context of South Africa). Similarly, *lo informal* paradigm was influential in shaping the insurrection movements for independence in the late 1800s, and as I will later discuss, the leftist-guerrilla movement led by Fidel Castro in the 1950s. In the following section, I examine how Fernández's three cultural paradigms took form in the *período republicano burgés* (1902 – 1958).

1.3 *Período Burgués*: Exposing the Fault lines of a Divided Society

Both my parents were labourers. So, basically, I am a descendant of the working class. When I was three, for economic reasons my aunt took me to live with her in Havana. In those times, people tended to have big families, and mine just continued to grow and grow, and this is when severe economic problems developed in my family. My aunt took care of me until her death in 1957, and then I returned to Pinar del Río, That is where I stayed until the first years of the la Revolución. *There were great changes after* la Revolución. *For example, changes in the standard of living, education and food. Many families before the* la Revolución *lived in very poor conditions.*

For example, before 1959, my neighbours also had a large family and the mother worked as a servant in a house, and the kids never had any food to eat. The smallest girl always ate in my house because in her house they always ate very poorly. Imagine, corn meal for lunch and then corn meal for dinner! We didn't live extravagantly, but at the least, we had rice and beans, the food of the poor. We ate, though. The salaries before la Revolución *were very, very small. My mother worked as an agricultural labourer picking tobacco. In a week I think she earned seventy and some cents, well, remember in those times things were much cheaper, but still the prices didn't allow access for everybody.*

As well, there were those people that worked cutting sugar cane. They were paid very little as well. In those times the peasants, for example, worked cutting cane and lived in the countryside and weren't paid directly. Instead, they were

given a quota that they could buy at the local bodega, which was wholly insufficient and so, as you can imagine, they were always in debt from buying food. There was not enough money to buy clothes or other essentials things. As well there was the "dead season" (tiempo muerto) or period of time between the harvests (zafras) when there was no work for the peasants and the people died of hunger, eating only root vegetables or what they could plant on the land, which they occupied, if they were allowed. There was also a great deal of racism at the time. For example, there were parks or restricted areas, one for whites and the other for blacks. In some places, for example, schools allowed blacks and whites to be together, but the kids with black skin were always made to feel inferior. La Revolución changed all of this.

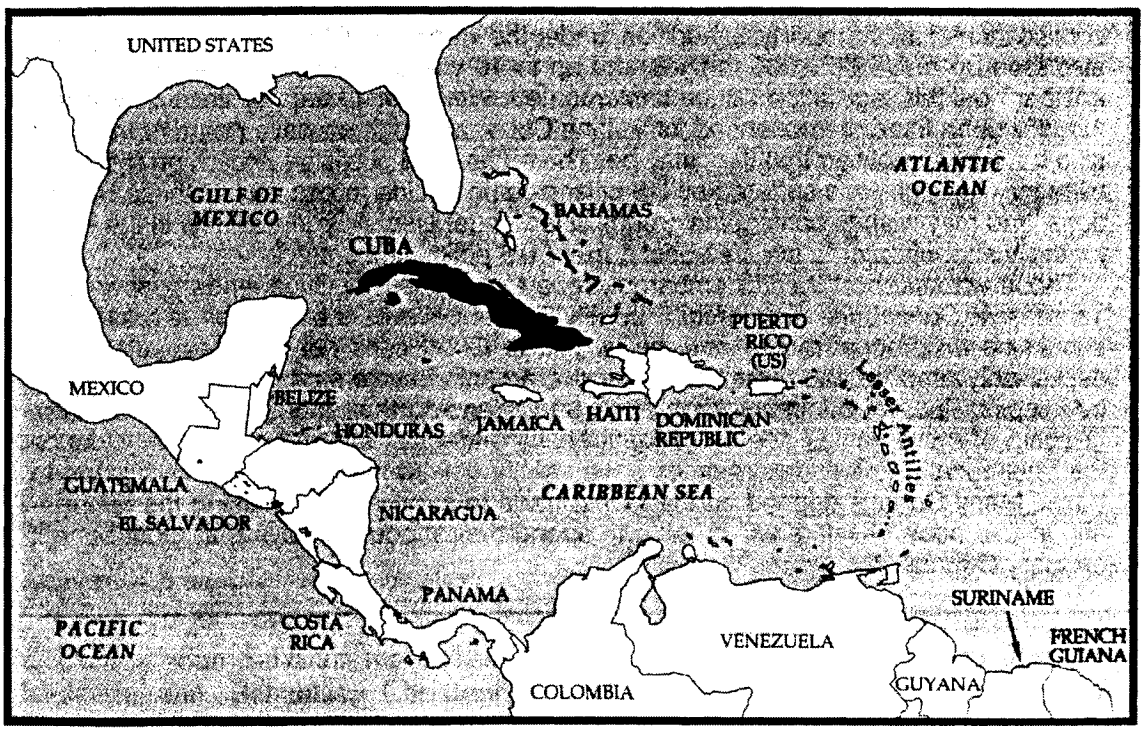
— *Olga Ríos Dilmé, university professor and CDR president, born in Pinar del Río, 1947.*

Located sixty kilometres south of Miami, lodged between the Gulf of Mexico and Caribbean Sea (see Figure 2-1), Cuba was settled by Spain in 1493, and used primarily as a naval base. Following the seventeenth-century introduction of sugar plantations worked by African slave labour, like many of its Caribbean neighbours, Cuba's monoculture export economy prospered, with the United States as its main trading partner. However, strained relations between Spain and the US, the dominant economic power in the region, culminated in the US government's occupation of Cuba after the second war of independence (1895-98). The US government imposed military government on the island from 1899-1902. Under the Platt Amendment to the new Cuban constitution of 1902, the US retained the right to intervene in the Republic's affairs, and exercised this right on several occasions (1906-09, 1917, and 1921).

A series of corrupt administrations, characterised by instability, authoritarianism and gangsterism, marked the period from independence in 1899 up until the 1930s. Despite the abolition of slavery and independence, the cultural underpinnings of the colonial heritage remained important factors in the postcolonial subjugation of Cuba under US tutelage. For example, the term of the Gerardo Machado administration (1925-1933), also known as the *machadato,* was characterized by unprecedented levels of popular protest and opposition, which was met by increasing levels of state violence that eventually resulted in him being ousted in 1933 (see, for example, Whitney 2001 for a more detailed discussion of political changes in Cuba between 1920-1940). In 1933, a rebellion by students and army officers brought Fulgencio Batista Zaldívar, backed by the US government, to power. According to Whitney from 1934- 1936, Cubans lived under a virtual

military dictatorship headed by Fulgencio Batista (Whitney 2001: 121). General Batista stepped down in 1944, although he managed to rule from by the backstage through carefully selected political puppets, but seized power again in a military coup following his defeat in the 1952 elections. Batista remained in power until New Year's Eve, 1958, when he fled with a planeload of his relatives to the Dominican Republic to avoid capture by the revolutionary insurrection movement.

Map1-1: Geographically Situating Cuba



The Batista government, aided, in part, by US corporate interests in Cuba, did little to reduce the problems of structural violence associated with the highly class-stratified Cuban society. By 1956, for example, US interests held 40 percent of the production of Cuba's major export product, sugar; they owned 23 percent of all non-sugar interests, and 90 percent of telephone and electrical services; they also owned and controlled over 188,000 *caballerías* (one *cabelleria* is approximately 13.2 hectares[7] of land), of which over half lay fallow (cf. Blackburn 1989). These enormous tracts of land called *latifundia* where acquired by single individuals or groups, of which large parts were used as reserves, idle, and unutilised (Huberman

[7] A hectare equals 2.47 acres.

and Sweezy 1989: 10). According to estimates by Skidmore and Smith (1989: 253), by the 1950s, close to 40 percent of Cuba's population lived in cities. Moreover, only 40 percent of urban lower class dwellings had inside toilets or refrigeration of any kind in their homes. The Census of 1943 showed that only 35.1 percent of the children in the required age group[8] were attending school. Ten years later, the Census of 1953 showed that Cuba had an illiteracy rate of more than 20 percent for the country as a whole. In rural areas, this figure rose to as high as 50 percent (Nelson 1971: 45). Given these dismal figures, the general standard of living for the majority of the population in Cuba's *período burgés,* according to Cuban historian Gregorio Delgado García, was one of "permanent misery" (1996b: 2).

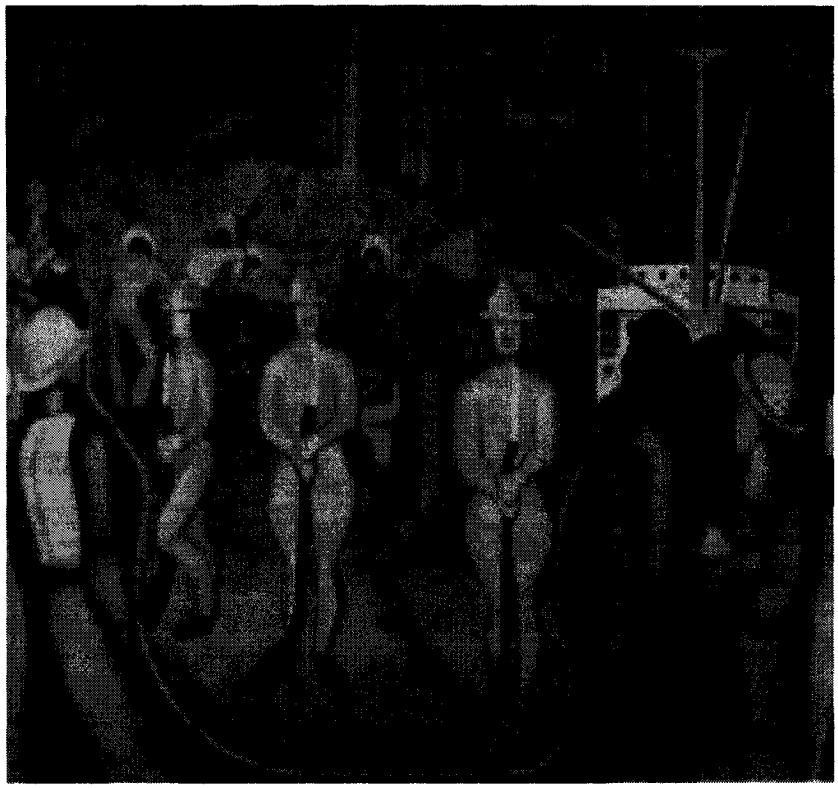
For example, the pervading social injustice and material inequalities that characterized the *período burgués* were critically reflected in the work of Cuban writer and painter Marcelo Pogolotti (1902 –1988). Pogolotti's famous painting *Paisaje cubano* (Cuban Landscape) stylistically captures the contrast and subtle power-relations as reflected in the exploitation of Cuba's sugar industry (*azucares*) and its workers under American neo-colonialism in the 1930s (see, Figure 2-1). Pogolotti's painting sought to represent the various social and political actors who were involved in Cuba's sugar cane industry: the military, the bourgeoisie, different corporate interests (domestic and foreign) and the exploited worker. As other scholars have noted, the place of the sugar industry in Cuba's history reveal the profound local and global interactions that shaped the production, extraction and consumption of this commodity, and help determine the social and political trajectory of the inhabitants of the small island (see, for example, Ortiz 1995; Barnet 1980; or Mintz 1985 for historical discussion of the sugar industry).

As the above excerpt from an interview I conducted in 2001, with Dr. Olga Ríos Dilmé attests, the technology of sugar production in Cuba in the pre-revolutionary period resulted in the appearance of what political scientists Skidmore and Smith (1989) term, a "rural proletariat." For example, by 1860 Cuba was producing nearly a third (500, 000 tons) of the worlds entire sugar supply (Skidmore and Smith 1989: 248). The Census of 1953 showed that sugar industry

[8]In 1943, "Cuban law made eight years of [elementary] school attendance compulsory, but government officials did not supply the teachers, schools, and equipment to make the enforcement of the law possible (For the children of the rich, of course, there were adequate private schools)" (Huberman and Sweezy 1989: 8).

employed a little over 23 percent of the total labour force in Cuba (Huberman and Sweezy 1989: 10). Given the reality that the sugar industry is a seasonal industry, the economic life of these workers oscillated between periods of intense labour during the harvest (*zafras*) — lasting three to four months — to widespread unemployment and underemployment during the "dead season" (*tiempo muerto*). Furthermore, the managers of the sugar mills (*azucares* or *centrales*) encouraged workers to go into debt throughout the "dead season" in order to maintain a permanent and accessible labour pool under obligation to the ownership (cf. Skidmore and Smith 1989).

Figure 1-1: *Paisaje cubano, 1933*



Source: Poupeye (1998: 56)

Given the widespread poverty in the *período burgués*, in 1959 the revolutionary government inherited what Fidel Castro called an "overdeveloped capital in a completely underdeveloped country" (cited in Lockwood 1967: 104). Part of this inheritance, however, was the cultural legacy of Spanish colonialism that had entrenched a Catholic world order "premised on hierarchy and elitism" (Eckstein 1994: 4). Within this world order, slavery and its associated forms of racism were widely pervasive and influential in the ordering of everyday social

relations. Importantly, the *período burgués* was encoded with a system of values, beliefs and attributes, passed on for generations, that was imbued with national as well as class, gender and race-specific experiences

Lowry Nelson's (1950) influential study *Rural Cuba* examined the conditions of the urban-rural divide in pre-revolutionary Cuba, particularly with regard to the differential experiences of gender, race and class in the mid-1940s. Nelson shows that the patterns of inequality in post-colonial Cuba were essentially the same ones that predominated in the colonial period. For example, by reviewing statistics and government reports, such as the 1934 "Committee for the Rights of the Blacks," Nelson illustrates the plight of the disadvantaged Afro-Cuban[9] population in Cuba's pre-revolutionary environment. Lowry's careful analysis of the statistic data in the pre-revolutionary period reveals that the Afro-Cuban population comprised the very bottom of the socio-economic pyramid in nearly all of the spheres of Cuban life. The problem of tracing history, however, as Nelson discovers, is the problem of attempting to chronicle historical events and experiences: whose voice is privileged and through what interpretive lens should such a history be analysed[10]? While space will not permit an elaborate discussion of the historical importance on the relationship between race, gender and identity in pre-revolutionary Cuba, it is nonetheless crucial to highlight that the situation in Cuba, similar to those in many other post-slavery Latin American and Caribbean societies, included problems with racial discrimination and corruption by post-colonial governments, which were more concerned with preserving the "state as a white preserve" than enacting any significant form of social change (Nelson 1950: 157; for example, see Alejandro de

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[9] There is an ongoing debate over the use of the terms "Afro-Cuban" and "black" (see, for example, Pérez Sarduy and Stubbs 2001). Arguably, all Cubans are "Afro-Cuban" due to 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 dissertation to "Afro-Cuban" indicate blacks and people of mixed racial heritage (*mulattos*).

[10] Heeding the advice of Comaroff and Comaroff (1992) in relation to archival material, it is necessary to go beyond the literal examination of text in order in order to uncover the ideas hidden behind "silences" and omissions. For example, in what conditions were such texts prepared? For whom were these texts prepared for? What purpose(s) did they serve? Interrogating these questions help place the text within the wider network of economic and social relations and, inevitably, inform how such information can be read and analyzed.

la Fuente 2001; Scott 1995 for critical discussion on race and identity in pre-revolutionary Cuba's discourses of nationhood)[11].

In other words, while slavery was abolished, the position of the Afro-Cuban population continued to be that of an underclass with little or no means for social mobility. This latter view, supported by Martínez-Alder's (1974) study of marriage, class and colour in nineteenth-century Cuba, examined how racial attitudes and the issue of race in general was influential in ordering society and social relations[12]. The relationship between colonialism and race, particularly with regard to the construction of national identity or nationalism through the regulation of family structure, the maintenance of a "pure blood" lineage, and adherence to the cultural norms of the colonizing power, has been well documented in different contexts (cf. Pérez 1995; 1999; Stoler 1995; R. Young 1995). These studies revealed how national identity in the colonial context became inextricably bound to the control and regulation of those who fell short of a colonialist notion of full citizenship (that is, of the "motherland," such as Spain, Britain, and Portugal) (cf. Mitchell 1991b; Stoler 1995). Mechanisms of control, such as miscegenation laws, were created to impose the colonizers' perceptions of what constituted a "family" and, thus "propriety" in the colonial dependents.

Nelson (1950) traces how the definition of the "family" in the *período burgués* inevitably varied according to social class and ethnic differentiation, as well as between rural and urban groups. However, Nelson identifies a basic pattern of family life, in general, which was part of the heritage of Spanish

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[11] A long-standing contentious debate in contemporary Cuba, which has its roots in the pre-revolutionary Republic, is what percentage or the population is considered "Afro-Cuban." The estimates vary depending on the source, but generally range from minimalist estimates of 30 percent to maximalist estimates of 60 to 70 percent (Pérez Sarduy and Stubbs2000: 6). It is interesting to also note, however, that Cuba still subscribes to 18^{h} century models of racial classification: white, black, mixed, yellow, which incidentally are used to mark and "identify" people on their ID cards: a practice that leads to interesting consequences when Cubans make reference to what their ID card says as "verifiable truth" of their racial origin, despite phenotypic features that may suggest otherwise (see also Estrada 1999 for a journalistic account of the heterogeneity of phenotypic features that exist in Cuba).

[12] For example, see María de los Reyes Catillo Bueno's exceptional autobiographical account entitled, *Reyita: The Life of A Black Cuban Woman in the Twentieth Century*.

colonialism. In particular, the roles of the father-husband, the wife-mother, and the children were those of the Roman Catholic family of feudal Spain (Nelson 1950: 175). These feudal roles delineated a patriarchal family structure in which the respective position of the man to his wife and children was one of superiority and authority. Nelson's work traces how this feudal order can be linked to "The Spanish Code" (1934), which was the basis of Cuban law until 1959. This juridical code established the husband as the protector of his wife, and she was obliged to obey him. In practice, however, this law differed in urban and rural locations[13]. This was based on the underlying class difference in the *período burgués,* during which the "rural family is most often a lower-class family" and the "upper-class people all, or practically all, live in the cities" (Nelson 1950: 182). Nelson suggests that the role of the wife and mother of an upper-class urban family (almost exclusively white) involved "few duties and few cares, as far as general appearances go, although there may be worries and anxieties beneath the surface" (Nelson 1950: 183). While these bounded categories are undoubtedly oversimplified, I find them useful to conceptualise broader trends and characteristics. A more vigorous historical analysis, which space will not permit, would reveal the complexities of such divisions and how they are informed by a multiplicity of factors, including the politico-economy of social mobility, rules of racial classification, and the role of gender.

The upper-class experiences contrasted with the poor urban and rural families that were "hard-pressed by poverty." Poor urban men and women tended to work in various domestic jobs and as physical labourers. For women, however, this usually meant the double burden of working both outside and inside of the house, which included the added task of child rearing. Oscar Lewis *et al.*'s ethnographies, *Living the Revolution* (1977a; 1977b), *Four Men* (Vol. 1) and *Four Women* (Vol. 2), detail the everyday experiences of life in a Havana shantytown, providing one of the most personal accounts of life before and since the 1959 Cuban Revolution. Working with poor, mostly Afro-Cuban, and some white urban shantytown dwellers, Lewis collected narratives that provide a glimpse of the realities of life under Machado and Bastista, and hardship in the years preceding the revolution. The studies link how issues of class, gender and

[13] Nelson also makes clear, however, that skin colour is the one factor that breaks down these generalizations (1950: 175).

race intersect and shape experience in a poverty-stricken municipality. The work of Lewis *et al* (1977a; 1977b) suggests that the poor urban family was usually composed of female-headed households in which men were an unreliable source of economic and emotional support. This contrasted with the countryside, which were predominately organized around a sexual division of labour. There, women tended to work in the house with the primary role of child-rearing and domestic duties, while the husband tended to work in nearby agricultural fields (Nelson 1950). Moreover, women also had participatory roles in agricultural labour during the harvest periods. I highlight these distinctions now to emphasize the way in which the 1959 revolution sought to break down the sexual division of labour and class distinctions that characterized the pre-revolutionary Republic. I will elaborate upon these themes in the last section of this chapter.

The individual oral histories presented in Lewis *et al.* 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 (cf. Barnet 1997). Since many of the slaves 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 *et al.* studies chronicle how individuals, marginalized by the poor physical conditions of their squatter settlements, confront the harshness of family life; they show the integral role of *Santería* in shaping the life experience of these individuals. Oral life histories in the Lewis *et al.* studies also reveal the high levels of racial discrimination that pervaded the pre-revolutionary era. For example, the shantytown under study by the Lewis *et al.* team was believed to be a stronghold of *santeros* (practitioners of *Santería)* and perceived by many wealthier city dwellers *(habaneros)* to be associated with high levels of criminality, filth and disease. This association was, in part, a colonial legacy, which, as several scholars have noted, linked "Africa" and "blackness" with inferiority, degeneration, disease and contagion (cf. Arnold 1988; 1992; Comaroff 1993; Gilman 1985).

Shaped by experiences of subjugation and systematic oppression, the majority of individuals who subsequently became incorporated in Castro's revolutionary army were the rural and urban poor of Cuba's *período burgués*. This is not to suggest, however, that a modest number of individuals from the middle and upper classes, including university students and professionals, did not also

become affiliated with the revolutionary guerrilla movement. This is perhaps best summarized in one of Fidel Castro's early speeches in the 1960s: "the peasantry is a class which, because of the uncultured state in which it is kept and the isolation in which it lives, needs the revolutionary and political leadership of the working class and the revolutionary intellectuals, for without them it would not by itself be able to plunge into the struggle and achieve victory" (Castro 1969a: 103).

As the leader of the guerrilla army, Fidel Castro, the son of a well-off landowning Spanish immigrant, effectively articulated many of the historic concerns of Cuban intellectuals of the late eighteenth and nineteenth century, for example, José Martí and his predecessors, such as Father Félix Varela and José María de Mendive, who were proponents of the struggle for nationhood and sovereignty, and critical of the problems they believed where inherent in the liberalist project. José Martí, for instance, shaped by a political idealism, which he defined as a search for a political utopia based on struggle (*lucha*), stressed unity and morality over individual rationality and self-interest. Martí's political vision was influential in Cuba's independence movements (*independentismo*)[14], particularly the second war of independence (1895 – 1898), in which he was a political organizer and armed leader. Martí became a martyr to the independence movement because he embodied the guiding principle of heroic sacrifice (*numancia*) for the nation. Some of Marti's principles were to become key symbols in Castro's revolutionary government, as I will later elaborate.

Fidel Castro and his core of revolutionaries, known as "the bearded guerrillas" (*los barbudos*), preached the need for equity, particularly in health, education, housing, and land reforms, in order to build up a network of informal and formal support for their guerrilla movement. Joining forces with a predominately rural peasantry in the 1950s, many from the least developed, easternmost provinces of Cuba, the rebel army secured popular support as they made their successful westward trek across the island to overthrow the Batista regime. Characterized in the mid-1950s and early 1960s as a democratic, popular,

[14] There was also a reformers movement (*autonomía*), which argued for greater autonomy from the Spanish crown, short of full separation or annexation to the United States.

agrarian, and anti-imperialist movement, it was not until Cuba formally entered into the melee of hostile Cold War politics that a noticeable ideological shift was registered in Cuba's long-term political objectives. I will further develop some of the latter themes in the following section on the construction of the socialist state in the *período socialista* (1959 – present).

1.4 The Construction of the Socialist State (1959 -present)

Before la Revolución there was a lot of misery. My father was a labourer and my mother was a peasant. We lived in Guanabacoa, a municipality within the city of Havana. Despite the fact that my parents were very poor, my father always made sure that we had the food, clothes and shoes we needed to go to school. Despite all our financial difficulties at the time, my father wanted us do something with our lives, wanted us to study and prepare to face life. The year la Revolución succeeded, I was nineteen and still needed one more year to finish at a teachers training college here in Havana. The leaders of la Revolución brought all us fourth-year students together and told us that we were needed in the eastern provinces of Cuba (also known as Oriente), to work as rural teachers.

Most of us had never been to the countryside and the first thing the new government did was to create a training camp in the Sierra Maestra region. We were sent into that rural area and found things very hard. There was no electricity or telephone service — nothing! We lived there for three months. When we finished our training, they sent us back to Havana and divided us into groups to work in different areas of Oriente. I was sent to the region of Boicurí, which is the most westerly mountain range of the Sierra Maestra. I was there in 1960, '61 and '62, working as a teacher and working in the alphabetisation (popular literacy) campaign.

In those days, I was a dynamic person in all the revolutionary projects. I was inducted into the military, and all the social-political activities. I joined the Voluntary Teacher's Brigade, Frank País. I was in the second contingent. Teachers had to sacrifice a great deal in those days. When we arrived we had to do a census of the population, including age, and educational level. There had never been a census of this type in those areas before. Each family might have 7, 8, 9 or 14 children — all without clothes, without shoes. These things were addressed by an especially-created institution called the National Institute of Agrarian Reform (INRA). This organization had a department of education that provided technical and material assistance for rural areas. I gave classes in the houses of the peasants. It was hard, because we had to live with the peasants, and the INRA sent us food and supplies, but that experience was marvellous because there were peasants that had never held a pencil in their hand before, and you had to say, "Okay, hold it like this." They were afraid and you had to show them over and over again, "No. Like this", and then when we'd showed them how to hold the pencil, we had to show them how to write in a notebook so that they would not rip the pages. In Cuba in that time there was a revolutionary fervour. Everybody wanted to be a revolucionario (a person dedicated to the la Revoulución). In 1959, '60 and '61 many families left Cuba, but they were ones that had good social positions and financial capital. They all left. We were the lower social classes, the poor. We were the ones that incorporated ourselves into la Revolución.

—Sra. Sonia Allende, retired teacher,

Soon after the revolutionary army arrived in Havana, Fidel Castro and his supporters (most prominently his brother Raúl Castro and Ernesto "Che" Guevara) transformed the Cuban economy from one of entrepreneurial capitalism to a centrally planned system. Castro united various political groups to form the Integrated Revolutionary Organization (*Organizaciones Revolucionarias Integradas, ORI)* to spearhead this transformation of Cuban society. These changes, including land reforms, the nationalization and socialization of private property[15], and campaigns[16] to reduce illiteracy, sought to equalize the vast disparities of resources, wealth, and education in Cuban society. Many Cubans who were against the government's initial changes fled to the US, 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 US 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 US enterprises, the US severed relations with Cuba and extended the partial embargo to all goods including food and medicine. The severity of this embargo may be seen from Cuba's trade figures

[15] One of the first formalized processes of nationalization was the Agrarian Reform Law, adopted May 17, 1959. This law prohibited private farms larger than 400 hectares. The expropriated lands were to be distributed among former tenant farmers and sharecroppers, but during 1961 and 1962, most of the land became state farms. In addition, in March 1968, approximately 55, 000 small business, largely family-owned and operated, were closed down by the government as part of a new "revolutionary offensive" to avoid private ownership. These were small steps in the revolutionary governments' greater plan to return the "means of production" back 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.

[16] Fidel Castro declared the year 1961 as the "Year of Education." This year was dedicated to eradicating illiteracy in Cuba. Schools were closed and 100, 000 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 re-educational training programs, such as the Worker Peasant Programs or *Educación Obrera-Campesina* (EOC's), offered to unskilled labourers to provide high school equivalency in order to be eligible for university-preparation programs.

for 1959, in which 75 percent of all trade was with the US. 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 (CMEA). Cuba thus entered a period of hostile relations with the US, framed by the geopolitics of the Cold War[17].

While Castro's revolutionary government had not earlier professed an adherence to a particular ideological framework, Cuba's alliance with the Soviet Union heralded the beginning of the importance of the Soviet model of socialism in Cuba's political 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 1965, the Castro government formed the Communist Party of Cuba (*Partido Comunista de Cuba*, PCC)[18]. A new constitution, approved by referendum in 1976, replaced the one suspended when General Batista fled in 1958. The new constitution describes Cuba as a socialist worker's 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 also sought to socialize the populace by creating an *"hombre nuevo."* These cadres of men and women were to work together with the revolution in realizing 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 and most ideal stage of development, a stage that followed feudalism, capitalism, and socialism. Echoing Marxist thinking, Castro advocated that under communism, people would contribute according to capacity and be rewarded according "to need."

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

[18] The PCC is the only legal political party in Cuba, and exercises *de facto* control over government policies.

Following Lenin, Castro envisioned that a "vanguard party" — the PCC — would facilitate this radical transition toward communism (Eckstein 1994: 33; Castro 1969a). For example, in the early 1960s, Ernesto 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 "Homeland or Death!" *(¡Patria o Muerte!)*, which sought to implement the notion of heroic sacrifice *(numancia)* and workers' dedication to the nation or Cuban people *(pueblo cubano)*. In line with this vision, the worker was exhorted to labour for society rather than for personal gain.

In place of material rewards, workers were to labour 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, Fidel 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" (Castro 1969b: 199). In line with these statements, the Castro government nationalized and expanded social services. Education, medical care, social security, day care, and most housing was provided free of charge, with access to them designed to be more equitable and need-based than ever before (Eckstein 1994: 34). Seeking to dismantle the former class-based privilege and elitism that existed in pre-revolutionary Cuba, the new government drew on the utopian ideas of Marx and on Cuba's independence hero, José Marti, to break down barriers between manual, non-manual and intellectual labour. City-dwellers and professionals were encouraged to voluntarily participate in seasonal agricultural labour, mainly in sugar-production. Such activities, the Castro government argued, would blur, if not eliminate, the contentious divide between consumer and producer, between bourgeoisie and proletariat, and so 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. These organizations brought people together on a territorial and functional interest-group basis (Eckstein 1994). For example, the Committees

for the Defense of the Revolution (CD)[19], Cuban Women's Federation (FMC)[20], and the Cuban Labour Federation (CTC)[21] were just three of many organizations that encouraged the adult population to actively participate in the revolutionary reform. Youth were organized into political groups during their schooling; for example, primary school children formed the Cuban Pioneer's Union, and students who were more senior formed the Federation of Secondary School Students, the University Students' Federation (FEU), or the Union of Young Communists (UJC). The formative role of these organizations was, and still is, to instil the values of the revolution and in turn loyalties to the "vanguard party," that is, the PCC[22]. As Dilla (1999) notes, 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. This relationship is reflected as Dilla notes, "in their [mass organizations'] negligible autonomy evident in their public stances on a variety of issues" (1999: 32).

More than 80 percent of the entire Cuban population belonging to one or more of the youth or 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. The formative role of mass organizations is best illustrated in the extensive research conducted by

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[19] 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 and political education, promoting urban reform, carrying out local administration, as well as actively pursuing surveillance work against counterrevolutionary activities. CDR members are known as *cederistas*.

[20] The *Federación de Mujeres Cubanas* (FMC) was founded primarily as a women's movement, playing a major role in mobilizing women to pursue post-secondary education, join the labour force, and participate in community defence and surveillance.

[21] 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 operation, the CTC is like a labour union organizing all employees at a workplace.

[22] Given the selective nature of membership to the Communist Party of Cuba (PCC), mass organizations often serve as a primary source for recruiting *militantes* (members of the PCC also known as cadres).

anthropologist Oscar Lewis and his team in municipalities of Havana during the early years of the revolutionary period (1977a; 1977b; 1978). The ethnographies provide a window into the lives of a group of people struggling to embrace the revolutionary campaigns — such as the campaign against illiteracy, or the programs for re-education and job training — in order to become active, productive members of their communities. The Lewis *et al.* studies also make clear that the *las masas* were inspired to devotion by Fidel Castro's almost messianic status[23].

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 Fernández (2000a: 65) notes, "[c]harisma, 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." Narratives, like that of Señor Rivera, cited in Lewis' (1977) *Four Men* (Vol. 1), reflect these commitments: "I have always favoured the Revolution and hated *gusanos*[24] . . . [T]hose *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" (Lewis *et al.* 1977a: 218). The state's various mass organizations were thus an important mechanism that fed on this early revolutionary fervour and rallied support around revolutionary objectives and projects, in particular the project of building an egalitarian communist state.

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[23] In addition, to the religious and symbolic affiliation of Castro as a messiah (see Fernandez 2000 for a more elaborate discussion), Castro also enjoyed the popular support of *santeros,* practitioners of Santería. Castro, known as *El Caballo* (the horse) in these circles, was assumed to have mysterious qualities similar to *santeros* who are also known as the "horses for the saints." Moreover, the colours of the flag of the "Movement of the July 26th" rebel army, which are red and black, also symbolize the colours of Changó, the warrior god in Santería.

[24] This term literally means a "worm." It is used in Cuba to refer to anyone who does not support the Cuban revolution. Often used in reference to Miami Cubans in exile, also known as the "Mafia of Miami" in Cuban popular discourses.

The early revolutionary years were not without causalities. While mass organizations grouped ordinary citizens into miniature polities, they also served as a prime means of surveillance and control of daily life[25]. Under siege by both direct and indirect counter-revolutionary activities being carried out by the United States 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 against the collective vision of a communist Cuba[26]. In 1965, for example, a special program (now defunct), the notorious Military Units to Assist Production (UMAP), was created to reform through hard labour people deemed "socially dangerous" or anti-social 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: 85). As a result, the Cuban state, rather than slowly wither away as Marxist-Leninist doctrine would dictate, has began to increasingly reflect

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[25] As ethnographic evidence will demonstrate in subsequent chapters, the economic crisis has seriously dampened the role of mass organizations as mechanisms of community surveillance.

[26] In line with "scientific atheism" — as part of the transition towards communism — the Cuban government declared Cuba to be an "atheist state" and began a gradual program of repression of different 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). *Santería,* the Afro-Cuban popular syncretic religion, was dismissed as a folkloric practice — an impediment to the project of modernity — and valued only for its redeeming qualities in the form of public cultural performances (see, for example, Hagedorn 2001). After the visit of the Pope John Paul II in January 1998, the Roman Catholic Church began to receive a resurgence of followers. In addition, there were also an increased number of individuals turning to *Santería* (see, for example, Cabrera 1999; Barnet 1997; Hagedorn 2001). The latter religious practice, however, never required the institutional infrastructure of Catholicism and has arguably continued to exist in private throughout the revolutionary period. I will elaborate upon the role of *Santeria* in individual's health seeking behaviour in chapter six.

the corporatist model, from which the socialist government believed themselves to have been liberated.

1.5 Conclusion

Damian Fernández (2000b) asserts that any interpretation of Cuban politics must also concomitantly examine how it has been shaped socially and culturally; only in this way, he contends, can we understand the interests behind the emotional intensity of Cuban politics. A study of Cuba, Fernández further argues, is a study of the combination "of the politics of passion — politics construed as a moral imperative for absolute ends — and the politics of affection — politics based on an instrumental logic in which anything goes, justified by who you know and who you love — which helps to sustain *and* subvert the institutions of modern nation-states" (Fernandez 2000a: xii). In the chapters that follow, I argue that Fernández's three cultural paradigms, which are schematic rather than immutable, have persisted — even if shaped into new modalities through time — in Cuba's socialist period.

Since the 1959 revolution, many of the practices employed by the state and individual Cubans, particularly during the current *período especial* (1990 – present), which I expand upon in chapters two and six, have clear continuities with the past. In this respect, then, I argue that the 1959 revolution is, in fact, not "revolutionary" in the sense of a dramatic shift in ideas and practice. Rather, I argue, we must understand the contemporary interaction (and competition) of different ideological principles in Cuba as the on-going expression of years of political struggle, which has historically existed between different sectors within the island's population. The research presented throughout the subsequent chapters reflects individual narratives of Cubans-in-Cuba. These narratives express ranges of experiences that, at times, are contradictory. For example, a self-declared revolutionary or *fidelista* (supporter of Fidel Castro) may also be a self-professed anti-communist; others, adamantly anti-Castro, may lament the crumbling of Cuba's socialist policies and the complicit role of US foreign policy in this process. Equally, I argue, another history would emerge if this research had included Cubans in the diaspora, for example, in Miami, or Cubans in other parts of the US, Canada or Europe. They, too, participate in constructing a

genealogy of Cuba's history. What I offer, then, in the chapters that follow, is a glimpse into some of the complex narratives emerging from Cuba, and a critical discussion of how the key themes expressed by individual citizens and health professionals are embedded within a broader discourse on the changing socio-political nature of Cuba's public health system, and, more generally, on socio-political change in Cuba.

Chapter Two

"Socialism with Commercials:[1]" The Paradox of the Dual Economy

Marianna looked at the blinking red light of the tape recorder.
"Is it taping now?" she whispered.
"Yes," I replied.
She looked around suspiciously and continued in a barely audible tone. "La 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 passing through a terrible crisis."
She clenched her fingers almost to a fist and moved her hand to her mouth in a rapid back-and-forth gesture.
"People don't have enough to ... " Again, she motioned with her hand toward her mouth and whispered, "Are you still taping?".
"Yes. Do you want me to stop"? I asked.
"Yes" she replied.
I pressed the stop button and the flashing red light stopped blinking.
"... enough to eat!" she said in a loud voice. "You know you can't say that to just anybody here because in Cuba everything is suppose to be perfect! There are a lot of problems with people speaking truthfully. The big problem now is that people are hungry".
She looked at my hand as I quickly scribbled notes. Without any prompting on my part, she said, "Communism is a beautiful idea, but in practice it cannot work, especially not in the tropics. In Cuba we are suppose to be a socialist country. But really, I don't know what we are".

—Sra. Marianna Díaz Rodríguez, accounting assistant, born in La Habana in 1951.

2.1 Introduction

Sitting in a crowded theatre in Havana watching the Cuban directed and produced movie of the year, entitled *A Paradise Under the Stars* — incidentally also the motto for *Tropicana*, the infamous Cuban cabaret of voluptuous dancing girls — the audience roared with laughter, and screamed out comments about the unfolding drama. A part of the movie that generated a particularly vociferous response was the death of one of the secondary characters. Falling to his death by slipping off a bridge while arguing with his neighbours is standard play for a Cuban soap opera. What was most remarkable about this death, however, was the rebirth of the character.

[1] The phrase is Ariana Hernández-Reguant's (2000).

During his funeral, his ex-wife, a Cuban living in Spain, arrived with her arms bogged down by shopping bags and boxes, dressed in the latest designer wear. The centre of attention immediately shifted from the lately deceased to the newly arrived "Cuban living abroad" *(cubana de afuera),* and her declaration that she had brought presents *(regalitos)* for everybody. While the mourners surrounded her, not to be left out of the general mayhem of gift distribution, the deceased 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 US dollars" *(divisa).* 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* differentially shapes lives and experiences. The audience in the theatre screamed out in jest, "*Vaya, no es fácil!*" (It is not easy!). A woman sitting next to me shook her head grumbling, "This country is *shit.*" Another man yelled out, "*Oyé*, there is nothing left that isn't in *divisa!*"

In Cuba today, a deep discontent runs below the reiteration of a series of catchy revolutionary phrases. Popular culture is one medium, among others, in which Cubans are beginning to voice serious concern and poke fun at the situation in which they find themselves. 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 importantly, citizens are beginning to question and challenge the rebirth of a class-stratified economy in which access to *divisa* indexes differential access to basic goods and services, and a rampant consumerism for the privileged few who are in the upper layer of this two-tiered economy.

This chapter provides an introduction to contemporary Cuba and in particular to the nature of Cuban socialism as it has come to redefine itself in the post-communist era that commenced with the fall of the Soviet Communist bloc in 1989. Cuban sociologist Haroldo Dilla Alfonso (2001) notes that from 1959 until 1990, a profound homogenizing process had been at work in Cuban society. The elimination of the upper and middle classes resulted in a social levelling process that was attributed to the accomplishments of a centralized economic system in which the state controlled the assignment of resources.

Since approximately 1990, however, largely as a result of the collapse of the Soviet Union — Cuba's major source of trade, credit and aid — the basic relations of production and distribution established in the first three decades of the revolution have been eroded and the social safety net left in tatters. Under the banner of "market socialism,"[2] or what Castro terms "socialism under siege," the social order in Cuba has been literally turned upside down, drastically affecting the lives and health of individual Cubans.

2.2 The "push for communism" and the "retreat to socialism"

Since la Revolución people have continued to learn from bitter experience, like when the United States broke off its relationship with Cuba. That was a critical situation. In 1963, about the time of the nuclear missile crisis, things became very critical. This is when we established a relationship with the Soviet Union. The Soviets started sending us everything. Imagine, at that time Cuba was a country that had all American technology, and when the Russians arrived they changed everything. They had to show the population how to work with the Russian machines. Everything that existed before was thrown out, everything. We started to work with Russian machines. Some worked and others did not. But from that point on Cuba slowly started adapting, for better or for worse, to the Russian way of things. The Soviet Union helped Cuba tremendously. This is the truth. We were their 'golden child.' We asked to be part of the CMEA, the Council for Mutual Assistance that allowed for special trade-relations with Cuba. For example, the surplus from Eastern Europe was sent to Cuba and stores became full of the goods: shoes, socks, underwear for women, jackets, everything. Honestly, our best period in Cuba was the early 80s, when the CMEA sent us their entire surplus and we lived in abundance, throwing things out, wasting everything. At that time, Cuba also started to provide international aide to countries in need. For instance, Cuba started sending petroleum and food supplies overseas. The government told us that this would help us amplify our program of international solidarity with other countries.

However, things started to slowly change in the late 1980s. There were massive shortages and you could not even get a sack of cement to fix your house or a piece of wire to tie something up. Machines started breaking down and there were no parts to replace them. This is when people started to become disenchanted with la Revolución. This is when all the problems of communism started to become evident

— *Sra. Sonia Allende, retired teacher, born in La Habana, 1940.*

In the mid-1970s and in particular in 1974 when the world sugar price reached a record high, Cuba's export earnings skyrocketed. The country expanded its foreign trade with its Western counterparts. Cuba's "simultaneous

[2] This term is defined as the use of the market as a means to build socialism and is similar to reforms used in China and Vietnam (cf. Mesa-Lago *et. al* 2001).

construction of communism and socialism" was well underway as the government sought short-term loans from Western lenders in order to implement various programs of economic diversification and, above all, industrialization. However, as the world market price for sugar fluctuated in subsequent years, Cuba's ability to make repayments on these high-interest, short-term loans was severely compromised. Contrary to Marxist principles, the government introduced market reforms in the early 1980s and sought to reduce bureaucracy in various sectors to stimulate the economy. Agricultural cooperatives were created in order to boost decreased agricultural production, hindered by inefficiencies related to the Soviet-style of governance reflected in a massive bureaucracy. These cooperatives allowed state and private farmers to market and sell any surplus they produced beyond their commitments to the state. Further distancing itself from communist principles, the state reversed its decade-old stance on foreign investment and formalized legislation on joint ventures to attract private capital from abroad in order to help develop tourism, light industry, medical equipment, construction, and the agro-industry. Investors were promised tax-free use of land, and tax exemption on imported materials.

In the late 1980s, the world price for sugar dropped to an all-time low, with dire domestic consequences for the revolutionary government and the citizenry. Despite minor advancements in industrialization and Cuba's economic diversification plan, sugar remained the key agricultural crop for the funding of Cuba's social transformation. For example, as foreign export income dropped, Cuba experienced widespread shortages in basic food rations, as well as primary raw materials for housing and consumer goods. In addition, general worker morale reached an all-time low, which effectively widened the gap between rhetoric and reality, between promise and delivery. As a result, the government lost support and legitimacy. As Eckstein notes, " Foot dragging, absenteeism, and other forms of resistance became widespread, adversely affecting the productivity of state activity," particularly as the "government's moral campaign had failed to convince enough of the population, as workers and consumers, of the virtues of the theoretically utopian society-in-the-making" (1994: 40). For instance, Cubans, unhappy with the system of rationing "according to need," started turning to the black market to purchase limited goods in excess of their allotments.

At the same time, Cuba's desire to "remake a utopian society," let alone to "export revolution" to other Latin American and African countries[3], was hindered by other factors. One factor was a mounting hard-currency debt and domestic budgetary deficit. Another was socio-economic change occurring in Soviet-bloc countries where citizens were calling for reforms: *perestroika* and *glasnost*[4]. With insufficient financial capital and political instability in Cuba's major investor, the Soviet Union, Castro conceded to a "retreat to socialism" in which Cuba was defined as undergoing a transitional phase in its march toward socialism and was forced to adapt to conditions that were far short of the ideals of communism.

2.2.1 Cuban Socialism in a Post-communist Era

> *I can remember when we were in primary school. We use to have to recite, "Pioneers for Communism? We will be like Ché!" (¿Pioneros por el Comunismo? ¡Seremos como El Ché!). In those days we were supposed to be dedicated to communism and follow the example of Ché Guevara. For example, the teacher would ask, "What kind of person was Ché?" We would always respond, "Brave, honest, and determined". Similarly, the teachers would ask "What was it like before the revolution?" We would respond, "Misery, hunger, and exploitation." In secondary school we had classes in the Russian language, and courses in Marxism and Leninism. Now, this has all changed. Now, the Youth Pioneers recite, "We are happy here" (¡Somos felices aquí!). Students learn basic human values and political orientation or something. What happened to communism? It was the utopia that Fidel knew could never be accomplished and that is why he abandoned it.*
>
> — *Sr. Louis Martinez, state newspaper editor, born in La Habana, 1974.*

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[3] For example, Ernesto "Ché" Guevara was a strong proponent of "exporting revolution" to other Latin American countries. See, for instance, Fidel Castro's speech February 4, 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 1969b: 104). Ché was killed in 1967, while attempting to aide rebel fighters in "making revolution" in Bolivia.

[4] By the mid-1980s, Cuba was already experiencing some of the economic effects of the pending break-up of the Soviet Union. In 1986, a process known as rectification of errors and negative tendencies (*proceso de rectificación de errores y de tendencias negativas)* began; it attempted to address problems inherent in the Soviet style of governance, namely to reduce bureaucracy and allow more decision-making at local levels. However, Cuba rejected the liberalisation policies (*perestroika* and *glasnost*) being adopted by its Soviet counterparts at the time.

In the late 1980s, news of the crumbling of the Soviet bloc reverberated around the world, and nowhere was this news most strongly felt than in Cuba. Buffered for over three decades by highly favourable terms of trade with the former USSR and COMECON countries that had been major catalysts in its social development, Cuba was now faced with a severe economic crisis. This crisis was triggered and compounded by Cuba's nearly complete dependence on the Soviet Union, and the economic embargo imposed by the US government on Cuba more than 40 years earlier. Between 1984 and 1989, 77 percent of Cuba's export-trade was attributable to sugar, and nearly 70 percent of import-export trade was with a single country, the Soviet Union (Pastor and Zimbalist 1995: 8). As a result, between 1989 and 1993 the country's gross domestic product (GDP) fell 35 percent and exports declined by 75 percent (PAHO 2001). In the face of this situation, Cuba in the early 1990s entered a *Período Especial en Tiempo de Paz* (Special Period in Time of Peace) and introduced a series of readjustments and restructuring measures aimed at halting the crisis and reviving the economy.

Complicating the aftermath of the Soviet withdrawal from Cuba was the US government's tightening of economic sanctions against Cuba in the 1990s. The 1992 so-called Torricelli-Graham Act[5] (also known as the Cuban Democracy Act) and then the 1996 Helms-Burton Bill[6] made clear that the intent of US foreign policy towards Cuba was to foster the socialist governments' defeat through what US Senator Jesse Helms called "a final push over the brink" (Brenner and Kornbluh 1995: 39). In late December 1997, Cuban vice-president Carlos Lage estimated that the US embargo and other political factors[7] cost the Cuban economy $800 million a year, equivalent to about 20

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

[6] The Helms-Burton Bill halted all direct flights and remittances to Cuba, and allowed US investors to take legal action in the American courts against foreign companies that were utilizing their confiscated property in Cuba.

[7] A number of other causal factors are responsible for the current crisis. These include what policy analysts Ritter and Kirk argue was the dysfunctional economic architecture, which was inadequate in dealing with a set of three interlinked crises as result of the cessation of foreign exchange earnings. First, an energy crisis emerged as a result of the reduction of petroleum. Secondly, an agricultural food-nutrition crisis resulted from reduced agricultural production including the sugar harvest. Thirdly, a general macroeconomic crisis was reflected in open unemployment, hidden

percent of Cuba's current import bill. The economic crisis had, as noted scholar of Cuban studies Pérez Lopez (1994) pointed out, threatened the survival of the Cuban revolution, particularly in regard to its continued commitment to basic human needs. However, the economic crisis had also undermined health, according to Cuban public health historian Delgado-García (1996c), by affecting the availability of food, medicines, and equipment, and this subsequently challenged the developments achieved in public health. I will expand upon this theme in chapter six.

With the fall of communism in the Soviet Union, Cuban socialism underwent a number of severe blows that resulted in drastic shifts in governmental policy as well as everyday experiences for ordinary citizens. For example, in early August 1994, during the most difficult stretch of economic hardships in Cuba, a new crisis emerged in the form of a surge of illegal immigration to the US. Desperate Cubans captured international media attention as they launched inflated inner tubes, small boats, and homemade rafts in hopes of reaching the shores of the US. Immediately known as the boat people (*los balseros*), they were fleeing what was believed to be Castro's crumbling socialist government[8]. Cubans in exile anxiously awaited the fall of the socialist government. The events leading up to this crisis, however, transpired at the time of an intersection of several interrelated factors. First, Miami radio stations, particularly the US-funded, counter-revolutionary, anti-Castro Radio Martí, began beaming inflammatory messages into Cuba that led to rioting in Havana. Second, the 1966 US Cuban Adjustment Act meant that any Cuban reaching US territory by any means was eligible for a residence permit. Third, the Cuban government announced in 1994 that it would no longer police the illegal emigration of *balseros*. As a result, more than 35, 000 Cubans took advantage of this opportunity and began to arrive in the US via the sea. Besieged by the growing number of Cubans seeking refuge in the US, the US government quickly reached a new migration accord with Cuba, hoping to staunch the uncontrolled

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"unemployment-on-the-job" (people being paid but not producing anything), high absenteeism and a shift to legal or illegal economic activities (1995: 3).

[8] This event was seen as a replay of 1980, when an estimated 125, 000 Cubans left via the sea in what became known as the Mariel Boatlift.

flow of refugees[9]. The US government was also later forced to concede that the majority of the 1994 immigrants — over 80 percent reported to be under the age of 28 — were in fact economic migrants rather than, as the popular myth would have it, political refugees fleeing communism (E.I.U. 1999).

Realizing that economic hardships were seriously challenging the survival of Cuban socialism and, more importantly, popular support for the ruling communist party, the revolutionary government declared that, "socialism was under siege." In the early 1990s, an older revolutionary slogan re-emerged: "Socialism or Death! We shall overcome!"(¡*Socialismo o Muerte! ¡Venceremos !*). This slogan took precedence over the commonly used "Homeland or Death!" ("¡*Patria o Muerte!*"), and reflected a shift in revolutionary thinking and practice. Under the revived slogan, Cuban socialism was envisioned as undergoing relentless changes, many of which appeared in contradiction to the underlying revolutionary principles. As Castro reassured *las masas* (the masses), however, the socialist goals of Cuba would remain intact. More recently, in June 2002, in response to accusations by the US government that Cuba was unduly imposing socialism on its citizenry, the Cuban government held a referendum asking the population to vote on constitutional changes[10]. The major change was the declaration that "Cuba is and will always be a socialist state" (see, for example, Figure 2-2). Collecting signatures nationally thorough municipal CDRs, over 98 percent of the total voting population in Cuba agreed to the various constitutional changes[11]. In early July 2002, in a live televised meeting of the

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[9] President Clinton was forced to rescind the US open-door policy toward illegal Cuban immigration and order that the *balseros* be taken to the Guantánamo US naval base in Cuba. Eventually most were admitted to the US. However, the US government vowed in future that all illegal immigrations intercepted by US authorities would be returned to Cuba. In addition, the US also made a promise (yet to be fulfilled) to grant a minimum of 20, 000 visas a years to Cubans wishing to immigrate.

[10] In June 2002, dissident groups on the island submitted "The Varela Project," a petition that called for a referendum under the terms of the Cuban Constitution, to the Cuban National Assembly. In response to the Varela Project, Fidel Castro held a vote for a constitutional amendment declaring Cuba's socialist state "untouchable."

[11] It is interesting to note the popular commentary in the street, in which many individuals who described themselves as apolitical and tired after many years of political saturation, voted "yes". As many individuals interviewed made clear, despite the supposed voluntary nature of the "voting process," they felt obliged to sign. "Can you imagine having to write your name, present your ID card, and write the number alongside your signature?" asked a young woman who was currently processing documents to leave Cuba on a temporary visitor's visa for Spain. She later confided that this was only a means to get to Spain to later seek asylum. "They say that voting is

National Assembly, delegates were called out one-by-one by name, to vote with either a "Yes" or "No" response to constitutional changes. Not a single one of the 601 delegates rejected any of the proposed changes or engaged in any form of visible debate or discussion.

Figure 2-1: "We have and will always have socialism"

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2.3 *Lo informal* and the State-approved Dual-economy

In the 1980s things were not so bad in Cuba, but now everything is a disaster. If I didn't rent out my apartment there is no way I could live on $8US a month. That can't buy anything. For example, I have to pay $125 US a month to the state in rental taxes. This is not to mention a percentage of my total rental

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voluntary, but can you imagine the local Committee for the Defence of the Revolution (CDR) president knocking on your door and saying, *comapañera,* you still haven't signed the vote yet'? They know who signs and who doesn't. You have no choice but to sign the referendum. If you don't, theoretically, nothing will happen to you. But you won't accomplish anything in this country if you don't support the socialist government. In Cuba, everything is based on politics. You are judged whether you are for or against *la Revolución* and thus, for or against the government. Things are fairly black and white here."

earnings at the end of year. Can you imagine, I have to pay this rental tax independent of whether I have clients renting! This means, of course, that I have to rent anywhere from $25 to $30 US a day just to be able to pay the tax and have a little left over for me. The problem in Cuba is that El Bobo *("the fool"*[12]*) doesn't want anybody to make too much money. This is the problem with socialism. There was nothing wrong with Cuba before* la Revolución *and things have only gotten worse. I don't have children or a husband or anything, but I still have expenses. I like to drink milk every morning for my breakfast and that costs about $1 US a pound in powder in the street [black market]; these things are not cheap. I am lucky because my brothers in the US send me money every now and then. Like everybody, I like to live comfortably and eat well. In Cuba, all these things cost money. I am old, but I am not stupid. Everybody likes good things. Can you imagine the misery and hunger there is now? People have nothing to eat. What they give you at the* bodega *[where rations are distributed] is worthless. Well, of course, it cost almost nothing, just pennies, really. At the bodega you get a ration of 5 grams of bread a day per person. However, the baker usually steals the flour or eggs and the result is bread as hard as a rock. You also get a ration per person per month: 8 eggs; 6 pounds of sugar (three pounds of white sugar and three pounds of brown sugar); 6 pounds of rice, and sometimes, a little piece of chicken, beef, or fish, if and when it arrives. Who can live on that?*

I don't have any health problems, thanks to God, but my sister who lives with me is a diabetic and has to stick to a strict diet. I have to buy everything in the street; drugs, needles, special foods that the state is suppose to provide! Everything that you see in this apartment was a sacrifice to buy. I don't like to rent my apartment. If I had the option, I would never rent and have all these strange people coming in and out of my house. It is not easy! I rent out of necessity. I am no longer young, can you imagine I have to be in this struggle everyday, associating myself with all kinds of people that I would never normally be around. But you have to turn to the black market for everything. For example, I bought my air conditioner, new from the box, from a man who worked as a marine in the Navy and travelled. It costs me about $400 US. How expensive! One has to be millionaire in Cuba to be able survive. I also bought my VCR in the mid 1990s from a diplomat, and it cost me around $350 US. I used to rent my apartment illegally, before this licensing business started up, and sleep on a cot on my terrace. Now, the government wants to control everything. Most people think people who rent their apartments are rich, but I am only making a living. In Cuba, now, there is a lot of envy and people are always looking at what other's have or don't have. I have what I earned and sacrificed for. Nobody gave me anything for free. Everything I have I struggled for (lo luché).

—Sra. Raquel Hernández, retired administrator, born in Cienfuegos, 1930.

The term, *la lucha* (the struggle) appeared with 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 words — that take on a new meaning in contemporary Cuba. The term *la lucha* addresses the multiple ways Cubans are dealing with the widening gap between their current

[12] In this context, the term "*El Bobo*" refers to Fidel Castro.

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?," I'm struggling (*Estoy en la lucha*) has become a way of expressing a generalized frustration with the current economic crisis. Moreover, as I will argue, the term *la lucha* has become a way of describing the personal struggles of everyday life. This struggle demands engagement in a complex web of informal practices in a thriving non-state-regulated economy in order to mitigate the increased pressures in daily life.

Cuba's recent economic recession has meant that average Cuban citizens have experienced significant reductions in their standard of living. This is not only because of the diminished availability of consumer goods, but also because of the daily inconvenience associated with the lack of such basic services as electricity, running water, and public transportation. As the above interview excerpt affirms, Cubans have also begun to experience for the first time "actual or impending cutbacks in education and public health services, achievements of the revolution to which the citizenry had grown accustomed and which it took for granted" (Pérez-López 1994: x). Several reports, largely by US critics, have revelled in what they believe to be the demise of Cuban socialism. For the most part, they are supported by grossly exaggerated journalistic accounts. These accounts, such as that of Gold's, conjure up images of the daily toils of Cuban citizens experiencing "ambulances crippled by lack of fuel and spare parts, [the] sick Cubans often flag down passing cars or trucks in emergencies" or are forced to use "aloe vera plants to prepare anti-inflammatory creams due to severe shortages of medicine" (1995: 483-487). These statements, which more closely reflect the volatile nature of US-Cuban foreign relations than actual concerns for the daily experiences of individual Cubans, fail to equally comment on the complicit role of the US trade embargo against Cuba.

The US embargo against Cuba has played a significant role in blocking aid and trade (which includes medicine and medical supplies) with Cuba's potential trading partners. Accounts of the socialist government's supposed demise, which have become a regular staple in counter-revolutionary circles and publications such as *The Miami Herald*, often present glaringly inaccurate information regarding Cuba. Moreover, these reports fail to take into account everyday reality in the US, where, despite enormous wealth, large segments of

the population are still without access to adequate medical care or health services. Cuban political pundits do not leave this selective reporting of apparent "facts" by US-based media outlets without comment. Cuban political leaders at international conferences and meetings such as the United Nations have questioned the US government's dedication to human rights and democracy, particularly in light of the US government's own commitment to equity and fair government.

More recently, an emerging body of literature on Cuban studies has illustrated that ordinary Cubans have been negotiating the changes to their daily lives and challenging government authority, most typically in non-political ways, and this has largely eroded the government's political order (Eckstein 1994: 127; Fernández 2000a; Léon 1997). In the wake of government cutbacks in basic services and the decrease in total food rations[13], a proliferation of informal activities have surfaced. These activities include black market trading in goods stolen from state enterprises (*el bisne*); a rapid expansion of small private businesses such as *paladares*[14]; legally and illegally renting rooms to tourists; prostitution and hustling (*jineterismo*[15]); and an increased dependence on a network of client-based relations (*socios*).

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[13] Space will not permit a detailed discussion of the system of food rationing in Cuba. See, for example, Medea Benjamin, Joseph Collins and Michael Scott's (1984) *No Free Lunch: Food and Revolution in Cuba Today,* for a more elaborate discussion. In addition, see Adriana Premat's (1998) *Feeding the Self, Cultivating Identity in Havana, Cuba* (unpublished M.A. thesis, York University, Canada) for an ethnographic account of the different ways Cubans negotiated food shortages and rationing during the *período especial.*

[14]Small privately owned restaurants (operating in US dollars), which are sanctioned by the state, as long they seat less than 12 people and serve only pork or chicken. In practice, many of these establishments have a clandestine existence and offer menus with state-regulated items such as lobster, shrimp and beef.

[15] This term generally means prostitution or hustling in Cuba (which literally means "jockeying"). This term, in addition to signifying sexual favours for money, includes individuals who hustle foreigners to pay for clothes, purchase clandestine goods (e.g., cigars), facilitate trips outside of Cuba (via letters of invitation or marriage), and more generally, hustling foreigners for access to goods and services only available to people with US dollars (for example, the term *jinetear* means to "to hook tourists"). This activity involves both men and women, and despite the state's disapproval, occurs openly in the main streets of Havana, such as on *La Rampa* and *Quinta Avenida.* However, the Cuban government passed a law in February 1998, which imposed severe penalties ranging from jail terms to monetary fines to Cubans found guilty of such activities; so far, this law appears ineffective in curtailing this practice.

The state, rather than increasing its control, as many state-centered analyses would suggest is the case (cf. Horowitz 1995), has begun reinventing its role as guardian of the underlying principles of the socialist government, namely the maintenance of national sovereignty and the ability to provide equitable social development. 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 from 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 (E.I.U. 1997). Many of these activities, though once part of what Eckstein refers to as the "culture of illegality" (1997: 148), have been subsequently incorporated into the state's program of "economic reform" and thus practitioners are required to pay license fees and taxes — only, of course, when the state is aware of such activities.

As Castro argued, these economic strategies were designed to "save *la Revolución*" and he defended the increased marketization and privatization as not "violating any principles of socialism" (see Figure 4-2; *Granma Weekly Review,* 1991: 15). Similarly, political analysts such as Cuban scholar Monreal (1999) suggest that the Cuban government has not deviated from the roots of its Guevarist and Marxist-Leninist principles, but rather is seeking ways to control their integration into the international economy. Monreal's (1999) view is also supported by international policy analysts such as Ritter and Kirk (1995), who argue that the survival of Cuba's political regime is dependent on its ability to reorient and reform its economy successfully in the context of the international market-oriented economic system. The consequences of these new economic policies, however, have many paradoxes; the most striking paradox is the very concept of a dual economy (McFadyen 1995: 20; cf. Ritter and Rowe 2000).

In 1993, the Cuban government legalized the use of US dollars among the population. This strategic move by the government aimed to obtain much needed hard currency and, in addition, to compete with the clandestine trade in US dollars on the black market. The government opened a series of *Cadecas (Casa de Cambio, S.A.)*, an operation designed specifically for currency exchange,

where Cubans could legally exchange US dollars into Cuban pesos (or vice versa) at a rate higher than that on the black market. Cuba thus entered into a state-approved dual economy. Calderón (1995), a Cuban scholar, writing for the influential Latin American and Caribbean Studies journal *NACLA*, discusses some the daily experiences of the new dual economy during "life in the special period." Writing about the experiences of Roberto, a lawyer, Calderón describes how, even with the relatively high salary of 300 Cuban pesos a month (equivalent to $15 US) but with no access to dollars[16], Roberto routinely lacks many basic living supplies and must frequently go without running water as part of the state's program of conservation and economic reform.

With the advent of state-run stores that sell goods in US dollars (*shopings*), Calderón argues, most Cubans' salaries are inadequate to purchase the rapidly increasing services and products that are now being sold only in *divisa*. As he notes, "We all resort to the underground market because the authorized quotas in the state stores are sufficient for perhaps 12 of the 30 days of the month. We have few conflicts of conscience over the double standard implicit in considering ourselves good revolutionaries and at the same time participating in the black market" (1995: 19). Calderón suggests, as do others I interviewed in the course of this research, that the recent economic crisis is as much about the changing nature of Cuban socialism as it is about reinventing the "new revolutionary" (though not the "New Man" and "New Woman" originally envisaged by Ché, and discussed in chapter one).

[16] One of the greatest sources of US dollars before the law changed allowing Cubans to legally hold dollars was through remittance payments from Cuban aboard. The government, however, had an official procedure by which the state would exchange these dollars at a one-to-one exchange for Cuban pesos. However, as many Cubans note, a flourishing black and grey-market trade was well under way before the advent of the "special period." These activities tended to be in non-essential things (e.g., blue jeans, electronic equipment, etc.) and not in basic provisions (i.e., rice, different kinds of meat, oil, soap, etc.). Throughout the term of this research (2000-2001), one US dollar had a value of 20 Cuban pesos on the street, and 22 Cuban pesos was the official state rate of exchange. However, after the September 11 terrorist strike in New York, these figures drastically changed. The official state rate of exchange as of November 26th 2001 was 1:27, this decrease in value is also reflected in the exchange rate in the street. This was attributed, according to the Cuban media outlets, to a drastic decline in the island's tourism industry and, consequently, a drop in the amount of foreign currency entering the country.

In spite of Castro's assurances that Cuban socialism was still intact, the unintended consequences of the new economic reforms have created a situation wherein the 85 percent[17] of Cubans without regular access to dollars now look with envy at the minority who can enjoy the fruits of the dollar economy (McFayden 1995: 20). The irony of this situation, in a society that had prided itself on the amelioration of social stratification, is immense. For example, a journalist writing for the Cuban newspaper *Tribuna de la Habana* discusses the growing inequality in Cuban society and the saddening reality that even in places designated for Cubans, such as children's theatres, where one pays an entrance fee in Cuban pesos, the only refreshment stands are in the *divisa*, and are thus outside the economic range of most Cubans (Álvarez 2001: 3). As Alvarez ironically points out, "I will never understand that this currency [*divisa*] is the only option for hiring a taxi to the hospital, or buying school uniforms or buying children's books, to use three examples — fortunately, hypothetical ones" (2001: 3). The truth, undoubtedly no secret to Álvarez, is that the hypothetical examples such as these often use only the US dollar due to shortages in the Cuban peso economy. 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.

Hammond (1999), for instance, argues that the "dual economy" has threatened to resurrect the social divisions between different ethnic groups in Cuba. Afro-Cubans are not only less likely to have relatives who have emigrated — a source of dollars through remittances — but are also less likely to be hired in many of the newly co-owned foreign business due a resurgence of racial discrimination and prejudice. This reality has created a great deal of tension in contemporary Cuba (Pérez Sarduy and Stubbs 2001; Hammond 1999; de la Fuente 2001). In 1994, for example, riots on the Havana waterfront destroyed several state-owned US-dollar stores, and the rioters demanded freedom and changes in Cuba's political situation. Not only were such incidents of protest and rioting rare in post-revolutionary Cuba, but the demographic and social

[17]In 1995, this percentage was the officially reported figure; however, I suspect the percentage of Cubans with access (regular or intermittent) to US dollars is currently much higher. Some scholars estimated that the proportion of population that now has access to dollars through various channels reached 62 percent in 1999, up from 56.3 percent in 1998 (cf. Ritter and Rowe 2000: 11-12).

composition of the participants was unusual. The majority of the rioters were young Afro-Cubans, which brought the question of race into the forefront of Cuba's current economic and social crisis (cf. de la Fuente and Glasco 1997: 53; de la Fuente 2001; N. Fernández 2001).

Figure 2-2: "In Cuba there will be no transition towards capitalism"

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The problem of "race" is complex in Cuba's post-revolutionary environment, which in official state discourse is extolled as a harmonious racial mosaic[18]. Historically, the revolutionary government, informed by Marxist

[18] The long-standing revolutionary claim of Cuba as a "racist-free" country is more utopian than realistic. My personal experiences in Cuba, as some Cubans would refer to as a *mulatto* (mixed racial heritage), were far from "racist-free." It would be unfair to categorize the forms of racial prejudice and discrimination that I experienced as equal to that of the United States or Canada, that is, forms of structural racism. Similar to other Caribbean islands, local forms of racism in Cuba, including *shadism* (hierarchy of skin tones) and the association of African features with unattractiveness, criminality and inferiority are prevalent. It is important to note, however, that Cuba, unlike many of its Caribbean counterparts, has widespread racial intermarriages and, in general, the population is highly integrated. Discussions of *los negros* (the "blacks"), as in other post-colonial Caribbean societies, are often in relation to the purported propensity of blacks to commit crime. Not surprising, however, especially to people who have their cultural roots in the Latin America and the Caribbean, these complaints

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 follow suit. However, the concept of race must be situated in reference to the pre-revolutionary past, in which a discriminatory social order shaped the lives and experiences of the Afro-Cuban population. As several studies have suggested, Afro-Cubans have long been considered by many as the main beneficiaries of the Cuba post-revolutionary social order, and therefore have been deemed a group from which the current government draws unconditional political support (see, for example, de la Fuente and Glasco 1997). Now, no longer relegated to the discussion of Cuba's post-revolutionary racial harmony, issues of race, racism, and discrimination are being considered seriously as topics of popular debate (cf. de la Fuente 2001; Pérez Sardury and Stubbs 2000; N. Fernández 1997; 2001). The current economic crisis, therefore, is compounded by various influencing factors: a competition for scarce resources and shortages has created a new climate in Cuba, in which old and new conflicts are finding fertile ground.

2.3.1 *La Doble Moral* and "Apartheid Tourism"

> *My problems in Cuba at this moment are economic, not political. If I ever leave Cuba, I will always want to return, just like the foreigners who come to Cuba and then always return. But the truth is, I don't cover my eyes. I love Cuba a great deal, but I know the social and economic problems are serious. I hate politics. I have nothing to do with politics. When I see a political program on TV I turn it off. If I hear politics being discussed on the radio, I turn it off. If it is a political day in Cuba, like a special march or holiday or something, I stay locked up in my house. I hate politics because, no matter whether it is with good or bad intentions, it is there all the time! Every day in Cuba is politics. I don't like it. This is one thing that doesn't interest me. I would like to just live.*
>
> *I believe that the US economic blockade affects my life. It affects everybody in general. The blockade exists, but the Cuban people don't help much either. There is a blockade against Cuba, but the people in Cuba are blocked as well, that is, their heads are blocked. Lots of people see we have problems with petroleum, with the economy. But if you get up in the morning, let's say at 9 in the morning, and you see all the lights on the street are still on? What about the economic problems? If there's a political march, they need all the buses and cars to bring the people to the rallies, but where do they get the petroleum for this? I'm not involved in politics, but all these things are real; very real and true. You walk along the street and you see the pipes broken and water running like a river down the street and people passing by and nobody interested. Where are the politicians*

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are not only voiced by individuals in the "white" population, but by "blacks" as well. This discussion is a thesis onto itself and thus cannot be elaborated upon here (see, for example, Castillo Bueno 2001 for a discussion on internal racism).

who should be interested in fixing these problems? Who is responsible for this? What institution is responsible for these things? These are things that are being wasted and cost us money. For me, these things are small, but this is the country that always blames all the problems on the blockade by the government of the US. But these problems are a result of us. We created them. Sometimes I say, "Where is the problem really: outside or inside Cuba? Before the problems in the 1990s people were much better. I mean people's basic human qualities were much better than now. Now, there is widespread egoism, envy, and lots of social inequality: those who have and those who don't have, those who live well and those who don't live well. Then there are those people who look down on people who live poorly and — how should I say this? — these people feel superior to those poor people. They say, "I have a big house because I have money and I can buy good things," and they think that if you don't have money, you aren't worth anything. I think all these changes are the consequence of the change to the use of the dollar. For example, people whose families send them dollars, or people who have good jobs that pay in dollars — like in hotels — or people who steal — who work in places that provide them with access to things they can steal and sell — or people who rent their houses — all these people have more opportunities. Imagine, here, if you have divisa *you can buy everything. If you don't have it, like they say, you're fucked.*

— *Sr. Carlos Alberto Ramos, unemployed, born in La Habana. 1972.*

During the 1990s tourism became a priority sector for Cuba's economic development, and evolved from a peripheral activity to become the most dynamic sector of the economy, earning more hard currency than sugar. The gross revenue from tourism alone was $200 million in 1989, $700 million in 1993, and $850 million the following year. In addition, the gross revenue increased by an average of 20 percent annually from 1989 to 1997 (E.I.U. 1997). With increased foreign investment in joint ventures in the tourist industry[19], both hotel room occupancy and the number of airlines serving the island rose exponentially to accommodate the burgeoning number of people choosing Cuba as a tourist destination. However, Cuba's tourist economy has not developed without sacrifices. The consequences of the government's new economic policies have many paradoxes, the most striking one being the very concept of a dual economy itself (McFadyen 1995: 20). The tourist economy is a dollar economy. As earlier noted, Cubans were not legally allowed to possess US dollars up until 1993, and thus in the late 1980s and early 1990s were de facto excluded from many of the prime tourist venues, including certain beaches,

[19] Tourism constituted revenues close to $1.9 billion in 1999, and by 2001, had an estimated value of $4.2 billion.

hotels, restaurants, and discotheques, that previously had made use of Cuban pesos and were accessible to the entire population[20].

The situation since 1993, when US dollars began legal circulation, has not changed drastically as informal regulation by police, hotel security, and hotel staff have limited the access of Cubans to "spaces" reserved for foreigners (*extranjeros*). While Cubans haveaccess to, for example, the hotel stores and restaurants (though access is often limited to those Cubans accompanied by foreigners), they are prohibited from staying in *divisa* hotels (or entering hotel rooms). In addition, Cubans are prohibited from entering certain tourist areas in Cuba (such as Cayo Coco and certain beach resorts) without authorization, something that is virtually impossible for the average Cuban to obtain for tourist purposes. The formal and informal regulation by police and hotel security takes the shape of check-points — often amounting to outright harassment — in which Cubans are asked to present their Cuban ID cards (*carné de identidad*) and explain what their intentions are in any given location[21]. Out of fear of being handed a *multa* (fine), many Cubans — with the notable exception of hustlers (*jineteros*) and illegal taxi drivers known as *boteros* — refrain from frequenting tourist places. The general population is forced to witness the achievement of *la Revolución* — their "*Cuba libre*", their state of the people — being enjoyed almost exclusively by *extranjeros* or, even worse, by Cubans living abroad (*cubanos de afuera*[22]) armed with foreign passports and US dollars. Cubans popularly describe this situation as "apartheid tourism."

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[20] Hotels that charge in Cuban pesos still exist for Cubans, but the quality of these hotels is often substandard and the range of services provided is severely limited or completely absent. They often lack running water and other basic amenities and, while they are not for foreign tourists, it is not uncommon to find many *extranjeros* staying in these hotels paying a negotiated price in US dollars, which is often pocketed by the hotel staff who register them as Cubans.

[21] Similar to the massive overcrowding in urban cities, as is characteristic in other "developing" countries, Cuba in the early 1960s tried to eradicate internal migration to urban areas (specifically Havana) by using a internal passport or *carné de identidad*, which lists personal data (full name, date of birth, age, "race", height), occupation, and, importantly, place of residence. Cubans (and foreigners) over the age of 16 are required to have either a Cuban ID card or foreign passport at all times to be able to present to authorities in the event it is requested. Failure to produce a valid ID is subject to a fine and, at times, arrest. In addition, at the discretion of authorities, individuals present in areas in which they are not resident are also subject to a fine.

[22] Historically, part of the revolutionary education has been to teach the population that the Cubans who left the island, particularly to the United States, were

With the notable exception of those who work in the hotel stores, which are stocked with commodities such as perfumes, cosmetics, brand name clothes, Coca Cola and other prized packaged goods available only in dollars, the presence of Cubans in many tourist hotels is limited. The other exception is workers in the growing sex industry that has re-established itself in Cuba with the influx of tourism. Growing numbers of tourists, particularly in Havana, come to Cuba not merely for the rum, tobacco, and salsa music, but also for sexual partners who are racially and culturally different. For example, the Cuban government granted approval to *Playboy* magazine to feature a photo-spread on the "Girls of Cuba," and the Cuban Ministry of Tourism's travel advertisements started featuring string-bikini-clad women, capitalizing on the pre-revolutionary image of Cuba as the Las Vegas — or the brothel — of the Caribbean, and home to the famous *mulatta*[23]. The presence of young Cuban men and women on the arms of foreigners in many tourist locations now constitutes part of a growing sex trade.

A preliminary study by Strout (1995) on the effects of the *período especial* on women's lives suggests that, "unlike the women who worked to survive or who were tricked into prostitution during the period of economic destitution before the social and economic development of the *la Revolución*, modern-day sex workers are trading their bodies for consumer goods and recreational opportunities otherwise unavailable to them" (Strout 1995: 7–10). Drawing on interviews with *jineteras,* Strout's study suggests that, with very few exceptions, most of these women are not in such difficult situations as would require them to engage in these activities to survive. Instead, many, mainly dark-skinned

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gusanos (worms) who turned their backs on *la Revolución*. In particular, the population was led to believe through massive propaganda that the Cubans who fled to the United States were suffering from massive discrimination and poverty. However, when Cubans in exile (*exilios*) were granted permission to return to Cuba for tourism and familial visits in the late 1980s, the population witnessed, perhaps for the first time, that the majority of these individuals were actually living decent lives, lives that, by Cuban standards, were complemented by material luxuries. Many Cubans informally labelled these individuals "butterflies" (*mariposas*), playing on the metaphor of a *gusano* or caterpillar: leaving Cuba as worms only to return, transformed, as butterflies — well-dressed and armed with an excess of US dollars in an economy of scarcity.

[23]This term means women of mixed racial heritage. *La mulata* is also a popular brand of rum in Cuba, and arguably used as a national symbol of Cuba's racial harmony (cf. N. Fernández 1997; 2001; also see de la Fuente 2001 on the concept of *mestizaje*).

women without access to familial monetary resources abroad[24], are motivated by the desire to go out, enjoy themselves, go places where Cubans are not allowed to visit, and have fancy clothes (Strout 1995: 10-11). This latter view, supported by Cuban social scientist Armando Vallant's (2000) study of *jineterismo* as a juvenile social pathology, examined how this practice is reinforced by what he argues is an "alienated individualism" that emphasizes consumerism. Despite the strong moral overtones in Vallant's (2000) article, he importantly notes that many *jineteras* defend their actions as "struggling" or "fighting" (*luchando*), which many people in the general population can understand, thus forestalling judgement. The reality is that, among those engaging in the practice of *jineterismo,* many are university-educated professionals. This situation also applies to *jineteros* (the male counterparts[25]), who increasingly engage in both heterosexual and homosexual sex-tourism.

Many of the young men and women engaged in *jineterismo* do so unabashedly, despite its illegality and the occasional government prosecution of this practice. The explanation for this apparent contradiction, individual citizens interviewed for this research argued, was related to the widespread dual moral code or duplicity (*la doble moral*) of contemporary Cuban life. In this system, there exists a contradiction between two normative frameworks, the public and the private, in which one outwardly accepts the state's moral mode of conduct but rejects it in practice (cf. Fernández 2000; M. Pérez-Stable 1998). Beyond the simple linear opposition between public and private, *la doble moral* is much more complex and endemic in everyday interactions, both political and non-political[26]. For example, while many people preach the revolutionary principles, denouncing *jineterismo* as a regression in the moral standards of contemporary Cuban society, many of these same individuals will turn a blind

[24] Sarduy and Stubbs (2001: 34) argue that, "given the race composition of the exile and island populations, senders and recipients are far more likely to be Euro-Cubans."

[25] Another term for male *jineteros* is *pingüeros*. The latter term denotes a form of "hyper-masculinity" defined by exaggerated muscular bodies.

[26] The problem of *la doble moral* is best summarized in comments made by Raúl Castro, Minister of the Revolutionary Army (also known as the FAR), who stated in 1993, "We all know we don't say anything in meetings, but we talk a lot in the hallways," in reference to duplicity prevalent in Communist Party meetings (cited in Pérez-Stable 1998: 28).

eye to its existence (for example, policemen and other state officials) or economically benefit from this practice (private restaurant owners, rental property owners, and ordinary citizens), by establishing mutual agreements with *jineteros* to bring foreigners who will rent apartments, buy goods or services, or purchase medications or consumer goods abroad.

A clear example of this *doble moral* was a local CDR (Committee for the Defence of the Revolution)[27] meeting I attended on the block where I rented my apartment. Centrally located in a tourist area, which was also frequented by what one CDR delegate (*cederista*) referred to as "marginal individuals: gays, transvestites, *jineteras* and the sort," apartment renters and neighbours alike where asked to be vigilant about the types of people whom they allowed to rent their homes. Seeking to crack down on rooms and apartments that were rented to foreigners and Cubans without legal declarations, an official announcement from the Ministry of Housing proclaimed that houses found to be engaging in the promotion of "illegal activities" would be confiscated by the state. The majority of the participants in the meeting were in wholehearted agreement on what was to be done: report aberrant activities immediately to the relevant authorities.

Much later that same evening, sitting on the front steps on my building, many of my neighbours laughed and discussed the uselessness of the earlier CDR meeting. Despite their previous agreement and earnest nodding of heads, they explained that it was only to "show face" and that they had no intention of reporting anything. The reality was that *jineteros* (male and female) together with foreigners were clearly the vast majority of their clientele. In addition, there existed a general agreement between renters and *jineteros* that a $5US commission would be awarded per day for bringing along customers. On a different note, a usually timid older woman who attended the CDR meeting, frail and dressed only in a faded white nightgown, grabbed her breasts and shook them at us playfully, declaring, "I would be a *jinetera* too if I could, but I don't have what I used to." Laughing, most of my neighbours agreed that people needed to struggle (*lucha*) — engage in a complex web of informal practices — and that the *jineteros,* like everybody else in Cuba, were no different. They just

[27]For detailed description of CDRs, see chapter one, footnote 19.

wanted a good life. I encountered several families that supported this opinion: often one or more of the family members were dating foreigners (often several foreigners within a span of two weeks), a behaviour that did not arouse attention[28].

For example, Carmen Luisa, a woman I interviewed on issues related to her health, spoke about her daughter, a self-professed *jinetera:* "She can resolve (*resolver*[29]) many of her problems through foreigners. Hopefully, she will get married to one of them and leave. This is the only way she can have a decent life." Pictures of Fidel Castro and Ché occupied the centre space on the wall in the living room of Carmen's house, in addition to the clutter of store-bought luxury consumer goods her daughter had brought home, including bottles of prescription drugs and creams from Spain. On the fridge, there was a large picture magnet of her daughter smiling proudly on the arms of an older, overweight man on the beaches of Varadero; as Carmen later pointed out, the man was from Madrid. Lydia later commented that her daughter, who stood by bedecked in designer apparel and an excess of gold plated jewellery, was waiting for the "right one" (the right foreigner) before she finally left, despite having travelled extensively to Spain, Italy, and Holland. At the age of 27 and a member of the Union of Young Communists (UJC), Lydia had formerly worked for the state as a lawyer and was tired of what she described as "a new form of slavery in Cuba: working for nothing." Lydia[30] argued that the underlying cause of

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[28]This is not to suggest, however, that *jineterismo* is widely acceptable in the general population. Rather, many individuals dating foreigners (one or several) discuss these relationships in terms of "love" in order to avoid the stigma of calling them "clients." In Havana, if you pass by any of the foreign embassies during business hours, the line-up of foreigners with their Cuban "sweethearts" in pairs is immense. What I want to stress from this example is that *jineterismo* is much more complex than a simple exchange of sex-for-money. Many of these men and women end up marrying the foreigners they date — the ultimate goal — and are able to travel freely in and out of the country, unlike the rest of the population.

[29] In the context of contemporary Cuba, this also means to struggle to obtain a goal by relying on an informal network of people (cf. Hagedorn 2001: 253).

[30] At the time of writing this dissertation, Lydia had married a man from Spain and had moved to Madrid. We keep in regular communication via e-mail. Recently, Lydia's younger brother and mother secured visitor's visas and arrived in Spain – where they quickly claimed political asylum. According to several of my informants, this is common practice for "getting out" of Cuba: one person marries a foreigner and then attempts to get the rest of the immediate family out as well. It is a unique perspective on family immigration. However, it may also be the reason why certain foreign embassies in Cuba, such as the EU countries and Canada, have become increasingly

apathetic attitudes among the young (*los jóvenes*) in Cuba — and this opinion is supported by others interviewed for this research — is the extreme difficulty of solving the economic hardships of everyday life by dedicating one's self to *la Revolución*[31].

As Fernández points out, youth in contemporary Cuba — unlike their parents and grandparents who were compelled to support the revolution for personal and material reasons — "judge the government based on performance rather than on promise, on standards of efficacy and efficiency rather than on passion and affection" (2000a: xiv). As he further notes, "the young, disappointed with the difference between the public and the official, have started to find in the private sphere and in the informal alternative sources of identity, meaning, community, and economic survival" (2000a: xiv). I argue in this dissertation that Fernández's (2000a) argument should extend to other generations, as many qualified professionals (such as teachers, doctors or lawyers) either give up their salaried state positions or supplement them by turning to the informal economy or to the tourist sector (including *jineterismo)*, where the income potential far exceeds the salaried professionals of the socialist economy (Ritter and Kirk 1995: 4). The result of the cross-fertilization of formal and informal economies is a complex network of people who operate outside the realm of state control, the majority trying to make ends meet, and others — Cuba's new rich men and women — emerging as carbon copies of small-scale Western capitalists: the *macetas* (wealthy profiteers of large-scale black market operations) and *bisneros* (owners of small private businesses).

As Cuban writer and ethnologist Miguel Barnet notes, "A new type of Cuban has emerged: the new rich man with his beeper . . . these are the men who were raised in socialist society, who want to be capitalists but don't know what a capitalist is. The new type of Cuban is a sort of anachronism. He wants to imitate the Cuban of the 1940s and 1950s, but with the achievements of

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reluctant to issue visitor's visas to Cubans who wish to visit their family members abroad.

[31] de la Fuente (2001) and de La Fuente and Glasco (1997) make an important distinction, which is often ignored in studies of Cuba, namely, the importance of age (see, for example, Fernández 2000 for similar argument). Many younger Cubans born after 1959 or, more notably, during the 1980s economic crisis have formed critical opinions of the revolutionary government, particularly the provision of basic human needs.

socialism" (1995: 30). Nevertheless, as anthropologist Ariana Hernández-Reguant argues, socialism itself is being redefined in Cuba's *período especial.* Hernández-Reguant (2000) explored how Cuba's recent economic reforms have transformed age-old institutions, such as the media, from instruments of socialist ideologically-based education to flashy marketing campaigns, designed to promote basic necessities such as essential drugs and certain luxury items. As a result, Cuban citizens, long accustomed to a steady diet of revolutionary pedagogy in the form of staid socialist slogans plastered on billboards, are now also being subjected to advertisements for goods produced in Cuba, such as beer, beauty items and electronic equipment. Hernández-Reguant (2002) asserts that the state's return to certain capitalist strategies (albeit limited) have created two key concerns: first, the increasing economic disparities within the population; and second, the state's desire to take advantage of these disparities by promoting the sale of Cuban products — and thus earning much needed hard currency — over those imported products increasingly made available through savvy foreign companies operating in Cuba. Socialism has literally repackaged itself: "socialism with commercials."

2.4 Conclusion

> *There are people who feel deceived by the la Revolución. I do not feel deceived by the state because Fidel warned the population ahead of time that this period would be a difficult time for us and that many changes would occur. I can never say that I have lost all of my optimism. I have total confidence in la Revolución. If it were not for la Revolución I would never have been able to become a professor. I owe everything that I have to la Revolución because it removed the obstacles that existed before so that a person like me could achieve my goals. The current período especial has existed for some ten years now, and I don't like it but we have to make sacrifices for our goals. Also, the kind of influences and role models an individual has is very important. For example, there are people who do not show much interest in participating in la Revolución; at least, they are not as interested as they were in earlier years. I think this a product of the current período especial we are living in. Because there is a saying: how you live is how you think. If you live well, this influences how you think. If you live poorly you also think this way, for example, you think hell, why me and not other people? These people have very distinct mentalities.*
>
> *Now, there are huge differences in the standards of living during the current período especial, and these changes have had many consequences. These consequences, for example, are reflected in various sectors of society. Unfortunately, youth is one of the sectors that has been affected. There exists, for example, families that are not very concerned about the well-being of their children and they also consider that the current period we are living in is the result of sheer fanaticism on the part of Fidel. This negatively influences their children against la Revolución.*

Fidel has a great vision of the world and is taking determined measures to achieve this goal. For example, Fidel has currently implemented the "Youth Social Workers Program"[32] *and this has highlighted many of the problems that before, let's say, were out of the hands of the government. In essence, this program seeks to incorporate youth that have lost all interest in* la Revolución. *This program includes those youth who do not want to study and those that do not want to work. These individuals need something positive and productive to do during this difficult period. Now, we are seeing the light and beginning to see the problems for what they are. Of course, there are lots of problems and* la Revolución *cannot solve all the problems in one day. There are some problems that are easy to solve, and others that are more difficult. For example, many studies are currently being conducted to address problems related to demographic and nutritional factors. For instance, due to nutritional problems with children and the elderly, these groups are now receiving an increased assigned ration. They are receiving more special rations than before and currently the food situation of the population is getting better. We cannot say that it is the best, but it is okay.*

In general, I think that we are better off than we were, let's say, in the past couple of years. Of course, there has been an increase in tourism and this has helped out a great deal. We have also improved the economic situation in some small measure. We still have many problems, but the problems we have are not the product of one year. These are problems that have accumulated over many years, because la Revolución *has had to face many difficult situations. The revolutionary government has never been given any breaks.* La Revolución *has had to be like a tree: you plant it and you wait to harvest the fruits. It may turn out that not all the fruits turn out good or do not turn out they way you wanted them to, but you have to start over again, and plant another tree and wait. It is like this.*

— *Olga Ríos Dilmé, university professor and local CDR president, born in Pinar del Río, 1947.*

The economic crisis of the 1990s has severely weakened the revolutionary government, especially the state's "capacity to control the distribution of resources, social and political discourse and ideological production" (Dilla 1999: 30). The gradual dismantling of prevailing forms of the state's social and political control have led to what some scholars argue is the gradual emergence of a civil society in Cuba (cf. Dilla 1999; Eckstein 1994; Fernández 2000a; Léon 1997). "Civil society," argues Cuban political scientist Harold 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). However, civil society in Cuba must be understood in its cultural and

[32] The *Trabjadores Social* is a program recently implemented by the government to incorporate problematic youth in various social projects. Examples are projects aimed at improving the environmental, construction-related, and health problems such as the fumigation and general clean-up of the city to eliminate potential breeding grounds for the mosquitoes that can produce dengue outbreaks.

historical context as well as the national and local community in which it thrives (Dilla 1999: 32; see also Oxhorn 1995 for critical discussion of civil society formation in Latin America). As this chapter has illustrated, changes in Cuba's social and political arena do not prematurely spell the socialist government's imminent demise, but rather such changes must be situated within the changing objectives of the state itself (Eckstein 1994). Nowhere are the state's changes more evident, as I will discuss in chapters six and seven, than in Cuba's socialist health policies, which are currently undergoing revisions, experiencing constraints, and meeting obstacles as the economic crisis poses serious challenges to the state's ability to keep intact the underlying principles of the socialist government.

The popular assumption that all socialist transitions move along a progressive and linear movement toward a pre-determined end, liberal capitalism and democratic politics, fails to address the complexities and uncertainties in this transitory phase (cf. Zang 2001). In Cuba, while significant social and politico-economic changes have led to the proliferation of informal activities outside of the state's realm of control, this does not signify an outright withering of state power. For example, the state carries out periodic "crackdowns" on black-market ringleaders (*macetas*), illegal renters, and *jineteros*, among others, who are publicly arrested and denounced for their activities. While these selective displays of state power are relatively ineffectual in curtailing the widespread existence of illegal activities, they serve to keep them in check[33].

[33]More recently, in April 2003, the socialist government infiltrated several dissident movements operating in Cuba, which state security agents suggested were sponsored and funded by the US government. All of the dissidents were sentenced to long jail terms, mostly ranging from 14 to 28 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 also sentenced with "very grave acts of terrorism" and executed by firing squad. While there are clear differences between political repression and the control of the private informal economy in Cuba, I was informed via personal communication with several of my friends and informants in Cuba that the state's severe (and brutal) response to the dissidents and hijackers had 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 [that is, sacks of cement, window frames, and other items stolen from state enterprises]). As one Cuban I spoke to briefly through e-mail noted, the recent events in Cuba were harkening back to the "old days" and the state's hard-line approach to illegal practices. Whether this "hard-line approach" by the Cuban state will have a long-term effect on the private informal economy remains to be seen.

That the informal economy is an integral part of the basic subsistence patterns for many Cubans is a reality that the state can neither deny nor compete with. Rather, as I will argue in chapter six, the state, to a certain degree, must rely on this informal economy to fill in the gaps that have been created as a result of the deterioration of government social welfare programs. By turning a blind eye to certain practices, the state provides a safety valve by which *las masas* obtain material and non-material goods and services (including basic medicines, food items, and luxury consumer goods) and find solutions to their more immediate problems, which the state can no longer solve. This is not to suggest, however, that this delicate balancing act between interest groups and the state is entirely unregulated (cf. Gupta 1995 and Scott 1969 for discussion on corruption and the state).

The visible decrease in overt state power has been countered by an increase in more subtle forms of vigilance and control, including an infiltration of agents of state security in the form of state informers (*chivatos),* who are often neighbours, work colleagues, or classmates. During fieldwork for this research, for example, I left Cuba briefly to visit my family in the neighbouring island of Jamaica. Upon my return, my landlady informed me that state officials from the Cuban Ministry of the Interior (MININT) had paid her a visit to inquire about my daily activities. The MININT asked my landlady a number of questions: What kind of friends did I have? Where did I go during the day? Did I live with anybody? Did I have a computer? Did I have Internet access? Undisturbed by what she felt was a routine investigation, my landlady answered all their questions fairly accurately, which in itself surprised me in view of my very infrequent exchanges with her. While I had nothing to hide, I felt uneasy about state officials probing into my personal life and my daily activities. The landlady calmly stated that, "The MININT knows everything, especially regarding foreigners living here. What they don't know they always find out from certain people in the building or on the block, people who you might not know. But trust me, they know everything about you. For this reason, you have to be careful about who you tell what kinds of things."

While the MININT visit never produced any consequences that I was aware of, I became immediately suspicious of the inquisitive nature of my neighbours and the people I encountered on a daily basis, who always wanted to

know more about my research or about me personally. As a result, I became more selective of the friends I made, and in general distrustful of new people who I met. As I came to realize, however, after relaying this experience to Cuban friends, these feelings are quite common in contemporary Cuba. Subtle forms of state power, such as that exercised through *chivatos*, have created a climate of distrust among many Cubans, emphasising the importance of working within groups of proven trust (*confianza*). This buddy system, also known as *sociolismo*, was a characteristic feature of the pre-revolutionary era. It has once again taken centre stage in Cuba's current social milieu.

Part II

Socialist Governmentality, Public Health, and Risk

Source: http://www.cubanfineart.com (May 31, 2003)

The general ethos of the Cuban revolution, as the "revolution of the common people," is reflected in the later works of Cuban painter Servando Cabrera Moreno (1923-1981). The above work, *Milicias campesinas* (Militant Peasants), is one of Moreno's most celebrated works, which draws on the revolutionary themes of struggle (*lucha*) and heroic sacrifice (*numancia*).

There are, of course, plenty of examples of the exercise of sovereignty in the twentieth century that have practiced a decidedly nonliberal form and program of national government both in relation to their own populations and those of other states. Does this mean that a form of government of such states is assembled from elements that are radically different from the ones we have discussed here [neo-liberal states]? Does this mean that state socialism and National Socialism, for example cannot be subject to an analysis of the arts of government? The answer to both these questions, I believe, is no? The general argument of this essay is that the exercise of government in all modern states entails the articulation of a form of pastoral power with one of sovereign power.

(Mitchell Dean 2001: 53)

The experience of socialism in the twentieth century has been framed by a series of simultaneously curious and momentous paradoxes; none is more curious in its perversity nor more momentous in its impact than the manner in which socialism – its essence, its meaning, its purpose – somehow became separated from the idea of democracy.

(Carollee Bengelsdorf 1994: 3)

Chapter Three

(Re)Inventing Healthy Bodies in Post-Revolutionary Cuba

> . . . the emergence of the health and physical well-being of the population in general [is] one of the essential objectives of political power. Here it is not a matter of offering support to a particularly fragile, troubled and troublesome margin of the population, but of how to raise the level of health of the social body as a whole. Different power apparatuses are called upon to take charge of 'bodies', not simply so as to exact blood service from them or levy dues, but to help and if necessary constrain them to ensure their own good health. The imperative of health: at once the duty of each and the objective of all (Foucault 1980: 170).

3.1 Introduction

As you walk along the waterfront — the *Malecón* — or tour the hospitals, schools and monuments in the municipalities of Havana, you see billboards advertising the successes of the revolution as if, in the words of fiction writer Cristina García, " . . . they were selling a new brand of cigarettes" (1992: 215). Covering the sides of buildings and erected on movie-size screens, signs read: "Millions of children in the world die of curable diseases, none of them is 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 (re)invent history. Another message, perhaps less subtle, expresses the anxiety of the Castro government to convince the Cuban citizenry and the rest of the world that the revolutionary project is working. This is particularly true in the case of Cuba's primary public health system.

In this chapter, I describe the antecedents of Cuba's current primary health care system, central to which is what is known as the "Family Physician-and-Nurse Program." I will examine how Cuba's socialist health ideology — as reflected through state health policies and public health campaigns — have used

the health of the individual as a metaphor for the health of the body politic, effectively linking the bodies of individuals to the political project of socialism and its governmental apparatuses. Danielson (1979) notes, it is impossible to speak of the Cuban revolution as external to the "revolution in the health sector"; to speak of the two phenomenon 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" (Danielson 1979: 2).

In addressing Danielson's concerns, this chapter will examine how, since the 1959 revolution, during the Socialist Revolutionary Period[1] (1959-1989), the Cuban public health system has undergone several changes that have led to the creation of a comprehensive health care and prevention program. This health program has sought to provide an integrative approach to health care, encompassing the physical, social, and psychological needs of the individual, and popular participation in health initiatives. The gradual development of these public health services, I will argue, were historically influential in defining and reshaping a more intimate relationship between the individual and the state. More importantly, this relationship established the framework within which socialist ideals and norms could be mobilized to construct a new Cuban citizenry. I will begin this chapter with a brief review of the public health services during in the pre-revolutionary context, the *período burgés* (1902-1958), in order to provide a historical framework for subsequent analysis.

3.2 The Public Health Revolution in Historical Perspective (1902 -1958)

In those days medicine was private, that is, doctors had private offices and charged on a fee-for-service basis. There were "mutual benefit societies" (mutualista) as well, in addition to the state hospitals that the majority of people who didn't have money tended to use because the service was free. Access to the state hospitals, however, was difficult. You always had to know somebody who was well connected, for example, if you needed to get checked in overnight or something. It wasn't like you arrived at the hospital and that was it. If you had other minor health problems you could always go to the emergency hospitals or places such as ambulatory stations (casas de socorro). The service was very not very good, though.

I had passed through some very difficult experiences back then. There was an illness that we used to call acidity, and it provoked severe diarrhoea and vomiting almost always in babies. For example, there was place close to my house for mothers and babies to help treat this, but the service was bad. You have to

[1] *Período Revolucionario Socialista*

remember as well that this was the countryside and the hygiene wasn't the best. If you didn't have the money to buy the needle then you couldn't inject the medication. A needle cost about 3.50 Cuban pesos and many people couldn't afford even that. My father was very poor, but a very trustworthy man and he used to collect money among people like us, other poor people, to try to help those worst off.

There is one incident I will never forget. There were kids that use to sit out on the front steps of my house, you can imagine, they hadn't eaten anything and he would take them into the house and we would share what little food we had. There is also something I will never forget, in addition to everything else, the illness of my mother. She was a diabetic and at that time a diabetic didn't have much possibilities, for example, if you were poor, you couldn't have a special diet, actually no diet existed! You bought what you could and that was it. A doctor, a private Chinese doctor who lived in my area at that time, told my mother "you have a disease of the rich." My mother ate everything and we had to separate the proportions that she could eat. There was one year that she ate almost exclusively boiled taro and this produced severe malnutrition. After that things went bad. She died when she was 52, but by that point, she could barely see and her hair was falling out.

—*Sra. Norma Herrera, retired administrator, born in Cienfuegos, in 1930.*

As the above quote attests, public health services during the *período burgués* reveal a system characterized by an 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 pre-revolutionary period describes a health-care system that was profit-oriented and focused on diagnosis and treatment of diseases rather than on their prevention through education and other services essential for the long-term improvement of health (Gilpin 1989; Gilpin and Rodriguez-Trias 1978: 4; Nelson 1950). As such, the diversity in healthcare access and quality resulted in a high concentration of privately owned clinics, which 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 *mutualista* — consisted of exclusive hospital plans organized to serve descendants from specific geographic regions of Spain who paid monthly membership dues similar to medical insurance collectives. In 1958, 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), only admitting those members enrolled in their health programs (Danielson 1979: 127-63: Gilpin 1989; Díaz Novas *et al* 1989). As Danielson (1979) notes, the *mutualista* system, with the exception of the program's exclusionary politics[2], represented one of clearest antecedents for what was later to become Cuba's socialized health care system.

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[3]. However, the aggregate statistics masked enormous regional, racial, and class inequalities (A. Chomsky 2000: 332). For instance, in 1959, more than sixty percent of Cuba's population of six and half million had virtually no access to health care. Given that more than fifty percent of the doctors and seventy percent of hospital facilities were in the capital province of Havana, where costly services catered to the fortunate few, those left without service were the people of rural Cuba and the majority of the urban poor. This segment of the population depended on the few state-run services[4], which were so corrupt that even admissions to hospitals were bestowed in exchange for favours or bribes to politicians (Gilpin 1989).

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 (Gilpin and Rodriguez-Trias 1978: 4). Estimates suggest

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[2] As several scholars have noted, those left without formalized health care in pre-revolutionary Cuba were in the majority drawn from the "black" and "coloured" population (Danielson 1979). The racial and demographic composition of Cuba's social stratification during the *período republicano burgués* was a direct parallel to the colour-class hierarchy of the colonial period. Furthermore, as Danielson (1979: 6) notes, "blacks" were also excluded from many of the prepaid medical plans *(mutualistas)* during the pre-revolutionary period.

[3] Modest estimates at the time placed the infant mortality rate at 60 per 1, 000 live births and life expectancy at approximately 61 years old (Díaz and Fernández 1989). In addition, in the 1950s, Cuba had the highest ratio of hospital beds to population in the Caribbean, of which 80 percent were in the city of Havana (Benjamin *et al.* 1986).

[4] Many individuals also used the services of traditional healers *(curanderos)* or healers who were practitioners of *Santería (santería spiritualistas)*. While traditional and religious healing services played an active role in the lives of poor rural and urban Cubans in the pre-Revolutionary context (see, for example, Lewis *et al.* 1977a; 1997b; 1978), I will not be dealing with traditional and religious healing in this chapter. *Santería* in the post-revolutionary context will be discussed in chapter six.

that up to forty percent of the population "died from diseases that had more to do with colonialism that with the parasites" (Stark 1978: 23). Before 1959, then, Cuba was typical of an "underdeveloped" country, lacking in hygiene and sanitation which, combined with low nutritional levels, contributed to high infant mortality and lower life expectancies at birth. In sum, the general state of public health care in Cuba's *período burgés* is best summarized in Fidel Castro's speech "History Will Absolve Me," given in his 1953 defence before the Batista government's magistrate[5], where he stated:

> 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 upon hearing of the kidnapping or murder of one child, but they are criminally indifferent to the mass murder of so many thousands of children who die every year from lack of facilities, agonizing with 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 (1983: 72-73).

As Castro's landmark speech highlights, access to medical services and facilities reflected class stratification in the *período burgés*. Those who were on the margins of Cuban society 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, as I have outlined in chapter one.

3.3 The Development of Socialist Primary Health Care System (1959 - 1989)

> *I have many memories of my childhood and the early revolutionary government and all the changes that have taken place since. For example, in my adolescence, I lived through the stage of the polyclinics and hospitals. I'm no specialist in these matters, but I have had a lot of experience, and these times were the best as far as our health care was concerned. You must remember that in those days there was another consciousness, another culture. The social, economic and political situation in this country was distinct then. You received the best from*

[5] On July 26, 1953, more than one hundred revolutionaries led by Fidel Castro attacked Batista's troops in Moncada Barracks (Santiago de Cuba), which was then 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."

health care workers, whether it was a nurse, an x-ray technician, a physiotherapist: they were all dedicated and professional.

The polyclinics — the rural hospitals in the countryside, in the mountains, everywhere — have always been taken care of by the government. Not one of these isolated places lacked a polyclinic, a hospital, or a nurse and a doctor, at the very minimum. There were always enough vaccines for everybody. I remember that there were mass vaccinations of children against diseases like polio, a childhood disease, and all those diseases that we know to be characteristic of poverty, diseases that could have become major epidemics in any population, especially those in the tropics. I remember that the health brigades use to come to the houses and vaccinate us as children. The nurses and doctors would come and search all the houses to vaccinate the children — the whole family, really — against tetanus, typhoid, diphtheria, against tuberculosis, and all those diseases.

When la Revolución *arrived there was 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. I realise now that this was a product of ignorance. 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 using shoes in children 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." I think in the beginning this was an immense effort and the people were extremely grateful.*

I also think that the majority of the people were very receptive from the very first moment, Fidel and the other revolucionarios, *dedicated themselves to constantly talking to the people about the problems of the Republic when they took power: the problems of misery, of disease, of prostitution, of unemployment, of racial inequality and violence, and everything connected with the dictator Batista that the people had worked together to get rid of. Fidel let women know that they need not worry about their children dying of parasites, or having to see a child die of a curable disease for lack of a doctor or information or resources. I have travelled outside of Cuba to capitalist countries and I have seen the exceptional resources that are available in those countries. But I have also seen the horrors in those countries of the people who have no access to health care. I have lived the revolutionary experience for nearly my whole life — and I am 45 years old — and I can honestly say that I am not a* revolucionario, *but I also see the good in our system of health care and the respect this government has for humanity.*

—Sr. Julio Ceasar Serra, self-employed, born in Santa Clara, 1955.

On January 1st 1959, when the Cuban rebel army marched victoriously into Havana, the emphasis of the new government was on dismantling discriminatory practices and making universal provision for basic needs and healthcare[6]. Similar to other developing nations with socialist ideologies of the

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

same era[7], Cuba embraced a vision of modernity that entailed not only taking advantage of the scientific-technical revolution but also being part of it. Incorporating science as a part of their strategy for the overall socio-economic development of Cuba, the revolutionary government embraced the socialist vision of science as a means for the rational and planned social transformation of Cuba[8] (cf. Feinsilver 1994). Public health and medicine were key areas in which considerable investments were made in research facilities, technology, research and development strategies, and human resources. In the revolutionary context, health took on an important status as an index of the larger social transformation associated with the socio-economic development of Cuba, including the elimination of hunger, inadequate housing, discrimination, and the reduction of exploitative labour practices.

At the onset of the revolution in 1960, influential figures such as Argentine-born doctor turned revolutionary, Ernesto "Ché" Guevara, assisted Fidel Castro to outline 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 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" (Guevara 1968b: 115). Under Guevara's (1968b: 114) plan for "the creation of a robust body with the work of the entire collectivity upon the entire social collectivity"[9] the revolutionary government invested considerable amounts of attention to expanding and democratising access to the public health system. 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,

[7] For example, China and the former USSR.

[8] 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 post-revolutionary environment. This situation changed in the *período especial,* on which I will expand in chapter six.

[9] 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.

an "*hombre nuevo*[10]." This "*hombre nuevo*" was to be egalitarian in outlook, selfless, cooperative, non-materialistic, hardworking (at both manual and non-manual tasks), and morally pure. This new model of citizenship set the precedent for defining what constitutes a good revolutionary (*buen revolucionario*), and by extension, an individual integrated with the objectives of revolutionary reform.

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 or 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" (1968a: 119). Instead of the Hippocratic oath, medical graduates promised to abide by revolutionary principles. As Eckstein notes, "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" (1994: 130). 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 health the full responsibility of the state.

Of the 6,300 physicians in Cuba in 1959, only 3,433 remained in 1967, due to their exodus *en masse,* principally to the US and Spain (Gilpin and Rodriguez-Trías 1978: 4). In addition, in 1960, only 16 professors remained at the only medical school in the country, in Havana. Severely hampered by a drastic reduction in available medical professionals, the government encountered initial difficulties in extending health care to marginalized groups in urban and rural locations, and in maintaining the existing health services in the city of Havana.

[10] The president of the Federation of Cuban Women (FMC), Vilma Espín, later changed this term to the "new human being."

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 1965, the Havana Medical School graduated 395 physicians[11]. 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[12]. In 1972, when the number of doctors reached 7,200, the quota was dropped to 20 percent (Werner 1983: 25). To help address the shortages of physicians in marginalized areas, all new medical graduates were assigned to three years of rural service[13] (Gilpin and Rodriguez-Trías 1978; Danielson 1979: 133).

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 (Danielson 1979: 143). Following the Czechoslovakian model of health planning, which concentrated

[11]Admissions to medical school were opened to all people in the country and campaigns were organized to recruit new medical students. This differed from the pre-revolutionary context in which the medical school tended to cater to those students who could afford to attend. Under the revolutionary administration, free tuition and residential scholarships changed the socio-economic make-up of the student body. It is important to note that the selection of medical students is not only based on good examination results from grade 12, but the reference from the applicant's CDR. MacDonald (1998), a health care specialist who has carried out extensive research on Cuba's education system suggests that, "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" (pp: 95-96). Moreover, as Dalton (1993) has noted, this selection process seeks to promote those students who have most actively participated in *la Revolución* and, thus, are more likely to espouse the values of the dominant state ideology.

[12]The training of auxiliary medical personnel also increased during the early years of the revolution. By 1968, there were 17,085 graduates of basic training in nursing and the paramedical professions and 1,470 had completed specialty training after two years of practice (Danielson 1979: 184).

[13] For example, in 1960, the revolutionary government introduced Law Number 723 (*El Servicio Médico Social Rural*) also known as the Medical and Social Services for Rural Areas. This 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 countries.

the administration of health care in one governing body with an administratively decentralized delivery system, Cuban public health officials formed the current National Health System or *Sistema Nacional de Salud* (SNS). The SNS is organized at three levels: national, provincial, and municipal. The national level is represented by the Ministry of Public Health or *Ministerio de Salud Pública*[14] (MINSAP), which coordinates everything pertaining to health and health care, and fulfils the methodological, regulatory, coordination and control functions for the whole country. 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 (Danielson 1979: 143-144).

As earlier noted, the pre-revolutionary period in Cuba was characterized by three different health systems: the state-run services, the *mutualista* program, and private health care. Under the direction of the SNS, the first of these systems to fall under the control of the revolutionary government were the state services, which were subsequently restructured. The two remaining systems were left intact to handle the severe shortage of medical personnel. However, a new law was introduced in August 1961, known as Law Number 959, indicated that the MINSAP was in charge of all the health activities in the country, including the private health and *mutualista* system. The latter two health systems were slowly phased out by 1970, and were either closed or changed into public facilities and integrated into the National Health System. In 1965, the integral polyclinic program (*políclinico integral*) was the first health services system embarked on under the new National Health System.

Políclinico Integral

Representing the earliest stage of establishing primary health care in post-revolutionary Cuba, the integral polyclinic program provided outpatient

[14] The Ministry of Public Health was created in 1959. 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 1959 (cf. ACIMED 1998).

care that sought to "decentralize" the services traditionally provided by hospitals by targeting medically marginalized groups in both rural and urban areas (Dalton 1993; Delgado García 1996a; 1996c; Eckstein 1994). 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 (Gilpin and Rodriguez-Trías 1978: 4). The polyclinic system was designed to provide, integrate and address these founding principles through the provision of four basic services in a specifically defined area and population: clinical services (e.g. curative-preventive care); environmental services (e.g. hygiene and sanitation); community health services (e.g. health promotion campaigns); and related social services (e.g. social workers) (Danielson 1979: 168).

Between 1962 and 1970, the number of polyclinics in the country steadily rose from 161 to 308, and by 1976, there were a total of 345 fully staffed and operating polyclinics in the country and an additional 140 rural medical posts (Gilpin and Rodriguez-Trías 1978: 5-6). The polyclinic's health coverage was subdivided on a regional basis into sectors, each with about 30, 000 inhabitants served by health teams that included preventive and curative wings. Polyclinics typically offered primary care specialists including several internists, a paediatrician, an obstetrician-gynaecologist, 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 (Gilpin and Rodriguez-Trías 1978). The foremost objective of the integral polyclinic was to reduce the morbidity and mortality from communicable diseases, which were a major health problem in Cuba in the 1960s. It was believed that continuous care by the same health team promotes a better understanding of the patients and their environments for the staff (Feinsilver 1993: 36). 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 already being implemented, in an elementary form, in every municipal polyclinic (Díaz Novas *et al.* 1989: 556-564): (1) Comprehensive attention to women; (2) Comprehensive attention to children; (3) Comprehensive attention to adults; (4) Hygiene and epidemiological surveillance; (5) Dental care; and (6) Post-graduate training programs for medical staff.

The *policlínicos* relied heavily on the popular participation of state-promoted mass organizations in order to carry out various public health campaigns. For example, during the October missile crisis in 1962, MINSAP needed to organize people to give blood in order that the country would have a sufficient reserve should it be needed. Through the help of CDRs, originally formed in September 1960 as vigilance committees to protect Cuban citizens from counter-revolutionary activities and US-sponsored incursions such as the 1961 Bay of Pigs invasion, the CDRs mobilized 8,000 Cubans to give blood in less than 10 days (Gilpin and Rodriguez-Trías 1978: 7-8). Moreover, the mass organizations participated in health education, literacy training, and other social activities, which sought to incorporate the wider community in participating in the state's various campaigns for reform. These campaigns included mass immunization programs, blood donations, and disease-control campaigns such as hygiene and sanitation lessons. A well-known example of mass participation in disease-control was the participation of mass organizations in the polio vaccination campaigns of the early 1960s. These campaigns were carried out throughout the entire country in as little as 72 hours. As a result, polio was completely eliminated from Cuba by 1963, years ahead of the United Sates (Werner 1983: 23). In addition, poor sanitary conditions that contributed to disease transmission were eliminated through the creation of mobile sanitary units that worked with mass organizations, travelling around the country to address environmental problems and implement health promotion and disease prevention.

Despite the optimistic efforts of the integral polyclinic, the polyclinic program was not entirely successful in dealing with the burgeoning health needs of the population, which for many years had been without basic health services. Cuban public health officials found problems with this system (see, for instance, Díaz Novas *et al.* 1989). A shortage of medical personnel specializing in primary health care, for instance, meant that patients were often treated by different physicians from one visit to another. This reduced the chances that a particular doctor would be familiar with a particular patient's life history. Secondly, 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. Thirdly, health care tended to be primarily curative, and physicians

lacked the appropriate doctor-patient-community relationship required for the new socialist society. This was compounded by the poor training of primary health care workers. This led to an increased number of cases referred to secondary specialists and to more people in the emergency rooms in hospitals.

The lack of physicians entering primary health care was a result of the lack of opportunities for physicians 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 " Medicine in the Community" (*Medicina en la Comunidad*). 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 Cuban public health system (Delgado García 1996a; Danielson 1979; 1981). In 1969, "The Ten Year Health Plan" was enacted, which sought to carry out various health initiatives between 1970 until 1980. One of the priorities of the Health Plan was screening for asymptomatic diseases. This was meant to ensure better care for those individuals who visited the doctor looking for relief of symptoms, but who were unaware that they suffered from a particular disorder such as high blood pressure, which was at the root of the symptoms. Health related activities were thus 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 non-transmissible 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 those individuals who were healthy but exhibited low risk factors.

The "Medicine in the Community" program, also known as the *policlínicos comunitarios,* was first tested in the *Policlíniclo Alamar* in 1974 and incorporated the health programs discussed above in the *políclinico 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, also known as CARE. Each municipality had a defined number of health areas, and each urban health area of 25,000 to 30,000 inhabitants had a polyclinic, while rural areas were served by rural hospitals.

Before the "Medicine in the Community" program (1959-1974) came into existence, people went to the polyclinic in their catchment area and saw the appropriate primary care physician (Gilpin and Rodriguez-Trías 1978: 9-10). 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 analyse the needs and resources available (Ordóñez Carceller 1976:12).

As Feinsilver (1993: 37) notes, not only did "the physician-nurse teams attend patients in the polyclinic, but they also visited patients in their everyday environment: the home, school, day-care centre, and workplace." During the 1970s, in collaboration with the World Health Organization (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 Cuba's successful 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.

In 1977, MINSAP established a series of objectives to be met by all primary health-care centres nationwide: "early detection of pregnancy (before the third month); early consultation with the obstetrical health team (also before 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 counselling with regard to childbirth; instruction in birth exercises; and finally, provision that all childbirth take place in hospitals" (MINSAP, *Programas básicos* 1977: 79-85; Eckstein 1994: 136-137; Feinsilver 1989: 17). Consistent with its objective to manage the country's infant mortality rate, the government also began targeting perinatal diseases and congenital problems that were 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 (Eckstein 1994 136-137; Feinsilver 1989: 17).

Utilizing the extensive network of public organizations, specifically CDRs and the FMC, 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 show up for scheduled appointments (Feinsilver 1993). 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 institutionalisation of childbirth in Cuba in the early 1980's. In addition to basic health coverage, all women who were pregnant or breast-feeding were provided with 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 facilities such as maternity homes, guaranteed that nearly 100 percent of all babies were born in hospitals with the staff trained to detect all 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 37 weeks. There, women await the birth in 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 scheduled a minimum of two monthly paediatric visits along with one home visit.

The development of maternal-infant health-care programs was carried out against a background of broad socio-economic changes, such as the

redefining of traditional female roles in a revolutionary context, that affected women's lives. 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 1976 family code noted that men were to share household duties when women were gainfully employed. This was matched by the massive extension of public day-care facilities and a 1974 maternity law that guaranteed women a paid maternity leave and the right to take time off from work to attend to their children's health-care needs. For example, as the Lewis *et al.* (1977b) study *Four Women* illustrates, under the new revolutionary system many women had become actively involved in juggling the roles of working mother and being a good *revolucionaria.* The latter included women's incorporation into mass organizations and participation in revolutionary projects such as seasonal agricultural labour and health education campaigns.

Significantly, the FMC was an extension of the state apparatus that provided women with a collective voice and ensured their full and equal participation in the revolutionary movement. A well-known indicator of women's changing role in post-revolutionary Cuba was the birth rate in the first two decades after the revolution, which steadily declined since 1963 and represented one of the lowest in Latin American. For example, by 1979 the birth rate had dropped to 18.0 per 1000 inhabitants from 28.3 per 1000 before the revolution. While the revolutionary government always provided birth-control methods at low-cost to women who wanted them, it conducted no public campaign to promote family planning. As Werner (1983) notes, such a remarkable decline in birth-rate 'without even trying', while other countries (for example, Mexico) have used high-pressure tactics without success, indicated that the socio-economic pressures for having many children had been mitigated, and women were beginning to assess on their own accord the advantages of smaller families.

The successes of the "Medicine in the Community" health system such as 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 socio-economic development of Cuba. MINSAP officials 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 known as the greatest global measure for the health of a country. Before the triumph of the Revolution the infant mortality in Cuba was greater than 70 deaths per 1000 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, allows us to determine the state of health of our population" (Delgado García 1996b: 11)[15]. The MINSAP's statements reflected the official public health discourse in Cuba, which cites the country's low infant mortality rate as a metaphor for the health of the body politic.

Despite Cuba's success in achieving 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 (Santana 1987: 116-117). Specifically, chronic illnesses such as cancer and high blood pressure and related heart diseases were not adequately detected, and thus not treated (Díaz Briquets 1983: 118-119; Santana 1987: 117). Cuban primary public health professionals commented that there were inequalities between the care offered at the training polyclinics, which were centres associated with teaching hospitals (less than 10% of those clinics in the country), and that offered in non-training polyclinics. In addition, health teams were unable to

[15] Julie M. Feinsilver (1993) has argued in *Healing the Masses: Cuban Health Politics Home and Abroad* that Cuba's impressive health statistics have been the basis for the island's "global empowerment" (Eckstein 1994: 128) and a significant source of Cuban nationalism.

effectively address the "behavioural 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. 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 and this impeded a holistic and 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 it's broader biological, emotional or social origins.

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 waited for "morbidity to arrive" instead of seeking out, preventing and controlling the health problems of their patients after a careful analysis of the morbidity of the population. The excessive workload of the non-training 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, thus bypassing the polyclinics altogether (where the assistance was, at least, faster). 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 (cf. Díaz Novas *et al.* 1989).

Given the above conclusions, in the 1980's the Castro government became concerned 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 (Eisen 1996; Jardines 1995). Given that the pattern of morbidity and mortality in Cuba had slowly changed from what Feinsilver (1993: 40) described as "diseases of poverty (for example, parasitic and infectious diseases) to diseases of development (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, which was subsequently designated as a new generalists' residency program termed "General Comprehensive Medicine" (*Medicina General Integral*, MGI) thus eliminating the distinction between the practice of general medicine and specialization. MINSAP instituted a curriculum that extended medical education from six to ten years. The new curriculum required six years of undergraduate and pre-doctoral medical education and a four-year residency in MGI (see, for example, Cardelle 1994 for detailed description of curriculum reform; *Granma Weekly Review* 1986: 4; Dalton 1993: 123). This meant that medical students would now graduate as "Basic General Physicians" (*Medicos Generales Basicos*, MGB). In order to integrate these new medical professionals in the National Health System the revolutionary government designated an interdisciplinary commission to "elaborate the conceptualisation of community medicine within the Marxist-Leninist and socialist ideology and character of the health system" (Fernández Sacasas *et al.* 1976: 1). Out of this process emerged the current primary health-care system, and the "Family Physician-and-Nurse Program," created in 1984, that is central to it. These more recent developments in the primary health-care system will be the focus of chapter four and chapter five.

3.3 Conclusion

> It is only through analysis of historical process that one can begin to comprehend such important matters in Cuba as the legacy of institutional concentration in Havana, the cultural reasons for not developing *feldshers* [ambulatory outpatient stations] in the socialist period, the social bases for conflict and compromise within the medical profession, or the process by which conflict itself has formed the contemporary consciousness and ideology of Cuban health workers. Without understanding such matters, it is hardly possible to say what the revolution has actually been; for revolution is not outcome, but process; not statistics, but work and struggle (Danielson 1979: 2).

Heeding the above quote by Rosswell Danielson (1979), from his book *Cuban Medicine*, I argue that comprehending the history of Cuba's public heath system requires placing specific events, people and experiences in context. The post-revolutionary government's strategy to create healthy bodies, which entailed broadening the definition of individual health to integrate healthcare into the overall socio-economic development of Cuba, has served as an

important source of political legitimacy in Cuba's official public-health discourses. The state, through an elaborate network of mass organizations, has 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, are rooted in the underlying principles of the revolution. These principles suggest 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" (Eckstein 1994: 128).

The historic development of Cuba's public health system, however, must also be put in the context of a historically, socially and politically contingent "way of seeing" individual and social bodies as a population 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 campaigns of health reform. These reforms, which were synonymous with the betterment of all in the socio-economic transformation of Cuban society, were increasingly linked to the construction of a socialist society. However, consistent with this vision of a socialist society was the increasing focus on science and medicine as the rational means to develop Cuba. The implementation of public health programs provided the state with quantifiable means, such as 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.

The precipitation of these events, however, must not be seen as comprising a clear continuity between cause and effect. It would be misleading to suggest that early health reform campaigns produced subjects who passively took up government imperatives. Rather, as subsequent chapters will examine, the 1980s marked another distinct phase in the development of Cuba's public heath services. In this last phase, which overlaps with Cuba's current health

system, and is the focus of this dissertation, the recent economic crisis undermined the function of the state, mass organizations, and as I will illustrate, many citizens' dedication and participation in socialist health policies and objectives.

Chapter Four

Socialist Health Policy as a Technology of Politics

> For this task of organization, as for all revolutionary tasks, fundamentally it is the individual who is needed. The revolution does not, as some claim, standardize the collective will and the collective initiative. On the contrary, it liberates one's individual talent. What the revolution does is orient that talent. And our task now is to orient the creative abilities of all medical professionals towards the tasks of social medicine. (Guevara 1968a: 112)

4.1 Introduction

In chapter three, I argued that the gradual emergence of Cuba's primary health care system was intimately tied to the construction of the state's socialist apparatuses, and in turn to a particular form of subjectivity: the revolutionary "New Man" and "New Woman." The state, through narrowing the gap between governmental health objectives and individual practices, had historically encouraged citizens to embrace the socialist vision for society and the implicit role they held in this "utopia-in-the-making." In this chapter, I extend the discussion in chapter three, tracing the most recent phase in the development of Cuba's current primary health care system, and the Family Physician and Nurse Program, created in 1984, that is central to it. I will argue in this chapter that the state's gradual refinement of socialist health policies, with an emphasis on treating both the individual and social body, was influential in reshaping the individual citizen's sense of self.

The revolution, according to Ernesto Guevara (1968a) in his famous speech "Revolutionary Medicine," attempts to liberate and orient one's individual talent. In this way, the revolution is envisaged as an agent capable of shaping behaviour, particularly in redefining an individual's notions of the self in relation to the demands for the new socialist society. By drawing on interviews and participant observation with individual citizens and family physicians, and by examining current public health policies and government speeches, I explore the interrelationships between the practices of professionals and ordinary people, health policies, and state power in Cuba. My central argument in this

chapter is that Cuba's current public health policies serve as a vehicle for introducing socialist rationalities of governance: that is to say, Cuba's health policies work to (re)produce socialist ideology in the institutions and practices of everyday life. Following the work of Shore and Wright (1997: 29), this chapter deals with health policy not so much as political discourse, or as an instrument for forging large-scale collective social identities as I discussed in chapter three, but rather as a form of power that works upon the individual's sense of self (cf. Foucault 1991; Lupton 1995; Petersen and Lupton 1996).

My argument in this chapter is divided into two parts. First, I present the ethnographic data. In the decades of the 1980s, also known as the most ambitious phase of the National Health System, the MINSAP initiated a proposal to train family physicians to participate in an innovative family medicine program. The new program, which called for a family physician-and-nurse team to live and work in the communities they served, was to become the cornerstone of the revolutionary vision of accessible community medicine. As was evident shortly after the launch of the Family Physician and Nurse Program, Castro declared the participating physicians to be "symbols of the Revolution" (cited in *Granma Weekly Review* 1986: 4), and focused on the physicians' roles as reinforcing the values of the revolution through their continual contact with the population. In this respect, Cuba's family physicians, I argue, operate as part of the state apparatus, working in tandem with state objectives to promote state-defined healthy lifestyles and to defend, if need be, the socialist character of the health care system from competing and subversive ideologies.

In the subsequent analysis, following the work of Lacombe (1996: 334), one can fruitfully interpret Cuba's current public health program through the framework of a productive notion of state power that includes strategies for self-development that both constrain — through objectifying techniques — and enable — through subjectifying techniques — individual agency (cf. Foucault 1990; 1991). I find Foucault's (1990) concept of "bio-power" important for the analysis of the MEF program, particularly the "minute workings of power in everyday interactions." Central to Foucault's notion of bio-power is the link between the *micro* and *macro-* politics of power and, thus, the management of individuals and populations. In Foucault's terminology the term "bio-power" designates a certain set of techniques that exist along a continuum. On one side

of the continuum there are the "bio-politics of the population," that is, those techniques concerned with the socio-economic regulation, control, and intervention of the population, and at the other end of continuum, there are the 'anatomo-politics of the human body', which focus on the body as a machine, that is, the docility or usefulness of the body.

Second, I argue that the interrelationships between state power, health policy, and individual practices — manifest in the Family Physician and Nurse Program — require a nuanced understanding. Drawing on ethnographic evidence, I examine health governance in Cuba, particularly the ensemble of institutions, procedures and strategies that allow a certain kind of power to be exercised over populations in order to regulate relations between individuals and the state (cf. Burchell *et al.* 1991). I argue that the family physician's integration into local communities as confidant, neighbour and physician is not strictly about prescribing change as part of a regimental authority. Rather, the family physicians work — often in subtle ways — with and upon individuals' notions of self. This latter process often entails encouraging citizens to achieve health and well-being through obtaining a delicate balance between "bio-psycho-social" factors, as I outlined in chapter three. Equally important, however, as I will argue in this chapter, physicians also promote a relationship between the individual and the state, one that includes promoting citizens to become socially integrated into their communities, and actively involved in revolutionary initiatives.

4.2 The "Defence of Health": The Family Physician and Nurse Program

> The practice of the health professional has in itself a profound ethical underpinning that is geared toward promoting the highest values in human beings in order to pay homage every day, and in every sphere to the work of *la Revolución*, of which we are children. (MINSAP, *Carpeta Methodólgica*, 2001: 11)

Starting as a pilot project in the *Policlínico Lawton* in the municipality of the "10 of October" in 1984, with the incorporation of ten physicians and nurses, the Family Physician and Nurse Program — *Programa Médico y Enferma de la Familia* (MEF) — called for specially trained health teams to create a closer

patient-physician relationship than in the past, and to provide extensive physician and support-staff care. Trained under the new medical-school curriculum instituted by the MINSAP in the early 1980s, as outlined in chapter three, all new medical residents were to receive training in general medicine, and then pursue a residency in comprehensive general medicine[1] (MGI). The MGI residency provides specialized training in primary health care including a rotation in each of the primary care specialities — that is, internal medicine, paediatrics, obstetrics and gynaecology — as well as a rotation in neighbourhood-based clinics, supervised by family physicians.

By the end of 1985, the MEF program had expanded to include ten thousand physicians; by 2001, it included 31,500 physicians[2] overseeing 99 percent of the entire population (MINSAP, *Annuario Estadístico* 2001). Physician-and-nurse health teams — *equipos básico de salud* (EBS) — are stationed in small clinics known as *consultorios del médico de la familia* (CMF) — serving 120 families, approximately 600-700 persons, everywhere in Cuba. Each *consultorio* is located in a designated health area (*área de salud*) that is attended to by the physician-and-nurse team. In organization, the MEF program calls for family physician-and-nurse teams to live and work on the city block or in the rural community in which they serve[3], as stipulated in the program. Moreover physician-and-nurse teams are stationed in every factory and school.

The role of the new family physicians, following the MEF work program issued by the MINSAP — *Programa de Trabajo del Médico y Enfermera de la Familia, el Políclinico y el Hospital* (1988) is to carry out clinical and social-epidemiological vigilance of the population, the promotion of health, and the prevention of disease by working in tandem with the community. As further

[1] According to the MINSAP, over 50 percent of Cuban physicians remain family practitioners.

[2] In 2001, 50 percent of Cuban physicians and over 60 percent of family physicians were women (MINSAP, *Annuario Estadístico* 2001).

[3] In practice, my ethnographic field research suggests that, due to a severe housing shortage in the city of Havana, a significant portion of physicians and nurses do not live in the communities they serve. Rather, the health teams commute to their *consultorios* in their respective neighborhoods on daily basis. Out of the 10 *consultorios* visited in this research, only two physicians lived in the same complex (all the nurses lived elsewhere).

stipulated in the MEF work program, the specific functions of the participating health professionals are: 1) to promote health through education, life-style changes, and an improvement in hygienic and sanitary habits and conditions; 2) to prevent illness and conditions dangerous to health; 3) to guarantee early diagnosis and comprehensive outpatient and inpatient medical care over time; 4) to develop community-based rehabilitation for the physically or psychiatrically disabled; 5) to aid the social integration of families and communities; 6) to complete residency training in family practice with scientific excellence and a willingness to serve humanity; and 7) to do research that responds to the health needs of the population (in Gilpin 1989: 470).

According to the MINSAP, the design and structure of the MEF program allows for greater accessibility to health-care services and a closer relationship between health teams and their patients (see, Figure 4-1 for examples of residential *consultorios*). This tactic, the MINSAP proposes, will allow health teams an opportunity to obtain a more intimate knowledge of their patients and family members, enabling family physicians to better comprehend their patients' psychological and physical problems, and thus to provide immediate and continuous care (Díaz *et al.* 1989). However, as Castro further stipulated, the goals of the medical team are to be more than this.

> These physicians do good work. I know that it goes as far as crime prevention, because they're working with youngsters going astray, and organizing them and channelling them into sports. So the physicians' work is going to be very helpful in crime prevention, in eliminating factors that go to making delinquents. These physicians know where their patients live and what their living conditions are like. The physicians in the polyclinic or hospital doesn't know how a family, person, or patient lives, but those at the grassroots level are the committees for the *defence of health*, and they will be closely associated with you because they're organized the same way the Committees for the Defence of the Revolution are (cited in *Granma Weekly Review* 1986: 4, emphasis mine).

Castro underscores how health teams should additionally carry out the important duties of medical social work. A clear example of what Castro refers to as the "defence of health" can be seen in the MEF health team's assessment of socio-economic factors in each of the households in their respective health areas. Health teams, as stipulated by the MEF methodological manual, qualitatively assess the socio-economic factors of each household in three

categories — cultural hygiene, psychosocial characteristics, and the provision of basic necessities — by assigning a letter of rating, for example, 'G' for good, 'R' for regular and 'B' for bad (see Table 4-1 for a more detailed description). Thus the role of family physicians clearly extends beyond the stereotypical "doctor in the clinic" to an active engagement and assessment of the social and material condition of their patients. Since the launch of the MEF program, family physicians have moved away from the state objectives that were quantitatively defined (for example, mortality and morbidity rates), to a qualitative assessment of specific community health needs.

Figure 4-1: Examples of Residential Family Doctor Offices (*consultorios)*

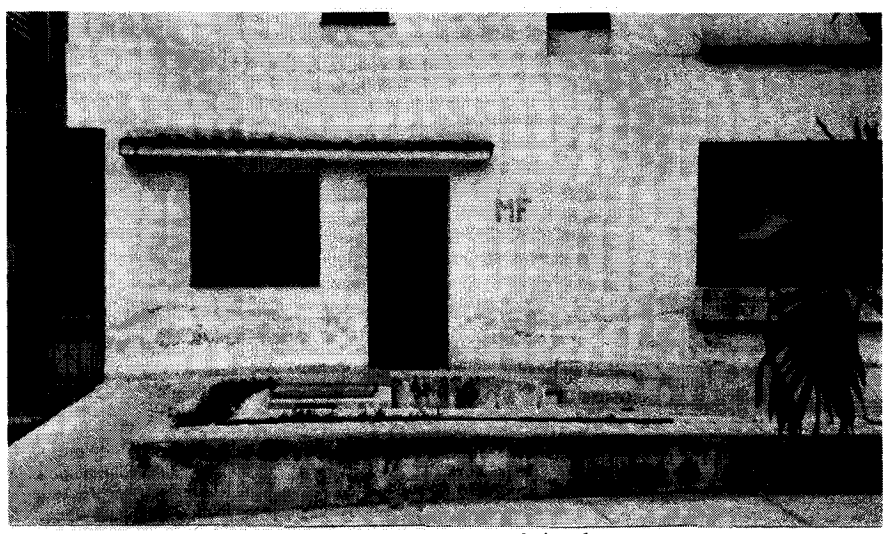

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Table 4-1: MEF Guidelines for Assessing Socio-Economic Factors in Health Areas

Cultural Hygiene:	
G	Follows physicians' advice and is familiar with appropriate orientation toward health promotion and practices. Has a good personal hygiene and collective well-being.
R	Only partially follows the physicians' advice towards health promotion, but does not practice them. Personal hygiene and collective well-being is not the best.
B	Does not accept the physicians' advice.
Psychosocial Characteristics:	
G	All of the members of household of working age are working; those of studying age, study; maintain harmonious relations in the family and with neighbours, and regularly participates in the initiatives of mass organizations.
R	At least one individual does not study or work in accordance with their age for reasons beyond their control; have conflicts with their neighbours for inappropriate behavioural patterns; and participates infrequently in the initiatives of mass organizations.
B	At least one individual does not work or study in accordance with their age for reasons of their own choosing; have conflicts with their neighbours based on inappropriate behavioural patterns including unlawful activity; and almost never participate in the initiatives of mass organizations.
Satisfying of Basic Necessities:	
G	Provision of their basic necessities including nutrition, recreation, and maintain good personal and community hygiene.
R	Provision of some of the basic necessities or partially satisfied them.
B	Presents serious difficulties in provision of their nutritional, recreation, and education needs and, lacks the necessary means to guarantee personal and environmental health.

Source: MINSAP (2001), *Carpeta Methodológica de Atención Primaria de Salud y Medicina Familiar.* VII Reunión Metodlógica del MINSAP (pg. 143 - 144)

Health teams, as stipulated in the program, carry out the above assessment (Table 4-1), in addition to making an extensive review of each of the occupants in every household (for example, full names, age, date of birth, gender, profession, level of study); an identification of at-risk groups (for example, smoking, excessive drinking, and so on); and a description of each of the households and it's surrounding environment (for example, a house may have poor ventilation or lighting, low maintenance of hygiene and the presence of animals). As evident from the qualitative descriptions in Table 4-1, the

assessment of socio-economic factors by family physicians includes a host of factors — among them, psychosocial characteristics such as revolutionary involvement (that is, participation in mass organizations) and community and familial relations — that significantly extends the scope of the physician's primary health care assessment. The Family Physician and Nurse Program, Cuban leaders assert, is the culmination of Cuba's socialist health ideology. The Cuban government sees the MEF program as it's ultimate achievement in the field of health care. The government believes the program goes beyond the World Health Organization's (WHO) Alma Ata Declaration (1978) on primary health care[4], and has made significant headway in a holistic approach to health care that addresses biological factors in tandem with an individual's material and social environment, thereby providing a diagnosis of individuals as part of the social fabric (see, for example, Rodríguez and Zayas 1997).

In the years following its launch, popular Cuban newspapers and journals such as *Bohemia* and the Communist Party daily *Granma,* and state-sponsored non-fiction publications ran a number of feature articles on the MEF program. For instance, Marta Rojas, a widely read Cuban journalist, wrote a non-fictional novel, entitled " Doctors in the Sierra Maestra," which chronicled the relentless sacrifice of physicians in the rural Sierra Maestra mountain ranges — a geographic region symbolically tied to the origins of the revolutionary guerrilla movement. Rojas' novel draws on revolutionary metaphors such as heroic sacrifice (*numancia*) and the importance of moral (as opposed to material) rewards in order to portray the doctors as similar to their revolutionary predecessors such as Fidel Castro or Ché Guevara, but battling ill health armed with stethoscopes and compassion (which she suggests are products of Cuba's socialist ideology) rather than guns. Overall, the description of the MEF program in state-sponsored publications deftly integrates the trope of the valiant family physician as a revolutionary hero. In many ways, these publications emphasize the uniqueness of the MEF program and declare it an exemplary

[4] Central to the Alma Ata Declaration was a definition of health, as ". . . a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, [it] is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sections in addition to the health sector" (WHO 1978: 2).

model in holistic primary health-care delivery (cf. Rivera 1995). Undoubtedly, these publications also serve as crucial media by which the government educates the population about the role of the new physicians and, in no subtle terms, explains why people should warmly accept them into their homes and communities.

Community participation in health-care initiatives and the health-care decision-making process is crucial to the MEF program. The earlier creation of popular councils (*poder populares*) in 1976 theoretically allowed citizens more grassroots involvement in the government decision-making process. For example, to allow citizens further participation in what Castro referred to as the "defence of health," popular participationin health campaigns was to be facilitated by strategically placing *consultorios* in an area circumscribed by one or more mass organizations such as CDRs or delegations of the FMC. As I noted in chapter three, mass organizations historically worked in tandem with the primary health-care system in disseminating health education and health-promotion campaigns, and actively participated in programs for hygiene and disease prevention[5].

In 2001, the City of Havana Province[6], where my research took place, had approximately 2800 *consultorios*, which constituted approximately 19 percent of the total *consultorios* in Cuba (see, for example, Cuba's general public health statistics, Table 4-2). In line with Cuba's revolutionary objective of egalitarian geographic distribution of health care facilities, the number of *consultorios* in each province parallels the relative provincial-to-national population ratio. For example, in 2001, the City of Havana Province had a population of 2,181,377, which was approximately 19.4 percent of the total population of Cuba (11,229,688)

[5] Moreover, historically, the increasing participation of the citizenry in state health reforms through mass organizations effectively led to the extension of the state surveillance apparatus into everyday local practices under the umbrella of collective health and well-being (for example, the CDR's campaign for weeding out "anti-social" individuals in the 1960s and 1970s).

[6] The City of Havana Province is divided into 15 municipalities. This is different from the surrounding Province of Havana, which has 19 municipalities.

Going beyond the community primary health services provided in the past, the *consultorios* are supported by a massive expansion of secondary and tertiary health-care institutions. In the 1980s, for example, in the drive to make Cuba's National Health System comparable to those of other industrially developed countries, the revolutionary government made significant financial investments in state-of-the-art tertiary care institutions, such as the Clinical Surgical Hospital *Hermanos Ameijeiras*[8] and the Centre for Medical Investigation and Surgery (CIMEQ), and research facilities such as the Centre for Genetic Engineering and Biotechnology (CIGB). These institutions offer a wide range of health-care services, including organ transplants, in-vitro fertilization, laser surgery, and magnetic-resonance imaging (MRI); they have also been involved in the development of genetic engineering and biotechnology, and the production and research of vaccines and pharmaceuticals[9].

Acting as an intermediary between the *consultorios* and tertiary institutions, a complex network of local polyclinics and municipal hospitals provide laboratory, ancillary, and emergency-room services, as well as supervision, teaching, and sub-speciality consultation. To facilitate this organization, each polyclinic in every municipality oversees 10 to 15 *consultorios* that form a basic working group — also known as a *Grupo Basico de Trabajo (GBT)*. Each polyclinic is staffed with a specialist in internal medicine, a paediatrician, an obstetric-gynaecologist, a psychologist, a dentist, a supervising nurse, a social worker, a statistician, and an epidemiological-and-hygiene technician.

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[8] The *Hermons Almejerias* Hospital "stands as a striking symbol of Cuba's zeal for high-technology medicine" (Ubell 1989: 439). It is the first major hospital to be built in the city of Havana since the revolution. The 24-story tower was under construction for ten years. "The $45-million [US] center, designed for postgraduate work, offers 36 specialties, primarily in six areas: advanced heart, brain, and reconstructive surgery, gastroenterology, psychiatry, and nuclear medicine. Five of the centre's 25 operating rooms are sued for microsurgery . . . The hospital is well-equipped with high-powered diagnostic tools from all over the world; the latest and most sophisticated equipment is mostly from Japan (Ubell 1989: 440).

[9] In chapter seven, I will further expand upon the theme of high technology medicine in Cuba and, in particular, the politics associated with the MINSAP's significant financial investment in biotechnology and medical specialist clinics for paying foreigners, especially given the overall financial contraction occurring in other areas of the primary health care sector.

Table 4-2: Cuba's Public Health Statistics, 2001

Human Resources:	
Total health service staff	328,543
Physician per 10,000 inhabitants ratio	58.2
Nurses per 10, 000 habitants	74.8
Population covered by MEF program (%)	99.1[10]
Service facilities:	
Hospitals	281
Consultorios MEF	14,671
Polyclinics	442
Health posts	164
Dental Clinics	167
Maternity Homes	209

Sources: PAHO, Country Health Profile: Cuba (2001); *MINSAP, Annuario Estadístico de Salud* (2001)

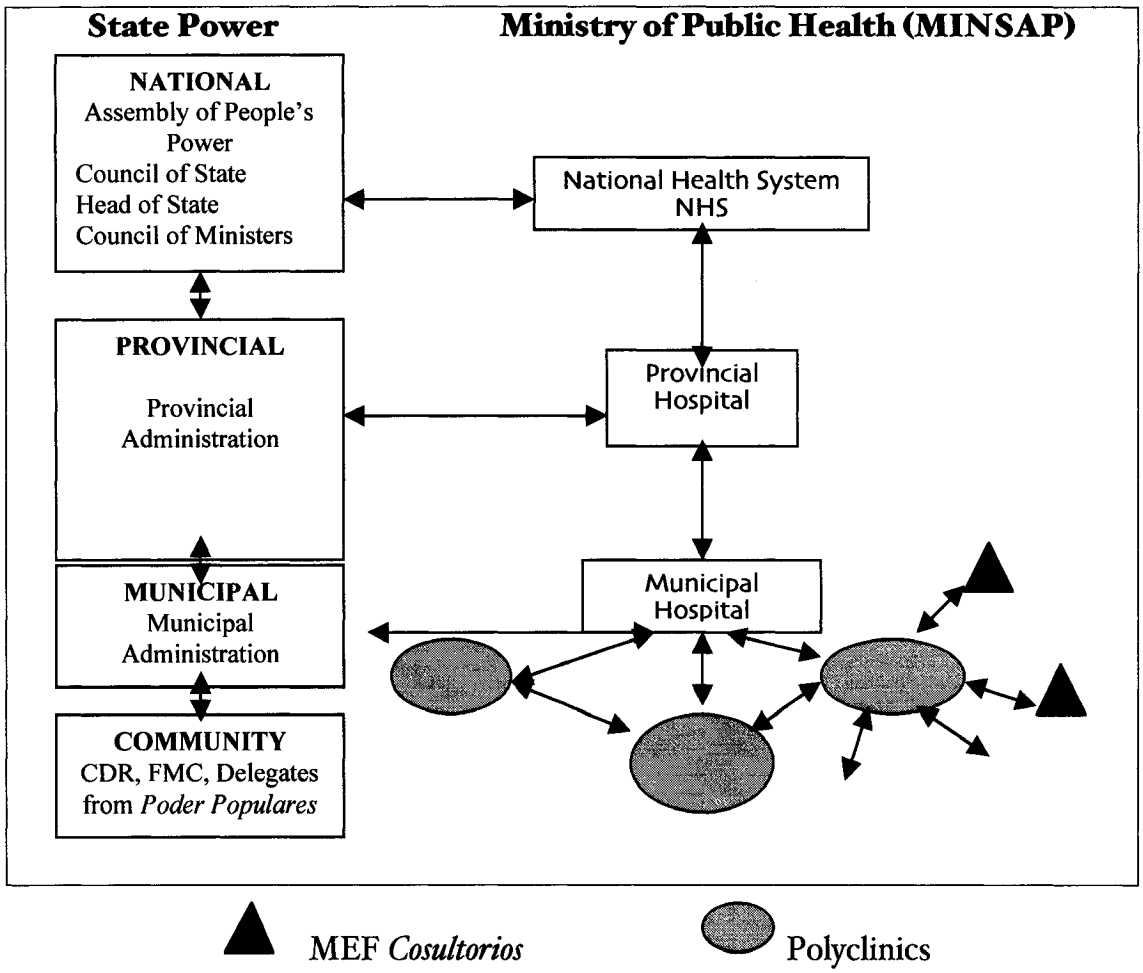
All public health services are institutionally integrated, both horizontally and vertically (see Figure 4-2). For example, under the MEF program, a physician can refer a patient to the services in the polyclinics, which in turn can make referrals to a municipal hospital (that is, family medicine *consultorio* ⇔ polyclinic ⇔ hospital). The family physician is always the patient's primary provider and is consulted during diagnosis and treatment. Moreover, the family physician is required to follow up on patients who have been treated at other levels of the health system, such as at polyclinics and hospitals. In this way, the family physicians never lose contact with their patients, even if the patients are admitted to an intensive care unit. Physicians can also make suggestions on the treatment of their patients while they are in more specialized institutions (Díaz *et al.* 1989).

The local *consultorio*, according to the MINSAP, is the pillar of the primary health-care system because it works at the level of a specifically defined community and acts an intermediary between the community, the local polyclinic, the municipal and provincial hospitals and the national health system (MINSAP). This organization permits all health initiatives to be specifically tailored to the needs of local communities (see, Figure 4-2). Although their role as specialized centres continues to be crucial, secondary and tertiary institutions have adjusted their structural and functional framework to meet the demands posed by the multi-level, comprehensive and integrated health-care delivery

[10] This figure reflects an average of all fifteen provinces.

approach (Páez and Rodríguez 1997: 2). As Páez and Rodríguez, both Cuban physicians and health administrators, note, "Hospitals are no longer considered the mainstays of medical attention in the Cuban health-care system; rather, one of their principal duties is to contribute to solving local needs, when a solution requires more specialized services" (1997: 2)[11]

Figure 4-2: Organization of the NHS parallels Politico-Administration



The scheduling of physicians' hours, according to the MINSAP, is determined by patients' needs rather than a predetermined structure. However, the typical day for the family physician-nurse team is to conduct morning office

[11] All health services in Cuba (regardless of level of specialization) are provided free-of-charge. The only out-of-pocket expenditures for individuals include drugs prescribed for outpatient treatment, hearing aids, dental and orthopedic apparatuses, and so on. The prices for all these items are low and are subsidized by the state.

hours (usually, from 8am to 1pm) in the *consultorio* for routine visits and check-ups. In the afternoons (usually, from 1pm to 5pm), the health teams carry out home and field visits — literally known as "*en el terreno*" (in the field). Physician-and-nurse health teams follow a number of health programs set out by the MINSAP's guidelines for primary health care or *atención primaria de salud* (APS). I will further expand upon the specific APS programs in chapter five and, in particular, examine the state's preoccupation with preventive health and epidemiological-risk as key programs in the primary health program. In theory, the family physician is required to see every patient in his or her *área de salud* at least twice a year. The physician is also required to maintain a *fiche familiar,* which is a record of preventive services and conditions for all patients in their area. This record is updated and reviewed at least monthly with a clinical supervisor, who is an academically-based family physician. Acute and chronic health problems are coordinated in a database at municipal, provincial, and national levels of the Ministry of Public Health. The monitored services and conditions include prenatal and natal care, immunizations, cancer screening by smear and mammography, risk factors such as smoking, hypertension and follow-up for chronic conditions, as well as psychosocial problems and sources of stress in the family or at work.

A unique aspect of the MEF program is its consideration of the family as the basic unit of attention. Health teams are to treat the family as a basic social unit, considering the repercussions of the problems of the individual on the family as a whole, and vice versa. Furthermore, ideally, the family is to be an integral part of all prevention, treatment, and rehabilitation of health problems. One of the hallmarks of the MEF program is the introduction of at-home treatment, based on the family physician's judgement, the patient's condition and the family members' ability to care for the patient at home. Cuban health care administrators believed that this approach would reduce the high expenses incurred by admitting and treating people unnecessarily in local hospitals, thereby freeing up the total number of beds available. Furthermore, as public health officials proposed, at-home treatment, when appropriate, encourages both patients and families to participate more fully in health care activities. Therefore, MINSAP officials argue, individuals and their families are also taking a greater responsibility for their own health.

4.2 "Curing" the Social Ills of Society

> These family physicians have a special professional code, especially a code of ethics, which is rigorous. Why is this? For the access these physicians have to families, and for the trust that these families offer them. The new family physician needs knowledge of psychology and psychiatry. In certain ways, many of the families these physicians will serve will ask them for advice about problems that will make them professionals of significant influence with great prestige. These physicians will be of substantial help in providing the health welfare of our people. Furthermore, I think these physicians will contribute to the prolonging of the average life expectancy of our population. Cuba will be among the leaders in the world in the field of public health. For this task, the family physician will play a fundamental role. (Fidel Castro [1984] in MINSAP, *Carpeta Metodológica* 2001: 4)

Since the early 1960s, as I outlined in chapter three, Cuban leaders have envisioned physicians as akin to soldiers, though armed differently, in Cuba's historic battle against disease and suffering. In an address to the nation in 2002, Fidel Castro argued, "health care is one 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 that this one" (Castro 2002: 2). Castro's latter words, read alongside his 1984 speech reproduced above, reinforces the metaphor of the valiant physician-soldier who plays a crucial role in the ideological battle against ill health, and by extension, the health of the nation. In this section, I argue that the family physician acts as a conduit for promoting socialist ideologies in local communities. Physicians' discussions of health, both in rhetoric and practice, are implicitly couched within discussions of socialist principles. For the ten family physicians interviewed for this research[12], the concept of heath is a complex and dynamic process, which is at the intersection of broad socio-economic and ideological change.

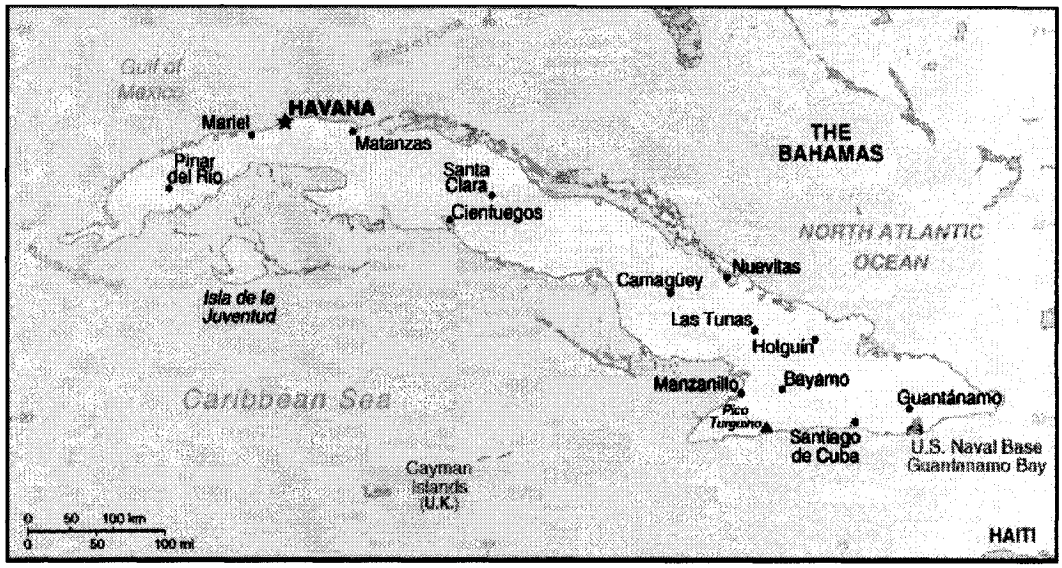
[12] A total of 17 physicians and medical specialist were interviewed for this research, ten of whom were participating physicians in the Family Physician and Nurse Program; four were physicians working in polyclinics (2) and tertiary-care hospitals (2); the remaining three were physicians working in primary health care research institutions (for example, focusing on traditional medicine, bio-statistics and epidemiology).

In the following case studies, I provide the experiences of two family physicians (*médicos de la familia*) and their respective experiences in their *área de salud.* I attempt to juxtapose physicians' narratives with those of their patients. Moreover, I also address specific issues related to the municipal infrastructure in which the *consultorios* were situated, and where possible, I review the diversity of population (that is, gender, age, race, class division and so on); ultimately, I attempt to situate each *consultorio* within the wider society[13]. As I mentioned above, there were a little over 2800 *consultorios* in the City of Havana Province in 2001. Interviews with physicians and the general public revealed that experiences varied significantly from one *consultorio* to another. I purposely chose two distinct socio-demographic communities[14] in order to address the different ways physicians and individuals are dealing with the recent macroeconomic changes in their respective communities. The first case study, *Consultorio Molinos,* is located in a predominately working-class neighbourhood in an outlying suburb of Havana (San Miguel del Padrón). The second case study, *Consultorio Santa María,* is located in the city centre of Havana, which is also a popular tourist area (in Central Havana/Plaza de la Revolucón). The residents in *Santa María* reflect a diverse socio-economic make-up. (See, for example, Map 4-1 and Map 4-2 for the municipalities of the City of Havana).

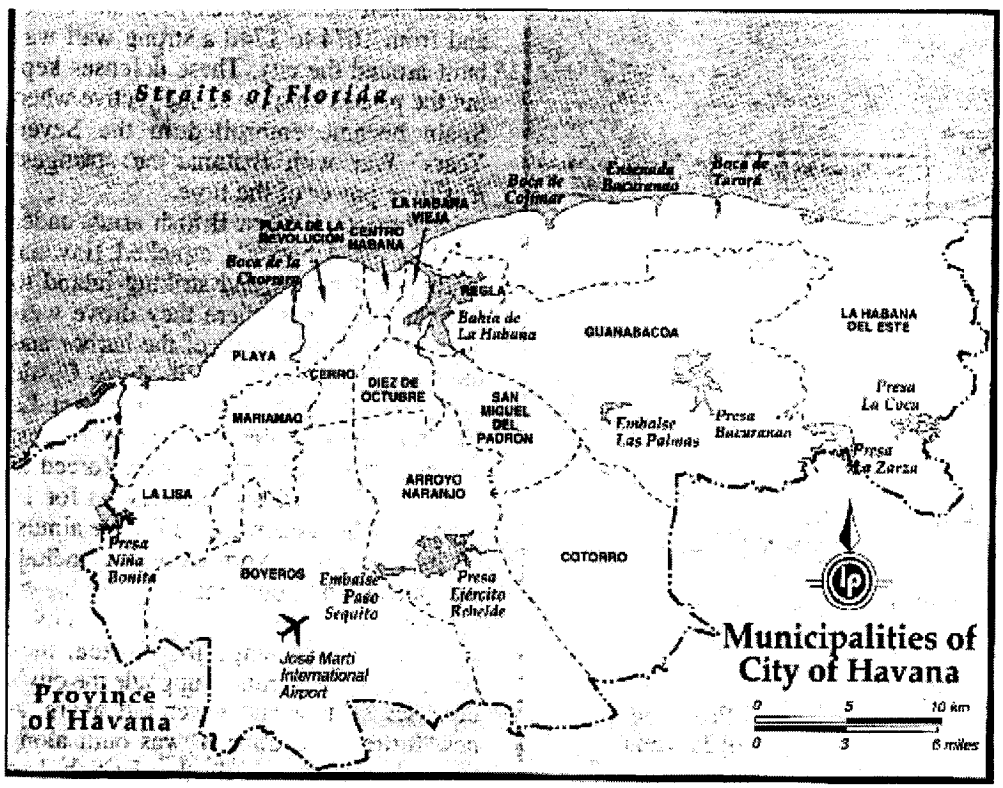
[13] Fieldwork suggests, for instance, that some municipalities are stigmatized for being resettlement communities (that is, former shantytown dwellers that have moved to new state-built apartment complexes, or individuals who were provided with apartments in formerly middle-class suburbs of Cubans who fled the country after the revolution). For example, the municipality of Central Havana or certain areas of El Cerro, which has a high population of Afro-Cubans, is often associated with a thriving "culture of illegality" (Eckstein 1994), danger and filth. This contrasts with municipalities such as Miramar or certain parts of Plaza of the Revolution, previously wealthy suburbs, perceived by many citizens to have preserved much of their former characteristics (that is, a higher percentage of professionals and diplomats).

[14] I distinguish these communities socio-demographically based on extensive participant observation and interviews with individual citizens living within these municipalities. I also checked local historical records to corroborate citizens' descriptions of the former uses of these municipalities in the pre-revolutionary period. I was unable to get specific information on the *consultorios* under study from the MINSAP due to the multiple levels of bureaucracy I encountered. Formal written requests (which is the requirement of the MINSAP) would have compromised the anonymity of the participating physicians and individuals in their health areas. However, only in September 2002 did Cuba initiate a census of population and housing, after a 21-year hiatus of demographic data collection. The latter census data is still unavailable; thus, I am skeptical of the accuracy of any information, dated from 1981, that the MINSAP would have provided.

Map 4-1: Situating the City of Havana Province



Map 4-2: The Municipalities of the City of Havana



Consultorio Los Molinos

I met Dr. Louis Pérez serendipitously at the birthday party of a friend we had in common. He was, at first, reticent and shy. After I was formally introduced to the physician by the host of the party, as a 'good friend from Canada,' he smiled and looked almost relieved. He had detected a foreign accent in my Spanish, but could not geographically place me. My physical appearance had been deceptive, he later admitted. I did not look like the foreigners he was used to; much less the stereotypical Nordic-looking, blue-eyed Canadian he would have expected. Taking advantage of this chance meeting to practice his English, we talked extensively about Canada and Cuba. It was from this conversation that I established an agreement to visit his *área de salud* so that I could carry out extensive interviews.

Several weeks later, when I visited the *consultorio* of Dr. Louis Pérez in *Los Molinos*, his neighbour, Louisa, quickly caught sight of me from her front patio, where she sat painstakingly sifting through her ration of rice, separating the rice grains from the small pebbles and debris. "He is doing house visits in the neighbourhood (*en el terreno*)," she cried out. When I scanned over the scheduled hours posted on the front door of the *consultorio,* I noticed that, according to the schedule, Dr. Pérez should have been consulting with patients. I returned to my apartment in the centre of the city about 30 minutes away in a Cuban-peso taxi and Dr. Pérez called me later that same evening. He apologized for missing my visit, sounded exasperated and quickly began describing the three-paediatric cases he was treating. He had changed his normal schedule, he said, to accommodate his new 'high priority' infant patients. The infants, he stated, required antibiotic injections every four hours, which meant he was constantly trying to juggle his regular consulting duties with the scheduled visits to the infant's homes.

Dr. Pérez's *consultorio* is similar to many of the other residential houses in his neighbourhood, with one exception: the physician's two-storey house is built of pre-fabricated materials but tower over the surrounding bungalows. The bungalows are purely functional in design and are in contrast with the ornate Spanish- and French-colonial architecture of the city centre. However, all the houses in the small subdivision (*reparto)* of *Los Molinos* — located in San Miguel

del Padrón, a working-class municipality southeast of Havana — share one feature in common: they all are in various stages of disrepair. The incoming narrow roads to *Los Molinos* are lined with gaping potholes, broken light posts, and overgrown fruit trees that had engulfed many of the small houses. On one occasion, I had mistakenly referred to *Los Molinos* as the countryside (*el campo*) because of plush greenery and the rural atmosphere, but the doctor quickly corrected me, saying that the *reparto* was officially located in an urban municipality, in the city of Havana. The residents of *Los Molinos*, he added, were proud that they are *habaneros* (city dwellers)[15].

The first floor of Dr. Pérez's two-storey house comprises the *consultorio*: a simple multi-room complex with a small examining room, complete with health promotion campaigns, nutritional advice, and various health programs to be followed, all plastered on the painted but crumbling walls. The second floor of the house is the physician's apartment; a modest two-bedroom unit with almost no furniture, a borrowed black and white TV, a broken bed, a kerosene stove, and a small Russian fridge. Dr. Perez apologized for the poor physical condition of his apartment. He indicated that the state had promised to improve his living conditions. He rolled his eyes and added half-heartedly, "At least, that is what the state has promised me, but you know how things are in Cuba. Currently, I am not a priority."

There is one luxury in Dr. Pérez's apartment, however, rare in this *reparto*: a phone. The phone, while still a scarce commodity, is essential to a growing and complex social network of people. Dr. Pérez's acts as a messenger, he stated, receiving calls from nearly all the provinces of Cuba, the US, and Spain. He ends up relaying messages, he remarked, for about 20 to 25 people; some of whom live several blocks away. Many of his immediate neighbours are also reliant on his phone to place calls and neighbours often knock on his door at all hours of the night. However, the doctor explained, he had recently devised to scheme to avoid these frequent interruptions. His neighbour, Louisa (whom I encountered on my first visit to the *consultorio*), who is always on her front patio "to keep an eye on things," had agreed to regulate any impromptu after-hour visitors. She

[15] According to PAHO in 2001, 75.5 percent of the population in Cuba is urban and 24.5 percent is rural.

would inform these people that "the doctor is not home" if Dr. Pérez so desired. This tactic, Dr. Pérez said, would allow him a reprieve from frequent visitors without causing conflict in the small community. As he also noted, after-hour medical emergencies, theoretically, should be attended to by the 24-hour local polyclinic, or equally in the *Cuerpo de Guardia* (Emergency Rooms) at local municipal hospital.

Despite the availability of other health services, many of Dr. Pérez's patients do not have access to reliable transportation. In fact, most of the residents, the doctor noted, rely on him as a first line of defence for many of their medical emergencies. The doctor explained that this is what the state had intended by placing doctors in the community. But many residents hope the doctor can do more: "do them special favours." His amicable nature put people at ease, and people feel comfortable in requesting favours, he said. For example, one woman in his health area wanted to get her niece from another province checked into one of the popular tertiary institutions, *Hermanos Ameijeiras,* in Havana, for medical diagnostic tests. Dr. Pérez's stressed that this was well beyond his capabilities. At the most, he noted, he could make strategic calls to the local polyclinic to organize ambulatory services in cases where people needed emergency transportation. Most people, he stated, cannot afford to splurge money on peso taxis, which charged anywhere from 10 to 20 Cuban pesos per person (fifty cents to one dollar US).

Dr. Pérez further stated that, the community is less reliant on the nurse (*enfermera*), which is the other half of his health team. Historically, the government had placed so much emphasis on having fully-trained family physicians that there was a point at which the number of nurses had actually lagged behind the number of doctors. When I asked Dr. Pérez if I could arrange an interview with the nurse on another day, he sarcastically remarked, "If she shows up." The nurse lives in another municipality and, the doctor commented, was often late or didn't show up at all. As it turned out, there were barely enough houses to accommodate the physicians and their families, much less houses for the nurses. This was a common theme in all of the *consultorios* I visited. None of the nurses lived directly in the communities in which they worked. The nurse assigned to Dr. Pérez's *consultorio* is a recent graduate, he explained, although the *consultorio* had seen several nurses throughout Dr. Pérez's

ten-month assignment. As he stated, many of the former nurses left because of "personality conflicts." He chose not to elaborate on this latter term, although I suspected it had to do with what he later characterized, as his "very demanding personality."

Returning to the *consultorio* on another day, Dr. Perez was again off *en el terreno.* I struck up a conversation with a man who was hanging around the front of his office. Holding two small bread rolls loosely wrapped in a nylon bag, Sr. Benarndo Ortiz, as I later found to be his name, was conversational and began to tell me what a "wonderful guy" the physician was. In an unsolicited confessional style, Sr. Oritz began to explain to me why he was bringing bread for Dr. Pérez. The physician, who had recently moved from the eastern Province of Santiago de Cuba to take on the position of the *médico de la familia* in this neighbourhood, was still awaiting authorization from the appropriate municipal authorities to provide him with a ration book (*libreta*)[16]. Without a *libreta*, Dr. Pérez is unable to collect his designated ration of subsidized foods, including rice, beans, bread, sugar, and so forth. *El pueblo* (people in the community), Sr. Ortiz proudly informed me, were pitching in to make sure the physician wasn't left without sustenance. Sr. Ortiz's wife, Mariella, had recently sent over her speciality, *papas rellenas* (stuffed potatoes), because the physician had worked late the previous night attending the cases of the sick infants. She wanted to make sure that, at the least, Dr. Pérez had something to eat.

After explaining my reason for being in *Los Molinos*, Sr. Ortiz listened attentively. "I can tell you a great deal about the *médico,*" he offered, and invited me to his house, located no more than three minutes away from the *consultorio.* A man of 53 years old, but who looked years beyond his age, Sr. Ortiz quickly searched his house for an appropriate glass to offer me rum, a practice common

[16]Rationing of food products began in March, 1962. In principle, the system ensures equality of food consumption to 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 it should be pointed out that rationing does not guarantee that those products will be available for purchase each month (Benjamin *et al.* 1984). See, for example, Adriana Premat's (1998) *Feeding the Self, Cultivating Identity in Havana, Cuba* (unpublished M.A. thesis, York University, Canada) for an ethnographic account of the different ways Cubans negotiated food shortages and rationing during the *período especial.*

to the majority of men that I had interviewed (women generally offered me coffee). After I politely refused, Sr. Ortiz insisted that he would not take no for an answer. Watching Sr. Ortiz quickly down a glass of the acrid smelling liquid, I reluctantly sipped at the small shot glass of unrefined white rum and tried to disguise the burning sensation as I swallowed less than a teaspoon. "You won't get this stuff in Canada," he beamed, prodding me to shoot back the glass, as he had just done. "This is my first drink in 16 days," he pronounced solemnly. Benî, as he later asked me to call him, said he had "a little drinking problem." Dr. Pérez is working with him to provide a "cure," Benî stated. "Louisito, the *medico,* comes by the house every so often and sits down with me and watches the TV and talks about my problem. He gave me some pills (*pastillas)*, which I think are some kind of vitamin because I need to get my appetite and strength back," he described.

When Benî's wife appeared in the door without notice, he quickly became agitated. "Where did you get the rum from," she demanded. "It's just a little," he whimpered. I quickly introduced myself to Benî's wife — her name was Mariella — and she sat down and apologized that her husband was drinking again. As she explained, Dr. Pérez was trying to cure her husband's drinking problem. She didn't have much hope, though. "The *médico* said we all have to work together like a family to support him. The *médico* said it is not Benî's fault that he suffers from this illness, but I can't take it anymore," she declared. Looking upset, Benî offered his defence: "I am working with the *médico* and making progress." Immediately, he started to enumerate the various changes and ongoing projects of social reform he was involved in: painting the window frames, cleaning up the yard and surrounding streets, and trying to be more actively involved in the community. He was, Benî emphatically stated, trying to become integrated into the community and take responsibility for his drinking and the effect his drinking had on others. With the encouragement of the *médico,* Benî had recently joined a volunteer micro-brigade to help with various revolutionary initiatives. The latest project, he told me, was Fidel Castro's project to fix all the schools nationwide, before the opening of the new school year in September.

Mariella, hearing Benî's long list of projects, sighed in frustration. In a matter of hours, Benî would be drunk again, she said. She contradicted Benî's

claim that he was cutting back on his drinking and reminded him that only the day before he was drunk. "Louísito works with him and has made so much progress, but Beni is surrounded by so much temptation," Mariella sighed. Pointing to the house of her neighbour, she described what the problem was. The neighbours in the crumbling house next door had built on their roof a patio that resembled a bar with large speakers and umbrellas emblazoned with the brand name of one of the national beers of Cuba, *Cristal.* As Mariella pointed out, her neighbours ran an informal bar and club from their house and Beni was a frequent visitor. Mariella apologized for Beni's behaviour and asked if I would come back again to interview her about her opinions on the health care system. She accompanied me back to Dr. Pérez's office, where I left a note for the doctor, and she emphasized how she thought of the *médico* as one of her sons. "Louísito is all alone in *Los Molinos* and we try and take good care of him," she smiled. On Mariella's back patio, as she had pointed out, several of Dr. Pérez's white lab coats were on her clothesline swaying in the breeze. She also washed the *médicos* clothes as if he were one of her children (now absent) — "just to help out," she said.

Later that evening, Dr. Pérez visited my apartment, which was an hour and half away by multiple local buses, and apologized for missing my visit again. Mariella had already informed him of my meeting with her husband. Dr. Pérez proudly stated that he was personally working with Sr. Ortiz to treat him. "He is a good man and needs specialized attention, but I cannot do it alone," he said. The *área de salud* for which he is responsible is quite difficult, the doctor described. Faced with over 800 people spread over a wide geographical area, Dr. Pérez and the nurse have to deal with serious social and health problems. According to Dr. Pérez's records, a little over 40 percent of the people in his *área de salud* were under 35 years old. In addition, 45 percent of the residents were women. Surprisingly, Dr. Pérez also was able to recite, without looking over any notes, the exact number of people in his health area who were hypertensive, diabetic, over the age of 65, fertile women, and so on. As he stated, he had memorized his *fiche familiar* because he dealt with it on a daily basis. He could also provide, he noted, a social history of each of the households in which he worked. The doctor explained that he made a point of visiting all of the households in his community on a regular basis.

Los Molinos was a housing settlement built in the 1940s as rental accommodation for service staff and agricultural workers from other provinces. Many of the residents of *Los Molinos* used to make the daily trek to various large plantations that were located nearby. According to Mariella, whose mother (now deceased) was a former servant in the house of one of the previous landowners, the house Mariella currently occupied was awarded to her mother through the agrarian reform laws after *la Revolución*. This history was similar to that of other residents of *Los Molinos*. The agrarian reform nationalized large segments of private land and property for redistribution to the population. The former landowners, Mariella indicated, fled to the US, but rumour had it, she noted, they were waiting to return to Cuba "after-Fidel" to reclaim their property. Many of current residents of *Los Molinos* traced their family history, usually through their parents, back to a working-class background on the former plantations.

In addition, however, a growing population of illegal migrants from rural eastern provinces, many of whom were people of colour — hence the derogatory racist label in local parlance as *palestinos* (Palestinians) — had now settled in *Los Molinos*. The recent arrivals to the city — often related, if only tangentially, to somebody in the neighbourhood — had built what Dr. Pérez described as abominable make-shift houses on vacant property. He described these houses as reminiscent of the over-crowded tenement housing in the congested city centre, houses known as *solars*. He dubbed these parts of his health area *Oriente* (because the majority of the occupants were illegal migrants from the Eastern provinces). He sighed. The growing population of 'unregistered' residents in Dr. Pérez's *área de salud* made his task of risk evaluation and treatment more difficult. The general problems — for the recent arrivals and long-time residents — of teenage pregnancy, infant and adult malnutrition, and alcoholism were matched by an increasing number of chronic health problems such as diabetes, asthma, and high blood pressure. All of these problems, Dr. Pérez added, were compounded by a critical lack of material resources.

When I visited Dr. Pérez *consultorio,* it had little medicine and even less sophisticated equipment. The situation in his *consultorio* was not unique. For the most part, massive shortages were evident in all the *consultorios* I visited.

According to the MINSAP, the *consultorio* should have approximately 26 types of medicine on-site (cf. MINSAP, *Carpeta Metodológica* 2001: 31). Dr. Pérez had less than half of what appeared on the stipulated list. A small unkempt plot of land on the side of the *consultorio* was home to a sparse garden of medicinal plants. These herbal remedies, Dr. Pérez explained, supplemented — and in some cases supplanted — the dwindling armoury of drugs that he had at his disposal. "Some are actually quite useful," he offered sardonically. He claimed that, with the right knowledge of herbal medicine (*medicina verde*), a physician could make efficacious treatments (a theme I will expand upon in chapter six). 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 other older family members," the doctor said.

The dwindling supply of allopathic treatments meant that Dr. Pérez often sent patients directly to the local polyclinics for routine injections because, at times, he didn't even have the necessary needles. However, in special cases, such as with infants and pregnant women, Dr. Pérez noted that he would personally and immediately notify the local polyclinic or municipal hospitals of any shortages or required medicines or supplies. The death of an infant in one's *área de salud,* he noted, was subject to serious investigations by the municipal authorities. Dr. Pérez had to meet on a monthly basis with a clinical supervisor, an obstetrician-gynecologist from the polyclinic, to review all of his paediatric cases and pre-natal appointments. As he made clear, the maternal-infant care programs were the most important of his daily activities. Using a notebook and pen, he spent hours reviewing his notes and getting them in order before the supervising obstetrician-gynaecologist made her monthly rounds in his *área de salud.* Without a computer, Dr. Pérez assembled the majority of his files and notes in a black binder. For the most part, as stipulated by the MEF program, patients kept their own clinical history (and that of their underage children) and were required to bring this file with them on their visits to the family physician, *políclincio* or local hospitals. .

Working anywhere from 60 to 70 hours a week, Dr. Pérez is paid $400 Cuban pesos a month (in 2002, approximately $19US). Although he complained of being 'poor' in comparison to Cuba's new US-dollar economy, his salary is actually on the high-end of the scale for state employees. While Dr. Pérez did not have to pay rent or utilities where he lived[17], he informed me that his salary is unable to meet his basic expenses. In addition to his regular duties, which included a certain number of night shifts (*guardia*) at the local *policlínico*, he also covers several other physicians' night shifts to earn extra money. The other physicians made informal agreements with Dr. Pérez to pay him $100 Cuban pesos per night shift (approximately $5US) under the table so they could avoid the undesirable red eye shifts. The extra money, Dr. Pérez added, provides few luxuries.

Dr. Pérez has to send money to support two sons from a previous marriage. His two children, both in their teens, lived with their mother in *Oriente*. Dr. Pérez was also responsible for sending his parents money, both of whom were living on state pensions, which for the two of them totalled no more than $220 Cuban pesos a month ($11US). As the doctor ironically stated, he left the countryside with the hopes of becoming a 'big-city-doctor,' so his parents, former unskilled labourers, had high expectations for him. Dr. Pérez told me that he had three siblings who lived in the US, but who almost never called, and sent money even less often. His siblings had become "Americanised" he concluded. "You know the saying, "Drink Coca Cola and forget about everything," He smiled. In Spanish, this forms a rhyming jingle in the style of a commercial (*"toma Coca Cola y olivido todo"*).

One day, looking physically exhausted and still dressed in his white lab coat (*bata*), Dr. Pérez visited my apartment. He stated that his current medical post was one of the hardest assignments he had held since he graduated from medical school in 1987. Born in the Province of Santiago de Cuba in 1963, Dr.

[17]For those family physicians that are fortunate enough to be provided housing in the communities in which they work, generally speaking, they do not have to pay rent or utilities. However, in general the population, for the many Cubans who have legal titles to their property, they usually do not pay rent either, unless the property was inherited. If they do, the figure is usually a nominal sum of 10 to 15 Cuban pesos a month and all utilities are subsidized, for example, one Cuba peso per person for water per month, and so on.

Pérez had worked in various rural medical posts in his home province and throughout *Oriente* before requesting a transfer to the City of Havana Province. He had hoped to leave the country lifestyle behind him and receive a posting in one the fashionable municipalities of Havana such as the Plaza of the Revolution or Old Havana. But when he had arrived only 10 months earlier, Dr. Pérez was disappointed to find he was assigned to one of the outlying municipalities in the city of Havana. *Los Molinos* resembles a small rural town rather part of a large city. As Dr. Pérez noted, his move to the city was not motivated by money. The pay for a physician was fairly standard across Cuba. Rather, the physician was looking for more satisfying work and life experience, something he described as working with the "cultured" city-dwellers, rather than working with what he termed "ignorant rural peasants."

The residents in *Los Molinos,* the physician sighed, were unfortunately no better than the people in the countryside. They were functionally literate, he claimed, and for the most part worked as labourers in the local factories — if they worked at all. The socio-economic conditions of *Los Molinos* were deteriorating. The community had gone through several *médicos* in short periods, each one requesting a transfer after only brief stints. "I too want to transfer to another area," he told me. However, the community had responded well to him and treated him with respect and generosity, perhaps, he added, with the hopes of convincing him to stay. Referring in general terms to the patients in his *área de salud*, Dr. Pérez discussed the various cases he was currently treating. Home visits, he made clear, were the only way he could get an adequate diagnosis on the chronic and acute problems in each of the households.

The two children with pneumonia, he sighed, lived in two separate households where nobody was employed — at least, not legally. "They live off the air *(el aire),*" he sniffed ironically. In these houses there were more mouths to feed than those registered in the *libreta.* He claimed that the infants, age 3 and 4 in the respective households, suffered as a result of poor household management. "The infants are malnourished," he said. He further added that, he had already called a social worker in to help him work with the families. The local government, Dr. Pérez said, was not to blame for the plight of the infants. He suspected that the food for these children, already heavily subsidized

by the state and rationed out to the families, was being bartered on the black market in exchange for cigarettes, rum and money.

The physician's suspicions were later confirmed when a concerned community member informed the doctor of black market dealings by these families. Based on this information, Dr. Pérez spent several days with the families involved, explaining the importance of infant nutrition. He told me that he had handled the matter of the illicit black market trading delicately and stressed to the families that the infants must come first. He let the families know that he would be making regular house calls to ensure his orders were being followed. He also strongly recommended that several of the family members of working age — who were not gainfully employed — become more involved in the community. The doctor also informed them that the CDR would be keeping an eye on the family for aberrant behaviour. Dr. Pérez concluded, "I don't involve the police, because most times these things can be handled diplomatically. This is a community and to create tensions and distrust among residents is dangerous. Most people respect what I say. Cubans are gossips (*chismoso*) by nature, so word usually gets around on who is doing what." Many people viewed Dr. Pérez as a local authority, someone occupying a position similar to other state officials. He dealt with various complaints, and was often called upon to tactfully handle disputes between neighbours.

The latest scandal, the doctor said, was that Benί, drunk again, had recently exposed himself in front of a group of neighbours where small children were present. The doctor, annoyed by the lack of involvement of Beni's sons, contacted one of them immediately to inform him of what was going on. Benί, whom I had interviewed on several occasions, had agreed that I could speak with Dr. Pérez about him. Benί was a lonely man who used alcohol as an escape, Dr. Pérez said. Benί was a former *militante* (communist party member), but voluntarily turned in his membership to the Party over 10 years ago because of his alcoholism. He now worked as a general labourer in a local factory, earning $156 Cuban pesos a month ($6US). When the factory was low on primary materials, which Benί claimed was becoming a regular occurrence in recent years, he was temporarily laid off. He made a little extra money on the side by fixing Russian radios, which were distributed to the population in the 1960s and 1970s. However, this specialized skill was becoming increasingly obsolete with

the fall of the Soviet bloc, and the consequential decreasing use of Soviet technology in everyday life. Nowadays, Benî sighed, people had their hopes set on Sony and Panasonic mini-stereos sold in the US dollar stores; for the lucky ones, their relatives abroad send them the money, and others usually worked at informal jobs to earn extra cash to make such large purchases.

Benî's two sons were in their late twenties; both had left home several years earlier and rarely spoke with him. On the occasions that the sons did visit, Benî asked the *médico* if he would speak with them about his progress. He wanted his sons to know he was trying to get better. Benî's wife, Mariella, in her early 50s, revealed in an interview that she was prone to depression and "nervous attacks." She solved this problem by taking a cocktail of various tranquillizers and sleeping pills that she bought on the black market (*bolso negro*), but these pills often caused her to doze off quickly after coming home from work. She had worked as an accountant for over 20 years in the same factory as her husband. Unlike many of the other residents I interviewed in *Los Molinos*, Mariella had completed a technical college degree, and was paid a reasonably high salary of $300 pesos a month ($15US). However, she admitted that at least half of her salary was spent on coffee, cigarettes, and the cocktail of *pastillas* (pills) she bought on the street.

Dr. Pérez explained that he was also working with Mariella to stop her dangerous habit of self-medicating. "All of these factors are part of the same problem," he said, and "depression and alienation" were the root causes of many the problems he encountered such as Benî's alcoholism and Mariella's addiction to prescription tranquillizers. Aware of the challenges he faced, the doctor, with a touch of pride and a cadence reminiscent of Fidel Castro, offered this: "I live in the community, and like anybody else here, I know intimately what people's domestic problems are. The solutions for many of these people's problems lies outside of the *consultorio* and in the environments they live in. This is what makes the *médico de la familia* program so unique. I do not simply diagnose the individual; rather, I diagnose the family, and the community as a whole."

I asked Dr. Pérez whether, based on his experience, he would venture to "diagnose" the problems of his community, and by extension, the nation. "We live an enigma in Cuba," he replied. "What we are building in Cuban society is a

great thing." But he went on to say that the growing economic problems were creating insurmountable barriers for everyday life. He was adamant about one thing, however: as with the other physicians that I interviewed, he stated that to stop working because of financial hardships would be immoral. "People have a right to health care," he asserted bluntly. Unlike the countless physicians who, at the beginning of the revolution and in more recent years, had fled Cuba in search of a better economic life, mainly in the US and Spain, Pérez was still committed to the underlying principles of the Cuban revolution, which he described as committed to humanity. He laughed when I asked if he considered himself a *revolucionario*. "Don't think I am a saint," he said. "I skip off work some days because I'm exhausted. I'm not perfect. I would love to have what we Cubans refer to as the holy trilogy: a colour TV, a VCR and a new stereo. I do not agree with all of the policies of *El Señor* [Fidel Castro] either. However, health care is fundamental to our society. The right to health must be protected. I know I am a role model in my community in many ways. It is obvious that my job in the community as a physician is not only to tell people what to do, but to show them that it can be done. I guess you can say I lead by example. "

Consultorio Santa María

I met Dr. Ochoa through a friend of a friend, which I found was the most common way to get access to the usually tight-lipped family physicians. Dr. Ochoa, a 42-year family physician, finally agreed to several interviews with me, but only after she had a chance to meet with me informally on various occasions. Dr. Ochoa had previously been a family physician in a high school for several years. Her work in the school consisted primarily of health promotion campaigns on issues such as sexual health and healthy lifestyle choices (for example, not smoking, eating nutritional foods, getting exercise, and so on). As she commented, community-based medicine was a complete change from what she was used to. Two years earlier, she was assigned as a replacement physician at *consultorio Santa María*, when the original physician became an *internationalista* — a Cuban health professional who provided voluntary medical services in third world countries. Despite being told the post would only be temporary, she had been at *Santa María* ever since.

Consultorio Santa María is located in the municipality of Central Havana at the border of the municipality of Plaza of the Revolution. The *área de salud* comprises a burgeoning population scattered throughout an intricate network of dilapidated low-rise buildings. The apartment buildings, collectively known as *Edificios Santa María*, are a striking contrast to Havana's post-revolutionary social order. Formerly prime real estate in the pre-revolutionary era, each building is approximately 7 to 8 floors high, and overshadowed by several high-rise hotels located nearby. From the streets, the grand ornate balconies and large picturesque windows of *Edificios Santa María* speak volumes about their former grandeur. In the inside of one of the buildings, a majestic foyer with crumbling marble floors surrounds a small bust of independence fighter Jose Martí, symbolizing Cuba's post-revolutionary mantra: *la Revolución* is independence.

The majority of the apartments in *Edificios Santa María* have decorative wrought-iron front doors — recently added for security reasons, I was told — giving the place the eerie atmosphere of a jail. Behind the barred font doors, the majority of the apartments in the building — originally large three and four-bedroom suites with en suite bathrooms and maid quarters at the back — have undergone multiple transformations. Several of the residents in the *Santa Maria* buildings, formerly wealthy urbanites in the pre-revolutionary era, have remained in their apartments until the present day. The decorations and furnishing in their houses, from what I surmised from the apartments I entered, are testaments to the wealth they once held. However, other wealthy residents fled Cuba in the early 1960s, and now many of their former servant staff and their extended families are the legal occupants of the apartments. The pre-revolutionary past and revolutionary present are seemingly intertwined, if unevenly, in *Edificios Santa María*, in a complex fusion of rich and poor, old and new. However, these categories do not necessarily overlap in predictable ways.

At the base of one of the low-rise buildings, the insignia "MF" is written in white block cap letters on one of the outside doors to signify the *consultorio del médico de la familia*. This sets it apart from the other nondescript residential doors. Dr. Ocha's *consultorio* is literally an ad hoc space. Built into the base of one of the buildings in the mid-1980s, it is obvious upon entering the *consultorio* that it had previously been a residential apartment. Dr. Ochoa's small three-

room *consultorio* is neatly laid out: waiting room, office, and examination and treatment room. Throughout the *consultorio*, health promotion posters on infant-maternal health, STDs and nutritional advice formed a colourful collage on the walls. Dr. Andrea Ochoa smiled when I asked her how many people she was responsible for. "Officially about 700, but I suspect there are well over 850, if not more," she stated. Dr. Ochoa is generally upbeat and gregarious and seemed unfazed by the maze of run-down buildings that literally engulfed her *consultorio*.

Dr. Ochoa lives in the neighbouring municipality of Plaza, which is about 15 minutes away from her *consultorio* by a local bus. However, as she explained, she often rides her large old-fashioned "Chinese bicycle" — one of the many bicycles sent by the Republic of China to Cuba in the early 1990s during the height of the petroleum shortage — to work. Her *área de salud* is rather typical, Dr. Ochoa indicated, of the generally over-crowded city centre. The area is such a compact mass of humanity that various Cuban scholars have reported that the temperature in Central Havana is often one to two degrees Celsius hotter than the daily average temperatures in other parts of Havana (cf. Campbell 2001). The MINSAP, Dr. Ocha noted, is well aware of the health problems posed by the densely overcrowded pockets in the city. The government, however, did not currently have the financial or material resources to address the problem. The latter problem, Dr. Ochoa noted, were partially to blame on the US embargo (*el bloqueo*). However, another problem, she remarked, was the shear magnitude of rebuilding a city that had gone without basic maintenance for over 40 years.

Currently, all the restoration and construction activities in the city centre are in prime tourist areas and, for the most part, are undertaken with the help of significant foreign investments through joint ventures (for example, financial aid from Spain, Italy, and other countries) or special programs, such as UNESCO (for example, Old Havana was declared a 'world heritage site'). According to several of residents of neighbouring areas, *Santa María*, despite its close proximity to hotels, is still in a relatively undesirable area. At night, walking down the small streets that surround *Santa María* is considered dangerous. With a police officer located on every major city corner in the heart of the city, I found this characterization surprising. However, the "dangerous element," as I found out, was a growing number of prostitutes and young hustlers (*jinieteros*), peddling illegal boxes of Cuba's famous cigars and other wares on the street.

The *jiniteros* apparently lure unsuspecting tourists away from their hotels to complete their illicit transactions away from the watchful eye of the army of police that surrounded the hotel areas.

Several of my neighbours in the apartment building where I lived, for example, insisted that I be accompanied to do my evening interviews in *Santa María.* What they didn't want to say, but which was apparent in their descriptions, was the racialization of *Santa María.* As my landlady and several other people remarked, the area was known for a high population of blacks (derogatorily referred to as *los negritos),* who were apparently known to rip chains from people's necks and assault both Cubans and foreigners alike. As was usually the case, I was unable to substantiate any of these claims. They were based on the preconceptions of the individuals, rather than on any actual lived experience.

When I asked Dr. Ochoa about the rumours of *Santa María* being considered a dangerous place by nightfall, she attempted to delicately skirt the issue. The reality was, as several of Dr. Ochoa's patients pointed out, that she left *Santa María* by five each day to return to the relatively affluent suburb where she lived with her parents, her husband and two children. Dr. Ochoa stated, however, that *Santa María,* while far from the worst area in the city, had significant problems with illicit activities that made health care in her area difficult.

Dr. Ocha was born in 1958, shortly before the revolutionary government came into power, and she graduated from medical school in 1984 — coincidentally the year the MEF program was inaugurated. She grew up in a middle class family in the neighbouring Province of Mantanza. Her family had moved to the city of Havana in the 1970s, where her father worked in a high-level position in the Ministry of Sugar. Dr. Ochoa had completed all of her schooling under the revolutionary pedagogy and, as she stated, firmly believed in the underlying principles of *la Revolución.* However, she noted that in practice, the recent economic changes were affecting everyday life, making it difficult to fulfil her revolutionary commitments.

Health education, Dr. Ochoa stressed, was key to her job. She stated that her health area included several professionals, who made her job easier in

many respects. However, a large number of the residents in *Santa Maria* arrived only shortly after the revolution from the countryside. Dr. Ochoa reiterated concerns reminiscent of Dr. Pérez's discussion of "uncultured peasants." Dr. Ochoa remarked that people from the countryside (*campesinos)* were much harder to "reform" than city-dwellers. However, she told me, *campesinos* also had a greater respect for the revolution, and doctors in general, than the city-dwellers. "The *campesinos* are people who before the *la Revolución* never saw a doctor. They tend to treat you with a great deal of respect and are *extremely* grateful." As several other doctors I interviewed pointed out, it was not uncommon for *campesinos* to show up at *consultorios,* polyclinics and hospitals with presents of gratitude for the attending physician. Most of the time, the presents were food items that were highly desired (and expensive) in Havana, such as a roasted pork legs, lobster, shrimp, vegetables and certain fruits. While the gifts were not necessary, the doctor noted that they were always welcome.

Dr. Ochoa organizes several meetings on a regular basis to discuss particular themes with state-defined demographic groups. She schedules informal chats (*charlas)* with adolescents to discuss sexuality and contraception, especially with women over the age of 14. She also meets with the "elderly club" (*circulo de abuelos*) to discuss the importance of exercise to combat sedentarism. One of the major problems in Dr. Ochoa's *área de salud,* she reports, is the increasing socio-economic stratification within the local population, and the severe problems with hygiene and housing maintenance. These conditions are matched by a rise in chronic health problems and, as Dr. Ochoa notes, "unhealthy lifestyle choices and entrenched cultural habits." As she makes clear, many people simply do not heed her advice.

For example, she explained to me, lack of money plays a significant part in why many people consume unhealthy foods — foods high in animal fat, for instance — and shy away from purchasing more costly fruits and vegetables, thereby causing hypertension and heart problems. Entrenched cultural attitudes, she said, "are also difficult to change. Cubans like fatty and salty foods." Many individuals smoke and drink heavily, because they feel it was one of the few luxuries they can still afford, especially given the recent shortages in rationed food items. "The younger ones are easier to deal with because they listen — at least, in my experience they do," she said. Despite her continued efforts to

keep her *fiche familiar* updated, Dr. Ochoa feels overworked and this is compounded by the obligation to regularly attend post-graduate courses and to keep abreast of current developments in primary health care.

Her *área de salud* has become more complex due to the recent influx of tourists in the building complex. Several of the residents in *Santa Maria* rent their apartments (or rooms in their apartments) to foreigners legally or illegally. One day, for example, I was interviewing a single elderly woman, Snr. Lydia Morales, in a large, beautifully decorated apartment. She has a large three-bedroom apartment that she has inherited from her parents. She has never been married and has no children, so Snr. Morales began illegally renting rooms to supplement her state pension. Several young German tourists were sun tanning on her front terrace drinking beer, when I interviewed her. Snr. Morales was unbothered by the fact that she didn't have a state-license to rent to foreigners What she was worried about, however, was that the young men might bring *jiniteras* into her house. She didn't want "strange Cubans" in her house, she emphatically stated.

Dr. Ochoa was well aware of the problem of illegal renters, but the complex infrastructure of the building, she stated, made it difficult to pinpoint where exactly the foreigners were staying. Most of the building's residents are tight-lipped about the illicit activities. I also suspected that Dr. Ochoa, seeing how residents were not complaining about the matter, did not want to get involved: "I try to build a sense of community," she stated. Dr. Ochoa's *consultorio* is located in close proximity to the CDR headquarters. On several occasions, problems had arisen between foreigners and Cubans (or between building residents), for example, loud parties or disputes and fights over money. Dr. Ochoa — who in reality does not live in the "community" — is informed of these events when she arrives at work and she then meets with the local CDR representative to discuss the matter. She makes notes of the various problems and, also officially documents these problems, as with all community health matters and, her *fiche familiar* is reviewed by municipal authorities on a regular basis.

Several residents of *Santa María* recounted how the state housing authorities had arrived unannounced one day to check people's housing

registrations but apparently without a particular reason. In addition, the Cuban Ministry of the Interior (who runs immigration) arrived in the building the same day to verify that the foreigners staying in various apartments were legally registered. News spread quickly in the building, and as Dr. Ochoa noted, people started acting suspiciously around her. Unlike the local CDR representative who lived in the building complex, Dr. Ochoa was an "outsider." It was also evident that Dr. Ochoa worked in a social environment that was very distinct from that of Dr. Pérez's *consultorio*. Several of the residents in Dr. Ochoa's *área de salud* had regular access to US dollars, from formal and informal work in the local tourist industry and from friends and relatives abroad. The local socio-economic stratification was visibly noticeable, to me.

An interview I conducted with one of the residents in this building complex, Sr. Julio Caesar Serra, best illustrates some of the contrasts in the *Santa Maria* complex. Following a long narrow corridor between two adjacent buildings, I entered the heart of the building, which forms a narrow ' L' shape core. This winding corridor, which was once the former service entrance for the building, is now home to 20 or more families. As one climbs a narrow and crumbling staircase that hugs the inner wall of the building, another life emerges. A myriad of brightly coloured clothes and sheets hang off back patios, and are complemented by the stench of garbage, including everything from soiled diapers, egg shells, and orange peels, that people had thrown from their windows onto their neighbours' space below. The waste forms a pile of rotting refuse on the narrow ground floor, which also served as the back terrace for several residents.

Doors of small studio apartments line the inner artery of the building, and were the former maids' quarters for the wealthy apartment dwellers whose ornate balconies face the front. After I had negotiated six flights of a precarious and crumbling stairwell I arrived at the tiny one-room apartment of Julio Caesar. This apartment is where the former maid of his neighbour had slept, cooked, and bathed. "We were, and I think I can still speak in the present tense, are, the ass (*culo*) of the rich," Julio Caesar remarked.

Julio Caesar Serra, a 45 year-old man, is an eloquent and poised speaker. Julio was not shy about expressing his disdain for the *médico de la familia* program.

His complaints, however, tackled head-on some of the problems raised by over 50 percent of the general population that I interviewed in connection with various health issues for this research. From our first meeting, I was convinced that Julio was an ardent counter-revolutionary (locally called a *gusano*), and in the course of several interviews it became apparent that, for the most part, he is anti-Castro. But while the distinction between counter-revolutionary and anti-Castro may appear blurred, they speak to the contradictions that are inherent in the way people make distinctions between ideology (socialism as a theory) and practice (the actions of the government represented by Fidel Castro).

Julio Caesar moved into the *Santa Maria* buildings when his partner, Jose de Jesus, a designer for a state-run clothing company, travelled to Spain on business in the late 1980s and decided to stay. When the state became aware that Jose had "defected," they confiscated his house and all of his property. Julio Caeasar, originally from another province, had no legal claim to the property. A year later, after much bureaucratic wrangling Julio Caesar decided to follow his partner to Spain, but shortly after his arrival in the Canary Islands, things broke down with his partner and he was unable to get a resident permit in Spain. He decided to return to Cuba. Upon his return to Cuba, he rented a small studio apartment from a woman in the *Santa Maria* building. After many years, and against the law, he managed to buy the title of the property[18] for $1500 US from the previous owner, and has lived there ever since with his current partner, Carlos Alberto Ramos.

Julio Caesar has had various encounters with state security, he claims, for openly expressing his views against Fidel Castro. In 1993, he was arrested and detained for several days for screaming anti-Castro obscenities from the building stairwell. He states that, the *período especial* had created an untenable situation,

[18] Property sales are not permitted in Cuba. Rather, Cubans can exchange apartments, for example, the exchange of a two-bedroom apartment for two separate one-bedroom apartments (and vice versa), in the case of divorce, family expansion, or increasingly to live in 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 "informal real estate agents" have emerged to facilitate these illegal acts, which effectively profit by manipulating the laws regulating exchange facilitates. See Lewis *et al.'s* 1977 ethnography, entitled *Neighbors*, or the Cuban-directed and produced movie entitled *Se Permuta* (For Exchange) for a light-hearted (and humorous) examination of the politics of "housing exchange" in Cuba.

and he wanted to let people known that "Fidel Castro and his minions in the Party" were living the high life at the expense of the people. Given Julio's history of conflict, and his vocal stance against the government, I anticipated him painting a negative picture of the health care system. However, his comments fit neatly within other people's narratives. In many respects, Julio Ceasar, a former physiotherapist who now worked as a self-employed beautician, is a firm supporter of the basic tenets of socialized health care system. Implicit in Julio Caesar's narrative is the underlying premise that access to health care is a basic human right. After over 40 years of socialism, Julio had internalised the socialist government's position on health care. He was, as he stated, not concerned with critiquing what he believed were Cubans fundamental rights, defined as basic access to health services free of charge.

When I asked Julio Caeasar about his experiences with the MEF program, he gave me the following account:

> In my opinion, I don't like the *médico de familia* program. No doctor can know every speciality. For me, this idea of family doctors with a speciality in general internal medicine is very limiting. Scientifically speaking, I have my doubts about these family doctors. At least, I don't have confidence that they know what they are doing. I mean, if I have a dermatological problem, I want to see a dermatologist. Before in the polyclinics or community medicine programs, we could go directly to the specialist we needed to treat our specific problems. Now, the objective of the family doctors is to work within a defined area and work with people first to help eliminate people unnecessarily going to specialists directly. To me, it is another form of bureaucracy.
>
> At this point in Cuba, and I know this is an elitist thing to say; the majority of the population has been inundated with basic medical knowledge thanks to *la Revolución*. Generally speaking, most people are sufficiently educated to know, for instance, that if you get a blow to your arm or leg, you don't want to see a family doctor. You know you want to see an orthopaedic doctor, because you know that he is specialist in this area. You want x-rays and stuff. You go to the family doctor when you have a high fever or need to be vaccinated. If nothing else, *la Revolución* has raised the level of medical awareness in Cuba to a surprisingly sophisticated level.
>
> This whole idea about living together with your personal family doctor as your neighbour is a farce. I don't want any doctor interfering in my personal life. Personally, I don't want the doctor to know anything about me. Nobody knows what these doctors do with this information they collect on you. I am not sure these doctors are very ethical. I know of very serious cases, for example, of people who went to the family doctor for a sexually transmitted disease or something. These things are supposed to be kept strictly confidential, that is, between the doctor and the patient. However, very quickly the neighbours were gossiping about

it. This is the kind of lack of professionalism, and breach of ethics I am talking about. I think this is typical of the characteristics of *latinos.* Above all, we have characteristics typical of our Spanish heritage. We Cubans often refer to Spaniards as *chismoso* (gossips). Unfortunately, and I don't know why, I think Cubans have inherited a lot of this behaviour.

The mixture between neighbour, doctors, nurses, and patients is very intimate. It becomes hard to separate personal conversations from medical conversations. This is obvious. Of course, you cannot ignore the importance of having a doctor right there at your convenience, close by. However, I think the divisions between *médico* and neighbour need to be clearly defined. These doctors work closely with the government, and so you have to think, how much do I want this doctor to know about me?

Julio Caesar raises some important points that are recurring themes in this research, most notably the problem of local family doctors being considered as "unethical" or "state informers." Several individuals in both Dr. Pérez's *consultorio* and several other health areas stressed that, ultimately, the physicians work for the state. However, as several of these individuals further commented, family physicians are, in practical terms, of little use. As Julio Caesar and other interviewees remarked, it is more advantageous to have a friend who is a physician in secondary and tertiary institutions because (at the very least) they have more resources available to them than do local family physicians. Julio's Caeasar's neighbour, Dulce Frances, provides an excellent example of the latter.

Dulce Frances scoffed when I asked her about the family physician. "She is useless," she stressed. Dulce's mother had undergone chemotherapy recently and is severely ill. Her brother, she added, had sent all the medications and equipment needed for her mother's medical care from the US. Opening a drawer in her kitchen, Dulce Frances pulled out a stethoscope, needles, medicine vials, pills, and various bandages and gauze. She stressed that her brother had sent almost everything that she needed. She maintains close friendships with doctors who work in local hospitals, and calls on them if she needs medical advice. Dulce Frances is convinced that the family physician is a state informer (*chivato).* "Clearly," Dulce Frances remarked, "*el médico* is unable to solve the majority of the most basic medical problems." As Dulce Frances stated, on the rare occasions she needed Dr. Ochoa to write prescriptions for the local pharmacy, the doctor did not even have the correct paper to do so. Moreover, Dulce Frances resented the doctor wanting to visit her apartment and check up on her mother. She remarked that the doctor was absent throughout the treatment of her mother's cancer, which the doctor must have been well aware was taking

place, so she does not see any reasons why the doctor wants to become involved at such a late stage. The doctor, Dulce Frances declared, was simply being "noisy."

When I asked Dr. Ochoa if she would comment on her role in the community, she stressed that she had her work cut out for her. Some of the patients she treated are receptive and grateful, but others, she admitted, are outright resentful. The majority of the residents interviewed in *Santa María* see the doctor as being rather ineffectual. While several of her patients characterized Dr. Ochoa as a nice person, most people in *Santa María* could not recall the last time they had seen the family physician. Dr. Ochoa admitted that, despite her attempts, she was not familiar with all of the residents in her health area, as is stipulated by the program. In her own defence, Dr. Ochoa argued that many of the residents of *Santa María* go directly to one of the major hospitals that are within walking distance. In the emergency rooms, as Julio Caeasar noted, one can seek out the help of the relevant specialist directly. Having visited the emergency room several times myself, it was surprising to see that emergency room specialists are not too concerned about whether one first goes to the local *consultorio* or not. In addition, the local hospitals can carry out medical tests that are not possible in the local *consultorio,* and as a result many patients bypass the *consultorio* altogether. In effect, this practice is working against the stipulated objectives of the MEF program.

Part of the problems with the MEF program, Dr. Ochoa noted, is the legalization of the US dollar. Differential access to US dollars, according to the doctor, changes the inter-personal dynamics of the *Edificios Santa María.* Throughout her two years in *Santa María*, she had noticed a visible decrease in community participation in mass organizations, although a recent dengue fever outbreak in the city had brought the building's residents closer together. Dr. Ochoa had helped coordinate a massive hygiene and clean-up campaign. Residents of the building worked together in the revolutionary spirit, she said, to eradicate potential breeding grounds for mosquitoes. This was a sign, she suggested, that there is still hope for *Santa María*, but more resources are definitely required to better equip family physicians and local *consultorios.*

4.3 Social Medicine as Political Ideology

In my community, and other similar rural communities, the doctor arrives like the chief (cacique) of the place. Everybody depends on the doctor to solve his or her problems. I remember one day in particular, the people called on me to decide if a person should be thrown out of the community. I said, "How is this possible?"

They said, "Doctor, you are the one who can decide who can stay or who can be removed from here. This man is a thief and a drunk." The pueblo (community of people) depended on me to hand out justice as the médico de la familia. In these communities, the doctor is everything. Logically, the pueblo identifies with the doctor as a person that is more cultured than they are. The doctor is considered to have greater reasoning skills than the average person. In the capacity as a doctor, therefore, I may speak with greater authority about what the community's problems are, and so forth. In addition to everything else, the doctor works to identify the social problems or, let's say, the doctor manages the problems of the community. For example, I designed a project in my community that was not just about diseases, but also about fixing and cleaning up the streets. I knew that the community was in a poor physical condition and full of weeds and trash. I also wanted to fix the communal water well and paint all the houses.

Of course, these activities were not directly associated with individual health. However, it is my belief that by improving the overall social environment, I was also improving the mental well-being of the pueblo. The individuals in the community felt that I was participating in bettering their social situation, and therefore they respected me more. They loved me more and saw me as kind of a leader.

— Dr. Alberto Navarro, Family Physician, born in Cienfuegos, 1971.

In the above quote, Dr. Alberto Navarro described his experiences as a family doctor in the rural outpost he was assigned to shortly after his graduation from medical school. His sense of pride in describing his experience was linked to his ability to address the communities' health and well-being by attempting to improve their social environment. What is not explicit in Dr. Navarro's narrative, but of equal importance, was the physicians' *political* role in the community. Community health and well-being, for Dr. Navarro, are equally about managing dissent and reinforcing the state's sense of community. As Dr. Navarro further noted, his work in the community was effective because he was able, in his own words, "to manipulate people into participating in their own health reform." By prompting citizens to work together toward a common goal, that is, a healthy community, the physician was also promoting a specific orientation toward *la Revolución:* integrating the individual's notions of self into state objectives.

In many ways, the role of physicians in local communities (whether urban or rural) is about "curing" what Ernesto "Ché" Guevara suggested are the social ills of society. One the clearest programmatic statements that links Cuba's family physicians to a political agenda is provided by the MINSAP, which declares family physicians should " . . . abide by moral and ethical principles of deep human, ideological and patriotic content; such as to dedicate [their] efforts and knowledge to the improvement of the health of humankind, to work constantly where society requires [them] and to be always available to offer the necessary medical attention where it is needed . . ." (MINSAP, *Carpeta Metodológica* 2001: 10). Furthermore, part on the honour code for Cuban health professionals is to pledge allegiance to *la patria* (homeland) and make an oath to maintain the socialist character of the health system, which the MINSAP declares as the moral and ethical basis for all of their actions (MINSAP, *Carpeta Metodológica* 2001: 8-11).

While Dr. Navarro's narrative is easier to read in many respects because of the self-aggrandising tone, the two ethnographic case studies presented earlier are also revealing, if in less obvious terms, particularly for the purpose of examining the disjuncture between Cuba's social health ideology and individual and governmental practices. Various cross-sectional studies carried out by Cuban public health officials (Medina Lorente *et al* 1998) have indicated that, in general, close to 80 percent of the population in specific areas of Havana are satisfied with the MEF program (see, Table 4-3). In addition, several longitudinal studies (implemented before and after the incorporation of the MEF program) suggest that the MEF program has significantly (statistically speaking) affected the level of health awareness of the general population in the City of Havana Province (Vera Castillo *et al.* 1989; Jova and Padrón 1989; Pérez Peña 1989).

In health areas similar to the *consultorio* of Dr. Pérez it is possible to see where community members respond positively to the MEF program (with results similar to Table 4-3). Dr. Pérez's effectiveness in his communities, I would suggest, stems from his ability to seamlessly integrate himself into people's households. For instance, with his patient Benî, it is evident that a "cure" includes Benî's participation in public mass organizations, which, as I have discussed in chapter three, are an effective means by which to encourage

people to embrace socialist values and ideas. It would be erroneous to see this process as one in which individuals are being duped by a form of false consciousness, uncritically embracing the values of socialism wholeheartedly. Rather, I argue, this process operates in a more subtle fashion. The MEF program relies heavily on the underlying tenets of Cuba's socialist ideology, such as treating people as an integral a part of their specific social and material environment. Given the restricted resources available to physicians participating in the MEF program, it is evident that their activities are limited in many ways to disease prevention and health promotion rather than treatment. However, the importance of the former approach cannot be underestimated. I will examine this theme in chapter five and six, in particular, the role of physicians in buffering the effects of macro-economic changes brought about by the *período especial.*

Table 4-3: Satisfaction of the population with the MEF Program by sex, 1996

Level of Satisfaction	**Females**		**Males**	
	No.	**%**	**No.**	**%**
Satisfied	190	85.7	53	81.6
Partly satisfied	17	7.6	10	15.4
Not satisfied	12	5.4	2	3.0
No opinion	3	1.3	0	0
Total	222	100.0	65	100.0

Source: Medina Lorente *et al* (1998).

As Dr. Pérez noted, "alienation and depression" are at the root of many people's health problems. A recent MEF survey of 121 Cuban family physicians, 17 health leaders, and 26 administrative personnel leaders suggested that, following direct biological problems, socio-economic factors were among the major contributors to health problems. Two other areas were also identified as following in relative importance: lifestyle choices that presumably put individuals at risk, and personal and community hygiene (cf. Rodríguez and Zayas 1997). The results of this study are not surprising given that, as I outlined in chapter three, up until the 1980s, the revolutionary government had been effective in combating the "diseases of poverty" that typically fit within the one agent-one disease model of causation. However, the rise of chronic non-communicable diseases that became major health problems in the 1980s severely challenged the MINSAP's approach to social medicine. The implementation of

the MEF program represented an epistemological shift in the approach to dealing with various health problems. The MEF program stresses the importance of relative associations between variables — including those defined as socio-economic and cultural — and between clusters of variables and diseases (I will expand upon this theme in chapter five).

In practice, highly trained physicians with little equipment are better suited to managing non-communicable chronic health problems than to addressing complex health problems. In many ways, the physician's role is limited to promoting healthy habits in communities and to screening community members for referrals to other secondary and tertiary institutions (cf. Dunning 2001). However, when viewed through a more theoretical lens, Dr. Pérez's "alienated" patients bear a resemblance, in Marxist terms, to the effects of the historic class struggle toward socialism (and then communism). In this respect, then, Dr. Pérez's prescription of healthy doses of "social integration" in his *consultorio* appears in line with the state's objectives of producing "healthy socialist citizens".

Evident from the interviews conducted in Dr. Ochoa's *consultorio*, physicians must negotiate a fine line between their role as health providers and that of perceived state officials. The ability of physicians to integrate themselves effectively into local communities is key to their success in completing their stipulated mandates. Historically *la Revolución* diminished the class stratification that was apparent in the pre-revolutionary era. The state's sense of community, defined by a strong sense of social cohesion, was easier to enforce because individuals, theoretically, were provided with equal opportunities and equal rewards. In an environment of egalitarianism, the work of physicians was facilitated by the strong presence of the state, which, in response to community health matters, reinforced the ideology of various institutions, such as the control and distribution of resources, the media (for example, health education campaigns), and mass organizations. As I will argue in chapters five, six and seven the recent *período especial* has redefined the state' sense of community. The current ideological tools of family physicians are thus compromised in combating the ever-increasing socio-economic stratification and the subversive practices that work against revolutionary principles. A physician I interviewed at MINSAP suggested that the MEF program would soon be undergoing major

transformations that would allow it to become better suited to confront the new problems faced by individual Cubans. In this respect, health policy was once again being refined to confront new social and political challenges.

4.4 Cuban socialism on the International Stage

Cuba's domestic health policy is not the sole form of political technology being developed in Cuba's revolutionary armoury. Like its domestic public health policy, Cuba's foreign policy has also used health care as a tool to promote socialism. Feinsilver (1993) suggests that "medical diplomacy" — Cuba's program for "proletariat internationalism" — has historically been used as a form of symbolic capital (prestige), particularly in relation to the US. However, beyond Feinsilver's (1993) limited assertion, the Cuban state uses family physicians (among other health professionals) as a means to promulgate its socialist ideology, illustrate the strength of political will to achieve specific goals, and bolster support for its commitment to a humanitarian regime, a commitment it believes to be a defining feature of socialist governance.

In closing this chapter, I turn to the experiences of one physician I interviewed who best sums up my assertion that Cuba's health policy is a technology of politics. The physician worked as an *internationalista* in a remote region of Nicaragua for two years in the early 1990s, running the "Integral Health Program," a program funded by the Cuban government and similar to Cuba's MEF program. In the context of political changes in Nicaragua in the early 1990s and the popular backlash against the leftist-leaning Sandinista movement, the doctor explained that many of his patients disparagingly referred to him as a 'communist' when he walked through the villages. Yet these same individuals lined up in droves for medical care, which was provided free of charge by the Cuban government. As the doctor stressed, while treating the patients he reminded them that, despite being communists, it was Fidel Castro and the Cuban people who had paid for their medical care. The doctor felt that by the end of his two-year post in the village, the community had grown to respect him, and with that, the Cuban government's commitment to a humanitarian approach, that he noted was a product of Cuba's socialist orientation. From this perspective, then, Cuba's international health policy can be viewed as being as deeply rooted in politics as in its domestic program.

Unlike the mid-1960s and 1970s when Cuba, as part of its program to "export Revolution," was active in leftist insurrection movements throughout Latin America and parts of Africa, the government's foreign policy now adopts other means to attain the same ends. According to the Cuban Embassy in Ottawa, Canada, Cuba's "medical missions" currently consists of 1929 men and women who make up 47 medical teams in fourteen countries. A total of 2638 collaborators have already contributed their services through the "Integral Health Program." This has involved giving medical attention to more than 4,666,913 persons, including more than 42,611 surgical operations. They have also assisted at 22,655 births and in addition Cuban assistance has provided vaccinations to 142,975 persons to provide protection against ten different kinds of illness (http://www.embacuba.ca, March 2003).

An interview I conducted with a former Cuban diplomat in London who worked in several Latin American countries provides an excellent example of the underlying reasons behind Cuba's "medical missions." The diplomat claimed that, despite the involvement of certain governments, for example Nicaragua and Guatemala, in political acts against Cuba, the Cuban government was still committed to providing free medical assistance to those countries. As the diplomat concluded, Cuba wanted to demonstrate that socialism was about promoting solidarity, but not about forcing people to embrace socialism against their will. Similar to Dr. Pérez's belief that he "leads by example," the official claimed that Cuba uses actions and not words to demonstrate the power of socialism. He asserts that political will is the reason that Cuba accomplish its goals, and that individuals in various countries who benefit from Cuba's free medical aid come to understand the extent of Cuba's generosity in their own terms.

Not surprisingly, the Cuban Television Network is often not far behind their *internatinalistas,* regularly featuring them (and the people they treat) in the daily news. The smiling faces of people from myriad countries are projected into Cuban households, replete with interviews with benevolent Cuban physicians — in some of the most remote regions of the world — treating individuals, many of whom have never seen a doctor before in their lives. The moment of epiphany, rarely lost to Cuban media observers, is when grateful patients chant the name

"Fi-del, Fi-del, Fi-del!" *La Revolución*, figuratively speaking, is reaching out its arms to the world.

In a similar vein, the Cuban government provides medical scholarships to students throughout Latin America, Africa and Asia. More recently, scholarships have been extended to include visible minorities from the USA, whom the Cuban government contends are victims of systematic discrimination. The goal of all medical-school scholarships, health officials assert, is to support Cuba's dedication to "internationalism," and to train students in social medicine from all over the world in order that they can return to their own countries to practice medicine (see, for example, Berman 2001; Gordon 2001). Equally, however, students receive training in a medical school curriculum that explicitly incorporates the underlying tenets of socialism. In this respect, Cuba's program for "international solidarity" is about producing physicians on an international scale who reflect Cuba's socialist values and ideals.

4.5 Conclusion

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (Foucault 979: 94)

Cuba's MEF physicians, similar to physicians in neo-liberal contexts, are not neutral members in the communities in which they work. Rather, these physicians work on the individual and social body, and this work constitutes a form of governance over both the individual and the community. In other words, the family physicians actions constitute " a form of activity aiming to shape, guide or affect the conduct of some person or persons" (Gordon 1991: 2). For example, central to Foucault's argument is that in Western democracies, the ". . .modern state has been deployed mainly through social regulation that acts on the heart, mind, and the will, dedicated to making individuals, families and collectivities 'governable'" (Ong 1995: 1243). Cuba's current MEF program, analysed here as a form of governance, is considerably more than an "innovative" approach to primary health care. In effect, the MEF program is a means by

which the state, at both the collective and individual level, works through physicians to foster socialist values.

Some of the stated objectives of the MEF program, as described above, have led to accusations by international health-policy critics that Cuba's current program of health care is not solely social medicine, but a form of social control. Dalton (1993), for example, argues that, "the reorganization of medical care in Cuba reflects the Cuban regime's attempt to harness the medical profession in the service of social control well beyond that necessary to meet acceptable standards of individual health" (1993: 126). His argument is clear. Cuba's socialist primary health care system goes well beyond the *acceptable level* of social control that is implicit in the practice of contemporary medicine. However, what Dalton (1993) fails to address is, what are the parameters for a "necessary" level of social control? Clearly, several analyst of medicine have argued that, the rise biomedicine in neo-liberal contexts is involved in the regulation, surveillance, medicalization and, importantly, control of subjects (see, for example, Foucault 1980; 1984 Lupton 1995; Navarro 1977; Taussig 1992). The question, then, remains, how is the practice of medicine in Cuba's socialist context different (or similar) to neo-liberal contexts?

The assumption in much of the literature on socialist governments is that state power is manifested in explicit forms of oppression and domination (cf. Horowitz 1995 critique of Cuban socialism). However, an interpretation of the MEF program making use of a theoretical lens that focuses on of the social control and discipline is limiting. A more fruitful analysis, I argue, is to examine how different political subjects are produced by the means of subterfuge of state power. Employing the latter perspective, which I have done in this and the following chapter, enables a critical examination of the way in which the revolutionary government has used individual health as a building block in the construction of the socialist state. The MEF physicians have a dual role. In one respect, physicians' work to alter unhealthy lifestyle choices, and in this respect their work operates within a normalizing model of 'disciplinary power.' In this sense, part of the physicians' job is about the "corralling" of individual behaviours to meet state objectives. For example, under the auspices of the MEF program initiatives, family physicians assess not only "bio-psycho-social" factors, but also political factors that address their patients' revolutionary involvement

and adherence to ideological principles. In this respect, physicians operate as part of the ideological state apparatus. However, physicians do not act directly as agents of the state strictly through a process of control and repression. As I have illustrated in the two-case studies, physicians' effectiveness in promoting change in their communities is dependent on several factors. These factors include the physicians' abilities to integrate themselves in the communities in which they work, and more specifically, the degree to which any given community is reliant on the services of the local physician.

On the other hand, physicians also promote a form of individual self-regulation, which is closely related to 'techniques of the self,' that of educating citizens to take responsibility for their own health. This is where the role of Cuba's physicians is unique. The processes and mechanisms by which new norms of conduct — often promoted through state health policy — become internalised, resisted, and adapted to, as part of people's everyday lives (see, for example, Lock and Kaufert 1998; Shore and Wright 1997; Nichter and Lock 2001) is often eclipsed by a focus on social control. Physicians' work to produce a new kind of subject, that is, the revolutionary, and this has interested results, as I will review in chapter six and seven, in Cuba's changing socio-political context. As the two-case studies suggest, communities that reflect greater socio-economic diversity have a level of community cohesion that is quite different from those with less socio-economic stratification. The role of the family physician is diminished when citizens find more advantageous means to solve their immediate health problems: for example, to solve individual health problems, citizens with regular access to US dollars bypass the local physician altogether, or simply seek out friends who work in the medical field, or rely on relatives who reside outside the country. I will expand upon this latter theme in s six and seven. In the next chapter, I examine one of the key areas of the MEF program: the epidemiological-risk evaluation program also known as *dispensarización*. The notion of being at risk, I will argue, has become a central feature of Cuba's current public-health program, especially its health-promotion campaigns.

Chapter Five

"Making up People:" Epidemiological-Risk, Preventive Strategies and Productive Bodies

In 1990, during my last pregnancy, when I was expecting my son José, I had this young médico de familia *who was a complete nuisance. He told me that at my age — I was only 36 years old — I should not have become pregnant a second time. But I had then the financial conditions to have another child and I wanted to have another child. It was clear, however, that the doctor was not in agreement with me. For example, when I asked the doctor to give me a medical certificate so that I did not have to work one day because I was physically exhausted, which is quite normal during a pregnancy, he told me there was absolutely nothing wrong me and that if I could get pregnant at my age, then I could work. I am a strong-willed person, so of course, I was not going to go to work if I felt that I was weak, so I went to directly to the paediatrician that attended my first child and he signed the medical certificate without any problem. The other* médico *acted the way he did out of spite because he was convinced that as a 36 year-old woman, I should not have become pregnant. I gave that young* médico *a piece of my mind the next time I saw him. I told him, "It is my body, and I will do whatever the hell I want with it." This imaginary age when you cannot have kids is rubbish. Just go to the countryside (*el campo*). The women there are giving birth at 40 and still having more kids, and they are born perfectly fine, without all this bureaucracy (*mucho papeleo*) around them! If I have a choice, I avoid the young* médicos*, because they are too eager and try to do everything by the book but without enough practical knowledge. In real life, no* médico*, much less those young ones, can do all the stuff the state wants them to. If I need any kind of medical attention for my kids, or myself, I go directly to the paediatrician, who is an older, knowledgeable man. The* médicos de familia *are all talk, but what can they really do?.*

— Sra. Elíana Gutiérrez, self-employed, born in La Habana in 1955.

5.1 Introduction

In chapters three and four, I argued that the revolutionary government places a strong emphasis on specific primary health-care programs: for example, for women of childbearing age, with priority given to maternal and infant-care programs. As I previously argued, this commitment reflects in part the official public-health discourse in Cuba, which extols the virtues of Cuba's socialist health policies and cites the country's infant mortality rate, highly praised in the

international community[1], as an example of Cuba's important status as a "medical power." All of these activities have meant a dedication of considerable amounts of institutional, financial and popular support to achieve these goals. What is at stake in Cuba's drive to "manage" its health statistics? For example, what are the everyday experiences of the people subjected to increased "public health incursions" into their daily lives? These issues have not previously been addressed. This chapter pursues these questions, and in particular examines several of Cuba's health promotion and health education campaigns that survey communities to detect, register, treat and educate the general population on factors affecting their health. As the opening excerpt from an interview I conducted with Sra. Elíana Gutiérrez attests[2], individual citizens are not disciplined subjects who passively incorporate the state's primary health-care objectives into their everyday practices. Rather, individuals can and do critically respond to their daily bombardment of health-education and disease-prevention campaigns that address their everyday lives: the *consultorios*, family physician home visits (*terreno*), and health campaigns carried out through mass organizations and the popular media.

In the first part of this chapter, I provide a brief theoretical discussion concerning the emergence of epidemiological-risk and its role in public health,

[1] As has been noted by many scholars (A. Chomsky 2000; Roemer 1963; Santana 1987; Ubell 1989), Cuba's population health profile is a leading example of success in Latin America and the Caribbean, and the country's health profile is closer to that of "developed" countries than of "developing" ones. In acknowledgement of this fact, in 1985 Castro announced that Cuba would no longer compare its health statistics with those of developing countries but with that of the United States (cited in *Granma Weekly Review,* 1985: 3). This move, both strategic and ironic, was reflective of the tenuous US-Cuban relationship, and Cuba's desire to become a "major actor" on the world stage despite its status as a "developing" country with scarce material resources.

[2] This chapter will not deal with the ethnographic experiences of expectant mothers. In chapters three and four, I provide a detailed description of the maternal and infant health-care programs. Under the MEF program, the basic requirements of mandatory pre-natal care and the daily monitoring of newly born infants remain the same. It is important to note, however, that none of the women who participated in this research (in total, over 65 percent of my informants were women) expressed any complaints regarding the mandatory pre-natal exams, institutional childbirth, or, importantly, the daily visits from the family physician for newly born infants. Without exception, however, all of the women with children interviewed were upset that "Fidel" (often times used synonymously for the state) had taken away the special rations (such as milk) for children when they turned 7 years of age. As one women stated, "Older children are no longer important because they are at an age when the statistics do not count." I interpreted these remarks to be in direct reference to the frequent reporting of the IMR in Cuba, which is classified in two categories: one rate, from birth to the first year of life, and the second rate, from birth until the infant's fifth birthday.

where public health is part of the governing of populations. In the second section, I draw on ethnographic case studies in Cuba — for instance, the HIV/AIDS education and prevention campaigns and the campaigns against dengue — to explore how epidemiological-risk discourses and preventive strategies operate, and how they may be taken up, negotiated or resisted by those who are the subject of them. In the final section, I examine how the notion of "community surveillance" was historically influential in Cuba's programs for epidemiological vigilance (for example, the involvement of mass organizations in health initiatives). The arrival of the *período especial*, however, has seriously dampened the intimate relationship that previously existed between the individual and the state and, as a result, subtly undermined the ability of the institutions of the state to identify "risk behaviour" (for example, social, political and health-related) in local communities.

5.2 Epidemiological-risk: Some Theoretical Considerations

There exists a vast body of literature on the relationship between risk, public health, and epidemiology. It would be unrealistic, however, to attempt a comprehensive review of all of this material. Rather, the scope of this discussion will be restricted to tracing the historical interrelationship between the meteoric rise of the concept of "risk" in public health and the emergence of the field of epidemiology. Ian Hacking (1991), for example, advances his thesis of how "statistics has helped determine the form of laws about society and the character of social facts" (1991: 181). Arguing for a historical approach that emphasizes explanation rather than "therapy," Hacking suggests that philosophers need to deliberately limit themselves to several questions in order to make " . . . use of the past for understanding some of the incoherence in present ideas" (1991: 184). Such an approach, he argues, "... cannot aim at exhausting the historical material, but rather at producing an hypothesis about the relationship between concepts in their historical sites" (1991: 184).

Extending on Hacking's approach, I argue that the emergence of the science of probability and statistics in the nineteenth century provided a template in which public health, through epidemiology, could determine norms and identify deviations from the norms. This embodied the belief that rationalized counting and ordering practices could bring disorder, namely the

transmission of disease, under control (Hacking 1990). Thus, in this section I trace the historical development of public health in liberal democratic societies, and emphasize how epidemiology became the predominant mode of inquiry in public health (cf. Inhorn 1995). As I will illustrate, the emergence of public health in the nineteenth century was conditioned, in part, by three factors. First, the rise of statistics and probabilities resulted in the "making up" of people (Hacking 1986). Secondly, the mass urbanization and industrialization of the Industrial Revolution wrought great social change and upheaval. Thirdly, health became an economic concern that was in need of surveillance and regulation (Foucault 1980).

The History of Statistics and the Taming of Change

Ian Hacking's *The Taming of Chance* (1990) is often cited as the most significant piece of work to argue that statistics produced novel forms of social relations and, through this, modern society. At the heart of Hacking's position on the "erosion of determinism" at the end of the nineteenth century is the belief that, as a result of this erosion, we now live in a society where previous conceptions of human nature have been replaced with the laws of chance, expressed in terms of probability. Gigerenzer and Murray (1987) have coined this transition the "probabilistic revolution," which describes the transition from a deterministic understanding of science, in which recognition of uncertainty and variability were not acceptable, to an understanding of science where probabilistic ideas became indispensable[3].

The success of this "taming of chance" in the nineteenth century, Hacking argues, led to an increased concern by nation-states with classifying, tabulating, and counting their subjects. As Hacking (1982) points out, however,

[3] As different historians of statistics have noted (see, for example, Gigerenzer and Murray 1987; Porter 1986), statistical probabilities came into existence between 1820-1900 out of earlier concerns with classical probability. It was not until the eighteenth century, when further developments in mathematics such as the application of probability theory to data (that is, a sample space or population groups), called "statistics," did probability theory become institutionalised. Statistics, first used in the eighteenth century as a descriptive and non-historical science of states, became in the early nineteenth century increasingly identified with numbers, and by the 1830s it was perceived almost unanimously in Britain and France as the numerical science of society (Porter 1986). Only at the end of the century was there a reasonable basis for defining it as a mathematical field concerned with manipulating and, more particularly, with inferring conclusions from numerical data.

this new desire for enumeration was connected to "an avalanche of printed numbers" that arose chiefly from attempts to govern populations through taxation and military recruitment. It became possible to imagine a world where the art of governing populations required the enumeration of people so that they would be fit into statistical categories. Enumeration technologies served the ever-wider practice of inventing categories into which "people could conveniently fall in order to be counted" (1990: 3). This process of counting and categorizing inevitably led to a second process of separating and ordering, and this classifying led to what Hacking refers to as the "making up of normal people." By applying the laws of chance to people, it became possible to identify people as falling within the category of normalcy, or as deviating from that norm. As Hacking asserts, however, the paradox of this process was that "people spontaneously [came] to fit their categories" (1986: 223). Such transformations have had consequences for the ways in which we both classify and conceive of ourselves, and indeed, others (Hacking 1986). Hacking (1986) suggests that, rather than think of classificatory labels as static, we should view this process as a kind of 'dynamic nominalism":

> The claim of *dynamic nominalism* is not that there is a kind of person who came increasingly to be recognized by bureaucrats or by students of human nature, but rather that a kind of person came into being at the same time as the kind itself was being invented. In some cases, that is, our classifications and our classes conspire to emerge hand in hand, each egging the other on. (Hacking 1986: 228)

In this respect, these newly invented categories not only produced "populations" in which people could be identified, but also became the categories through which people produced their identity. This generated a particular way of governing people.

Population Changes and the Public Health Movement

From about 1750 through to the height of the Industrial Revolution in the later nineteenth century, the population of Europe increased rapidly, and with this increase came a heightened awareness of the rapid urbanization and changing conditions of the urban poor. The increase in the urban populations, for example, far exceeded available housing and led to the development of conditions of widespread disease and poor health (cf. Armstrong 1983). As the

Industrial Revolution developed, the health and welfare of the workers deteriorated, and the effects of ill health on the productivity of the labour force became a source of concern for the state. Within this context, the state's concern with health as a political-economic resource that people must strive toward emerged out of a set of historical circumstances, which, I argue, can be analysed as tripartite: first, state counting practices (quantification) which made it possible to start thinking about bounded "populations" (for example, census data and community surveillance); second, the clinical recognition of disease as a countable phenomenon; and, third, the spread of ideas connecting sanitation and hygiene to disease transmission. The rise of public health as an institution was interdependent with the ability to think of a "population" which could be managed, and the possession of the techniques and strategies in which to do so.

Public health has often viewed the body as dangerous, problematic and, when diseased, even imminently threatening to the rest of society (Lupton 1995). Foucault (1980) argues that the modern state's preoccupation with controlling bodies developed in Europe in the eighteenth century in concert with the birth of the medical clinic (cf. Foucault 1963). The rise of the medical clinic, he argues, conditioned the growth of demand for individual medical care and focused on clinical care a concern with the preservation and upkeep of the labor force. During that time, Foucault points out a new discourse emerged, which viewed disease as an economic and political problem for societies, not just an individual concern, and which therefore required collective control measures (Foucault 1980: 170-172).

By the turn of the eighteenth century, "different power apparatuses [were] called upon to take charge of 'bodies' ... to help and if necessary constrain them to ensure their own good health" (Foucault 1980: 170). Surveillance was directed in particular towards the family unit, including such behaviors as child-care, physical exercise, food preparation, inoculation and vaccination, and the maintenance of hygiene (Foucault 1980). In the eighteenth-century, the early modern European states began to think of society as an aggregated "population" of citizens. This social body required intervention, management and protection so as to maximize wealth and productivity. Characterizing populations with demographic estimates, marriage and fertility statistics, life expectation tables and mortality rates became a technology of population control, central to the

project of government (Foucault, 1980; Lupton 1995). Both the individual body and social bodies (as populations) became systematically associated with recognizable variables. These variables included not only those that distinguished between the healthy and the sick, and the strong and the weak, but also those that differentiated the more from the less productive (Foucault 1980: 171). As Foucault notes, these changes represented a point of intersection of a new "analytical economy of assistance with the emergence of a general police of health" (Foucault 1980: 171).

Medico-Social Surveys: The Emergence of Epidemiology

With the emergence of a "general police of health," the public health movement in the late nineteenth century developed a new technique to aid in the surveillance of bodies. What Armstrong (1983) refers to as medico-social surveys were tailored by the development of quantitative methodologies: for instance, methods acquired through the development of statistical methods and concepts. This led to a concern with "crowd diseases" or the study of the transmission of diseases throughout populations (Armstrong 1983). Armstrong (1983) points out, for example, that the medical Dispensary in nineteenth century England was concerned with disease as a social phenomenon and that this led to an increasing practice of community surveillance. However, community surveillance was a self-fulfilling prophecy: the discovery of disease in the community necessitated further surveillance (Armstrong 1983: 37). As Armstrong argues, these factors were influential in the release of "epidemiology from its 'experimental' cul-de-sac" (Armstrong 1983: 46). The increasing detection of diseases in communities emphasized the importance for epidemiologists of extending their "laboratory" beyond experiments with animals to include the observation of human populations.

One of the most significant contributions to the development of epidemiology has been the systematic recording of such vital events as births, deaths, and illness in the population during the period of industrialization and urbanization in Europe and the United States (Lilienfeld 1976). This information provided material for comparative statistical studies of morbidity (illness) and mortality in different population groups. In England, for example, in the early nineteenth century, the need for a national system of birth and death registration was recognized and, in 1837, a General Register Office was

established (Armstrong 1983). William Farr, a physician, became responsible for medical statistics as the "Compiler of Abstracts." Farr was influential for his use of statistical data to make epidemiological inferences and test various epidemiological hypotheses of the time (including the miasmatic causes of cholera) in an attempt to describe the development of epidemics in mathematical terms. As a result of his work, vital and health statistics came to assume an important role in the emerging field of epidemiology (Lilenfeld 1976).

At the same, research in bacteriology was also important in shaping the objectives of epidemiologists, particularly the way in which they sought to identify the transmission of disease in populations (Gifford 1986; Trostle 1986b). In the last decades of the nineteenth century, for example, a team of French and German chemists — Louis Pasteur, Ferdinand Julius Cohn and Robert Koch among others — developed methods for isolating and characterizing bacteria. The isolation of agents responsible for causing various diseases, such as typhoid, tuberculosis, and cholera, led to the development of the Henle-Koch postulate, which states that each disease must have a unique cause (Trostle 1986a). The Henle-Koch postulate built on earlier work — the germ theory for example — that explained the aetiology of disease in terms of sufficient or weakly sufficient causes: which is to say, a particular effect (a disease) occurs after exposure to one or more causal influences, of which contagion might be one.

The impact of the germ theory and of Koch's postulate was to introduce the notion of causal necessity in addition to that of causal sufficiency (Kunitz 1987). Stephen Kunitz (1987) describes these two notions as follows:

> A necessary cause is one in whose absence a particular effect cannot occur. In the case described by Koch, tuberculosis could not occur in the absence of the tubercle bacillus. The bacillus was also sufficient, or weakly sufficient, in that tuberculosis had a high probability of occurring in its presence ... Many diseases could now be classified etiologically as well as anatomically or symptomatically. Disease specificity became increasingly possible, and with it the possibility of disease-specific interventions that would be applicable in all places and among all people, regardless of topography, climate, and culture (Kunitz 1987: 380).

In the nineteenth century, therefore, the efforts of health departments to control contagious diseases consisted of attempts to improve environmental conditions. As bacteriologists identified the microorganisms that caused

specific diseases and learned how they produce their effects, progress was made toward the control of specific infectious diseases. The emergence of the field of epidemiology in the late nineteenth century documented patterns of disease across groups.

As in laboratory experiments, epidemiologists required human control populations. This entailed the creation of "normal control groups" by which disease became constituted in the social body rather than the individual body and the identification of deviant types requiring control for the sake of the health of the whole population (Armstrong 1983). Nineteenth-century pubic health endeavours sought to tackle hygiene and sanitary conditions in the city, such as the air and water quality and sewerage arrangements, to reduce the incidence of epidemic diseases. As Armstrong notes, the new medico-social survey became an important instrument in this growing concern to discipline populations, "an instrument of order and control, a technique for managing the distribution of bodies and preventing their potentially dangerous mixings" (Armstrong 1983: 51). The germ theory, Kunitz (1987) argues, had made possible a more efficient and economical attack on the causes of mortality.

In England, the Poor Law Commission, created in 1834, explored problems of community health and suggested means for solving them. An 1838 report argued that the expenditures necessary for the adoption and maintenance of measures of prevention would ultimately amount to less that the cost of the disease then constantly engendered. Sanitation surveys proved that a relationship existed between communicable disease and filth in the environment (this putting older miasma theories on a scientific footing), and it was said that safeguarding public health was the province of the engineer rather than of the physician. Filth was declared to be a public enemy that endangered the health of whole communities (Armstrong 1983). Epidemiological strategies, therefore, were directed at altering environmental conditions in an attempt to improve health at the population level. In other words, the emergence of epidemiology as a medico-social survey involved "the tracing of illness and disease in specified populations using statistical and screening techniques, linking illness and disease with their causal variables in the attempt to predict health outcomes at the population level" (Dean 1997: 218).

While improvements in environmental sanitation were of great value in dealing with some problems, they were of only limited usefulness in dealing with many health problems found among the poor of the community. In the poor areas of England and the United States, for example, malnutrition, venereal diseases, alcoholism and other diseases were widespread. In addition, the rise of chronic diseases in the late nineteenth century demanded a critical reworking of the simplistic Henle-Koch model of disease causation (causal necessity), calling for a multiple-causation model of disease (multiple sufficient causes). Causes of morbidity and mortality in industrial societies thus changed from infectious diseases (which fit the model of causal necessity) to chronic diseases (which fit the model of multiple weakly sufficient causes) (McKeown 1976a;b; Kunitz 1987).

Thomas McKeown's (1976a; 1976b) explanations of the contemporary shifts in mortality patterns outline how, until the twentieth century, therapeutic and preventive measures undertaken by individual physicians with individual patients had no impact on the decline in mortality. As he further argues, even after the development of antibiotics, the contribution of the personal physician system has been minimal and, until the middle of the nineteenth century, the protection of water supplies and disposal of sewage had had no effect on mortality either. The main influences, in order of time and importance, McKeown argues, were environmental (nutrition and hygiene), behavioural (control of reproduction), and medical developments (immunization and therapy) (McKeown 1976b: 98; Kunitz 1987). What makes McKeown's work so important is that he asserts that the personal physician system and biomedical research made only a minor contribution to declining mortality. Rather, he emphasizes that social and economic development had proceeded so far that individuals were "now freer than they had ever been before of exogenous forces affecting mortality, and that endogenous forces under the control of individuals themselves were now the major determinants of morbidity and mortality" (Kuntiz 1987: 392).

In this regard, causal variables, including "factors of risk" such as the link between smoking and chronic heart and lung disease[4], became crucial to the project of individuals taking responsibility for their health (Gifford 1986; Trostle 1986b). Thus, the epidemiological concept of risk created a complex picture of "webs of causation" and presented disease incidence in populations as the sum of the individual cases, thus thinning the social context of disease to measurable attributes of individuals (DiGiacomo 1999: 440). Increasingly, then, populations from the late nineteenth century onward were managed on the basis of profiles of "naturalized and unproblematized" (DiGiacomo 1999: 440) social variables such as age, social class, occupation, and gender. The enumeration technologies (Hacking 1986) and interventions used to identify "risk factors" took diverse forms. Moreover, these technologies were influential in the rise of the notion of "risk[5]" in contemporary epidemiology, highlighting the relationship between

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[4] In the 1940s, the Framingham coronary heart disease (CHD) study suggested that, "certain factors" are associated with "increased risk of development of coronary heart diseases" (cf. Kunitz 1987: 386). What was important about this study was that it marked the first use of the term "risk factors," which was similar to the previous understandings of "multiple weakly sufficient causes". In other words, this study represented a methodological shift away from the one-agent/one disease model of causation and stressed the importance of relative associations between variables — including those defined as socio-economic and cultural — and between clusters of variables and diseases (see, for example Aronowitz's 1998 discussion of the social construction of the risk factors for coronary heart disease).

[5] There are several different approaches to the study of risk "to which various ideological meanings have been attached" (Skolbekken 1995: 297). I have divided these approaches into three categories. The first approach, informed by a positivist position suggests that only science can produce knowledge that has not been predetermined by circumstances lying outside the facts it wants to understand (cf. Young 1978 on positivism and objectivity). In this respect, risk is viewed as an "objective" hazard, threat or danger that exists in nature and can be measured independently of social and cultural processes, but may be distorted or biased through social and cultural frameworks of interpretation. The second approach is a strong constructionist approach to risk, which I have divided into two parts. The first part, inspired by Foucauldian approaches, argues that nothing is a risk in itself, but rather what we understand to be a risk is a product of historically, socially and politically contingent "ways of seeing" (cf. Castel 1991; Dean 1997; Ewald 1991; Lupton 1995). For example, scholars who have taken up this approach illustrate how concepts of risk construct particular norms of behaviour, which are used to encourage individuals to engage voluntarily in self-regulation in response to these norms. The second part is that epidemiological-risk must be situated within a particular style of reasoning (see, for example, Hacking 1985; and Young's 1995 discussion of diagnostic categories for PTSD). For example, what are the ways in which epidemiological knowledge and practices are produced, applied, and rationalized. The third approach can be considered reconciliation between the first two approaches. It incorporates the epistemological critiques of epidemiological-risk into epidemiological practices. For example, the recent call in medical anthropology for a "cultural epidemiology" (Trostle and Sommerfeld 1996), which seeks a greater

public health and the governing of populations. The next three sections will further develop some of the theoretical points raised above and illustrate them with ethnographic data from Cuba's MEF primary health programs.

5.3 *Dispensarización*: Analysing the Health Situation of the Community

Over the past twenty years, Cuba's epidemiological profile, similar to the profiles of other economically developed countries, has come to reflect high levels of urbanization and low levels of fecundity and mortality. In contrast to the pre-revolutionary period, the mortality from infectious diseases and parasites has steadily decreased, from 45.4 per 100,000 in 1970 to 6.9 in 2001 (MINSAP, 2001, *Anuario Estadístico*). This rapid decrease in infectious diseases however, is now replaced with an increase in chronic debilitating illnesses, such as mortality from diabetes, which has risen steadily, increasing from 9.9 per 100,000 in 1970 to 21.3 in 1993 (MINSAP, 2001, *Anuario Estadístico*). For the past two decades, the principal causes of death (all ages) in Cuba were cardiovascular illnesses, cancer and accidents. A report authored by the MINSAP in 1996 contended that trends occurring in Cuba's epidemiological profile were directly linked to the

> "... factors of risk such as the habit of smoking, the ingestion of alcoholic beverages, cultural attitudes toward the consumption of unhealthy foods, and unsafe sexual behaviour all leading to illnesses whose prevention and control are dependent on changes to lifestyle" (MINSAP, *Analisis del Sector Salud*, 1996: 4).

In 1991, the Cuban Ministry of Public Health drafted a document entitled "Objectives, Aims, and Guidelines for Improving the Health of the Cuban Population 1992-2000"(*Objetivos propósitos y directrices para incrementar la salud de la población cubana 1992-2000, OPD)*. In 1996, this document was revised to stress four priority health programs. The priority programs included those dedicated to maternal and child health, chronic non-communicable diseases, communicable diseases, and the care of the elderly (cf. PAHO 2001: 2-3). These programs were to be integrated into the daily functions of the MEF program, which I outlined in chapter four. The MEF physicians follow ten basic primary

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collaboration between anthropologists and epidemiologists. My analysis draws on the Foucauldian approach to the study of risk and governance.

health care programs: five for treating people, three for improving the health environment and two for health administration.

My research was primarily concerned with examining three out of five of the programs addressing the care of individuals. These programs include the integral care of women aged fifteen and above, integral care of adults over fifteen, and the epidemiology program[6]. The program for the integral care for women gives priority to maternal and infant-care education, while the integral care of adults focuses on educating people to recognize, manage and prevent chronic and contagious diseases. Lastly, through the epidemiology program, all health education campaigns run by the MINSAP are monitored to survey their overall effectiveness in communities, in detecting, registering, treating and following up on persons who fall within their designated target categories, or on patients targeted through a health initiative called *dispensarización*. Under the surveillance system of *dispensarización*, it is expected that, after an evaluation of the health situation in a defined area has been carried out and the at-risk populations are defined by the physician-and-nurse health teams (*equipos básico de salud)*, each patient — for example, hypertensive, diabetic, expectant mother, and so on — will receive an assigned priority and differentiated treatment in accordance with nationally prescribed procedures and programs appropriate for their age, gender and risk factors (Waitskin *et al.* 1997: 1-2; Reed 2000: 1).

After the MEF health teams conduct an extensive risk-evaluation in their respective *áreas de salud*, a document known as a *fiche familiar* is formulated. As I discussed in chapter four, the *fiche familiar* is a record of preventive services and conditions for all patients in a region and is regularly updated (at minimum, every three months). In principle, the *fiche familiar* divides the health area into four basic risk categories (see, for example, Table 5-1 for detailed description of risk categories). Dr. Alberto Navarro, a primary health care physician I interviewed, and who worked for several years in a rural community, best summarizes these risk categories:

[6] The two remaining programs for individuals include integral care of children (under fifteen), and dental care.

> The *fiche familiar* allows physicians to categorize the population into four fundamental groups. Group One is the "healthy group", that is, "supposedly healthy." Group Two is the group with risk behaviour. Group Three are individuals who have illnesses that need to be monitored and kept in check. Group Four are people with illnesses that have specific consequences, for example, disabilities or specific impairments. As you can see, in each group, we assess the risk and what needs to be done. Group One, the healthy group we do not monitor; at the minimum, we must do an evaluation of an individual's health status at least two times a year. We monitor Group Two depending on the nature and severity of their risks. We have to assess the health status of individuals in this group at least three times a year. Group Three, the group with illnesses, we have to monitor as much as is necessary, depending on their illness, in order to able to effectively control their illness. Group Four is similar to Group Three, but the population in this group is often very small.

The *fiche familiar* is used as a template to record and assess the "health situation" of any given community. Moreover, the *fiche familiar* serves as primary material for the derivation of local, municipal, and national epidemiological data. Ultimately, epidemiological data provides the base from which to construct appropriate health-education and disease-prevention campaigns in response to specific community health needs (see, for example, Figure 5-1 for the flow of epidemiological data). For each identified risk group and/or illness, for example, there are national health-education and disease-prevention programs, with a clearly outlined criterion, to be followed, including the number of times an individual and/or family unit is to be monitored in a year.

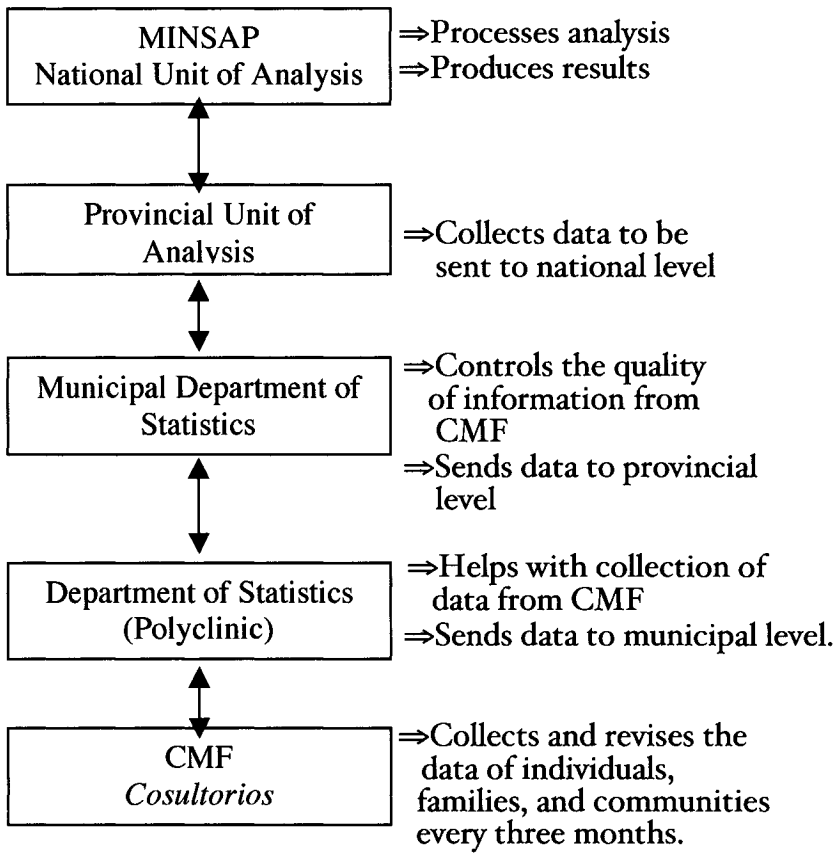
On a more general level, the *dispensarización* program, under the auspices of MEF physicians, is designed to follow life histories: the development of a woman's pregnancy and the period after delivery; the growth of the child, his or her psychomotor development and behaviour at school and later; his or her maturation and entry into the work force; his or her actions at work and in the family (*Granma Weekly Review* 1986: 4). The program, therefore, not only aims to identify and target risk, but to monitor the overall development of individuals in their family unit, environment and, ultimately, their involvement in the wider society.

Table 5-1: Detailed Description of Risk Groups for Analysing the Health Situation of a Community[7]

Group 1	Supposedly healthy. Person in whom no illness has been detected after being examined and who does not have risks to his/her health.
Group 2	Exhibits risk factors. Person who, after examination, does not have any illness, but is subject to determined risk factors including biological, psychological, and/or social factors, that can make them ill. The risk factors that are the object of *dispensarización* are the following: 1. Infants (less than one year old) 2. Lactating (less than one year) 3. Maternal-perinatal risk 4. Pregnancy 5. Smoking 6. Risk due to contact of certain illnesses (for example, tuberculosis) 7. Anti-social risks (for example, desertion, failure to attend school, lack of integration in family unit/community) 8. Other risk factors (for example, frequent international travel)
Group 3	Person who suffers from one or more diagnosed debilitating illnesses. 1. High blood pressure 2. Cancer 3. Cerebrovascular illnesses 4. Diabetes mellitus 5. Alcoholism 6. Parkinson Disease 7. Bronchial asthma 8. Epilepsy 9. Chronic Diarrhoea 10. Malnourished child 11. Tuberculosis 12. Obesity (adult) 13. Syphilis 14. Hepatitis 15. Other Illnesses
Group 4	Person who, due to the result of an illness or an accident, shows changes that are either temporary or indefinite and that affect sensory-motor and/or psychological abilities.

[7] MEF physicians use the same four risk categories, with different examples and methods of evaluation, for children under five years of age and for the rest of the population. I have merged the two tables and given examples from MINSAP (2001), *Carpeta Methodólogica*: 44-47.

Figure 5.1: Organizational Flow of Basic Health Statistics[8]



5.4 "For your own good": Popular Participation and Health Education

One of MINSAP's stated objectives under the MEF program is the containment and eradication of contagious diseases. Under the aegis of the epidemiology program, MEF health teams carry out surveys in communities, as I outline above, to "detect, register, treat and follow up persons with acute respiratory or diarrheal diseases, tuberculosis, venereal diseases, leprosy, malaria, and other communicable diseases. Diseases that are prevented through vaccination are managed in this manner" (Feinsilver 1993: 82). Moreover, the sources of all infections are investigated to determine if there are other ill persons, or carriers of disease, who, when located, must be treated as well. In this section, I provide a micro-examination of several aspects of the *médico de*

[8] I have modified this chart from Suárez (1994): 46.

familia program, namely the policies geared toward disease prevention and the treatment of communicable illnesses.

Popular Participation and the Battle against Dengue

"Good morning, compañero," said the young woman. She was dressed rather shabbily in a faded grey uniform, with a small, official looking badge on her front pocket and a folder in her hand.

"Your apartment will be fumigated in 15 minutes," she said, " Please remove your sheets and store any open food in the refrigerator."

"Why?" I asked. "I don't want the place to be fumigated." Based on my last experience with the fumigation brigade, when they sprayed pungent black smoke into my apartment and told me to wait on the street with my neighbours for half an hour, I was in no mood to spend half the day cleaning the smelly residue from my apartment. Now, the fumigation was becoming nearly a daily event.

"I'm sorry but you have no choice in the matter," she insisted. "Where is the foreigner (extranjero) who lives here?" She had obviously made a connection between the bright blue triangular logo on my door that indicated my apartment to be 'rented to foreigners.' She looked past me to address my Cuban friend, whose white skin caught her attention and addressed him directly.

"Please Señor, España (Spain) right? Can I speak with you?" she inquired, her tone sweet, perhaps, as she shifted to formal Spanish upon assuming that it was he who was the foreigner.

"Soy cubano (I am Cuban)" he replied.

"Why are you (tú[9]) making my job so hard then?" she barked at me, now again in her original unfriendly manner and, of course, the informal parlance.

"You both know we must fumigate. We are fumigating against the mosquito that is the transmitting agent of dengue fever[10]. It is a very dangerous illness." She huffed, frustrated by my questioning. "Can you please show me where you have tanks of water."

"What kinds of chemicals are you spraying?" I persisted.

"I don't know exactly. It is some kind of insecticide to kill mosquitoes," she replied. Oddly enough, in my two years in the same apartment, I have never once seen or been bitten by a mosquito, although the rumour of people coming down with dengue fever was always present around the time of these fumigation campaigns.

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[9] In Castellan Spanish the use of *tú* (you) denotes familiarity and is often used informally. The use of *usted* (you) is for formal contexts (and to strangers). Forty year of Cuban socialism and, importantly, the rhetoric of egalitarianism, have drastically affected the way in which Cubans oscillate between formal and informal Spanish. The use of informal language among the population reflects an idiom of camaraderie; for instance, the terms *compañero* or *colega* both denote colleague, friend, and compatriot. These terms are used in tandem with the *tú* form. According to several of my informant's, the formal use of *usted* only became more frequent with the influx of tourism. Tourists (and generally foreigners), almost without exception, are addressed with the use of *usted.*

[10] Dengue is a viral disease characterized by "high fever, rash, severe headaches, and pain behind the eyes, but the disease can also present with very mild symptom or no symptoms at all. It is rarely fatal, but epidemics can cause considerable disruption, especially in countries dependent on tourism. A severe and relatively new variant known as dengue hemorrhagic fever or DHF makes dengue particularly dangerous" (Kendall *et al* 1991: 259).

After entering the apartment, the young woman checked each of the storage water tanks[11] *and then initialled and dated a small white MINSAP card behind the door to indicate that an inspection of the premise had been conducted. No hygiene violations were found, that is to say, there were no areas in which mosquitoes could breed (focos) in the apartment.*

Less than ten minutes later, a young man with a tank strapped on his back and equipment that looked like a leaf blower entered the apartment, closed all the windows, and started spraying the apartment with clouds of black smoke.

The above account of my experiences with the "mini-brigades against dengue," which I will describe in more detail below, was an oddity for several of my neighbours, who questioned why I would not welcome the regular fumigations and household inspections. "It is for your own good," several of them chastised, and on several occasions.

"Why inspect our homes when the filth and stagnant water is all over the city?" I inquired. I pointed out the garbage strewn in the alleyways on either side of our building and the rotting piles of household refuse, now the home to a family of aggressive stray cats who were in plain view. One of my neighbours, who often took advantage of the time we waited on the street while the building was being fumigated to gossip with everybody, turned to me:

"Oh, my dear," she laughed, "take it easy (*no cogas lucha*). When Fidel wants to kill mosquitoes, let him kill mosquitoes! You should know better than anybody else, as a foreigner, that things in this country do not have any logic! Look at the broken pipes over there, oozing sewage down the streets and people throwing garbage everywhere. If mosquitoes were going to eat us alive, they would have done so years ago. Now, at least we can attempt to get people, as a community, to participate and clean up the streets. Of course, after the scare goes away, things will return to normal and people will continue to litter filth everywhere without any regard for anybody. Several of my neighbours merely nodded their heads. "This is politics," she concluded.

My passive-aggressive resistance to participating with the fumigation campaigns quickly dissipated when one morning very early I refused to leave my apartment. Although it may have appeared I was being difficult, my rationale at

[11] In the city of Havana, water is provided intermittently in different areas due to frequent overall water shortages. For example, in the building where I lived, most apartments had installed internal storage tanks for water. When the main water pipes serving the building were shut off, which was the case except for three hours in the evening, people switched to internal tanks.

the time was that I did not want to languish for 30 minutes on the street at 8 in the morning. Asserting that I was indeed the "resident foreigner," I told the brigade to come back later. Shortly thereafter, a middle-aged man appeared at my door dressed in typical military garb, firmly telling me that I had no choice in the matter. "Fumigation is the law," he stated. He left with no discussion. When the fumigation brigade triumphantly arrived at my door. I asked if the pungent smelling chemicals they were spraying could at least kill cockroaches. Cockroaches the size of dollar coins had recent begun to have a field day in my apartment in the late evenings and early mornings. They were causing me much grief. Based on the fumigation staff's assurances that the pesticide spray, which I later found out was malthion[12], would not only rid me of the offending mosquitoes, but the roaches as well, I eagerly opened the door for the nearly daily onslaught for the weeks of the campaign. Despite the repeated intrusion of the "mini-brigades against dengue," the cockroaches still continued to haunt my apartment and I learned, thankfully, to ignore them.

In September 2002, the Cuban Ministry of Public Health broadcast an alert due to the increase of *Aedes Aegypti* mosquito breeding-grounds in the city of Havana. Immediately after the MINSAP's announcement, *consultorios*, polyclinics, and hospitals in each municipality were on high alert, working work with their respective Municipal Centres for Hygiene and Epidemiology, and various health professionals to carry out house-by-house fumigations and inspections. The *consultorios* coordinated local mass organizations to help with massive community clean-up programs and education campaigns. These stressed the importance of eliminating potential breeding areas for the offending mosquito.

The presence of dengue in Cuba is not a new phenomenon. The first case of dengue-1 was reported in 1977 (there are four known strains, labeled dengue-1 through dengue-4). In 1981, the appearance of a dangerous serotype, dengue-2, " . . . spread rapidly, reaching epidemic proportions within a month; 344,203 cases were recorded during the four month period (June-September) that

[12] Also known as *o,o-dimethyl-S-(1,2-dicarbethoxyethyl)* malthion is an organophosphorus pesticide widely used for both domestic and commercial agricultural purposes. Malathion is often used in public health campaigns against pests because it is an *adulticide*, used to kill adult mosquitoes on contact.

the epidemic lasted" (A. Chomsky 2001: 338). A total of 159 people died as a result of this epidemic.

The Castro government, weary from the last battle with dengue-1, contended that Cuba's exposure to dengue-2 was no accident[13]. As Castro pointed out in his "26th of July" address to the nation in 1981, he suspected the involvement of US-based counterrevolutionaries (Cubans in exile) using biological operatives against Cuba and, indirectly, accused the US government of fostering these bandits of biological terrorism against the small island-nation (cf. Feinsilver 1993: 86). Castro's speech, infused with recurring tropes of anti-imperialism, heroic sacrifice, and Cuba's struggle for communism, provided an ideological framework in which to situate the battle against the dengue, which then took on a symbolic and political fervor. Shortly after Castro's speech,

> ... a "health army" (*ejército de la salud*) was established comprising 13,061 trained men and women rigorously selected by People's Power, the municipal health administrations, the FMC, and the Union of Young Communists, with the assistance of the party. The health army was charged with continuous inspection and the elimination of real and possible breeding places and equipped with back-pack larvicide sprayers. This group of trained volunteers would remain available to carry out vector elimination in the future (Feinsilver 1993: 89).

The "health army" organized to eradicate the *Aedes aegyptis* mosquito forms a crucial part of the socialist government's primary health-care philosophy — that is, the popular participation (*popular participación*) of the community in health initiatives. On a brief visit to Cuba in February 2002, I was once again in the apartment building where I had previously rented, and this time the city-wide fumigations were being carried out by small mini-brigades of students. These small groups of students were from the state's Social Workers Program, which incorporates wayward youth into various community projects (see chapter two, footnote 31 for a detailed description of this program). A group leader, usually a recent university graduate completing his/her required year of social

[13] At the time, Castro argued that the strain of dengue affecting Cuba was not found anywhere else in the world. Castro's suspicions were compounded by the admission of several counterrevolutionary groups that they had exposed the Cuban population to a form of germ warfare (see Feinsilver 1993 for discussion of these events).

service or *servicio social* to the government[14], oversees a group of students, known as a mini-brigade (*microbrigada*). Each *microbrigada* is responsible for a specific area of the city.

One of the group leaders that I interviewed told me that, in this recent campaign against dengue, many of the students participating in *microbrigadas* were from other provinces, thereby making their work efforts in the capital city also an enjoyable excursion[15] (for example, see Figure 5-2: "Social Workers" from Santiago de Cuba). As he further stated, the socialist government was hoping to channel the negative tendencies of these problematic youth into productive endeavors of social transformation that would form part of their social reform. Through cleaning up the city and specifically targeting areas that could be potential sites for the breeding of mosquitoes, the *microbrigadas* coordinate all of their efforts with the local, municipal and national health-education and prevention campaigns. The students are trained to provide detailed explanations to the population on the reproduction of the *A. aegypti* mosquito and the importance of eliminating stagnant water and trash in order to eradicate the problem.

As with every other accomplishment achieved by the revolutionary government, Fidel Castro best summarizes the success of the *microbrigadas* against dengue in one of his speeches:

> The enormous wealth of human resources that has been created and the traditional spirit of sacrifice and heroism demonstrated by our professionals, technicians and workers in the health care sector ... the immediate and crushing offensive that wiped out the latest outbreak of dengue in just 70 days at the beginning of this year; all of these things demonstrate and will continue to demonstrate the immense power achieved by our people, their health-care workers, and our medical-

[14] All recent graduates from university must complete two years of social service to the government. The exception is men, who at the age of 16 complete two years of mandatory military service (*servicio militar*) (for women, military service is optional). In theory, this means that the majority of individuals completing the social service program are women, but increasingly, more men are getting out of the military service for a variety of reasons, such as openly declaring they are "gay" or by obtaining medical certificates for specific ailments (which, in recent years, could be purchased illegally from state officials).

[15] This can be seen as a parallel to city-dwelling high-school students, who are required to complete a number of months each year participating in agricultural labor, popularly known as "Special Country School" or *Escuela al Campo*.

science sector (Castro cited in *Granma Internacional Digital,* October 21 2002: 16).

Similar to the dengue campaigns carried out in the early 1908os, this recent mass mobilization of the population can be interpreted, as Feinsilver (1989; 1993) notes, as reflecting the symbolic importance of Cuba's battle against the United States. Within this battle (*lucha*), Cubans are asked to give of themselves selflessly and follow the state in achieving collective goals against a common enemy. What is interesting to note, however, is the popular opinion among the citizenry regarding the dengue campaigns. Many of the citizens are well aware that the dengue campaigns are one-part public health-safety measure and two parts political propaganda. During the regular fumigations throughout the height of the campaign, I heard repeated "rumours" that, while the MINSAP was not using the word "outbreak," but rather speaking of fumigations as the control and prevention of limited breeding areas of the offending mosquito, the actual epidemic was more pronounced. For example, a physician I interviewed intimated that the epidemic was a little more severe than what was being said. When I asked him to elaborate, he stated almost in a hushed voice, "Well, we are not suppose to say this, but I know there were quite a number of fatal cases." However, this supposed hushed revelation was already widely known and circulated among individual citizens in the streets, many of whom often prodded other people on to "safeguard" their houses against what was now described as the "deadly mosquito." When I asked individuals in private if they actually believed these rumours many simply stated, "No."

While I was walking through central Havana with a family physician during the height of the dengue campaign, patients from his *área de salud* complained to him that he was not doing enough, since the fumigation brigades still had not come to their homes.

"Miguelito!" a woman shouted, affectionately addressing the physician by his first name, "What about us? Why haven't the brigades come to our houses? Look at this place! I know there must be mosquitoes everywhere!" . Her arms were flailing in the air.

The physician firmly admonished her and the small group of dissatisfied residents who were adding their own commentary on the failure of the brigades to include them.

"*Señora*, the fumigation is not going to work if you still have filth on the street." He pointed to the crushed cans and garbage that was strewn about. Why, he wondered, if she were so concerned about her well-being, had she not taken the initiative to organize a street clean up campaign with her local CDR.

"*La Revolución*" the physician proclaimed, "helps those who help themselves!"

As we were leaving, the same woman started to yell at her surrounding neighbours for being pigs (*cochinos*) and for allowing the neighbourhood to become littered with trash.

Figure 5-2: *Microbrigadistas* against Dengue

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Having met the physician on various occasions[16], I was relatively sure these actions were not being staged for my benefit, but rather reflected his

[16] The physician often expressed his discontent with certain aspects of the *la Revolución* (such as the lack of material resources he had at his disposal) by setting up mock scenarios and then turning to me and asking, "Now, do you think I can do my job with what I have?" Inevitably, the answer, from my limited perspective, was "No." (For

general approach to dealing with patients, whom he normally described as apathetic and belligerent. When I ask the physician about the "rumours," he expressed serious reservation about the validity of such claims. Instead, he argued that, in his opinion, the rumours were a way to get people to actively participate in the campaigns. With many of the mass mobilization campaigns in Cuba, including those directly related to public health, the use of slogans, matching clothing and *microbrigadas* organized into separate but competing units, is a form of collectivisation[17]. In these collectives, people are strategically rallied around particular causes. As Fagan notes, "A primary aim of political socialization in Cuba is to produce a participating citizen, not just one who can recite the revolutionary catechism perfectly. The test of the new Cuban man is how he behaves" (1969: 7).

As is evident from the popular participation in the campaigns against dengue, "risk" is meant to mean a threat to the collective, that is, a concern for everybody and, therefore, the socialist government politically mobilizes communities in a battle against a common enemy — in this case, a viral-borne illness symbolically linked to US imperialism — and attempts to draw individuals into the revolutionary ideology. In recent years, however, the ability of the state to motivate people to participate in these mass campaigns, for example, the campaigns for voluntary agricultural labour, has become increasingly difficult. Despite the government's widely televised reports of mass participation in various rallies and marches, the general public is well aware that the participants, for the most part state-employees, are bussed into the city for the occasion[18]. As

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example, if your only stethoscope is broken then clearly you are unable to take people's blood pressure, which, for a primary health-care physician, is fairly essential.)

[17] These forms of collectives can be traced back to the early 1960s. The socialist government has formed everything from literacy brigades to construction brigades, youth brigades and public health brigades, all based of the same philosophy of "popular participation" in the development of social transformation. Using the rhetoric of the state, these activities promote social cohesion and the importance of putting the collective well-being before individual wants and desires.

[18] For example, in the summer of 1999, I was collaborating in the teaching and training department of a state-run institution, where we were informed on several occasions, after showing up for work, that we would be bussed into the city to participate in protests against the US Special Interests Office in the famous Elían Gonzalez custody battle. Elian was a six-year old Cuban boy in the custody of his family in Miami after being found floating in an inner tube off the coast of Florida. (As a brief chronicle of events: the child's mother, and several other people, had died fleeing Cuba

I have argued in this case study, however, many individuals are clearly aware of subtleties of the socialist government's hybrid public health/political programs and, rather than protest by not getting involved, participate with the hopes of improving their immediate circumstances. As the physician walking with me through central Havana noted, "Whether politics or a public health crisis, the results in the end are good for everybody: a cleaner city free of a potential threat." I do not intend to suggest, however, that the threat of dengue is a fiction of politics, but rather to show how the notion of "collective risk" in this context can be interpreted to reinforce political ends. In the following case study, I will review one of the most controversial public health initiative administered under the *médico de la familia* program: Cuba's HIV/AIDS prevention and treatment program.

A Critical look at Cuba's HIV/AIDS Education and Prevention Program

> *I knew I was HIV positive long before the doctor gave me the results. I remember the day that I went to pick up my results and the doctor handed me the results on a slip. He was a little taken aback because I did a little pirouette and extended my arm out to pluck the slip from his hand. I was trying to be light-hearted about the whole thing, you know, sort of like a ballerina from Swan Lake. At least, the other people in the waiting room laughed. When I went in for counselling the doctor informed that I would have to spend eight weeks in the HIV/AIDS education "resort" to learn about my illness. I am joking, of course. I know it is not a "resort," but for any Cuban, not just an HIV positive one, it is quite luxurious. You get three meals a day, and I mean real meals with meat and vegetables, not this rice and beans shit. You have an air-conditioned room and TV. Also, there are doctors, psychologist, and heaven knows who else there to help you adjust to your illness. I am being playful here, but seriously, I did not go out and get HIV on purpose, but I was stupid and reckless. However, I get upset when foreigners come to Cuba and make it sound like the government is locking us up and throwing away the key.*
>
> — *Javier Sámchez, unemployed, born in La Habana, 1970.*

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in a makeshift raft. The child's father, backed by the Cuban government, launched an international custody battle against the father's family in Miami, who, with the help of prominent members of the Miami exile community, resisted the return of the child; they claimed that there could be no fate worst than sending a child back to Castro's Cuba.) Given flags and T-shirts emblazoned with "Return Elian," the state employees (at that time, including me) were theoretically substituting our normal work hours to march. As my work colleagues informed me, if you do not go to the march, or simply went home, these things will be held against you. In the end, we (myself and my work colleagues) marched down the street waving a Cuban flag and chanting "Return Elían" among the masses of several thousand other state-employees in front of the US Special Interest Office in Havana. This is not to suggest that the people involved did not support the Cuban government's position, but many, including myself, would not have demonstrated this support by marching.

In the mid-1980s, when HIV/AIDS presented itself as a potential epidemic, Cuba's response was similar to the other epidemics it had faced, such as dengue and African swine fever: to take measures to rapidly isolate, confine and treat those infected. Throughout the course of this research, I did several interviews with individuals who were HIV positive. The above excerpt is from an interview I conducted with a charismatic young man in 2001. In addition, I discussed the HIV education and prevention campaigns with the MEF primary health-care physicians who participated in this research, and carried out several interviews with health professionals working at the National Centre for HIV/AIDS Education and Prevention, Cuban Society for Family Planning (SOCUPF), and the National Centre for Sexual Education (CENESEX).

In 1985, the first case of HIV was detected in Cuba. Shortly thereafter, the MINSAP made a national announcement in 1987 that they would test the entire population over the age of fifteen for the HIV virus, which, when left untreated, leads to full-blown AIDS, or, in Spanish, *SIDA*. By the end of 1990, the Cuban government had carried out over eight million HIV tests, detecting 449 positive cases, of whom 325 were male and 124 female. Of this group, sixty-three persons had shown symptoms of AIDS, and 32 of them had died. According to an article entitled, *Hablemos Francamente* (Let's talk Frankly) in the popular Cuban magazine *Bohemia*, the majority of new HIV cases in 1995 were from heterosexual transmission (53.7 percent), with 44.8 percent attributed to homosexual transmission (cf. Rivera 1995). The remaining cases, health officials believed, were due to maternal HIV-transmission and blood transfusion recipients.

As of October 31, 2001, a total of 3075 persons had been diagnosed as HIV-positive in Cuba, this being the cumulative number of total cases since the beginning of the epidemic in 1986. Of this total, 2,923 cases were men (77.94 percent) and 827 women (22.05 percent). Of the 1464 HIV-positive persons who developed full-blown AIDS, 940 have died and 584 are today living with AIDS (Reed 2001). The highest rates of transmission exist between people 20-24 years old, followed by the group between 24-29. Eighty percent of the cases involve people between 15 –29 years old (Reed 2001). While open to more critical discussion, these recent figures of transmission and prevalence of HIV/AIDS in

Cuba represent one of the *lowest* internationally[19]. However, although Cuba's HIV/AIDS transmission rates are low, this should not draw attention away from the source of the international debate, namely, the highly controversial nature of Cuba's HIV/AIDS-prevention program: a program that implemented an initial policy of quarantining all people who had tested positive to the HIV antibodies in sanatoriums, also known as *sidatoriums* (AIDS sanatoriums).

The government's implementation of a quarantine policy in the first sanatorium, popularly known as *Los Cocos*, established 11 km outside of Havana in 1986, and administered by the Ministry of Defence (MINFAR)[20] — was severely criticized from its inception. The Ministry of Defence stated that quarantining was voluntary, although they later admitted that considerable pressure was brought to bear on those who resisted (cf. Fensilver 1993). Many international critics interpreted the actions by the Cuban government regarding the AIDS sanatoriums as a form of "imprisonment" (cf. Lumsden 1996) or "repressive discrimination against homosexuals" (Chestnut 1991). As Marvin Leiner argues in *Sexual Politics in Cuba, Machismo, Homosexuality and AIDS,* the quarantine program was seen to reflect the *machista* (machismo) assumptions underpinning the approach to the AIDS prevention programs, especially the belief that homosexuality, similar to "male sexuality is uncontrollable and unchangeable"[21] (1994: 133-35). Of course, such criticism assumed that all the individuals quarantined were male, which was clearly not the case (close to forty percent of the residents of *Los Cocos* were heterosexual women).

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[19] Opponents of Cuba's socialist government have argued that Cuba's HIV/AIDS statistics do not reflect the "real" numbers (cf. Chesnut 1991; Pérez-Stable 1991). However, as Lumsden (1996: 102) importantly notes, "Critics have not been able to demonstrate why Cuba's AIDS statistics would not have the same integrity as its other highly reliable epidemiological statistics."

[20] Nancy Scheper-Hughes (1994) claims that the mandatory testing of Cuban soldiers returning from Africa in the mid-1980s, several of whom were found to be seropositive, was the underlying reason why the AIDS sanatorium was initially under the authority of the MINFAR.

[21] For example, popular stereotypes such as "men naturally cheat" or "men will be men" posit male sexuality as somewhat inherent and, thus, assume that men are biologically programmed to be sexually promiscuous. As Leiner (1994) points out, literature on Latin American *machismo* and male sexuality, rather than diminish these popular stereotypes, has reinforced them.

Despite the attempts of the socialist government to diffuse the issue, some international commentators were quick to draw on remarks made by Fidel Castro in his earlier revolutionary years, such as "Nothing prevents a homosexual from professing revolutionary ideology and, consequently, exhibiting a correct political position. But I will be frank and say that homosexuals should not be allowed in positions where they are able to exert influence upon young people. In the conditions under which we live, because of the problems which our country is facing, we must inculcate our youth with the spirit of discipline, of struggle, of work" (Fidel Castro cited in Lockwood 1967: 107). Castro's remarks were problematic, especially given that in the 1970s and '80s the socialist government had embodied the Stalinist-Maoist notion that homosexuality was a manifestation of capitalist decadence.

While Castro's statements during the height of *la Revolución* obviously fuelled the fire for many of his opponents and rallied international gay and lesbian rights groups against Cuba's human rights record, these international critics neglected to situate Castro's remarks within the context of the equally volatile political positions many of their own governments had pursued toward homosexuality (especially the United States, Canada and Great Britain) in the early 1960s. For example, "homosexuality" was classified in North America and Great Britain as a psychological disorder that required treatment[22]. While by no means a justification for the socialist government's action, before 1959, homosexuals in Cuba were subject to extreme isolation and repression that was enforced by civil law and augmented by Catholic dogma (cf. Young 1981). Thus Castro's earlier remarks, which he subsequently retracted, should not be criticized in light of his subsequent AIDS prevention policies. Rather, such remarks should be criticized for their general hypocrisy and ignorance in matters of sexuality.

While AIDS was presented, at least in the North American context, as a "gay disease" during the initial responses to the epidemic, there has been no evidence to support claims that the quarantine program in Cuba was motivated

[22]For example, see the *Diagnostic and Statistical Manual of Mental Disorder* (DSM-I) (1952), which categorized homosexuality as "sexual deviation" under the general psychiatric category of "socio-pathic personality disturbance," or in the DSM-II *(1968)* that classified homosexuality as a "personality disorder."

by a homophobic agenda. In the HIV/AIDS educational campaigns, as Lumsden (1996) notes, though rife with heterosexist language and assumptions, the emphasis has always been on the number of sexual partners and on the sex acts performed rather than on the sexual orientation of those involved[23]. (See, for example, the health promotion campaigns for condom use in Figure 5-3. Note the cartoon figures only represent heterosexual pairings). This is not to suggest that repression of homosexuality has not or does not occur in Cuba, but does suggest that we move the debate away from sexuality and identity politics to the more salient question: is Cuba's AIDS-prevention program, as critics of the Family Physician and Nurse Program assert, really a means of social control[24]? To answer this question requires an examination of the most controversial aspect of Cuba's AIDS-prevention program, namely, the initial decision to quarantine all HIV-positive people regardless of whether they manifested any signs of illness, and to physically separate them from the rest of society.

Although health officials described the luxurious living conditions (especially by Cuban standards), abundance of food, necessary medicines, and on-site, around-the-clock medical care (as the above interview excerpt attests), many international critics viewed the quarantine as expressing a complete disregard for the human rights of people with HIV/AIDS. Cubans, in general, were subject to increased mass screening programs (for the most part voluntary), especially those who had been abroad and those with a history of sexually transmitted diseases. Additionally, those individuals who tested positive were

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[23] In health-education pamphlets produced by the Ministry of Public Health, such as *¿Qué es el SIDA?* (What is AIDS?) and *Hombres... hablando entre nosotros* (Hombres . . . talking among ourselves), the focus is on unsafe sexual actions rather than identifying, as many North American campaigns did in the 1980s, "unsafe sexual orientations"[23]. (See, for example, Figure 5-4: A health van that runs outreach programs throughout the city, which targets, among other areas, popular gay hang outs).

[24] Systematic oppression of homosexuals was common practice during the period of the Military Units to Aid Production (UMAP) programs in the 1960s (as I discussed briefly in chapter three). In more recent years, the internationally acclaimed film *Fresa y Chocolate* (Strawberry and Chocolate), made in 1993, deals with the theme of homosexual oppression in contemporary Cuba. In a considerably more polemic vein, the autobiography made into a movie of the late exiled Cuban writer, Reynaldo Arenas entitled *Antes que anochezca* (Before Night Falls), also deals with the theme of homosexual repression in Cuba. A recent article in the Cuban magazine *Alma Mater* suggests that in recent years the Cuban population has been become more relaxed toward homosexuality, though, as the article further contends, this does not necessarily suggest that the population is more tolerant (cf. Jiménez 2003).

compelled to disclose their sexual contacts. Many Western observers argued that these tactics were not necessary and, in fact, produced mass hysteria rather than effective management of the epidemic (see, for example, the criticism voiced by Feinsilver 1993; Lumsden 1994). With the notable exception of Nancy Scheper-Hughes' (1994) article, "AIDS and the Social Body," which provides a very cursory, yet supportive examination of the HIV/AIDS prevention program in Cuba, few social scientists have carried out a critical, systematic study of the of HIV/AIDS prevention in Cuba (cf. A. Chomsky 2000; Santana 1990; Pérez-Stable 1991). Of the other limited studies available, which are characterized by conflicting claims to provide ethnographic accounts, (for example, "AIDS in Cuba: Patients Speaks Out" (Ross 1991)), most commentators are firmly planted in a tug-of-war game of ideological posturing, doing little to sway ardent critics or supporters. As my own direct observation and interviews show, the quarantine system is much more liberal and open than the way it has been described by many scholars. For example, Feinsilver (1993: 83-84) describes a system in which those in sanatoriums "have unlimited controlled contact with their families and friends, are allowed to go out for various social purposes, and get weekend passes to go home . . . only under the watchful eye of a relative or a designated medical student[25]."

The five individuals whom I interviewed for this research and who self-identified as HIV positive, openly discussed the fact that they were provided with a "good life", a life, many of them added, that was slowly disappearing in Cuba's current economic crisis characterized by massive food and medicine shortages. After an eight-week HIV/AIDS education course, all of the individuals I interviewed returned to their homes and were in regular contact with their friends and family. In 1993, the MINSAP implemented an ambulatory care program, similar to the MEF program, that stresses "home-care" and states that, when possible, HIV individuals are to be incorporated into the community, thereby reducing the stigma associated with HIV as an illness that should be hidden. All new MEF physicians receive extensive education on the treatment

[25] This material is now outdated. While Cuba did employ these practices in the late 1980s and early 1990s, by the end of 1993, the HIV/AIDS treatment program underwent drastic changes, which I will describe in detail shortly.

and the special arrangements that need to be made for treatment of HIV-positive patients in their respect *áreas de salud*[26].

While the above information is itself cursory, the popular perception of HIV and AIDS among those members of the Cuban public whom I interviewed, was that the government's program of using sanatoriums was "effective." However, several individuals and physicians did voice concerns that given the recent economic changes in Cuba the "epidemic was no longer under control." Many people that I interviewed questioned whether the government was capable of monitoring and containing the undetected number of cases of HIV due to *jineterismo* (prostitution). As I argued in chapter two, *jineterismo* is spiralling out of control with increased tourism and the desire expressed by young men and women to earn US dollars. Many individuals asserted that "foreigners" having sexual relationships with Cubans was leading to unregulated "points of entry" for the virus. Several citizens argued that the origin of HIV, like several other viral illnesses such as dengue, was abroad, particularly in the US government's supposed armoury of biological weapons to use against Cuba. Several individuals repeated rumours that HIV-positive Cuban-Americans were "on the loose" having sexual relations with Cubans without protection in order to knowingly infect them. Surprisingly, several primary health care physicians I interviewed, who firmly believed the Cuban exile community was behind the new cases of HIV transmission, also repeated this "rumour."

Physicians also remarked that, due to the low incidence of the virus in Cuba, the population, especially young people, had become complacent. According to a study carried out by Cuban physicians in 1995 and surveying 669

[26]Currently, Cuba has 15 hospices for people living with HIV/AIDS, which house a little over 380 persons and also serve a small outpatient population. The remainder of the HIV-positive patients remain in their homes. Cuba's domestic pharmaceutical industry, in opposition to the international patenting laws, produces its own HIV/AIDS medications (cf. Pérez Avila *et. al* 1996). For instance, after 1996, Cuba produced generic equivalents of the antiretroviral (ARV) drugs, including AZT, ddI, 3TC, d4T, Zalcitabine, Nevirapine, Indinavir, Nelfinavir and Interferon. Following the Cuban guidelines, the treatment for HIV-positive patients begins after the development of an opportunistic infection or a CD4 less than 200. After 2001, all HIV patients were receiving therapy. Cuba also receives HIV medication from international donations from other countries and currently has 120 individuals on triple-therapy (the combination of various HIV medications, argued to be more effective in combating the virus). According to an article in *Granma*, in 2003, Cuba also sold over one million US dollars worth of anti-retroviral to other developing countries (cf. Riera 2003)

patients who where identified "at risk" (*dispenzarizados*) in one polyclinic in the city of Havana, the leading "risk behaviour" was adolescent sexual activity (17.3 percent), followed by social risks (12.6 percent), which were well ahead of problems like asthma (9.6 percent) and hypertension (8.2 percent) (Lugones Botell *et al.* 1995: 114). Another study, in 2000, led by a group of Cuban physicians, surveyed 2,703 adolescent[27] students in the city of Havana regarding their attitudes toward HIV/AIDS education and prevention and determined that 69.5 percent of those who were sexually active did not use condoms[28], 43.1 percent had several sexual partners that year, and 24.9 percent had more than one sexual partner simultaneously. The adolescents began sexual relations at an early age, with a mean age of 13.84 for males and 14.83 for females (Cortés Alfaro *et al.* 2000: 253-260).

Several of the physicians that I interviewed, such as Dr. Louis Pérez (chapter four), complained that, despite regular *charlas* (health promotion chats) on sexual health, the adolescents in his *área de salud* repeatedly arrived at the *consultorio* with minor sexually transmitted illnesses and, increasingly, unwanted pregnancies. As many of the physicians complained, especially those in the city-centre, there was no way in their busy days that they could identify the long list of "risks" outlined in the MINSAP's requirements. As Dr. Andrea Ochoa's in *consultorio Santa María* (chapter four) noted, it is not possible to monitor the behaviour of so many people and, unlike in the past, neighbours are not as willing to report each other's activities. This latter theme leads us the notion of "community surveillance," and the role of individual citizens in alerting authorities, including physicians, of "risk behaviour", for example, a woman trying to conceal her pregnancy, or people involving themselves in illegal activities.

[27] "Adolescence" in this study is defined as the following: early adolescence (10 – 15 years old) and middle to late adolescence (15 –19 years old).

[28] Other forms of contraception (for example, the birth control pill and the IUD)are widely available in Cuba at very low cost. The rate of induced abortion — legalized in Cuba in 1969 — decreased from 70.0 per 100 deliveries in 1992 to 59.4 in 1996 (PAHO 2001). Cuban health officials have noted that the latter number is still relatively high (cf. Peláez Mendoz *et. al.* 1999). Currently, there are health promotion campaigns to reduce the number of induced abortions.

Figure 5-3: Examples of "Use a Condom" campaigns found at local pharmacies. The poster on the left reads: "The best friend of couples." The poster on the right reads: "If No, No! Protect Yourself."

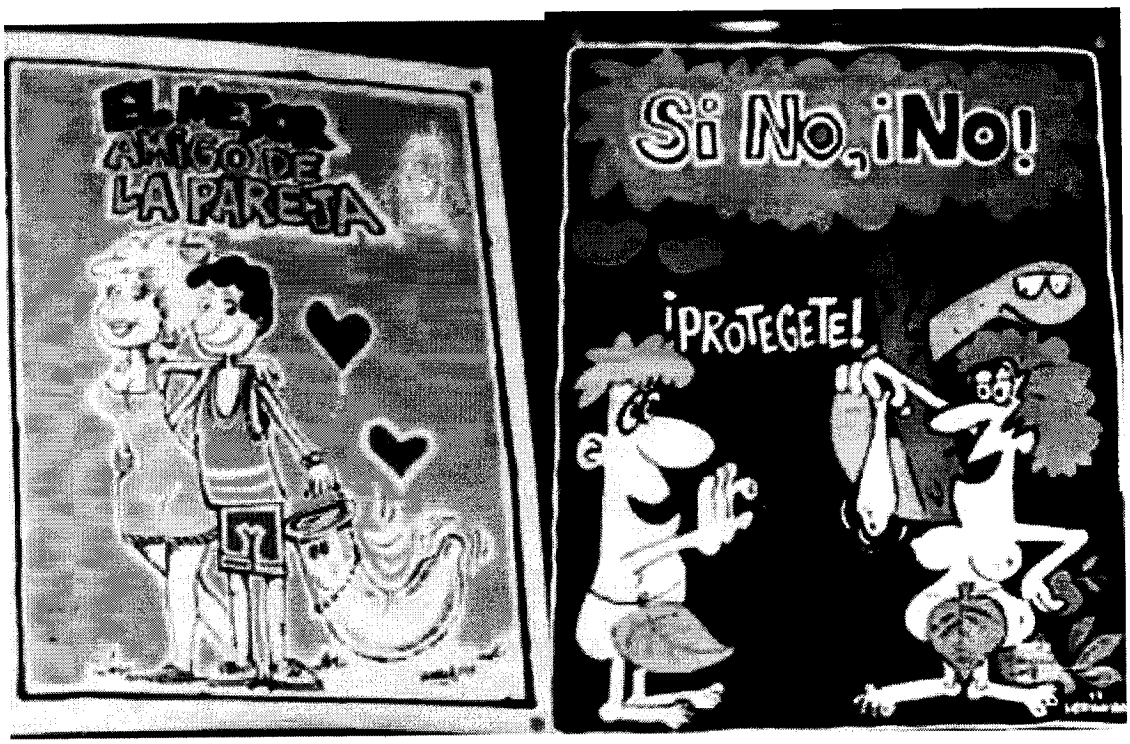

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Figure 5-4: An outreach health van called "The little car for life." The van distributes condoms and health learning materials in different locations in the city.

Source: Pamphlet entitled "*Carrito por la vida*" funded by *Medicos Sin Fronteras* y MINSAP (2001)

5.5 Community surveillance, mutual vigilance and the Redefining of Individual-State relations

> If a Cuban citizen doesn't belong to any organization, people think he isn't with the Revolution. Then if he has to go to the law for anything, the Committee for the Defence of the Revolution [CDR] investigates him, and if they find he doesn't belong, nobody will back him up even if hasn't done anything wrong. If you belong to the Committee, it stands up for you, so to speak. I mean, it's a kind of guarantee that you're a revolutionary. And if the Committee speaks well of you, that's the biggest recommendation you can get. It's really of great value to a person to belong to the Committee (Leticia Manzanares, cited in Lewis *et al.* 1977b: 45-46).

In chapter four, I outlined how concerned citizens in the close-knit community of *consultorio Los Molinos* reported on their neighbours for bartering their infants' rations in the black market. As the above quote attests, the role of the Committees for the Defence of the Revolution (CDRs) are optimally to stimulate these kinds of behaviour: "mutual vigilance" that guards against anti-social and counter-revolutionary behaviour. Joseph Colomer, a political scientist who wrote on the history of CDRs in Cuba, notes, "Any CDR member can choose between reporting illegal acts and not reporting them ... By reporting an illegal act, the CDR member or leader can expect to be rewarded as a good 'revolutionary' (or avoid the risk of being persecuted as a counterrevolutionary, which is the same thing)" (2000: 127). On October 10, 1961, the Castro government formed the CDRs as community-based surveillance units to work "side by side with the army, the militia, and the police" to carry out "denunciations, arrests, and imprisonment" of so-called counter-revolutionaries (Colomer 2000: 122). As Fidel Castro declared in later years, "Who can make a move without the CDRs knowing about it? Not even an ant!!" (cited in Colomer 2000: 123).

In the 1960s and 70s, the CDRs, which were quickly labelled models of social control by outside observers, lived up to their reputation by carrying out 24-hour community patrols, holding neighbourhood courts headed by elected community members to denounce people and monitor in detail the coming and going of vehicles, people, and packages within their defined territories. From an epidemiological point-of-view, this unprecedented level of surveillance, which amounted to a kind of "panopticon" gone awry, with people watching and being watched, was an ideal model, theoretically speaking, for the control and

prevention of communicable illnesses. Nevertheless, over the course of 40 years, the role of the CDRs in the city of Havana has lessened in many respects[29], with a greater percentage of the people only giving lip service to its existence and objectives, that is, to its a commitment to "mutual watching." In the following case study, I shed light on some of the recent changes within community surveillance and, ultimately, what this means for "identifying risk."

Consultorio Los Pocitos

On the outskirts of Old Havana is an area known as *Los Pocitos* but which most *habaneros* refer to as *la candela* (literally, the fire) because of the boisterous nature of its occupants in the formerly grand colonial houses converted into *solars* (tenement housing). In a cramped two-room apartment, I interviewed Sra. Norma Herrera. Almost 70 years old and a chain smoker, she was eager to talk about her experiences with the local *médico de la familia.* She began her interview with a startling revelation: "I am not a communist, you know, nor have I ever been one, although I respect communists and my children are communist." Laughing apprehensively, she explained to me why this clarification is necessary. Having worked as a former secretary to a high-ranking minister throughout the Batista administration, she explained that she was afforded many opportunities to leave Cuba after *la Revolución*, but for personal reasons decided to stay. Now, as an elderly woman suffering from a number of medical complications due to a recent stroke, she made clear that *la lucha* (the struggle) that has characterized contemporary Cuban life cannot be separated from issues of health and, in general, the collective well-being of *el pueblo*.

Sra Herrera was a former adherent of Catholicism; however, she suggested that she left church in the late 1950s because it was an institution that was out of touch with the people's everyday realities and was rife with hypocrisy. Drawing a comparison between the church and the contemporary Cuban state, Sra. Herrera explained that the contemporary socialist government was slowly

[29]I make this statement based on my experiences in the several communities in which I lived and worked since 1997. My opinion is supported by the work of Colomer (2000), who notes that empirical evidence shows decreasing levels of CDR membership, mobilization, and effectiveness. As various informants argued, in rural communities and several cities in other provinces, the revolutionary fervour is still high and, by extension, the role of the CDR still retains much of its original force. See, for example, Rosendahl's (1997) ethnography of a small municipality in Oriente.

moving away from meeting the needs of the people, which, in theory, worked against the notion of Cuba as a "state of the people." Born into a poor family in the Province of Cienfuegos in 1930, Sra. Herrera won a scholarship to attend a Catholic private school where she was eventually trained to become a high school Spanish language teacher. She only worked briefly in this career before getting married to her first husband, with whom she had two children, and moved to the city of Havana in the early 1950s to seek out better employment opportunities. After a brief stint of working as a secretary in a lawyer's office, she was recommended, through friends of friends, to take on a secretarial post in *El Capitolio* (parliamentary building). Her husband, however, found it very difficult to find a permanent position and was growing increasingly frustrated. Shortly after *la Revolución,* he fled Cuba, leaving his wife and children behind. To date, Sra. Herrera has had no contact with him, although he does communicate with his two children directly.

Although unwilling to describe herself as a *revolucionaria,* Sra. Herrera, now living alone, was previously an active member of various mass organizations, such as the CDR and FMC; however, she now finds these institutions increasingly obsolete. As she made clear, her initial integration into *la Revolución* was shaped by her lived experience:

> Before the *la Revolución* I had never had any consciousness of class. I was very poor and I was never involved in a union, because in reality, there was no union that I could join at the time, especially given my profession as secretary. I did not really feel anything toward politics. When the Batista government started to commit all of the crimes against *el pueblo*, I was right there in *Capitolio*, but I was the kind of person that kept to myself. I knew I was in an environment of criminality, but at least, my boss was not part of the crime rings that were operating in the government in those days. It became clear that things were going downhill when the government officials started openly stealing from the state coffers. Those who spoke up ended up as a cadavers, or worse, people were found burnt alive. Horrors! For this reason, I would say I become more political when *la Revolución* took power, because Fidel exposed these atrocities and condemned them. Although I never formally considered myself part of Fidel's movement, I had great respect for it from the beginning. In those days, the FMC and CDR had a common goal and we worked toward building a new society. In those days, we could become involved and *actually* see the changes you were involved in. Now, what you have is *El Bobo* [Fidel Castro] making a bad situation even worst. The days of revolutionary fervour are long gone; now people need to know how to get food on the table.

As Sra. Herrera remarked, the recent increase in corruption is directly linked to changes in the relationships between the state, related institutions, and individuals in the community. For example, Sra. Herrera indicated, as did several other individuals interviewed for this research, that it was not uncommon before the *periodo especial* for people working with mass organizations in local neighbourhoods to report on other community members for being promiscuous, or drunk, or shirking work duties. Such behaviours, Sra. Herrera asserted, were deemed anti-social or seen as possible signs of counter-revolutionary attitudes. These networks of community surveillance closely linked the state to individual activities. In this manner the state had, up until very recently, managed to effectively keep counter-revolutionary discourses at bay, muffle internal political dissent, and monitor lifestyles deemed "risky" or "unhealthy." The *período especial,* however, has changed this relationship. Dr. Concepción Hernández, a young family physician working close to Sra. Herrera's *área de salud,* summarizes this point:

> Nowadays, the president of the CDR needs to feed his family as well, which means he too is going to be doing things to get dollars to be able to buy stuff. So, he isn't going to be too concerned about looking at what other people are doing. I mean in Cuba now, there is lots of jealousy and envy of what other people have or don't have. Things are not like before, when people cared about their neighbours. Now, everybody wants the dollar to live well. Doesn't matter if you are physician or a taxi driver. There is no reward in Cuba anymore to be a good worker. I mean if you are a doorman at a hotel you make more than a heart surgeon. Can you believe that? I mean there is no justice in that. I am a *revolucionario*, and like anybody, I too want access to good things. You hear people saying, look, to be a *revolucionario* means to be a *come mierda* [shit-eater]. To be dedicated to *la Revolución* doesn't matter anymore.

Sra. Herrera commented that, before the *período especial,* she could rely on her neighbours to check up on her once in a while, because she was an elderly woman who lived by herself. In recent years, she remarked, this "helping out your neighbour" is practiced less and less. One evening, Sra. Herrera invited me to her apartment to talk and, as she said, "keep an old lady company." As she was a wonderful storyteller, I accepted her offer, despite the difficulties in finding reliable transportation to her municipality, which was prone to frequent power outrages, leaving the densely populated area in blackness for hours at a time. Arriving a little after 8 in the evening, I found Sra. Herrera in good spirits, and we sat on her front terrace that overlooked the street. Almost as if planned, Sra. Herrera started pointing out her various neighbours to me, who

came into view throughout the evening: the CDR president, who was at the time illegally renting out his apartment to foreigners; two younger women, dressed provocatively, both with older male foreigners on their arms, and who, on Sra. Herrera's account, were *jineteras* with new foreigners nearly every night; her immediate neighbour to the right, who sold rice and milk powder from her door, all stolen from her job at the local *bodega* (the store that distributes the population's rations); and, finally, her immediate neighbour to the left, who had a car that he drove for a state company, but instead used it on the side to run an illegal taxi operation.

Summarizing all of the illegal activities, Sra. Herrera inquired, "Who is going to report whom?" As she stated, she saw her neighbours' involvements in private informal practices as being endemic to the community, if not the country as a whole, and said, "It is part of life, now." As I will further elaborate in chapter six, the rise in illegal activities — particularly those related to health care, such as the black market trade in drugs or the increasing use of informal networks (*socios*) to get access to specialized health services — signals a breakdown in the state's network of "mutual vigilance." What this means for Cuba's primary health-care system, particularly its public health program, is an inability to identify and monitor so-called individual and collective "risk behaviours"; and this inability has led to a redefining of the relationship between the individual and the state. In revolutionary pedagogy, all crimes, even the "stealing of food in context of scarcity," are crimes against the collective (Colomer 2000: 122); therefore, the breakdown of this system of surveillance is a direct affront to the underlying tenets of the socialist government.

5.6 Conclusion

In summary, in this chapter I have shown how the concepts of epidemiological-risk and health surveillance in Cuba's primary health-care system are intertwined within social and political processes. In Cuba, the complex interplay around the ubiquitous concept of "risk" and between MINSAP objectives, primary health physicians, and individual citizens challenges the notion of the state as a monolithic entity. Rather, the state is embodied in a proliferation of institutions and social actors (cf. Gupta 1995). Throughout this chapter, I have drawn on a theoretical framework of

governmentality, risk, surveillance, and public health, all the while cognizant that Cuban socialism poses certain epistemological challenges to theories that were produced in liberal democratic settings. One of the dominant features of liberal governance and public health, for example, has been a concern with autonomous individuals as members of a population, in which issues of risk intersect with issues of national policy and power. The question then remains: are Cuban citizens autonomous individuals capable of choice?

Drawing on the ethnographic evidence that I have presented in chapters three, four and five, I would argue that the answer is "Yes." Primary health-care physicians work in tandem with epidemiologists and various state officials to "encourage" citizens to embrace the philosophy of a "New Man" and "New Woman," which, in many respects involves training people about a "new way of being" (in sum, a new subjectivity). In recent years, the rapid increase of primary health-care physicians to record high numbers throughout the island, preaching health education and disease prevention in Cuba's current socio-political climate, is revealing. To a large extent physicians diagnose and attempt to treat individuals who are increasingly becoming alienated from the state's objectives. In sum, they treat a form of social malaise. The primary health-care philosophy in Cuba, which health officials argue is a holistic-based approach to health and well-being, has historically proven an epistemological challenge for contemporary biomedicine. The failure of much of contemporary biomedicine to integrate the triad of mind-body-society, anthropologists Lock and Scheper-Hughes argue, leaves us ". . . suspended in hyphens, testifying to the disconnectedness of our thoughts" (1987: 10). In Cuba, however, this melding of hyphens has resulted in a kind of hybrid physician: clinician/epidemiologist/social worker/psychologist and, importantly, revolutionary cheerleader. In practice, however, the role of community physicians in identifying risk, including anti-social behaviour, wayward youth, sexually promiscuous adolescents, and elusive expectant mothers, is part of a larger project of corralling the population into the state's prescription for so-called "normal" behaviour.

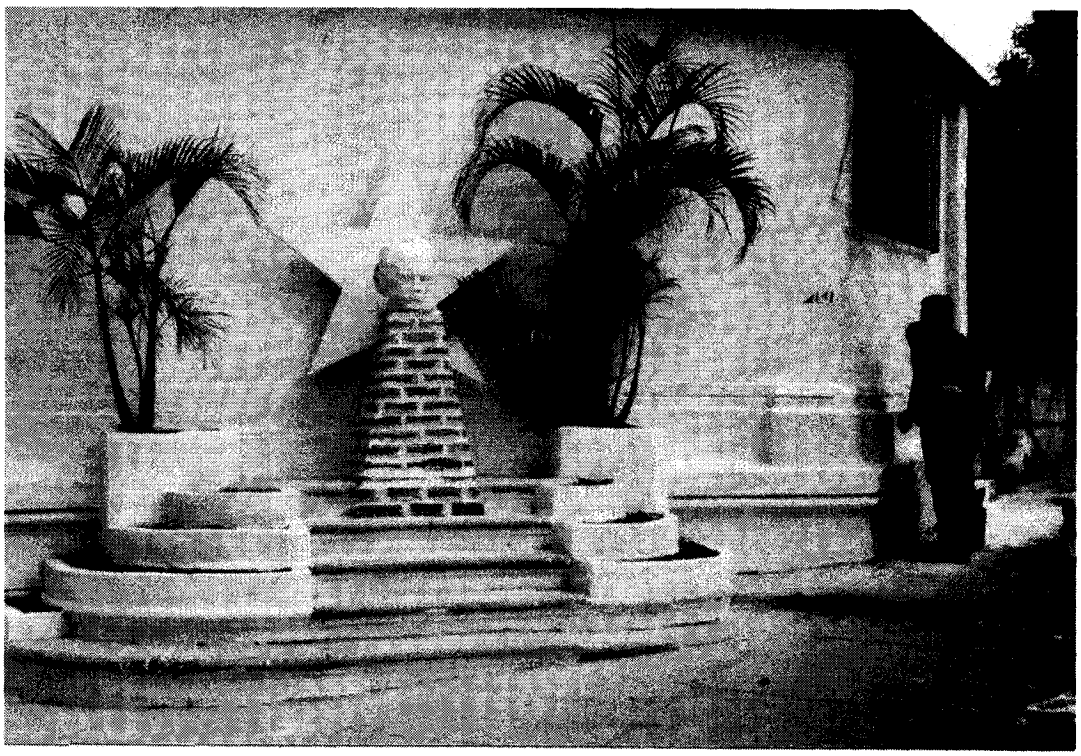
Sandra Gifford (1986) argues that the concept of risk has two dimensions: a technical, objective or *scientific* dimension and a socially experienced or *lived* dimension (Gifford 1986: 215, emphasis original). A problem arises, however,

when epidemiological statements about risk, which are statements about groups of people, are translated into clinical practice. As Gifford writes, contemporary concepts of epidemiological risk describe relationships between uncertain knowledge and unwanted outcomes, and thus the problem for medical practitioners becomes one of how to apply this knowledge in the clinical context (cf. Mol 1998 work on "multiple norms"). Gifford (1986) illustrates her argument by focusing on the relationship between risk factors for breast cancer and the complexities of accurately defining epidemiological-risk. Gifford argues that due to the uncertainty that a woman with a benign condition will develop breast cancer, "the condition comes to take on the double meaning of being both normal and pre-malignant at the same time" (Gifford 1986: 225). As a result, the women whom epidemiological-risk discourses have classified as having high "risk factors" are predisposed to a higher degree of clinical medical surveillance, and must live with the belief that a benign lump can become, cause, or mask breast cancer.

If we extend Gifford's observations to Cuba, the *dispensarización* of the population into an exhaustive listing of "risk groups" has left the majority of the individuals in the categories of "pre-pathology." An example from Dr. Louis Pérez's *consultorio* (*Los Molinos*) illustrates this latter point. After going through his *fiche familiar,* noting the various illnesses that people suffered from and a listing of major risk behaviours, I asked Dr. Pérez how many people were "supposedly healthy" (*supuestamente sanos*), or in Group One, in his *área de salud.* "Not many," he replied. Between chronic and infectious illnesses, illegal migrants, smokers, sexually promiscuous youth, alcoholism, criminality, and general anti-social behaviour, Dr. Pérez's *área de salud* was an epidemiological nightmare of risks waiting to unravel into health problems. This is not to suggest that this hyper-surveillance has drastically affected the practices of individual citizens. What these extensive health-education and disease-prevention campaigns have achieved, as I will argue in the following chapter, is the creation of a medically literate population that uses this knowledge to its own ends.

Part III

Cuban Socialism and the Pragmatics of Everyday Life



Author © 2002

The bust of Cuban independence fighter, Jose Martí, is being refurbished in a neighbourhood in the city of Havana for the "26th of July" celebrations.

Anthropology, with its sensitivity to the actors' points of view and the ways these contradict or clash, combined with its capacity for problematizing the taken for granted (including its own theories and models), is particularly suited to analysing how ideologies infiltrate the institutions of practices of everyday life. Reconfiguring basic categories of political thought to create new kinds of political subjects is one of the most effective strategies governments can employ to achieve this hegemonic power.

(Chris Shore and Susan Wright 1997: 24)

Chapter Six

Cuban Health Politics in the Período Especial: Pragmatic Strategies and Re-Emerging Subjectivities

> . . . the state at times makes mistakes. When this occurs, the collective enthusiasm diminishes palpably as a result of a quantitative diminishing that takes place in each of the elements that make up the collective, and work becomes paralysed until it finally shrinks to insignificant proportions; this is the time to rectify.
>
> — Ernesto "Ché" Guevara cited in *Man and Socialism*, 1965: 23.

> *In Cuba, health care is free. But, when you go to el médico, the polyclinics 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 light bulb —you can guarantee the hospital's light bulbs have been stolen. 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 (conseguir) the medications you need, if they are not available, which is often the case; even the most basic drugs, such as aspirin. But, yes, healthcare is free. In capitalist countries you might have to pay for health care, but everything is guaranteed for that reason. 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!*
>
> *—Sra. Marianna Díaz Rodríguez, accounting assistant, born in La Habana in 1951.*

6.1 Introduction

I open this chapter with the above quote by Ernesto Guevara, from his treatise *Man and Socialism,* because I believe his words, written in 1965, were harbingers of the current plight of Cuba's socialist government. Read alongside Guevara's text, the above excerpt from an interview I conducted in 2001 with Sra. Díaz Rodríguez, is revealing. Her words, bitterly ironic, express frustration at the Cuban state's increasing problems with the adequate provision of health and social services. As she poignantly argued in her interview, rather than focus on Cuba's health accomplishments, as defined through the widely published vital

health statistics, one should critically examine the role of individual Cubans and professionals who are *luchando* (struggling) to achieve health-care goals and importantly, generate these statistics. This latter approach requires a shift from the *macro-* to the *micro-politics* of health, a shift that necessarily moves us away from an examination of the state as a monolithic entity that acts on individual bodies, to an examination of individuals' interactions with and around institutions of the state. This chapter, then, through detailed interviews and observance of practices of individual citizens and health professionals, will explore the complexity, nuances and many points of conflict, resistance and conformity that shape individuals' everyday lives.

In this chapter and the following one, I argue that the *período especial* (1991 – present) has been characterized by an "economy of scarcity and material constraints placed upon everyday life" (Fernández 2000a: 107). Following the work of Michel de Certeau (1988), I suggest that the state and individual Cubans have resorted to a variety of strategies and tactics for survival (*sobrevivencia*). These practices, which I describe in the following analysis, have changed the relationship among citizens, government institutions, public associations and the state. In this respect, the recent economic crisis is clearly both a social crisis and a crisis of identity. In effect, Cuba's recent economic crisis has served as a catalyst for the emergence of new, and re-emergence of old, subjectivities in the island's changing social and political landscape.

In the first section of this chapter, I critically examine the international fetishism surrounding Cuba's vital-health statistics, particularly the way in which statistics have a way of eclipsing the everyday realities of the people or things they claim to represent (disease prevalence, birth rates, life expectancy, and so on). In particular, I examine how the collapse of the Soviet bloc (post-1989) is changing the relationship between socialist health-policies and individual practices and how it has redefined how state power becomes enacted through and upon individual bodies. In the second section of this chapter, heeding the above words of Sra. Díaz Rodríguez, I examine how individual practices play an important role in the maintenance of Cuba's population-health profile, as individual citizens give priority to their own health care needs, both material (such as food, medicines and medical supplies) and spiritual (including the re-emergence of religious participants). I look at how citizens negotiate the gap

between the role of the state in providing health and social welfare, and their individual desires to seek positive health outcomes, increasingly at their own expense.

In this respect, my primary goals in this chapter are to examine individual and group responses to state power in the context of changes to the state's provision of health-related welfare (that is, food, medicine, and basic supplies) and to emphasize that these responses exist at multiple levels. Several social scientists have pointed out that resistance is complex, blurred, fractured, and functions at times as organized collective political action against sites of control and discipline. For example, resistance may take the form of pragmatic behavior (Lock and Kaufert 1998), bodily reform (Boddy 1989; Comaroff 1985), or the quotidian practices of routine actions (Scott 1990; de Certeau 1988; Bourdieu 1990). This link between power and resistance, as researchers have noted (Lock and Kaufert 1998; Lock 1993b; 1997; Rabinow and Dreyfuss 1982), profoundly shapes an understanding of power not as a coherent or coercive force exercised only through class relations, but as "an all pervasive, normative and positive presence, internalized by, and thus creating, the subject" (Evans 1993: 1). Power, in this context, is both constructive and oppressive. Thus, while it cannot be taken for granted that self-directed agency is everywhere (Abu-Lughod 1990), neither can one assume that subjects do not try to modify, manipulate or escape the effects of those forces that "construct them."

6.2 'Seeing like a State[1]': Statistical Fetishism and Docile Bodies

> At the heart of current conventional wisdom in economics, we find the concept of *growth* and a number of assumptions about the relationship between *economic growth* and quality of life. *Economic growth* usually refers to the real (inflated-adjusted) annual percentage changed in a country's grow domestic product (GDP). Strong GDP growth is commonly taken as the primary vital sign of a healthy economy and the best proof that a society is "developing." Worldwide, economic and political policy over the last decades has been driven by the perceived imperative to achieve and sustain growth. The conviction that enhanced economic growth automatically brings with it increased prosperity and a better life for all — not only the already affluent but, in the long run, the disadvantaged members of society as well —is widespread, and until recently, virtually unquestionable. (Millen *et al.* 2000: 6)

[1] I borrow this title for James C. Scott's (1998) book of the same title.

Authors of the edited volume *Dying for Growth*, from which the above quote is taken, argue that the "conventional wisdom of economics" (2000: 6) has fueled the misguided belief that positive changes in a country's gross domestic product (GDP) will result in positive health outcomes. Yet, as various authors in the volume point out, this faulty linear assumption often proves to not be the case. One need look no further than documents such as the World Health Organization's "Health Report 2000." This report ranks the world's health-care systems according to an overall index of performance and responsiveness based, among other things, on vital-health statistics, in the process showing that the correlation between the wealth and the health of a nation is often misconstrued (see, Navarro 2000 for critique of the "Health Report"). For example, in the WHO's "Health Report," Cuba is ranked 39th among 191 countries surveyed, whereas the US is ranked 37th — suggesting that no link exists between GDP and health outcomes.

The WHO's "Health Report" ranking for Cuba, a small developing nation with a socialist-based economy, rare in today's age of 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. For example, one of the articles in the *Dying for Growth* volume, entitled *The Threat of Good Example: Health and Revolution in Cuba*, makes a case for Cuba as a kind of "anti-model" for the development logic that fuels the top-down structural adjustment policies so common in contemporary Latin America and the Caribbean. The author of this article, Aviva Chomsky, examines several of Cuba's best known public health successes, such as the island's low HIV/AIDS transmission rates, low IMR and longer life-expectancies at birth, and concludes that, in the face of scarce material resources, the country has still managed to achieve "first-world" health outcomes through strong 'political will[2]'. This argument, echoed by a vast number of scholars who discuss the success of Cuba

[2] See Morgan's (1989) critique of the term 'political will.'. Morgan argues that, in the context of public health reform, the use of this term diverts attention away from the global inequities that prevent the implementation of effective health policies in the first place. Moreover, this term uncritically reproduces the idea that states are monolithic entities and, thus, devoid of internal fragmentation and struggle.

in the sphere of health and education, is an important one. For example, in Latin America and the Caribbean[3], the impact of structural adjustment policies, for the most part funded and implemented through international bodies such as the World Bank and, to a lesser extent, the IMF, has spelled financial ruin and deepening poverty for many countries, thus leaving large segments of the population without basic health care.

Nonetheless, Chomsky and other scholars who follow this line of thinking, are blinded by what I argue is a kind of statistical fetishism[4]. Ultimately, this form of fetishism serves a specific purpose: Cuba's health-care statistics provide a *model of* and *model for* reality, borrowing anthropologist Clifford Geert's famous dictum[5], but do not constitute a critical examination of what those numbers reflect, or more importantly, how they are produced. It is not my intention to argue *counter* to the prevailing rhetoric of Cuba's "revolutionary" success in their vital-health statistics, but rather to move the debate away from a moral discourse, which reproduces specific political and ideological positions, to an examination of the interaction between Cuba's public health discourses and individual practices[6].

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[3] See, for example, the exceptional collection of articles by Alma Guillermoprieto (1994) in *The Heart That Bleeds: Latin America Now*, for a richly detailed on-the-ground journalistic account of inequality, violence, and suffering in contemporary Latin America. For a more scholarly account on the effects of the introduction of neoliberal structural adjustment policies in Latin America, see Halebsky and Harris (1995).

[4] For the purposes of this discussion, the best way to define fetishism, following anthropologist Michael Taussig, is when "[d]efinite social relationships are reduced to the magical matrix of things" (2002: 479). Taussig is building on the Marx's discussion of the relationship between capital, workers and social relations in developed capitalist cultures.

[5] I am extrapolating on the work of Geertz (2002), who was 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"). The "model of" reality articulates a description of natural and cultural phenomena, whereas the "model for" reality shapes how one ought to behave and act in the natural and cultural world. This model can be extended to an examination of Cuba's health statistics because, in one respect, scholars have analysed 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 as alternatives to, the status *quo* in international development circles.

[6]Undoubtedly, at both the level of the vital health statistics and the "real" tangible results of health outcomes, Cuba has made impressive gains in the sphere of health care reform. My argument is not intended to diminish these accomplishments.

I will argue that we must examine the multiple on-the-ground broad social processes that shape and influence Cuba's contemporary primary health care system. I move my analysis away from what Foucault refers to as "docile bodies" — individuals who are *acted upon* through regimens of discipline (cf. Foucault 1990a; Rabinow 1984:182) — to an account that examines how individuals are active subjects operating in specific socio-political and historical contexts. I argue that the state's emphasis, since 1984, on the expansion of the MEF program was influential, in part, in buffering individual health from the effects of general economic contraction brought about with the cessation of Soviet aid. Indeed, many of Cuba's basic health indicators continued to improve over the course of the *período especial*, particularly as the state gave priority to specific groups through specialised primary health-care programs. The groups targeted, as I outlined in chapter three and five, were those groups whose improved health care would most likely lead to quantitative changes in key health indices that define the health and economy of the population.

With the advent of the *período especial* in the early 1990s, the political economy of Cuba's health sector was directly affected by the structural-adjustment programs implemented in the face of mounting macroeconomic changes. According to the MINSAP, the total expenditures in hard currency for the health sector fell between 1989 and 1993 from $227 million US to $56 million US. In 1990, the country reportedly imported approximately $55 million US in medical and pharmaceutical products, while by 1996 this figure had dropped to $18 million US, a decrease of around 67 percent (see Table 7-1). The agricultural-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 Cuba's agricultural industry crashing to a halt in the early 1990s. Food production plummeted. An often cited case of Cuba's nutritional crisis was the outbreak of an epidemic of neuropathy[7] in 1993. This outbreak was

[7]From 1991 to 1993, an epidemic of optic and peripheral neuropathy — commonly associated with a painful inflammation of nerves — affected more than 50,000 people in Cuba. The prominent clinic features were subacute loss of visual acuity, diminished color vision, optic-nerve pallor, and decreased sensitivity to vibration and temperature in the legs. According to an article in *The New England Journal of Medicine*, the epidemic was linked to a reduced nutrient intake and the high prevalence of tobacco use (Garfield *et al.* 1995; see also Molina-Equivel *et al.* 1998). The number of new cases decreased after the widespread distribution of vitamin supplements through family

due, in part, to nutritional deficiencies resulting from the dropping per-capita daily food consumption from 3,100 calories in 1989, to less than 1,800 in 1993 (PAHO 2001; see also A. Chomsky 2000)

In the early 1990s, a decline in medical and pharmaceutical imports seriously compromised many physicians' treatment options. With a reduction in therapeutic options, and growing numbers of broken and unrepaired pieces of medical equipment in the country's hospitals, the capacity of secondary and tertiary institutions to undertake high-technology procedures decreased significantly. Political scientist Thad Dunning, for instance, studied the effects of the *período especial* on the ability of hospitals in the city of Santiago de Cuba to perform major surgeries. Dunning (2002) found that, between 1989 and 2000, the number of surgeries decreased by 46 percent in selected hospitals, and further predicted that this trend was reflective of the overall decrease in high-tech procedures being performed in other hospitals throughout the country. Several other studies have come to similar conclusions. These studies suggest that the withdrawal of Soviet aid and, importantly, the deleterious effects of the US embargo — popularly known as *el bloqueo* — can be linked to such negative trends as massive shortages in pharmaceutical drugs and medical supplies.

In 1997, the American Association for World Heath (AAWH) sponsored a well-known study of the impact of the US embargo on health and nutrition in Cuba. The study suggested that, of the 1, 297 medications available in Cuba in 1991, physicians in 1997 had access to about 889 of these same medicines, and many of these were only available intermittently (AAWH 1997: 2). The strengthening of the US embargo in the mid 1990s, as previously discussed in chapter two, resulted in drastic changes in Cuba's ability to trade with foreign countries. Despite the US Department of State's contention that the embargo against Cuba did not prohibit US 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 the US legislations (see, for example, Nicholas' 1997 statement from the US Department of State). Legislations imposed by the US government, which required multiple levels of bureaucratic approval, resulted in inordinate delays, cost increases and

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doctors to every citizen (see A. Chomsky 2000 for a more detailed discussion of the MINSAP's response to this epidemic).

limited access to some of the most important medicine and medical products. Nayeri has noted that the added expense of imports for public health due to indirect costs of the US embargo cost the Cuban government an extra US $45 million in 1993 (Nayeri 1995: 326). From this perspective, then, according to Kirkpatrick (1997), the bureaucratic obstacles put in place by the US government amounted to a *de facto* embargo on important medicines and medical supplies (see, also Burns 1997; Kirkpatrick 1996; 1997; AAWA 1997 for similar arguments).

Strangely enough, despite the significant macroeconomic changes affecting Cuba's health sector, the country's basic health indicators still continued to increase over the course of the *período especial.* For example, between 1990 and 2001, the infant mortality rate declined significantly from approximately eleven to six deaths per 1, 000 live births, and life expectancy improved slightly between 1990 and 2001, from 75.22 to 76.3. According to the United Nations Development Report (1997), the infant morality rate in some neighbouring Latin American and Caribbean countries such as Mexico and the Dominican Republic, tottered in the low 30s per 1,000 live births, and these countries reported life expectancy averages as low as 59 years, which, when read alongside Cuba's statistics, made the Cuban government's health statistics even more impressive. Given this seeming paradox in Cuba's health care system, I follow Dunning's lead: "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.

Dunning argues that from 1989 to 1999, health-care expenditures, in absolute terms[8], " . . . which depended on foreign exchange — such as the purchase of imported medical products — decreased substantially during the

[8] As Dunning points out, these figures are in absolute terms; that is, while the numerical value increases, this does not take into account the real value of the peso from year to year. For example, the legalization of the US dollar in 1994 significantly devalued the Cuban peso. As he notes, if you examine the same figures from the fixed value of the peso at 1981 prices, health expenditures decreased from 912 million pesos in 1989 to 859 in 1998. This decline in "real value" may reflect the shift to dollar-based spending and consumption. Clearly, a more detailed analysis is required to arrive at definitive conclusions.

special period." However, as he further noted, " . . . the budgetary support for peso-dominated health care expenditures remained strong" (2001: 7 – 8). In effect, Dunning attributed Cuba's quantitative success in basic health indicators to Cuba's concentration on resources for " . . . health care within the internal, Cuban-peso dominated sector and emphasized the expansion of the family doctor system, primary care and other low-tech but human-capital intensive investments" (2001: 1; also, see Table 6-1 and Table 6-2). However, if increased peso-based spending led to positive changes in Cuba's basic health indicators, what was the result in health outcomes of decreased hard currency expenditures during the same period? For example, did the downward spiral of foreign spending produce a deleterious impact on other Cuban national health statistics such as morbidity rates? The answer, Dunning suggests, is "No." While the evidence is sketchy, he argues that unilateral transfers of equipment and medicine from developed countries in the forms of humanitarian aid can be credited with partially filling the gaps in Cuba's reduced foreign expenditure. Clearly however, a more systematic analysis tracing the entry of humanitarian aid to Cuba is needed to provide a definitive answer.

Dunning's argument, while compelling, has several limitations. His focus on resource allocation in the form of human capital is one aspect of a much more complex series of processes. As I argued in chapters four and five, the MEF program is dependent on peso-based salaried physicians who are essentially clinicians and who in most cases have very little equipment or medicine at their disposal. The MEF physicians' primary goals are in health promotion and disease prevention, and thus their role is effectively to identify health problems that can be referred to more specialized institutions. What is important, however, is that in the context of material scarcity, the majority of the primary health-care physicians in the MEF program are motivated by moral incentives — to be a good *revolucionarios* —and the political belief, reinforced in their medical training, that health care is a basic human right.

Table 6-1: Decline in foreign exchange expenditures for health care (US millions of dollars)

	First year in series	Last year in series
Total health care spending, 1989 – 1993	227	56
Imports of media and pharmaceutical products, 1990-1996	55	18
Imports of raw materials for pharmaceutical manufacturers, 1990-1996	43	10

Source: Thad Dunning, *The Political Economy of Cuban Health Care in the Special Period.* Washington, D.C, 2001.

Table 6-2: Health Expenditures in millions of Pesos, Selected years 1989 - 1999

Year	1989	1990	1991	1997	1998	1999
Health Expenditure	905	937	925	1265	1345	1410

Source: Thad Dunning, *The Political Economy of Cuban Health Care in the Special Period.* Washington, D.C, 2001.

In this respect, the expansion of the MEF program which, as argued in chapter four, went from ten thousand physicians in 1985 to include over 31, 500 physicians in 2001, was undoubtedly a crucial factor in maintaining Cuba's basic primary health statistics, if only because of these physicians' efforts to mobilize communities around health education. As various studies have illustrated, 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 (cf. McKeown 1976a; 1976b; see Navarro's 2000 critique of WHO). However, an analysis of Cuba's resource allocation and funding patterns neglects other important factors, to be outlined below, that were occurring in Cuba from 1989 until the present: namely, the role of individual Cubans in negotiating their own health and well-being. In chapter two, I argued that the informal economy was an integral part of the basic subsistence patterns for many Cubans. Rather than falling prey to an economic determinist argument, that is, an analysis of one sector of the economy as if it existed in a vacuum, we must move the discussion beyond the "avalanche of printed numbers" (cf. Hacking 1982), as Sra. Díaz Rodrîguez's opening quote to this chapter suggests, and examine the social, political, and economic environments in which these statistics were produced.

Clearly, beyond the quantitative success achieved in Cuba's population health profile, the *período especial* had indelible social and political consequences

for the revolutionary government and the popular support given to it by citizens and health professionals. As discussed in chapter two, with the termination of Soviet aid and the strengthening of the US economic embargo against Cuba, the state lost a significant part of its resource-assignment powers to other actors, such as the market and the community, which had emerged as new resource-distribution mechanisms (cf. Dilla 1999; 2001). For example, one area among many that could considerably affect Dunning's conclusions was the formal and informal economy of remittances[9] that increased from 50 million US in 1990, to over 750 million[10] in 2000, representing an increase of over 150 percent in foreign exchange circulating in the hands of individual Cubans during the *período especial* (Orozco 2002: 1). If we take into account the market-based reforms being implemented by the state during the same period — for example, the legalization of the US dollar and the opening of US-dollar shops (*shopings*) and hard currency pharmacies selling a host of medicine, medical supplies and basic necessities — 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 sections, I will examine several of the aforementioned themes as they relate to Cuba's primary health care system.

6.3 Macroeconomic Change and the Biopolitics of Health

> *Some of the major differences that I have noticed after the período especial are differences in the standard of living in Cuba. There are two important areas that I would identify as being affected. One is the moral stimulus to work is decreasing among health professionals. Second, is the state salary you receive is insufficient to live on. Before the período especial you could live on the money you made as a physician, and live reasonably well. However, beginning in the 1990s, the peso salaries were insufficient to meet basic living expenses. For example, I make 400 pesos a month ($20 US) as a primary heath care physician. In the late 80's, I use to make about 325 pesos and this salary was very good then. However, now you find yourself having to struggle in two different economies. Twenty dollars is not much to support a family, especially, when the majority of the basic*

[9] Space will not permit an elaboration on 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 (1997) for a discussion on the politics of remittances to Cuba.

[10] 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. 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 being sent to Cuba originated from Cubans living in the United States (Orozco 2002).

necessities are now sold only in divisa. It is hard to talk about moral incentives to work, when you cannot buy clothes and food for your children.

Another major change 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 1980's. If you look at the basic health statistics you see that individual health has actually improved with the life expectancy grower longer. 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 40 years. Our infant mortality figures nationally are seven or eight, 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. All the primary materials we receive, 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 from whom I managed to get a treatment that lasts 14 days and the antibiotic cost $100 US. 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 (network of client-based relations), you can find solutions.

— Dr. Alfonso Valdés, Director of Primary Health Care Research in Plaza of the Revolution City Hospital, born in La Habana, 1963.

As reflected in the above interview, Dr. Valdés, a primary-health-care researcher in a local hospital, discusses some of the underlying changes in the everyday experiences of health professionals and individuals that accompanied the advent of the *período especial* in Cuba. Dr. Valdés' commentary, and those of several other health professionals that I interviewed, cited Cuba's vital health statistics, the IMR being the most widely referenced, as an embodiment of their hard work and daily sacrifices. However, the physicians, like individual citizens, are not immune to the struggles of everyday life in the *período especial*, and many of the strategies and tactics that health professionals employ, such as working through *socios* to obtain crucial medications for their patients, as Dr. Valdés indicates above, suggest that the revolutionary work-ethic is now merged with a pragmatic engagement in the private informal economy.

I argued in chapter two that Cuba's recent economic crisis has served as a catalyst for the re-emergence of practical social relations, characterized by

sociolismo, and strikingly reminiscent of the informal practices of Cuba's *período burgés* (1902-1958). Under a system characterized by *sociolismo*, social relationships are no longer strictly defined by state politics or affiliations, but by personal contacts and *socios* (networks of client-based relations) framed primarily by access to material resources (such as medicine, food items, and luxury goods) and specialized services (including unofficial access to health-care services and supplies). However, this recent trend is exacerbated in the context of Cuba's thriving private informal economy. The legalization and circulation of the US dollar has effectively destabilized the state's ability to control wealth and income disparity within the population[11].

Dilla (2001) notes that, prior to 1989, 94 % of the workforce in Cuba was employed in state enterprises; they were divided into about twenty salary categories with fixed remuneration matched by subsidized consumer goods. By 1996, that percentage had shrunk to 78 %, and a significant portion of the population had moved into the private, mixed or cooperative sectors. As Dilla (2001) further notes, relatively high concentrations of market-based wealth and power began to appear in the hands of a small group of people, especially in economically expanding regions such as those catering to tourists. Moreover, as the purchasing power of the Cuban peso drops and a greater percentage of the Cuban economic consumption shifts to the local US-dollar economy, individuals are becoming increasingly concerned with their individual health and well-being. The devaluation of the peso-based salary means people are increasingly engaging in informal activities (such as black market purchases and sales, prostitution, and private enterprise) to obtain US currency (*divisa).* The impact of the economic crisis on the primary health-care system, which had prided itself on community participation and an effective surveillance program, has been immense. The growing lack of interest in community participation, and by extension in the state itself, has meant that many people no longer feel concerned with the

[11] One of the greatest sources of US dollars before the law changed allowing Cubans to legally hold dollars was through remittance payments from Cubans aboard. The government had an official procedure by which the state would exchange these dollars at a one-to-one exchange for Cuban pesos. As many Cubans pointed out during interviews, before the advent of the *período especial,* there was a black and gray market that existed since the mid-1960s. Importantly, however, as several informants also pointed out, the private informal economy tended to be in non-essential items (e.g. blue jeans, electronic equipment) and not in basic provisions (e.g. medicine, medical supplies, rice, different kinds of meat, oil, soap).

overall objectives of the revolutionary project, that is, the maintenance of the collective good, defined as putting state objectives ahead of individual wants and desires.

In the vignettes that I present below, I examine the different ways individual Cubans and primary health care physicians are negotiating macroeconomic changes in their everyday lives. These vignettes reflect a growing reality among a number of people with whom I conducted my research, people whose access, or lack thereof, to US dollars has shaped their everyday experiences in Cuba[12]. For example, at the level of the individual citizen, there is considerable discontent over the growing economic gap between those Cubans who have access to US dollars and those who do not. My hypothesis is that many individual citizens with access to US dollars are increasingly (and ironically) becoming active health consumers in a climate of increasingly scare resources. In the following vignette, I discuss the experiences of Sra. Isabella Esparza, a fifty-three year-old woman I interviewed, who stayed at home to take care of her bedridden mother, and is a firm advocate of "taking health care into your own hands."

Consultorio San Lazaro

Living in a small two-bedroom apartment with her mother, husband and son, in a run-down area of central Havana, Sra. Isabella Esparza discusses how her daily struggles with the primary health-care system result from the massive changes brought about by recent macroeconomic problems and the widespread corruption that has ensued. Her mother, Sra. Adelfa Castilllo Esparza, paralysed on the left side of her body, is in need of regular check-ups and medication. However, Sra.Castillo is unable to walk, and thus it is the family physician's responsibility to visit her house on his local afternoon rounds. As Sra. Esparza stated:

> I can't bring 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

[12] What remains to be seen, however, is whether the increasing socio-economic stratification will have significant effects on Cuba's health profile, effects similar to the negative trends occurring in the vital health statistics of former socialist countries such as those that comprised the Soviet Union (see, for example, Field *et al.* 2001).

whatever emergency, I call the *consultorio*. Sometimes they come. Other times, they tell me they cannot come. It is more often that they do not come than they actually come. When they arrive, they often do not have a stethoscope or the equipment to take the blood pressure. It is like, why come then? I understand though, there is no motivation to do the work they are suppose to do. Imagine they make 400 pesos per month. That is about $20 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, worst 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* (long bus, which is mounted on a flat-bed 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 in 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 that 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 as a disinfectant; if you needed cotton or bandages you had to bring your own. Slowly, the *médico de la familia* no longer solves our problems.

Sra. Esparza's narrative reflects the concerns of several of the citizens whom I interviewed, including the family physicians themselves. As several family physicians 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 Sra. Esparza's neighbourhood stated, "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's sentiments, however, are blunter than those of 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."

Importantly, though, rather than passively accept the massive shortages of important medications and supplies, Sra. Esparza is 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, Sra. Esparza has been fastidious in making contacts at various institutions and pharmacies in order to help facilitate the care of her mother. Sra. Esparza has created a *socio* in strategic places. She would bring coffee to a local pharmacist, who in return would save her the essential drugs that she needed in Cuban pesos when they were available. As an anthropologist, I was not exempt from Sra. Esparza's network of contacts. She often called on me to make purchases of prescription drugs at international pharmacies with my passport, a theme I will elaborate upon in the second vignette. In addition, when I was in Canada, Sra. 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. Sra. Esparza, instead of consulting with her designated family doctor for regular check-ups, as stipulated in the MEF program, would call her friend, who was a physician in a large hospital in the city-centre, and get him to attend to her mother personally.

Given that Sra. Esparza's mother was not mobile, and the subsidized Cuban-peso taxis, historically designated for bringing patients to the hospitals for their health appointments, were now involved in the thriving private informal economy and operated as *boteros* (illegal taxis that charge 10 to 20 Cuban pesos to go between specific locations), Sra. Esparza relied strictly on tourist taxis that charged in US dollars to pick her up from her house, take her to the hospital, and then drop her back at her house. With 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 $80 to $100 US a month, Sra. Esaparza also washed clothes and cleaned apartments for people in her building to earn extra money to meet her mother's health care needs. Sra. Esparza's husband, a *militante* (Communist Party Member) and former member of the 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.

Clearly frustrated, Sra. 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 Sra. Esparza, she would always respond to my standard greeting, "How are you?" with her characteristic phrase, "I am still here, my dear, *luchando* (struggling)." Sra. Esparza's son was in his last year of university, where he was studying immunology. Legally, her son could not work while registered in school and was also dependent on the remittances sent from Miami to buy his school clothes, books, and the money he needed for his meals. The end of every month, when her son picked up the Western Union money transfer from her aunt in Miami, was always fraught with tension for Sra. Esparza. As she remarked, her son increasingly demanded more and more money to purchase brand-name clothes and shoes, now sold at the US dollar stores. While critical that her son was trying to "live like a capitalist," Sra. Esparza was upset that the state was selling over-priced consumer goods in US dollars to a population that was, for the most part, officially paid in Cuban pesos. As she stated, the state has created unreasonable, and in many cases unobtainable, desires among young people. As Sra. Esparza remarked, youth, 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*."

Sra. Esparza's husband, Sr. Ramón Crespo, a 55-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 in his wife's interview, by offering a sort of armchair commentary from where, on one occasion, he sat apparently glued to the baseball game on the television. Asking to speak to me one day, Sr. 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*. Sr. Crespo, who had no relatives living outside of Cuba — something that he was proud of — had great disdain for his wife's extended family that fled Cuba to the US in the early

1960s, and often referred to his wife's relatives in Miami as the *gusanera* (bunch of worms; see chapter two, footnote 18, for a more detailed discussion of this term). Sr. Crespo made it clear that the remittances sent by his wife's aunt were strictly for his mother-in-law's health-care needs, and he saw none of the money. In fact, he refused to allow his wife's family, when they visited from the US, to visit his home, and equally refused to greet them on the phone when they called. Sr. Crespo argued that, although the Cuban government was going through a hard time, things were slowly changing for the better in recent years.

Unable to live on his state pension, Sr. Crespo had recently returned to work, with the help of the FAR, as a manager of a distribution warehouse for a popular chain of state-run stores. His company regularly awarded Sr. Crespo vouchers — material incentives to reward him for his good work. These vouchers could be redeemed in US 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 US dollar prices. For example, his new washing machine, valued at $200 US, was purchased with a voucher for 200 Cuban pesos ($10 US). The government cared, he argued, for those who worked well and were dedicated *revolucionarios.* Sr. Crespo was involved in several of the mass organizations and regularly participated in the voluntary labour campaigns. Throughout the years, the local CDR had presented him with various medals and certificates of accomplishment for his revolutionary activities. The problem with the health-care system, Sr. Crespo noted, was the deteriorating values of health-care professionals, who were tempted by desires for material wealth, and thus had fallen into the trap of making money on the side through informal practices.

Sra. 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*. Sra. Esparza stated that the state was taking care of selected people, especially the 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 themselves. In pre-revolutionary times, Sra. Esparza remarked, her mother was an associate of the Spanish insurance scheme, known as *mutualista* (described in chapter three). "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." Sra. 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 semi-privatised health-care system that existed in the pre-revolutionary period where, as she stated, "you got what you paid for." I will return to this discussion later.

Sra. Esparza's and her husband's experiences are important because they reflect the challenges faced by individual citizens in the face of massive social and economic changes. Sra. Esparza is torn between her commitment to *la Revolución* and her first-hand experiences with a health-care system that is rife with massive shortages and which 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 Sr Crespo has less direct experience with the health- care system, his narrative is equally important. The ideas and values that he discusses reflect sectors of the Cuban population that, despite massive 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 US influence — an influence, Sr. Crespo's 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.* The following brief vignette from *consultorio Las Vegas* provides another clear example of the ways in which individuals are becoming increasingly active in the pursuit of their health-care needs.

Consultorio Las Vegas

Dr. Maria Menendez, a family physician in her late 30s working in a comparatively wealthy neighbourhood in the municipality of Plaza of the Revolution, was assigned to a relatively affluent *área de salud.* Popularly known as

Las Vegas, Dr. Menendez's *área de salud* is made up of about 600 people, the majority of whom are involved either directly or indirectly with the tourist economy. Dr. Menendez remarked that a large percentage of her patients have family members living abroad, that makes 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 *consultorio Las Vegas* because I lived in very close proximity to many of Dr. Menendez's patients and encountered them on a daily basis in the market, at the local US dollar store or, more often than not, buying prized food items from the same vendors in the private informal economy.

The neighbourhood of *Las Vegas* has a high concentration of people with access to US dollars, perhaps because it is also home to foreigners who live in many of the state-licensed housing; it also has many wealthy apartment owners who earn as much as $400 to $600 US a month renting out their homes. For these reasons, the area is a prime target for various vendors in the private informal economy. A regular topic of discussion in *Las Vegas* was the availability of various food and medicines from informal contacts, who were recommended by word-of-mouth to different clientele. In the building where I lived, for instance, several of my neighbours had put various vendors at ease in my presence by informing them that *"está en confianza"* (he can be trusted). Although I was a stranger, they knew I was not going to report them to authorities.

As word spread to other vendors in the area, I ended up purchasing well over 60% 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, I may add, 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. While, at first, I was uncomfortable with making these transactions, I quickly got over any "conflicts of conscience," especially seeing that the local US dollar store (*shoping*) only carried a limited selection of liver, gizzards, chicken back and legs, canned goods, milk, beverages (alcoholic and otherwise) and other packaged consumer goods that were often overpriced and, if one read the labels, clearly already expired. The other option, the diplomatic

store, was a considerable distance away, and the prices there were often exorbitant. While I was less concerned with purchasing medicine and medical supplies, *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 non-generic brands being sold at significantly higher prices[13].

Several of the individuals I interviewed in Dr. Menendez's *área de salud* were regularly both buyers and sellers of pharmaceutical products. Often bringing the doctor *regalitos* (little presents), many of these patients stressed that the gifts were tokens of appreciation because Dr. Menendez often prescribed medicines that she knew were not available in local Cuban pharmacies — at least, not for sale in Cuban pesos. Sra. Meybol Tomas, a 65 year-old diabetic living in Dr. Mendendez's *área de salud,* for example, made frequent visits to *consultorio Las Vegas* with her foreign-purchased medications. Meybol wanted Dr. Menendez's to translate the complicated instructions and warnings on the package from English into Spanish. Furthermore, Meybol wanted Dr. Menendez to advise her on the other medications her over-zealous relatives in Miami had sent her, which they indicated "were also good for diabetes." Meybol, unlike many of the other residents I interviewed for this research, was cautious before taking too many drugs based on word-of-mouth advice. Dr. Menendez also used these visits to stress the importance of diet and exercise in Meybol's daily routines. As Dr. 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."

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[13]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 low. While individuals discuss with admiration Cuba's scientific research community (*el pueblo cientifico*), 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 for sale on the black market.

Armed with prescriptions obtained through different physicians, an increasing number of Dr. Mendendez's patients convinced friends and relatives abroad to send them medications[14]. While several of them revealed in interviews that the various ailments which they claimed to suffer from were not clinically diagnosed, they were adamant that their medications were essential. Alternatively, I interviewed some patients who, armed with US dollars, tried at international pharmacies in hotels and hospitals that treated foreigners to get access to medications recommended by Dr. Mendendez. On several occasions, I accompanied Cuban friends (and friends of friends) to international pharmacies at certain hospitals and clinics, such as the *Cira García* International Clinic, to buy prescription drugs and rudimentary medical supplies such as gauze, antibiotic ointments and vitamins. The only requirement to make these purchases at these locations was a foreign passport. As I soon found out, Cubans anxious to make purchases but without a foreigner in tow would often linger outside the pharmacy, waiting for foreigners to enter to help them facilitate their transactions.

On one occasion, in addition to making purchases for a friend of mine, two individuals whom I did not know approached me to facilitate the purchase of their prescription drugs as well. The pharmacy staff, clearly aware of what was transpiring, went about their business courteously. When I inquired why such a rule was in effect, the staff informed me that the pharmacy was not geared for Cubans. Rather, the pharmacist stated, Cubans had the option of going to their local pharmacies and paying in Cuban pesos. One of the unknown individuals, a middle-aged woman, became visibly upset and roared, "You know damn well there is nothing in those pharmacies. In this country, *los extranjeros* (foreigners) come first. *El pueblo*, on the other hand, we eat shit." The pharmacy staff purposely ignored her comments. As we left the pharmacy the irate woman,

[14] Despite the long list of restrictions on items brought by travellers to Cuba, one notable exception is the allowance by Cuban customs (*Aduana General de la Republica de Cuba*) for people to enter the island with relief from the payment of duties and taxes of up to 10 kg of medicines in original packaging (cf. http://www.aduana.islagrande.cu, March 2003). In addition, some agencies are dedicated to sending medicine and medical supplies to friends and families in Cuba. Several of these agencies have their offices conveniently located in Canada to avoid limitations imposed by the US embargo (see, for example, CIMTI Financial Services Ltd.; "Medicines to Cuba" (http://www.medicines2cuba.com, March 2003).

whose name I never found out, held up the receipt in the air, shaking it violently and stated, "Look, $86, and for what?" She cursed the woman in the pharmacy as being two-faced, and said her medications, which she remarked were for her heart, had been unavailable in her local pharmacy for months. Her daughter, who lived in Spain, had sent her money to buy the drugs she needed to make the purchase. The scene played out in the pharmacy was typical of the two-tiered health care system slowly emerging in Cuba, as several individuals I later interviewed pointed out. While this particular pharmacy required a foreign passport to make the purchase, the reality, as I found out, was that many others would make the sales without a foreigner present; several individuals I interviewed made purchases at international pharmacies in hotels without a foreigner and others merely offered hospital pharmacists *regalitos,* which they considered were material incentives rather than bribes. Conveniently, the distinction between these two terms, as described by my informants, was purposely vague. I failed to see the difference.

In one local pharmacy, a 45-year-old woman I interviewed, Sra. Magarita Pérez, who lived in my building, tried to buy vitamins without the required prescription and was told that they were sold out. However, the pharmacist added, there was another brand of vitamins available for ten pesos, if she was interested. Sra. Pérez, knowing full well that the normally subsidized vitamins and drugs, which rarely cost more than 1 to 2 Cuban pesos, were being significantly hiked in price, decided that it was the best way for the pharmacist to "turn a blind eye" to the fact that she had no prescription. This routine, Sra. 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, local pharmacies, clinics and hospitals find themselves burdened with heavy caseloads and dwindling supplies that are often funnelled into black market networks and not to those individuals who follow "official" channels. Sra. 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.

The majority of physicians who participated in my research were well aware of the proliferation of black-market 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 (*bolso negro*) — many without consulting a family physician. In general, though, throughout the duration of this research, I met countless individuals, of different educational backgrounds, who could discuss with advanced knowledge the aetiology and treatment of various illnesses, for example, the different kinds of parasites that one can be exposed to, the symptoms one exhibits, and the specific drugs and dosages that are required to treat these infestations. Most people knew drug names (either by their generic or brand name), the class of drug they belonged to (whether an antibiotic, anti-inflammatory, or for hypertension and so on) and the corresponding treatment regimen. Moreover, many people were equally literate in translating different drug names from North American brands (mostly sent by relatives in the US) to their equivalents manufactured in Spain, Italy or France, and in mastering a dizzying array of treatment plans and dosages.

As Figure 6-1 attests, many individuals have a large collection of pharmaceutical drugs and medical supplies that far exceeds the contents of the average first-aid kit. This photo in Figure 6-1 was taken in the house of a woman I interviewed, who proudly pulled out her medicine drawer to show me how well-equipped she was for any unexpected illnesses. Her collection included an armoury 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. Moreover, 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 would be offered a spectrum of medications and be subjected to *ad hoc* medical diagnoses from my neighbours, each of whom had a small pharmacopoeia in their homes.

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 individuals interviewed stated that they felt comfortable with this practice and felt they were active consumers in seeking out their desired health outcomes. The family physicians for many of these individuals 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 US dollars ranged from $10 US to $80 US 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 or diabetes, or cardiovascular–related problems. These individual health-care expenses are significant when put in the context of the average official state salary for a Cuban, which in 2001 was approximately 180 to 200 Cuban pesos per month ($8 to $10 US). The informants I worked with suggested that this meant that individuals were increasingly seeking out US dollars, whether through remittances or the informal economy, to meet individual and family health-care expenses.

Figure 6-1: A personal collection of medicine, ointments, needles and guaze (the majority of which were expired) of one of my informants.

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The private informal practices described above are carried out in tandem with the Cuban Ministry of Public Health's extensive health — education programs that, ironically enough, strongly advise individuals against engaging in self-medication. These education programs are regularly broadcast on the TV and radio, or published in local newspapers and various popular journals. Health campaigns, which focus on hypertension, diabetes, HIV and STDs, in addition to providing nutritional advice, and promoting healthy activities such as regular exercise, reduced alcohol consumption, and abstinence from smoking, form a daily part of the educational initiatives occupying various domains in public life at school, work, and local *consultorios,* and on TV and radio. As a result, and contrary to the claims of various international health-policy analysts (cf. Cortiñas 1985, Werner 1983) who build on the work of Ivan Illich (1975) to suggest that Cuba mystifies the power of professional centralized medical expertise by delegating almost every level of curative and preventative health measure to an army of fully-trained physicians, the informal practices of individual Cubans indicate that years of massive health education and disease prevention campaigns have, in fact, created a highly medically literate population.

It would be unfair to suggest that individual Cubans do not have health care options available 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, 54 year-old Sra. Eva Castañeda, who lived in a remote rural area an hour outside of Havana, had undergone a heart-valve replacement two years earlier. With no access to US 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. Unlike people living in the United States, she added significantly, "The kind of surgery that I got would have cost nearly $20, 000US in the States." She told me 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 towards *la Revolución,* she openly criticized the US government and was convinced — based on images from documentaries, frequent on Cuban TV, that feature the US government's problems with drugs, racism, illiteracy and, importantly, health care — that a person such as herself was better off in Cuba. In the more than 80 interviews that I carried out in various municipalities, all the individuals expressed respect and admiration for a

health-care system that was without barriers according to 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 own personal experiences of Cuba's local health care system, as opposed to going 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 "ears, nose and throat" specialist. Despite my accompanying friend's insistence that I invent a more Spanish sounding name, so that as a foreigner, I would not be charged the US consultation fee, I resisted. The Cuban government offers free medical and dental assistance to students who are classified as "temporary foreign residents," which at the time, I was. Despite the deteriorating appearance of the hospital and the dismal-looking examination room, the unenthusiastic specialist attending me briefly glanced up only once when going through her routine of questions, to remark, "Oh, you are a foreigner." Carrying out her physical exam, she wrote extensive notes on a piece of scrap paper and determined that I had inflamed sinuses. She prescribed anti-histamine nasal drops and sent me on my way. I picked the medication, manufactured in Cuba, at the hospital pharmacy for 75 *centavos* of a Cuban peso (less than 5 cents US). I left the hospital less than 15 minutes after entering. My symptoms were gone within three days.

While my accompanying 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 that I could only dream of being out of an emergency room in a hospital (or even from a doctor's office) in Toronto 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 US dollars are not simply left without basic health services. The circulation of the US dollar, however, has meant that individuals who have access to these dollars can now

strategically exploit the two-tiered health-care systems: one in US dollars and the other in Cuban pesos. I will elaborate on this theme in chapter seven, particularly on the emergence of US dollar health facilities. What I wish to stress in this section, however, is that — as with the recent restructuring of health-care systems in wealthier countries such as Canada that boast socialized health care systems — hospitals are increasingly being characterized by a shortage of funding, which results in longer waiting lists for different medical procedures, and as a result, are subject to vociferous criticism. The result of these massive changes in the health-care system in places such as Canada has been a call for of the gradual privatisation of various sectors of the health system, and the Cuba health-care system exhibits many similarities.

The Cuban population, which has grown accustomed to the privileges provided by the "cradle to grave" health and social welfare system that addressed the population's basic needs, is now witnessing the slow chipping away of the foundations of that system. The outrage expressed by citizens is directed toward the changing role of the state. Rather than viewing these individual forms of expressions as wholehearted critiques of socialism, I argue, they must be seen as quite the opposite. Historically, *la Revolución* was effective, at the levels of both ideology and practice, in convincing the population that access to health care was a basic human right. Therefore, the outrage expressed by people at the changes to health and social welfare during the *período especial*, which in many respects is similar to people's criticism in cities throughout Canada, is outrage at the slow withdrawal of the state in areas in which they believe the state should remain strong. As the following section will outline, one among many of the effects of the state's gradual withdrawal from people's everyday lives has been the recent resurgence of practitioners of informal religious traditions such as *Santería* who are sought out by many people for immediate solutions to their health problems and to provide spiritual well-being.

6.4 *Mamá Ochún* and the Search for Spiritual and Material Well-Being[15]

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, Sra. Trinidad Lopez, a black woman just over 60 years old, was eager to rent to me, although she did not have a state licence to legally rent to foreigners. Hoping to avoid paying the high rental tax to the state, she explained to her inquisitive neighbours that I was her *sobrino* (nephew) from the countryside. Packing up a few of her things, she left me with 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, to pay the electricity or water bill brought by the door-to-door state collectors for instance, she told me to speak as little as possible, and direct collectors to her neighbour's apartment. Her neighbour, whose outdoor patio was adjacent to my own, was clearly aware that I was a foreigner, despite Sra. Lopez claims that I was related to her. Her neighbour went along with the story and, politely, turned a blind eye to the holes in her story.

As if to test Sra. Lopez's explicit instructions not to open the front door, her neighbour and persistent friends were always knocking on the door in the hopes of getting her advice or a chance to discuss the 10-foot *Santería* altar, which also shared my apartment, built into the closet of my bedroom. The altar, always full of offerings and with over 15 rounded ceramic jars, each jar representing a particular *oricha* (syncretic Yoruba-Catholic saint), required frequent propitiation and maintenance. While I had initially "black-boxed" 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 provided detailed explanations of what they were hoping to obtain through consulting with Sra. Lopez, that issues of health and well-being were, for them, intimately interconnected with spiritual and material well-being. It was not until several weeks later, when I got my state research visa and, as a result, was

[15] This case study 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. However, *Santeria* was by far the most commonly followed religious tradition among those formally interviewed for this research.

forced to move into a new apartment building that was registered with the state housing authorities, that Sra. Lopez's altar in the closet took on greater significance. Once again, I saw people coming in and out of my new building in the hopes of consulting with one of my neighbours, Sra. Angela Ulloa, a *Santera*, and thereby solving both health-related and spiritual problems.

I met Sra. Angela Ulloa in an unconventional manner. 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 sales people selling black market goods at our doors. An older woman, Angela was vivacious and used crude bodily language to express her points, often punctuating her rough street-Spanish with English phrases for my benefit. Angela 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," also known as a *combatiente.* The revolutionary government had awarded Angela and her husband an apartment in the fashionable Havana municipality of *El Vedado,* one the many apartments vacated by wealthy urbanites in the mass departure shortly after *la Revolución* came into power.

After moving to Havana, and with little formal education beyond high school, Angela had little difficulty, she told me, in integrating her life into the revolutionary movement and taking advantage of the many benefits that this integration entailed, including retraining and adult education. Shortly after her arrival in the city, Angela started working as the director of the janitorial staff at a local hospital. She kept one secret, though: Angela and her husband were both active practitioners of *Santería.* Being a 'believer,' or *creyente*, in *Santería* meant that Angela and her husband had to be discreet about their faith in certain circles. Angela made clear that in the first three and half decades of the revolution, that is, up until the mid-1990s, one could not readily admit in public to being a *creyente* and *militante* (Community Party Member) in the same sentence. 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 removal of one's membership.

Maintaining a small hidden altar in one of the closets in her apartment, Angela and her husband tried, despite the difficulties involved, to maintain a close relationship with their *orishas* (pantheon of gods). The *orishas,* Angela

noted, were very demanding and needed to be propitiated frequently. As she remarked, her life grew increasingly difficult as her marriage became shaky due her husband's alcoholism and the physical abuse that ensued in the aftermath of his inebriation. Angela also discovered during that time that she was unable to have children and felt increasingly separated from her family in *Oriente*. As an active member of the FMC and a local CDR delegate in her municipality, Angela stated she also 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 provided people, particularly women, with options. The majority of men, Angela noted from her experience, remained set in their ways, despite the revolutionary teachings that stipulated the egalitarian delegation of tasks, both inside and outside of the home. Women, she said, 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, without children, she was not going to be like her mother and be defined solely by her husband. Rather, Angela asserted, she would live her life alone and in the way she deemed appropriate, without the added responsibility of a domineering husband.

Divorcing her husband after 20 years of marriage, Angela sought a *permuta* (exchange)[16] to switch her two-bedroom apartment for two separate one-bedroom apartments to enable her to start her life independently. 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, Angela said, the economic crisis of the 1990s marked a turning point 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. She further noted that, in the heart 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

[16] See chapter four, footnote 18 for a detailed description of housing exchange in Cuba.

Afro-Cuban drumming, she noted, was luring the *orishas* to the mundane world, where *santeros* were asking their patron saints for help and guidance[17]. 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 with necklaces visible above their state uniforms. Seeking out protection to ensure their well-being from their respective *orishas,* individuals brazenly appeared in the streets of Havana, Angela 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), Angela stressed, appeared complacent about the reappearance of blatant religious accoutrements. Angela and several other *santeros* interviewed for this research agreed that it was a widely held belief that Fidel Castro was "the son of Changó" (*el hijo de Changó),* an *orisha* known for being a fierce warrior and the embodiment of virility (see also chapter three, footnote 17 for a discussion of Castro's symbolic affiliation with *Santería*). In fact, Angela 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 *Santeria*, Angela remarked, could not simply be explained away as the superstitious beliefs of an ignorant group of poor Afro-Cubans. The practitioners, Angela stressed, were from all walks of life. As was evident from the many gatherings Angela held that I personally attended, there was no clear socio-demographic profile that could accurately describe the diverse group of participants I encountered on a regular basis in her living room.

In 1993, Angela retired and started to collect her state pension. Suffering from severe asthma and diagnosed with hepatic cirrhosis, her health was rapidly

[17] Katherine Hagendorn 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, liqur, 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* " (Hagendorn 2001: 213).

deteriorating. The state, Angela 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, or 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 *bolso negro* (black market). "People were becoming desperate and things were becoming critical for many people. People were drinking sugar water at the height of the special period, in 1993. That was one of the worst years of my life." Angela sighed. "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."

Angela 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 [$6US], 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, Angela was comforted that *Ochún* would protect her. Angela's help, 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 satin of Cuba. Naturally, Angela 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 Angela anywhere from $50 to $100 US

a month, in addition to sending all her necessary medications and vitamins. With the influx of money, Angela grew fiercely religious. As she remarked, she was no longer willing to hide her faith in a 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 *orichas*.

Recalling another critical time in her life when she fell ill, Angela 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," Angela 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," Angela 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 numbers 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, Angela added, had stopped fulfilling its function, which she defined as providing citizens with the basic material necessities for life.

As was evident from the several homes I visited to interview individuals who claimed to be atheist yet often 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, some people were uncomfortable discussing their religious beliefs. Moreover, when I attended several *fiestas de santos* (similar to a birthday party, but celebrating the day that one became initiated into *Santería*), I was often a silent observer, while several of my apparently atheist friends claimed they were present only for the abundance of food and drink, yet 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 *oricha*. When I finally asked several of these "non-believers" 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 of the people I spoke with pointed out that, "It couldn't hurt if an *oricha* would help give you an edge when confronting the problems of everyday life."

Several of these same individuals stated that, informally, they were "pragmatic religious practitioners", that is to say, there was no harm in drawing on religion in times of crisis, similar to people the world over. "It works," stressed a close friend of mine, a young physician and PCC member, who aggressively defended *la Revolución* at every opportunity. He argued that *Santeria* 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 became initiated into *Santeria*. At the time of his mother's illness, the 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 the best hospitals in Havana. His family, who lived three hours outside of Havana, were not previously *creyentes*, and turned to *Santeria* as an alternative.

Towards the end of this research, when I returned to interview Sra. Lopez, a retired nurse, she expressed the opinion that *santeros* propitiated the saints for bodily health and spiritual guidance. Sra. Lopez, who acted as a *madrina* (godmother) to a large network of younger *santeros,* was a little surprised to find an increasing number of people turning to *Santeria* hoping to find quick solutions to their problems, for instance, by asking the saints to help them "get papers to get out of Cuba." "The *orichas,"* she remarked ironically, "do not work in immigration." A reserved speaker, Sra. Lopez, 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 orichas,* 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. Sra. Lopez was a little disturbed by the apparent causal relationship between the recent economic crisis and the visible presence of *creyentes.*

This link between the increasing numbers of people being initiated into *Santeria* and the crumbling of the state's provision of social and material welfare has been recognized before. 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 and from aspects of one's life, who may help resolve everyday problems. In this way, individuals from the spiritual world are added to one's network of *socios.* Importantly, though, beyond material necessity — not necessarily considered profane, as I was informed by various participants of *Santeria* — one repeatedly propitiates the *orichas* 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 this religious practice 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, which focus more on spiritual redemption and the afterlife[18].

As was evident after the visit of Pope John Paul II in 1998, and his public condemnation of the socialist government for curtailing religious expression in Cuba and, perhaps more importantly for Cuba's Communist Party, his equal condemnation of the US embargo against Cuba, religious spiritualism has been gaining ground in recent years (cf. Cabrera 1999). The Cuban government previously espoused a militant atheism, and embodied Marx's dictum that

[18] The work of 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 one's everyday life. Moreover, as Cuban-American anthropologist Mercedes Sandoval, who carried out research on the role of *Santeria* 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 conceptualised 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 behaviour, which is to be rewarded in the afterlife" (Sandoval 1979: 144).

"religion is the sigh of the oppressed creature, the feeling of a heartless world, and the soul of soulless circumstances. It is the [opiate] of the people" (Marx 1977c: 64). The state now turns a blind eye to open religious worship. I interviewed several physicians and one MINSAP official who were sceptical of religious healing, and viewed people's return to *curanderos,* or what they termed *brujeros* (witch doctors), with disdain; however, I suspect that, given Cuba's current climate of scarce resources, 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* has existed as an informal practice both before and after *la Revolución*, it is difficult to discern a single underlying motive behind the recent and visible[19] re-emergence of *Santeros*. To date, no published study has systematically addressed medical pluralism in Cuba and, in particular, the role of *Santeria* in people's health-seeking behaviour in the *período especial*[20]. From the individuals surveyed in my research, I would argue that the state's reluctance to denounce individuals' return to religious practices is directly related to the ease and openness with which individuals are now exploring the different health options that are available to them, without fear of state reprisal.

6.5 Conclusion

In recent years, the Cuban state has lost a significant part of its resource-assignment powers to other actors, such as the market and the community, which have emerged as new resource-distribution mechanisms (cf. Dilla 1999; 2001). The result of the social processes described throughout this chapter, as manifest in the health sector, can be interpreted as the reduction of the state's sphere of influence in the political economy of health care. Francisco Léon (1997), a political scientist who specialises on Cuba notes that, in general, the

[19] Neophytes in *Santería* often stand out because they are required to wear white clothes and head coverings from head to toe for their first year in the religion. In downtown Havana, you can now meet countless individuals dressed in this fashion. As my informant Angela Ulloa pointed out, before the *período especial*, this was not the case.

[20] An unpublished dissertation by Wedel (2002) focuses on the aesthetics of healing in *Santería.* The author does not examine the theme of medical pluralism in contemporary Cuba.

state's withdrawal from various sectors of the economy, not simply health care, have encouraged the development of autonomous activities, practices of mutual help and other forms of cooperation that strengthen family, neighbourhood and occupational relations, and have gradually replaced the state as the sole means of addressing the problems of everyday life. Extending Léon's (1997) astute observations, I stress that Cuba's vital health statistics cannot be divorced from the *micro*-politics of individual practices that shape and influence these numbers. Thus, rather than focusing strictly on the actions of the state to buffer macroeconomic changes in Cuba's health sector, it is equally important to address, in the context of Cuba's *período especial*, how individuals are actively seeking out their own health-care needs. In some instances, individual practices are in tandem with the objectives of the state, for example, the seeking through remittances and *socios* of necessary medications. 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 processes.

As I argued in chapters four and five, the expansion of the MEF program in Cuba has worked to disseminate medical knowledge — across the population and in a highly personalized fashion — through health-promotion and disease-prevention campaigns. The concept of the family physician as one's neighbour creates a novel circumstance through which individual's not only integrate these health professionals into their communities, but increasingly, as I have demonstrated in this chapter, view them as reservoirs of accessible and specialized knowledge. In this way, family physicians, more often than not, are seen as *socios* in a complex therapeutic itinerary (borrowing Marc Augé's 1983 term), an itinerary in which individuals seek out different avenues, through informal activities and state-institutions, by which they obtain positive health outcomes. In many respects, individuals are becoming active in addressing and administering to their own health care needs and, despite the state's disapproval of these practices, they pragmatically[21] rationalize their actions by drawing on the state's socialist discourse of "access to health care as a basic human right."

[21] This view is in line with anthropologists Mark Nichter and Margaret Lock, who argue in their survey of the literature on medical pluralism that "patients are, almost without exception, pragmatic, and see nothing inconsistent about liberally combining different forms of therapy in their quest for restored health" (Nichter and Lock 2002: 4).

Thus, individuals 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. Whether these acts are to be viewed as a strategy, that is, defined by pragmatic action, or as individual tactics, that is, tactics that are consciously adopted to undermine the state's authority, comes down to a question of the individual's stated intent. Ironically, individual citizens draw on the metaphor of *la lucha* (the struggle)[22] to describe their actions in a way that is similar to *la Revolución*'s historical use of Jose Martí's notion of struggle and sacrifice. Marti's idea, as I outlined in chapter one, serves to express a form of moral absolute. While the contemporary socialist state still posits the collective good over individual wants and desires, the surfacing of a full-fledged parallel system of *sociolismo* is testament to the re-emergence of new and retention of old subjectivities in Cuba's *período especial.* In the following chapter I will explore how, with the advent of the *período especial,* the state itself began pursuing a number of strategic programs that reflect the socialist government's changing policies and objectives.

[22] As Fernández (2000a) notes, the language being employed in contemporary Cuba signals the rise of the informal (*lo informal*) paradigm. "*Lo informal,*" Fernámdez remarks, is an arena that provides "alternatives to official rituals, news, and state socialization. Informality allows people to relax; one of its messages is *no cogas lucha* (take it easy, don't worry, relax), as opposed to the government's calls for *sacrificio* (sacrifice)" (2000a: 110).

Chapter Seven

Shifting Ideologies or Incipient Capitalism: Cuba's Expanding therapeutic Itinerary

> An ideal destination for your health: *Cubanacan* "Health and Tourism" (S.A.) is the latest development in Cuban medicine. *Cubanacan* offers you specialized medical attention supported by an extensive network of institutions equipped with modern equipment and staffed by prestigious, internationally renowned scientists. Now you can enjoy your vacation without worries about your health. *Cubanacan* "Health and Tourism" provides you with specialized attention and even guarantees your hotel room. You can find our international clinics, pharmacies and optical stores in every important tourist destination throughout the country. We are your medical resource in Cuba, with the most modern medical technology for your health-care needs.
>
> — An advertisement run by the state-run travel agency *Cubanacan* in *Avances Medicos de Cuba* (Año VII, No 23, 2000, see Figure 7-1).

> I believe that, in the future, it will never be necessary again to ban the possession of dollars or other foreign currencies, but its free circulation for the payment of many goods and services will last only as long as the interests of *la Revolución* make it advisable. Therefore, we are not concerned about the famous phrase "the dollarization of the economy." We know very well what we are doing.
>
> —Fidel Castro, June 2000, *La Habana*
> (cited in Ritter and Rowe 2001: 1)

7.1 Introduction

Since the mid-1980s, the term "globalization" has frequently been employed to describe "the process whereby individual lives and local communities are affected by economic and cultural forces that operate world-wide" (Ashcroft *et al.* 1998: 110; Apparduari 1991). For example, Anna Tsing's *In the Realm of the Diamond Queen* (1993) examines the marginality of the Meratus Dayaks, a peripheral group in Indonesia. Exploring the narratives of various individuals, she shows how their local concerns about gender and politics are deeply intertwined with national and global discourses. Tsing's study demonstrates how "Meratus marginality in the Indonesian nation cannot be

divorced from Indonesian marginality in international ranking . . . [M]eratus marginality thus calls attention to the complexity and specificity of cultural intersections" (Tsing 1993: 17). These "cultural intersections" highlight the relationship between local and global factors and, importantly, as Fisher (1997) asserts, "enrich our understanding of local and transnational connections that enable and constrain flows of ideas, knowledge, funding and people" (Fisher 1997: 441). Following both Fisher (1997) and Tsing (1993), I examine in this chapter how external factors such as the US economic embargo and the recent collapse of the Soviet bloc have changed the course of health and medicine in Cuba. More broadly, I examine the impact of these factors on the everyday world of medical research and practice and on the lives and health of individual Cubans.

Shortly after the fall of the communist Soviet bloc in 1989, the Cuban government was faced, perhaps for the first time since 1959, with integrating the small island's centralized economy into the international world system. In 1991, Julio García Olivares, the former head of the Cuban Chamber of Commerce, described the Communist Party's logic as follows: "We have to think like capitalists but continue being socialists" (E.I.U. 1990: 17). It is evident from Olivares' statement that Cuba's unfettered path to socialism has encountered new and potentially insurmountable obstacles, as I discussed in chapter two. Shortly after the island entered a *período especial* in 1991, the state began pursuing a number of strategic programs. These included the development of a program on natural and traditional medicine and remedies ("green medicine" or *medicina verde*) and, under the rubric of "Health and Tourism" (*Salud y Turismo*), the expansion of high-technology[1] programs and research institutions geared to foreigners paying in US dollars.

By drawing on interviews with individual citizens, family physicians and research scientists, and by examining MINSAP reports, articles and program reports, in this chapter I explore how Cuba's controlled entry into the capitalist

[1] The term "high technology", in this context, denotes everything from the biotechnology and pharmaceutical industry to high-resolution scanning (for example, MRIs and CAT scans) and advanced surgical procedures (for example, organ transplantation, neurology, placentology and laser surgery for a host of illnesses, among other innovative treatments).

world economy as a profit-oriented enterprise has severely compromised the socialist rhetoric of the state, particularly the official discourse on the provision of basic human needs. The National Health System is currently characterized by massive shortages and fiscal contraction. The Cuban government has attempted to protect it from the market-oriented reforms occurring in other sectors of the Cuban economy, but the simultaneous construction and expansion of well-equipped health facilities that cater to foreigners paying in US dollars and, more recently, to Cuba's *nouveau riche*, warrants serious examination. As revealed by Fidel Castro's statement that opens this chapter and by the advertisement by the state-run group *Cubanacan,* which markets Cuba's health-care services for sale, the current socialist government has been forced to resort to certain capitalist strategies to stay afloat. Thus, this chapter also examines the processes by which external and internal forces interact with each other to produce, reproduce and propagate global capitalist ideals within local communities (cf. Appadurai 1997; 2002).

7.2 Incipient Capitalism: The "*Dollarization*" of the Health Sector

In 1996, the MINSAP drafted a document to define the state's health goals and objectives to be achieved by the year 2000 (PAHO 2001). Within this document, MINSAP designated biotechnology and high-technology medicine as priority sectors in which investments would continue despite the general program of economic and fiscal retrenchment. The purposes of the OPD strategies were twofold. First, the state sought a means to address the local shortage of pharmaceutical products created by the fall of the Soviet bloc and by the US embargo. Second, the revolutionary government sought to capitalize on their newly acquired high-technology medical capabilities through two means: (a) by becoming an important manufacturer of pharmaceutical products to be sold on the international market in hard currency[2]; and, (b) by offering state-of-the-art medical services on a treatment-for-pay basis to the growing tourism industry in the island, which now included foreigners arriving under state-sponsored programs for "Health and Tourism." These strategies, the government argues,

[2] In 1995, the total value of biotechnology and pharmaceutical exports was $200 million (Pastor and Zimbalist 1995: 8). A detailing of Cuba's budding biotechnology industry can be found in Feinsilver (1989; 1992; 1993; 1994), or in Cuban medical journals such as *Avances Medicos de Cuba.*

are part of the greater plan to build Cuba's economy and, ultimately, make the island more self-sufficient.

During the preliminary phase of this research (May 1999 – February 2001), I was hosted by a state-run biotechnology institute, which I shall call by the fictitious name of the *Jose Martí Vaccine Research Institute* in the city of Havana. The *Institute,* a prestigious state-run medical centre for research and production of human vaccines and serums, had recently signed a contract with a multi-national pharmaceutical company based in the UK to creatively market and sell their products in the international market, thereby subverting the US embargo against Cuba. My role in the *Institute* at the time was as a foreign language teacher in their Department of Teaching and Training, where I was helping to prepare Cuban scientists, epidemiologists and other professionals to write the Test of English as Foreign Language Exam (TOEFL). Having several of the *Institute's* top biotechnology scientists and administrators as students in my class, I thought, would provide me with an unprecedented entry point into my research interests on Cuba's budding biotechnology industry.

As became apparent during my stay at the *Institute*, several of the high-ranking scientists in my class were unclear on what exactly I did as a medical anthropologist. Despite my repeated explanations, I was still offered invitations to participate in seminars on Afro-Cuban *Santería*, a staple in Cuban anthropology — made famous by the late Cuban anthropologist Fernando Oritz — and I was also invited to conferences on everything from the medicinal components of plants, to seminars on flower-and-mud therapy, including one particularly interesting seminar on herbal aphrodisiacs that were indigenous to Cuba. The individuals I spoke with at the *Institute* were a little dumbfounded, or understandably strategically evasive, when I stated, in very benign language, that I was really interested in understanding the agreement between the *Institute* and a rather large capitalist multi-national pharmaceutical conglomerate marketing and advertising its products for sale on the international market.

Several of the scientists, whom I came to know on a friendly basis, advised me that the implicit irony of my proposed study would not be lost on the *Institute's* director, a well-known PCC member and the surrogate First Lady of Cuba. She would never allow such a study, several scientists remarked. I was

warned in a friendly manner that any reference on my part to "market socialism" or "late socialism," let alone the association of the socialist government with capitalism, would spell my quick removal from the *Institute*, if not the country. In the end, I decided not to pursue research on Cuba's biotechnology industry due to the difficulties in obtaining appropriate research clearance and because, ethically, such clearance would have required me to be transparent about the nature of my study at the *Institute*. As I was told, a study of the use of floral-therapy in Cuba would not have raised any eyebrows. Needless to say, I was still interested in examining how Cuba, a country characterized by massive shortages in pharmaceutical products, was now seeking to become a leading producer among developing countries of vaccines and certain classes of drugs, including antiretroviral medications used to treat HIV, as I briefly discussed in chapter five.

The Medical-Pharmaceutical Industry, also known as *Industria Médico-Farmacéutica* (IMEFA), oversees 19 companies and institutes of investigation, including 41 manufacturers who produce locally 87% of the drugs that are consumed on the island (MINSAP 1996)[3]. For example, the Hepatitis-b recombinant vaccine, developed through genetic engineering, has been used domestically to immunize the population against strains of Hepatitis. Due to the US embargo and the prohibitive costs of importing vaccines from foreign manufacturers, this vaccine would not have been available unless it was manufactured locally. However, as was clear from my brief stay at the *Institute* and from subsequent interviews with individual citizens, Cuba produces a series of pharmaceutical products for export only, and these drugs, ironically, are only available to the local population in US dollars, despite domestic shortages in the Cuban peso economy. One area in particular reflects the tension between the local peso economy and the US dollar economy: Cuba's "Health and Tourism" sector (see Figure 7-1 and Figure 7-2 for examples of Cuba's campaigns marketing their pharmaceutical products internationally).

[3] Most of the drugs that are manufactured in Cuba require the use of imported raw materials, some from the former Soviet bloc nations. This has forced the Cuban pharmaceutical industry to focus on the lines of production that can be sustained by Cuban research and materials. This may also feed the rationale for the sale of certain classes of drugs made in Cuba to the domestic population in US dollars. It is seen as a cost-recovery program, especially as the cost of producing certain classes of drugs is increasingly reliant on the import of expensive raw materials.

Since in the early 1990s, Cuba has began offering medical care to foreigners under state promotional campaigns such as "Sun and Surgery" and "Health and Tourism" which provide health packages including specific health services, travel to and from Cuba, and accommodations. For example, on a flight on Cuba's national airline *Cubana* last year, I saw several in-flight promotional commercials for the *Cira García Clinic*, which is the most popular institution for Health and Tourism in Cuba. Run by the state-sponsored travel group *Cubanacan "Turismo y Salud"* (Health and Tourism), the *Cira García Clinic* provides state-of-the-art medical and dental facilities, offering services ranging from plastic surgery to arterial grafts to neural transplants for treating Parkinson's disease. Flipping through the glossy Cuban magazine *Avances Medicos de Cuba* (Medical Advances in Cuba), only sold in US dollars, readers —presumably foreign subscribers — are bombarded with full-page color advertisements for Cuba's prized international clinics, such as *Hermanos Ameijeras*, *Cira Garcia* and *Fajardo Clinica International*, among others. The clinics' services include everything from organ transplants and drug rehabilitation to stress management, psoriasis treatment, cardiology surgery and oncology. One of the advertisements promises readers "the possibility to enjoy your vacation without worry about your health," alongside the *Cubanacan's "Salud y Turismo"* motto: "Honesty, Scientific Quality and Dedication to Humanity" (see Figure 7-3 for *Cira Garcia* advertisement).

The irony of this form of marketing is highlighted by various foreign critics and, importantly, local citizens, who question the underlying politics behind the investment of hard currency in high-technology medicine at the expense of primary health-care needs. As was obvious from my visits to local *consultorios*, where the availability of essential drugs and vaccines was intermittent at best, the sale to foreigners of drugs and high-technology services in US dollars is paradoxical. The Cuban government contends that foreign medical services represent a small percentage of Cuba's universal health-care system. By the MINSAP's account, only 400 to 500 of Cuba's 66,263 hospital beds are used by foreigners. In addition, Cuba's Vice-Minister for Economic Affairs reported that 98.5 % of the gross income from foreign patients remains within the health system. The hard currency earned from treating and selling medications to foreign patients, official reports claim, is used to purchase

medicines for Cuban patients who receive them free in hospitals and at subsidized prices in pharmacies.

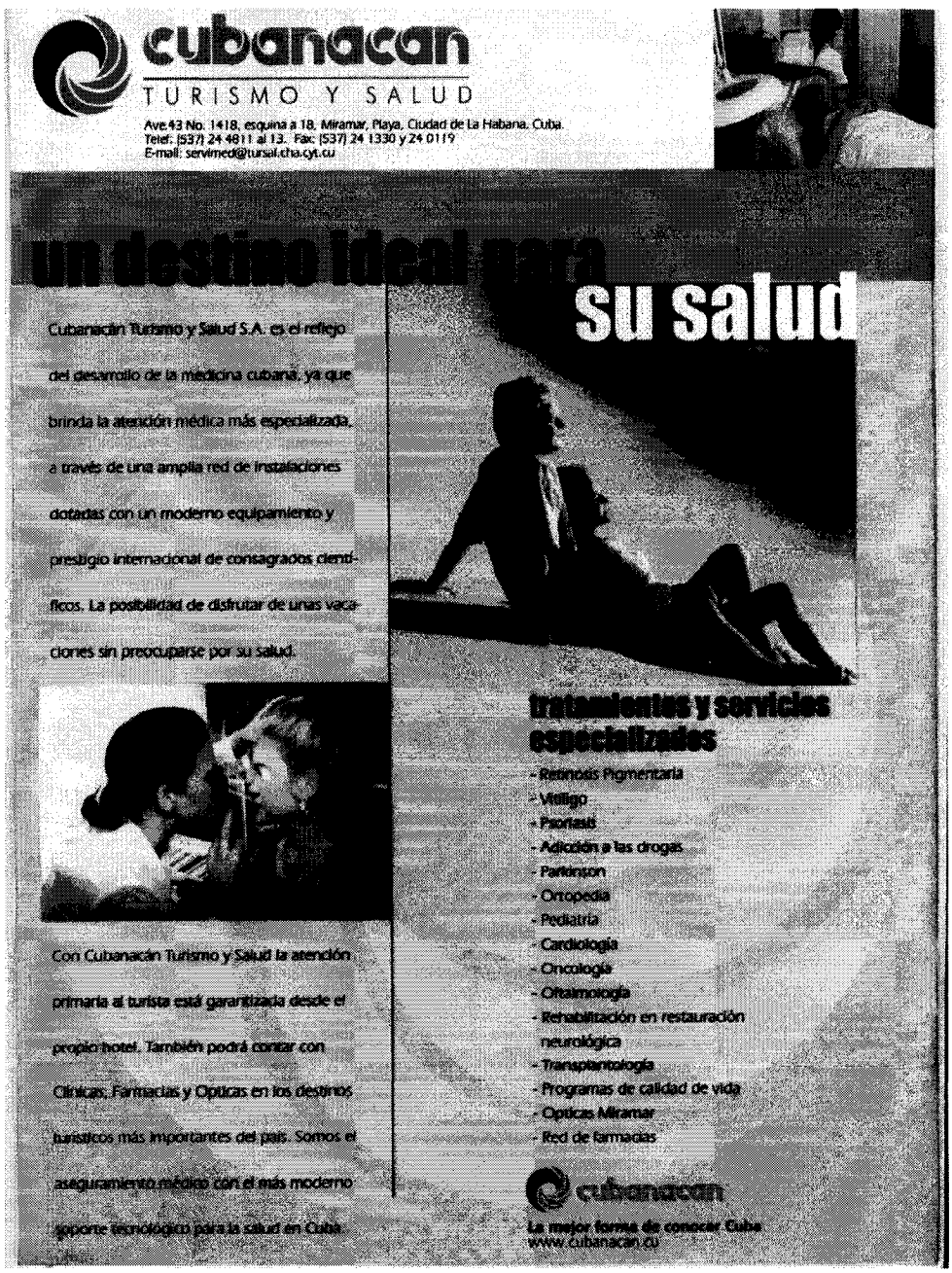
Aside from the official claims by government representatives, most of the individuals interviewed for this research, with a few exceptions, were outraged that a two-tiered health-care system existed. This opinion was equally reflected by several of the primary health-care physicians, who pointed out acidly that the health professionals who work with foreigners are often paid a portion of their salary in US dollars, as a material incentive. As several of the primary health-care physicians further complained, while they were celebrated in the state media campaigns as selfless individuals, dedicated to *la Revolución*, they were generally expected to work for little monetary compensation and for moral incentives, that is, to be good *revolucionarios*. Furthermore, as the following vignette will illustrate, the *Salud y Turismo* industry is not limited to foreigners alone, but has unofficially opened its back door to individual Cubans armed with US dollars, which signals the re-emergence of a parallel but hidden semi-privatised health-care system operating within Cuba's socialist economy.

'Salud y Turismo': "A life with dollars is not like living in Cuba at all"

On a blistering August night, while dancing at a party until the wee hours of the morning, Louis Martinez lost one of his contact lenses. He had neither eyeglasses nor replacement contact lenses. Suffering from severe myopia, the 28-year-old state-employee had been on a waiting list for months to be able to buy a pair of subsidized eyeglasses from the optometrist in his designated *área de salud*. He was frustrated, he stated, especially as, given his job as an editor for a state-run newspaper, he was required to read and write for 8 to 10 hours a day. Walking into the emergency room at a local hospital in the Plaza of the Revolution, he was quickly attended by an ophthalmologist. While sympathetic about his plight, the specialist suggested that the replacement for the lenses would take a minimum six months, if they could be replaced at all, in Cuban pesos. Examining his vision, she concluded that, given his poor eyesight, perhaps he should consider joining the growing number of people on a waiting list for eye surgery. Louis, having heard medical horror stories about Cubans going under the scalpel only to be followed by months of recovery, told the physician that he did not want to take the risk. Nor, he explained, could he

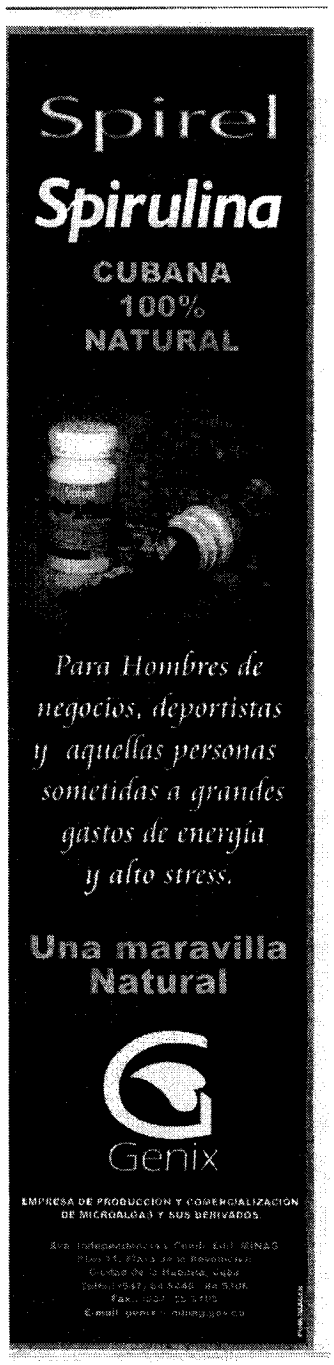
afford to be off work for the recovery time since he worked on a pay-per-assignment basis and relied on his vision to be able to carry out his daily work duties.

Figure 7-1: An ideal destination for your health: *Cubanacan, "Salud y Turismo"*. For English translation, see the excerpt in the introduction.



Source: *Avances Medicos de Cuba* (2000: back cover)

Figure 7-2: This is an advertisement for a vitamin, made from seaweed and manufactured in Cuba. In Cuba, it can only be found in US dollar stores (and, of course, on the black market). The advertisement reads: "*Spirulina*, 100% Natural, Made in Cuba. For businessmen, athletes and the kind of people who use a lot of energy and are under a great deal of stress: One of the natural wonders."



Source: *Avances Medicos de Cuba* (1999: 13)

Figure 7-3: Advertisement for the *Cira Garcia* International Clinic

Source: *Avances Medicos de Cuba* (2001: 21)

In an attempt to be optimistic, the doctor stated that MINSAP was considering incorporating laser technology for eye surgery in the upcoming months, but she was not sure whether it would available in Cuban pesos. Louis pointed out that even if the laser technology became available for Cuban pesos, access would depend on one's strategic connections or on *socios* who worked in those centers. This was the case with a growing range of high-technology medical equipment in Cuba such as CAT scans and MRIs. Several other individuals I interviewed for this research made similar suggestions. For instance, Sra. Esparza, whom I discussed earlier, had regularly sent her mother for CAT scans with the help of a technician who worked at the one hospital in Havana that carried out this high-technology procedure. Interviews with several citizens revealed that some people had been on waiting lists for up to five or six months and still had had no luck in getting an appointment for a CAT scan. Without connections, Louis noted, your chances of getting off the waiting list were slim to none. A close friend of Louis confirmed his concerns. Upon hearing of his plight, this man suggested that he could put Louis in contact with the chief ophthalmologist at a local medical center to help resolve (*resolver*) his problem, whether it be eye surgery or getting lenses quickly. As his friend stated, however, Louis would be expected to give the doctor a *regalito*. Louis declined, arguing that his money would be better spent at an international optometry clinic, where at least he could be assured of getting what he was paying for.

I accompanied Louis on his visit, sponsored by the *Salud y Turismo* program, to the optical store located in the diplomatic centre, Miramar. After briefly speaking with the receptionist, Louis paid US$5 for an optometrist's consultation. As we sat in a beautifully decorated air-conditioned salon, we were entertained by the Discovery Channel (in Spanish) via satellite TV, and browsed through the optical store, which sold, among other things, the latest American and European designer eye wear. When Louis' name was called out, a nicely uniformed optometrist accompanied us into the examining room and began her routine examination using what she explained was the latest in computerized diagnostic equipment. The technology being used in the optical store made the hospital appear, in Louis' words, like a stone-age facility. The optometrist, drawing elaborate diagrams of his eye, and explaining each test she conducted

and what the results meant, spent a little over 20 minutes informing Louis why his sight had been slowly deteriorating throughout the past several years.

The optometrist concluded that eyeglasses would be of little use for him because his peripheral vision was poor. In addition, the hard contact lenses he had previously been wearing for over 6 years without replacing, which were made from an impermeable glass that he cleaned and stored in boiled tap water, had prevented his corneas from respiring. What he needed, she concluded, were 'gas permeable' contact lenses, only available in US dollars in Cuba. They were made on site within three business days for US$76. Surprised by the price, Louis once again considered waiting several months for the state-subsidized lenses that were a mere 15 Cuban pesos (less than one US dollar). He considered his options out loud, in the hope that I would advise him on the decision: if lucky, perhaps he could get the impermeable lenses quicker from the state via a *socio*, although he faced the problem of damaging his vision even more with the impermeable lenses. The optometrist explained the various benefits: the three year warranty period which included the periodic onsite maintenance and cleaning and, of course, the various health benefits of wearing breathable lenses for a person whose sight was so poor. After five minutes of thinking, and attempting to gauge whether such lenses would cost as much in Canada,[4] he decided the lenses in the store dealing in US dollars were his best option.

The optometrist, pleased by her sale, turned to me and asked in English, if I would be making the payment by cash or by credit card. As she indicated, they accepted all major credit cards except American Express. As she smiled at me, it was obvious to me that she dealt with Cubans accompanied by foreigners on a daily basis. Unlike the international pharmacies, however, no foreign passport is required to access some of the health services provided by the *Salud y Turismo* program. Louis had intermittent access to dollars from his brother, who now lives in Venezuela and sends money infrequently. He paid for the lenses in cash, and the staff gave him a date on which he could pick them up. Louis confided that he found the price of the lenses a bit high. He was further shocked to discover that the new lenses required a specialised cleaning solution

[4] At the time, I was unaware of the going rate for contact lenses. As it turns out, when I returned to Canada I made inquiries about the lenses in Toronto, and I was told Louis' prescription would have cost $245 Canadian dollars.

and that boiled tap water would be insufficient. Clearly upset, he pondered why, if the state had the equipment to make the lenses in Cuba, it takes over six months if one pays in Cuban pesos. The answer, as he knew, was that the peso and dollar economy were, for the most part, mutually exclusive: one operating for the welfare of the people, the other as a savvy profit-making enterprise. Quickly leaving the diplomatic quarter and making our way back to the city centre, Louis reflected on his experience and exclaimed, "A life with dollars is not like living in Cuba at all!" This was made further evident by the other customers in the waiting room, a well-heeled group of Cubans, several of whom were clearly accompanied by foreigners.

As previously argued, the Cuban government contends that the health institutions under the banner of *Salud y Turismo* are structured for foreigners. There is an assumption that the Cubans who are using these services are doing so of their own free will, and not because of shortages in the heavily subsidized peso-based health-care institutions. Several of the Cuban individuals interviewed for this research made no bones about their use of the US-dollar health-care services and facilities. They stated their unwillingness to wait along with *las masas* for basic services; others made clear their willingness to pay physicians on the side to carry out aesthetic cosmetic surgery. In addition, some individuals are increasingly reliant on prescription drugs and wish to avoid having to contend with the regular shortages in the peso economy or having to pay intermediaries to get subsidized drugs or privileged access to MRIs and CAT scans. The reality is that, as many of the basic services in the Cuban peso economy shift to the dollar economy, many individual health-care needs are being met through that economy. It would be difficult to argue that the Cuban state, which has a massive internal security apparatus, is unaware that individual Cubans are increasingly turning to the US-dollar health sector to meet their everyday needs. Rather, I suggest that these trends reflect the "incipient capitalism" that has clashed with socialist discourse on the "provision of basic human needs."

The socialist state has perpetuated a dual moral code (*doble moral*), outlined in chapter two, by which the state has shifted its position on well-established policies by, for instance, creating the dual-economy (*doble moneda*) in US dollars and Cuban pesos. As a result, some citizens are now skeptical of the

state selling domestically produced pharmaceutical products and offering health-care services to foreigners in hard currency, while simultaneously preaching sacrifice for the common goal of socialism. The latest slogan to take precedence — "Cuba is and will always be a socialist country" — seeks to reconfirm what is increasingly being called into question: how many capitalist strategies can one incorporate into the local economy and still maintain the veneer of socialism? I do not have the answer to this question. However, the internal contradiction of a state that increasingly responds to external pressures by resorting to forms of economic pragmatism in its day-to-day operations is also reflected in the practices of individuals, who have incorporated — both willingly and begrudgingly — a form of incipient capitalism into their everyday lives.

Consider an anecdotal point that speaks volumes to this latter issue: products made in Cuba such as coffee, juices, and soft drinks often carry the slogan "*Lo Mio Primero*" ("Mine first", that is, Cuban products first), yet they are sold only in US dollars and thus are well outside the economic reach of the majority of the population. Consequently, many Cubans have informally suggested that the products should read, "Cuban products first, and Cuban people last!" This irony is also commonly applied to Cuba's burgeoning health institutions and international pharmacies developed for foreigners and people with access to US dollars. In the next case study, I will explore one contentious area in Cuba's primary health-care system: the motives underlying the socialist state's recent sanctioning and promotion of *Medicina Tradicional y Natural* (MTN), or, as Cubans informally refer to it, "green medicine" (*medicina verde*). Given the socialist revolutionary government's historic stance on modernity and development as synonymous with a heightened positivism manifested through science and technology, including the wholehearted embracing of biomedicine since 1959, the recent and official (re)emergence of MTN warrants serious attention.

7.3 "Green Medicine" and Cuba's Renewed Medical Pluralism

From the late 1970s, anthropologists have been examining the interaction and competition of different medical traditions within societies (for example, see Nichter and Lock's 2002 edited volume dedicated to Charles Leslie). While modernization campaigns throughout the world, including Cuba's, have resulted in the pre-eminence 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. As Nichter and Lock argue, "Economic necessity has, of course, been a driving force in sustaining this situation" (Nichter and Lock 2002: 3). 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 towards different medical traditions — and has carried out various campaigns to marginalize medical traditions such as herbal medicine that diverge from what the government believe is "evidence-based" medicine. 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 the MTN as part of a strategy — presented as benevolent — to provide the population with more health-care options. As I will examine, several intersecting factors must be highlighted in order to trace the emergence of a state-sanctioned medical pluralism in Cuba's health sector.

Practising "Medicina Verde"

Dr. Miguel Nuñez, a 34-year-old physician who pursued his medical training through the Revolutionary Armed Forces (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, Dr Nuñez wanted to pursue his research interests on 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, Dr. 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[5].

Finding his role at the FAR limiting, Dr. Nuñez, who had worked closely as a personal physician for several high-ranking military officials and PCC 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 Dr. Nuñez at a research institute run by the Ministry of Science, Technology and the Environment (CITMA), formed in 1994. Dr. Nuñez stated that the FAR had been very good to him, even awarding him an apartment in a prized area of the city centre overlooking the waterfront. Dr. 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 and eventually made his way to Miami. "I am *revolucionario,*" Dr. 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 that were afforded to him by the state. Dr. Nuñez believes that the FAR was being particularly generous to him in view of his relatively young age, perhaps in recognition of his unique credentials, that is, his title as a physician of Natural and Traditional Medicine (*Medicina Tradicional y Natural*, MTN). He completed a Master's degree in this specialty in 1996. At the time, he was one of very few people who actually specialized in this area and was trained in Cuba, as opposed to abroad, where this form of specialization is more common.

In 1991, Dr. Nuñez was part of unique group of physicians who benefited from the MINSAP's broadening of a previously 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 "Program for the Development and Generalization of Natural and Traditional Medicine" (*Programa para el Desarrollo y la Generalizacón de la Medicina Tradicional y Natural*).

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

An executive report issued by the MINSAP in 1996, "Analysis of the Health Sector in Cuba," outlines the reasons behind 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 clinic 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 multi-sector 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" (MINSAP 1996: 25)

While the MINSAP's strategic rationale behind the development of Cuba's program for MNT focused strictly on scientific inquiry, a 1999 report produced by the MINSAP puts the recent developments in a more historical and socio-economic 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 world-wide pharmaceutical monopoly. (MINSAP, *Programa Nacional de Medicina Tradicional y Natural* (MTN) 1999: 7)

It is clear from the MINSAP reports 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 mention of the reality of massive shortages in pharmaceutical drugs and medical supplies that was brought about the cessation of Soviet aid post-1989 and the strengthening of the US blockade. The strategic pursuit of MTN is rather discussed in terms of the scientific efficacy of these practices, with no discussion of the state's inability to provide pharmaceutical products, as it had previously done. As the MINSAP (1999) 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 . . . " (MINSAP, *Programa Nacional de Medicina Tradicional y Natural* (MTN) 1999: 9, emphasis original).

However, despite MINSAP's disclaimers, it is important to also examine the shift in the MINSAP's official policy from a more critical perspective. Dr. Nuñez provides a more detailed explanation behind the reasons underlying the MINSAP's shift in 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 in 1991 to develop programs based on natural and traditional medicine, 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 witchery (*oscuarantismo*). What happened in the 1959, 1960 and 1961, at the beginning of *la Revolución,* was that all of the pharmacies with medicinal plants disappeared or were eradicated. More than this, all of the traditional healers such as *curanderos* and *brujeros* (witchdoctors), 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 out 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, *el pueblo* had access to the socialist camp, which had opened up the access to industrial pharmaceutical products from abroad.
>
> I am sure that there are still health professionals in the upper-levels of the MINSAP — people above the age of 40 or 50 — who during the past 30 or so years where prohibited from using "popular medicine" and were never trained in it. I think these are the doctors, trained in 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 Dr. 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, Dr. Nuñez was the only physician I interviewed for this research who had completed a direct specialization 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 medicine," compiled by seventeen scientists in medicine and biology, that 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 picture-based posters with the plants' popular medicinal names, their scientific names, and a description of the medicinal properties of the plants. In addition, all of the local pharmacies started to carry a 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 anti-parasitic lotions for external application.

The interviews I carried out suggest that the result of the state's promotion of MTN has been mixed. While several of the citizens and medical practitioners I interviewed openly embraced the integration of MTN, the majority I interviewed saw this "*medicina verde*" as a clear sign that the state was trying to cover up for a lack of pharmaceutical products that it had been promoting with a zealous vigor for over 40 years. While several older people whom I interviewed, including several *santeros* who have always incorporated herbal remedies into their religious practices, were convinced about the efficacy of MTN and even acupuncture, a large percentage of the individuals interviewed, while not against MTN, would not substitute them for the apparent wonders of pharmaceutically-based medicine. Not surprisingly, many of the individuals interviewed, born and raised in the 1960s, 70s and 80s, and trained under the revolutionary pedagogy, were forthrightly resistant to MTN. A more systematic study would be necessary to identify specific trends that

might throw light on the relationship between 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. This was 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 begrudgingly, that were located alongside their *consultorios.* 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 around the tending of the herbal gardens. Dr. Nuñez elaborates on some of the challenges the new MTN program has faced among 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 a good education and understanding of their correct usage. There are other *medicos,* 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 experience. 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 10 or 12 years — Chinese, Vietnamese, Koreans, and some Canadians — who are very well-known.
>
> Look at acupuncture, which arrived in Cuba around the 60s. 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, 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.

Importantly, Dr. Nuñez provides a historical context in which to trace the influences on individuals' perceptions of various medical traditions. Several individuals interviewed, while willing to try acupuncture because of its proven history as a form of Chinese traditional medicine, were more sceptical of Cuba's fledging "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.

I conclude this section with an interview with a 54-year old physician, Dr. Alberto Guerrero, who was a former research scientist specializing in drug-transport mechanisms, and who now works as a family physician in a local polyclinic in a municipality of Havana. Suffering from stress, insomnia, and body aches and pains, Dr. 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 *colour*. 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. For the average Cuban out

there has no access to US 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 they are not providing. The government is supposedly giving *el pueblo* options for medical treatments, when really what they are doing is hiding the fact that they do not have the financial resources to provide the population with pharmaceuticals or, worse, are 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 doors to all kinds of innovative medical research, which previously the government would 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 Dr. 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" to appease the population with health options, when the state has nothing else to offer. In this sense, the state's promotion of MTN, whether seen as positive or negative, must also be viewed as a pragmatic strategy employed by the state. It has emerged in part from necessity to provide the population with health options and, ultimately, shift some of the responsibility for health and social welfare from the state onto the individual. Anthropologist Steve Ferzacca (2001), 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" (2001: 50). Extrapolating on Ferzacca's argument, I argue that we must view Cuba's renewed medical pluralism from a critical perspective. As Dr. Guerrero points out, we must question to what degree the promotion of MTN and alternative medicine by the Cuban government is offered as a means to placate a health-conscious population that is slowly realizing that the state can longer provide the same level of health care services as in the past.

7.4 Conclusion

In this chapter I have argued that Cuba's *Salud y Turismo* program and the MNT program are strategies employed by the socialist government that are

consequences of Cuba's integration into the global economy. The socialist state has been forced to retreat from long-standing policies in the health-sector. This has allowed 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 polices, for example, the maternal and infant-care programs that mandates institutional childbirth and does not recognize traditional birth attendants or midwives. The state has made choices that are not all visibly driven by economic pragmatism, though this is not to suggest that a strategy is not involved. I argue that the socialist state may be in pursuit of the symbolic "capital" that results from of Cuba's low infant mortality rate and the international status that is accorded to the Cuban government for achieving that low IMR. This is a strategy, as I alluded to in chapter three, that symbolically links Cuba's vital health statistics (such as the IMR) to the health of the body politic and, thus, the success of the project of socialism.

In concluding this chapter, I return to an example from the *Jose Marti Vaccine Institute*, where I was briefly affiliated. In addition to teaching a class on TOEFL at the *Institute,* I was also involved in a course of "Culture from English-speaking Countries." In this latter course, as the token foreigner and native English speaker among the group of instructors, I was often called upon to discuss the meaning of various holidays such as Halloween, Thanksgiving, Christmas and Easter, and other events such as Canada's Queen Victoria Day (May 17). While I struggled to explain events that I myself rarely celebrated, my students were eager to learn about what they had come to understand was, "bourgeois capitalist culture." As I was training my students to write the TOEFL exam, in a building not more than 20 feet away, marketing advisors had arrived from the UK to help the staff from the *Institute's* marketing and sales' department, several of whom were in my class, on effective strategies for selling their prized pharmaceutical products to the international community.

As the students from the marketing and sales department noted, "you have to learn the culture of capitalism in order to be an effective sales person." Clearly, as Cubans trained by *la Revolución,* this meant that they needed to be newly equipped for Cuba's new world order: teaching socialist business executives how to be capitalist, but in theory only. Almost as if embodying the

comments made by a Cuban official that, "we have to think like capitalists but continue being socialists" that I cited earlier, revolutionary pedagogy now included courses on learning about what Cubans have come to understand as the "other" — the capitalist (*el capitalista*). Ironically, this new world order now also means contending with the capitalist longings of a population who are increasingly exposed to the influence of widespread consumerism through tourism, the international media, and now the state's very own campaigns and policies. These recent events in Cuba are matched by the reemergence of class-based inequalities that have seeped into the daily operations of the primary-health-care system in the form of differential access to basic supplies and services that is based on differential access to US dollars. The critical challenges facing the Cuban government now are whether it can adapt to the encroaching capitalist economy and still preserve the socialist government's legitimacy in the eyes of the republic's citizens. Undoubtedly, both Cubans and the rest of the world eagerly await the answer to unfold.

Conclusion

Cuban Counterpoint

> In this period of the building of socialism, we can see the new man being born.
>
> — Ernesto "Ché" Guevara (1987: 252).

In the summer of 2002, the popular Cuban soap opera *Doble Juego* (Double Play) was a phenomenal success. While it was airing, three nights a week for a little over three months, the street activity in various neighbourhoods in the city of Havana was at a notable standstill. The massive network of city police officers stood post in front of the open windows of people's homes, so as not to miss the unfolding saga. Chronicling the everyday life of a group of adolescents in high school and their conflicts with their parents, the *telenovela* (TV soap opera) undeniably struck a chord with the population in its portrayal of the realities of contemporary Cuban life. The leading protagonist, Matilde, a 15 year-old girl, *revolucionaria*, shy, and overweight becomes pregnant, after the "popular guy" in the school accepts a bet from his schoolmates that he will have sex with her. Throughout the duration of the *telenovela*, Matilde skilfully hides her pregnancy from her family, physicians, and friends, for fear of their reprisals. Ironically, her only confidant is Isabelle, a foul-mouthed troubled teenager from a single-parent home, who struggles to forge out an existence after her mother is jailed for black market trading. Living in an over-populated slum in Havana known as a *solar,* Isabelle speaks the *lingua franca* of the street and regularly confronts the temptations of Cuba's thriving underground private informal economy.

The dramatic ending of the *telenovela* is the intersection of two powerful themes. First, the birth of child to a young *revolucionaria*, whose parents, friends, and attending physicians are astounded as to why such a significant event could have been overlooked. The newborn child is duly embraced signalling a new beginning, thus, creating a space for critical discussion to publicly address the increasing pressures that are facing Cuba's young *revolucionarios.* Importantly, this can also be interpreted as a mandate to bridge

the literal and symbolic gap between Communist Party officials and *las masas*, particularly as more citizens, especially young people, become increasingly disillusioned with the gaps between the public and private spheres of everyday life.

Second Isabelle gets onto to a high-speed boat (*lancha*) heading for the shores of the US, with the help of her mother's delinquent friends, in search of a new life and the apparent material luxuries of the US. Isabelle's journey is cut short, however. Suddenly changing her mind shortly after the boat's launching, she jumps off and swims to shore. In the end, she is reunited with her joyous classmates. It is a fitting ending for the soap opera, whose themes were inspired by Cuba's Union of Young Communists (UJC): choosing the struggle (*la lucha*) of everyday life in Cuba and, thus, a commitment to *la Revolución*, over individual wants and desires. Not surprisingly, the rest of the people in the fateful *lancha* end up drowning in the high seas. This is an ominous reminder to those who live in Cuba of the painful reality of the thousands of Cubans who have attempted to flee the socialist island on *lanchas,* or more crudely constructed floatation devices (*balseros*), only to become, in popular Cuban slang, "shark bait."

The complex layers of the *telenovela* are allegorical messages about the changing socio-dynamics of contemporary Cuban life. The title of the *telenovela*, *Doble Juego*, is a creative play of words dealing with the endemic problem of the *doble moral* (dual moral code and duplicity) in everyday interactions. As I have previously discussed, individuals are increasingly facing new challenges, which include living with the duplicity between rhetoric and practice, and which are affronts on the revolutionary system of ethics and values. The themes of the *telenovela* are important to my own study of Cuba. The main title of my dissertation is *The Pragmatic State.* I purposely chose this title because the term "state" is polysemic, and the two definitions of this term warrant closer examination. The first denotes the condition that somebody or something is in at a particular moment in time. The other meaning, commonly used to define a sovereign independent government, is often differentiated by capitalizing it as the State. I have employed both meanings in this study.

The title *Pragmatic State,* then, can be read in two ways, one inseparable from the other. First, the recent *período especial* in contemporary Cuba has

increasingly forced individual citizens to respond to the struggles (*lucha)* of everyday life with a renewed pragmatism —in short, their everyday lives are consumed by pragmatic concerns. On the other hand, in recent years the institutions of the State have increasingly modified policies, objectives, and age-old ideological positions, in response to the challenges of incipient capitalism evident in everyday practices — thus exemplifying the pragmatic State. I have argued that, rather than imagine the state as a tangible monolithic entity, we must see it as being disaggregated in multiple forms, dynamic, and responsive to political pressures.

I borrowed the title for this concluding chapter from Cuban anthropologist Fernándo Ortiz's often cited book, *Cuban Counterpoint.* Ortiz's deft comparison between sugar and tobacco as "the two most important figures in the history of Cuba" is a richly textured narrative of the social processes that produce commodities and, with them, the social worlds that encompass them (Ortiz 1995: 4). As Fernando Coronil notes in the introduction to a recently republished edition of Ortiz's book, the contrast of tobacco and sugar, while presented as a series of oppositions, has unexpected alignments that destabilize notions of fixed polarity: "indigenous/foreign; dark/light; traditional/modernity; unique/generic; quality/quantity; masculine/feminine . . . national independence/foreign intervention; world market/U.S. market" (1995: xxi). Similar to Ortiz's deft comparisons between two familiar social actors in Cuba's social and political development, I argue that the study of everyday life in contemporary Cuba *as a single phenomenon*, in and of itself, is a study of contrasts.

Beyond an examination of the contrasts between rhetoric and practice, this study has explored the indeterminate spaces between polarities such as the sharp ideological demarcation between pre- and post-revolutionary eras, or the clumping of individuals into categories "for" or "against" *la Revolución.* In doing so, I have chronicled the new, and the re-emergence of old, subjectivities in Cuba's *período especial.* Cuban ethnologist Miguel Barnet has recently bemoaned the arrival of a " . . . new type of Cuban . . . a sort of anachronism" (1995: 30): resulting in a mixture of individuals consumed by the capitalist aspirations of Cuba's 1940s and 1950s, yet rooted in socialist upbringings. His 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.

My examination of health reform in post-revolutionary Cuba has addressed the impact of health-indicator-driven public health policies on everyday lives, and the role of the state in mediating the impact of macroeconomic changes. The socialist government has done an extraordinary job of providing health and social welfare since 1959, and this has set a precedent, which recently has become increasingly hard to maintain while remaining a small developing nation with a socialist-based economy (at least, in theory), so rare in today's age of global capitalism. I have argued that the (re)creation of social relations based on a system of *sociolismo* has redefined — and challenged —the historic relationship between the individual and the state. Individual citizens forging out social relationships based on material and spiritual interests have reformulated some of the informal ideals and values of Cuba's pre-revolutionary past, and have combined them with a pragmatic twist to confront the new challenges of everyday life in Cuba's *período especial.*

My examination of socialist health governance has illustrated that Cuba's expansive primary health care program, supported by a massive network of family care physicians, is increasingly concerned with encouraging citizens to participate in *la Revolucíon.* The diminishing role of other institutions of state, such as the mass organizations, has signalled the channelling and reworking of state power through an exhaustive program of health education and disease prevention campaigns, which now include diagnosing problems of social malaise and productively directing people's wayward behaviour(s) toward popular participation in state initiatives. As I have argued, the above social processes must not be eclipsed by an exclusive focus on Cuba's vital health statistics. Statistics only provide a limited view of the much more complex social and political processes that are work in achieving Cuba's health profile.

The intention of my study is not to draw attention away from the significant accomplishments of the socialist state in health and social welfare. Almost half the globe's human population is without basic health care, and there is a growing economic gap between the North and the South. It is therefore

necessary to conduct research into how cultural, political and economic differences affect illness experiences and health outcomes in specific contexts. Similarly, it is necessary to question some of the entrenched practices and ideas in the arena of policy formation in connection with health and development. This is not to suggest, however, that I am promoting a Cuban model for health reform, nor do I advocate exporting the Cuban health experience elsewhere. The conditions of the *la Revolución* are materially, culturally, and historically situated and, thus, one should be cautious of engaging in the project of what Ché Guevara once termed "exporting revolution."[1]

* * * * * *

Ruminations on Cuba, *Post-Castro*

> More than thirty years had passed when, in the summer of 1993, a white, upper-class Cuban-American woman from Miami returned to the island for a visit. She was greeted there by her former maid, now retired, a black woman who was the mother of two children: an engineer and a medical doctor. It was an emotional encounter, full of common memories and mutual happiness. But when the unavoidable issue of post-Communist Cuba came up during the conversation, the black ex-maid asked: "Will my children be maids again"
>
> — cited in Alejandro de la Fuente's *A Nation for All: Race Inequality, and Politics in Twentieth Century Cuba*, 2001: 1

In international media circles, and even within certain academic milieus, the phrase "Castro's Cuba" always strikes me as odd. In a mere twist of words, the fate of the Cuban state rests of the shoulders of one man. For scholars working on contemporary Cuba, and international political observers alike — including the vociferous community of Cubans in exile — one of the foremost questions concerns the direction of the island-nation, post-Castro. The poignant anecdote above, while not dealing strictly with the discrete units of analysis of class, race and identity, forms part of a larger set of questions: what will become of the accomplishments of more than 40 years of *la Revolución* after Castro? The answer to this question is not easy to formulate; nor, I believe, can the future be predicted. As I have argued, there have already been noticeable changes in

[1] See chapter two, footnote 3 for a detailed discussion of this notion.

Cuba's existing health and social welfare services, as well as a visible re-emergence of class-based inequalities, that has served as a catalyst to bring to the surface deep-rooted problems of racism, corruption, and *sociolismo*, among others, that challenge the socialist rhetoric of egalitarianism and harmony.

In June 2002, Fidel Castro briefly collapsed, while giving one of his monumental addresses to the nation on the government's successful campaign to constitutionally declare that, "Cuba is and will always be a socialist state." As the cameras quickly panned away from Castro to take him out of focus, individual Cubans and, I am sure, the rest of world, interested in the ramifications of such an event, gasped. The question of Castro's mortality, or immortality, became the question of the day. Sitting in my apartment in Havana at the time, my phone began to ring off the hook: "*Seancito*, are you watching the TV?" How could you miss it, I thought. For anybody watching TV, the only three channels were broadcasting the same political speech. Several of my Cuban friends began to openly voice their concerns: "What will happen to us?" One thing was sure: all of them were adamant that they were unwilling to turn back the clock.

Within a matter of days, rumours started to spreading around Havana that Cubans in exile in Miami would be arriving by the boat-loads on the US Independence Day, July 4th, to rescue their relatives from socialism from the waterfront area — the *Malecón.* The images of the Mariel boatlift in 1980, and more recently the *balsero* crisis in 1994, were obvious points of reference for the plausibility that such an event could actually take place. While the rumour took on a life of its own, Cubans engaged in causal conversation on the streets and in the markets, and with their immediate neighbours, discussing, who would go and who would stay, if the rumour were true. While Castro quickly recovered from his minor spell of exhaustion (which was why, his political supporters claimed, he had collapsed), many individuals were still anxious about his possible successor. His younger brother, Raul Castro, who is head of the MINFAR, is simply "too radical," many complained. More people concluded, "Nobody else was competent enough to carry the torch of Cuban socialism with the passion and ferocity of Fidel."

As July 4th grew nearer, people became more and more anxious, and the Cuban radio and TV stations started broadcasting warnings that the *Malécon*

would be off-limits for that day. No explanations were given. On July 4th, from the view of my 8th floor high-rise apartment that faced the waterfront, the sea was calm and not a boat was in sight. Venturing out of my apartment with a close friend of mine, a fellow anthropologist from Canada, we made our way in the direction of the waterfront, despite the dire warnings of our Cuban friends that we were "completely crazy." They opted to stay home, reminding us that maybe as foreigners with passports, we could at least feign ignorance. Arriving one block away from the *Malecón*, a smattering of police armed with riot gear was to be found standing guard, and nobody was in sight. The Cubans we did see, for the most part, were going about their everyday lives. Within two days after the "big event," the rumour had little significance and people rarely commented on it. When I asked one of my neighbours, who had dramatically cried in my living room when Fidel momentarily collapsed, about the fate of Cuba post-Castro, she remarked, "I will deal with that day when it comes." I believe her attitude is wise.

APPENDIX

McGill University
Research Ethics Board I

Certificate of Ethical Acceptability of Research Involving Humans

Project Title: **"Revolutionary" Health and Medicine: Policy, Power, and Practices In Havana, Cuba**

Applicant: Mr. P. Sean Brotherton

Departments: Anthropology and Social Studies of Medicine

Academic Status: Ph.D. Student

Supervisor: Margaret Lock

This project was approved on July 6, 2000 by Full Review.

Departmental Review: (for research projects that are carried out by undergraduate and graduate students as part of their course work):

_____ (*Department Chair*) _____ (*Signature*)

The signatures below indicate that the project as described in this application is acceptable on ethical grounds.

1. G. W. Wenzel, REB-1 Chair (Geography)
2. D. Parent (Economics)
3. B. Ray (Geography)
4. P. Rains (Sociology)
5. Laurie-Anne White, Nunavut Government (Community Member)

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