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THE CUBA PARADOX: An Assessment of Primary and Maternal Healthcare in Cuba Today


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Keywords

Cuba Paradox, Factual Boundaries, Maternity Law, Acute Care, Active Care

Disciplines

Anthropology | Maternal and Child Health | Public Health | Women's Health

The Cuba Paradox:
An Assessment of Primary and Maternal Healthcare in Cuba Today

By

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In

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Abstract

Cuba's healthcare system is lauded on the Global Health stage as renowned. Low mother/infant mortality rates paired with low infectious disease transmission rates have garnered Cuba's maternal and primary healthcare systems significant fame. In addition to these healthcare feats, Cuban women experience challenges in finding access to basic forms of over-the-counter care. The Cuba Paradox emerges in which a Cuban woman's healthcare experience in places such as Mayajigua, Cuba (407 km southeast of Havana) is characterized by access to acute care (expensive treatments such as IVF) *and* lacks of access to active care (over-the-counter products such as Acetaminophen/Ibuprofen and feminine hygiene). This study aims to investigate the primary and reproductive care paradoxes presented to Cuban women today, specifically in rural Mayajigua, Cuba. A Mixed Methods approach that synthesizes information from a 2015 independent research quantitative survey alongside a 2016 independent research ethnographic project were used to assess the Cuban Medical Paradox in a holistic manner. Analysis showed that the Cuba Paradox exists due to a series of recent international developments, notably the 2016 Cuban Special Period. These results have implications on the study of the Cuban healthcare system at large in addition to implications for healthcare policy assessment beyond Cuba.

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Disciplines:

Medical Anthropology, Public Anthropology

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Chapter One. Cuba's Concentric Circles

Introduction

Circle One. The Outskirts

The US and western media, from the New York Times to the Huffington Post, has lauded Cuba for having one of the best healthcare systems in not only Latin America but the developing world (Lamrani 2014). An infant mortality rate of 4.2 deaths per every thousand births in 2014 has been a point of pride for the island (Lamrani 2014). Not even the United States, with an infant mortality rate of 5.82 per every thousand births in the same year (Fox 2017), has been able to match let alone beat Cuban mortality rates. Cuba has also achieved a globally low infectious disease mortality rate of 1.1% in 2014, an HIV/AIDS transmission rate of 0.1% among the population between the ages of 14-49 years in 2009, and a current life expectancy of 78 years (WHO Iris 2015).

When Margaret Chan, former WHO Director General, visited the island in 2014, she acknowledged that the Cuban healthcare system's emphasis on preventative medicine yields outstanding results. "We sincerely hope that all of the world's inhabitants will have access to quality medical services," Chan said, "as they do in Cuba" (Prensa Latina 2014). Paul Farmer also lauded Cuba as being a model for Haitian healthcare because of the Cuban healthcare's feats of protecting, en masse, Cuban citizens' universal right to health as demonstrated by low mortality rates.¹ The Cuban system's emphasis on research and development on a national level also grounds itself in the specific disease needs of the national Cuban population (research is informed in a bottom-up fashion). As Chan also stated, "Cuba is the only country that has a healthcare system closely linked to research and development. This is the way to go, because human health can only improve through innovation" (Agencia Cubana de Noticias 2014).

This innovation has created a myriad of different vaccines and treatments, including a novel lung cancer treatment and an experimental HIV/AIDS treatment center known as El Coco where HIV/AIDS patients are exclusively treated. Interestingly, El Coco is located near the shrine of San Lázaro, the patron saint of lepers and by extension the patron saint of patients who suffer from stigmatizing diseases (from leprosy in biblical times to HIV/AIDS in modern times). The fusion of the HIV/AIDS treatment with the religious significances associated with San Lázaro suggests that, in Cuba, HIV/AIDS is not a forgotten disease but is one that the health community attempts to be highly inclusive of and efficient in providing care.

Overall, a healthcare system that fuses preventative-based medicine with public health, research, and the protection of vulnerable populations (notably pregnant women, children, and those who live in impoverished communities) yields major national advances in the health sector, such as those cited earlier. These advances are made possible thanks to a healthcare policy that mandates healthcare be provided as “a fundamental human right” (Iatridis 1990). This right manifests itself through the provisioning of healthcare, from consultations to expensive treatment and medication access, free of charge.

*

In what follows, each circle described in Chapter One will represent a factual boundary. A truth that can stand alone, but when contextualized with other truths forms a unit of concentric circles in which true realities that seem to be contradictions against other truths and realities actually embed within each other. Witnessing how contradicting truths and realities embed can elicit an intellectual discomfort, making it easy for us to feel that we have come across an intellectual wall of thought. Throughout this piece, I explore the paradox that emerges upon macroscopic reflection of these factual boundaries of contradicting but embedded truths: How is

it that a Cuban can have access to chemotherapy or a novel lung cancer vaccine or IVF *and* not have access to Benadryl or Depakine (prescription medication for epileptics) or feminine care/hygiene products? The Cuba Paradox that emerges upon close consideration of factual boundaries creates a narrative arc that facilitates the exploration of tensions and adds momentum to an analysis laden with contradictions, particularly in the domain of women's health.

The ethnographic approach proved most fitting to investigate such bounded truths and contradictions in relation to each other. The initial stage of this project began in 2015 with a pilot study. In July and August of 2015, I travelled on an independent research trip to nine of Cuba's fifteen provinces and conducted a statistical assessment of the healthcare system. The method largely consisted of asking women yes/no questions that were recorded in an approximately 10-15-minute paper survey. 89 interviews were conducted and were analyzed in Excel. Upon analysis of the trends in this pilot study, I began to discover the existence of concentric truths that could not be captured by a simple yes/no response on a paper survey. For example, 75% of women I spoke with and interviewed in 2015 stated that they do not have access to over-the-counter products *and* 71.43% of women stated that they have access to prescription medicines. Contradictions such as these became pressing points of further study which is why in 2016, I decided to narrow the study's focus and refine the method used.

In August 2016, I returned to Cuba for a second independent research trip but with a more qualitative approach and assessment of the truths I began to uncover in 2015. I specifically remained in Mayajigua, Cuba (in the Sancti Spíritus Province). Mayajigua is a small, rural farming town approximately 407 kilometers southeast from La Habana² capital city. In Mayajigua, I formally interviewed twelve women often returning multiple times to clarify questions and build relationships. Initial interviews were semi-structured with a set of guiding

questions that were asked to each interviewee upon initial encounters. Future encounters, conversations and interviews with the women in Mayajigua were more fluid in which I asked follow-up questions or in which women offered information they believed was essential for me to know in the study. During this second ethnographic trip I also had the opportunity to immerse myself more in the healthcare system via participant observation since I had the opportunity to travel with informants and friends to local doctors' appointments, supermarkets, bodegas (rationing stores; Cubans can only purchase rationed goods from these "bodegas" or convenient stores) and pharmacies.

In 2017, my return to Cuba for a third trip was not for an explicitly research related purpose, but rather for a community-based bottom-up project in which I worked with friends that I had made over the course of the research period to deliver needed over-the-counter products (notably Acetaminophen and Ibuprofen, reusable feminine menstrual pads, and soap) to Mayajigua, Cuba all based on the data that I collected in 2015 and 2016. Although the 2017 trip was not an officially funded research trip, in contrast to the 2015 and 2016 projects, field notes and informal interviews were conducted to better understand and sample Mayajigua, Cuba's financial, social, political and medical standing at the time. This piece is consequently a reflection of the Mixed Methods data (quantitative and qualitative data) that has been collected over the course of my undergraduate career through various independent research trips.

The data and this corresponding thesis reflect the voices of the 100 plus women, men, patients, physicians, *Cubanos y Cubanas*³ I had the honor of meeting and speaking with over the course of several years. The voices in this piece are largely those of the *Cubanas*—of the Cuban *women* I met and interviewed. It is principally the Cubana's voice that enlivens the concentric circles illustrated below and that brings the Cuba Paradox to the forefront of our discussions on

the Cuban healthcare system today. In the subsequent circles, I encourage you to not only listen to these voices but to look for the paradox that exists in the spaces lying between each circle. Doing so will develop a greater understanding of the Cuban healthcare system and the Cuba Paradox underlying it.

Circle Two. Cuba's Greatest Export

A second characteristic dimension of the Cuban healthcare system includes a well-trained physician force that prides itself on delivering quality care to people on the ground in both domestic and international communities. ELAM (Escuela Latinoamericana de Medicina; Latin American School of Medicine) is considered one of the largest medical schools in the world, with an approximate enrollment of 19,550 students from 110 countries enrolled in 2013 alone (Lamrani 2014). The State fully pays for tuition and room/board fees, and additionally provides students with a small stipend. In return, the State expects medical students to not only succeed in their academic studies, but to uphold the mission of the school, which involves training doctors who are both efficient and cooperative within Cuba's larger mission of providing healthcare as a fundamental human right.

ELAM's socially conscious education of health professionals is generalized to Cuba's medical education system at large. After graduating from the six-year medical education program, all Cuban medical students (including those who did not graduate from ELAM) are required by the State to go on medical missions to volunteer their services. In these missions, doctors must travel to poor communities in need of healthcare. Physicians are expected to practice in these communities for a significant period of time, specifically an obligatory period of

two years of service in the public sector (or more if the physician so chooses). In 2014, approximately 50,000 physicians were exported to 66 different countries, notably Haiti, Brazil, Venezuela and Angola (Freeman 2015). Dr. Daymé,⁴ a physician from rural Cuba who I met in 2017, recalled his experience of being in Brazil for 2 years. “We would get sent to the places where not even the Brazilian doctors go.” In Dr. Daymé’s case, these “places” tended to be rural areas with poor infrastructure that he characterized as drug-infested and crime-ridden locations with minimal health resources (clinics that did not have supplies or an attending physician, empty pharmacies, lack of food).

This physician exportation brings fame to Cuba’s medical system as the world comes to know the quality of Cuban doctors. When the Ebola crisis struck in 2014, “after the United Kingdom, Cuba sent the largest number of doctors to Sierra Leone” (Freeman 2015). The Cuban Medical Brigade additionally sent “53 medics to Liberia and 35 medics to Guinea” (Freeman 2015): an “army of white coats” as proudly described by Fidel Castro in 2014. In total, approximately 12,000 medical staff were sent through the brigade to control the Ebola crisis (Freeman 2015).

This medical diplomacy, however, has been a trend since before the Ebola crisis. Health diplomacy continues to mark Cuba’s healthcare system as unique since doctors do not enter the profession to make money per se. In 2016 and 2017, the average medical physician (including Dr. Daymé, who was a leading physician in rural Mayajigua, Cuba), earned 17.50 USDS a month. Cuban pre-medical and medical students are correspondingly encouraged to enter the medical field not for the business of medicine but for the business of healing—attempting to provide for the health needs of various communities (not only the domestic communities) around the world. Practicing medicine for the sake of providing healing and access to health as a human

right is the expectation that grounds the system; doctors are trained and encouraged to participate in the medical system and to be motivated by human factors as opposed to financial ones.

Circle Three. Chemo and IVF Price Tags

Cuba's healthcare system is further characterized by access to medications that, in the United States, would be prohibitively expensive. Since health is provided on the grounds of being a human right, medications such as chemotherapy, vaccines, and IVF can be accessed quickly and freely when a patient demonstrates the need.

In 2015, I met and interviewed a young woman named Yamelli who at the time lived in La Habana capital city. In our conversation, Yamelli explained that she is infertile and that she and her significant other had been independently attempting to have a child for several years without success. At the time of the interview, she and her partner had recently decided and begun to undertake fertility treatment. "Here, I can receive IVF treatment for free [...] I don't have to pay a buck." She demonstrated thanks for and pride in her healthcare system. Not even in the United States could a woman have access to IVF for free. Yamelli noted this fact was quite contrary to women's sexual/reproductive health delivery in Cuba.

Yamelli's experience was echoed by that of Alonso, a Mayajiguan man diagnosed with late stage lung cancer and who received access to Cuba's novel lung cancer vaccine immediately upon diagnosis.⁵ In speaking with Alonso in 2015 I learned that he, just like Yamelli, did not have to pay for the expensive cancer treatments on the market. And although the vaccine did not save Alonso's life, my interactions with Alonso always pleasantly surprised me because he was able to live two more years with his cancer and live with a high quality of life. During these two

years of essentially living on borrowed time, Alonso was not bed-ridden but was able to continue daily routines, interact with family, and participate in activities that brought him joy (notably writing to friends and family living outside Cuba). This extension of a quality life became possible as a result of having access to the treatment, not on the grounds of his being able to afford it, but on the grounds that he was suffering from cancer and deserved the best possible care by virtue of being a person.

Free and mandatory access to vaccines forms another unique facet of the healthcare system. In Cuba, not only are vaccines (such as DTaP, the chicken pox vaccine, the small pox vaccine) free of charge for children, but they *must* be administered. Unlike in the United States, an anti-vaccination movement does not exist because it would not be tolerated. In 2016, I interviewed Yulia (a woman from rural Mayajigua, Cuba) who had recently given birth to a baby girl. After the child was born, Yulia returned home and missed the follow-up appointments to vaccinate her newborn in the local polyclinic. A week after discharge, a physician from the polyclinic in her area visited her in her home where he administered the vaccines in her living room. Yulia had not called to schedule the in-home vaccination. Her physician was the one who noticed that she had missed the vaccination appointments and so he visited her. Just because Yulia missed the appointment did not mean that the child could not or would not be vaccinated. The access to expensive medicines or vaccines correspondingly defines the healthcare on the ground. These treatments, vaccines, and medicines are not only made available but expected to be used when and as needed.

Circle Four. Medical Tourism

The combination of access to quality doctors and inexpensive treatments prompts medical tourism, or the “organized travel outside one’s local environment for the maintenance, enhancement or restoration of an individual’s wellbeing in mind and body.” This tourism inevitably includes “the organized travel outside one’s natural healthcare jurisdiction for the enhancement or restoration of the individual’s health through medical intervention” (Carrera and Bridges 2014, 447). In Cuba, medical tourism is largely supported by the State as an important source of income from the tourism industry. For example, the top floor of the National Hospital in La Habana prides itself on servicing the needs of medical tourists alone—a floor with an amazing panoramic view of all of La Habana is meant solely for the care of foreigners. Patients travel from around the world, ranging from Latin-American countries to ex-Soviet countries (such as Latvia and Russia), to receive inexpensive dental care and even chemotherapy. Furthermore, Cuba’s medical tourism specialty lies in skin and dental services. “Cuba emphasizes that the quality of its professionals in plastic surgery and dentistry is ‘unquestionable as shown by the health indices given the World Health Organization’” (Connel 2011, 107). In 2016 and 2017, work continued to be underway in Los Cayos (a tourist resort destination located 53 kilometers from Caibarien in the Sancti Spíritus Province) to build medical tourism resorts for dental and plastic surgeries in which non-Cuban citizens could travel to the island to receive medical services. Combining high quality and affordable care with a beach to relax on and heal has been a significant selling point of the medical tourism industry in Cuba today.

Cuban medical tourism assumes two unique flavors. The first, as described earlier, is related to “the Cuban government’s low-key effort to encourage people from other Caribbean Islands and Latin America to come to Cuba for medical examination and treatment (e.g., magnetic resonance imaging and surgery) rather than going to the US where treatment would be

more expensive” (Goodrich 1993, 38). The second form of the tourism is related “to the use of Cuba’s health spas and mineral springs by Cubans and tourist visitors” (Goodrich 1993, 38-39). Mayajigua, Cuba is one of these sites considering that the small, rural town has gained fame for its thermal springs provincially known for their medicinal healing qualities. The springs are specifically famous for their ability to provide relief to those with arthritic pain, gastric complications, or skin imperfections such as blemishes and acne. The use of certain spa treatments in tourist resorts (such as those in Los Cayos outside Caibarien) that use scrubs based in local sands or mineral waters also adds to the complexity of Cuba’s healthcare as experienced by medical tourists.

Circle Five. Limited Access

Limited access to over-the-counter products (OTCs) and certain prescription medications that people require on a daily or regular basis proves to be a feature of the system that is just as defining as access to quality doctors and expensive treatments. From Band-Aids, to *Diriprona* (Cuba’s nationally produced version of aspirin), to *Depakine* (a prescription medication designed to control epileptic seizures), to insulin testing strips for diabetics, to feminine hygiene products for women—in addition to hundreds of other over-the-counter products and regularly administered prescription medications—cannot be found reliably by Cuban citizens, especially in rural areas. In 2015, 75% of the women I interviewed in northern and central Cuba responded that they do not have reliable access to over-the-counter products and often go without them. Lack of access to more basic forms of care that might not be traditionally as expensive as chemotherapy or IVF but that affect daily quality of life is a repeated theme in the ethnographic

data. This theme is presented in terms of an “and.” Cubans have access to IVF *and* do not have consistent access to feminine care products. The “and” becomes a conjunction that conjoins two contradictory truths. In this conjoined realm of an “and”—the place where two conflicting truths tie together—the Cuba Paradox shows itself blatantly.

One example of a lack is that of the lack of access to *Depakine*, which proves particularly challenging for a Mayajiguan mother and son that I met with and interviewed in 2016. The medication no longer was being manufactured in Cuba (like *Diriprona*, primary ingredients to manufacture the drugs were no longer entering the country which translated into an inability to manufacture) and finding the pills in the local pharmacy became a hit or miss process. In the case of Irena and her son, they were forced to cut pills in half in an attempt to prolong their access to the needed medicine. Epileptic episodes became more frequent not only because daily doses were reduced, but because Irena’s son felt anxious about running out of pills. He explained to me that his anxiety about living day-to-day—pill to pill—wondering if he would be able to live long enough to watch his baby grow up, catalyzed more seizures and with an increased intensity. His physicians could only continue to suggest cutting the pills in half or contacting relatives in other countries (i.e. the United States) with the hope of being sent *Depakine* from abroad.

Unreliable access to feminine hygiene constructs a similar narrative. In my later conversations with mother and son, Irena recalled that when she used to menstruate, she had to invent. “We used mosquito nets because that was all we had.” This lack continues to the present. In June 2017, Mayajigua, Cuba had been without feminine care products for three months because the factories that manufactured the products in the Sancti Spíritus province no longer had the necessary supplies to manufacture menstrual pads. Without feminine hygiene, it became difficult for young girls in Mayajigua to continue with normal tasks, such as going to school

during her time of month, constantly fearing the shame and embarrassment that accompanies unwanted stains. The lack of feminine care products in Mayajigua was also specifically challenging for two wheelchair-bound young adolescents. In one of my conversations with Dr. Daymé, he explained to me that he believed it was inhumane to let the young girls just sit in their wheelchairs with this feminine discomfort, however, not many alternatives exist.

An interesting conjunction linking two seemingly independent clauses emerges, all elegantly summarized by a woman I met in 2015. “Here, in Cuba, a child can be without shoes but never without vaccines.”

Circle Six. Delay

Kristina lives in Mayajigua, Cuba and is in her mid-forties. She is a woman with a big smile and a gold tooth that blinds you when the sun hits it as she rocks back and forth on her neighbor’s porch rocking chair. She used to be able to catch the kids as they played in the street or run to the yard when she heard mangos falling from the mango tree in the back. Now, the pain she experiences in her knees often lands her in the local polyclinic where she hopes she can be seen by a visiting orthopedist. In Mayajigua, specialists come from out of town to the Mayajiguan polyclinic once a week to cater to the health needs of the rural, farming people. The lines of people waiting for a consultation with the specialist can become very long in a short period of time since, as Kristina states, “Everyone wants to see a specialist.” Due to volume, Kristina will often wait hours in the polyclinic knowing that although she may wait all day, her consultation with the orthopedist about her pain is not guaranteed. “I waited all day to see the orthopedist, but my turn [in the line] did not come.” Due to her pain, Kristina decided that it

would be worth her while to attempt to visit the specialist in his home office in Yaguajay, approximately 32 kilometers away. She travelled by an open bus early in the morning, hoping to be one of the first people in line but knowing fully well that there are never any guarantees because “everything depends on the line.” Her healing process has correspondingly been delayed on multiple accounts simply because she has not been able to see a doctor on time.

When Kristina shared her account with me in 2016, she spoke with frustration. There always seemed to be more people in the line no matter how early she managed to get to the polyclinic. Kristina’s chase for access to her orthopedist ultimately uncovers another unique conjunction. The specialists exist—Kristina will get care at some point. The principal question subsequently becomes not if Kristina will get care, but when and where.

Circle Seven. The Nucleus

I had accidentally touched the “pica pica” (itch itch) plant hours ago. I must have brushed past it when one of my key informants invited me on a hike to see a monument in honor of Mayajigua’s famous *Pelú de Mayajigua*.⁶ Since then, my throat had been tingling and my face, arms, and torso were covered in large, red welts. My lips were swollen shut and my eyes were so puffy it made it difficult to blink. The welts were not the bad part about the allergic reaction but the burning itch and the concern for my tingling throat. Would it close? If so, how much time would I have until it did? My neglect in packing Benadryl was ultimately what landed me in the polyclinic at around eleven in the evening.

After arriving at the polyclinic, I had to wait until the three people ahead of me in the waiting area were taken care of by the one physician on duty. When my turn finally came, a cleaning woman and a nurse ushered me into the doctor's office. I was told to lift up my shirt so that the physician could better examine the welts all over my body. The door and the windows were all open to ventilate the air some. The cleaning ladies and the people in line behind me filed into the room wanting to know what was wrong. Men gathered from the outside of the polyclinic standing right behind the windows asking the doctor, "What's wrong with the gringa?"

I had an allergic reaction. I told her I just needed Benadryl—it would solve everything. She explained that unfortunately, she did not have any to give me and suggested that I go to the Yaguajay polyclinic 32 kilometers away. If I wanted to be safe, I should travel to the Sancti Spíritus Provincial Hospital more than 100 kilometers away because she was not sure if Yaguajay would have the Benadryl or if they would legally be able to provide the medication to a non-Cuban since I needed to be treated in a tourist center.

I covered myself, asked for ice to cool the itch, and took my chances by driving to Yaguajay. As I got out of the car and walked over to the Emergency Room hospital entrance, I felt unsettled. Why was the morgue right next to the emergency room entrance? As I waited in line for my turn to see the ER physician in the hospital, I stole a picture of the ambulance parked outside the pharmacy fifty feet away and contemplated the initial, salient differences between the hospital and the two other polyclinics I had seen (Mayajigua's and Yaguajay's). The hospital was bigger than the polyclinic back in Mayajigua and there were more staff working—doctors, nurses, pharmacists and volunteers.

When the physician saw me, he explained that he had intravenous Benadryl but that it would not be legal for him to give the medication to a foreigner. I would have to travel to the

Sancti Spíritus Provincial Hospital. That said, he told me he would treat me with his job on the line. I had to agree to not publicize that he had granted me access to the medication. We made the deal. He and five nurses came into the room to administer the Benadryl. Men I had never met looked in through the open window from the outside, the “chismosos” (the “gossipers”).

The next day I told one of my grand-aunts about where I went the night before. She merely shook her head slowly at the conclusion of my account. I came to Cuba to understand the healthcare system as experienced by women on the ground in real-time. Her only response was, “Now you know.”

Overview

Each of the seven concentric circles described fit nestled one within each other in the order in which they were presented. When people initially hear the word Cuba, they imagine beautiful beaches, vintage cars, colonial architecture and a healthcare system acclaimed by many for its incredible healthcare feats that make any Latin American country and Third World nation envious. These feats, which culminate into the depiction of Cuba as a medical paradise that has lowered disease rates, is the outermost truth—a macroscopic vignette from Cuba’s medical reality. Fit neatly within this truth lies another truth—the strength of Cuba’s physician training and medical health diplomacy programs. Nestled within that lies the truth about access to expensive forms of medical treatment followed by a limited access to over-the-counter products, long wait periods in lines to see specialists, and my own autoethnographic experience.

The explanation for this conjoining of concentric realities lies largely in the fact that space exists between these realities. More simply, vacuums of understanding fill the gaps

between factual boundaries and separate one truth from another. These vacuums of understanding manifest themselves through contradictions because realities do not sum in a way that satisfies the initial expectations formed upon analysis of the outermost concentric circle, or reality. This essay acknowledges the concentric nature of the Cuban medical healthcare system as perceived and lived by women in Cuba today. Part of acknowledging this nature inherently involves confronting each reality and the gaps, the little vacuums, filling the voids between them. In doing so, the contradictions and “truth competitions” will become protagonists in an analysis that does justice to confronting contradictions as paradoxes.

I began this research project formally in 2015. Since beginning this project on the Cuban primary and reproductive healthcare systems as made available and used by Cuban women, my principal objective has been to traverse the gaps between concentric truths in an effort to understand the duplicity and simultaneity of expectations (such as the statistical expectations from WHO) alongside the realities and lived experiences of women who use the healthcare system daily. My principal lines of inquiry have included investigating how women on the ground in Cuba make use of their primary and reproductive care systems and how they interact with the healthcare delivery systems currently in place. Sub-inquiries that have naturally branched out of my principal research inquiry include assessing how the care delivered logistically differs from the healthcare system formally described in the legal health policy and investigating the non-biomedical factors affecting women’s use of the healthcare system.

It is important to note that in each of my inquiries I elucidate the feminine experience. My rationale is a simple one: I emphasize women’s voices in my work because the Cuban healthcare system places acute focus on women’s health. With the triumph of the Revolution in 1959, the Castro brothers and Vilma Espín announced that the Cuban Revolution would be a

“Revolution within a Revolution” (Chase 2015). The emancipation of the working class coincided with emancipation of women in which gender politics and women’s activism and leadership (epitomized by Vilma Espín) were critical at every stage of the revolutionary process. Mobilizing women brought about significant societal transformations not only by questioning normalized gender roles but also by advocating more rights for the female body. Laws, such as the 1963 Maternity Law (legal protection of the rights of working pregnant women) became the physical manifestation of the revolution within the revolution. The State’s continued emphasis on protecting the female body (giving her the opportunity to have access to birth control notably in the form of IUDs, permitting her use of abortion services, granting her access to IVF, ensuring her physical and psychological wellbeing in pregnancy through various State-run medical services designed specifically for pregnant women) becomes evident in the healthcare system. This unique emphasis on protecting the health of the female body paired with low infant and mother mortality rates in childbirth warrants a specific analysis that forefronts the voices of those women who make use of the unique services legally offered by their State.

Considering that the aim of this feminine-based project involves understanding truths that embed yet conflict with each other, the ethnographic approach proved most fitting to investigate bounded truths and contradictions in relation to each other. Through the ethnographic approach specifically, “the collection of concrete data over a wide range of facts” (Malinowski 1922, 190) became possible. Ethnography enabled assessment of concentric truths and their corresponding vacuums by facilitating a “thick description” of the Cuban medical healthcare system that “is interpretive; what it is interpretive of is the flow of social discourse; and the interpreting involved consists in trying to rescue the ‘said’ of such discourse from its perishing occasions and fix it in perusable terms” (Geertz 1973, 292). Being able to understand this flow becomes

paramount when co-analyzing women's experiences so as to understand not just women's experiences with the healthcare system but the various social, medical, personal and psychological meanings attached to accesses and lacks.

Through this "thick" description, the ethnographic approach prompted an analysis that could penetrate beyond the shielding effect of the outer concentric truths. When it comes to Cuba, policy analysis and statistics such as those presented on the outermost circle of the Cuban concentric unit can quickly shield the contradictory truths that exist further inside the Cuba Paradox analogous to how atomic electrons in outer energy shells can be de-shielded, or disconnected, from the energetic effects of inner chemical layers. Ethnography provides a means by which penetration into shielded and de-shielded layers can occur so as to analyze each section of the atom or the concentric unit individually and as a whole. Inner parts of the concentric circle can moreover be de-shielded without categorizing truths into a binary of good/bad, either/or, black/white. Instead, the analysis can be guided in terms of an "and" by leaning into the initial discomfort of vacuums of understanding. These contradictions can thus be first accepted and then confronted by viewing them as synchronized duplicities of one reality.

In addition to speaking with women of different ages, on each of the research trips I had the opportunity to bring not only informants but close relatives to doctors' appointments. Participant observation further permitted my entry into an emic analysis in which I could learn about the healthcare system by participating in it notably by using the system myself when needed or taking informants and relatives to polyclinics or hospitals in Mayajigua, Yaguajay, and Caibarien. The family member appointments were particularly laden with meaning that I attempted to understand as a researcher and as a niece, grand-niece, or cousin. My experience with the Cuban healthcare system in these moments with relatives became intimate and personal.

My personal connection to Cuba and to Mayajigua explicitly has consequently required significant reflection throughout all parts of the research process (from study design, data collection, analysis and writing). My mother, aunt, and grandparents were all born in Mayajigua, Cuba and were exiled in 1972. Growing up, I lived in a hyphenated household, a uniquely Cuban-American existence colored by bilingualism and ethnic integration. Having the opportunity to visit Cuba for the first time in 2015 became as much a personal as an intellectual experience where I had the opportunity to finally meet relatives who I could only ever speak with over the phone or write letters to. My visit to the field thus demanded rigorous self-reflection especially when investigating Mayajiguan reality through participant observation. I had to be aware of all types of biases—especially in being aware of how I romanticize Cuba and how I perceive the State.

My personal and intimate relationship with Cuba as a *Cuban-American researcher* has subsequently fostered aggressive inquiry in which I attempt to organize narratives without removing myself. On the contrary, I began to more fundamentally understand my role as an ethnographer. I became an archivist of *herstories* integrating information across sources (including my own experiences) not in an attempt to truncate truth into a clearly defined narrative, but into a series of concentric realities classically defined by moving and competing parts.

In Mayajigua, I also grew increasingly aware of not only my assessment but how my very presence can affect how people in the field treated me or related with me. People that I had never heard mention of in my grandparents' apartment in the States would find me, wishing to talk about how my family was and ask me to be an international Hermes of sorts relaying messages between two seemingly distant and separated groups—from Cubans to Americans. I had to be

aware of how people interacted with me as “Bituro’s granddaughter” just as much as I had to be aware of my own experiences as a Cuban-American and my role as a researcher in Mayajigua.

Part of my role as researcher in Mayajigua has also involved confidentiality, which has been and continues to be of utmost importance. All names, excluding those of physical places and locations, have been anonymized to protect the identities of the women and men that I have come to know. I acquired IRB approval for both formal research studies (2015 and 2016) in addition to IRB approval for 2017 data use from the University of Pennsylvania’s review committee under the condition that all interviewees would remain anonymous. Rightfully so. It is still not safe to speak freely about the paradoxes explored in this piece. Often, women would close the blinds to their homes or speak in hushed tones about “what life is like here in our beautiful island.” Anonymizing women respects their freedom.

Given the dynamic and contradictory nature of the bounded facts investigated, the main theoretical tool implemented to organize evidence is that of my so-defined Cuba Paradox. As “some ‘thing,’ a paradox may denote a wide variety of contradictory yet interwoven elements: perspectives, feelings, messages, demands, identities, interests or practices. Second, paradoxes are constructed [and] become apparent through self- or social *reflection or interaction* that reveals the seemingly absurd and irrational coexistence of opposites” (Lewis 2000, 761). When it comes to Cuba, the paradox heuristic fits the data snugly by providing the necessary room to explore opposites.

Naturally, consideration of the Cuba Paradox as the integral of interwoven elements that seemingly oppose each other, brings the image of the Roman god Janus to mind. The god was one element, one body, with two competing faces. Janus had a face that looked forward into the future and a second face that looked backwards into the past. His identity as a two-faced god is

defined by a contradiction and his existence becomes a paradox in of itself since he embodies duplicities that seem to be inherently separate from each other.

In what follows, I present these two faces of the Cuba Paradox, both of which are part of the same entity. By presenting the two faces as parts of the same larger whole, I hope to be able to better interpret the forces responsible for the creation of vacuums of understanding and the politics of acknowledging or not acknowledging the gaps. In this analytical process, the experiences of the women who live in these vacuums—how women make sense of the vacuums and how they manage them—becomes centralized. The Cuba Paradox therefore creates a narrative arc that facilitates the exploration of tensions and adds momentum to an analysis laden with contradictions.

Chapter Two. History and Fame

Defining the healthcare

Mutualism constitutes a defining, organizational characteristic of the Cuban healthcare system. Part of the healthcare system's success rests upon the "political commitment to equitable socioeconomic development and community participation" (Iatridis 1990, 29). Upon extension, mutualism (Sixto 2002) in which lay citizens become active participants in promoting the health and wellbeing of themselves, their families and their neighbors becomes the corner stone of the health equity policy. For example, the State encourages lay participation in public health efforts. When outbreaks of the flu occur, the president of neighborhoods or towns are expected to mobilize town meetings in which lay citizens can congregate alongside health professionals to

discuss how to maintain the health of the community during outbreaks or epidemics. Doing so ultimately melds public health with biomedicine so that the two, in Cuba, become inseparable. Integral community participation in which the doctor is mandated to develop strong ties to specific communities for extended periods of time forms the basis of Cuba's four-tiered healthcare system.

The Cuban healthcare system is a tiered system that is regimented into four principal levels, the first of which is the primary level. The primary level of the Cuban healthcare system is that of the CMF, an acronym that stands for *Consultorios médicos de la familia* or Family Consultation Centers (Figures 1-3).

The CMF is a numbered building specific to a neighborhood or town and consists of two floors. The center is home to the general physician or the family doctor who is expected to live in the CMF on the top floor and see patients on the bottom floor. "The burden of the public health system rests on the shoulders of [...] consultorio (clinic) teams [...] or] the assignment of a nurse and doctor to every 150 families [which established continual community-based patient care]" (Huage 2007, 40). Due to the CMF, the doctor quite literally becomes "of and for the people" (Randall 1981) because s/he is tasked with living in the community. The doctor consequently becomes the medical archivist often coming in contact with generations of people from the same family. The physician also becomes the guardian of the public's health since his/her integration with the specific community s/he serves enables the physician to monitor and track the general public's health and design public health protocols that are specific to the community. It is also because of the active presence of the CMF that people are uniformly vaccinated and examined, which prevents parasites, TB, malaria and even HIV/AIDS from spreading in predominantly poor environments (van Gelder 2007). Moreover, when an individual needs medical attention,

s/he first visits the CMF before travelling to see a specialist or to a hospital. If the CMF cannot deliver the required treatment or diagnoses, an individual is often sent to a polyclinic to see a specialist. It is likewise the responsibility of the CMF doctors to lead health charlas (talks) and inform the community members on how they can continue to live healthy lives by recognizing symptoms, using herbal treatments or medicines during the healing process, and so on. That said, the most salient responsibility of the CMF care providers includes going on “terrenos” (Huage 2007) in which care providers visit ill comrades when they are unable to come to the doctor’s office themselves. The terreno, or home-visit, proves to be a particularly powerful part of the primary care level since the doctor has the opportunity to witness the quality of life of his/her patients. Holding witness to the life of a patient outside of the clinic ideally offers the doctor a better understanding of the specific social determinants of health that affect patients. For this reason, the doctor is generally expected to stay in the CMF office for the early morning and go on terrenos in the afternoons. This “embedding [of] health professionals in the communities meld[s] public health with clinical medicine” (Reed and Keck 2012, e2) thereby allowing the primary care level to act as a safeguard and first line of defense towards ensuring community health and treating patients.

The subsequent level of the system is the secondary level. The secondary level refers to the specialized care that is delivered at the municipal level notably through the infrastructure of the polyclinic. Polyclinics are a “kind of health centre [...with an] emphasis on being well and staying well” (Bond and Beresford 2003, 551). Ideally, polyclinics offer more services than the CMF physician considering that the polyclinic is larger, has specialized health wings (i.e. a cardiology wing, an ophthalmology wing, and so forth), has more staff (multiple doctors and nurses work at the polyclinic), and has more technology for the service of the patient (i.e. X-

rays). In the case of Mayajigua, when the specialists visit every Tuesday to provide their services to the town, the specialists visit the polyclinic precisely because the polyclinic is larger with more consultation rooms and is better equipped with the necessary technology to conduct physical assessments (Figures 4-5).

The next level of the healthcare system is the tertiary level, comprised of hospitals. The most salient difference between a polyclinic and a hospital is that one cannot be hospitalized in a polyclinic (no overnight stays since the polyclinics are not equipped for offering this kind of medical care). In 2015, 41.67% of the women interviewed stated that there are salient differences between a polyclinic and a hospital. These women stated that hospitals tended to be bigger, cleaner, have a shorter wait-period in the line than the polyclinics, are better staffed (not only are there more health professionals in the polyclinics but these health professionals tended to be better mannered and give closer attention to patient needs), are more specialized, admit more people per day than the polyclinics, and possess higher quality technology (the technology in polyclinics can be broken for months or weeks at a time, as I discovered in Yaguajay when the polyclinic's phoropters for optometry exams were broken for over a year from 2015 into 2016). In addition, several of the women I interviewed explained that the hospitals tend to treat major diseases and illness, such as cancer. Chemotherapy is generally administered in a hospital setting instead of the polyclinic since patients can be better monitored in the hospital and for longer periods of time. Pharmacies are often constructed on hospital grounds as well (Figures 6-7).

The fourth and final tier of the Cuban healthcare system is the quaternary level, or the level of the national research institutes. The quaternary level has been defined as the super specialty care that occurs at the national health research level. At this level, the government funds health research from the lung cancer vaccine that was administered to Alonso to an

experimental HIV/AIDS treatment administered to patients in El Coco. Research institutes across the country tend to focus on designing innovative solutions to high-profile diseases or illnesses. The Labiofam research group in La Habana is one of the largest research groups in Cuba and it focuses on the creation of novel cancer treatment specifically. BioCuba Farm is another example of one of these 4th tier industries (Figure 8).

Much of this tiered healthcare system is supported by the 1983 Public Health Law. The primary premise of this law is “the protection and improvement of the health of the population [as] a fundamental and permanent obligation of the State. The law entrusts the Ministry of Public Health (MINSAP) and other institutions to organize and provide health services, and to assure that services are made available free of charge in all parts of the country, including rural areas” (Evenson *b* 2005, 8). The tiered healthcare system with an extensive primary level that services public health and focuses on preventative medicine (having access to physicians in health as well as in sickness) is one manifestation of the law in practice. Article 4 lists a series of foundational principles that ground and organize the Cuban health system, particularly:

- “The recognition and guarantee of the right to medical treatment and protection for all citizens in all parts of the nation;
- Health services to be provided by state institutions free of charge;
- The social character of the practice of medicine;
- High priority given to preventive measures and actions;
- Public health planning;
- Application of scientific and medical advances to health care;
- Active public participation in health activities and planning; and

- International cooperation in health, including provision of health services to other countries.”

(Evenson *b* 2005, 8)

Under the 1983 Public Health Law, health education became another imperative tool for promoting effective public health measures. Not only were doctors required to give health charlas (talks) as needed, but the “law requires the institutions that form part of the National Health System to develop health education programs and to pay particular attention to health issues arising in the work place” (Evenson *b* 2005, 8). In Mayajigua, there is a channel that plays television programs with a health-related theme. In these television programs several informants explained that they learned how to use herbal remedies to alleviate arthritic pain or even reduce acne inflammation. There are also State sponsored programs designed to help teach men and women how to participate in safe sexual relations and how to take care of oneself or a loved one in pregnancy. In addition to setting up educational programs, the law “mandates that workers receive pre-employment exams where appropriate as well as periodic examinations when they are subjected to a particular job-related health risk [...] Work places are required to adopt measures necessary to prevent work-related injuries and illnesses” (Evenson *b* 2005, 8). There are consequently multiple opportunities for the regulation and monitoring of an individual’s health in a preventative way, from learning how to take care of oneself through television programs to having the opportunity for routine checkups and workplace safety.

As stated earlier, the 1963 Maternity Law has also shaped the healthcare delivery system especially as pertaining to women. “Cuba’s maternity and parental leave legislation is among the most progressive in the hemisphere: pregnant women are entitled to 18 weeks fully-paid leave (six weeks before birth and twelve after), plus an additional forty weeks at 60% pay, assured of

returning to their same job” (Evenson *a* 2005, 6). Part of the law further mandates that “a woman ceases work at 34 weeks (32 weeks when the woman is pregnant with multiple births) and is granted fully-paid leave until the birth, after which she receives twelve additional weeks of fully-paid leave. During her pregnancy, she must take either six full paid days off from work or 12 half-days to receive prenatal care” (Evenson *a* 2005, 6). If she refuses to receive this care and routinely misses the appointments, it is the responsibility of her OBGYN to visit her in her home (appointments cannot legally be avoided). Post-birth of the child(ren), the law “facilitates regular well-baby check-ups during the first year of life. If neither parent takes the subsidized leave, then either parent is entitled to take one day off a month to take the child to the pediatrician and may take additional days off without pay if the child becomes ill” (Evenson *a* 2005, 6).

Between the Maternity Law and the Public Health Law, the government creates a system in which the health of the general population can be safeguarded through largely preventative measures. In the Maternity Law, allowing women to have generous access to physicians throughout pregnancy increases a woman’s chances of having a safe pregnancy with fewer complications and lower risks of mortality. Likewise, the Public Health Law and the design of a tiered healthcare system focuses on various forms of preventative health for individuals, which ultimately sums to protecting the health of individuals’ communities.

Historical Foundations

Once Cuba was declared a communist state in 1959, healthcare became explicitly focused on ideas of equality, making all forms of healthcare (regardless of age, gender, socioeconomic status, religious affiliation) accessible. This universal, revolutionary healthcare that grew out of

the triumph of the communist regime, was one that was heavily influenced by the USSR as a companion, communist state. Free socialist care, medical security during pregnancy, emphasis on preventive, community health and health education, were specifically rooted in the Soviet healthcare system and were correspondingly mirrored in the design of the Cuban revolutionary healthcare system implemented post-1960.

Prior to 1959, mass discontent with the Batista regimes catalyzed the success of the Communist Revolution and the creation of a socialist healthcare system. Under both of Batista's regimes,⁷ the Cuban state was characterized by "the sultanization of Cuban politics" (Chehabi 1998, 117). Sultanization was incentivized by "extreme desires of accessing political power and its rewards, including money and status" (Chehabi 1998, 116). The non-ideological tendencies created a nonpartisan system in which gaps between the wealthy and the poor were ever growing. "The large majority of the Cuban people faced increasingly intolerable conditions. [It] was a society dominated by large land-owners. High unemployment, illiteracy, disease and neglect of public services were rampant" (Espín 2012, 53). One of the largely intolerable conditions was a disparity in healthcare delivery. Under Batista disease was viewed as the poor's struggle since the wealthy frequently had access to care (Holt-Seeland 1982). Large discontent with the huge divisions between the poor and the wealthy culminated in revolution. The sentiment was: "if people do not dare/ to break their [political] chains with their own hands,/ they may find it easy to remove a tyrant/ but will never be free" (Espín 2012, 56). By January 1959, the Revolution triumphed, and Fidel Castro declared that the flag would have communist colors. With the success of the communist platform, Fidel Castro enacted a socialist healthcare system in which all Cubans would have equal access to healthcare, for the only legitimate healthcare option available would be state-provided care. This enactment was critical given the large

discontent that many Cubans felt with the Batista regime in which even health was reserved as a privilege for the wealthy.

Working Cuban women who supported the Revolution also encouraged the design of a healthcare policy that prioritized protecting the pregnant. For instance, one of Castro's main supporters was Vilma Espín. Espín was the critical representative of women's rights during the time of the Revolution. Prior to 1959, women had not achieved equality to men and there had not been a unified suffrage movement. Through Espín's efforts, the Federación de Mujeres Cubanas (FMC, the Federation of Cuban Women) was created alongside the new communist platform. The FMC promoted a series of new developments pertaining to gender differences, "notably helping women secure the rights of working outside the house, obtaining a formal education, and receiving medical care" (Randall 1981, 31). As a result, one of the FMC's most important legacies in Cuba was the creation of a socialist healthcare system that prioritized healthcare delivery to all women, especially when pregnant. The Maternity Law described earlier, one of Cuba's most famous pieces of legislation, was created because of the FMC's significant presence in local and state government immediately after Batista's fall.

A collective, community approach to health in which Cuban physicians become members of their communities has its roots in the Soviet system. Scholars such as Bond and Beresford have argued, "Soviet healthcare-deliverers [nurses, pharmacists, physicians] were regarded as distinctly ordinary members of society" (2003, 551). This unique acceptance of medical professionals as "ordinary" is one that Bond and Beresford contend was "not so much a demonstration of communism in action, [but] more a manifestation of a difficulty with the acceptance of ill health in a would-be ideal society" (2003, 551). Cuba also has integrated the notion of the "ordinary physician" into the current health infrastructure. The CMF epitomizes the

ordinary nature of the physician in the community s/he serves since the physician lives directly with patients in their hometown.

The notion of the polyclinic in Cuba (in comparison with a regular clinic) is also inspired by the Soviet Union's healthcare infrastructure. The polyclinics in both Cuba and in the USSR were designed to: promote preventative care, treat when necessary, and care for the body as a holistic entity. The healthcare is layered. Ideally a patient should visit a polyclinic and attempt to find or receive preventive treatment in the polyclinic before needing to be hospitalized. Moreover, the process of getting care is ideally an equal one for all (i.e. rarely should patients see the specialist first).

The emphasis on health education in the Cuban health infrastructure was likewise greatly inspired by the USSR's health education system. "Health education ...[was] considered as a method of preventative-curative medicine [in the USSR]" (WHO 1963, 9). In Cuba, health education is integrated in the schools by government design. For example, health education, including sex-education for secondary school (high school) students is mandatory regardless of religious affiliation. The curriculum for all school health programs is designed by the State with little variation in how the material should be presented from school to school. Just as in the USSR, Cuba planned and developed scientific methods of health education, taking into account "the different conditions of life and work among the various groups and the population to prepare and publish technical literature on health education" (WHO 1963). Cuba funds health researchers to analyze how people perceive health and likewise how health information can best be delivered uniformly and fairly. Such research proved critical for the development of health curriculums and in the design of health propaganda.

Cuba similarly modeled the USSR's health education services in an attempt to harmonize the efforts between multiple health organizations and individuals in a vast national health agenda which culminated into a centralized system (WHO 1963). Precisely because of a standardized health education (in middle and secondary schools plus health talks in the CMF and polyclinics) santería techniques⁸ are no longer perceived as effective treatment tools. Accordingly, health education allowed medicine in Cuba to be unified under modern approaches based on the disease-method (sickness as the result of a pathogen instead of a curse). "The Comandante really made sure that information and guidance [about health education, specifically sexual education] is made available" (Holt-Seeland 1982, 50) to the youth and adult populations. Subsequently, a kind of health literacy was achieved for many across the island, specifically learning how to take care of oneself (hygiene), how disease spreads, and how to recognize symptoms for various diseases and illnesses.

Chapter Three. The Health as Human Right Paradox

Privacy

Bella and I woke up early so that we could arrive at the Yaguajay polyclinic before the line got too long. After all, it was about 30-45 minutes away, depending on how many cows were grazing, and we wanted to make sure that we would make it on time. Bella needed to see the ophthalmologist. She felt as if she had grains of sand in her eye that, no matter how many times she rinsed, she could never remove. When the specialist came to Mayajigua a few weeks ago, he told her that she needed to see him in his main office in Yaguajay where he had more appropriate

tools to conduct the eye exam. The Mayajiguan polyclinic simply was not equipped for what he wanted to test for. She had been unable to travel to Yaguajay earlier because no one she knew in Mayajigua had access to a car. Public transportation, an open flatbed bus where people stand crowded together, was not an attractive way of getting to Yaguajay for Bella since she would not know where to put her cane or if her then 93-year-old bones would be able to withstand the impact of bumps from the road or accidental pushes from fellow passengers.

When the specialist could finally see us, he ushered us and six other patients into a large, poorly lit room. A phoropter stood at the back of the room, but no one used it. The machine had been broken for over a year and the Yaguajay polyclinic was waiting for technicians to come from the Sancti Spíritus Province to conduct the necessary repairs. If someone needed an eye exam for prescription glasses, they would need to travel to Caibarien, approximately 53 kilometers away from Mayajigua.

There were no curtains and no chairs, other than the seat accompanying the phoropter. The specialist had a clipboard and a pen. He went from patient to patient, collecting personal histories, reason for visit, and solutions. A medical firing squad of sorts. Doctor asked Patient One a series of questions. Patient One divulged the necessary information. Doctor provided a solution. Patient One left the room while the doctor continued on to Patient Two.

Bella and I were last. By the time our turn came, we had come to learn the medical histories of each of the previous patients, including their treatment plan and medical concerns. The lack of privacy in the polyclinic struck me just as much as the efficiency with which the physician approached his job.

Bella's experience in the polyclinic, in which a physician attends to multiple patients at a time in close quarters, does not prove unique. In my 2015 survey assessment, 77.38% of the women I interviewed stated that there is no privacy protection law (no HIPPA laws equivalent) that mandates physicians see them in private or are legally not permitted to divulge personal medical information in front of other patients and/or non-medical personnel. The ethnographic data, as evidenced by my visit with Bella in the polyclinic, further supported the lack of privacy theme on the ground in Mayajigua and in Yaguajay.

Kristina, a woman in her mid-forties explained to me in 2016 that it is easier for the physician to see six or seven patients at a time in an effort to increase the efficiency of the system especially when "the doctor is seeing you for something normal." Here, Kristina defined "something normal" as a check-up in which the doctor would not conduct an invasive exam or test that would require a patient to undress fully in front of other people. Being able to conduct routine check-ups in a mechanical, assembly line fashion reduces the wait periods in health centers since the doctor can quickly assess a group of people at once and move on without losing time ushering people into the consultation room one by one. For Kristina, this quick assessment of a large volume of people at once is in the patient's interest since the physician can significantly cut patient wait period outside the consultation room in the waiting room. Reduction of wait period translates into not only more patients being seen sooner, but into more patients being seen period. (If a patient's turn does not come in the line while the doctor is on duty, the patient will have to return to the polyclinic another day for a visit with his/her physician).

Of the informants who do not see their physicians in private, only Yulia clarified that the lack of privacy unnerves her. "I wouldn't like it if I had to divulge personal information, or if I

were getting negative results to a test.” For Yulia, the lack of privacy was only truly uncomfortable if she had to describe a severe physiological concern that would “*other*” her from either healthy individuals or individuals that would heal relatively quickly without severe, stigmatizing health consequences. For Yulia, the stigma from the fellow patients in the room (regardless if Yulia were to see them again) would be enough to make the visit uncomfortable.

Although many women, like Yulia, do not have private consultations with their physicians in the polyclinic or consultation centers, a significant number of women (22.62% per the 2015 survey conducted) do meet with their physicians privately. For Aimara, a sixty-six-year-old woman, “My doctor is family. I have four children. The doctor is black, but race has nothing to do with it. It was as if he were family nonetheless. He goes fishing with my kids, they play dominoes together. And for my husband too, the doctor was a son when my husband was sick. He has served me well.”

Aimara presents an interesting point. In her family her physician is kin. The fact that her physician is not of her blood nor even that he is part of her race proves important to her because blood and race did not become barriers that prevented her and her physician from having a close, mother-son kinship bond. As part of this bond, her family and her physician melded into one family. Out of courtesy, respect and heightened care for a kin that became family, Aimara’s physician sees her in private. In Aimara’s case there is not even a wait-period when she sees her physician. “He comes to the house. My kids call him, and he comes [...] I do not have to do anything, he sees me as is.” For women, like Aimara, who have a strong familial bond with their physician, treatment tends to be more one:one and personal because the physician treats his/her patient(s) as if s/he were treating a close relative.

Another instance in which consultations are more private is when the physician treats his or her own blood family members. In some cases, the physician is a woman's child, sibling or niece/nephew. "I go infrequently to the doctor because I do not like to bother her. And, my niece is a physician, so I go to her when I need prescriptions." Maria, a seventy-six-year-old woman I met in 2016, acknowledges that her polyclinic physician who treats her for her diabetes and her ulcer can sometimes be overworked. If she needs to simply refill needed prescription medications she believes that it is easier and more private to just ask her niece than to find the doctor or go to a center. In these explored cases, familial blood relationships with a physician, just as the familial but non-blood kinship relationship that Aimara shares with her respective doctor, also warranted a more private and immediate consultation simply by virtue of the fact that the physician might live in the same house as his/her patient family members or would frequently visit his/her family members for reasons outside of the health sphere.

Although there is no binding HIPPA law that mandates doctors see patients in private, there is still a discrepancy in healthcare delivery since not everyone gets strictly public nor strictly private care. That is, since not everyone in Mayajigua has the opportunity to build a familial relationship with their physician, care delivery differs simply by virtue of the personal connection. The personal connection a woman might have with their physician can open a more private consultation or more frequent interactions with the physician. More frequent interactions with the physician prove beneficial not only because the physician can be "on call" for the women when needed (to answer medical concerns even when they do not formally have their white coat on), but because the physician can have a better understanding of the health reality and living landscapes (i.e. lifestyle) that women occupy. A physician's intimate knowledge of a woman's life outside the clinic is responsible for a more expansive understanding of her health

history and medical reality which can then better inform treatment plans. The healthcare delivered to women who personally know their physician is thus not equal to the healthcare that is delivered to those women who do not personally know their doctor and who must see their physician in more formal, less private settings (cannot call the doctor to their home).

Upon consideration of these discrepancies in privacy, it becomes critical to note that not everyone in Mayajigua has equal opportunity to develop a personal relationship with their physician either. For example, the Mayajiguan CMF physician does not live in Mayajigua but in Yaguajay (approximately 32 kilometers away). The CMF physician must therefore travel from Yaguajay every day in strict violation of the healthcare system's design. When attempting to understand why the CMF physician commutes, I received a wide array of explanations. Some women explained that Mayajigua did not technically need access to the CMF physician 24/7 since the polyclinic (in the center of town) was open every day and every hour of the day. For Buchi, the explanation was even more simple, "His family lives in Yaguajay."

Regardless of why, the absence of the CMF physician has significant repercussions. Since the physician does not live in Mayajigua, the CMF physician does not become of and for the community. The physician's inability to become a fully-fledged Mayajiguan comrade means that not everyone in Mayajigua can come to know the doctor intimately outside the clinic. Not everyone can have the opportunity, if they so choose, to build strong kinship bonds with him. The result correspondingly is that patients who already have strong kinship ties with the physician (such as from the physician's childhood) receive a significantly different kind of care than those who do not.

Terrenos (home-visits)

As defined in the health policy, a terreno is a recorded home-visit in which the CMF physician (and in some cases, physicians who work at the polyclinic) visit patients in their homes. These terrenos prove particularly important when there are ailing community members who are too ill to travel (unable to commute to the polyclinic or the CMF office) and in the cases of conducting routine check-ups with the elderly.

Mayajiguan women specifically identified a two-fold purpose to the terrenos. The first is to demonstrate what some women called “healer humanity” in which the healer makes a valiant effort to conduct a thorough and personal medical encounter where a patient is humanized by being understood within the larger context of home-life. By travelling out of his or her home office and way, the physician shows that s/he cares for the community enough to see the patients on the patients’ terms (ideally, a patients’ inability to physically go and get needed care by travelling to a polyclinic or CMF does not disqualify patients from having access to a physician). In terms of healer humanity, some doctors even open up their own homes to patients in a very casual manner.

In 2017, I met Dr. Asos, an ophthalmologist in Caibarien. Not only does he go on terrenos and work at the polyclinic in Caibarien, but he opens his home on his days off so that patients can come to see him if they have a medical concern and cannot wait for him to go on duty. The terreno paired with this open-door philosophy demonstrates a healer humanity because the physician goes out of his way to learn more about his or her patients and build friendships through medical visits.

The second purpose of the terreno consequently is to increase accessibility to the physician. For example, Marí has “arthritis, diabetes, problems with my heart [...And my doctor] comes here, to my house [... because] going around walking is not easy.” Maria echoes the benefit of the terreno. “Every now and then the doctor comes to ask me questions in my house and take my blood pressure.” Although these visits are not the norm for Maria, they do save her the trouble of travelling to the polyclinic or to the CMF consultation office to get just her blood pressure checked. The terrenos thus facilitate physician access not only to sick individuals, but also to older individuals.

Terrenos are likewise conducted when critical appointments are missed. Consider Yulia, mentioned earlier, who gave birth to a baby girl and missed the vaccination appointments. It was the responsibility of her child’s pediatrician to ensure the child’s vaccination, regardless if he had a familial bond with her or not. In this particular case of vaccinating Yulia’s baby, the terreno became a public health service. If her child was not vaccinated, not only could the child potentially fall victim to lethal diseases, but the child could also begin an epidemic especially if the child interacted with other un-vaccinated children.

That said, Yodaza stated that “doctors only come to visit you in your home if you are friends or if you can offer them something like a meal.” Thus, in principle, the terrenos should be a way of enabling easy and fair access to health professionals and consultations uniformly, but in practice this is not the case for Yodaza. For Yodaza, corruption might be one explanation as to why a physician does not visit, especially if the physician is known to not have healer humanity. Mia echoes the importance of healer humanity in practicing medicine. A few years ago, she went to the polyclinic because of a medical concern. It was late and the only physician in the polyclinic was preparing to end his shift even though the doctor who would attend the clinic next

had not yet arrived. Mia found the doctor and asked him if he could quickly see her before she left. His response was blunt. “Ya entregué la guardia.” I signed out already. With that, the physician left Mia frustrated and waiting for the next doctor to arrive. In the case of physicians who do not possess strong healer humanity, corruption can be more widespread not only as far as terrenos go but also in health centers.

To further investigate differences in care access as pertaining to the terreno, consider the juxtaposed accounts of Marí and Bella. Both are retired, elderly women who contracted cholera within the last ten years. Both were hospitalized upon diagnosis. Only Marí had consistent interaction with her physician through terrenos. When Marí was hospitalized, her doctor reported information on her living situation to the State in the medical report which resulted in Marí receiving funds from the State to refurbish her house since the medical report explained that her inability to have reliable access to safe, clean water in kitchens and bathrooms might have been the source of her cholera. “80,000 pesos⁷ they sent me, and they fixed my house with a table, bathroom, sink, everything.” Although this was the case for Marí, Bella’s living conditions were not reported (her physician rarely met her in her home). Although Bella received the best quality care in the Yaguajay hospital, there was a lack of information about the social determinants of health that affected her wellbeing (which could have been assessed on terrenos and summarized in her medical report just as with Marí). Bella continues to live without access to running water, with spotty electricity, and with an outhouse instead of indoor plumbing.

The difference in care access between Marí and Bella is striking. Healthcare is a fundamental human right, however not everyone gets the same access to care seeing as not everyone benefits equally from the terrenos (nor does everyone even have access to terrenos). It becomes paradoxical that two accounts from two similar women who live less than a block away

from each other in Mayajigua, Cuba can exist in such close proximity. To get to Mari's house one must pass Bella's and vice-versa. Per the Cuban healthcare system design everyone is human and deserving of health care access. However, who you know and your luck in meeting a doctor who possesses healer humanity can significantly increase your chances of receiving healthcare rooted in a humanistic approach. Here, the paradox becomes one in which policy ideals differ greatly from practice seeing as the practice of the policy ideals is not uniformly executed by the state or its physician agents.

Obsequio

Given Cuba's socialist nature, all professionals are employed by the State and receive a monthly income. In the case of physicians, this centralized system of payment means that no patient must pay for access to healthcare services. However, the average salary for a typical physician (and for other professionals such as lawyers and engineers) is 17.50 USDS a month (this figure can increase over time as the physician matures and/or as the physician gets promoted; higher salaries can range from 40-60 USDS a month). Although these professionals do not have to pay mortgages/utilities for their homes or pay for their own healthcare needs, this low salary does not correspond to a low cost of living. Many basic necessities, even those that are rationed (including basic food items such as eggs, milk, meat, rice), can still be expensive to purchase. For those physicians who do not practice "healer humanity" and who do not treat patients solely based on their call to be a community healer, some health providers have been known to deliver slightly better treatment to those patients who could offer additional compensation for their services (i.e. a meal or snack or some other needed gift of the sort).

Historically, the obsequio was given to physicians as a gift for their services during the Batista regime. The polyclinic and CMF were instituted only after the Batista regime fell, so the primary form of routinized non-hospital medical access took the form of terrenos. When the Castro regime came to power, centralized payment of physicians was meant to eliminate the use of the obsequio. Today, use of the obsequio is not nearly as widespread as it was in previous years and only select women, notably Yodaza (2016 interviewee), admit to its infrequent use today. “When the doctor comes to the clinic, he’s treated with a silver plate. There are some who bring him breakfast, a snack. [...] On the ‘Day of the Doctor’ they will give physicians gifts too.” The obsequio can largely be used to convince physicians (especially those lacking healer humanity) to give slightly better care for those who can afford it. When physicians accept obsequios, the healthcare system is not delivered as a fundamental human right since there is an additional form of payment that singles out haves from have-nots.

The Day of the Doctor (December 3rd) that Yodaza mentions, however, is a distinct celebration that is separate but related to the obsequio. For one, the Day of the Doctor is a special day of celebration that is organized by the local government in which the Mayajiguan polyclinic partners with other local institutions (such as the school, the daycare center, the culture house) to acknowledge and celebrate the physicians’ hard work throughout the year. Gifts given on the Day of the Doctor are consequently not as charged as a bribe (or obsequio) would be because the gifts go hand in hand with the celebrations organized by the polyclinic specifically the activities, health charlas, the fun and food. On this day, many Mayajiguans tend to bring tiny little gifts to the doctors to demonstrate their gratitude since everyone is aware of the low salary and hard work characteristic of the profession in Cuba. It is a day of propaganda and celebration. “You celebrate in the polyclinic and the doctors are all there for the little gifts. You get used to the fact

that you always have to bring the doctor a little something [...] Just a little present for the doctor. They don't demand the obsequious, but it is something to help." The gift in this case is one of thanks, not one of sly encouragement to see the doctor in a terreno or sooner in line.

Upon further reflection, there is a fine balance between bribe obsequios and Day of the Doctor obsequios. When an obsequio is offered and received, the medical system becomes one of transaction which is in blatant contradiction of the healthcare law. As such, the bribe obsequios can cause problems to the development of the healthcare system since stratification between those who can offer an obsequio versus those who cannot destroys the healthcare as a human right theme in Cuba. The obsequio as bribe can furthermore cause resentment and lead to conflict since those patients who can afford extra payment (and an illegal payment at that) will have drastically different health outcomes. The obsequio simply results in more women, like Bella who do not know their physician and/or who cannot afford an obsequio, who live in a state of continual sickness (a consequence of poverty).

Even so, there is a nuanced distinction between the effects of bribe obsequios and Day of the Doctor obsequios. Day of the Doctor (which has its roots long before pre-Castro government was established in 1959) obsequios seem to carry a different meaning. There is no transaction associated with the obsequios given on December 3rd possibly because the obsequio is usually presented in bulk—a gift to the doctors (plural) instead of a gift presented to a specific doctor. The gift becomes one of community thanks, similar to a birthday gift in which one provides a present to give thanks for the person born and recognize the relationship between giver and receiver. In the typical case of a birthday, a present is usually not considered a bribe but a nice, feel-good gesture. On the Day of the Doctor, obsequios as presents can subsequently improve the healthcare system by inspiring doctors. Doctors realize how much they are needed since they

receive appreciation from their community in a way that can rejuvenate and boost their morale in the field, hopefully long enough to last them a year. The obsequio as present therefore becomes a symbol of thanks for a physician's healer humanity.

La cola – The line

La cola is another significant part of the Cuban health reality especially when visiting healthcare centers such as polyclinics and hospitals. In 2015, when I conducted the survey research study in northern and central Cuba, I investigated on average how long women typically wait before being seen by a specialist (non-CMF physician). Table One illustrates how the women responded (in percentages) to the 2015 survey.

As demonstrated in Table One, the majority of women (79.76%) explicitly stated that their wait-period depended largely on the length of the line. That said, almost 11% of women explained that, for them, there was no wait-period. (The remaining percentage of women stated that their wait-period ranged from 2-3 hours to half a day.) In these cases, the women either had close family members (children or grandchildren) who were health professionals and who would see them in-house. Other women who fell in this category explained that they lived close to or on the grounds of a military base with a military hospital. In the military hospitals, which tend to treat high-ranking families of officials, the wait-period is significantly reduced allowing women with access to military health services to experience care delivery faster.

When considering the almost 90% of women who do wait to see the physician, the largest explanation for long lines is related to a high patient to physician ratio. In 2015, one of the women I interviewed approximated the ratio to be about 20 patients for every doctor per day in a

polyclinic or consultation center. An important question emerges. Cuba graduates an incredibly high number of physicians annually. “The government initially offered to train 10,000 physicians” (del Rosario Morales Suárez 2008, 7) and met this goal (Cuba has been known to graduate approximately 10,000 international and Cuban medical students in a year from medical schools across the country). Furthermore, in “2005, Fidel Castro elevated Cuba’s international commitment once more, pledging to graduate 100,000 doctors from the Global South by 2015” (del Rosario Morales Suárez 2008, 7). Since Cuba graduates such a high number of physicians, why is the patient to doctor ratio so high in health centers? Where are the doctors going?

The explanation lies in doctor exportation: “Medical school enrollment of Cubans has increased since 2000 to keep pace with growing demand for Cuban doctors in other countries, who volunteer through a program providing medical services in poor and marginalized communities since 1963” (del Rosario Morales Suárez 2008, 7). Many physicians are sent out of country on medical missions to rural villages in Brazil, Angola, Venezuela, and beyond where they must serve impoverished communities for a period of at least two years. Massive exportation of specialists, even years removed from medical school graduation, also occurs as part of Cuba’s medical diplomacy efforts in which Cuba exports physicians in exchange for monetary benefits or access to resources (such as oil in the case of Venezuela, prior to 2016). For example, “Brazil pays Cuba roughly \$3,620 a month for each doctor [...] Approximately 18,000 Cuban doctors have done stints in Brazil; roughly 8,600 remain in country. The United Nations has called the program a success story noting that it has lowered Brazil’s infant mortality rate and extended care to indigenous communities [...] Thousands of Cuban doctors work abroad under contracts with the Cuban authorities. Countries like Brazil pay the island’s Communist government millions of dollars every month to provide the medical services, effectively making

the doctors Cuba's most valuable export" (Londoño 2017). The Cuba Paradox shows itself once again. Where are doctors most needed and where will they do the most amount of good? Are they needed abroad to serve communities without any healthcare access? Or, are they needed at home to care for the domestic sick? At what point does exportation hurt the domestic sick?

This large exportation indeed benefits the Cuban government in the form of compensations which can then benefit Cuban citizens. Gasoline reductions can occur for those who own vehicles or certain foods might become less expensive. Nonetheless, significant exportation of physicians affects patients in the clinic in an extremely challenging way. Exportation of newly graduated and high-quality physicians translates into less doctors working domestically which further translates into higher patient doctor ratios and longer wait periods which then translates into not knowing when a patient will get care (when their turn in la cola will finally come). There are integrated layers to this translating.

Similarly, since expert physicians are exported abroad in addition to recent grads, interns and medical students are often the ones left behind in clinics to treat domestic patients under supervision. Quality of delivered care is correspondingly compromised in some cases. My grand-aunt in La Habana offers an unfortunate example of this. In 2007 she was not feeling well, and her son drove her to the nearest hospital where she was seen by one of the doctors on duty—a physician who happened to still be an intern. The intern could not recognize that she was having a stroke. Due to the high capacity of patients being seen at the time by her supervisor, Manuela did not receive care on time. The stroke left her not only paralyzed but unable to communicate, unable to walk, unable to feed herself, unable to use the bathroom independently. Her son, my cousin, still wonders to this day if she would have been able to better survive the stroke with a higher quality of life if she had been initially diagnosed and treated by a non-intern.

Ethnographically, “la cola” was a salient theme supported in the 2016 data as well:

Maya is young. At the time, seventeen years old. She works at a local restaurant right outside Los Lagos in Mayajigua, Cuba when she has off from school over the summers. She has had kidney problems since she was little and every now and then must skip work to go see her nephrologist about a routine check-up or for her discomfort.

She and her peers (some of whom are in need of orthopedic care) wait long periods of time in the polyclinic’s cola and would often not be seen by virtue of la cola’s length. When her and her friends’ turns do not occur, sometimes she and her friends would “look for him, travel to the hospital [in Yaguajay], or see the doctor in the street.”

“What do you mean by ‘see the doctor in the street?’”

“If you see a doctor in town, and you have a question and your turn didn’t come, then you ask him right then and there.”

Maya’s experiences in searching for the doctor, even outside the bounded walls of a polyclinic, supports a central theme: the question is not if you get care, but when and where. Care largely depends on how early you get to the polyclinic and how many other people want to see the physician or specialist on a given day.

Despite the long wait, line etiquette does exist, and two groups of people are given priority when it comes to being seen first:

Several times, I had the opportunity to witness la cola and line etiquette when I would take Bella to her ophthalmology appointments in the Yaguajay and Caibarien polyclinics. On our

first trip to the Yaguajay polyclinic, Bella and I arrived too late. Leaving town at seven in the morning was not early enough since the tiny little wait-room in the ophthalmology wing was already full to capacity by the time we arrived. It was a Saturday. We should have known better.

I looked at Bella and the people around me and suggested that she sit because the wait would be long. She looked at me, held onto her cane, and sagged her body placing all of the weight of her torso and arms onto the three-pronged cane. At the time of this trip, she was 93 but her age was not defining of her physical ability in any way. Just the night before she had been dancing (she even pushed aside her cane and wiggled her body all the way down to the floor and back up again) while telling people around her that, “I only use this cane to ward off the dogs and the young boys who chase me.” As she sagged into her cane she dragged herself to the front of the line where several patients who had gotten there before us noticed her somber walk.

“Abuelita, pasa, por favor.” Little Grandmother, go ahead, please.

I made my way over to where she was and thanked the people who had let us go ahead of them in the line. No one behind complained of us cutting ahead. We were one of the first people to be seen in the polyclinic by the ophthalmologist that day.

Once we returned to Mayajigua after the appointment, I asked Bella about the line cut.

“Because I have this cane, and white hair, and wrinkles, people mistake me for a little old lady and they allow me to go first in line.” Allowing the elderly to see the physician first is a simple matter of etiquette and respect for *los ancianos*. Assuming ownership of her age permitted her to make use of certain benefits socially assigned to her out of respect.

The other group of individuals who, by etiquette, is socially permitted to be expedited through the line includes sick infants. Yulia explained to me once that when her first-born was

still an infant, she would get sick frequently. The people in the line would allow Yulia to be seen by the doctor first out of courtesy and care for her little one.

Allowing a sick infant or an elderly abuelito to be seen ahead of others in the line was never presented as a demand made by the physicians. Instead, permitting these two groups of people to be seen first is due to an unsaid agreement about what is courteous and socially acceptable.

Chapter Four. The Feminine Health Paradox

Pregnancy

“When you are pregnant they do not let you live” (2015 interviewee). Doctors’ appointment after doctors’ appointment are scheduled for women not only in Mayajigua but in northern and central Cuba throughout pregnancy. The monitoring of a woman’s body is heavy to say the least and as a pregnant woman, she is frequently expected to care for her own wellbeing and that of her child by meeting certain expectations. These expectations include ceasing work at the 34th week of pregnancy and meeting a series of appointments throughout the pregnancy, beginning with the initial moment a woman learns she has conceived and concluding with the birth in a medical facility (preferably a hospital over a polyclinic). During pregnancy, Cuban women are normally expected to see their OBGYN every 15 days when pregnant. For those experiencing complications in pregnancy or for women who will deliver multiple children and/or a child with a disability (high risk pregnancies in general), the women are expected to visit their specialist more frequently (in some cases, weekly instead of bimonthly). These OBGYN

appointments during pregnancy are mandatory for every woman not only in Mayajigua but in Cuba at large.

Since the appointments are mandatory, under no circumstances can they be missed. Paula, one of the interviewees I met in La Habana Province on my 2015 field work, explained that when she was pregnant with her firstborn, she did not want to meet the prenatal appointments simply because they happened so frequently. She did not want to constantly travel to the consultation center for her bimonthly meetings. Once her OBGYN realized that she was habitually skipping her appointments without re-scheduling, he came directly to her house to conduct the check-ins despite her not wanting to participate. Years later upon reflection of her pregnancies, Paula acknowledges that despite her initial hesitancy, she understood why her specialist visited her in her home. Paula laughs about the matter now and expressed no regret or anger with these in-house appointments. Legally, Paula's OBGYN was obligated to visit her (if not in the clinic, then in her home) because the prenatal check-ins were meant to ensure both her health and that of the child to be—a fact Paula came to appreciate after subsequent pregnancies.

Due to this careful monitoring of pregnant women, as Paula exemplifies, the healthcare system has also been described as “tenacious” (Browne 2016) by other scholars who specifically study Cuba's Maternal-Infant Program. “They send you to do ultrasounds, psychologists, absolutely everything day after day and it's obligatory. If you miss an appointment, someone will come to your door and bring you to the appointment. You don't have a choice” (Browne 2016). Moreover, “a study for the *International Journal of Epidemiology* entitled ‘Health in Cuba’ says the work of Cuba with regards [to] child survival shows how a ‘continuum of care that provides for the preconceptual health of women, prenatal care, skilled birth attendants and a

comprehensive well-baby programme can quickly reduce infant mortality to levels approaching the biological minimum” (Browne 2016).

In 2016, Browne interviewed a family who gave birth to Amalie, a young girl born with Wolf-Hirschhorn syndrome (which causes complications in heart, kidney and facial feature development). Per Browne’s findings, this early monitoring of pregnant and fetal bodies is significant in both protecting the health of mother and child throughout pregnancy, but also in the early detection of developmental and genetic disorders. For example, “the early detection of [Amalie’s syndrome] at six months pregnant is thanks to Cuba’s extensive Maternal-Infant programme, first introduced post-1959 revolution, which has seen the Caribbean country fall to the second-lowest child mortality rate in the Americas, 20% lower than that in the United States” (Browne 2016). Early detection becomes a key to better care post-birth. “Immediately, we [Amalie’s parents] were sent to specialists in different medical areas. Week after week they worked to resolve each and every problem [Amalie] had. Never once did we lack a thing or have to pay for anything even though a lot of this was really expensive medicine [...] I looked online to see how much the treatment Amalie received would cost in the United States; \$100,000 dollars apparently and here it cost nothing thanks to the revolution” (Browne 2016). Early detection of fetal/child and mother’s health pairs with free access to expensive necessary treatment to help increase chances of survival throughout pregnancy and in early childhood.

Just as vaccinating a child is a non-negotiable under the Cuban healthcare system, so is receiving prenatal care. The current militant vigilance and monitoring of pregnant women, in addition to other mandatory practices such as mandatory administration of childhood vaccines, effectively becomes a demonstration of “biopower,” or an “explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault

1978, 140). Classically, Foucault's biopower emphasizes the protection of life (compared to threats of death) which in turn gives way to a strict regulation of the body. Biopower subsequently becomes implemented for species preservation in which the Cuban State invests itself in protecting its general population's right to life (even if a woman might attempt to refuse her care). The Cuban State's militant monitoring of a woman's body in reproductive practices throughout her pregnancy consequently becomes an epitome of Foucauldian biopower in which a pregnant self is subjected under the control of her OBGYN (she *must* see him or her) and the State thereof. This biopower is meant to help women, such as my 2015 informant and Browne's 2016 informant, to have access to quality care period.

Nevertheless, this subjugation of high-risk bodies to a larger healthcare system directly benefits the State as a political institution. For instance, this almost militant delivered prenatal care (biopower) is responsible for the Cuban State's success in lowering mother and infant mortality rates in childbirth because women's bodies are monitored for their wellbeing well in advance of the delivery. This decrease in mortality rates in turn wins Cuba much fame domestically and internationally as one of the best healthcare systems considering that Cuban mothers are at incredibly low risks for complications and death in childbirth. Biopower over women's bodies seems to pay off for both pregnant women and the larger political system in which they operate.

This militant monitoring of women's pregnant bodies has quickly become the new norm since the 1960s although this explicit use of biopower was not always present in Cuba. Women from my 2016 study who were pregnant prior to the triumph of the Revolution explained that health services for pregnant women before 1959 were not nearly as effective nor as accessible as those that are currently provided today. "During that time, none of these services existed. I would

go to the doctor when I wanted. I did my first analysis at seven months. But my kids were born in the hospital. I went when I had the desire to. Now, you are obligated to go. Before the Revolution, it was expensive, and you had to pay the doctor when you felt sick and he would come to you. Five or ten pesos.” Maria acknowledged that she was fortunate that each of her five pregnancies concluded successfully, “they came out fine,” even without the militant monitoring of pregnancies enacted post-1959.

Unlike Maria, Bella was not as fortunate with her three pregnancies, all of which occurred during the time before the Revolution. Bella noted that the services provided, including those that can seem like nuisances today, are done to protect a woman’s right to having a healthy pregnancy and birth. As an older woman reflecting upon the contrasts between the pre- and post-Revolutionary healthcare systems, Bella wishes that she could have had access to higher-quality prenatal services when pregnant. “I had three bellies. The first was born three days too soon and the other two I had to interrupt because they were toxic bellies. I couldn’t tolerate them. The only water I tolerated was rainwater.” After 1959, the State began to offer an additional, unique service, *Casas de Maternidad* (Figures 9-10), to pregnant women who experience a difficult pregnancy, like Bella.

These Mother Homes are centers where pregnant women can spend a term or more of their pregnancy under the full 24/7 care of an OBGYN and women’s health nurses. The entire House staff works with the residents and their families to help a woman have the highest possible chance of a successful pregnancy. These centers additionally become refuges for women who are not only struggling with a physically difficult pregnancy but also an emotionally or psychologically difficult pregnancy. For example, if a woman lives with domestic abuse, she has the opportunity to spend time in a mother home to finish her pregnancy in a safe environment if

she has no other option. In the cases of abuse, Mother Homes also provide psychological services to help women and their newborn children suffering from abusive relationships post-birth. Another significant benefit of The Mother Homes is that these residences provide women with peer support seeing as women who are struggling with their pregnancies are encouraged to build community with each other within the house. These relationships are expected to last well beyond a woman's stay in the Homes.

Breastfeeding

Another salient characteristic of the reproductive healthcare system includes State emphasis on breastfeeding. State sponsorship of breastfeeding largely takes the form of encouragement through physicians, television programs that explain the benefits of breastfeeding, and propaganda. In terms of propaganda, murals of women breastfeeding a baby (Figure 11) captioned with phrases such as “Lactar es amar” (to breastfeed is to love) becomes a salient form of advertisement especially considering that these murals often face seating areas in CMFs or polyclinics.

Not only is breastfeeding encouraged by State and Cuban medical health professionals, but the vast majority of women were found to breastfeed their children for as long as possible. In 2015, 100% of women I interviewed in northern and central Cuba stated that they breastfeed/breastfed their children. The duration of the breastfeeding period ranged anywhere from a month to seven years. Women who could only breastfeed for only a limited period (especially those women who could only breastfeed for a period of two or three months) were found to express sadness with their inability to produce or provide milk for their child over a

longer period of time. There was a certain loss identified that accompanied the sadness. This loss was also found to pertain singularly to a loss at being able to provide basic, powerful nutrition to their child through breast milk than feeling a sense of loss over psychological bonding experiences built over the course of the breastfeeding period.

A woman I met in 2015, who breastfed her child until age seven, noted the benefits of breastfeeding and expressed gratitude at being able to provide for her child in this way for an extended period of time. The rationale was rooted in a purely biological and realistically Cuban thinking. Since milk in general can be difficult to find in Cuba, breastfeeding provides a more reliable source of dairy access than the supermarkets do. Milk is one of many foundational products that is rationed by the regime. Under the rationing system, a family is assigned a certain “bodega” (convenient store; rationed items can only be purchased in bodegas) based on the location of their “barrio” or neighborhood. Not only are families instructed to purchase rationed items from a specific bodega, but families are also given a rationing blue book. The blue book contains the names and ages of each of the family members that occupy a given residence. Based on the composition of the family, specifically based on the ages of the family members and on the size of a family unit, certain goods are rationed off and in specific amounts. Milk is one such good considering that it is principally rationed to families who have a child that is seven years old or younger or to families who have a prescription for milk (certain elderly citizens have doctors’ notes permitting them access to milk rations). That said, just because one is legally allowed to have access to a milk ration does not mean that the ration is available or can be easily obtained. The 2015 interviewee mentioned earlier explained that she breastfed her son until seven precisely because the milk rations were not consistent, and because she wanted to ensure that her son would not grow up to have calcium deficiencies.

Infant formula is just as difficult to find as milk not only in Mayajigua but in major city centers such as La Habana. In June 2016, I travelled to several supermarkets with a cousin looking for infant formula for his granddaughter. We travelled to three different supermarkets⁹ and were not successful in finding any product formula. Eventually, my cousin and I resorted to purchasing condensed milk as a substitute. Promoting breastfeeding on a State level consequently becomes a workaround to a lack of access to milk and substituent infant/baby milk products. The workaround, however, fails when women are not able to breastfeed or are only able to breastfeed for a limited amount of time and/or do not have access to formula. The breastfeeding workaround failure can cause acute sensations of grief for precisely the reason that no worthy substitute that is as nutritious nor as authentic as milk can be found. Even for the women who can breastfeed a child until toddler age, for approximately 2-3 years, not having reliable milk access for the next 4-5 years becomes a challenging reality and source of stress.

The paradox becomes grossly evident when militant monitoring of women's bodies in pregnancy is juxtaposed with a difficulty in finding access to milk products post-birth for their children. During pregnancy, women have access to routine, meticulous care with many opportunities made available to help women carry even "toxic bellies" to term. However, postpartum it becomes increasingly difficult to have access to more basic forms of healthcare such as good nutrition for oneself and/or for one's child.

Sexual Health

Just as with pregnancy, the State has had wide-ranging success in being able to lower the transmission rate of sexually transmitted diseases and infections. Part of this success comes from

a sexual and reproductive health platform based strongly in education. Sexual education programs are taught in schools at all grade levels. “Cuba first began teaching sex education in schools in the 1990s. Today, sex education content has been mainstreamed into all levels of Cuban education, from pre-K to the doctoral level. For example, condom use is discussed in primary school onward. Educators teach the concept that ‘no means no’ and that one must say no to any nonconsensual sexual experience. The curriculum also teaches contraception versus abortion as the first line of pregnancy prevention. Educational outreach has been credited with helping lower the country’s teen pregnancy rate. CENESEX creates the sex education curriculum promulgated throughout all levels of the Cuban education system” (AAUW 2011, 7-8).

Sexual education does not, however, occur solely in the classroom. All 2016 interviewees explained that in addition to sexual education in schools, the State runs television programs on sexual health featuring “lessons” on proper prophylactic use and how to recognize symptoms for various STDs/STIs that require medical attention. Sexual health “charlas” (talks) also occur in the polyclinic by health providers. In some cases, charlas can also be hosted and organized by an employer for his or her employees at work. Work places can also be given pamphlets about health education to distribute among their employees in addition to encouraging (but not mandating) workers to have routine check-ups.

I found that these health charlas became particularly relevant in 2016 with the concern about the Zika virus. Charlas focused on teaching Mayajiguans to search for household and yard objects that contained stagnant water and cleaning these objects appropriately. Explanations were also given freely so that townspeople had access to information about the virus (how it spread, possible symptoms, biological consequences). These charlas became particularly important sources of information in 2016 especially before Mayajigua was granted Internet access in 2017.

In terms of pregnancy termination, “abortions performed outside the national healthcare system are illegal. According to Mariela Castro Espín, the director of CENESEX, abortion was legal in Cuba before the revolution, however, it was extremely expensive. Many women sought illegal abortions at a cheaper cost, and botched abortions were a leading cause of mortality for Cuban women. In 1958, illegal abortion was the number one cause of death for women in Cuba. After the revolution, the Cuban government put abortion under the Ministry of Public Health and criminalized all abortions performed outside the public health system to prevent deaths from post-surgical infection and malpractice. Abortion in Cuba is illegal if it is: 1) done against a woman’s will, 2) performed for a fee, 3) done by untrained personnel, or 4) performed outside the Cuban public health system. With this reform in place, the Cuban mortality rate from abortion complications has dropped significantly” (AAUW 2011, 7). Outside abortion, prophylactic use and IUDs are encouraged to prevent pregnancy, but if a woman decides she wishes to have an abortion that option is made available to her. Even so, she is highly discouraged from using abortion as a form of birth control in favor of less invasive options.

Women’s health post-menopause

After pregnancies, health professionals conduct follow-up appointments with mother and child. These sessions often include the vaccination of the child or checking the mother for signs of post-partum depression. The heightened policing of bodies thus continues until approximately six months after the child is born (which also overlaps with the vaccination period; vaccinations during the first six-month period following birth are part of the vaccination regimen).

Post-menopause, visits to the gynecologist decrease significantly. Several of the interviewees from 2015 stated that their gynecological exams could range from annual appointments to once every two years after completing menopause (frequency of visit generally depends on the gynecological health concerns or complications experienced by individual women). Only one 2015 interviewee explicitly commented on the drastic difference in body policing between fertile and post-menopausal women. When I asked if Yana had been to the gynecologist recently, Yana explained that she had not been in years because “her parts” did not work anymore due to her age. Moreover, although Yana was no longer fertile, she was not as pursued by the State to get mammograms or other gynecological tests done, all compared to the strictness of making appointments and having analyses when pregnant. She expressed sentiments of feeling forgotten after she lost her fertility to time.

Some women’s bodies are subsequently perceived as more in need of policing than others. Prioritizing the policing of pregnant bodies over post-menopausal might be more critical for the State since two bodies (note the use of the words “bodies” here instead of “lives”) are affected directly whereas, in the case of a post-menopausal woman, missing consultation appointments affects only one body physically. It can thus be interpreted that the State attempts to better regulate pregnant women based on a utilitarian model of protecting a larger quantity of people at once. Pregnant women then require more resources as provided by more stringent policing compared to post-menopausal women.

Period poverty

60.71% of the women I interviewed in 2015 stated that they had access to contraceptives if they so choose.¹⁰ The most popular form of contraceptive in Cuba is the IUD which can be easily paired with prophylactic use (hormonal birth control can be found but there exists a certain degree of public skepticism concerning its use based on the unwanted side-effects).

Contraceptives in the form of IUDs can be implanted with minimal hassle (are usually implanted immediately following the birth of a child) and made available to women just as IVF and chemotherapy would be made available to those women who so require these treatments.

The availability of contraceptive pairs with an inaccessibility to feminine care. In July 2017, factories that manufactured feminine care products for the Sancti Spíritus Province (the provincial home of Mayajigua) failed to produce feminine care products for the entire province, which affected many rural farming towns in the area (from Mayajigua and beyond). Feminine care products were not produced for a period of three months because the province experienced a shortage of critical starting materials to manufacture feminine hygiene care (reminiscent of the lack in access to Diriprona). During this time, women were left to invent as Irena did with her mosquito net so long ago.

In the event where feminine care becomes available, it can be prohibitively expensive. Feminine care menstrual pads can cost approximately three or four USDS while a small box of feminine care tampons (about 8-10 tampons) can cost upwards of eight USDS. When a woman makes 17.50 USDS a month, she might find herself having a challenging time prioritizing her spending and leaving the pad or tampon purchase for another month. Inaccessibility becomes

compounded very quickly: either the products are not physically available, or the products are prohibitively expensive.

Inaccessibility to feminine care is ultimately responsible for the period poverty witnessed on the ground. This is a poverty that occurs in conjunction with the wealth of access to other fertility medications or treatments such as IVF and contraceptive—yet another manifestation of the Cuba Paradox.

Chapter Five. Active Care Defined

The coexistence of period poverty alongside the wealth of access to more expensive treatments or medications strongly bisects the theme of active versus acute care. Based on the 2016 ethnographic data, healthcare in Cuba can be truncated into these two specific categories. Acute care refers to the expensive forms of care that might not normally be made available to people equally on the basis of financial stratification (such as IVF, chemotherapy, HIV/AIDS). Acute care is best defined in comparison with its counter—active care. Active care is the care that a person actively seeks on a daily basis to promote his or her own day-to-day wellbeing. This is the genre of care that becomes part of a person's everyday existence and fosters a high quality of life and comfort in daily activities or routines. Active care includes all forms of over-the-counter (non-prescription care items such as feminine care, Band-Aids, Acetaminophen/Ibuprofen, etcetera) and prescription medications that are not classified as acute but that are required for chronic illness or disorders (such as Depakine for epileptics). Nutrition also falls under the category of active care seeing as nutritious intake can increase one's chances of living a comfortable quality of life (no deficiencies, low obesity propensity, no increased chance of developing diabetes, etcetera).

The Cuban healthcare system can subsequently be analyzed in terms of the acute versus active care motifs where the State's emphasis lies in providing access to acute care. This provisioning of acute care creates an uncomfortable paradox for those who encounter it: it can be difficult to understand how the government can design and create expensive new treatments but is unable to find component substitutes for creating pads or aspirin. A tension develops where, although the emphasis on acute care is often acknowledged as a unique and progressive healthcare perk, the majority of people require access to active care (not to acute care) on a daily basis. Furthermore, when a patient requires acute care (such as for cancer), their active care needs still exist and should ideally be met so that one can recover and receive acute care within a context in which basic active care needs are also met. Doing so promotes general wellbeing from chemo to an Alka-Seltzer.

Bella describes herself as a woman with “39 years of age, my real age with the numbers flipped” who wears glasses and would really like a glass of milk. She explained that, other than her cataracts, she is healthy and requires no form of acute care. What she did express a need for was active care. In 2015, she was unable to update her eyeglass prescription because the equipment used to measure her vision was broken in Mayajigua and in Yaguajay. If she wanted to have her vision tested, she would need to travel over fifty miles to the Caibarien polyclinic which was not an option unless a relative or a friend with a car could volunteer to take the trip with her. Her inability to update her lens prescription affected her daily quality of life in a substantial way albeit less dramatic than her quality of life would have been affected if she had another disorder, disease or illness that required acute care/treatment. “If I close my eye like this and you stand here, I can see you out of the corner of my eye.” Bella is an active “anciana”

(elderly woman) who cares for her younger sister (also in her nineties). Being able to have a higher quality of vision would make tasks (notably caring for her sister, cleaning her sister's home, and tending to her extensive garden) easier and more pleasurable. Similarly, on the topic of nutrition, Bella exclaimed: "Oh, how I wish I were in the United States."

Mmm-hmm. In that country, the supermarkets have rows and rows of milk for miles." Kristina echoes Bella on the lack of basic fundamentals: "Oh, Alkaseltzer. [...] Here, there aren't Band-Aids, nor Alka-Seltzer. None of that."

A vast array of human needs, from feminine care to Depakine to milk, lie beyond the scope of acute care. Lacks of access to active care thus create paradoxical challenges: more extreme, acute forms of care can be covered while more basic yet equally critical forms of care fall away in the vacuum. Acute care is free and available; active care is harder to find and when it is, it tends to be expensive.

In response to this active/acute care paradox, some uniquely Cuban solutions in the form of alternative or "Green Medicine" were invented. Throughout my ethnographic field work in 2016, I collected a number of "Green Medicine" workarounds from various women and families I came in contact with. These "Green Medicine" inventions aim to ameliorate active care lacks. Table Two summarizes some well-accepted Green Medicine solutions discovered during the ethnographic component of this project.

Green Medicine, "Medicina Verde," refers to herbal-based medicinal remedies which are often passed down between generations and can be likened to old-wives tales remedies in their mysticism. Despite similarities to the wives' tales, Green Medicine is unique in that the most trusted herbal remedies have been tried and tested with time and are accepted as decent, if not superb, forms of invented and natural active care. For example, Diriprona (Cuba's version of

aspirin) has not been entering Mayajigua since 2016. When speaking with the Mayajigua pharmacist, she suggested a series of local herbs that could alternatively provide relief. Green Medicine is consequently normalized by health professions including not only pharmacists but also doctors. Yulia's mother interjected in one interview to state that at times, doctors will "prescribe" a Green Medicine solution. Her mother clarified that the "prescription" did not mean that one needed a physical physician's signature to sign-off on the use of herbal remedies. Instead, she aimed to convey the medical legitimacy of certain forms of Green Medicine as valid forms of active care—some of which are rubber-stamped by a health professional. The State has likewise been known to support Green Medicine through television programs that teach which herbs, plants or vegetables can be used for a given disorder or illness. Marí, thanks to the television program, once used the inner flesh of a pumpkin (the pumpkin meat) to treat her daughter's acne by massaging the pumpkin into the affected areas.

That said, Green Medicine workarounds are still not perfect. During one interview, Yulia's grandmother interjected to explain that she once ate pumpkin seeds as an alternative to Alka-Seltzer noting, "the pumpkin was nothing like Alka-Seltzer, but was better than nothing." Green Medicine becomes a source of comfort and healing (similar to a placebo), but still can fall short of providing the high quality of relief that a familiar yet scarce over-the-counter-product would. Additionally, not everyone can make use of Green Medicine. Bella explained that she cannot make use of most Green Medicine techniques due to a medical condition that prohibits her from consuming various roots and vegetables often implemented in herbal concoctions. Allergies must also be considered when deciding to use certain Green Medicine remedies.

Chapter Six. Acute and Active Care Paradox

The Cuba Paradox presented throughout this piece exists largely because of a series of independent albeit related reasons. Although Cuba is frequently perceived as an “isolated” state, the country is very much so connected and dependent upon a myriad of different international relationships. When these relationships become strained the tension between competing truths embodied within each healthcare paradox becomes more and more striking.

Upon first glance of the Cuba Paradox, the most seductive explanatory model for understanding the gaps that lie between low infant/mother mortality rates and a lack of access to active care, is the Embargo. In 1962, John F. Kennedy officially enacted the Embargo against Communist Cuba. Since then, it has been difficult for Cuba to have access to many products that are relatively accessible in the United States, particularly those forms of medical products and care that fall into the category of active care (purchasable at a local pharmacy). Even so, in the latter twentieth century and in the first few years of the twenty-first century, Cuba was still able to have access to equivalent products through political alliances with China, the USSR and later Russia, Venezuela and Brazil. Granted, Cuba was not able to obtain American brand-name products or even to obtain a large-scale product supply as is typical in most American pharmacies. However, the political alliances did allow for products to be made available when needed. So, although the Embargo seems to be an obvious explanation for the emergence of these paradoxes, it is not a principal reason. The Embargo was officially enacted in 1962. Cuba’s economic crisis during times of peace began in 1989—27 years after the Embargo went into effect. In this interim, Cuba’s financial position was better compared to times during the economic crisis. There was better access to over-the-counter care compared to the ‘89 depression

and subsequent depressions. Today, the Embargo is instead a factor that augments financial crises, which interestingly enough have roots in other places.

More than the Embargo, the Cuban Special Period is a crucial factor responsible for not only opening the vacuums but accelerating the number of paradoxical gaps that exist in the healthcare system as made available to women on ground. The Cuban Special Period began in 1989, the same year that the Soviet Union, and by extension the Comecon, dissolved. Many Cuba scholars pin access lacks on the Special Period. However, most scholars (including Huage and Randall) isolate the Special Period to the latter twentieth century considering that the Special Period is frequently defined singularly in terms of the immediate years of poverty and financial crisis in Cuba following the collapse of the USSR. This truncated description of the Special Period fails to capture its dynamic nature especially considering that, in practice, there have been multiple Special Periods that have each been related to Cuba's financial and political predicaments at a given time.

The June 2016 Special Period, which continues into the moment this piece was written, is the critical explanation for the heightened paradoxes observed and explains lacks in active care. Two years ago, the State declared that Cuba would enter the worst Special Period the country has experienced to date. Propaganda ranged from commanding citizens to "stay strong" to learning how to live with less. This recent, devastating financial crisis began when Cuba's major allies significantly reduced or eliminating funding. Russia and China diminished the amounts of goods being sent. For instance, prior to June 2016 China sent Cuba buses and cars that were used for public transportation for Cubans (not tourists) and that were used as ambulances. Due to the poor quality of Cuban roads, one key informant explained that the vehicles would undergo an accelerated wear and tear. China was not able to financially meet the demand nor was Cuba able

to provide adequate compensation. The result is that, in the public transportation sector, it can be challenging to find access to a car. Throughout my field work, I would frequently witness hitchhikers attempting to catch a ride from passing cars. The method was simple. A person would have a wad of cash in their hand and run into the highway or street waving the money, hoping that a driver would stop. This method proves highly inadequate when needing to get transportation in the case of an emergency, but it is utilized. Consider rural towns. In the case of Mayajigua, there is one ambulance (owned by the Yaguajay hospital) that services not only Yaguajay and Mayajigua but other rural farming towns in the area. Mayajiguan patients who seek medical care from Yaguajay's hospital must wait for the ambulance to complete other emergency routes in the surrounding area. The transportation sector is only one example of how the Special Period continues to affect the health reality on the ground, especially when it comes to care that is principally made available due to external international relationships.

China, the USSR, Brazil and Venezuela have also been known to send certain over-the-counter products such as feminine care, toothpaste, toothbrushes, etcetera. In the cases where final products were not provided, ingredients for manufacturing certain goods were sent (such as the ingredients required to manufacture Diriprona, Cuban aspirin). In June when four major allies cut funding, the economic implications were severe and almost immediate. The Embargo merely exacerbated the access crisis since Cuba's workaround to trade with the US had been significantly reduced.

Despite the fact that the Embargo augments (instead of causes) paradoxes, US sanctions classically assume the most blame in both the US and Cuba. Outside the José Martí Airport in La Habana and outside La Habana City stand billboards (Figure 12) depicting the island of Cuba inside a noose. The underlying caption reads: "EMBARGO: Largest genocide in history."

It is indeed true that the sanctions continue to affect Cuban reality in a negative way by causing access reductions. However, the Embargo is only one factor that must be understood within broader contexts, such as other economic relationships between Cuba and the world. When the Embargo is singularly depicted as the sole perpetuator of the crisis, as in the aforementioned billboards (Figure 12), other explanations that equally reinforce the same tense paradoxes go unnoticed.

Increases in tourism paired with the Special Period are one such example of a hidden yet equally significant paradox reinforcement. In 2015, the first year of this study, Cuba experienced a “record arrival of nearly 3.5 million visitors” (Ahmed 2016). Increases in tourism occurred explicitly after Obama’s 2014 December declaration to begin a more open relationship with the island nation. One of the side effects of this declaration was an increase in tourism.¹¹ Increases in tourism compounded with the Special Period made access to active care increasingly difficult since resources were first to be allocated to guests. “Tourists are quite literally eating Cuba’s lunch. Thanks in part to the United States Embargo, but also to poor planning by the island’s government, goods that Cubans have long relied on are going to well-heeled tourists and the hundreds of private restaurants that cater to them, leading to soaring prices and empty shelves. Without supplies to match the increased appetite, some foods have become so expensive that even basic staples [including rice and beans] are becoming unaffordable for regular Cubans. The private tourism industry is in direct competition for good supplies with the general population” (Ahmed 2016).

In my 2016 field trip to Cuba, I witnessed this redistribution of active care items. In the country, sugarcane grows for miles and miles. In one of my late-night conversations with Irena, I mentioned how the sea of sugarcane impressed me as a New Yorker. She explained to me that

what I saw was an irony. Sugar, a substance that freely grows along with rice and certain legumes, would not be made readily available to Cubans as it used to be. She clarified the recent Special Period as a cause but linked the Special Period directly to tourism. “Go to Los Cayos” she told me. At the end of the week, I took her suggestion and travelled an hour or so by car to the popular tourist destination to spend the day. Once I arrived at the entrance of the Keyes, I had to present my foreign passport.¹² I went to two different hotels and the medical tourism hospital on site at Los Cayos. There was simply more in these exclusive resorts. Based on the food displays, one would not guess that Mayajigua (an hour away) was having a food shortage. Based on the abundant amenities (from toilet paper to feminine care to sunscreen) one would not realize that finding active care would be a challenge. Even the medical tourism hospital was different. It was modern in design and had several ambulances parked on freshly paved asphalt. A chic, clean surgical center that could not compare with Yaguajay’s hospital let alone with Mayajigua’s polyclinic served as a point of entry to Cuba where the building practically met the beachfront. Redistribution was clear cut and was not limited to food alone.

The State is critically involved in this redistribution. In 2017, I met with Dr. Daymé. In our discussion he explained that earlier in the year, an EU delegation came to Mayajigua to simply observe how the healthcare system in the rural farming town was delivered. At the end of their stay, the delegation left a generous gift for the polyclinic which included sterile gloves, disinfectant, and needles. Dr. Daymé accepted the gift but was obliged to leave the needed products in a corner unused and contact his director in the municipality of Yaguajay. The day after the EU delegation left Mayajigua, professionals from Yaguajay collected the donations and took them for redistribution. The implication was that the donation would not be used for towns like Mayajigua that had a need for such products, but that these products would be redistributed

to medical centers, possibly such as those in Los Cayos which are solely to be used for medical tourism.

Further conversation with Dr. Daymé revealed an element of pride. “Here, the word ‘donation’ falls on top of people like a bomb.” Irena, one of Dr. Daymé’s patients, also believed that the State’s pride in the healthcare system makes it difficult to accept active care donations and allow these donations to stay in health facilities that might need them. The Cuban healthcare system has achieved renowned for its provisioning of acute care. The world knows Cuba for its high-quality doctors with healer humanity, excellent medical education system, and novel medicines that Cuba hopes will one day hit markets globally (including US markets). For Irena, falling short in active care can be a point of “vergüenza” or shame. The act of accepting active care would be an acknowledgement of this need which can run contradictory to the renowned of the healthcare system at large. This “vergüenza” comes in the acknowledgement of the lacks that exist within the vacuums. That said, the vergüenza coexists with something novel and uniquely Cuban: Cuban viveza.

Chapter Seven. Viveza

Conclusion

Vergüenza, ingenious work-arounds, lacks, accesses, paradoxes all merge into one conceptual principle: viveza. Viveza is directly translated to “liveliness.” In Cuba, however, the word assumes a unique connotation. Cuban viveza is walking on the street past the elderly rocking the heat away in steel or wooden rocking chairs on a porch. Viveza is the smell of tobacco coming from the parks where children play while men of all ages participate in intense domino competitions. Viveza is stopping by a neighbor’s house just to say hello. Viveza refers to

a particularly Cuban liveliness which involves learning how to mediate and manage vacuums and paradoxes.

In my field interactions in Mayajigua, *viveza* became particularly evident in conversation as well. From greetings, to comments made after formal interviews concluded, to little asides mentioned post acknowledgment of a gap or a paradox (notably those explored in this piece), many of the women would insert a casual phrase into our conversation: “*Todo bien.*” All is well. How are you? All is well. Thank you for the interview. All is well? Limited access to active care? All is well. *Viveza* drips from this “*todo bien*” phrase.

Despite vacuums and paradoxes, women in Mayajigua try to manage them and attempt to confront them optimistically, all synthesized in these two words. Learning to mediate the gaps and live in a way where one can attempt to manage them with workarounds or ingenuity becomes a unique demonstration of Cuban *viveza*. There is no surrender in the vacuum but an optimistic resilience that yields camaraderie and innovation. Camaraderie in the form of sharing what you might have if someone you know needs it. Innovation in the form of, “*Espérate, espérate. Vamos a ver cómo podemos resolver*” (key informant 2015). Wait, wait. Let’s see how we can resolve this. One innovative solution that I witnessed on the ranches outside Mayajigua includes maximizing the amount of people who can ride by horse: two on the back of a horse and a third riding in a wheelchair behind tied to the horse’s tail. *Viveza* is learning how to operate within vacuums by finding strength in community and by learning how to “*resolver*” or resolve. This *viveza* is ultimately what can help Cuban women find “all to be well” despite the fact that “*la cosa aquí, no es fácil* [‘the thing,’ or life here, is not easy].”

In this piece, I have demonstrated how factual boundaries and vacuums give rise to paradoxes, such as this “all is well” and “life is not easy” tension. Choosing to selectively assess

the outer truths, the statistics from WHO or the advertisements for the lung cancer vaccine, will singularly depict the “all is well” part of the equation. Diving deeper into the system to penetrate shielded parts of the Cuban medical reality reveals that life is not easy on various levels. However, exclusively focusing on the difficulties presented in the system ignores significant realities on the outskirts. A closer and longer gaze must be held when assessing the Cuban primary and maternal healthcare systems today so that all truths are acknowledged individually *and* as part of a larger whole. The Cuban medical reality is a conjoined one.

Thus, evaluating the reality must be done in a way that offers a wide and wholistic understanding, which is contextualized. In my assessment, a concentric unit composed of factual boundaries and vacuums provides this assessment. When thinking about Cuba as a concentric unit the paradoxical realities are explored freely through the Cuba Paradox at large. To date, no ethnographic, current (within the last five years) piece on the Cuban healthcare system exists. Moreover, many scholars either operate on the outskirts or closer to the nucleus. This piece does something unique by tying both together. Additionally, many of the recent studies on the healthcare system minimize ethnography and participant observation, choosing instead to elucidate statistics which effectively remove experiences of women using the system on the ground and shield the paradoxical parts of the Cuban woman’s medical health reality. This thesis is therefore instrumental in adding to the body of research by offering an assessment that forefronts *her*stories with the healthcare system in Cuba today all in an effort to better investigate the Cuba Paradox.

There is, nevertheless, more room to explore the Cuba Paradox outside of this study. Areas for future research on the Cuba Paradox include investigating why certain towns, such as Mayajigua, do not have a CMF physician living in the community as legally established. It

would specifically be interesting to study who decides if a doctor can live outside of the community s/he serves and under what circumstances. More importantly, future research studies should attempt to ethnographically investigate and quantify (if possible) the severity of each Special Period that Cuba has had all in relation to the historical and/or political contexts of the State at the time. This study should also evaluate how Cubans have been able to improvise workarounds to living during each of the Special Periods. An assessment of the various Special Periods to date would provide needed information on the current Special Period in addition to offering insights on how to alleviate or predict future Special Periods that might ensue in Cuba in the near future and beyond. If these additional areas for investigation are researched, an even more expansive review of the Cuba Paradox can be achieved.

Understanding the Cuba Paradox (as this work does) becomes paramount, specifically since studying the Cuba Paradox can have wide-ranging and global implications for the healthcare systems of other countries. Cuba has much to offer the realm of Global Health. For instance, the system can indeed be a model for countries like Haiti since an implementation of a Cuban-like system in terms of reproductive care can lower mother/infant mortality rates in childbirth. Cuba's fusion of public health with clinical medicine can also offer global insight to epidemiology and world health by offering potential solutions to curbing the spread of disease in a highly globalized world. This is not to say that every healthcare system should be like Cuba's (it cannot since different countries operate within different cultural spaces and traditions), but I do believe that studying Cuba's healthcare system can have incredible benefits in the creation of solutions to global and public health dilemmas today (such as in lowering childbirth mortality).

Moreover, understanding the paradoxical nature of the Cuban healthcare system becomes imperative for understanding the reality of women, such as those in rural Mayajigua, living on

the ground. “Todo bien” cannot be a denial of the paradoxes that exist because if it is, significant repercussions will ensue. Epileptics who cannot find access to Depakine will have a shorter life expectancy. Children and adolescents will suffer nutrition deficiencies due to restricted milk access. Infections can occur for women and girls who cannot maintain feminine hygiene in the heat. Acknowledging the paradoxes specifically becomes imperative. Once the paradoxes are acknowledged it can become possible to work with women on the ground to create sustainable, bottom-up ventures in which international workarounds can be made to alleviate lacks (workarounds that are more successful than the EU delegation’s workaround in just donating necessary health items to a healthcare facility). As such, this project also has significant implications for Public Anthropology on an international level—beginning in Cuba.

Upon final reflection, the Cuba Paradox and viveza all serve as proof that a Cuban woman in Mayajigua is a rhizome. She exists at the intersection of so many forces and bodies—from social to economic to political. A synthesis of all of Schepher-Hughes and Lock’s “Three Bodies” (politicaleconomic bodies, social bodies, and personal bodies). By evaluating these forces in synthesis, it becomes evident that a Cuban woman occupies a space of intersection where all factors enmesh. This enmeshing ultimately emplots women into a larger narrative filled with contradictions and paradoxes. Cuban viveza gives her the energy to push the horizon of care she receives through clever improvisations and community-building which can give her feelings of autonomy even in the voids of the vacuums lying between bounded facts.

Endnotes

1. Statement made in Dr. Paul Farmer's March 2016 visit to the University of Pennsylvania Irvine Auditorium.
2. Havana City, Cuba's capital city, is written and pronounced as La Habana in Spanish. Spanish names for major towns and cities are used in this piece to preserve the authenticity of a place's name.
3. Translation: Cubans, men and women. Can be abbreviated to Cubanos/as.
4. All interviewee names in this piece have been anonymized to protect the identities of the women interviewed. Penn IRB approvals for the 2015, 2016, and 2017 studies also required all identities of those interviewed to be anonymized.
5. The term "vacuna" or vaccine is used to refer to the treatment on the ground. However, the treatment is not technically a vaccine since it is administered once one already has cancer, hence can be considered a misnomer. The vacuna has currently been found to be most effective when administered in the early stages of the lung cancer.
6. El Pelú is a classic icon of Mayajigua. During the Spanish War, he was a soldier from out-of-Province who ran up into the mountains to hide from the Spanish. Years after the war ended, the Pelú continued living in the mountains under the pretense that the war had not yet been won. When he was found by local Mayajiguan men, the townspeople in Mayajigua attempted to re-introduce El Pelú to town and farm life. El Pelú preferred the cave he had inhabited throughout the war and in the years following the war's end. He died shortly after he was brought down to Mayajigua. He continues to be celebrated as a cultural Mayajiguan figure and icon today.
7. Fulgencio Batista was elected the President of Cuba from 1940-1944. In 1952, Batista returned to power as a dictator until he was overthrown in 1959 by the Revolution.
8. Santería is a custom that was practiced and promoted by Afro-Cubans since the times of Spanish colonization. As I found in my interviews, santería involves superstition and "magic" and was once used for medical purposes among other things. Santería today is no longer viewed as a valid form of treatment for any condition (medical or non-medical). It is instead viewed as an interesting cultural artifact of previous times in Cuba.
9. Note that infant formula is sold in regular supermarkets since infant formula is not a good that is rationed; supermarkets sell "commodity" goods that do not require a blue book. These goods are often referred to as goods "por la libre" whereas bodegas sell strictly goods that are rationed.
10. The 39.29% of women who responded that they did not have access to contraceptives were not questioned further in 2015. If the study is to be repeated, contraceptive use is to be more thoroughly investigated.

11. This increase was not limited to an increase of US tourism. Also note that although Obama declared he wished to create friendlier relations with Cuba, the Embargo was never removed nor was it made legal to travel for touristic purposes only from American soil. Tourists had to instead travel under educational or humanitarian purposes.
12. At the time, only foreigners were allowed to enter Los Cayos. Since 2016, this has changed. However, Cubans must be able to pay an expensive entrance fee (the equivalent of 20 USDS, more than an average Cuban's monthly wages) to enter the premises.

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Figures

Figure 1: Two-floored structure of a CMF that serves both Mayajigua and nearby Chambas. Photo was taken in 2016 by Ivana Kohut.



Figure 2: CMF near Topes de Collantes. Health professional lives on the second floor and sees patients on the first floor. Photo was taken in 2015 by Ivana Kohut.



Figure 3. Each CMF is numbered based on province and “barrio” or neighborhood. Photo was taken in 2015 by Ivana Kohut.



Figure 4: The Mayajigua polyclinic is much larger than the local CMF building with more medical wings and more staff. Photo was taken in 2015 by Ivana Kohut.



Figure 5: Yaguajay polyclinic is featured in contrast to the Mayajiguan polyclinic from Figure 4. The Mayajigua polyclinic is much smaller than the Yaguajay polyclinic since the Yaguajay polyclinic serves the entire municipality whereas the Mayajiguan polyclinic has a much smaller patient population. Photo was taken in 2015 by Ivana Kohut.



Figure 6: Yaguajay Hospital Main Entrance. Photo was taken in 2016 by Ivana Kohut.



Figure 7: Yaguajay Hospital pharmacy depicted behind sign. Photo was taken in 2016 by Ivana Kohut.



Figure 8: Quaternary-level care occurs at the level of national research institutes funded by the State. Photo was taken in 2015 in La Habana by Ivana Kohut.



Figure 9: Mother Home in Yaguajay, Cuba. Photo was taken in 2015 by Ivana Kohut.



Figure 10: Palacio de las Madres (Palace for Mothers). Photo was taken in 2015 by Ivana Kohut.



Figure 11: “To Breastfeed is to Love.” Breastfeeding propaganda on the side of the Mayajiguan and Chambas CMF. Photo was taken in 2016 by Ivana Kohut.



Figure 12: Embargo Billboard Outside La Habana City. Identical billboard found outside José Martí Airport in La Habana City. The spider webs being released from the noose suggest that the Embargo is a remnant of the past that continues to drastically choke Cuba today. Photograph was taken in 2016 by Ivana Kohut.



Tables

Table One. Wait in a Polyclinic (2015 data)

Length of Time	Percentage
None	10.71%
2-3 hours	3.57%
All day	5.95%
La cola	79.76%

Table Two. Green Medicine Alternatives to Active Care Products

Symptom	Unavailable OTC Solution	Green Medicine Workaround
Stomach Pain or Discomfort	Antacid	Pumpkin, Anon, Hot Water with burnt bread crumbs
Acne, Burns and Rashes	Burn Creams	Aloe gel, Tomato meat, Pumpkin meat, Banana leaves
Arthritis Pain	Ibuprofen	Concoction of Cuban garlic, pure Cuban alcohol and Cuban tobacco fermented for 20-21 days in the Cuban sun on a tin roof