REVOLUTIONARY MEDICINE

HEALTH AND THE BODY IN POST-SOVIET CUBA

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

In contrast to this serene image is the blaring sound of American pop music coming out of 1950s-model Fords and Chevrolets with large Sony or Panasonic speakers from the U.S.-dollar store placed strategically in the cars’ rear windows. The booming, repetitive bass and synthesized voices remind me that, despite appearances, we are in the new millennium. Laundry hanging out of ornate colonial windows and the buzzing sound of pressure cookers softening the daily fare of frijoles negros (black beans) are accompanied by the shrill laughter of brightly uniformed children on their way home from school. People standing in a winding queue in front of the local bodega (ration store) converse, laugh, and share a collective sigh, as most of the daily rations fail to arrive or simply run out. Unbothered by a river of water flowing from a broken pipe in the street, people smile obligingly as a passing tourist snaps a photo of what is, for him, a novelty: Cubans lining up for bread. These are the participants in the making of history, as it passes by in a series of rhythmic beats.
In a crowded theater in Havana in the summer of 2000, as I sat watching the Cuban-directed and Cuban-produced movie of the year, *Un Paraíso bajo las estrellas* (A paradise under the stars)—incidentally, this is also the motto of the Tropicana, the infamous Cuban cabaret that features voluptuous dancing girls—the audience roared with laughter and shouted comments about the unfolding drama. One part of the movie that generated a particularly vociferous response was the demise of one of the secondary characters, who, while arguing with his neighbors, slipped off a bridge and fell to his death, standard fare in a Cuban soap opera. What was most remarkable about this death, however, was the character’s rebirth.

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

The mourners, stunned into disbelief, began to question him. “What happened?,” they cried out. Responding quite matter-of-factly he stated, “When I got to Heaven, they wouldn’t let me in because the entrance fee was in *divisa* [U.S. dollars].” Rejoicing in his rebirth, the mourners silently accepted the reality that the afterlife is merely an extension of everyday life, in which access to divisa shapes lives and experiences differentially. The audience in the theater screamed out in jest, “*Vaya, no es fácil!*” (It is not easy!). A woman sitting next to me shook her head and grumbled, “This
country is shit.” A man yelled out, “Oye [listen], there is nothing left in this country that isn’t in divisa!”

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

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

While many social scientists have examined public health care in Cuba, none have ethnographically explored how health reform might be analyzed in terms of larger economic and political considerations, many of them external to Cuba, as well as in terms of changing practices in the everyday lives of citizens. To address these concerns, I ground this book in what I call an ethnography of contradictions, and, in order to map such an ethnography, I advocate a theoretically promiscuous approach, one that is wedded not to a single theoretical camp or framework, but to an engagement with a diverse body of
recent scholarship on the anthropology of the state, critical-interpretive medical anthropology, and postcolonial and postsocialist studies. Such an approach is necessary in order to analyze an ethnographic context—contemporary Cuba—that has occupied multiple positions throughout history: from Spanish colony (1492–1899) to capitalist democracy under the tutelage of U.S. domination (1902–59) to socialist state (1959–present).

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

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

She pulled out a scrap of paper and began to draft a new proposal, one which, she stated, would be of “greater scientific interest” and, importantly for state reviewers, appropriate in the Cuban context: a comparison of the “cultural models of health care” in the United States, Canada, and Cuba. Excitedly, she sketched out a chart with three columns: on the left was Capitalism–United States; on the extreme right of the page was Socialism–Cuba; and in the middle was a Mixed–Model–Canada. She seemed impressed by the new “culturally appropriate” project she had drafted and once again stressed that the new project was only a suggestion. As I maintained an expressionless face throughout her frenzied sketching and exclamations that
the project was of “vast interest,” she finally looked up at me and gauged that I was not terribly enthusiastic. “You are aware that several social scientists have been removed from Cuba, aren’t you?” she queried. Her comments had a ring to them that made me feel I was privy to some kind of secret information. After forty minutes of explaining the importance of a sound methodology, as opposed to anthropological methods, which she disparagingly referred to as “simply hanging out,” she finished drafting the new proposal. By her account, it followed the grant guidelines set out by the Pan American Health Organization, a format, she indicated, that state reviewers responded to well. Handing me several sheets of paper, a draft of my “new project,” she wished me good luck. After thanking her for her help, I left her office with the clear sense that I had my work cut out for me.

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

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

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

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

My most troubling experience involved several interviews I conducted with family physicians in Havana, all of whom were recommended to me through my Cuban host research institution. This experience made me rethink my methodological approach and wonder whether I had dismissed the notion of Big Brother too quickly. During several of the interviews with
family physicians, I was surprised to find a striking similarity among their responses to my questions. They were reminiscent in both cadence and content of Fidel Castro’s popular speeches, and I thought I had fallen prey to the official harangue of prescribed state discourse—what many Cubans refer to as *el teque* (literally, a spinning top).³ The physicians’ responses, replete with discussions of the successes reflected in Cuba’s vital health statistics and peppered with accolades for the country’s family physician and nurse program, which is popularly understood as being the product of Castro’s innovative thinking, shared critiques of what was to blame for recent changes to the Cuban health care system: the withdrawal of Soviet aid and the U.S. embargo against Cuba, popularly known as *el bloqueo*.

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

Having carried out extensive formal and informal interviews among the general public, I encountered a diverse range of opinions and experiences, particularly in regard to the public health system. Were these physicians, who had been recommended to me by my host institution, just feeding me state rhetoric? A close Cuban friend of mine made an astute point that helped shed light on my dilemma. As he put it, two kinds of people typically flock to Cuba. The first group, the idealists, come to Cuba in search of the image of Ernesto “Che” Guevara, and they have a romanticized vision of Castro and socialism. The second group, he suggested, are the critics, who arrive in Cuba in droves to point fingers, cast doubt, and castigate the socialist government. Unfortunately, as my friend further pointed out, while
some individual citizens may happily bare their souls without thinking twice, many state professionals, especially physicians, are in a different position. They are more conscious, he suggested, of the way in which open dissent may have negative consequences for their careers, particularly as they work so closely with the government. This is a risk, he added, that many physicians are unwilling to take with people who have not demonstrated themselves to be *de confianza* (trustworthy).

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

Looking noticeably uncomfortable, Domínguez asked, “You do know our Comandante is the mastermind behind this current program, don’t you?” She paused and then added, “I believe the program is ideal, and no changes are needed.” Upon further questioning about how her consultorio was affected by the recent shortages of food and medicine in Cuba, she became visibly disturbed and adamantly stated, “Nobody in Cuba is without adequate food or medicines. If people are telling you that, they are absolute lies.” Taken a little aback by her hostile response, I inquired about the general shortages that many of the ordinary citizens I had interviewed complained of. “Well, yes,” she admitted, “we have some shortages, but they are getting better. Surely you do not want to focus on this topic when we have accomplished so much in Cuba.” I made it clear I was not on a fact-finding mission to identify only the faults in the system or to criticize the government, but to put in context recent changes in the health care system caused by social and political shifts in Cuba. Seemingly unimpressed by my explanation, Domínguez concluded, “Cubans are prone to exaggerate things, especially with foreigners.”
My formal meeting with Domínguez was similar to several others I had with people I refer to as low-level bureaucrats—social workers, MINSAP officials, and so on—who were recommended to me through my host institution. Rather than dismiss these interviews as mere rhetoric, I include them alongside other interviews, many of which involved informants with whom I had developed long-term relationships, such as those I met in 1998 or 1999. Others warmed up to me only after repeated interviews and extensive participant observation. I do acknowledge, though, that Domínguez’s comments about the questionable interaction between foreign researchers and exaggerating Cubans have a certain ring of truth, however limited.

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

For example, several individuals painted images of starvation and at times complained that the state had not provided basic monthly rations, such as meat or fish. When I asked to see their state ration books (libreta), which I justified by stating that I was merely curious, meat and fish products were indeed provided. I asked people to explain the discrepancies in their stories. “But those are not the choice parts of the meat,” many of them would claim, or “Yes, we got fish last week, but it was in a can.” The notion of starvation, in this context, was the inability to eat culturally appropriate foods. Moreover, other individuals complained of having no access to U.S. dollars yet smoked a particular brand of cigarettes that was sold only in this currency. When I asked them how often they smoked, on average, several individuals indicated they smoked a pack a day. The popular brands of cigarettes for sale in U.S. dollars sell for anywhere between fifty cents and one dollar per pack.
Therefore, some people were smoking from fifteen to thirty dollars’ worth of cigarettes per month. Yet by their own accounts they did not have access to U.S. dollars. These are only some of the many discrepancies among the multiple realities of people’s lived experience. Ethnographic research, in this context, is the best way to address the many nuances and contradictions of contemporary Cuban life.
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Tracing the deep, furrowed lines that branched out from slightly under her nose and created a crease on either side of her mouth, María Luisa laughed apprehensively. The permanent frown of etched lines temporarily transformed.

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

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

Using her body as a diagnostic map, María Luisa walked me through her many ailments: a case of optic neuropathy in 1993, which resulted in a prolonged period of temporary blindness. She found out circuitously from a friend who had access to the international media that foreign presses were reporting severe nutritional deficiencies as the cause. Only later did her doctor intimate that this was, indeed, the cause. Shortly thereafter she
started experiencing flare-ups of gastritis, severe migraines, body aches, and fatigue, all of which she medicated through a combination of prescription pills. To make matters worse, she added, because the local state pharmacies were increasingly unable to fill prescriptions, even for aspirin, she was often forced to rely or impose on her friends, friends of friends, and the bolsa negra (black market) to fill the void.

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

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

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

In 1991 the government declared, “Socialism is under siege” and formally announced the beginning of the Período Especial en Tiempos de Paz (Special period in time of peace, hereafter, período especial). The logic of everyday life in post-Soviet Cuba was radically transformed under the rubric of
“wartime measures in times of peace.” Operating in many ways as a “state of exception,”3 government policies institutionalized corrective measures by creating new and refining older policies (migration laws, banking practices, employment categories, and access to basic needs and services, to name a few) as part and parcel of a general program of economic recovery and revival.4 In 1991 Julio A. García, the former head of the Cuban Chamber of Commerce, described the Communist Party’s logic behind these changes: “We have to think like capitalists but continue being socialists.”5 As implied by García’s statement, the island started charting a new course for the social, political, and economic survival of the country’s socialist revolution.

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

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

Based on more than a decade of field research (1998–2010) conducted in the city of Havana, this book chronicles the experiences of family physicians, everyday citizens, public health officials, and research scientists participating in the country’s primary health program, central to what is known as the Programa del Médico y la Enfermera de la Familia (mef, Family physician
and nurse program). This program calls for family physician-and-nurse teams to live and work in small clinics known as consultorios on the city block or in the rural community they serve. Through an ethnographic exploration of the relationship between health policy (of which the MEF program is an example) and individual experiences, I explore two central themes. First, I focus on how state policy, enacted through the government’s public health campaigns, has affected individual lives and changed the relationship among citizens, government institutions, public associations, and the state. Second, I look at how the collapse of the Soviet bloc and the strengthening of the U.S. embargo are changing the relationship between socialist health policies and individual practices; specifically, I discuss how these changes have redefined the way in which state power becomes enacted through and upon individual bodies.

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

A GENEALOGY OF INDIVIDUAL BODILY PRACTICES

The analysis presented throughout this book is informed and shaped by what I call a genealogy of individual bodily practices. For the purposes of this book, I define individual practices as the complex ways in which individuals communicate, improvise, enact, and revise ideology. Yet the task of genealogy, according to Michel Foucault, is to expose a body totally imprinted by history. Genealogy provides an empirical methodology by which to explore the truth claims individuals make regarding the knowledge they have of themselves, their bodies, and society at large, while at the same time
understanding such knowledge as a relation of power. By unraveling the multiple historical layers that contribute to bodily formations, both culturally and materially, a genealogy of individual bodily practices offers an analytical lens through which to examine the lived experience of bodies. This approach addresses three interrelated ethnographic and theoretical concerns.

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

Since the revolution in 1959, many of the practices employed by the state and by individual Cubans, particularly during the período especial, have obvious continuities with the past. In this respect I argue that the revolution was in fact not revolutionary in the sense of provoking a dramatic shift in
ideas and practice. Rather, I suggest that one must understand the contemporary interaction and competition among different ideological principles as the ongoing expression of years of political struggle, which has historically existed between sectors within the island’s population.\textsuperscript{20} In an attempt to address this approach, I have integrated the narratives of several of my interlocutors throughout the text as a way of presenting their personal lived experiences and accounts of historical and current events in Cuba.\textsuperscript{21} Each personal account, I argue, represents a separate genealogy that reflects a complex web of values, ideas, and, ultimately, lived experience before and since the Cuban revolution.

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

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

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

**STATES OF CRISIS**

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

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

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

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

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

**STATISTICAL FETISHISM AND DOCILE BODIES**

As one walks along the waterfront or tours the hospitals, schools, and monuments in the neighborhoods of Havana, one sees billboards advertising the successes of the revolution, as if, in the words of the fiction writer Cristina García, “they were selling a new brand of cigarettes.” Covering the sides of buildings and erected on movie-sized screens, these enormous signs contain such various aphorisms as “Millions of children in the world die of curable diseases, none of them are Cuban”; “The weapons of the Revolution are our ideas”; “We believe in socialism now more than ever before”; or “Hey Imperialist. We have absolutely no fear of you.” The messages conveyed by these clever forms of political rhetoric are open to multiple interpretations. One
message, deeply rooted in the demarcation between Cuba’s past and present, suggests the power of “political will” to reinvent history. Another, perhaps less subtle, expresses the socialist government’s anxiety over convincing the Cuban citizenry and the rest of the world that the revolutionary project is working. In the case of Cuba’s primary public health system this is particularly true.

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

In one respect Cuba’s success in the field of health reform, most celebrated in international development circles, helps boost the egos of Cuban Communist Party officials, who find moral solace in these tangible results of years of revolutionary fervor and sacrifice. Hinging on the success of their public health reforms and corroborated by concrete health outcomes, as evidenced in their health statistics, Cuba became, as Castro made clear, “a bulwark of medicine in the Third World.” In this way Cuba has gained the status of a kind of antimodel for the development logic that fuels the top-down structural adjustment policies so common in contemporary Latin America and the Caribbean. Several of Cuba’s best-known public health successes, such as the island’s low HIV/AIDS transmission rates, low infant mortality rate, and longer life expectancies at birth, have led a vast number of scholars to conclude that even in the face of scarce material resources the country has managed to achieve First World health outcomes through strong political will.

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

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

In the end, both groups reify an uncritical statistical approach in which individuals are perceived as passive subjects of state rule; in short, individuals become a caricature of Foucault’s idea of “docile bodies,” bodies manipulated and controlled in the management of the population. This process is further driven by international governing bodies such as the WHO, which explicitly link global agendas to local practices and circulate health statistics as a means to rank and classify the countries of the world on a scale from developed and First World, on one extreme, to underdeveloped and Third World on the other. Cuba, when viewed through such a polarized lens, becomes an enticing case study. But what do the statistics actually reflect? More important, what light can the numbers shed on the so-called anomaly of Cuba, a country in which, to quote a popular Cuban saying, “people live
like the poor, but die like the rich.” I believe the answers to these questions can be found by exploring how “statistics tell stories. They are techno-representations endowed with complex political and cultural histories. . . . One should be able to analyze counting in terms of its political consequences, the way in which it reflects the crafting of subjectivities, the shaping of culture, and the construction of power—including what these figures say about surplus material and symbolic consumption in those parts of the world that think of themselves as developed.”

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

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

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

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

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

4. Rationing of food began in March 1962. In principle, the system ensures equality of food consumption among the population since every Cuban is, in theory, legally permitted to buy the same amount of basic food products at the same prices. Ration cards (libretas) set limits on the quantities that one person can purchase at
subsidized prices, although rationing does not guarantee that those products will be available for purchase every month (Benjamin, Collins, and Scott, 1984). See, for example, Premat (1998) and Garth (1988) for an ethnographic account of the ways in which Cubans negotiated food shortages and rationing during the período especial.

INTRODUCTION

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

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

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

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


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

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

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

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

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


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


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

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

16. See Butler’s (1997, 2) important discussion on the paradoxical nature of state power.
18. Foucault 1983, 208. Also see Verdery’s (1996) application of étatization to examine the regulation of time in European socialism. Similarly, Farquhar’s discussion of how the Maoist past is embodied in the political and historical character of pleasure in modern-day China also speaks to variants of the genealogical method.
19. See José Quiroga (2005), Cuban Palimpsests.
20. Fernández (2000a), for example, identifies three major cultural paradigms that can be identified in Cuba’s history: the liberal, the corporatist, and the informal (lo informal). Central to the liberalist project were the ideas that individual rationality and self-interest were to be wedded with the autonomy of social organization in a free market economy. Corporatism, Fernández argues, “endorsed the notion of law, order, stability, and elite leadership through a centralized bureaucratic authority—the state—that would rule over, and function in coordination with, sectoral groups hierarchically and organically integrated” (2000a, 27). Lo informal, on the other hand, subverted the institutions and regulation of daily life in order to satisfy the material and nonmaterial needs of the self, the family, and the community.
21. This book privileges the analysis of the way in which the creation and transfor-
mation of medicalized subjectivities are part and parcel of a broader matrix of socioeconomic and political changes. This is not to suggest that other factors, such as gender and local categories of racial classification, among others, are not equally important factors. Yet this form of finite analysis should be elaborated on in separate scholarly works: for example, gendering la lucha or discussions of race and the dual economy. I only briefly touch upon these latter themes in chapter 1.
23. There are several notions of citizenship in relation to biomedicine and medical practice with which this work is in dialogue. See, for example, biological citizenship (Petryna 2002; Rose 2006; Rose and Novas 2004); and therapeutic citizenship (Nguyen 2010).
24. See DelVecchio Good’s (2007) work on the “political economy of hope” and the “biotechnical embrace.” This work demonstrates how biomedical intervention, in fields such as oncology, increasingly take on affective and imaginative dimensions, enveloping physicians, patients, and the public. She argues that analyzing the “multiple regimes of truth” circulating in high-technology medicine serves as a nexus for examining the subjective experiences of patients, clinical scientists, and the political economy of biomedicine.
This is not to suggest that the informal economy is a new phenomenon in Cuba. As many Cubans pointed out during interviews, a black and gray market had existed since the mid-1960s, before the advent of the periodo especial. However, as several informants also pointed out, the private informal economy tended to be in nonessential items (e.g., blue jeans and electronic equipment), not in basic medical provisions (e.g., medicine, medical supplies, and access to medical services). I highlight the qualitative differences in the informal economy from before and after 1989 in chapters 1 and 2.

See the work of Alena Ledeneva (1998).

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

I borrow the term from Augé and Herzlich 1983.

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

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

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

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

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

34. Roitman 2004b, 194.


38. See Harvey 2003.


40. Ibid., 192.

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

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


44. Cited in Constantin 1981, 1.


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

47. Geertz’s (1973) paradigm was primarily concerned with how religious symbols provide a representation of the way things are (the “model of “) as well as guides and programs directing human activity (the “model for”).
49. See Dalton 1993; Werner 1983; and Hirschfeld 2008.
50. Ernesto “Che” Guevara was a strong proponent of “exporting revolution” to other Latin American countries. See Fidel Castro’s speech of 4 February 1962 entitled “The Duty of a Revolutionary Is to Make Revolution: The Second Declaration of Havana,” in which he stated, “The duty of every revolutionary is to make the revolution. It is known that the revolution will triumph in America and throughout the world, but it is not for revolutionaries to sit in the doorways of their houses waiting for the corpse of imperialism to pass by. The role of Job doesn’t suit a revolutionary” (Castro Ruz 1969a, 104). Che was killed in 1967 while attempting to aid rebel fighters in “making revolution” in Bolivia.
52. This echoes Appadurai’s (1988) discussion of the complex mechanisms that imbue meaning and value to things.

1. THE BIOPOLITICS OF HEALTH
1. See Brotherton 2008; Doyon and Brotherton 2008; and Spiegel and Yassi 2004.
2. The Council for Mutual Economic Assistance, 1949–91, was an organization composed of the countries of the Eastern bloc and a select number of socialist countries elsewhere in the world.
5. The Torricelli Act forbids foreign subsidiaries of U.S. companies from trading with Cuba and places a six-month U.S. port ban on ships that have called at Cuban ports.
6. The Helms-Burton bill temporarily halted all direct flights and remittances to Cuba and allowed U.S. investors to take legal action in American courts against foreign companies that were utilizing their confiscated property in Cuba.
8. A number of other causal factors are responsible for the current crisis. These include what the policy analysts Ritter and Kirk (1995, 3) argue was the dysfunctional economic architecture, which was inadequate in dealing with a set of three interlinked crises as a result of the cessation of foreign exchange earnings. First, an energy crisis emerged with the reduction of petroleum. Second, an agricultural food-nutrition crisis resulted from reduced agricultural production, including the sugar harvest. Third, a general macroeconomic crisis was reflected in open unemployment, hidden “unemployment-on-the-job” (people being paid but not producing anything), high absenteeism, and a shift to legal or illegal economic activities.
9. See the work of the noted Cuban public health historian Delgado-García 1996c.
10. See PAHO 2001; see also A. Chomsky 2000.
11. See, for example, American Association for World Health (AAWH) 1997; Kirkpatrick 1996, 1997.