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# Guantanamo: Healthcare Delivery to Women in Cuba

Ivana Kohut  
*University of Pennsylvania*

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## **Cover Page Footnote**

Ivana Kohut, Anthrofest 2016

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On December 17, 2014, President Obama stated that, “In the most significant changes in our policy in more than fifty years, we will end an outdated approach [...] and we will begin to normalize relations between [Cuba and the United States]. Through these changes, we intend to create more opportunities for the American and Cuban people, and begin a new chapter among the nations of the Americas.” The political statement has and most likely will continue to inspire change, notably change pertaining to travel and trade restrictions. The United States of America’s desire for a new relationship with Cuba has more-over created an intense fascination, a unique *Cuba Locura*, in USA media. Travel agencies, as an example, paint Cuba as unique due to its scenic beaches and greenery. The rich architecture in Old La Habana and cobblestoned streets frequented by cars that would make any collector green with envy, are strong pieces of evidence to the fact that Cuba has been frozen in time. And though these qualities are uniquely Cuban, they are by no means the only characteristics that set Cuba apart from other Caribbean and even Latin American countries. Universal access to healthcare, and an explicit prioritization of women’s health during pregnancy, constitute a unique facet of the Cuban healthcare and policy. Cuba boasts one of the highest doctor-patient ratios, a statement that separates the country from many others in the Western hemisphere. The Cuban state has likewise implemented many resources to revolutionize healthcare so that the right to health is as fundamental as any other right upheld by the state.

The Hassenfeld Family Social Impact Foundation through the Center for Undergraduate Research and Fellowships (CURF) at the University of Pennsylvania, funded my three-week research opportunity to Cuba in the summer of 2015. The study I conducted aims to analyze the unique and renowned Cuban healthcare system currently in practice. With impressively low TB, AIDS and malaria mortality rates, Cuba is the frontrunner for healthcare delivery in Latin

America, and is deemed the “healthcare model” for many Caribbean countries (Paul Farmer). In addition, “at approximately nine deaths per every one thousand newborns” (Randal), Cuba has one of the lowest infant mortality rates in the world. The study was developed in order to examine how Cuba translates written health policy into practice. Logistically, how does the Cuban government explicitly protect women’s health in terms of services and broader systems? In turn, how are these systems accessed by the average Cuban woman on a daily basis? What makes the current system practical and impractical? That is, the research studies the effectiveness of the current, general health system for women through qualitative interviewing procedures. A total of 89 interviews<sup>1</sup> were conducted in 9 provinces (Pinar del Rio, Artemisa, La Habana, Mayabeque, Matanzas, Cienfuegos, Villa Clara, Sancti Spiritus, and Ciego de Ávila) with an average of about 8-10 interviews per province. Interviewees were categorized into three cohorts (ages 18-32, ages 33-69, ages 70 plus) so as to assess the healthcare system’s delivery at various stages of development. The collected data evaluates which primary, reproductive, and geriatric care services are delivered effectively.<sup>2</sup> Access to medications, to physicians, and to health information were analyzed when measuring effectiveness.

Availability of general practitioners, free of charge, constitutes a defining quality of the primary care system. The Consultorio Médico de la Familia (CMF, the Family Doctor Consultation Center) is an establishment supported by the Cuban government to increase access to physicians (in both urban and rural areas). A CMF is specific to each town, city, or community equivalent (based on location boundaries, such as in more rural areas). The CMF is a two-floored structure in which a general practitioner sees patients on the ground level and lives permanently in the center on the second level. The state encourages these physicians to live in the CMF for an extended period of time (a decade or more) so as to truly get to know and understand the community

1 84 valid interviews.

2 Note that the only healthcare system made available to Cuban citizens is the government provided care.

that s/he serves. The program fosters stronger patient-doctor relationships in which the doctor quite literally serves the community as a doctor of the people (a concept inspired by the health systems in the former USSR). As a result, the doctor becomes family-like within a town, and in this way practices her/his profession better since s/he gains the trust, and in many cases the love, of the greater community. The CMF system hence reduces the lab coat boundaries between doctors and patients for the better.

The CMF system additionally facilitates a more logistical access to the physician. As an interviewee stated, “Here in Cuba, a child can be without shoes but never without vaccines.” Again, the CMF enables such an incredible feat considering that through this institution, the doctor is made available, is trusted, and is able to firsthand observe the community and act according to the health needs s/he witnesses as not just a doctor but as a community member. For instance, 88.10% of the interviewees stated that they have easy access to a doctor because of their local CMF.<sup>3</sup> The CMF doctor is most often a general practitioner considering that the CMF rarely houses specialists. Even so, the only specialist who frequently visits the CMF is the OBGYN specialist. The CMF physician is obligated to report any pregnancies that occur in her/his vicinity and to contact an OBGYN specialist to visit her/his CMF. The pregnant woman then meets the specialist in the CMF of the district she lives in.<sup>4</sup> If the pregnant woman consistently refuses to keep her appointments with the OBGYN specialist, the specialist is legally obligated to visit her in her home and conduct the tests there (even if she does not want to undergo examination). This extreme measure ensures not only her own health during pregnancy, but also the health of her child. All of which contributes to impressively low infant and mother mortality rates in childbirth.

Through health policy, notably the Maternity Law, women’s reproductive health is designed to protect all women (medically and in the workforce) before, during and after pregnancy. Under

3 Access here is defined in terms of walking distance.

4 In some cases, she can meet appointments in a polyclinic or hospital.

the Maternity Law, a woman’s employer must grant her paid leave of absence post-partum. The law states that a woman is permitted up to a year of paid leave after the birth of her child.<sup>5</sup> The paid leave of absence is furthermore flexible. For instance, if the woman gives birth to multiple children, to a child with disabilities, or to a child born prematurely, she is automatically eligible to request more paid time off from work. In some cases, women can also be eligible for a paid leave of absence up to two weeks prior to her due date. This is especially the case if the woman has had a difficult or high-risk pregnancy. The state largely supports paid leave for these women and protection for pregnant women in the workforce, so that women do not have to choose between being professionals (and being active participants in the Revolution thereof) versus being mothers.

The state additionally provides Hogares Maternos (Homes for Mothers) for women who experience a high-risk pregnancy. (These pregnancies can be deemed “high-risk” based on the medical health, emotional health, and or domestic circumstance of the mother.) These homes are fully staffed with medical personnel 24/7 and are environments that offer a strong, reliable community for women during a vulnerable time. Again, her stay in the Hogar Materno is fully funded by the state.

Likewise, in the event that a woman gives birth to a child prematurely, the state offers her the opportunity to stay with her child in the hospital. This hospital stay is fully funded by the state so that the mother can: a) learn how to care for the child and b) breastfeed her child regularly. The concept of breastfeeding is interestingly a recurring theme in the interviews. One hundred percent of the women interviewed stated that they breastfeed/fed their children (the average is a period of 1-2 years post-partum). According to many of the interviewed women, the state encourages breastfeeding so that mothers can nurture a relationship with their children and because access to infant formula is incredibly limited.

Under the current healthcare system, the state also ensures that most women have access

5 Details concerning pay are ultimately determined by the employer.

to contraceptives. Correspondingly, 60.71% of the women who participated in the study stated that they have/had access to contraceptives. Often, such access is made available through the CMF, polyclinics,<sup>6</sup> and schools. Similarly, infertility treatment is funded by the state under the health-care.

Comparatively, the state healthcare supports geriatric health specifically through care centers intended for aging populations. In the field, I came across various full time care centers (nursing home equivalents) throughout the provinces visited. However, when speaking with the women, I found that culturally many women considered taking care of aging relatives at home more acceptable than sending them to a nursing home. That is, sending one's aging relatives or friends away to be taken care of in their advanced years is ubiquitously considered culturally taboo. In many cases, the elderly live together in the same house but are constantly "checked" upon by relatives, neighbors or close friends. Full time care centers are truly, only utilized if an elderly individual has a severe medical circumstance. Another less taboo and more utilized service includes *Círculos de los Abuelos*. This phrase quite literally translates to "Grandparent Nursery." The center is open for a few hours every few days and serves as a place for the elderly to socialize, dance, and exercise. There are no actual doctors or health professionals present since the center is not meant for admissions or check-ups of any kind. It is simply a way for

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6 A health center that is modeled off of the polyclinics in the former USSR. Polyclinics are designed to: promote preventative care, treat when necessary, and care for the body as a holistic entity. 58.33% of the women interviewed stated that there are salient differences between a polyclinic and a hospital. These women stated that a hospital is: bigger, cleaner, attends better (staff is more mannered), has a significantly shorter wait period, has better technology, has more seasoned doctors, treats major diseases and illnesses (i.e. cancers), generally has more staff and greater staff variation, is significantly more specialized, and is designed for admissions.

retired Cubans to have increased physical activity while socializing with peers.

Another unique aspect of the care policy includes the distribution of health information to citizens. Access to Internet is difficult considering that the few servers present on the island are not currently equipped for the ever growing demand. Consequently, when a woman or man has a medical question in Cuba, finding an answer is not as easy as emailing a nurse or searching WebMD. As a result, the state financially supports Medical Information Centers. These centers are often separate wings in polyclinics or separate buildings (not associated with the CMF in any way). The purpose of the Medical Information Center is to provide a space where citizens can ask medical professionals questions about a health disorder, concern, etcetera. These centers do not treat nor admit patients, but rather were created so that people have uniform access to medical information. In addition to Medical Information Centers, the state designs and implements health courses in schools (elementary and secondary schools). Lastly, through television programs and the cooperative efforts of the CDR (Communist Defense of the Revolution, which is analogous to USA town governments or councils) with the CMF, the state promotes ways in which citizens can stay healthy, particularly during flu or cold seasons, on community levels.

Though the current health system has incredible benefits for Cuban women, there seems to be a general deficiency of doctors domestically in hospitals and polyclinics due to the state's tendencies towards Health Diplomacy. Cuba "boasts more than 30,000 physicians [Cuba also has the most medical schools than any other country in the world], yielding one of the highest doctor-patient ratios in the world" (Randal). However, many of these doctors and specialists are exported to countries like Brazil, Haiti, and Angola. In return, Cuba gains political alliances and economic benefits (receives money, products such as toothpaste, and so on). Ultimately, however, less specialists are present at home to take care of the Cuban people. As a result, the provided healthcare in polyclinics and smaller hospitals tends to be inefficient because of the general lack of medical specialists (i.e. long waiting periods,



fewer technicians that can operate machinery for specialized tests, etcetera).

I witnessed the lack of accessibility to medical specialists firsthand in the field. While in a small town in central Cuba, I met a woman who needed a copy of her prescription for glasses since the original was misplaced. Unfortunately, her local polyclinic and CMF do not offer ophthalmological services and do not maintain a copy of such records. It became necessary for the elderly woman to travel 21 kilometers to the polyclinic where she had her initial evaluation. Transportation, particularly for the elderly in rural environments, is very challenging since it often involves riding in the back of trucks where the passenger must remain standing and balance as best as possible. This particular elderly woman ambulated with the use of a cane and had the beginning of Parkinson's, which limits her transportation options. The woman had to wait until a relative who had access to a vehicle visited her so that she could be driven to the polyclinic. Upon arrival to the polyclinic, the woman was informed that records of previous exams were not kept and that she must have another examination. However, the equipment in the polyclinic was out of order and the staff did not know when it would be repaired. It was suggested that the woman travel an additional 49 kilometers to the nearest polyclinic where the examination may be completed. Eventually the woman decided to return home since she was aware that there would be no assurance that she would be seen. Later on that week, her relative transported her to the polyclinic that could complete the examination. This polyclinic was approximately 70 kilometers away from her home. When the woman arrived at the polyclinic, the staff informed her that she would not be able to have the exam performed on that particular day. Even so, she would be examined by an eye surgeon who would provide a prescription for the examination. As the woman waited for her turn to see the specialist, she spoke with the other patients who were also waiting to be seen by physicians. Through conversation, it became apparent that it was not unusual for patients to wait five hours or more to see the specialist (especially if the specialist had a reputation of being an excellent surgeon). When the elderly woman

was finally called to be seen by the surgeon, she entered a room with six other patients who had also been waiting. There was no privacy in the room; the doctor and multiple patients were present as the woman offered her medical history and was examined by the surgeon. The physician assured the elderly woman that she was indeed a good candidate for surgery, but that it was first necessary for the ophthalmological to be completed. Unfortunately, the woman had to wait until the equipment was in working order.

This ethnographic account supports another recurring theme in the interviews. When asked how long the average wait-period is in a polyclinic or hospital, 89.29% stated that they wait over 3 hours before seeing the health professional. The political tendency towards Health Diplomacy is one factor that can explain long wait periods in hospitals and polyclinics in spite of the high doctor-patient ratio.

Access to emergency transportation and care is likewise not as meticulously delivered nor made accessible to women universally. In Cuba, the SIUM (Servicios Intensivos de Urgencia Médica, intensive urgent medical services) is the equivalent of an ambulatory service. When an individual needs urgent ambulatory care (cases of strokes, heart attacks, major accidents, etcetera), the SIUM transports the individual to an emergency room. However, 15.48% of the women interviewed stated that in the case of an emergency, they do not make use of the SIUM but of the "other" option. "Other" included the following: personal car, flagging down drivers on highways or roads, a friend/neighbor's vehicle, a military vehicle (respondent's son is in the military), "whatever you find", street car, bus, or a polyclinic's car (if the individual had already arrived at the polyclinic and needed to be transferred from the polyclinic to the hospital). For women in rural areas particularly, the SIUM has been known to never arrive or to be severely delayed in the transportation process, especially if called at an odd hour (such as nighttime). Therefore, although everyone can have access to emergency care, logistically the SIUM is not made readily available to everyone, especially to women from rural areas.

Similarly, the current health system demonstrates a need for improvement concerning the availability of non-prescription and over-the-counter products. In the field, 71.43% of the women interviewed stated that they had easy access to prescription medications. However, this number essentially flips when asked if women had access to non-prescription medications. For instance, 75% of the women interviewed stated that they do not have easy access to non-prescription medication or over-the-counter products. Examples include the following: band-aids, feminine care products, non-prescription pain medications (Advil, Tylenol, Aspirin, or any other equivalent), medications for hemorrhoids, diabetes test strips (and in some cases insulin), and antacids.<sup>7</sup> Subsequently, many interviewed women identified that the doctors in Cuba are excellent because they know “how to do so much, how to truly help a person heal, with very few devices and medications” (including prescription and non-prescription products).

At first glance, lack of access to such medical products could be explained by a lack of access to pharmacies. However, 92.86% of the women stated that they have a pharmacy within walking distance. When further attempting to explain the lack of access to such products, many of the women I spoke to stated it is a negative consequence of the embargo. Several women explained that because of the embargo, it is difficult to find goods since pharmacies are simply poorly stocked. Even so, some claimed that medications or products from China and Brazil are more readily obtained since these countries share political and economic ties with Cuba.

Lastly, though no one personally pays for healthcare in Cuba, fine lines to such a statement exist. For instance, 100% of the women interviewed stated that they do not pay their doctor nor do they pay to be admitted nor seen in health centers (chiefly hospitals, Hogares Maternos, polyclinics, mental health institutions, Grandparent Nurseries, the CMF). These women also stated that they generally do not pay for very expensive treatments that are administered in these health facilities. However, these women are expected to pay for medications (prescription med-

ications purchased in pharmacies) and over-the-counter products (such as feminine care products and toothpaste). Some women also stated that their orthodontic work is not included in the healthcare and must be paid for out of pocket.<sup>8</sup> Generally the healthcare costs are assumed by the state, but the state prioritizes equal, financial access to more expensive forms of medication in comparison to minor ones.

Cuba’s healthcare policies and the resulting healthcare systems prove distinctive primarily because of the uniform and meticulous delivery of medical care regardless of financial, racial, or gender bias. The fulcrum of the state’s health policy is to uphold the promise of protecting a person’s health as a human right, especially for women during pregnancy. This fundamental promise of healthcare access to the best of the state’s abilities has accelerated life-expectancy to an impressive 76 years of age (Randal). Even so, a lack of access to emergency transport, long wait periods in medical facilities (notably hospitals and polyclinics), and the scarcity of more minor medications and medical products are significant setbacks. As geopolitical relationships between the United States of America and Cuba become more open, crucial changes to healthcare systems and health resources will be inevitable (notably changes in the access of non-prescription products, of specialized care, and even of ambulatory care). With these changes, ethnographic studies will grow increasingly more important so that the voices of the Cuban people can be recorded and amplified—so that a conversation can occur between two forces that have been opposing each other for nearly half a century. Through ethnography combined with qualitative interviewing, conversations about health in Cuba will become people-centered, truly Cuba-centered, so that successes of the system can be voiced in tandem with the areas for improvement. Such a centering will hopefully promote peaceful dialogue between the two countries on the accounts of healthcare, but also on more difficult topics such as politics. With time and true understanding, the dialogue has potential to mature into a mutualistic relationship in which Cuban medical

<sup>8</sup> However, costs for teeth pulling are assumed by the state.

<sup>7</sup> This list is not exhaustive.

needs can be met through the United States of America, and even vice-versa.

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