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A Rights-Based Analysis of Reproductive Health in Cuba

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UNIVERSITY OF MIAMI

A RIGHTS-BASED ANALYSIS OF REPRODUCTIVE HEALTH IN CUBA

By

Rachel Libby

A THESIS

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Master of Arts

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A thesis submitted in partial fulfillment of
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A RIGHTS-BASED ANALYSIS OF REPRODUCTIVE HEALTH IN CUBA

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Despite tremendous growth in health and human rights literature over the past two decades, discussion on relationship between the two disciplines has remained noticeably absent from academic work on general health and medicine in Cuba. This thesis intends to demonstrate the value of a health and human rights approach in presenting a balanced analysis of reproductive health in Cuba. Ethnographic information collected over two trips to Cuba, interviews, and extensive literature reviews are systematically analyzed through the Jonathan Mann's health and human rights framework. The resulting conclusion is that a rights-based analysis of healthcare in Cuba can lend greater understanding to the healthcare system and how it relates to the complex political and social themes of present-day Cuba.

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Chapter One: Introduction

The American historian Pauline Maier wrote that the most important facet of a declaration is that it “rests less in law than in the minds and hearts of the people and its meaning changes as new groups and new causes claim its mantle” (qtd in Gruskin, et al. 69). This has certainly proved true for the Universal Declaration of Human Rights, whose language has been adopted by groups as diverse and contradictory as progressive reproductive rights groups and traditional religious lobbies (Morgan, “Claiming”). In fact, human rights rhetoric has expanded from its traditional, legal connotations and been incorporated into nearly all disciplines, including medicine and public health.

The relatively new marriage of health and human rights language has revolutionized the approach to global health and development. It is the theoretical foundation of the right-to-health movement, massive campaigns by international organizations and governments to improve primary care and prevention, and more recently, the development of diagonal development models aimed at improving not only health outcomes, but also their social determinants (Gatti 57). The health and human rights framework, developed by the late Dr. Jonathan Mann, has been widely applied throughout medical and public health literature and celebrated for its conceptual and practical applicability. However, there is one area of health literature where the human rights framework is noticeably absent: works on general health and the primary care system in Cuba.¹

¹ Human rights perspectives have been included in the discussion of Cuba’s response to the HIV/AIDS epidemic, see Tim Anderson, “HIV/AIDS in Cuba: A Rights-Based Analysis,” *Health and Human Rights*, 11.1 (2009) and Nancy Scheper-Hughes, “AIDS, Public Health, and Human Rights in Cuba,” *Lancet*, 342.8877 (1993): 965-7.

There is no shortage of writing on health in Cuba. In fact, their system of community-based primary care has been lauded in many publications for its ability to produce health outcomes out of proportion for such an economically disadvantaged country. However, the introduction of human rights language into a discussion on Cuba is inherently problematic. The authoritarian Cuban government is frequently cited by international watchdogs for its poor human rights record, which includes violations of the freedoms of free speech and press, privacy, peaceful assembly or association, religion, and movement, as well as its harsh treatment of political prisoners, severe restrictions on workers rights, and lack of self-determination and political participation. These well-known human rights violations make the introduction of human rights language into healthcare analysis in Cuba a politically charged approach and have traditionally discouraged the use of Mann's framework in the discussion of health in Cuba.

The general purpose of this investigation is to demonstrate the value of a human rights approach to studying health in Cuba, while the specific objective is to use this framework to understand the interplay between reproductive health and human rights in the Cuban context. My own image of the Cuban healthcare system, developed from ethnographic experience, first-hand interviews, and extensive literature review, leads me to believe that the absence from this approach in literature on healthcare in Cuba has had a detrimental effect on our knowledge of the subject. A majority of the academic works on the Cuban health system are more or less dictations of the revolution, while the rest are negative political or social commentaries. Only a small handful of authors acknowledge more than one perspective on the Cuban system, leaving the information available on health in Cuba overwhelmingly polarized.

There are many reasons for this distortion of the Cuban health system within academic literature. It is partly a consequence of the difficulties of completing research in Cuba, which restricts academic freedoms and limits available information, leading many researchers to weigh too heavily the information collected directly and indirectly from the state. It is also the result of the fact that the Cuban revolutionary experience is ongoing and that many who write on it admit a sincere emotional connection to the country and the system or seek to argue their viewpoints instead of presenting the system rationally. This reason is particularly pervasive in Miami, the city with the largest Cuban Diaspora, where I have been fortunate to develop this analysis.

The value of systematically applying the basic health and human rights framework to health or a subset of health in Cuba is that it forces us to look at all sides of the Cuban health delivery system and to present it in an even manner. It provides a methodical way to examine the success and failures of the system and explore the many ways in which health and human rights interact under an authoritarian regime. Even more importantly, it brings Cuba's healthcare system into the global health and human rights movement, which could have important, and largely positive, consequences for Cuba and all countries seeking to improve their health system.

Chapter Two: Definitions, Theory, and Literature Review

Historically health and human rights have been viewed as distinct disciplines, but in recent years the language of “health and human rights” has become increasingly popular. Globalization has brought forward the reality of genocides, natural disasters, the HIV/AIDS pandemic, and other complex emergencies, demonstrating the urgent need for a new and innovative approach to global problems. In response, a growing number of international leaders and scholars are championing the integration of the concepts of health and human rights, citing the usefulness of a combined perspective in addressing these complex challenges. The conceptual and practical applications of this integrated approach are quickly transforming health and human rights into one of the preeminent frameworks for international development. In fact, the last two decades have witnessed an explosion of health and human rights efforts, including the founding of the advocacy group Physicians for Human Rights, the scholastic François-Xavier Bagnoud Center for Health and Human Rights, and even a widely-distributed publication, titled *Health and Human Rights: An International Journal*, devoted solely to the promotion and application of health and human rights as a unified and essential perspective.

Understanding the health and human rights rhetoric requires a fundamental knowledge of both health and human rights disciplines, as well as the many ways in which the two interact. Health, while inherently meaning different things to different people and groups, is most frequently defined by its description in the preamble of the World Health Organization’s charter as “a complete state of physical, mental, and social well-being and not merely the absence of disease or infirmity.” This definition has been crucial in establishing a place for health in the social sphere and promoting the

importance of interdisciplinary methods in addressing health issues. It is also important to note that health inherently encompasses the different and complementary fields of medicine and public health, which traditionally deal with the health of individual and populations, respectively. The inclusion of both these fields into the definition of health becomes increasingly important in the context of human rights (Mann, et al. 9). The modern definition of health has additionally been influenced by the 1978 Alma Ata declaration, which reaffirmed the WHO definition, expanded the emphasis on primary care and prevention, and set a goal of achieving “Health for All by the Year 2000.” Although the international community failed in this goal, Alma Ata represents an urgent call to the world for equity in health care services, specifically the availability and accessibility of primary care, maternal and child health programs, infectious disease control, and family planning (Gruskin, et al. 25).

Human rights are most easily defined as those rights articulated in the International Bill of Rights, which is the informal name of the collection of declarations, covenants, and protocols on the subject. The rights listed and explained in these documents share a few basic features that are essential in truly understanding human rights and their application. Human rights are universally and equally applied to all humans and are intended to protect the individual from infringements on humanity by other individuals, organizations, or governments (Mann, et al. 22).

The backbone of the International Bill of Rights is the Universal Declaration of Human Rights (UDHR), which was accepted by the United Nations General Assembly in 1948, the same year that the World Health Organizations charter, and thus the modern definition of health, went into force. The thirty articles that make up the UDHR were

written largely in response to the gross human rights abuses of the First and Second World Wars and were intended to be, according to the document's preamble, "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family as the foundation of freedom, justice, and peace in the world" (Marks 1).

The most elemental feature of the UDHR is that it is not a legally binding document, but a moral foundation for the development of international laws. The document serves as a template of principles so fundamental to the ideas of humanity and dignity that they are relevant in all realms, including those future challenges we do not yet understand or anticipate. As such, numerous covenants and protocols have interpreted and built upon the principled outline of the UDHR, including the Covenant on Economic, Social, and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR), both of which adopted by the United Nations General Assembly on December 16th, 1966 (Marks 4).

Unlike the UDHR, the ICESCR and ICCPR are binding legal documents for those parties present to the covenants. The ICESCR is also far more generous than the UDHR in its inclusion of health-specific rights. For these reasons, the ICESCR is one of the mostly highly cited documents in the health and human rights debate. It blatantly states "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and further provides direction in the areas of healthcare that are fundamental to the human rights arena, especially maternal and child health, environmental health, and infectious disease control (Marks 7).

The International Covenant on Civil and Political Rights (ICCPR) discusses health-specific rights as well, although not as explicitly as the ICESCR. It states that “no one shall be subjected without his free consent to medical or scientific experimentation,” and later that “no one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice” (Marks 16). Thus, it forms a human rights basis for informed consent and freedom of choice in medical decisions. The ICCPR is also important in that it established a Human Rights Committee now known as the Office for the High Commissioner for Human Rights (OHCHR), which along with the new United Nations Human Rights Council is responsible for overseeing compliance with the International Bill of Rights (17).

Numerous other covenants, treaties, protocols, constitutions, and laws have impacted the current understanding of human rights. Most relevant to the health and human rights dialogue and this analysis is the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), signed in 1979 and popularly known as the Women’s Convention. This document is the basis for many of the health and human rights issues centered on women, including maternal and child health, reproductive health, and gender violence, which are all at the forefront of the health and human rights debates (Marks 81). Article 12 of the convention plainly names family planning as a fundamental human right, a controversial move aimed at empowering women and going against a long-standing tradition of faith-based approaches to health development (215). Additionally, the population conventions of the 1990s, often referred to by the names of the cities they took place, Beijing and Cairo, are important documents in the context of

this health and human rights analysis as they also specifically address issues of reproductive health and family planning.

While the intrinsic relationship between health and human rights may appear obvious upon review of literature, the two spheres operated relatively independently until the early 1980s. Political and civic rights dominated the human rights language and, in light of tremendous technology improvements, health had largely been examined from a biomedical perspective independent of social, economic, or political determinants. Jonathan Mann, a Harvard educated physician and former director of the WHO's Global AIDS Program, was the first to urge the international development community that health and human rights are completely and inextricably linked. His 1987 WHO Global Response to AIDS strategy was the first time health and human rights were named explicitly in a public health policy (Gruskin, et al. 4). He argued for the rights of people living with HIV/AIDS, who at the time had been marginalized, mistreated, and discriminated against as a result of their diagnosis. At first, his work focused on holding governments and international policy makers accountable for violating the rights of HIV/AIDS patients, but his work later transitioned into criticizing the human rights violations that lead individuals into contracting the HIV in the first place, including a lack of education, shelter, water, food, and civil liberties (Mann, et al. 4).

Eventually Mann resigned from his WHO post in protest of international HIV/AIDS policy, but the revolution had already started. The HIV/AIDS pandemic became the catalyst for the modern health and human rights movement and Jonathan Mann became its unofficial patriarch (Gruskin, et al. 1-2). In the inaugural issue of the *Health and Human Rights: An International Journal* he published an article by the same

name, outlining a framework that has become the fundamental basis for analysis of health and human rights within numerous contexts. His framework consists of three basic assumptions on the relationships between health and human rights. The first is that health policies, programs, and practices impact human rights, specifically in the public health arena where human rights abuses have traditionally occurred. The second is that the violation of human rights impacts health, which includes not only the obvious and direct health impacts of blatant rights abuses like torture, but also the less apparent impacts of violations in the provision of basic positive rights, such as sanitation and shelter. The third relationship, and arguably the most important, reinforces the duality of the two disciplines and the idea that the two should be “equal partners in the belief that the world can change” (Gruskin, et al. i). These three relationships have traditionally been presented in this order, but for the purposes of this analysis the order of the first two relationships will be inverted in an effort to more efficiently present health and human rights in the Cuban system.

The first dynamic that will be explored in this analysis is the impact and influence of human rights on health. Although Mann and other health and human rights scholars are quick to reference the obvious and direct health consequences of human rights abuses such as torture or unjust imprisonment, this relationship actually has far more complex manifestations. This relationship encompasses some of the more subtle human rights abuses and their impact on health, namely violations of positive or prescribed rights, commonly known as entitlements (Mann, et al. 15). Support for these types of rights have catapulted the health and human rights movement into the mainstream as big names in international development have championed their causes. In fact, it is likely this

perspective that has accounted for most of the growth of health and human rights discourse over the last three decades.

One of the big names in the “right to health” debate is physician-anthropologist Paul Farmer, who rose to mainstream fame after his biography hit the bestseller lists. In his book *Pathologies of Power: Health, Human Rights, and the New War on the Poor* he asks a simple question: “If access to healthcare is considered a human right, who is considered human enough to have the right?” (231). In asking this question he attempts to highlight the injustices he has witnessed working in Haiti’s Central Plateau, Russia’s Prisons, Peru’s Slums, and Mexico’s Chiapas; injustices that arose from violations of both positive human rights, specifically a lack of clean water, quality food, sanitation, shelter, and additional negative rights, including social abuse, political exclusion, economic marginalization, and religious, cultural, and racial discrimination. He writes that these factors convene to form significant structural violence, which while not violent in the traditional, physical sense, denies individuals of the most basic human rights to life and dignity. Furthermore, he argues that while human rights are universal, structural violence is not (Farmer 231).

Dr. Solomon R. Benatar, the Rhodesian researcher and chair of the Department of Medicine at the University of Capetown, has written extensively on structural violence from a developing world perspective. He groups these injustices as a form of “sophisticated exploitation,” arguing that the days of slavery and colonialism have been replaced by cultural imperialism and economic manipulation (298). The influence of market-driven medicine in countries leading global development consistently shifts the rhetoric surrounding healthcare away from the human rights arena. He argues that any

improvement in healthcare delivery in the developing world would require a return to these basic principles of humanity and service in medicine and public health. A human rights perspective, grounded in the universality of entitlements and freedoms, has the potential to bring about this return and correct the imbalances and structural obstacles that prevent the majority of the world's people from attaining health (299).

While the majority of attention has been concentrated on the developing world, it is important to remember that inequality and structural violence are not isolated phenomena. Poverty, lack of access to basic services, and cultural hurdles impact health in the world's most advanced countries. *Deadly Deliveries*, an Amnesty International report published in 2010, highlights the injustices that poor and minority women in the USA face while trying to receive effective pre and post-natal care. The report sites that nearly one half of the of the maternal deaths in the United States could be prevented by improving access to healthcare and reducing discrimination and other forms of structural violence. *Deadly Deliveries* further points out that the United States has signed four separate international human rights treaties, and as a party to these treaties, has an obligation to ensure and protect the rights of its citizens (3). Recent reports commissioned by the European Union have shown similar human rights deficits, including an increase in inequality of mortality between those from different socio-economic groups, and made similar calls for the improvement of basic services (Mackenbach 3).

Perhaps no one has better articulated the impact of human rights on health, in both the developed and developing worlds, as Nobel Laureate Amartya Sen. In his landmark work *Development as Freedom*, Sen calls the aspects of structural violence

“unfreedoms,” which are rooted in both inadequate processes and inadequate opportunities, and persist in all societies. The processes and opportunities incorporate both infringements on classic freedoms as well as on entitlements that together counteract not only the well being of a population, but also the development of entire nations (Sen 17). He argues that freedoms, ranging from political liberty to economic opportunity, are what facilitate self-determination and enable an individual to pursue his or her best health, individually and through advocacy, program development, and participation in the policy drafting process (17). He also argues that political and civil liberties, like all freedoms, are the very foundation for improving the human condition and that participation and empowerment in spheres ranging from politics to health is crucial to making sustainable improvements (15).

In light of the ever-increasing awareness of the plight of the world’s most marginalized citizens and the growing inequalities within the developed world, the major growth in the health and human rights dialogue has been centered on structural violence and unfreedoms, and their impact on an individual’s ability to pursue the highest attainable standard of health. Consequently, we have witnessed a much-needed improvement in health promotion. The challenge lies in the fact that incredible increases in health promotion: expansion of healthcare services, proliferation of health technologies, and increased number of stakeholders does not necessarily ensure health protection: maintenance of quality in healthcare, culturally appropriate solutions, and avoidance of human rights abuses. This dichotomy is illustrated in the second relationship explored in Mann’s framework, the impact of health on human rights.

Unfortunately, there are all too many examples of health policies, systems, and practices that have been the source of human rights violations. Moreover, they have not enjoyed the same international publicity or impetus as the right to health movement. Many of these abuses have been subtle, such as the failure of international development groups to provide culturally appropriate solutions. With a growing number of migrants and the increased exportation of health services, it is important to ensure that the application of western medicine does not conflict with the religious and cultural beliefs of a society. Certainly, every individual deserves healthcare that is from a professional who understands, or at the very least respects, their belief system.

Others human rights violations are more obvious and result directly and overtly from health practices and research, such as alleged forced abortions in China, forced sterilizations in the United States, and lack of informed consent in research studies worldwide. Even more outrageous is the reported rate of medical professionals' complicity and participation in torture and the cruel and degrading treatment of prisoners. In fact, between one third and one half of modern torture survivors report having a physician supervising their abuse, monitoring their vitals signs, and advising when it is appropriate to increase or modify torture tactics (Miles).

Medical and public health ethics are incorporated into this relationship within the health and human rights framework to demonstrate the professional efforts made to avoid abuses of human rights by health care practices and practitioners. Health ethics are complex and philosophical principles based in the belief of medicine and public health as fiduciary fields, patient autonomy, beneficence, and non-maleficence. Their purpose is to ensure that a patients rights and interests remain the utmost important facet of healthcare

delivery (McCullough 5). Consequently, health ethics are an integral component of health's impact on human rights.

This relationship is particularly relevant to the field of public health, which inherently walks the fine line between restricting and violating human rights in the name of the greater good. Governments and public health practitioners were berated for their human rights abuses during the initial stages of the HIV/AIDS pandemic, when infected individuals were forced from their homes into mandatory quarantine and publicly degraded as homosexuals or drug users. However, studies have shown that the subsequent human rights enforcement made it nearly impossible to control the HIV/AIDS outbreak, specifically in Africa, leading to the massive proliferation of the disease (Freeman 378). This tricky relationship between public health and individual rights has been examined widely in the health and human rights debate. The challenge in adapting this perspective is finding the happy medium in the ability to protect against unjust violations of individual or collective rights in the implementation of effective public health policies.

The third, and arguably most important, relationship in Mann's framework is the symbiotic nature of health and human rights and the necessity to promote both simultaneously in development efforts. While this point seems straightforward after an explanation of the different ways health and human rights impact one another, few states and development actors have embraced it in its entirety. Health promotion is still overwhelming focused on biomedical interventions. Even those who have adopted the "wealth-health" model of health promotion, which argues that economic well-being is an essential prerequisite of good health, often fail to provide meaningful economic solutions.

Their work is complicated by the narrow definition of poverty (relative poverty is largely ignored in favor of abject poverty) and the exclusion of the mental and social aspects of health (Mann, et al. 16). Furthermore, because health provides the ability and human rights provides the forum for individuals to voice their opinions, this third relationship also incorporates the importance of enfranchising individuals in their own health decisions.

Once the necessity of a mutually exclusive health and human rights framework has been established, the question of who is responsible for promoting and protecting health and human rights is invariably raised. Proponents in the right to health movement, most of whom are healthcare professionals, are quick to quote the famous German physician Rudolph Virchow, “doctors are the natural attorneys of the poor” (qtd in Farmer 85). Healthcare providers also most frequently have the research, education, and field experience necessary to support a health and human rights approach (Mann, et al.18). It is thus fitting that they are on the forefront of this movement, although it is important to not let the full burden fall on them. Governments, too, have an obligation to protect their citizens and (to paraphrase Hubert Humphrey) take care of their most vulnerable, including the children, elderly, sick, handicapped, and those living in poverty. Of course, drug companies, insurance giants, aid groups, development organizations, and other stakeholders all have a responsibility to promote health and protect human rights. In fact, we all play a part in protecting and promoting our own health and human rights. As such, this framework extends the burden of development past developing countries and medical professionals, making it a collective responsibility and one that should be embraced by academics studying health in all contexts.

Chapter Three: Reproductive Health and Human Rights in Cuba

Methodology

This work is an analysis of health and human rights in Cuba, using reproductive health to narrow the scope of the discussion and provide clear, focused examples of how incorporating the human rights framework in the Cuban system can change our analysis. It is not intended to be position paper on controversial family planning issues or a political commentary on health in Cuba. It is instead meant as a systematic analysis of what Cuba is and isn't doing to ensure human rights and the highest attainable standard of care for women and mothers.

This analysis focuses on Cuba for many reasons, but primarily because the human rights approach is noticeably absent from works on general health in Cuba. This is particularly surprising considering that Cuba is unique among developing countries in its ability to provide its citizens with free, comprehensive healthcare. While Cuba does not release official economic information, experts estimate that Cuba's per capita GDP is roughly \$5,000, which would place Cuba in the same income bracket as Peru, Surinam, and the Dominican Republic. Estimates that do not include remittances are even lower, placing Cuba's income in sharp juxtaposition to the U.S. and other developed countries, which have GDP per capita measures topping \$29,000 (McGuire and Frankel 84). However, Cuba demographic indicators, such as life expectancy, literacy, and health outcomes are consistently in line with these wealthier countries. For example, Cuba's infant mortality rate from 2005 to 2010 was 5.1 deaths per 1,000 live births, which is lower than the infant mortality rate in the United States for that same time period (6.3 deaths per 1,000 live births) and substantially lower than infant mortality rates in

countries with comparable economic indicators (“World” 86-89). Under-five mortality, life expectancy, and infectious disease prevalence are similarly low and more comparable to the United States and Western Europe than Cuba’s developing counterparts (Spiegel and Yassi 86). As Fidel Castro put it in one of his marathon speeches, “our health indicators are the best in Latin America, the best in the third world, and among the best in the world” (Smith and Padula 57).

Furthermore, Cuba’s healthcare system has been largely constructed by an authoritarian regime, a rarity in world history. A study on politics and health outcomes published by the British medical journal *Lancet* in 2006 found that authoritarian regimes are the least pro-redistributive of all government types and spend a minimal amount on health expenditures. Consequently, dictatorships were found to be the least likely to produce good overall health indicators of all forms of government examined. This proved especially true in the case of reproductive and women’s health (Navarro). Cuba’s authoritarian government is singular in its ability to produce good health outcomes, especially for women.

In addition to this unique co-existence of health with poverty and authoritarianism, this study focuses on Cuba because I felt compelled to study the country based on my own experiences. In his most recent work on health and human rights Paul Farmer wrote that, “the inclusion of personal experiences is meant to demonstrate how reality has shaped my perspective on health and human rights” (219). Similarly, how I present reproductive health in Cuba has been shaped extensively by my own experiences as a student in Cuba, as these were crucial to my development as a scholar and as a proponent of the health and human rights movement. Additionally, the writing process

has been cathartic in that it allowed me to reconcile my mixed feelings on healthcare in Cuba by systematically exploring the facts from a human rights perspective. It has allowed me to come to a conclusion, albeit not a simple one, on the moral implications of the Cuban system.

I specifically choose to further narrow the focus of analysis to reproductive health for a few reasons. The biggest reason is because Cuba, too, focuses on reproductive health, with a hugely disproportionate amount of its health budget going towards programs to promote it. The health and human rights literature also focuses on reproductive health, as it is often the source for some of the biggest human rights abuses. Additionally, I choose to focus on reproductive health because of the broad range of health and rights it encompasses. The Fourth World Conference on Women (commonly referred to as “Beijing” for the city in which it took place) is one of the UN meetings mentioned previously as crucial to the articulation of health and human rights. It defined reproductive health in the following way:

“[Reproductive health is] the constellation of methods, techniques, and services that contributes to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health...the human rights of women include their right to have control over decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence.”

Because reproductive health, by definition, includes general health of women, sexual health, family planning, and maternal health, it provides an array of health areas to apply a human rights perspective.

Importantly, reproductive health also includes the concept of maternal mortality. Maternal mortality provides an interesting forum for the discussion of reproductive health

in Cuba. Globally, it is considered to be the one health indicator least impacted by overall improvements in health systems or the social determinants of health (sanitation, water, food, shelter, education, political participation, etc.), because, in the developing world, maternal deaths are generally caused by biomedical factors like hemorrhage, infection, obstructed labor, and eclampsia, all of which require professional medical intervention. This is not to say that social and economic determinants do not play an important role, but simply that once minimum living standards are met it is widely acknowledged the best way to further impact maternal mortality is by making skilled birth attendants, medicine, and supplies available (Reichenbach and Roseman 97). Cuba has credited the majority of its health successes to improving the social determinants of health and has also implemented the necessary medical interventions, yet the maternal mortality rate remains stubbornly high compared to Cuba's other health indices. It has become the most misunderstood indicator in Cuba and, consequently, the one most likely to reveal the strengths and weaknesses of Cuba's healthcare system from a human rights perspective.

The research methodology for this analysis is a blend of ethnographic observations, informal, in-person interviews, and an extensive literature review. The ethnographic observations and majority of informal interviews took place on two separate visits to Cuba. The first visit, which took place in the summer of 2008, was part of a three-month study abroad program focused on language acquisition and educational exchange. It was this visit that first peaked my curiosity about the Cuban health system because of the surprising popularity of healthcare as a conversation topic among Cubans and an accidental first-hand exposure to the reality of the Cuban medical system. The second visit was to attend the annual Global Forum for Health Research held in Havana

from Nov 16-20th, 2009. This visit provided a forum for direct exchange with Cuban health professionals and allowed me to reconnect with many of the citizens I had talked to on my first trip.

My experience doing research in Cuba closely mirrors the experience which Katherine Hirschfeld's outlines in her popular ethnographic work on health in Cuba. She points out that a combination of fear and extensive bureaucracy make the solicitation of formal interviews in Cuba futile and that she was able to elicit far more information in informal dialogue with Cubans outside their official capacity. She also includes a chapter on how her personal exposure to Cuban hospitals as a result of a bout of dengue provided her significant insight and drastically altered her views. Similarly, the information I collected on my first visit to Cuba was entirely ethnographic and fragmented, resulting from informal chats with Cuban friends (many of whom were either trained as physicians, but currently working in the informal sector, or students in medical school) and listening while they talked to one another. I also spent a day in a Cuban hospital not typically seen by foreigners with a friend who was emergently transported there after we were involved in a bus accident. The hospital was far different from the Cuban hospitals I had read about in the United States and I was struck by not only by the incredible lack of supplies and lackluster facility, but also by the compassion and demeanor of the physicians and nurses who were treating their patients even under these difficult circumstances. This exposure, in combination with many informal conversations, significantly altered my perspective on the Cuban health system.

My second visit, where I was part of a university delegation attending an international conference, proved to be a very different experience. I had many more

official exchanges with Cuban officials, mostly through question and answer sessions mediated by moderators of the Global Forum. The information I received from these exchanges was shallow and scripted, the kind of information expected from Cuban health officials that were hand-selected by the Cuban government to attend the forum. The site visits to a Cuban *policlínica* and the international medical school, *Escuela Latinoamericana de la Medicina*, were equally scripted and far different than the impromptu hospital exposure I had over a year earlier. The most valuable part of the second visit from a research perspective was that it provided a chance to reconnect with the Cubans I had met on the first visit and candidly discuss the issues being raised at the conference.

After my first few visits to Cuba, I traveled to Nicaragua, Panama, and Haiti on university-sanctioned trips and was able to speak with Cuban-trained physicians completing service and the patients they were working with. I was also fortunate to have extensive contact with Dr. Rodolfo Stusser, an influential Cuban cardiologist now residing in Miami, who spoke openly with me, filling in the blanks of my ethnographic information and playing devil's advocate to many of the official testimonies I had gotten during the Global Forum. The sum of these exposures, coupled with an extensive literature review, has shaped the way the Cuban health system is portrayed in this analysis.

The information is presented through Jonathan Mann's health and human rights framework, using his first two relationships to illustrate the dichotomy of human rights in the Cuban healthcare model. The third relationship, the mutual exclusivity of health and human rights, facilitates an analysis of the two concepts in revolutionary Cuba and

verifies the importance of applying a human rights framework to health even in politically challenging environments where human rights rhetoric has been previously omitted.

The First Relationship: The Impact of Human Rights on Reproductive Health in Cuba

The official stance of the Cuban Ministry of Public Health (MINSAP by its Spanish acronym) is that health is a human right and that the responsibility for providing the conditions for health is that of the government (Ministerio de Salud Pública). No other developing nation has made such a vocal and proactive commitment to the health ideals espoused by international organizations, including the millennium development goals, Alma Ata's "Health for All by the year 2000" campaign, and additional WHO and UNICEF initiatives (Feinsilver 25). Furthermore, none have done so with as much lip service to the holistic definition of health that includes both mental and social well being in addition to the absence of physical illness. As a result, the revolutionary government in Cuba has set forth healthcare policy that is lauded by international health professionals as a salient example of health equity (Susser). In Cuba, the right to health is promoted as the moral success of the revolution and remains a major source of pride for Cubans living on the island.

It is first important to put the origins of the Cuban healthcare system in context because it was not built entirely by the revolutionary government. Contrary to official state histories, there is ample evidence that pre-revolutionary Cuba enjoyed a relatively high standard of health, with the lowest infant mortality rate in Latin America, about 39 deaths per 1,000 live births, and a life expectancy of 65.4 years (McGuire and Frankel 84,

Sixto 338). In fact, Cuba had an even higher percent decline in infant and maternal mortality in the 50 years prior to the revolution than in the 52 years of the revolution, leading some to argue that Cuba current health indicators are partly a result of the progress made from 1900-1959.

Pre-revolutionary Cuba was also home to many important medical and public health advances, including the discovery of the type of mosquito that spread yellow fever by Dr. Carlos J. Finlay and the development of the first angiogram by Dr. Agustín Castellanos. In fact, Cuba had four different doctors nominated for the Nobel Prize in Medicine before 1959. Unlike its Caribbean neighbors, Cuba also had a well-respected medical school and a network of technologically advanced hospitals, including a small number of maternal hospitals known as “la ONDI,” or *Organización Nacional de Dispensarios Infantiles* (Hirschfeld, “Health” 189). Havana even boasted a maternal hospital for homeless women as early as the nineteenth century (Smith and Padula 58).

Despite these achievements, Cuba’s health system had some notable drawbacks, most of which are notably comparable to the health system in the United States. Public services were often substandard and failed to meet the needs of the poor even with the assistance of church-run free clinics. Quality medical care was isolated to fee-for-service hospitals concentrated in Havana and Santiago and there were vast disparities in care between urban and rural citizens, as well as between white Cubans and Afro-Cubans (Hirschfeld, “Health” 196).

After the revolution Cuba’s healthcare system evolved into a decentralized, vertically integrated tier system focused on primary care and illness prevention (Ministerio de Salud Pública). The number of doctors has grown tremendously since the

early years of the revolution, from 3,000 to nearly 71,000 doctors, with the number of women in medicine increasing from six to 48% (Smith and Padula 57). Overall, Cuba has more doctors per capita than any other country (Sixto 326, 327). Contrary to before the revolution, when nearly two thirds of physicians practiced in urban areas, the Rural Health Program of 1960 and the Family Doctor Program of 1984 have spread physicians relatively evenly throughout the country, expanding care equally to rural and inner-city citizens (327). Additionally, all Cuban doctors are required to complete a three-year general medicine residency or service in a designated community or abroad before they are permitted to pursue a specialty (Mason, Strung, and Beder 30).

Most of these residencies are completed with a *Consultorio* or Family Doctor, which is the first tier of care in the Cuban system. *Consultorios* are actually nurse/doctor teams that live in the neighborhoods they serve (often in their own clinics) and provide primary care (Mason, Strung, and Beder 29). Family doctors are required to see every one of their patients at least twice a year, regardless of their health status, and must be available for consultation 24 hours a day. When individuals cannot or choose not to make it to the *consultorio*, the family doctor is expected to make home visits. In addition to providing basic examinations, procedures, and medicine, these primary care teams can also provide psychiatric counseling, health promotion programs, sex education, nutrition counseling, and exercise programs (Cooper, et al. 27). These Family Doctor teams are one of the truly remarkable parts of the revolutionary Cuba's health structure. They foster the development of trust and personal relationships between patients and their doctors; a concept that has been largely lost in for-profit medicine and continually impresses American observers (Whiteford and Branch 51).

When further medical care is needed a patient is referred by his or her *consultorio* to one of more than 400 *policlínicas*, most of which are housed in old private practices or *casas de socorro* that were nationalized by the revolutionary government. *Policlínicas* are community-based clinics that provide more focused services, including specialty consultations and outpatient surgeries (Mason, Strung, and Beder 21). They employ teams of providers, including physicians, nurses, and psychologists, as well as public health experts and social workers to address underlying health issues. A single *policlínica* officially serves as the referral center for six or seven family doctors (although in practice it is many more) as well as a community health-training center for Cuban medical residents and a forum for health education and prevention programs (Spiegel and Yassi 99).

The third, or tertiary, level of care is the hospital system. There are over 200 hospitals in Cuba, including many specialized facilities in pediatrics, oncology, and psychiatry, housed mainly in commercial buildings that were seized by the revolution. Nearly all of these hospitals are teaching hospitals, training students from Cuba's impressive matrix of medical schools. However, it is widely acknowledged that the hospital system in Cuba is double-sided, with separate facilities for communist party leaders, high-ranking military, diplomats, and tourists, affectionately known as *yumas*. These hospitals are similar to what is seen in the developed world, with well-maintained facilities and fewer supply shortages than other Cuban hospitals. In fact, these Cuban hospitals host a profitable medical tourism industry, with an estimated 20,000 medical tourists visiting over the course of one year for both elective and non-elective surgeries (Cooper, et al. 274).

Completely integrated into this health system is the *Programa nacional de atención materno-infantil* or Cuba's Maternal and Child Health Program (known by its Spanish acronym PAMI). PAMI receives more funding and attention than any other government healthcare initiative (Cooper, et al. 819). It is blueprint for maternal and child health based on the idea of providing a continuum of care from the beginning of pregnancy through the early years of a child's life. It works in tandem with programs in sex education and family planning to help ensure the highest attainable standard of reproductive health and give women the knowledge and resources to choose if, and when, they become pregnant (Swanson). As one Cuban official writes, "We fervently defend the right and choice of all women to be mothers, of all men to be fathers, but we energetically refuse to echo the 'pro-life' campaign...in the capitalist world" (Smith and Padula 69).

Unlike other developing countries, Cuba has officially abandoned the use of midwives, although many were retrained as obstetric nurses and still practice in rural areas (Cooper, et al. 272). Instead of relying on midwifery, Cuba focuses on incorporating women into the formal healthcare system early in their pregnancy, with an estimated 90% seeing a doctor in their first trimester (Sixto 336). Pregnant women are assigned to one of over 300 maternal homes across the country, which provide nutritional supplements, prenatal vitamins, counseling, and education. The centers also serve to connect them to the maternal clinics and hospitals that will be providing their care during their pregnancy (Mason, Strung, and Beder 300). An average Cuban mother receives 12 check-ups during her pregnancy, a number that not only exceeds the minimum amount recommended by PAHO, but has even been called "excessive" by obstetricians in the

United States (Sixto 335, Whiteford and Branch 53). However, Cuban health officials stand by this practice, arguing that home visits which makeup some of the pre-natal appointments provide the physician with insight into the health of the family and future environment for the baby (Whiteford and Branch 53). Furthermore, virtually 100% of Cuban women give birth inside a hospital, many of which are maternal hospitals with specially trained providers and specific equipment to handle the complications of labor and birth (Sixto 330).

The reproductive health program expands past maternal health to include sexual health. MINSAP believes that sex is a necessary, natural, and positive experience, with potentially negative consequences, and structures their sexual education accordingly. Family doctors, who bear the primary responsibility for sex education, start talking about sexual health early, some report as soon as grade school. Once girls reach adolescence (defined by MINSAP as 10 to 20 years of age) they can participate in *círculos de adolescentes*, which are forums organized by family doctors or *policlinicas* to address sexuality, contraception, and sexual health (Perez 152, 160). However, how often these discussions actually happen in practice is debatable and the family unit ultimately has the most influence of the sexual practices of Cuba's adolescents. Despite officials' efforts, many Cuban adolescents and even young adults remain relatively unknowledgeable on the health consequences of sexual intercourse or their contraceptive options.

Contraception in Cuba is available, but severely limited due to economic constraints. Hormonal contraception (including the Pill) is almost unheard of and condoms are not readily or consistently available. While official statistics show that the most frequently elected method of birth control is the intrauterine device (IUD), given the

early age of sexual activity and the only 40% prevalence of IUDs, the most common form of birth control in reality is likely abortion or menstrual regulation (Perez 165). Abortion, despite being vehemently opposed by Castro during the early years of the revolution, was legalized in 1965 due to the pleading of Ministry of Health officials worried about unsafe, illegal procedures (Smith and Padula 71,74). It has since become a mainstay of Cuban reproductive health. Cuba has one of the highest abortion rates in the world and these figures do not include menstrual regulation. Menstrual regulation, although a foreign procedure to most Americans, is a relatively common early-abortion technique in the developing world that involves suctioning out the uterine lining and newly implanted egg. The average Cuban woman undergoes the procedure three to four times, and many use it far more frequently (Perez 176). Similar statistics show the average Cuban woman has 2.3 traditional abortions in her lifetime (Bélanger and Flynn 21).

Another facet of the reproductive health programs and overall health system is community collaboration, which has allowed the health programs to be very responsive over the past 50 years of revolution, particularly during the difficult economic span of the “special period.” Community groups such as the *Comités de Defensa de la Revolución* (CDRs), the *Federación de Mujeres Cubanas* (FMC), *Federación de Estudiantes Cubanos* (FEC), as well as local communist party groups and workers unions all have a voice in the development of health policy and the delivery of health services in communities. Many have argued that this participation in the Cuban system is largely utilitarian; a necessary means to reach more people and keep costs down, instead of a strategy for true empowerment (Morgan, “Community” 221). Nevertheless, these groups serve as watchdogs within their communities to help make sure that no one slips through

the cracks, specifically encouraging women to enter the formal medical system very early in pregnancy. They also work with family doctors to alert them of potential health threats. Most importantly, community members have been known to serve as “public health armies” during a crisis. For example, during previous dengue outbreaks members of these groups worked together to scour their communities for mosquito breeding grounds like uncovered pails of water or flooded drains (Hirschfeld, “Health” 74).

In addition to the community based health programs and emphasis on maternal and child health, Cuban women of reproductive age have benefited significantly from the improvement of other programs, mainly education, housing, and food assistance. Education has long been recognized as a necessary factor for good reproductive health because it empowers women to make informed and assertive decisions regarding their sexual health. Revolutionary Cuba has overhauled their education system, making education compulsory through the secondary level and combining school with agricultural programs in rural areas in order to make it universally achievable. It has specifically focused on increasing the education levels of women and providing them vocational training (Guerrero-Borrego 76). To help with this the government also created child-care programs, allowing women the freedom to work or continue their education (Spiegel and Yassi 95).

Improved housing, which was redistributed following the revolution, has also contributed to greater health. The government significantly lowered rents and halted evictions, over time leading to an estimated 85% of Cubans adults being homeowners (Spiegel and Yassi 95). However, it is important to note that until November 2011 they were not homeowners in the American sense. Cuban “homeowners” did not have the

freedom to sell their home, except to the government at a fixed price. Anytime they wanted to move, they followed a system of *permutar*, locating someone who wanted their home and literally swapping places with them. Furthermore, urban Cubans often have to share their homes with other families or extended relatives, leading to crowded living conditions. It is not uncommon to see three or four generations living in crowded apartments in urban areas like Havana. Despite the obvious drawbacks of this system, Cuba has managed to create adequate housing and avoid the homelessness and shantytowns that have become indicative of the rest of Latin America.

Food assistance is another program that has benefited health. *Libretas* or ration-books are distributed to Cubans by the government and include monthly provisions of basic food stuffs, including eggs, sugar, rice, coffee, and milk for children and pregnant women. The *libretas* also include toiletry items, which help to promote basic hygiene. While these rations are in no way sufficient to sustain a person throughout the month and need to be supplemented with individual incomes and black market purchases, they have helped Cubans avoid the hunger and malnutrition associated with extreme poverty. Although government officials have recently started to question the economic feasibility of continuing this ration program, it is likely that it will continue, at the very least, to supplement the diets of expectant mothers and young children.

The provision of these entitlements is perhaps best examined by looking at Mann's first relationship: the influence of human rights on health. This perspective has led many to endorse the right to health movement and protection from unfreedoms and structural violence stemming from extreme poverty. Freedom from homelessness,

hunger, and ignorance, as well as access to basic services, do permit Cubans to pursue a level of physical health not achievable in other developing countries.

Reproductive health provides another dimension for examining human rights impact on health in Cuba. While the human rights and reproductive health debate in the wealthy world has been concentrated on the ethical implications of abortion, for disadvantaged women, whether in the developed or developing world, the reproductive health and human rights debate is focused on their right to choose if and when to have children and their safety during the process (Perez 129). In Cuba, the healthcare system is designed to ensure this right, at least in theory, to all Cuban women, regardless of age, race, or another factor of discrimination.

There is something to be said for the Cuban government's commitment to and support of reproductive health. It is the only developing country in the region that has formulated its healthcare system with the belief that health is both a human right and the responsibility of the government. The liberal application of these ideals has created a system that allows Cuban women to develop healthy sexual relations, safely reproduce, and reach the highest academic and professional levels, despite the poor economic and political state of their country. It has also helped Cuba achieve the lowest fertility rate in Latin America, which supports the idea that when people attain the necessary services to ensure a basic level of security they will likely choose to have fewer children (Guerrero-Borrego 73, Werner 22).

One of the most important, but least followed, directions in the ICESCR, which Cuba became party to in early 2008, is that a government must "take steps [to ensure rights]...to the maximum of its available resources" (Marks 7). To the extent that Cuba

appropriates significant resources towards providing health and social services to benefit the reproductive health of women, it has complied with the ICESCR perhaps more than any other country party to the covenant. Nearly 9% of Cuba's GDP is consumed by the health sector, which is twice the percentage of most developed countries. In fact, Cuba is often cited as the premier example of a country maximizing its meager resources in order to prevent human suffering (Garfield 2-3). This financial and political commitment to community-based, universal health programs aimed at providing women the tools they need to live healthy life-styles is an important result of the impact of the human rights rhetoric on health in Cuba and something that the rest of the world should strive towards.

The Second Relationship: The Impact of Reproductive Health on Human Rights in Cuba

The second relationship proposed by Mann is the impact of health on human rights and it helps to illustrate how the delivery of reproductive health services in Cuba has unfortunately been both the direct and indirect source of human rights abuses. These abuses range from incidents as overt as coerced or unconsented courses of treatment to the more subtle use of medicine as a form of social control. However, all of the following health practices represent significant violations in the most basic medical and public health ethics, as well as human rights principles.

The Cuban government is quick to recall its health indicators, namely infant mortality, which is actually lower than that of the United States. In an effort to maintain and improve these health outcomes, MINSAP, like most countries, publicly sets targets for maternal and infant deaths. However, unlike other countries Cuba does not treat these targets as goals, but rather as production quotas (Hirschfeld, "Health" 12). Physicians are

consistently pushed to meet these quotas, even at the expense of ethical patient care. As a result, there is significant anecdotal reporting of coerced or forced abortions and the emergence of an “abortion culture,” similar to what was experienced in the Soviet Union. It has become so pervasive that Cuban physicians have taken to calling it a “contraceptive consciousness” (Smith and Padula 73).

Under this culture the practice of abortion, both by menstrual regulation and traditional methods, has become so commonplace that many forget that it is a relatively significant, invasive procedure. Women are not counseled on the medical risks, nor do they receive any type of psychological counseling, despite the fact that anecdotal reporting indicates that complications (including infection, inflammation, discomfort, and even symptoms resulting from the fetal tissue being only partly removed) occur at normal rates (Hollenbach 104). In fact, patients do not even need parental permission, despite the fact that many of Cuba’s abortion patients are as young as 13 (Bélanger and Flynn 21). In the late 1980s, one patient came forward to the Cuban media, stating that the procedure she had been led to believe was minimal had caused her such psychological trauma that she was unable to resume a healthy sexual life (Smith and Padula 75). This sentiment was supported by a Cuban physician who likened the abortion procedures at the *policlínicas* to a “factory,” with lines of women nonchalantly waiting for their procedure. Another Cuban doctor echoed claiming, “[the population] doesn’t know about the morbidity associated with abortion.” One Cuban girl stated that her peers, “talk about [abortion] like it’s nothing, it’s like drinking a glass of water,” (Bélanger and Flynn 21).

There is also significant evidence for coerced abortions. In an effort to reach MINSAP quotas physicians are expected to terminate any pregnancy deemed “risky,”

with little regard for the mothers wishes. In a short article by Katherine Hirschfeld, she explains how she asked a Cuban doctor what would happen if any fetal abnormalities were noted on a woman's ultrasound and the doctor simply replied that the women would be expected to have an abortion "so as not to raise the infant mortality rate" ("Re-examining" 12). In addition to the pressure for abortions, there is also an "invisible pressure" for sterilizations, which are routinely performed on women who have had two children or are older than 35 (Stusser).

Another Cuban doctor I spoke with mirrored these concerns, saying that the state labeled doctors as "monsters" if they lost an infant, or more importantly a mother, and would subtly punish doctors by removing them from their neighborhoods and relocating them to less desirable areas (Stusser). The same doctor continued saying you could be "famous like Biscet" for being a bad doctor, referring to the famous dissident Dr. Oscar Elias Biscet who was imprisoned and barred from practicing medicine in Cuba for his vocal objections to the use of late term abortion methods.² Doctors are even routinely dismissed for what are considered "failures" by the MINSAP, including when pregnant women in their areas failed to achieve appropriate weight gain (Garfield 16). This treatment, which is alluded to by most Cuban-trained physicians, is especially harsh when you consider that most of these doctors are overwhelmed with patients and operating with very few supplies. This kind of state pressure has often prompted physicians to promote decisions in the best interest of the state and their own medical careers.

² Dr. Elías Biscet González and Rolando Muñoz Yyobre published "El Rivanol: un método para destruir la vida" through their human rights group the Lawton Foundation in 1998. Dr. Biscet was subsequently expelled from the Cuban National Health System and sentenced to 25 years in jail.

While abortions and sterilizations in Cuba are rarely done without “consent,” the meaning of consent in Cuba is different from the Western understanding. Cuban medical services are notorious for being paternalistic, authoritarian, and even militant, and anecdotal reporting demonstrates that pregnant women are often scolded or publicly berated for missing appointments or ultrasounds (Hirschfeld 175). Doctors are trained in the highest levels of discipline and obedience for superiors, and patients are expected to exhibit the same reverence. Numerous Cuban physicians and anthropologists have noted that women are often coerced into consenting to an abortion or sterilization based on the information presented by their doctors, who are actively trying to convince their patients to follow a specific course of treatment. Patients do not challenge their physicians, nor can they request a second opinion (Hirschfeld, “Re-examining” 12). And even though medical malpractice suits have become somewhat of a spectacle in the United States, their absence in Cuba has negative consequences. At the most fundamental level, medical malpractice suits are intended to protect patients and serve as a check on the health system, much as a justice system serves as a check on democracy. In the case a woman feels mistreated by a physician in Cuba, there is no formal recourse available to her.

Overall, Cuban women are often not given the chance to make an autonomous decision about their own health. One Cuban woman explained that her “cousin in Miami said that an American can look to his or her physician for an explanation of what is happening to them. He or she can sit with the doctor who will listen and explain to the best of their ability until the patient is satisfied with the explanation” (Crabb 177). This is especially troubling in light of a recent 1996 study that showed significant misinformation among Cuban gynecologists on appropriate contraceptive methods and

diagnosing Sexually Transmitted Infections in women (Smith and Padula 80). Despite potential misinformation, patients are expected to listen to the physician without question, even if they believe the physician is wrong or do not understand the reasoning behind their decisions. Furthermore, medical journals, foreign periodicals, the Internet, and second opinions are all restricted by the government, leaving women no choice but to submit to the advice of their physicians, whose judgment is often unjustly influenced by the state (Werner 29).

Other forms of human rights abuses stem from reproductive health practices in Cuba. The disproportionate amount of resources devoted to maternal health and child health has detrimental effects on other areas of the healthcare. Women who are not pregnant cannot enjoy the nutritional diet offered to expecting mothers, nor do they receive pre-conception care. In fact, one Cuban researcher has attributed the stubbornly high maternal mortality rate, which has remained at roughly 50 deaths per 100,000 live births since 1983, to the fact that too many resources are concentrated on expectant mothers and babies, but not to the health of adult women (Stusser). As a result, women of childbearing age are not healthy when they conceive; often suffering from conditions like chronic malnourishment or anemia. The Cuban maternal health program works to correct these defects by providing excellent care during gestation, creating an ideal intrauterine environment for the developing fetus, which is reflected in the low infant mortality rate. However, this nine-month stint of “artificial care” is not sufficient to compensate for a lifetime of deficiencies in the mother, which could be a significant contributor to the relatively high maternal mortality rate (Stusser).

The concentration of resources on programs that produce good maternal and infant mortality statistics also impacts the care offered to other Cubans on the island. The elderly, for example, are often denied expensive, life saving procedures. There is also a lack of attention towards public health issues like accidents and suicide (Stusser, Diaz-Briquetz 41). Men, too, suffer from the overemphasis on maternal and child health. In fact, during the “special period” of the early 1990s an estimated 50,000 men developed optical or peripheral neuropathy because nutritious foods were reserved for pregnant women and children (Cooper, et al. 820). Hospitals in Cuba are known for keeping a “sacred” stash of medicine available only to children under five, whose demographic information affects Cuba’s mortality statistics, leaving doctors to “play God” with those patients who are left; a sentiment that is lamented throughout the literature (Possehl). In particular, the elderly, those likely to die, and prostitutes are extremely likely to be denied medicines (Garfield 10). As such, the Cuban system denies some individuals the right to health based on age, gender, profession, and wellness.

Moreover, this lack of resources for use in healthcare delivery disproportionately affects Afro-Cubans, who have fewer relatives abroad and consequently fewer “dollars” (or convertible currency known as CUC) to supplement their care with supplies and services from Cuba’s extensive black market (Hirschfeld, “Health” 221). There is further anecdotal information that Afro-Cubans are discriminated against in the formal system as well, with physicians often expecting them to use acupuncture, herbal, or an alternative form of medication or sedation when nothing else is available.

What is an even bigger human rights violation is the fact that medical care in Cuba, whether it is for reproductive or any other kind of health, serves dual roles as a

service and a tool of political repression. “Authorities handle doctors as toys of the state,” expecting them not only to uphold the ideals of the revolution, but also to report on any of their patients that do not (Stusser, Werner). In fact, the patient-doctor confidentiality that is so healthy in the United States is virtually non-existent in Cuba. Many report not feeling comfortable disclosing all information and opinions to their physicians, who are often tightly in line with the revolution, even when that information is relevant to the state of their health (for example, the use of medication purchased from the black market) (Hirschfeld, “Re-examining” 11).

The Cuban government also seeks to perpetuate a kind of mysticism regarding the knowledge of medicine. Simple medical interventions (such as rehydration after mild diarrhea) in other countries are usually handled by nurses, community health workers, or taught directly to the people themselves. In Cuba, they are dealt with strictly by doctors. Citizens are instructed to seek professional care for even the most mundane medical issues, including minor cuts and burns, and first aid information is noticeably absent from health education materials. One physician explained that this was because they don’t want to teach anyone anything that might “lead them to put off getting adequate medical attention at once” (Werner 29). However, scholars have pointed out that it is likely another layer of centralized control on information aimed at making the masses dependent and subservient to the knowledge of a few (28).

Furthermore, while participation is theoretically encouraged in the development of health strategies, it is only done through organized political groups that are not empowered to make meaningful suggestions. International medical journals and other outside information is reviewed by only a select group of government officials and

doctors, and incorporated into the health system from the top-down. Citizens do not have access to information on health that could lead them to form an opinion different than the one of their physician. For example, babies are separated from the mothers for an extended period immediately after birth for monitoring purposes, even though there is extensive evidence that physical contact between the mother and the baby can improve both of their health and be important in bonding. When questioned, women's groups involved in the health policy making process were unaware of this research and unquestionably yielded to the physician's judgment, assuming that they always know best (Werner 29). Accordingly, the participation of citizens groups in Cuba's health system is not for the purpose of providing the best possible care or even care that reflects the desires of the population it serves. It is a façade of *poder popular* that more likely is meant to ensure that no doctor strays from revolutionary ideals and that all interventions are in line with strict public health policy.

The welfare policies aimed at improving health and quality of life have also had negative impact on human rights. Education, while free, helps the government to restrict free speech and monitor students, while simultaneously promoting a revolutionary agenda. Even the daycare centers that are so popular among working Cuban women serve to indoctrinate political ideals. It is a common story in Cuba that preschool-age children are told to go home and ask God for candy, only to return to daycare the next day and receive nothing. They are then told to go home and ask Fidel for candy, and when they return the next day, are given sweets by the daycare staff.

The housing reorganization plan developed by the government, while helping to avoid the urban shantytowns indicative of the rest of Latin America, lacks plans to

renovate decaying homes or improve rapidly deteriorating infrastructure. Other public services, such as trash collection and water treatment are similarly failing. As a result, Cubans are actually seeing an increase in illnesses caused by poor sanitation and living conditions (Hirschfeld, "Health" 220). Tuberculosis, for example, has increased from 5.5 cases per 100,000 people to 15.3 cases per 100,000 due to crowded living conditions (Garfield 14). There have also been outbreaks of pestilential diseases like leptospirosis in urban areas due to an increasing number of rats (Faria 184).

Human rights abuses in the Cuban healthcare system stem from the fact that the government has a hand in nearly every aspect of healthcare delivery. The virtual suspension of certain, important medical ethics, like patient autonomy, doctor-patient confidentiality, and informed consent leads to a type of healthcare that is, by its very nature, "intensely dehumanizing" (Hirschfeld, "Re-examining" 9). This is especially true for men and the elderly, who are excluded from medical and public health efforts intended for women and children (Garfield and Santana 19). Additionally, the manipulation of the healthcare system to further the political ideals of Cuban leadership and suppress the Cuban populous is a serious departure from how medicine was intended.

Even though reproductive health services have empowered women by giving them the resources necessary to achieve a physical state of good reproductive health that is necessary for their upward mobility in society, the same services also subjugate women by impacting their mental and social health, stifling other freedoms, and forcing women to become reliant on the state. In these ways the Cuban healthcare system is both the source and support for numerous human rights abuses happening in Cuba.

The Third Relationship: The Reciprocity of Reproductive Health and Human Rights in Cuba

Although scholars have been shy to use human rights language in their analysis of health in Cuba, the first two relationships in Mann's framework demonstrate that the two disciplines are inextricably linked even under Cuba's unique authoritarian system of governance. In Cuba, human rights have had a tremendous impact on the design and delivery of health services, which have been formulated on the basis that health is a right of every individual and the responsibility of the state. Health, too, has influenced human rights in Cuba, contributing to and supporting human rights violations of the Cuban dictatorship. Looking at health and human rights through the two opposing lenses of Mann's framework allows us to see that reproductive healthcare in Cuba both empowers and hinders women's ability to achieve the highest possible state of reproductive health.

The vast majority of literature on health in Cuba does not reflect this dichotomy of the healthcare delivery system. Instead, even the scholarly literature largely serves as political propaganda from one side or the other. Many academics and professionals who have visited Cuba are quick to adopt the ideas presented to them by the state as a "native's point of view," when in reality the image set forth by an authoritarian government rarely matches the lived experience of its citizens (Hirschfeld, "Health" 234). On the other hand, conservative political opponents of Cuba frequently use the injustices the healthcare delivery system to criticize the Cuban government without recognizing the system's merits. This polarization of Cuba in the literature extends past the field of health to nearly all issues including economics, food security, and cultural expression. While studying in Cuba in the summer of 2008, I came to the realization that the Cuban reality is not as bad as they say it is in Miami, nor is it as good as they say it is in Havana. It is in

a difficult-to-define limbo between the two realities. David Werner best explained it 1979 when he wrote that he “came away from Cuba both deeply impressed and deeply disturbed” (35).

When I asked a good friend from Santa Clara, Cuba, what he thought about this he explained what impressed him about his healthcare system, “If we get sick, we can go to the doctor and get medicine, it might not be the best medicine or a brand name, but it’s medicine, and it works, and we are lucky, you guys can’t always do that.” He is right. The incredible extension of comprehensive health services in Cuba has led to a population who’s physical health needs are almost entirely met, which is in sharp juxtaposition to its Caribbean neighbors and countries with similar economic indicators. Unlike the people of Haiti or Bolivia, Cubans do not die from easily preventable or treatable diseases, chronic illnesses do not go unmanaged, and accidents or disabilities do not signal the end of a person’s productivity. A Cuban child is born with a chance of morbidity and a life expectancy that is the same as a child born in the wealthiest countries in the world, and has an even better chance to pursue education. Cubans are truly given the opportunity to achieve a standard of physical health that is unmatched in the rest of the developing world. The government’s commitment to health should be recognized, applauded, and emulated.

However, as one Cuban scholar writes, “nothing in Cuba is as it first appears” and we must be careful to also recognize the limitations of the Cuban system (Whiteford and Branch 1). Although the government provides impressive entitlements, they systematically deny their citizens some of the most basic and fundamental rights, including the freedoms of expression, speech, and movement. They also restrict cultural,

economic, and religious rights, creating a unique and subtle system of state-sponsored structural violence.

It was commonly said by Russians during the height of the Soviet Union that, “the violence of our system will never be seen by tourist or a visitor” (Mestrovic, Gorenta, and Letica 112). This is largely true for Cuba as well. Cubans suffer quietly from the unfreedoms perpetuated by their government. They have the physical health necessary to pursue their goals, but they do not have the requisite political, economic, social or academic freedom. I am always reminded of a close friend of mine in Cuba, who trained as a physician and practiced psychiatry. Despite her love for the profession, she had to stop working as a doctor so that she could make enough money to support her two children. She now makes a living cleaning up after tourists in a *casa particular*, which is similar to a bed-and-breakfast. Another Cuban doctor explained to me that the government tried to force him back into veterinary school after he had completed his medical education despite his protests. In Cuba, the ability to do what you want simply does not translate into the feasibility of doing what you want, largely because of economic and social unfreedoms.

The violation of rights are particularly disheartening in the context of Cuba’s stated holistic approach to health. As explained earlier, few countries have attempted to approach healthcare with the same commitment to the WHO definition that includes physical, mental, and social well-being. Yet violations of freedoms and other human rights abuses have serious, detrimental effects on the mental and social health of Cubans, which is evidenced by the suicide rate in Cuba, which according to the World Health Organization is one of the world’s highest, especially among young women.

The fact remains that while human beings are equal, we are not the same and “the thirst for a unique, autonomous identity and self-reliance is as basic to man as his need for air and food” (Werner 35). By systematically denying Cubans the freedoms needed to pursue their own individuality, the government has prohibited them from achieving the highest levels of mental and social well-being. No amount of lip service to holistic definition of health changes the fact that being “healthy” in Cuba means only the “absence of disease or infirmity.”

Chapter Four: Conclusion

In looking at the third relationship in Mann's framework, it seems intuitive to draw a conclusion about the state of reproductive health and human rights in Cuba and the previous examination of the merits and drawbacks of the Cuban system certainly provides the necessary insight to do so. However, in the process of trying to come to a conclusion authors are too often led into the trap of attempting to compare, and even rank, the social injustices of Cuba against those of other societies. This trap is evident in much of the literature on health in Cuba, which often ignores human rights abuses of the system simply because it provides good care or ignores the good care provided by the system simply because there are human rights abuses. Scholars who write on health in Cuba overwhelmingly try to position the system as better or worse than those around it and the desperate situation of Latin America's poorest citizens only contribute to this practice. For scholars with exposure to both worlds, it is difficult not to think that the economic oppression experienced by a rural woman in Haiti is greater than the political oppression experienced by a woman in Cuba. However, a human rights approach to analyzing health rightfully does not leave room for opinions on the varying severity of different injustices. The health and human rights framework serves as a reminder that all human rights abuses are equally heinous and it therefore allows us to examine health systems from an unbiased, moral high ground, based on the fundamental definitions of health and human rights set forward in international legal documents.

As such, the conclusion that can be drawn on how the Cuban health system addresses reproductive health based on analysis through the health and human rights framework is simply a reiteration of the strengths and weaknesses of the system. It is not

as simple as the conclusions drawn in the polarized academic literature, which usually advocate for or against the Cuban model. Instead, healthcare in Cuba demonstrates the interesting dichotomy between what Cuba is doing right and what it is not. The revolutionary government's commitment to health is a return to medicine's most humble origins as a compassionate service, a novel idea in a time when the concept of taking care of one another is lost on most health systems. The practice of health as a human right and responsibility of the government should be recognized and emulated, not rebuked for political reasons. By the same token, it is important to acknowledge the right to health cannot be guaranteed at the expense of other human rights. The fact that reproductive healthcare in Cuba, despite its ability to produce and maintain impressive indicators, has been achieved at the expense of the liberty of the Cuban people is unacceptable and inevitably harmful to health itself. This must be acknowledged in tandem with the successes of health policy in Cuba.

This is the value in the health and human rights approach. It provides a methodical way to critique the Cuban health system without being negative or judgmental. No other theoretical framework forces authors to look at the issues through two very different lenses in order to provide more complete picture of health. Ironically, the politically charged language of human rights actually takes politics out of the analysis of health in countries with difficult political atmospheres.

Moreover, the application of the health and human rights framework to the Cuban system brings Cuba into the international health and human rights debate. This is important because the Cuban example is truly unique and provides many lessons relevant to the health and human rights movement. It serves as proof that health quality and health

equity are possible despite economic constraints and that political will goes a long way towards fostering health. It also cautions governments and development actors against losing ethical considerations in the process of health promotion and violating rights in the name of the greater good. All of these are extremely valuable lessons as global health moves to the forefront of the international agenda and many developing and developed countries struggle to improve their health outcomes.

This analysis is also valuable to Cuba itself, which is likely on the brink a new political era. Recent economic restructuring and even small political concessions announced at the April 2011 Party Congress indicate that the political climate of Cuba is starting to change. Over the next decade, the introduction of presidential term limits will end half a century of Castro rule and likely usher in a younger generation of Cuban politicians with their own plans for the Cuban revolution. As the island transitions into this next phase of Cuban politics, and perhaps into eventual democracy, the human rights analysis of Cuban healthcare will be useful to the Cuban people who will for the first time be deciding the future of their own healthcare system.

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