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(RE)IMAGINING CUBAN MEDICAL INTERNATIONALISM: INDIVIDUALS, POWER RELATIONS, AND *MAIS MÉDICOS*

Porto Alegre
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Dissertação submetida ao Programa de Pós-Graduação em Estudos Estratégicos Internacionais da Faculdade de Ciências Econômicas da UFRGS, como requisito parcial para obtenção do título de Mestre em Estudos Estratégicos Internacionais.

Orientador: Prof. Dr. André Luiz Reis da Silva

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To Marilin, Oviedo,
Lilli, and JeanCarlos

And to all of the women of Cuba and Brazil

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Not everyone at the bottom rung has a zinc roof; some only have thatched. Not everyone at the bottom carries equal weight when the decision is made whether to use a condom in bed at night. Yet none of these distinctions is of a potency that can be decisive in determining flows of weapons trade, patterns of investment, rules for inter-state peace.

Thank goodness, then, for the anthropologist. Let them listen to the laundry lyrics, let *them* meticulously chart those mind-boggling kinship patterns and the distribution of zinc roofs. They can afford to be open to the sort of populist values imported by socialists and feminists. None of them has to shoulder the heavy responsibility of finding economical explanations for the workings of entire international systems.

To study the powerful is not autocratic. It is simply reasonable.

Really?"

-Cynthia Enloe

"Tengo los lagos, tengo los ríos
Tengo mis dientes pa cuando me sonrío
La nieve que maquilla mis montañas
Tengo el sol que me seca y la lluvia que me baña
Un desierto embriagado con bellos de un trago de pulque
Para cantar con los coyotes, todo lo que necesito
Tengo mis pulmones respirando azul clarito
La altura que sofoca
Soy las muelas de mi boca mascando coca
El otoño con sus hojas desmalladas
Los versos escritos bajo la noche estrellada
Una viña repleta de uvas
Un cañaveral bajo el sol en Cuba"

-Calle 13

RESUMO

O internacionalismo médico cubano é um termo que está na literatura acadêmica desde a década de 1960, e que se refere a programas de assistência médica no exterior, conduzidos pelo governo cubano. Esses programas vão desde auxílio após desastres naturais de curto prazo, até projetos de assistência médica intensiva de longo prazo. Dois dos exemplos mais conhecidos desses esforços de cooperação são o programa 'Barrio Adentro', na Venezuela, e o programa 'Mais Médicos', no Brasil. No entanto, a maioria das abordagens acadêmicas sobre o internacionalismo médico cubano concentram-se em seu efeito sobre macro-indicadores de saúde, como taxas de vacinação, mortalidade infantil etc. – ou em sua utilidade como instrumento da política externa cubana e de *soft power*. Nesta dissertação, leva-se o nível de análise ao nível local e interpessoal para entender como esses programas de cooperação médica afetam a vida cotidiana dos médicos cubanos, e as comunidades em que eles trabalham. Argumenta-se que o internacionalismo médico cubano tem diversas alterações, dependendo do país ou lugar, e que a introdução do capital financeiro alterou muito seus resultados nos últimos anos. Além disso, analisa-se raça e gênero e as maneiras pelas quais eles complicam nossa compreensão da cooperação Sul-Sul. No geral, sustenta-se que a cooperação Sul-Sul pode apresentar desequilíbrios de poder que lembram àqueles que afligem as relações Norte-Sul, e que esses programas apresentam efeitos diferenciados para o *agency* das médicas cubanas, dependendo de numerosas variáveis. Finalmente, este estudo examina os vários discursos políticos que se constituíram em torno dos médicos cubanos, e do programa Mais Médicos especificamente, empregando uma perspectiva foucaultiana. Os resultados e conclusões baseiam-se em 30 entrevistas semi-estruturadas realizadas com médicos cubanos que trabalham tanto no programa Mais Médicos, como em outros países; bem como médicos e políticos brasileiros.

Palavras-chave: Internacionalismo médico cubano. Mais Médicos. Cooperação Sul-Sul. Gênero. Discurso. Brasil. Cuba.

ABSTRACT

Cuban medical internationalism is a term that has been in the academic literature since the 1960s, and refers to foreign medical assistance programs, conducted by the Cuban government. These programs range from short-term natural disaster relief to longer-term intensive medical assistance projects. Two of the best-known examples of these cooperation efforts are *Barrio Adentro* in Venezuela and the *Mais Médicos* program in Brazil. Yet, most academic approaches to Cuban medical internationalism have focused on its effects on macro-health indicators, such as vaccination rates, infant mortality, etc. – or on its utility as a tool of Cuban foreign policy and soft power. In this dissertation, we bring our level of analysis down to the local and inter-personal level to understand how these medical cooperation programs affect the daily lives of individual Cuban doctors, and the communities in which they work. We argue that Cuban medical internationalism varies greatly depending on place, and that the introduction of financial capital has greatly altered its outcomes in recent years. Furthermore, we analyze race and gender, and the ways in which they complicate our understanding of South-South cooperation. Overall, we contend that South-South cooperation can present power imbalances that resemble those which plague North-South relations, and that these programs present nuanced effects for the agency of female Cuban doctors, depending on numerous variables. Finally, this study examines the various discourses that were constituted around Cuban doctors, and the *Mais Médicos* program in Brazil specifically, by employing a Foucauldian perspective. Results and claims are based on 30 semi-structured interviews conducted with Cuban doctors working both in *Mais Médicos*, and in other countries; as well as Brazilian doctors and politicians.

Keywords: Cuban medical internationalism. Mais Médicos. South-South cooperation. Gender. Discourse. Brazil. Cuba.

LIST OF ABBREVIATIONS

CREMERS	Rio Grande do Sul Regional Medical Council (*Conselho Regional de Medicina do Estado do Rio Grande do Sul*)
FMC	Federation of Cuban Women (*Federación de Mujeres Cubanas)*
GDP	Gross Domestic Product
IR	International Relations
PT	Worker's Party (*Partido dos Trabalhadores*)
SSC	South-South Cooperation
SUS	Unified Health System (*Sistema Único de Saúde*)
US	United States

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1 INTRODUCTION

Since coming to power in 1959, the Cuban revolutionary government set out to create an impressive domestic healthcare system with tremendous results in terms of public health indicators. Life expectancy in Cuba is currently about 77 years for men and 81 years for women, which is considerably higher than in other developing countries (UN, 2016, p. 90). Childhood mortality in Cuba is around 4,3 deaths per 1.000 births, which is lower than in the United States (US), around 6 per 1.000 births (UN, 2016, p. 436-7). Cuba also has a surplus of doctors, considering it has more doctors than Canada, which has a population three times that of the Caribbean island country (KIRK; KIRK; WALKER, 2015, p. 5). Internationally, Cuba has translated its comparative advantage in the medical field into soft power by carrying out countless disaster relief operations as well as long-term medical missions throughout the Global South (BUSTAMANTE; SWEIG, 2008). In 2016, for example, the Caribbean country earned about $8.2b from its 25.000 doctors, 30.000 nurses, and other medical professionals working abroad in 67 countries, $500m from Brazil alone (WATERS, 2017). In 2018, Cuba brought in an estimated $11b from its healthcare workers abroad, making it a larger source of revenue than the country's tourism industry, and a considerable amount of money for a country whose total Gross Domestic Product (GDP) is estimated to be below $90b per year (NUGENT, 2018).

Cuban medical internationalism, as these exchanges are typically called, is not new and the academic literature is ripe with in-depth studies of these programs and how they affect public health indicators, such as infant mortality, vaccination rates, disease infection rates, and so forth (see KIRK, 2015; KIRK; KIRK; WALKER, 2015; BROUWER, 2011; KIRK; ERISMAN, 2009; FEINSILVER, 2008a, 2008b; and others). These scholars have focused on the Marxist ideological foundations to Cuban medical internationalism, stemming from Che Guevarra, as well as the resulting legitimacy and soft power it brings to Cuban foreign policy (BUSTAMANTE; SWEIG 2008; FEINSILVER, 1989). Soft power that the Cuban government then translates into help from other global actors against the US embargo, as well as a continued presence in South-South affairs and international political discussions.

The first Cuban international medical mission occurred in 1960, when an earthquake devastated Chile (FEINSILVER, 2010, p. 87), and has since evolved into a long-stranding tradition of assistance, ranging from disaster relief to longer-term missions around the entire world. For example, between 2001-2 Cuban doctors and epidemiologists coordinated a campaign that brought together both Cuban and local healthcare workers in Haiti and

vaccinated around 800.000 children (KIRK; ERISMAN, 2009, p. 4). Cuba has also helped establish medical schools in numerous countries such as Yemen in 1976, Ethiopia in 1984, Ghana in 1991, and Guinea Bissau in 2004, to name a few (KIRK; ERISMAN, 2009, p. 5). Cuba's record of worldwide action and involvement in medical care delivery, as both practice and discourse, is impressive, to put it mildly.

These facts and ideas present well the nuances which this dissertation seeks to address, as it attempts to understand Cuban medical internationalism in a more profound manner. In other words, going beyond their impact on local public health statistics, and beyond the discourse of disinterested humanitarian goodwill, how can we comprehend the impact of Cuban doctors on the lives of individuals, both in Cuba and in the countries where they go to work abroad? Likewise, how can factors such as gender, geopolitics, and racialized narratives be read and analyzed within this context? And finally, how does participation in these medical missions affect the lives of the Cuban doctors themselves, considering they spend on average two-year periods working in other countries?

Turning towards Brazil specifically, in July of 2013, what would amount to over 11.400 Cuban doctors began arriving in Brazil to work within the *Mais Médicos* program. The program, which literally translates as "More Doctors", seeks to eliminate disparities in access to public healthcare between Brazil's urban and rural areas by placing doctors in underserved communities, as well as increase care in urban peripheral and economically disadvantaged spaces (see MAZETTO, 2018; JENNINGS, 2015). This is a monumental challenge for a country of over 200 million people, and which on average has only 1,8 doctors per 1.000 inhabitants[1] (GARCIA; ROSA; TAVARES, 2014, p. 27). To meet this demand, the Dilma Rousseff government decided to include foreign doctors in the program, who would be assigned to these underserved areas for two-year periods. Participation in the program though was open to all Brazilian doctors, even those who graduated from foreign medical universities. The inclusion of Cuban doctors in the *Mais Médicos* program was negotiated through the Pan-American Health Organization, whereby both countries agreed on the pay structure and rules governing the exchange. The doctors were paid a salary of about R$ 10.513,00 a month[2], of which the Cuban government kept the majority[3]; while also receiving

[1] This is considerably lower than the number of doctors in neighboring Argentina and Uruguay, which are at 3,2 and 3,7 doctors per 1.000 inhabitants, respectively; and also well below the United Kingdom average of 2,7 doctors per 1.000 inhabitants (GARCIA; ROSA; TAVARES, 2014, p. 27).

[2] R$ 10,513.00 in 2014 was about USD $2,841.35 considering the exchange rate at that time was about USD $ 1 to R$ 3.70.

[3] The rules governing the pay of these Cuban doctors were altered during the first year or so of the *Mais Médicos* program, so they could keep a larger share of their salary, as a result of public outcry in Brazil.

added bonuses, such as a housing stipend from their municipal host government, which varied between R$ 1.500,00 and R$ 3.000,00 per month (VILLEN, 2018, p. 224).

The Brazilian constitution of 1988 guarantees every citizen access to doctors and healthcare free of charge, which resulted in the creation of the Unified Health System (*Sistema Único de Saúde*), or SUS, to meet this constitutional obligation. SUS is based on the principle of healthcare as, "a citizens right and the state's duty" (PAIM et al., 2011, p. 1778). This vast public network of healthcare delivery services spans all of Brazil, ranging from local small clinics to larger more specialized and expansive hospitals. SUS, despite being the primary means of healthcare access for a large portion of the Brazilian population, is still subject to the same overall social inequalities that plague the South American country. Many analysts, in fact, describe SUS as underfunded, resulting in long waits and underserved areas[4] (PAIM et al, 2011). Specifically, the country has a shortage of public doctors in rural area, because most doctors tend to work in larger metropolitan regions and are concentrated in the Southeastern region (PÓVOA; ANDRADE, 2006). This trend creates a regional shortage of doctors throughout the country, for instance the Brazilian Northeast has about 27,6% of the country's population but only about 17,8% of the country's doctors (SCHEFFER et al., 2018, p. 44). Conversely, the Southeast has about 41,9% of the country's population, but is home to about 54,1% of the country's doctors (SCHEFFER et al., 2018, p. 44).

Mais Médicos, overall, initially brought 12.165 foreign doctors to work in Brazil, of which the largest contribution came from Cuba, at 11.452 doctors (see VILLEN, 2018, p. 225). Other countries contributed fewer doctors proportionally, such as Argentina (145 doctors), Bolivia (72 doctors), Spain (54 doctors), and so forth (VILLEN, 2018, p. 225). Of the 12.165 total doctors, the majority, 6.974 were women, compared to 5.191 men, and the same type of demographic holds for Cuban doctors, where 6.676 of the original participants were women, in comparison to 4.776 men (VILLEN, 2018, p. 225). Considering that the majority of these "more doctors" were, in fact, women it is crucial that we analyze and understand the experiences and outcomes (both intended and unintended) of this medical exchange program through a feminist and gendered prism. As these numbers also reveal Cuban doctors comprised the bulk of *Mais Médicos* participants with smaller contributions from other Global South countries, such as Venezuela, Haiti, and Paraguay; as well as

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Cuba, for its part, justified keeping the majority of their salary as a means to improve the income of doctors back in Cuba, and invest in the island's own healthcare system, and training of future medical professionals.

[4] As a result many Brazilians have turned towards private insurance plans, for instance in 2008, 26% of Brazilians had private healthcare coverage. Curiously though, 61.5% of healthcare companies and 65.5% of contracts are held in the Southeast region of Brazil, the country's wealthiest (PAIM et al., 2011, p. 1786).

participants from European states, for instance: Portugal, Germany, and Italy. Hence, why this dissertation focuses its attention on investigating *Mais Médicos* through a Cuba-Brazil, Cuban(s)-Brazilian(s) nexus in other to enrich our understanding of Cuban medical internationalism in the 21st century, and contribute towards our knowledge of current Global South political processes.

This brief discussion raises the question where did so many Cuban doctors come from? And how did Cuba gain this comparative international advantage in the training and professionalizing of healthcare workers? As Kirk and Erisman (2009) explain, before the Cuban revolution, most doctors were trained in a style very similar to doctors in the US and tended to concentrate around Havana, which greatly facilitated their ability to immigrate to the US after the revolution and continue their medical practice (2009, p. 27). In fact, about half of the country's 6,000 doctors, and most of the island's medical school professors left during or shortly after the revolution (KIRK; ERISMAN, 2009, p. 32). The early revolutionary government focused considerable attention on improving this situation by recruiting students who were close to graduation and having them instruct those who had recently entered medical school. Likewise, medical school training became free, but graduates were then required to spend a year working in a rural area (KIRK; EIRSMAN, 2009, p. 32). Across time, this broke doctor's reluctance to work in rural areas, and created a new identity and posture for Cuban doctors that would result in a rupture with market-driven considerations until the end of the Cold War (BROTHERTON, 2012). During the 1960s, as historian Antoni Kapcia (2008, p. 55-6) argues, the revolutionary government spent sizable time and effort in both rebuilding and improving the country's healthcare system, and this eventually paid off during the 1970s when these professionals took over health services. By 1982, infant mortality on the Caribbean island had fallen to first world levels, at 17,7 per 1.000 (KAPCIA, 2008, p. 56). A shifting discourse in medical practice that the Cuban state then exported through its international solidarity brigades and missions (BUSTAMANTE; SWEIG, 2008).

From this review of historical facts one can also see why the *Mais Médicos* program caused such a negative public outcry within Brazilian civil society as Brazilian doctors, media groups, and right-wing demonstrators took to the streets and airways to denounce the program as a possible government take over of healthcare (see BECKER, 2017). Some right-wing politicians and leaders also feared Cuban doctors could act as foreign intelligence officials and undermine Brazil's national sovereignty and security in the run-up to the 2014 presidential election. Brazilian doctors, specifically, saw *Mais Médicos* as an attack on their

livelihoods and as a government attempt to silence any possible dissent among their ranks. Some Brazilian doctors even argue that despite the government's promise to send the majority of the *Mais Médicos* doctors to underserved areas – most ended up in larger metropolitan regions.

The Dilma Rousseff government, in part, justified the program along those very lines, stating that foreign doctors would only go where Brazilian doctors did not want to work – mainly in rural parts of the country; the peripheral impoverished zones of major cities; and throughout the country's most underdeveloped regions, mainly the North and Northeast. *Mais Médicos* doctors were, however, well spread out throughout the country and came into contact with many different types of patients, and experienced the country's diverse cultural and economic spheres. These conflicting discourses between the state, in the form of the Worker's Party (PT) government, and Brazil's medical class, as well as their political ramifications, will be further examined in chapter 6. According to the Pan-American Health Organization, for instance, *Mais Médicos* doctors treated around 63 million Brazilian patients, across over 4.000 different municipalities and 34 indigenous districts, during the programs first two years alone (MAZETTO, 2018, p. 48; OPS/OMS, 2015). To put this into perspective, at the time of the program's establishment in 2013 there were an estimated 701 municipalities in Brazil without any public healthcare doctors, a disparity that *Mais Médicos* helped to reduce (OPS/OMS, 2015).

Mais Médicos is thus one more chapter in the extensive and historic trajectory of Cuban medical internationalism to which one can add numerous missions to Chile, Algeria, Venezuela, and other countries since the 1960s, as well as extensive aid to Angola during its civil war, as described earlier. Yet, Cuban doctors were not well-received in Brazil as fellow Global South or thirdworldist brothers and sisters helping decrease the nation's public health inequalities – instead they were met at airports with chants of "Slave" and by having bananas thrown at them (WATTS, 2013). Many Brazilians also expressed a panic concerning the threat these possible Cuban "agents" could bring to Brazilian democracy. This was also a return, in a way, to protests within Brazil in the years leading up to the 1964 military coup, where right-wing protestors used "Cuba" as an example of a communist threat and possibility to be avoided. For these reasons, the arrival of Cuban doctors in Brazil caused an impassioned social debate about their possible political roles and qualifications as medical professionals. Meanwhile, many in Brazil's peripheral and underprivileged areas welcomed the Cuban doctors, along with their medical care and expertise.

For point of case, let us reflect on what a local healthcare official, Thomas,[5] who supervised numerous Cuban doctors within the *Mais Médicos* program shared during his interview:

> Interviewer: What are some of the differences you remember between Cuban and Brazilian Doctors?
> Thomas: Well one thing I remember is the favor that a Cuban female doctor asked for because in her clinic office there was an ultrasound machine with which to examine pregnant patients. And that Cuban doctor, she arrived on one day and on the next [day] she went to examine a pregnant patient, and she asked that we remove that equipment, saying she was not used to it, and that she preferred a smaller piece of equipment that cost like 10-15 *reais*, and not that ultrasound machine which cost like 1.000 *reais*. But that made a big difference because with the smaller equipment she could be closer to the patients, for her that built a bond as she was closer to the patient than with the more expensive equipment.

Thomas went on during his interview to share about another case of a friend of his who was also a municipal health official and hosted Cuban doctors:

> In this municipality of his there is a small indigenous population on a small island in the middle of this lake that they have there, and until the arrival of the *Mais Médicos* there had never been a doctor to visit that island. When the Cuban doctor arrived, we took her there to that island – she was the first doctor ever to treat those people on the island.

These recollections appropriately summarize the types of insights and discourses upon which this dissertation focuses its analysis. How can the academic community better understand the experiences of those female Cuban doctors working in these settings so different from the ones they are accustomed to in Cuba? How can we discuss and read the outcomes of these varied encounters between different social groups, in terms of race, income, and nationality? How can we interpret the power relations that were created, transformed, destroyed, and nuanced through the *Mais Médicos* program?

By "power" this research study employs Foucault's definition that:

> Power must be understood in the first instance as a multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them, as the support which these force relations find in one another, thus forming a chain or system, or on the contrary, the disjunctions and contradictions which isolate them from one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies (FOUCAULT, 1978, p. 92-3).

In other words, I take "power" here as *not* only a physical act or motion, or a force exerted by one stronger agent over another weaker agent – but rather as an entire universe of possibilities of social interactions that are in a constant state of flux, never well-defined, not

[5] All of the participants' names have been altered in order to protect their identity to another name that is not similar to their original one. The author has translated all of the responses from the original Spanish or Portuguese.

completely solidified, and which together order and arrange the complexity of human social existence. Power does not only course through the *visible*, it also runs through the invisible, the naturalized, the normalized, the institutionalized, the subconscious, the gestures, and so forth. Power, and moves of resistance against power, must be detailed and understood in their complexity, as we resist the urge to define it as that which A imposes or acts upon B. In this research study, the nuances that undergird this understanding of power are vital for my analysis of *Mais Médicos*, and for interpreting the ways in which it reshaped healthcare, and socio-political conversations and discourses about healthcare within Brazil.

This is the same type of reasoning employed by feminist scholar Joan Scott when she writes:

> To pursue meaning, we need to deal with the individual subject as well as social organization and to articulate the nature of their relationships, for both are crucial to understanding how gender works, how change occurs. Finally, we need to replace the notion that social power is unified, coherent, and centralized with something like Foucault's concept of power as dispersed constellations of unequal relationships, discursively constituted in social "fields of force" (SCOTT, 1986, p. 1067).

Hence, the purpose of this research study is to understand the different "fields of force" within which Cuban doctors, Brazilian doctors, patients, community leaders and so forth meet and interact. Secondly, my drive is to understand how power is exerted within these circumstances and what room this leaves for individual identity, agency, and subjectivity. Lastly, these relations of power cannot be understood as existing detached, or apart, from social systems of oppression, differentiation, and otherness. Race, gender, class, and so forth, are intimately connected to power relations – they in fact stem from these relations – and work to circumscribe these within the social space that I seek to interpret in this dissertation. Thus, Scott's definition of gender at the end of her theoretical analysis as, "a primary way of signifying relationships of power", sums up my line of reasoning (SCOTT, 1986, p. 1069). I seek to expand her definition, though, to understand how *Mais Médicos* and Cuban medical internationalism (re)signify, (re)create, and (re)shape power relations between the different communities and peoples which they bring into contact within a setting of South-South cooperation (SSC).

This brief review of historical developments and theoretical positioning encapsulates the tensions I seek to unpack and analyze: Cuban medical internationalism has typically been studied from the point of view of the Cuban state, or empirically approached to delineate its effects on public health statistics (as displayed at the beginning of this introduction) – yet the daily inner-workings of the programs and their effects on individuals has been largely ignored by the academic literature. My objective is to move beyond the point of view of the state, and

bring my level of analysis down to the individual to make sense of how race, gender, and geopolitics undermine and/or enhance the purported mission of these medical programs. Our research objective, in other words, is to employ various post-modern approaches within international relations (IR) to see what insights can be gained about these SSC programs, and how does this problematize our understanding of *Mais Médicos* and Cuban medical internationalism, more broadly. In particular, I center my discussions around the research question: how does Cuban medical internationalism affect race, gender, and social discourses, both in Cuba and in its host countries, and what does this tells us about power relations within the international system?

The results presented here are based on 20 semi-structured qualitative interviews conducted with Cuban doctors who have completed missions in countries such as, Venezuela, Angola, and Bolivia; and many who are now participating in *Mais Médicos*, as well as 10 interviews with Brazilian doctors and politicians. In chapter 2, I outline how these interviews were conducted, how my data was analyzed, and present an analysis of both my positionality, as well as my participants' positionality. Following common anthropological methodology, I approached this project as a *tabula rasa*, meaning I did not go searching for any specific research variable or category. Instead I went into the field asking a wide-array of questions on many topics ranging from: family relations, education, daily routines, children, future goals, etc., to see what knowledge and novel insights could be obtained.

Utilizing the data gathered from my fieldwork stage, I have divided my results into four main groupings, which are each presented separately in chapters 3-6. These four chapters will also be presented individually to the academic community as upcoming research articles. In chapter 3, I employ post-modern IR theories to argue that the introduction of capital within post-Soviet Cuban civil society has changed the formulation and outcomes of medical missions in recent times, and suggest how medical internationalism varies drastically depending on geopolitical setting, such as Brazil, Venezuela, or Angola. In chapter 4, I utilize post-colonial approaches to IR to trace the ways in which race and racialized thinking undermine the supposed objectives of medical missions. Using post-colonialism, and many statements made during the course of my fieldwork by participants, I demonstrate how SSC can be imbued with imbalanced power relations that resemble those found within North-South relations.

In chapter 5, I employ a feminist theoretical approach to see how the experiences of female doctors within medical missions are different from those of their male colleagues and what this tells us about the international system. Specifically, I detail how participation in

these medical missions alters female doctors' family relations, while also presenting them with increased capital and a means for personal empowerment. In chapter 6, I carry out a post-structuralist reading of Cuban medical internationalism, especially *Mais Médicos*, and argue that these medical missions create an internal struggle within each host country over medical discourses and who has the right to wield biopower, medicalize the body, and for what ends. In chapter 7, I will review my findings and place them within the broader scope of Global South and discursive research, and present further areas for possible future research.

Viewed quickly or haphazardly, "*Mais Médicos*" or "Cuban doctors" might seem a trivial project that would only reveal certain and place-specific insights about Cuba, which itself is often an outlier in global politics. What I demonstrate in this project is that Cuban medical internationalism, whether by comparing *Mais Médicos* to missions in Venezuela, or reflecting on the experiences of a black female doctor working in the countryside of Rio Grande do Sul, actually provides useful and intricate case studies for many of IR's most pressing questions. During the discussions that follow, findings and conclusions are always placed within their greater theoretical position and are connected to greater themes within global politics. Specifically, this dissertation sheds light on: relations and cooperation between Global South states, women and migration in the Global South, and intra-Latin American relations. Overall, this master's dissertation aims to analyze and unpack the place of the individual, power, identity, and other crucial variables within international politics. This process is not easy, as it requires strenuous reflection on both object of study and self; but it is crucial in order to thicken and further the academic conversation of contemporary world politics.

2 METHODS AND PROCEDURES

In this chapter I will outline the research methods and procedures utilized to obtain my research results. As previously stated, there are many preexisting studies on Cuban medical internationalism (see KIRK; KIRK; WALKER, 2015; BROUWER, 2011; KIRK; ERISMAN, 2009; KIRK, 2009; FEINSILVER, 2008a, 2008b; and others), but they have mainly focused on a quantitative analysis of these programs, specifically their affects on macro-health indicators. This research project instead utilized a qualitative approach and interpretative methodologies (see DELLA PORTA; KEATING, 2008) for understanding Cuban medical internationalism. I will first outline who was interviewed and how, then present how I analyzed the data collected from these interviews. This project was approved by an institutional review board, the Research Ethics Committee (*Comitê de Ética em Pesquisa em Seres Humanos*) of the Federal University of Rio Grande do Sul in Porto Alegre, Brazil, where I was a student.[6]

I conducted 20 semi-structured interviews with Cuban doctors who are or have completed medical missions before, as well as 10 semi-structured interviews with Brazilian doctors and politicians in order to include as many different viewpoints as possible in my results. Thus, a total of 30 interviews were conducted. In order to make my research sample as diverse as possible, the 20 Cuban doctors interviewed are 13 women and seven men who range in: age (from 25 to over 50), years of work experiences, number of previous medical missions, marital status, and race. The 20 doctors also represent Cuba's three geographical regions: Havana, Central Cuba, *Oriente*; and come from both provincial capitals and more rural municipalities.

Furthermore, out of the sample, 10 are (or have) completing medical missions within the *Mais Médicos* programs throughout all of Brazil's geographic regions: South, Southeast, North, Northeast, and Center-West. The other 10 are (or have) completing missions in countries such as: Venezuela, Honduras, Ghana, etc. This diversity of places where the doctors have worked truly allowed me to delineate the ways in which geopolitical setting affects the inner-workings of these programs. To account for the possible bias of the Cuban state some of the doctors interviewed have deserted or defected from a medical mission, since immigrated to other countries, and no longer have ties to the Cuban government. To my surprise, the responses of every participant appeared to correlate rather well, regardless of

[6] This research project is registered under project number: 78641317.2.0000.5347.

their location or status within or outside of a mission. As part of my original research proposal, I had also wanted to interview patients about their experiences with Cuban doctors. However, due to time constraints, and bureaucratic barriers in gaining access to those at public healthcare clinics, those interviews were not possible.

The interview process began by identifying the research participants, which was usually by word of mouth or mutual friends. For instance, a former English student of mine helped make contact with two Cuban doctors she knew through a cousin of hers. One of my aunts identified other doctors she is friends with and were working in Venezuela, and so forth. At the end of each interview, doctors were also asked if they could suggest other possible participants. Following this method, I was able to identify multiple early leads and follow them through to successful interviews. Considering that many independent sources, which had no relation to each other, were used to contact interviewees, this controlled for any possible bias of the sample being an insular group with the same points of view.

Once identified, I usually had an intermediary make a first contact to introduce me to the future interviewee. These intermediaries, usually friends or family, thus acted as a sort of cultural broker to reassure the participants. My first personal contact with the possible interviewee was typically via Facebook or WhatsApp, where I first engaged in general conversation to introduce and talk about myself to them. The research project and the invitation to be interviewed were introduced later on in the conversation. Most people were willing to participate and answer my questions, two people did decline to be interviewed due to lack of time, and a third person due to fear of reprisal. The biggest difficulty was in getting a date and time set for the actual interview, due to the exhaustive and busy schedules most doctors have.

The interviews were conducted in person when possible. Interviews with doctors in other countries or regions of Brazil were done via Skype. Doctors in the state of Rio Grande do Sul where I was based were easier to meet in person in their host cities. In-person interviews were usually conducted at cafes and other public venues to ease any tension that the participant could have. I never pulled my notebook and pen out at the beginning, hoping to set an informal tone. The process was begun with casual conversation to build rapport with the participant and ease any nerves they could have. Casual conversation included personal introductions, talk about the weather or traffic, and/or asking what region of Cuba each of them was from. After this initial conversation, I would explain the project, review the consent form, and ask if they had any questions before we began.

Interviews usually began with basic questions to make the participants feel at ease before going into more sensitive topics. For instance, first I asked where they had studied medicine, their age, and birthplace. I then moved into general cultural questions, about how they were received in Brazil and so forth. In the middle of the interview, I asked questions related to gender and feminism. Then I moved onto other topics, such as overall experiences, their salaries, families back in Cuba, and so forth. Towards the end, I once again asked more general questions to wrap up the interview, such as "What experience do you remember the most from your time here in Brazil"? At the end, I always asked them if they had any questions for me. The interviews typically lasted 30-50 minutes, and were conducted in either Spanish or Portuguese, depending on the native language of the participant. I prepared a general questions guide to help me during the interview process:

1) Your full name, where were you born, where did you study medicine, and your age?
2) In how many countries have you been (and when)?
3) How were those experiences? How were you received in those countries?
4) What type of training and preparation did they give you in Cuba before going to those countries? Language training, medical courses, etc?
5) In what way is the practice of medicine different here in comparison to Cuba?
6) Did you face any kind of racism or prejudice during your time in these countries?
7) What image did you find that those people had about the Cuban people? What previous notions? Ideas?
8) How was the power structure in those countries? Did you have to report to a Cuban or local boss? Hierarchy?
9) Why did you decide to participate in these programs?
10) What effects did this have for your family and family dynamics back in Cuba?
11) What understanding of or experience do you have with feminism? What does "feminism" mean to you? Do you consider yourself a feminist?
12) How do you think your experience participating in these programs would have been different if you were a woman/man?
13) What is the most important memory you have of your participation in these programs?
14) How is the *Mais Médicos* program in Brazil different from other programs? What do you know about the program?
15) How was your day-to-day routine in those countries?
16) What were things to which you could have access to in those countries that you did not have access to in Cuba? Resources? Technology? Social networks?
17) Did you have to live with other Cuban doctors? How much freedom did you have to interact with people in those countries?
18) Do you have children? You are married? How does being in this program affect those relationships?
19) How did you communicate with Cuba when you are in those countries? Was it easy?
20) In what way did the money that you earned in those programs help your family? And you? Do you think you were paid enough?
21) How much do you get pay here? How are your expenses divided?
22) What were the most difficult cultural differences for you?
23) Would you participate in another international medical mission in the future?
24) Any other comments or memories?
25) Any questions for me?

Questions for Brazilian doctors and politicians:

1) Introduction to the project. Participant's name, age, and profession?
2) What is your opinion about the *Mais Médicos* program, specifically the use of Cuban doctors within the program?
3) Do you think Cuban doctors are any different from Brazilian doctors?
4) What interactions have you personally had with Cuban doctors?
5) What would you change about the *Mais Médicos* program?
6) What are the biggest challenges facing public health in Brazil?
7) Do you think Cuban doctors should suffer some kind of professional scrutiny here in Brazil?
8) Do you think there is any kind of prejudice within the field of medicine here in Brazil?
9) Do you think the program helps the people who need it most?
10) Do you have any other comments to make or any questions for me?

These questions were not always followed one-by-one and rarely were all of them asked. This question guide helped me prepare me thoughts and guide the interview from question to question. However, I tended to let the interviews flow freely and ask follow-up questions to interesting comments and reflections. As participants responded I attempted to keep a neutral face to not induce any responses from them. In order to make people comfortable and also not bias their results, I also made myself neutral by phrasing questions with, "A lot has been presented in the news… Other people have said… I have heard…" I also followed the "mood" of the interview and asked questions being mindful of that, for instance a very probing personal question was not followed up by another probing personal question. At the end of the interview, interviewees were thanked for participating, and the project was once again explained, as it had been at the beginning.

Asides from the 20 Cuban doctors, I also interviewed 5 Brazilian doctors and 5 politicians (total of 10 interviews with Brazilians). These 10 interviewees also ranged in gender and age, and these interviews followed basically the same line as those with Cuban doctors. Contacts were made through mutual acquaintances, followed by scheduling an interview. All of these interviews were typically conducted in the Brazilian doctor or politician's office, instead of in public spaces. The interviews began by introducing myself and explaining the project, followed by reviewing the consent form. At the end of the interview I also asked them if they knew anyone else whom they could put me in contact with to be interviewed. I also had to explain myself and identity, as both a person from Cuba and the United States, and what I was doing in Brazil.

I chose to either record or not record the interview, depending on time and if the interviews were in-person or via Skype. For those interviews that were not recorded, I took precise and constant notes throughout and wrote down important responses word for word. I would then read back to the interviewee something they had said to make sure the quote was

accurate and exactly what they had said. During the interview, I would also ask them to pause so I could finish writing down something they had said or stated.

After collecting the interviews I embarked on the arduous task of analyzing all of the data to discern patterns and contrasts and reach my conclusions. This process entailed not only analyzing the given responses, but also meta-data responses, and both the researcher and participants' positionality. By meta-data, I mean Fujii's (2010) definition of spoken and non-spoken responses that must be deeply analyzed beyond literal value, and can include: rumors, silences, denials, evasions, and so forth. In other words, the participants' given responses, as well as meta-data responses, were then weighed against each other's answers, and then compared to the results of previous scholars to trace patterns and divergences within all of the responses. I drew upon a wide array of previous empirical scholarly works, both focused and not focused on Cuban politics, to triangulate as many of my results as possible. Where disagreements and discords did arise in people's experiences, those points are presented in the following chapters, as I attempt to explain them using situational factors or previous scholarly productions, as well.

By positionality here I mean the importance of the researcher's and participants' personal experiences to the research process, because of this I approached the interview process as a *tabula rasa* (BRAY, 2008) seeking to gather data and then analyze it without "looking for" any specific data and thus biasing my results. My positionality as a white male Cuban, who was educated in the United States, and is now conducting research under the hospices of a prestigious Brazilian university, was constantly reflected upon – before and after each interview and – throughout the entire research process for the possible affects that could have on my fieldwork, considering the resultant power relations it creates. The ways in which class, gender, race, and other variables, could impact the responses my interviewees gave caused me to constantly reflect upon the "deeper" possible meanings of their responses and attempt to weigh them against preexisting fieldwork and studies.

I was also always very upfront about my background as someone who was raised in the US and is naturalized as a US citizen. But my "Cubanness" and the fact that I was living in Brazil seemed to ameliorate any tensions that could create. Secondly, I went out of my way before, during, and after the interviews to build as much rapport as possible with my interviewees. I even dialogued with 5 other researchers (both males and females) before starting the project, who have conducted research in Latin America, Brazil, Cuba, and even with Cuban doctors – to see how they conducted their interviews, managed their positionality, and reassured their participants. Even though I am a white man conducting research with

many women, some of them afro-descendent, I strove to make them as comfortable as possible, give them a place to speak, and present their experiences as faithfully as possible. The field of gender studies can be greatly enriched by contributions from male researchers who grapple with their positionality and feminist reflections. Or as Ackerly (2008, p. 28) writes: "Feminist inquiry is not reserved for women or even for those who identity themselves as feminists. It invites every scholar to revisit his or her epistemology and core conceptualizations throughout the research process".

Furthermore, I acknowledge that my participants represent an elite portion of Cuban society, considering they have been given the opportunity to travel abroad and earn foreign currency, and are part of an elite profession. Therefore, my results may not be applicable to the experiences of, say, rural Cuban farmers or urban industrial workers. As for my Brazilian participants, they tended to have higher education and have elites positions in Brazilian society, either as doctors or elected politicians, thus their responses may also not be representative of every Brazilian. However, their insights, which I draw upon most in chapter 6, as elite members of society are rather useful to explain the role of the state within biopolitics.

A variety of texts on how to conduct fieldwork were also referenced, and used to guide the procedures of this study, specifically, *Approaches and Methodologies in the Social Sciences: A Pluralistic Perspective* by Donatella Della Porta and Michael Keating and *Doing Oral History: A Practical Guide* by Donald Ritchie. Furthermore, many research articles were used to help structure and guide the interviews (see FUJII, 2010; WEDEEN, 2010; ACKERLY, 2008; VRASTI, 2008; LEECH, 2002). I must also give special recognition to the text *Laughter Out of Place* by Donna Goldstein that acted as an example on how to conduct fieldwork in Brazil as a person coming from the US. Collectively, all of these texts informed and guided this study, making it as academically rigorous as possible. This dissertation also attempted to be interdisciplinary, relying on the theoretical perspectives and methodological approaches of various fields: international relations, history, political science, anthropology, Latin American studies, sociology, etc.

Moreover, I base my arguments on the premises of post-positivist theories and approaches in order to corroborate my findings. I do not envision this research project as the end of a discussion, but rather as the beginning of a conversation that invites self-reflection and asks many new research questions. Likewise, it is very difficult to obtain reliable data and figures from official sources about Cuban government revenue from these medical programs, or the economic impact that these programs have on the lives of Cuban doctors and the local

economy. This is why many of the figures presented in this dissertation come from journalistic sources which interviewed experts on the Cuban economy, or from previous studies. On the other hand, data about the impact that Cuban doctors have on public health indicators is much easier to find. Hence why, in part, this dissertation hopes to contribute towards "bridging the quantitative-qualitative divide", to borrow Tarrow's (1995) description, through the qualitative analysis presented in the following chapters. Although parting from an interpretative epistemology, I have striven to make my claims and findings as robust as possible by engaging in critical reflection of both researcher and participants, as well as dialogue with previous scholarship. Or to use Wedeen's (2010, p. 264) words, "By navigating between concrete details and conceptual abstractions, we can refine and undermine, negate and create novel explanations about politics".

3 CUBA, BRAZIL, AND INTERNATIONAL POLITICS IN THE GLOBAL SOUTH

When included in studies of Cuban medical internationalism, the voices and points of view of the numerous doctors that participate in these medical programs abroad, only reflect the positive effects their presence has on access to medical care, despite Cuba's own lack of resources. Scholarly discussions of Cuban medical internationalism have never critically analyzed the power relations and internal nuances that arise from these medical missions, and what this tells us about hierarchy within the international system. This chapter is centered on the question: in what ways is Cuban participation in *Mais Médicos* unique, and what does this tell us about Cuban medical internationalism and international politics more broadly? I content that Cuban medical internationalism should not be viewed as a monolithic entity and that its outcomes and inner-workings are rather place and time specific. Furthermore, I argue that the organization and inner-workings of *Mais Médicos* reveals the turn towards capitalist and market-driven economic thinking that Cuba, and Cuban foreign policy, have taken in recent decades, as a result of discursive shifts.

Since its inception, the field of international relations has been plagued with questions concerning which is the proper level of analysis – the system, state, or individual (WALTZ, 1959). Many realist thinkers have chosen to focus on a system-level analysis and the international dynamics that result from a perpetual state of anarchy (MEARSHEIMER, 2001; WALTZ, 1959). Others scholars, such as Hudson and Vore (1995) have called for the importance of opening the "black box of the state" and understanding the internal factions and aspirations that collectively compose the "national interest", which realists take as a given singular entity. For Hudson and Vore, one cannot ignore the role that individuals, say certain bureaucrats, thinkers, business leaders, and the groups they represent, have in shaping foreign policy decision-making.

In this chapter, I employ post-modern and post-structuralist theoretical lenses to understand recent shifts in Cuban civil society and foreign policy through the individual and micro-level. As scholar Richard Ashley (1989) has argued there is no clear division between domestic and international political processes, the alleged "border" between the two is in fact rather tenuous, at best. By extending this logic, one can argue that there exists an inter-relationship between the domestic and the international whereby they co-constitute each other (ASHLEY; WALKER, 1990). Or as David Campbell has argued, utilizing Judith Butler's line of reasoning regarding the human body, that the limit between the "internal" and the

"external" when it comes to states in the world system is not clearly defined or given *naturally* (CAMPBELL, 1992, p. 8-9). The boundary between the domestic and international "spheres" is hazy, giving way to a complex interplay between the two at the global, state, and individual levels.

This logic holds when one examines the Cuban revolutionary process. As many anthropologists and historians have argued (GOLD, 2015; STOUT, 2014; BROTHERTON, 2012; HAMILTON, 2012; KAPCIA, 2008), the Cuban revolution is neither a static and consistent entity, nor is it marching towards one given point or "end of history", as Marxists would have it. Rather, the Cuban revolution is nuanced and defies easy categorization in its domestic, and foreign policy, engagements and arrangements. Or as Walker (1991) would argue, the territoriality and temporality of these political processes, which he refers to as "political space/time", cannot be conceived of using a modern lens of "cyclical time" that divides history into well-defined epochs. To quote anthropologist Noelle Stout for example, "In the post-Soviet era, a wide range of Cuban cultural experiences were packaged and sold to tourists, including Afro-Cuban religion, *socialist health care*, and tropical beaches" (STOUT, 2014, p. 161, italics mine). Concurrently, Cuban medical internationalism, as a tool of Cuban foreign policy, cannot be thought of as a consistent term or process, as it is inherently subject to alterations based on time and place. Furthermore, Cuban medical internationalism is also subject to inflections based on the different discourses that surround it, and that emerge from changes in Cuban domestic and foreign policy thinking.

Quoting Campbell at length:

> I want to suggest that we can understand the state as having 'no ontological status apart from the various acts which constitute its reality'; that its status as the sovereign presence in world politics is produced by 'a discourse of primary and stable identity'; and that the identity of any particular state should be understood as 'tenuously constituted in time…through a stylized repetition of acts,' and achieved 'not [through a founding act, but rather a regulated process of repetition' (CAMPBELL, 1992, p. 9).

In this chapter, I will analyze how the identity of the Cuban revolutionary state is constituted, in part, through the "process of repetition" that Cuban medical internationalism entails, as I attempt to deconstruct it in terms of time and place. Acts of repetition, which are, in fact, carried out by the individual doctors who engage in these medical missions abroad. Furthermore, I seek to understand how a discourse of capital and market-driven thinking has emerged within Cuban civil society since the fall of the Soviet Union, and how this discourse has subsequently also entered into Cuban foreign policy thinking and medical internationalism. By "discourse", I employ Foucault's meaning of a, "group of statements

which provide a language for talking about a particular topic at a particular historical moment" (see HALL, 1997, p. 44). Discourses, thus, work as fluctuating socially constituting forces that render the material, object, symbolic, and textual worlds, that together organize and compose human social experience (see DER DERIAN; SHAPIRO, 1989).

As anthropologist Marina Gold has written in regards to the relationship between Cubans, the Cuban state, and the Cuban revolution, all of which can be viewed as separate and often times opposing social forces: "In political accounts of Cuba, Cubans are often portrayed as voiceless, suppressed victims. Many Cubans decry this position, as they are, generally speaking, politically savvy" (GOLD, 2015, p. 9). Therefore, one can read Cuban social spaces, as well as the domestic and international political processes that emerge from these spaces, as contested grounds in which agency presents itself in unexpected ways. My point here is to examine the encounter between a discourse of financial capital and markets that has appeared with ever-growing strength in Cuba since around 1991, and recent Cuban medical internationalism programs in Brazil, Venezuela, and other countries.

Turning more specifically towards Cuban foreign policy, since 1959, it could in many ways be read as an attempt to find a place and clout within the international system, where after failed attempts to spread revolution in Latin America in the 1960s, attention was turned towards Africa (GLEIJESES, 2002). With its large afro-descendent population and legacy of colonialism, the Caribbean country was well-suited to capitalize on African de-colonization (HATZKY, 2015; VALDÉS, 1979, p. 109). The biggest ventures were in Angola and Ethiopia where eventually 19.000 and 16.000 Cuban troops, respectively, aided the Marxist regimes there in coming to power (WESTAD, 2007, p. 235-8; THOMPSON, 2003, p. 54). Cooperation in Africa went well beyond soldiers though, as over 110.000 Cuban doctors, teachers, and other civilians would spend time in Africa by the end of the 1980s (ECKSTEIN, 2003, p. 175). This created a thriving network and system of South-South Cooperation (SSC) SSC between Cuba and African states (HATZKY, 2015; KAPCIA, 2008). Overall, Cuban foreign policy can be interpreted as a, "[B]alance between open 'activism' and more recognizable pragmatism; yet… often the seemingly 'ideological' made practical sense, while the pragmatic usually also had an ideological dimension" (KAPCIA, 2008, p. 132).

Beyond Cold War politics, Cuban involvement in places like Angola and Ethiopia was also strategic because it gave younger Cubans, who at that time were craving economic opportunity, the ability to travel abroad, learn new skills, and improve their financial situation (VISENTINI et al., 2013, p. 262; KAPCIA, 2008, p. 124-5). Beyond this, participants in Cuban *internationalismo* throughout Africa got to see places that were economically and

politically worse off than Cuba, which probably gave them a new appreciation for the social benefits of the revolution, as Kapcia argues (2008, p. 124-5). This also reflects the relationship between domestic and international political processes that post-structuralist scholars of IR interpret within the international system (CAMPBELL, 1992; ASHLEY, 1989). The academic literature on Cuban medical internationalism (BROUWER, 2011; KIRK; ERISMAN, 2009; KIRK, 2009; BUSTAMANTE; SWEIG, 2008; FEINSILVER, 2008a, 2008b; and others) though focuses on these types of dynamics giving preference to the role of Cuban doctors as a tool of Cuban foreign policy or the host country's public health system. Here, I hope to contribute to the literature by focusing on the experiences of the individual doctors who participate in these programs to help us better understand the role of different discourses.

Despite the nuances in Cuban medical internationalism pointed out by the scholars presented above, the Cuban government and state have attempted to maintain a rather stable discourse surrounding foreign medical cooperation initiatives, since their beginning. For point of case, let us examine the words of Fidel Castro Ruz in a speech delivered on September 19th, 2005, at an event marking the inauguration of the "Henry Reeve" International Contingent of Doctors, as well as the graduation of medical students:

> Not once, throughout the selfless history of the Revolution, have our people failed to offer its supportive medical assistance to other nations in need of this aid at times when catastrophes have hit them, regardless of wide ideological and political differences, or the serious insults received from the government of any of these countries. Our concept of the humane condition of the peoples and the duty of brotherhood and solidarity has never been, nor will they ever be, betrayed. Tens of thousands of Cuban doctors and healthcare professionals stationed around the world are irrefutable proof of what I am saying (CASTRO RUZ, 2005).

These are certainly strong statements, which this chapter will attempt to decode and better place within an understanding of political shifts both within Cuba, and the world system, especially since the end of the Cold War. Moreover, with the fall of the Soviet Union, Cuba experienced a difficult economic period, known as the "Special Period". The island country's gross domestic product shrunk by 11.6% in 1992 and 14.9% in 1993, closest trading partners disappeared, and the US tightened its embargo, pushing the resolve of the regime to the brink (VALDÉS 2011, p. 356-7; ERISMAN, 2006, p. 3.). The Cuban regime overcame the crisis with economic reforms, such as the legalization of US dollars, and by allowing small entrepreneurial ventures (KAPCIA, 2008, p. 190). By the end of the 1990s, the Cuban regime was further aided by the arrival of the "Pink Tide" which brought many leftist leaders to power in Latin America (CLEARY, 2006). The first new alley of the Cuban regime was Venezuela, where Hugo Chávez was eager to battle US imperialism and recalibrate the

region's status quo (CORRALES; PENFOLD, 2011; REID, 2007). This gave rise to a new wave of Cuban medical internationalism, as the Caribbean country began sending doctors and medical technicians to Venezuela in 1999, in exchange for oil and other supplies. As of 2016, there were over 30,000 Cuban doctors and medical staff posted in Venezuela (PENTÓN, 2016).

As Bustamante and Sweig argue, through its foreign medical missions in Venezuela and in other places, Cuba engages in "public diplomacy", which, "traditionally refers to ways in which governments use aid, cultural, media, and exchange programs to influence the ways in which they are seen by citizens in other countries" (2008, p. 226). This "public diplomacy" builds Cuba's prestige on the world stage and allows it to further its policy interests despite the US embargo. Feinsilver (2008a, 1989) argues these actions are an impressive example of soft power outside of a US-centric context and defines them as "medical diplomacy". Soft power here defined as, "the ability to get what you want through attraction rather than coercion or payments" (NYE, 2004, cited in BUSTAMANTE; SWEIG, 2008, p. 248). Thus, since the end of the Cold War, Cuba has been able to turn its foreign policy focus towards Latin America, once again, and use its healthcare professionals to acquire hard currency for the island as well as international political clout.

In other words, Cuba has constituted an international identity for itself as a Global South country of goodwill through its medical missions. As Kirk writes, "Havana will continue to champion the interests of poorer and underdeveloped nations and will continue to be highly respected in that sector" (2006, p. 341). However, this view of Cuban SSC leaves out many considerations, for instance, the ways in which using these programs to increase foreign currency reserves can affect the purely good-hearted nature of Cuban medical internationalism, as originally intended by Fidel Castro (BENZI; ZAPATA, 2017, p. 83). We must critically analyze SSC, and the power hierarchies that result from it, in order to better understand the internal nuances that arise from Cuban medical internationalism and other attempts to move beyond a North-South development dynamic (BERGAMASCHI; MOORE; TICKNER, 2017; CHATURVEDI; FUES; SIDIROPOULOS, 2012). As Bustamante and Sweig (2008, p. 236) write, "Clearly, symbolism is also an important component and driver of Cuba's medical diplomacy", yet this symbolism must be viewed within Cuba's search for economic development and shifting domestic political dynamics with the rise of Raúl Castro to the presidency in 2008, and Miguel Díaz-Canel in 2018 (SWEIG, 2016, p. 258).

Cuban scholar Carlos Alzugaray (2015)[7] has argued that around 2009 Cuban foreign policy entered into a new "cycle", which he labels as "Anti-hegemonic economic pragmatism". This new period, ushered in by Raúl Castro, shifted political attention towards economic relations and cooperation, and even ushered in claims of "updating" Cuban socialist approaches and policies (SWEIG, 2016, p. 261). This new phase of Cuban foreign policy decision-making and grand strategy has focused its energies more on the pragmatic and less on the idealist side of foreign policy endeavors, and coincides roughly with the beginning of the *Mais Médicos* program (FEINSILVER, 2010). This chapter will analyze the temporality that resulted in this new "cycle" of Cuban foreign policy thinking in order to better situate this evolving discourse within the praxis and processes of Cuban revolutionary politics. Secondly, I will compare and contrast the experiences of Cuban doctors working in Brazil, to that of Cuban doctors completing missions in other countries, to see how Cuban medical internationalism varies from place to place, and what this tells us about international politics in the Global South.

3.1 EXAMINING THE TERRITORIALITY AND TEMPORALITY OF CUBAN MEDICAL INTERNATIONALISM

As discussed above, the academic literature has tended to treat Cuban medical internationalism as a monolithic entity, devoid of geopolitical and temporal considerations. In this section, we will problematize that notion by exploring the nuances and complexities that exist among and within every Cuban medical program abroad. In fact, one of the first observations made during my fieldwork was the striking diversity of experiences afforded to Cuban doctors depending on their host country. We cannot view "Cuban medical internationalism" as a single entity or tool of Cuban foreign policy that simply provides medical care across the Global South and to countries ravaged by natural disasters – instead we must delve into the contours that arise from these encounters. As Miranda, who previously completed a mission in Venezuela and is now completing *Mais Médicos* in Brazil explains:

> Interviewer: How is your experience in Brazil different from your time in Venezuela?
> Miranda: Venezuela is a very different experience. You have to work 24-hour shifts and you work seven days a week. You can't leave the clinic after 7 p.m. and you live behind the clinic. Even the medications that you give to the patients are from Cuba.

[7] Alzugaray divides Cuban foreign policy since the Revolution into four "stages": 1959-1972, the formative or heroic years; 1972-1989, under the protection of a superpower; 1989-2009, post-Cold War; 2009-present, anti-hegemonic economic pragmatism (ALZUGARAY, 2015, p. 184). Kapcia (2008), on the other hand, refers to the cyclical quality of Cuban domestic and foreign policy.

> You only work with other Cubans. It was very "Cubanized". It was Cuba in Venezuela.

Many of my research participants within *Mais Médicos* had previously completed missions in countries such as: Angola, Ghana, and Venezuela, so they were able to delineate well the differences between the programs. It appears, from my fieldwork, that completing a medical mission currently in Brazil is probably an ideal or auspicious scenario for Cuban doctors because it offers them a higher pay, access to material goods, and engagement with locals. Over the past few decades the Brazilian government under the Worker's Party (PT) made considerable investments in social welfare and poverty reduction (KINGSTONE; PONCE, 2010), which has made Brazil more attractive to international investors and tourists, and also to Cuban doctors who participate in these programs.

Conversely, being stationed in Venezuela has become increasingly less attractive to Cuban doctors over the past decade, especially with the death of Hugo Chávez and rise of Nicolás Maduro to power. The Venezuelan economy has come under particular strain in recent times due to falling oil prices, which has curtailed the government's ability to spend on social welfare programs, and led to subsequent rises in inflation (PENTÓN, 2016; SWEIG, 2016, p. 295). Furthermore, the political situation in Venezuela has become more and more polarized since Chávez's illness and even led to sanctions against the South American state, worsening the domestic economic panorama. These variables affect not only the Venezuelan people, but also the numerous Cuban doctors that are currently in the country, working to provide medical care within its most underprivileged communities, or as Ana Clara a young Cuban doctor, working in Venezuela, shared:

> I have seen things that I was never going to see in Cuba, from bullet wounds to dead people. The police arrive with 1, 2, 3, 4, sometimes 5 corpses, and they arrive dead, without vital signs and we say, "They are dead"! And the police, speaking with I don't know who on the phone saying, "They are giving him first aid". And you are there saying, "No, look they're dead"! Because those are some of the *malandros* [bandits] that the police kill and the police make sure that they are dead by the time they arrive here, but then they write [in the death certificate] and make it seem like they arrived alive and died at the health clinic. In other words, they say that it was the Cubans who let them die – and this never happened with me personally – but there have been cases of then family members coming and complaining to the Cuban doctor, but the person arrived here dead.

Cuban doctors participating in these foreign medical cooperation programs find themselves not only at a cultural and medical cross-roads, but also often at the nexus of international political discussions, as the doctors who arrived at Brazilian airports to chants of "Slave" and having bananas thrown at them well understand. Yet, while the political controversy surrounding Cuban doctors in Brazil seemed to wan after their arrival, their

position within Venezuelan politics continues as contested as ever. From my interviews, I was able to gauge that pay structures, working hours, obligations, access to resources, and so forth, vary drastically between every country where Cuban doctors are sent.

Asides from spatial differences, it also appears Cuban medical missions have radically evolved over time from haphazardly put together aid programs, to an important and methodically planned source of foreign power projection and capital. As historian Piero Gleijeses recounts about one of Cuba's earliest medical missions to Algeria in 1963:

> "We didn't even know how long we were going to stay," adds [Doctor Sara] Parelló, "or where [in Algeria] we were going, or anything at all." Cuban officials knew little more. The two countries had not yet signed an agreement, and many important points (such as the duration of the mission) had yet to be decided (GLEIJESES, 2002, p. 36).

The confusion and lack of details within Cuba's earliest missions, as described above, contrasts greatly to the level of bureaucratic oversight and institutionalization that exists within its modern programs, especially *Mais Médicos*. Since the Cold War, Cuban medical internationalism has also evolved into an important source of revenue for the Cuban state, as will be further analyzed in the next section. Moreover, medical missions are closely scrutinized, whereby Cuban doctors must pass certain exams in Brazil to revalidate their medical degrees; and the parameters of their stay and payment are arranged well before arrival in-country. Details regarding visas and the conditions under which doctors may stay in Brazil past their tours are also extensively monitored and negotiated to ensure that the majority of them return to Cuba.

In other words, one can think of Cuban medical internationalism as a spectrum, on one end is Brazil, a country which has seen relative economic prosperity over the past two decades (until a recent recession) and which has strong labor laws and judicial processes, in comparison to its neighbors. Intermediately, one can place Venezuela, Bolivia, and other countries which give Cuban doctors access to certain material goods and capital, but whose own economic and social disparities can leave Cuba doctors feeling as, "agents of a culturally superior civilization and superior social system" (HATZKY, 2015, p. 247). At the other end of the spectrum one can categorize Angola and many of Cuba's earliest SSC programs throughout Africa during the 1960s-80s where doctors were sent into war zones. Or as doctor Gonzalo, who completed a medical mission in Angola during the 1980s and is now working in *Mais Médicos* said:

> In Angola I arrived and everything shocks you, even the smell. Everything is different, well everything was different in those times. I remember that when I arrived there were rumors about a doctor [Angolan] who was with the *contras* and every patient who went to see him he would cut off a leg or an arm, regardless of

> how insignificant [their illness] to handicap them. I don't know if that's true, but they told me that story and I remember being impressed by the number of people with crutches in the hospital. I saw people die, my comrades, and I saw poverty…

Doctor Gonzalo's reflection on Angola illustrates well that when examined from the point of view of the individual doctors, the differences that exist between and within each mission become strikingly clear. A Cuban doctor in Brazil can buy a car, re-marry, and travel to other cities in Brazil. They can also purchase luxuries probably that are out of reach to Cuban doctors in Venezuela, or those who participated in the earliest missions. Medical missions, from their start were not intended to be leisurely trips abroad, and I am certainly not trying to exoticize Brazil as an ideal place to work as a doctor; rather what I am presenting here are the differences that exist between these programs.

Asides being treated by the academic literature as a monolithic entity across time and place, scholarly works on Cuban medical missions are also devoid of critical analyses of hierarchy and variables such as, gender, race, and class.[8] Cuban SSC is, perhaps naively or purposefully, treated as if Cuban society were inherently free of racism and sexism, without pondering the ways Cuba's (and by extension Cubans') preconceived notions of gender, race, and other factors, could affect the tone and outcomes of these missions and vise-versa. Or as historian Christine Hatzky argues:

> I also use the word "cooperation" to distance myself from the term "mission," which is frequently found in the Cuban context to refer to an engagement abroad. My choice of terms has not only to do with the fact that "mission" is ideologically tendentious. The word also has the paternalistic connotation of one-sided activity on the part of Cuba […](2015, p. 27).

Said differently, even the use of the word "mission" to describe Cuban solidarity efforts abroad implies a certain unequal power relationship whereby Cuban agents, whether doctors or other technicians, deliver "superior" knowledge and understanding to their host countries. Certainly, this critique is not limited to Cuban involvement in Angola during the Cold War, but remains in many Cuban doctors' implicit thinking about their time abroad, or as doctor Ines who completed missions in Ghana, Venezuela, and Brazil, reflects upon her experiences:

> Interviewer: How was your experience in Ghana?
> Interviewee: It was very different. Food, languages, they had different dialects, the way they dress, the way people interact with each other, there were people from different tribes who could not communicate with each other because they did not speak the same dialect. Religion also, they were very *creyente* [faithful], very Muslim.

[8] These themes, and their impact, will be better elaborated in the following chapters.

What one can see here, subtly, is the way in which racial, religious, gendered, and other hierarchies affect the ways in which Cubans read their host communities and are read by them. Cuban doctors participating in *Mais Médicos* are not only providing medical care; they are also navigating Brazil's domestic political and cultural landscapes. The outcomes of this encounter will vary greatly depending on the Cuban doctor's: gender, race, age, sexuality, and other factors. This observation is reminiscent of Brah's claim that, "Structures of class, racism, gender and sexuality cannot be treated as 'independent variables' because the oppression of each is inscribed within the other – is constituted by and is constitutive of the other" (1996, p. 109). Secondly, these encounters also differ greatly across time and place, as I have outlined in this section by comparing and contrasting the experiences of Cuban doctors working within *Mais Médicos* and those who are (or have been) stationed in other countries and settings. Overall, this shows us the complexity within Cuban medical internationalism and how it has evolved since its first incursions in Africa and Latin America into a complex web of medical care. This web though is entangled in local, (post-)Cold War, and Global South political processes, hierarchies, and temporalities. Despite its overt efforts to present itself as an apolitical tool for human solidarity, Cuban medical internationalism cannot escape the apparatus of international politics.

3.2 THE DISCURSIVE TRANSFORMATION OF MEDICAL INTERNATIONALISM AFTER CAPITAL

The "Special Period" that ensued in Cuba with the fall of the Soviet Union and its economic hardships drastically altered the domestic political landscape, as the government legalized the circulation of US dollars, condoned small businesses, and enacted other neoliberal reforms (KAPCIA, 2008, p. 190). The extent of the economic crisis, with GDP shrinking by 11,6% in 1992 and 14,9% in 1993, and gross internal investment falling by 58,3% in 1992 and 39,7% in 1993, pushed the psyche of the Cuban people to the brink (VALDÉS, 2011, p. 357-8; ERISMAN, 2006, p. 3). The neoliberal reforms that followed radically altered interpersonal and power dynamics among the island's residents as capital-induced thinking seeped into the communist island (see STOUT, 2014; BROTHERTON, 2012; HAMILTON, 2012). With an influx of tourists and dollars as part of the government's plan to overcome the crisis, Cubans began looking at their lives and economic prospects "differently", placing access to foreign capital towards the top of their list of priorities. Put differently, the economic liberalization that emerged as a necessary response to the Soviet

Collapse introduced a new discourse of market thinking and capital acquisition into the folds of the Cuban revolutionary process. In this section, I argue that this discourse has not only essentially altered Cuban domestic politics, but also foreign policy, specifically medical internationalism programs, altering revolutionary temporality.

When asked about their reasons for participating in foreign medical missions, for instance, interviewees always listed financial reasons first, followed by getting to travel, new experiences, helping people, changing lives, and so forth. This makes it clear that although the primary *stated* purpose of medical internationalism, both historically and at present, is to deliver healthcare services in another country – it does not necessary mean that the individual doctors who deliver these services have that as their foremost motivation. This does not imply that their resulting performance is lackluster[9], as these are all trained medical professions who follow certain standards when treating their patients; but rather that they have complex motives and desires that affect these foreign policy programs. As Miranda phrased it:

> Interviewer: Why do you think that Cuban doctors participate in these medical missions abroad?
> Miranda: A house, a car, a business back in Cuba, everyone has a different project in mind, either buying something or starting a business. Of course, you can't spend it [money] all here on parties and merrymaking [*fiestas y pachanga*], as we say.

This quote captures the essence of the very real financial considerations that drive people to participate in these programs and which they must keep in mind while "completing the mission". Economic considerations have also come to the forefront of Cuban domestic politicians' thinking in terms of these missions, not just in the minds of the doctors. In 2016, Cuba received $8.2 billion from its medical missions abroad, meaning that the approximately 55.000 medical professionals Cuba had stationed in Brazil, Venezuela, and numerous other countries, were a lucrative and important source of income for the government (WATERS, 2017). This trend has led some to quip that doctors are now Cuba's largest export product. But their percentage as a total of foreign earnings may possibly fall in the near future, considering the economic crisis in Venezuela only continues to gain force, and newly-elected Brazilian President Jair Bolsonaro has caused Cubans to exit the *Mais Médicos* program with comments he made shortly after his election in late 2018.

Whether they are the country's largest source of foreign revenue or not – we still have individual humans with personal aspirations and dreams that are contributing a considerable sum of money back to Cuba for the island's social spending and economic development. On the other hand, the deployment of a sizable amount of doctors abroad is not a solely positive

[9] Cuban doctors participating in *Mais Médicos* have generally been praised for their competency and patient satisfaction (KIRK; KIRK; WALKER, 2015).

opportunity for the Cuban state, since sending doctors abroad could eventually create a shortage of medical experts for the Cuban people, especially in Cuba's more remote rural provinces (FEINSILVER, 2008b). Even though Cuba has an impressive number of doctors, about 90,000 for a population of 11,2 million,[10] making it one of the highest per capita in the world (WATERS, 2017), sending so many trained medical specialists abroad could one day cause a possible deterioration in the island's own healthcare system (KIRK, 2009; HUISH; KIRK, 2007).

From this analysis, we can see how political identity in Cuba has moved away from idealism and more towards pragmatic matters (KAPCIA, 2008, p. 132). The Cuban government now seems less preoccupied then before in spreading quality care throughout the Global South, and more with how much hard currency it will bring into the state's coffers. The economic and pragmatic rationale that has come to characterize Cuban medical internationalism is best represented through the experiences of doctors that deserted from *Mais Médicos* or from *Barrio Adentro*. As part of my fieldwork, I interviewed seven doctors that deserted, some of them now living in the US. These individuals who are not directly tied to the Cuban government anymore, when asked their motives for deserting always listed a financial reason first. In other words, none of them listed ideological disagreements with the Cuban state or political reasons, all simply felt they could make more income and live more prosperous lives by deserting from the program than by staying in the international mission. As Antonio who deserted, and is now married to a Brazilian woman stated:

> Interviewer: Do you think that the majority of people who desert, the majority of them do it for economic motives or because of some ideological/political disagreement with the Cuban government?
> Interviewee: No, no, no. The majority do it because of economics, because all of us grow up inside of the system over there [in Cuba] and there are a lot of things there that are worthy of defending, some not; but there are good things… The majority that leave is for economic reasons, of course there are some that leave for political reasons, but not the majority. But also because of the Cuban government, itself, that sometimes forces us to desert, for example, I know a man that lives about 40 kilometers from here, and he got married [to a Brazilian] and he was close to finishing his mission. He asked to change his flight back to Cuba for a latter one so he could do some paperwork here, and the leadership of the mission they said, "No"! They said that or either he went back on that flight or he deserted, and well he deserted.

In this recollection we clearly see the convoluted dynamics and forces at play in Cuban medical internationalism and that have been evolving for some time, as we have an individual who allegedly wanted to complete his tour in *Mais Médicos* but was obligated to

[10] By comparison, Brazil before *Mais Médicos* only had about 1.8 doctors per 1,000 inhabitants (GARCIA; ROSA; TAVARES, 2014). Cuba has more doctors than Canada, a country with a population three times as large (KIRK; KIRK; WALKER, 2015).

desert due to bureaucratic issues. My fieldwork and interview results all seem to support Alzugaray's (2015) point that Cuban foreign policy has undergone an *official* shift in discourse since 2009, turning towards an extreme focus on economic matters. Yet, this official change is reflective of a slower and heavily contested discursive process that has been underway within Cuban civil society since the fall of the Soviet Union. In other words, one should not read this shift in Cuban foreign policy as an abrupt break in temporality that occurred instantaneously, or as a sudden result of Raúl Castro's rise to power. On the contrary, it is the end result of a gradual discursive process that has been unfolding within the Cuban revolution for quite some time.

However, despite an official shift in government discourse or tactics surrounding foreign policy and how to best advance Cuba's foreign policy interests, there still seems to be an interest on the part of the Cuban government to present international medical cooperation efforts as something "different". Let us analyze the words of Cuba's new president since 2018, Miguel Díaz-Canel, in a speech he gave in late 2018 to Cuban doctors returning after participating in *Mais Médicos*:

> You all who will be back in your places of work or leave to fulfill another mission are part of a group of people that gives us evidences of heroism. On behalf of the Party and Government, I would like to reiterate that we are deeply proud of each of you, as we are of the rest of the healthcare workers who are carrying out missions in 66 other countries…You are a symbol of the country that formed you, and provide evidence of the kind of men and women we aspire towards in Cuban society, based on justice and humanism, not the law of the strongest (ARTEAGA IBAL, 2018, authors's translation).

Díaz-Canel's words demonstrate well how the Cuban government has a vested interest in maintaining the discourse around its foreign medical missions as one of positive contributions toward the development and prosperity of other's healthcare systems. Díaz-Canel's reference to Cuban doctors as "a symbol of the country that formed you", is also revealing of the discourse and identity that the state wants to constitute around its healthcare professionals, a theme that will be further explored in the next chapter. Although, Cuban medical internationalism has taken on an important role for the country's economy and balance of payments deficit, as well as having a tremendous impact on the purchasing power of the thousands of individuals doctors that go abroad, official discourse would prefer to eschew that transformation and focus on the foundations, and original principles that guided Cuba's medical worldliness.

Or as Benzi and Zapata explain it in their analysis of Cuban internationalism:

> [A]n important economic shift in Cuba's approach to cooperation that is challenging the very humanitarian and ideological foundation on which it was initially conceived. The "revolutionary fervor" in Cuba's orientation to internationalism has

> been gradually fading since the collapse of the Soviet Union, and nowadays, in a context of the urgent economic reforms needed by it, a truly market-oriented approach is taking its place (2017, p. 101).

Once again, this is not to say that Cuban doctors who participate in these programs, only care about the money; but that economic motives, unlike in previous generations, seem to factor heavily in the decision to leave one's family behind and go work in uncertain conditions abroad. This shift poses an interesting discursive question about the possible long-term effects that the introduction of this pragmatic economic thinking could have for the Cuban regime as thousands of doctors who worked abroad in capitalist countries return home, and considering capital and capitalism's universalizing tendencies (CHIBBER, 2013).

Beyond Cuban medical internationalism, one can also see this market-driven thinking in other aspects of Cuban foreign policy, such as Raúl Castro's efforts to negotiate with Barack Obama a rapprochement with the US. This capital-centric discourse has altered the minds of Cuban decision-makers and individual citizens towards a conscious, and subconscious, desire for hard financial capital acquisition – a type of thinking that early revolutionary instincts and moves attempted to extract from Cuban society. This process shows the extent to which capital, working subtly, can affect foreign policy in the 21st century, as the rationale and thinking behind medical missions have been transformed, while the public presentation of its goals and intentions remains humanitarian goodwill.

Furthermore, when we consider that both the PT and *Chavista* leftist governments of Brazil and Venezuela, respectively, engaged in these programs with a strikingly neoliberal and market-oriented economic thinking at their foundation, one realizes it is not only in Cuba; but rather that a grander discourse of economic and market-based thinking has spread throughout the Global South. Put blatantly, there exists a complex and polymorphous relationship between capital and politics in the post-Soviet world, both within Cuba and beyond, whereby, "Geo-economics impinges upon geopolitics as much as economics impinges upon politics" (BARU, 2012, p. 9). As Stephen Gill argues, recent pushes in globalization and neoliberalism have redefined the relationship of both states and individuals towards capital, making both more disciplined and focused in their drive towards capital acquisition, regardless of stated political preferences or goals (GILL, 2008, p. 169-175).

3.3 CONCLUSIONS

Cuban medical internationalism has a long-standing history since the 1960s of providing medical care and aid to numerous countries and peoples in need. What I have done in this chapter is problematize and critically examine Cuban medical internationalism across different spatial and temporal arenas in order to gauge its development, nuances, and shifts. When compared to the employment of Cuban doctors in Angola during the 1970s, or Venezuela in the early 2000s, one notices that Cuban doctors in Brazil working within *Mais Médicos* have had a considerably different experience. Thus, Cuban medical internationalism cannot be viewed as a monolithic entity, but instead as a process that is affected by changes in local and international political contexts, such as the end of the Cold War, or resistance to the "Pink Tide" governments that came to power across Latin America since the late 1990s. Likewise, we cannot treat the delivery of medical care as if it were a neutral and powerless relation within the social sphere. On the contrary, we must account for the nuanced ways in which race, historical legacies, gender, and relations of power, work to complicate the expected or desired outcomes of these medical missions.

Furthermore, using a post-structuralist theoretical approach, I have outlined the shifts that *Mais Médicos* is indicative of within Cuban foreign policy thinking during the past few years. This discussion reveals the complex ways in which global capital and neoliberal thinking regiment and permeate the international system through various hierarchies, which complicate both national and international discourses of leftist political stances and goodwill internationalism advanced by the Cuban state. Secondly, when examined at the level of the individual, analyzing the rise of capitalist market thinking within Post-Soviet Cuban medical internationalism, reveals how the doctors themselves can wield power and agency by participating in these programs that further, not only the interests of the Cuban and Brazilian governments, but also their own personal long-term financial goals.

This analysis suggests that Cuban medical missions, such as *Mais Médicos*, are at the intersection of countless and at times conflicting social discourses, not just a simple stream of healthcare delivery. Moreover, despite official rhetoric and stances, economic considerations play a role in the thinking of both government and individual within medical internationalism and how they position themselves to take advantage of its outcomes. What we have seen here is, an intricate personal and state-level political calculus on the part of numerous actors, that goes well beyond what we could capture within a rationalist model of marginal loss and benefit. Cuban doctors, the Cuban state, Venezuelan doctors, the Brazilian state, and so forth

are affected by and affect prevailing discourses on healthcare, socio-economic development, and social justice. These discourses and actors, all driven by capital, engage in a complex social struggle that then, at least partially, shapes each other's possible choices and decisions. This discussion raises the question, which will be the focus of the following chapters: how do race, gender, and medical discourses also affect the outcomes of Cuban medical missions?

4 (RE)INTERPRETING SOUTH-SOUTH COOPERATION

A recent book (BERGAMASCHI; MOORE; TICKNER, 2017) on SSC includes chapters on India's engagement with Senegal and Mozambique, Turkish aid to Somalia, and Brazilian partnerships with Mozambique, to name a few examples. Over the past few decades emerging and Global South countries have vigorously entered into the international development conversation and process through countless SSC ventures that have worked to transform the traditional map of aid donors and recipients (BESHARATI; ESTEVES, 2015). SSC has created a challenge to preexisting discourses on *who* can contribute to another country's progress and *how*, through "political, economic, and cultural relationships" that range from short-term humanitarian aid to the formation of regional blocks (BERGAMASCHI; MOORE; TICKNER, 2017, p. 1). These changes in IR and cooperation have led some optimistic scholars even to proclaim the beginning of a "Post-Western World" (STUENKEL, 2016) and speak about a substantial reconfiguration of power and agency within the international system.

The purpose of this chapter is to present a more elaborate interpretation of SSC that does not only look at economic outcomes and measurable statistics – but which also analyzes the uncountable and unintended. Specifically, I contend that SSC can be imbued with power imbalances and asymmetries in a similar way to North-South encounters, and that this similarity reveals the ways in which race, power, and identity affect IR. Since the Bandung Conference of 1955, and with the creation of the Non-Aligned Movement, Third World or Global South actors and states have attempted to reconfigure the global order by calling for more attention to their problems, the enduring legacies of the colonial period, and the preponderant power asymmetries that traverse the world system (PRASHAD, 2012, 2007; DOS SANTOS, 2011). From these movements, arose post-colonial theory within IR (see CHIBBER, 2013; PRASHAD, 2012, 2007; LOOMBA, 1998; FANON, 1986; SAID, 1977; CÉSAIRE, 1972; NKRUMAH, 1965), which critiques the ways in which racialized thinking and typologies have constituted a subaltern and inferior place for ex-colonial states within the modern state system.

Colonial structures left the economies of these states highly dependent on the capitalist "core" through a marginalized position that cannot be simply overcome by declaring independence from the metropolis. These "relations of dominance and submission", as Césaire (1972, p. 42) describes them, have even seeped into the academic discipline of IR, or as Funk (2013, p. 5) writes, "Many of IR's supposedly universal concepts and truths are in

fact generalizations based on Northern (specifically European) experiences, and are of questionable relevance to the South". Following this logic, some have called for "decolonizing" IR and moving past viewing the Global South as nothing more than the North's "Other" (GRUFFYDD JONES, 2006; cited in FUNK, 2013, p. 6). As scholar Roxanne Doty (1993, 1996) posits using a post-positivist approach, a discourse has been created around Global South states, and they have been represented within the international system, so as to make them inferior, uncivilized, and disorderly vis-à-vis the Global North. Furthermore, this legitimizes and permits the intervention, violence, and presence of the Global North within Latin America, Africa, and Asia (THAKUR; DAVIS; VALE, 2017; VITALIS, 2015, p. 25-7).

These academic reflections have led towards calls to "provincialize Europe" (VASILAKI, 2012; CHAKRABARTY, 2000) and to "unsettle the South" (PIEDALUE; RISHI, 2017, p. 548). SSC has been presented as the "natural" panacea to the power imbalances and asymmetries that pervade North-South encounters, considering it is an interaction between two or more states that share a similar subaltern position and colonial legacy. Secondly, SSC allowed Global South states to maneuver the power competitions of the Cold War, and since then to construct their soft power, expand technical knowledge, and build their influence within international cooperation schemes. Yet, the critical question remains: can SSC escape from the negative side affects; racialized and sexualized narratives; and resultant (direct and indirect) exploitation that plagues North-South relations and recalls the colonial past? This dissertation attempts to contribute to the growing academic literature that analyzes this conundrum (see BERGAMASCHI; MOORE; TICKNER, 2017; BENZI; LO BRUTTO, 2013; CHATURVEDI; FUES; SIDIROPOULOS, 2012).

"Global South" and "Global North" emerged as terms around the end of the Cold War to replace the previous divisions between First, Second, and Third World. Western thinkers reconfigured their taxonomy of states along developmental lines, since the fall of the Berlin Wall, and the end of the struggle between capitalism and socialism. Former German Chancellor Willy Brandt, famously proposed the 30°N latitude line, as roughly the division between the Global North/South. In the North, are the G8 or "wealthier" states and regions: US, Canada, Europe, Russia, Japan, and Australia/New Zealand. In the South, would be roughly the G77 or "poorer" countries and regions: Latin America, Africa, the Middle East, and parts of Asia. The problem with this classification system is that it seems to suggest a correlation between geographic position and economic wealth or development (FONT; RUFÍ, 2006, p. 51-57). This reasoning speaks back to ancient Greco-Roman and pseudo-scientific

explanations that justified Europeans' alleged superiority over Africans and other peoples that lived to the south of them (CORREIA, 2010). Dividing the world along a North-South binary creates a linguistic category whereby peoples and states closer to the Equator are constituted as naturally impoverished and less developed than states closer to the Arctic Circle. This linguistic identification system is problematic because it "represents" the Global South as inherently inferior and unequal to its counter-part (DOTY, 1996). In international politics, as well as in society, words and their meaning, along with the resultant identities they formulate have power (LAPID; KRATOCHWIL, 1996). This power results in modifying the way we think about and look at an object (KRATOCHWIL, 2008, p. 82), here states and individuals in the international system, and the roles we attribute to them.

By identity, this study employs Avtar Brah's definition of: "*as that very process by which the multiplicity, contra diction, and instability of subjectivity is signified as having coherence, continuity, stability; as having a core – a continually changing core but the sense of a core nonetheless – that at any given moment is enunciated as the 'I'* " (1996, p. 123, italics in original). Stated differently, identity can refer to the rationales and systems by which intersubjective meanings and understandings are co-constituted within society through encounters with the "other" and "self", and how these serve to craft and reaffirm our sense of belonging and place within a greater group (ONUF, 2013; LAPID; KRATOCHWIL, 1996). Or as Kratochwil (2008, p. 86) explains: "…the human world is one of artifice, then the notions the actors have about their actions matter. They cannot be left exogenous to the descriptions and explanations of actions…" My point here is to view race, power, and identity through the prism of SSC in order to critically analyze the latter and how these manifest themselves in nuanced, and at times problematic, ways when individuals from different Global South states meet on a daily basis through these programs. The ultimate objective being to critically analyze the changes and inconsistencies within Cuban SSC (see BENZI; ZAPATA, 2017) in order to demystify and better situate SSC within our understanding of global order and power.

The discussions advanced here, fit into a greater academic debate on how to (re)think and (re)interpret IR beyond a state-centric and Eurocentric science that legitimizes the interests and actions of the Great Powers (see STUENKEL, 2016; VRASTI, 2013; TICKNER; BLANEY, 2012). This conversation has called for a better understanding of the foreign policy approach and positioning of emerging and other non-traditional powers (KAHLER, 2013; NOLTE, 2010) and has attempted to "see IR differently" (TICKNER, 2003). Moreover, recent attempts have been made to decolonize the way we view the Global

South, both socially and academically, as well as decolonize how we analyze and comprehend Latin America (TAYLOR, 2012; MIGNOLO, 2011; QUIJANO, 2010; DE SOUSA SANTOS; MENESES, 2009). In other words, the academic literature has generally accepted North/South relations as negative, asymmetrical, and oppressive – while tacitly accepting its South/South variant as *naturally* positive, equal, and emancipating – without closely analyzing it at the micro, local, and interpersonal level. "Coloniality" is seen as an evil that can only come from the North, as Chibber (2013, p. 14) well characterizes it when he calls for a, "Dislodging of Eurocentrism". Yet, few have asked: what then are we inviting in through SSC? As will be detailed in the following sections, the answer would be a more nuanced outcome than originally predicted.

4.1 RACE AND POWER WITHIN CUBAN MEDICAL INTERNATIONALISM

Despite the best intentions of academics and world leaders to decolonize global politics through SSC and confront the international system's racialized matrix – racialized thinking and hierarchies still pervade. I was struck during my interviews by the subtle or subconsciously racialized language that my informants, who are goodwill ambassadors for thirdworldist solidarity, expressed as they commented on their experiences in these medical missions abroad. As doctor Katia, who completed missions in Honduras and Venezuela shared:

> Interviewer: How was your experience in Honduras different from your time in Venezuela?
> Interviewee: In Honduras I was in a village that did not have electricity, and I was responsible for 28 villages, there were some villages that when I went to visit them it took me four hours on horseback. It was in the middle of the jungle, there was everything imaginable, snakes, everything. The people there were completely illiterate, very humble. There were days when we would see 102 patients. It was very difficult. They never attacked me. They used to say, "First God in Heaven and then the Cuban doctor"! They used to say that. In fact, they used to say I was a *gringa*, because they thought that every Cuban, that we were all black.

The reflection above reveals more than an admiration for Cuban doctors – it reflects a greater racialized component to SSC. As the many Cuban doctors who were greeted at Brazil's airports with chants of "Slaves" can relate to (WATTS, 2013), SSC unintentionally creates an "encounter" between two different racial imaginaries and visions that results in clashes and representations. For Katia, who is blonde and white, working in Central America gave her a superior position of power and agency because she fulfilled what the local population expected a doctor and educated professional *should* "look like". Meanwhile, for other Cuban doctors, their reception and rapport among their patients and host community

was hindered by their race, as Antonio, a young doctor completing *Mais Médico*s in the Brazilian state of Rio Grande do Sul, expressed during his interview:

> I had luck here because I am white, because I have green eyes, because my municipality is small, I didn't suffer any racism. But I have colleagues who are black and the discrimination towards them is horrible. If you ask over there in the Northeast maybe [doctors] there didn't see so much racism because people there are more *moreno* [brown complexion]. Maybe there you don't see that. You know that Brazil is an enormous country with many cultures, but when we speak about the South, where there are German, Portuguese, and Italian peoples, there is a lot of racism.

My point through these reflections is to demonstrate how racialized thinking, behavior, and conceptions of the "other", are so pervasive within the international system that they also infiltrate (or taint) SSC. Secondly, it is not only the donor state exerting a racialized and racist image of the recipient country, but rather that the resulting racial hierarchy depends on temporal and geopolitical settings. As many scholars of Latin America have argued (QUIJANO, 2010; MIGNOLO, 2000) one's racial, gendered, or class standing, can morph drastically depending on location or in terms of who is the subject being considered (and who is doing the considering), which is problematic when left unchecked in a SSC context. As Doty explains:

> In international relations, hierarchy has been more of a background condition from which analyses proceed rather than something which is itself in need of examination… these approaches exhibit an unspoken agreement *not* to problematize the construction of the subjects that constitute the world and the *categories* through which these subject and objects are constructed. I suggest that we need to denaturalize hierarchy (1993, p. 303-4, italics in original).

In other words, racial thinking and hierarchies are well-engrained within the international system (THAKUR; DAVIS; VALE, 2017; ANIEVAS; MANCHANDA; SHILLIAM, 2015; VITALIS, 2015, p. 98, 106), even SSC, and affect the outcomes and substances of these programs, in spite of the usual notion of SSC as a *better* and *different* alternative to North-South aid and relations. This unexpected outcome is not new either, as historian Christine Hatzky points out, after conducting interviews with numerous Cuban participants in SSC missions to Angola during the 1970s-80s:

> Their descriptions were generally linked to stereotypical images such as dirt, poverty, and backwardness. They felt sorry for the pupils and tried to help them, but again their accounts demonstrate that they saw themselves as the agents of a culturally superior civilization and superior social system… The basic tenor of many interviews was that the participants believed that they had "taught something" to the Angolans (2015, p. 247).

During the course of my interviews doctors who completed missions in Angola, Venezuela, Ghana, Honduras, and Bolivia experienced similar feelings of being "agents of a

culturally superior civilization". On the other hand, they often felt themselves at the receiving end of these stereotypes and hierarchies in Brazil, as doctor Migdalis shared:

> You go there [Gaucho Highlands] and you only see white people. The further up the mountains you go, the whiter they are. They say they are German, they live like Germans but in Brazil, they go to see me at the clinic for a consultation and they speak in German. It enrages me, and they don't even know how to write in German, they only speak it… That German culture is strong, they are traditionalists… They speak ill of the Italians also, one nurse told me not to *misturar-me* [get involved with] Italians because they are not good people.

What all of these experiences seem to reflect, more broadly, is that there exists an important nexus between power, place, and South-South interaction, which reflects the racialized and gendered imageries that also plague North-South relations. As Vasilaki (2012, p. 5) writes about global politics: "Western Enlightenment culture and the associated idea that the West/Europe held a unique or exceptional – read superior – position against what has been called 'the Rest', 'the Other', 'the underdeveloped' or 'the premodern'". What my fieldwork reveals is that Western notions of superiority – whether stemming from race, economic position, or gender[11] (or a mixture of the three) – also influence the ways in which SSC is carried out on the ground. The result of this process is *not* a simplistic relation of power where one agent or group holds power over another agent or group, a notion also refuted by Foucault (2001, 1978; see also SCOTT, 1986, p. 1067).

On the contrary, what emerges here at the inter-personal level is a is Weberian web-like, and at the same time hierarchical, ordering to power relations within the international system that is subject to inflections and changes depending on time and geopolitical setting. This recalls feminist scholar Joan Scott's words, which were quoted in the introduction, when she speaks of, "power as dispersed constellations of unequal relationships, discursively constituted in social 'fields of force'" (1986, p. 1067). This is a similar hierarchical power arrangement to that observed by Nolte (2010), as he attempted to characterize and define the differences between regional powers, middle powers, and other state-level classification systems. In other words, Foucault's (1978, p. 92) assertion that, "power must be understood in the first instance as a multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization", is an element, identifiable, at both the inter-personal and international level. This revelation demonstrates how power presents itself – at times unexpectedly or subtlety – within SSC because, "there is no power that is exercised without a series of aims and objectives" (FOUCAULT, 1978, p. 95).

[11] This is what Quijano refers to as "coloniality of power" (2010, p. 25).

Returning to Midgalis' experience in Rio Grande do Sul state, her recollection is rather telling when examined through a post-colonial lens. Midgalis has faced discrimination for not being German, but she personally identities as white, thus her discrimination incenses her because it denies her the "whiteness" and resulting social privilege she has come to expect from it back home in Cuba. At the same time, she is well-aware of ethnic divides in her host community between German and Italian immigrants and even uses the Portuguese word, not the Spanish word, when retelling the advice she received from a co-worker. This interaction is full of racialized and overlapping conceptions of numerous "others", created by differing views of: ethnicity, whiteness, race, and who is a member and who is an outsider in this Brazilian community (GOLDSTEIN, 2003). These simultaneous encounters between white/black, Cuban/Brazilian, German/Italian, all serve to further illustrate how power relations in the international system are often constituted along racialized lines. Moreover, these relations are not easily or singularly defined; but rather they operate through hierarchical and overlapping systems of oppression that are in a constant state of flux and of re-definition.

Cuba and Brazil were the two countries in the Americas that received the highest number of enslaved Africans, and the last two that emancipated them, which has left long-lasting colonial and racial legacies, still to be addressed within both countries. Furthermore, Cuba, despite revolutionary rhetoric, has attempted to silence social conversations on race and its resultant privilege (see SAWYER, 2006; FERNANDES, 2003). Therefore, one should not expect any SSC program between the two, such as *Mais Médicos*, to be *inherently* free of race and racism. By taking my analysis to the level of the individual, I was able to trace the nuanced ways in which "power" and "power relations" function within the international system. Or as Sterling-Folker and Shinko (2005, p. 637-8) write: "It [Power] is a web that permeates all relationships, institutions, and bodies of knowledge…It cannot be measured in a positivist sense, but it can be revealed by examining the marginalised silences on the borders of the hegemonic (Westphalian) discourse".

Moreover, in a country like Brazil or Cuba, considering the history both have of forced human labor, calling a foreign doctor of African descent "slave", as many Cuban doctors heard at airports across Brazil, carries a deep meaning. The usage of the word "slave" is not just a reference to the salary, or lack thereof, which Cuban doctors would allegedly have within the *Mais Médicos* program. On the other hand, the chant of "slave", and the historic and racial imaginary which that evokes, tells us a lot more, as it demonstrates the social position, or lack thereof, these Brazilian elites were willing to cede to Cuban doctors. It also reflects an existence, even today, of poor labor conditions throughout the Brazilian economy,

and which many are willing to tolerate because it protects their own social position. In other words, Brazilian elites categorizing Cuban doctors and their labor as somehow inferior, and akin to slavery, is something that Brazilian domestic workers, street sweepers, bus drivers, garbage/recycling collectors, street vendors, and numerous other informal workers, can relate to as a social invocation that works to denigrate their social status and position.

This is also rather telling about the international system, more broadly. Slavery might have legally ended in the 19th century throughout the Americas, yet it imposed throughout Latin America a complex and convoluted system of racial representation and categorization that still has an effect on social and power relations until today. The social "roles" and "privileges" that slavery created throughout Latin America may have morphed overtime to meet changing international norms about human decency, but their purpose in ordering society remains in place. Evoking narratives of slavery thus reflects how history and past systems of oppression can be utilized throughout the international system, even within SSC schemes, to impose a desired order and possibly outcomes from an interaction, be it interpersonal or between states. Altered senses of temporality here work to transmit what some may view as outdated or past discourses about labor, the economy, and race, which are then adapted to encounter and help discursively decipher and order current social exchanges.

Thus, the polemic and overtly racist reception that many Cuban doctors received in Brazil was not a singular or unusually racialized reception of a foreign "other". It was, instead, a prelude to the racial contours they would have to navigate, some more easily than others, during their entire stay in Brazil. Racial hierarchies were imposed throughout the Global South during the colonial period, and have not been easily erased by independence or revolution. In fact, these hierarchies still enact and reinforce, albeit at times subtlety, Westphalian and Eurocentric narratives of superiority among Latin American and other third world elites, men, and white people. As Midgalis, Katia, and many of my other participants well demonstrate, there is great diversity within the margins of IR, to use Enloe's term (1996). The difference in agency and ability to assert/wield power between an Afro-descendent Cuban doctor in the Brazilian South, and a European-descendent Cuban doctor in the Brazilian Northeast, reflects the imposing nature of racial hierarchies within (and between) Global South states, regardless of efforts to cooperate through international solidarity efforts and programs.

Likewise, this discussion is not meant to suggest that "race", as a system of social exclusion, works and is constituted within Brazilian and Cuban civil society in the same way. Cuba and Brazil both have very different racial legacies, and the way in which race is read

and decoded within both societies is different. However, it seems that race, taken as a social process whose aim is to institute difference across bodies and spaces, evolved differently in Africa, Asia, Latin America, and so forth, respectively. Throughout Latin America, it appears, to me as somebody who has spent time in both Cuba and Brazil, that race, paradoxically, is both ever-present and hidden at the same time. What I mean by this is that, for instance, the Cuban revolutionary government, shortly after coming to power, stripped from legal books laws that had previously instituted housing segregation, for instance (see SAWYER, 2006). The revolution, in discourse, has constantly maintained that Cuba is a society without racism, and where white, black, and mixed Cubans can live as equals within a socialist market logic of equality; however, social reality does not seem to match this discourse (see JOHNSON, 2012). Meanwhile, Brazil has a long history of presenting itself as a "racial democracy" where, once again, people of every racial heritage are part of and can participate in society as equals. It seems then that both countries have, in part, built their national identities on a purposeful negation and obfuscation of race, and more importantly racism, in an effort to maintain social order (read the privileged status of elites) and progress, to borrow from Brazil's national motto.

Moreover, both Cuban and Brazilian national identity appear to be deeply aligned with a drive towards negating and denying blackness.[12] Of course, this is not the type of blackness that can be commodified, commercialized, and sold such as: Salsa, Samba, and Carnival; nor is it the type of blackness that allures tourism dollars through investments and sexualized narratives of deviant natives. Moreover, it is not the type of blackness that can be called up esoterically and rhetorically to enhance one's soft power and legitimize foreign policy strategies on the world stage. Rather, it is the type of blackness that is attached directly to real human bodies, not abstract narrative bodies; and which can be used for the social purposes of empowerment, creation of subjectivity, organization and mobilization, and ultimately disruption of norms and hierarchies (see FERNANDES, 2003). That type of "inconvenient" blackness is negotiated, dealt with, and hidden away, throughout Cuban and Brazilian national identity, usually under Westernized and Eurocentric tropes of whiteness and its alleged racial and social superiority, as has been described in this section.

Despite efforts to discursively circumscribe race as a social topic distant from individual's daily life and social existence – race and racialized thinking remain prevalent within both of these societies. This thinking might emerge in different ways within Cuba and

[12] The same reading can be made of indigeneity and the way in which it is submerged or blurred, except in politically useful moments, throughout national identities across Latin America.

Brazil, and has certainly been altered by Cuba's revolutionary process, as well as Brazil's redemocratization process, but it still plays a role and has an impact on the quotidian lives of every individual in those two societies. Racialized thinking is much more difficult to eradicate from individual's psyches, than are racist policies and laws from official documents and legal books. Race, thus, works to codify and decodify how individuals interpret, understand, and feel their daily encounters and routine experiences with others, both those whom they already know and those which they may come to know. In other words, racism is usually thought of as a conscious declaration, usually verbal, of dislike, or feeling of superiority towards others because of their skin color. This notion though must be expanded to include that which is not declared verbally, but is equally transmitted. Furthermore, feelings of superiority can stem not only from skin color, but also from cultural/ethnic origins, social status and type of employment, as well as social recognition of one's personal superiority, as the interviews presented above well exemplify. Race, then is a system of social exclusion and inclusion, one that partially works as a means to provide cartographic guidance for peoples' exchanges and practices, while simultaneously aiding in the production of individual and collective identity, as we will turn our discussion towards now.

4.2 (RE)AFFIRMING PERSONAL AND NATIONAL IDENTITY THROUGH SOUTH-SOUTH ENCOUNTERS

This section explores how *Mais Médicos*, and other Cuban medical missions, work to constitute the personal identity of Cuban doctors and their counterparts, and by extension, both Cuba and the host country's national identity. Returning then to doctor Katia, her statement about her patients in Honduras who used to say "First God in Heaven and then the Cuban doctor"! illustrates rather well my argument. The mythology built around Cuban doctors and the medical profession in Cuba, combined with the social weight that medical professionals carry in our society, as Foucault (2003) argued, has often resulted in a relatively sizeable agency and position of power for Cuban doctors who participate in these programs vis-à-vis their host communities and even their family members back home. The images, discourses, and narratives, that are used to constitute the identity of the *global* Cuban doctor, whether stemming from revolutionary goodwill or third world solidarity, have helped advance the position of the individual doctors and of Cuban foreign policy, more generally.

The Cuban doctor as disinterested, the Cuban doctor as more professional, the Cuban doctors as inherently friendlier than the local doctor, are all social discourses that have

collectively resulted in Cuba becoming a "world medical power", as Feinsilver (1989) argues. Or as Doctor Antonio also shared during his interview:

> Interviewer: In what ways do you think that Cubans change Brazil, in other words, in what ways do you think that all of you affect the people with whom you interact?
> Antonio: Of course, look let me give you an example that I often use with people when that topic comes up. Cuban doctors are made to be family doctors, to touch and interact with the patient. I remember that when I arrived at the clinic, for the first time, my chair and the patient's chair were on opposite sides of the desk. I went in and immediately changed them, I want the patient here by my side [points at himself] so I can touch them and feel closer to them… From this alone the patient leaves the consultation feeling better, it's like a placebo, you know, only Cuban doctors are able to do that.

Beyond explaining placebos and medical tactics, Antonio is also detailing the agency that the identity of Cuban doctors as international Samaritans conveys upon him and his colleagues. Or as Doty (1996, p. 2) puts it when describing the international system, "In the process of attempting to formulate policy, resolve problems, and come to terms with various issues, subjects and objects themselves have been constructed".

This might be positive for Cuban doctors because it makes their patients in these foreign countries more willing to seek and accept their medical attention without fear or lack of trust. However, the co-constitution of Cuban doctor's identity, and the identity of their counterparts in their host communities, can create a resulting intersubjective meaning, usually, to the detriment of the latter. For instance Kirk and Erisman (2009, p. 133) write:

> German Padgett, the Honduran minister of culture, explained well in 2002 the vital role of Cuban doctors, comparing their attitude with that of their Honduran counterparts: "the Cubans are excellent professionals who provide loving care to their patients and their professional ethnics come first, before anything else, unlike their Honduran colleagues who put money first."

This conception of Cuban doctors as superior, and local doctors as inferior, works to denigrate the capabilities and actions of local professionals and reaffirms existing global power hierarchies and political projects. Or as Bruno, the leader of a Brazilian doctor's union, who vigorously refuted the notion that in-country doctors are somehow less caring stated:

> When the government proposed *Mais Médicos* they started a campaign against Brazilian doctors, that Brazilian doctors didn't want to work in the countryside, didn't want to work in public hospitals, didn't pay attention to patients, didn't talk with patients, didn't hold the patient's hand. I don't know what else. They did this as if Brazilian doctors were some guys only interested in making money.

Certainly, one could debate if the training that Cuban doctors receive makes them more amenable to patients' needs,[13] or that their willingness to participate in these programs proves some higher moral calling that doctors within a capitalist market system lack – but the bottom line is that these encounters and representations of Cuban and local doctors typically

[13] This discussion is continued further in chapter 6.

degrade the reputation of the latter. In a global political sense, this works to further the interests of the Cuban state and its foreign policy projection capabilities, while in a post-colonial sense reaffirming dominant narratives of other Global South people as "needing" aid, unable to provide for themselves, and as being naturally inferior. This identity, when combined with racialized thinking and the relations of power that were explored in the previous section, can result in SSC having power imbalances similar to those found within North-South relations.

Furthermore, the identity that is crafted for both Cuban doctors and their host communities can also work to (re)affirm and constitute the national identity of both. As presented earlier, Cuba as a "world medical power" or altruistic state sharing its sparse resources, is a potent narrative that feeds into Cuba's national identity, and which the revolutionary government has been carefully shaping since 1959. As anthropologist P. Sean Brotherton (2012) has detailed, the survival of the revolutionary project during the post-Soviet economic crisis was in many ways due to the personal sacrifices of individual Cubans (many of them doctors and medical professionals), who felt the idea of *Cubanidad* was in many ways tied to certain advances in public health and education that had been made since 1959 and that had to be protected. As Lapid (1996, p. 8) writes, "Culture and identity are emergent and constructed (rather than fixed and natural), contested and polymorphic (rather than unitary and singular), and interactive and process-like (rather than static and essence-like)". In other words, both Cuban and other national identities are not stable, given, or steady. On the contrary, they are negotiated daily through the encounters that occur both domestically and internationally through these SSC programs, and other political moments.

More specifically, the encounters that occur between Cubans and other Global South citizens through international medical cooperation work to (re)affirm each other's national identities often through stereotypes and pre-existing notions of the "other". As Solange, the director of a Brazilian non-governmental organization, exemplified during her interview:

> Cubans remind me a lot of people from Bahia, that way of always being happy that all of you have, always walking around Havana in the afternoon. There was a little group dancing and playing music [when she visited Havana], and they'll teach you how to dance *Salsa*!

This statement concisely demonstrates the way in which international encounters work to co-constitute national identity. The same can be said of the Cuban doctors who expressed many stereotypical images and notions as they shared the intricate "knowledge" they have acquired about Brazil during their time in *Mais Médicos*. Many of my interviewees commented on the differences between Brazil's regions (the Northeast as being more friendly

than the South), and the different groups that have migrated to Brazil over time (Portuguese, Germans, Italians, etc.), with authority on the topic. As historian Jeffrey Lesser (1999) has argued, Brazilian national identity is constantly morphing and anyone who lives in Brazil is entitled to negotiate their own space within its folds. My informants revealed how they have personally begun to carve out their own spaces within Brazilian national identity, as they become acculturated to its racial, ethnic, and other social hierarchy.

Cuban medical internationalism, whether it be cooperation in Angola, *Barrio Adentro* in Venezuela, or *Mais Médicos* in Brazil, works to discursively constitute intersubjective meaning about the "other" and both personal and national identities. However, these identities are not typically based on a decolonized reading of the other that places a collective understanding of hierarchy, Eurocentrism, and narratives of oppressor/oppressed at the forefront. On the contrary, they are usually based on stereotypical readings of the other. These stereotypes can work to reaffirm notions of the other as exotic, inferior, or fetishized. Perhaps this unintended consequence partially explains the negative backlash and hesitancy among many of the communities that receive Cuban doctors. That Brazil, which views itself as a rising power, needed to bring in over 11.000 foreign doctors to meet its domestic healthcare needs, works to confirm a negative image of the Brazilian state as unable to meet internal demands and thus reaffirms the country's subordinate position in the international system. As Benzi and Zapata write about Cuban doctors in Venezuela (2017, p. 97): "Even though numerous conflicts occurred with local medical unions and some sectors of Venezuela's population fearing the 'Cubanization' and the loss of jobs, nonetheless the communities served by Cuban doctors have been in general or overall very grateful for the attention given to them". Fear of "Cubanization" can also be read as fear of encounter with the other and being examined and placed in an inferior position.

Medical internationalism is a convoluted political project that goes well beyond providing care abroad, as it creates a space for different citizens of the Global South to encounter each other for the first time. Likewise, the activities and relations that Cuban doctors engage in while abroad go well beyond the intended scope of these medical missions, as the identity that is created for Cuban doctors is then amplified to create, not only an identity, but also a *role* for the Cuban state. The discourse of Cuba as a "world medical power" (FEINSILVER, 1989) establishes Cuba as a state that can, and should, provide medical care for its neighbors across the Caribbean basin and beyond. Therefore, what is presented as humanitarian work or uninterested goodwill, in effect, grants Cuba an economy of scale in the global production of medical practices and discourses, as well as a role in

regional political processes. This analysis gives us insights into how identities can take on an almost concrete appearance, which is then transformed into roles and tactics for foreign policy-making. This transposition of identity into roles has far-reaching consequences for how world politics plays out as the debates and discussions around Cuban medical professionals in Angola, Venezuela, Brazil, and probably many other countries to come, well demonstrates. Furthermore, when we examine the racial contours to these national identities, the power which these roles grant certain states, and not others, becomes even starker. It is power that goes beyond soft or symbolic power, and can become racialized and crystallized through foreign policy roles.

4.3 CONCLUSIONS

SSC is commonly spoken about from the level of foreign policy, and discourses of Global South solidarity. In this chapter, by taking my level of analysis down to the individual, I have demonstrated the complex encounters that occur between the medical professionals who participate in these programs and their host communities. Cuban doctors do not go to Brazil, Venezuela, or any other country, with just their stethoscope in hand. Quite the opposite, they carry all of their preconceived notions of self, society, and other – and are met by an entirely different set of these notions. Despite state-level efforts to develop and enact SSC regimes as inherently "better" and more "equal" than North-South encounters, these can still be imbued with injurious and racialized notions of the "other".

This is not to suggest in any way abandoning SSC. Instead, I argue for IR's need to better acknowledge the hierarchies that exist between and within both Global North and South states. Elites in Latin America, Africa, and Asia can think through the same colonial prisms as elites in the Global North and this hierarchical thinking infiltrates even the best-intentioned SSC schemes. These types of analyses and considerations are important in a world where international cooperation and aid regimes are being redefined daily by Chinese investments, Arab states' aid to other regions, and emerging powers traversing new spaces within the international order. There has been much talk of decolinization and dewesternization within IR, but one must look to the local, the individual, and the miniscule to better understand these processes, and the ways in which they may represent previous international political developments.

Moreover, the discussions advanced here are part of the growing critique within the social sciences of international ventures, from volunteer tourism (see VRASTI, 2013) to even

international development, which call attention towards the unintended consequences of humanitarian involvement and discourse. Rather naively, or not, race and identity are often forgotten categories of analysis when it comes to internationalized processes that involve investment, money, and profit. Capital and the discourse of "the markets", especially since the fall of the Soviet Union, have redefined the relationship between self, other, and state, and worked to transform how each one views themselves and the other two.

As presented in the previous chapter, Cuban doctors abroad typically work within *public* health institutions and programs, while their labor abroad is negotiated in a way that brings considerable profit to the Cuban state, and gives their work a *private* sensation, in a way. The line in their activities between public/private becomes tenuous at best, and difficult to draw. The same nuance unfolds when we consider race and identity, as these social processes morph across time and space, and are affected by changes within the international system. Overall, the interaction between neoliberalism and self is complex as it affects individual subjectivity and psychology, but also interplays and interconnects with social systems of exclusions, such as racism. This resulting discursive instability recalls a need to closely examine international political cooperation for traces and signs of colonial and/or neoliberal mentalities, an examination that is only further complicated when we add gender and feminism to our analysis, as our discussion will now turn towards.

5 CUBAN MEDICAL INTERNATIONALISM THROUGH A FEMINIST PERSPECTIVE

In this chapter I hope to make feminist sense (ENLOE, 2014, p. 3) of contemporary Cuban medical internationalism. Approaching this Cuban foreign policy tool from a feminist perspective is crucial because approximately 61.7% of doctors and 70.8% of healthcare workers in Cuba are women; and the majority of the participants in these foreign medical programs, as presented in the introduction, are also women (MINSAP, 2016, p. 120, 123-4). The medical profession in Cuba, it seems, was in a way gendered after the revolution as a profession suitable for women to enter the formal labor market through, and contribute towards revolutionary ends. This same process of feminization of the medical profession was also true of the Soviet Union, where by 1986 women composed 68% of the country's doctors (RYAN, 1990, p. 41). Hence, there seems to be a pattern of socialist states having an impact on women's labor and workforce participation, specifically as doctors, and this then spilling over into greater domestic and international ramifications as these women engage in their daily activities, and travel abroad. Specifically, I part from the question: what insights about international politics can be gained by employing a feminist IR perspective to analyze Cuban medical internationalism? Examining Cuban medical internationalism from a feminist IR perspective furthers our understanding about the nuanced status of "feminism" within Cuban civil society, how internationalization affects family relations both positively and negatively, and how these programs present opportunities for transformative experiences and agency. Through the discussions advanced here, I seek to expand pre-existing feminist IR literature by arguing that women – especially women from the Global South – are not a singular entity with parallel needs and experiences, and problematize our understanding of the role of women within Cuban society and foreign policy.

Since the introduction of feminist perspectives to IR in the 1980s, many advances have been made towards demonstrating that women and gendered perspectives provide needed insights for security studies, international economics, and our understanding of the international system (GENTRY; SJOBERG, 2015; ENLOE, 2014, 1993; TICKER, 2001, 1992; ACKERLY, 2000). Specifically, feminists have challenged IR's traditional focus on interstate politics (TICKNER, 2001, p. 2), and the binaries it creates around gender (TICKNER, 1992, p. 7). Instead of looking at domestic/feminine and international/masculine spheres, feminist IR scholars have challenged Western metaphysics to include dialogues about agency, power, hierarchies, and other processes that traverse the international system.

Third world scholars have also critiqued feminist perspectives as being based on the experiences of women from the Global North, and much research has been conducted on the intricacies within the margins of IR (PIEDALUE; RISHI, 2017; MOLYNEUX, 2001; CHIN, 1998; ENLOE, 1996; MOHANTY, 1988). These scholars have introduced intersectionality and other variables beyond gender to understand the experiences of Global South women and *not* interpret their experiences as a singular story of oppression. This chapter seeks to explore the nuances of experiences that result when diverse Cuban women and men participate in medical missions and find themselves in new social and political settings. Likewise, I will analyze how these doctors exert power, and challenge traditional gender roles and family structures.

Women have been present in Cuban medical internationalism from the beginning as historian Piero Gleijeses reveals through the story of Sara Perelló, one of the first female *internacionalistas*, who enlisted in a medical mission to Algeria in 1963 (GLEIJESES, 2002, p. 34-7). As Blue (2010, p. 37) presents, the majority of Cuban doctors and participants in these foreign medical missions are women, but academic approaches have often focused on empirical assessments of outcomes. Or as Enloe (2014, p. 3) writes "Making useful sense – feminist sense – of international politics requires us to follow diverse women to places that are usually dismissed… as merely 'private,' 'domestic,' 'local,' or 'trival'". Here, I seek to bring the experiences of women to the forefront to better understand the international system. But as Vrasti (2008, p. 288-90) has criticized Enloe's work, even feminist scholars can fall into the trap of objectifying and neutering their participants' voices when employing interviews in feminist research. This dissertation hopes to avoid that pit-fall by not viewing women as a monolithic entity or what Fujii (2010, p. 236) calls, "neat, analytic packages". Instead, I give precedence to the diversity of women's lived experiences and the opportunity to express them in their own words, while simultaneously noting the importance of intersectionality. Secondly, the experiences of women also affect men and vice-versa, which is why feminist research should also analyze the experiences of men, as Baldez (2012, p. 320) argues.

Turning more specifically towards Cuban women and society, as historian Michelle Chase (2015, p. 44, 80) contends, women were present at every stage of the revolution, but were only allowed to participate in the anti-Batista struggle by "acting" within traditionally feminine roles, such as mother. Or, as Lisa Baldez (2012, p. 322) phrases it, "Revolutionary policies challenged the subordinate role of women within Catholic-dominated culture, but did not transform it". Consequently, women and their contributions to the revolution were largely

sidelined, while the contributions of men were highlighted and lionized (CHASE, 2015), a common occurrence throughout revolutionary processes (ENLOE, 2014, p. 108-14). In fact, a common critique of the post-revolutionary Cuban state is that it challenged class and inequality, while at times silencing discourses surrounding gender, race, and sexuality, in order to maintain social cohesion (see CHASE, 2015; BALDEZ, 2012; JOHNSON, 2012; SAWYER, 2006; FERNANDES, 2003). Although Fidel Castro once called women, "The revolution within the revolution", the Cuban regime after 1959 did not radically alter gender hierarchies and patriarchal norms (CHASE, 2015). Early advances, such as the Family Code of 1975, which defined household duties and rights between men and women, were soon left on paper as the leadership realized how troublesome and difficult it would be to shift society at its bedrock (KAPCIA, 2008, p. 50-1).

However, the agency of Cuban women cannot be totally discounted or ignored. As many scholars have posited, there exists a complex relationship and tension within contemporary Cuban society between individuals and the state, whereby the former have multiple interests and identities that are negotiated in intricate ways against those of the latter (GOLD, 2015; HEARN, 2008; FERNANDES, 2005; LUTJENS, 2002, p. 219-20). Or as Gold advances, "the revolution is made by people in their daily practices, not just as political subjects, but as human beings, thoroughly situated in social, cultural, and historical circumstances (2015, p. 193)". Thus, post-Soviet Cuban society is a complex setting where agency manifests itself in unexpected ways and social relations are constantly being (re)examined (STOUT, 2014; BROTHERTON, 2012; HAMILTON, 2012). This chapter seeks to contribute to that conversation by also (re)examining the ways in which social relations are constantly altered through participation in international medical missions. As Blue (2010, p. 32) writes, "The fact that Cuba's medical profession is unique in its gender and racial parity means that international missions are providing groups that have been disadvantaged in the dual economy access to the dollar economy and a higher standard of living".[14] This claim must be further unpacked and contextualized through qualitative research. Thus, I aim to contribute to the growing academic literature on women's participation and experiences (see JERÓNIMO KERSH, 2017; BLUE, 2010; NÚÑEZ SARMIENTO, 2010, 2010) in the post-Soviet Cuban workforce, and to better situating those previous findings.

[14] This refers to the existence of two currencies in Cuba: the Cuban *Peso* and the *Peso Convertible Cubano* (or CUC). Salaries are in the weaker currency, the *Peso*; while all imported and luxury products are in CUC. Tourism industry employees and Cubans who receive remittances have greater access to CUCs.

The arguments advanced here should further discussions on the functioning of international politics, and what happens when women from the Global South migrate. Or as anthropologist P. Sean Brotherton (2012, p. 53) writes:

> The implementation of public health programs provided the [Cuban] state with quantifiable means […] by which to measure success and bolster domestic and international recognition of the revolutionary achievements of the state. In the process, the government expended considerable capital – financial, social, political, and symbolic […]

Here I delve behind those quantifiable means and various types of capital to grasp Cuban medical internationalism from a feminist perspective.

4.1 FEMINISM, CUBAN CIVIL SOCIETY, AND INTERNATIONAL POLITICS

I structured my interviews to begin with less sensitive topics, such as: cultural differences, first impressions of their host country, etc., as recommended by Leech (2002, p. 666). From there, I moved onto more sensitive topics, such as: their opinion about feminism, family relations, and other personal topics. Early on, I noticed that the question, "What do you think about feminism"? and variants of it, were usually met by participants with silence, looks of confusion, and blank stares. After being pressed a little or being asked to answer the question as they saw fit, interviewees gave a wide-array of responses that expressed confusion with the term, or what could be categorized as sexist responses. For instance, Miranda, a Cuban doctor working in Brazil answered with a blank stare and silence, followed by:

> Miranda: Wow, difficult question. [Pause.] What do you mean?
> Interviewer: What do you think about feminism? You can answer however you like.
> Miranda: Well [Pause] I think [Pause] that there is a big effort to make laws for a lot of things that sometimes do not exist, or that the woman herself, I think, is at times responsible for, and made up.

Or as another Cuban doctor in Brazil, Beatriz said:

> Interviewer: Did you ever face any discrimination as a female doctor in Cuba?
> Beatriz: Discrimination is not quite the word, I would say. Cuba is a sexist country, the world is sexist, I lived with that, but discrimination is not the word. It's more like being an object. It carries all of that feminism stuff I hate and don't want anything to do with, but for example, it was more like if a male and female [doctor] were working the night shift together then he would think, "Well if I can feel you up also, then good"! I would not say discrimination, but more like feeling like an object.

These meta-data responses of silence, confusion, and blank stares tell us a lot about the status of feminism within post-Soviet Cuban civil society. Specifically, that despite official government rhetoric about addressing feminist concerns and working towards gender equality, drastic changes have not occurred, at least as could be discerned from my fieldwork. This is not to say that feminism and feminist actions are non-existent in post-revolutionary

Cuba; but rather as Lutjens (2002, p. 221-23) argues there is a complex relationship between the modern Cuban state, its institutions, and individual women. Or as Fernandes claims, social progress in Cuba, when it comes to gender, has often been framed as legal and economic equality stemming from a feminine – not feminist – approach to political activism (2005, p. 440-43). Put differently, although 48.9% of the 612 delegates[15] in Cuba's national assembly are women (WHITNEY, 2013), this has not yet *completely* or *naturally* led to a radical restructuring of gender roles and social power throughout Cuban civil society (KAPCIA, 2008, p. 50-51; LUCIAK, 2005). This line of reasoning is not meant to imply feminist "thinking" and "feelings" are absent in post-Soviet Cuban civil society, as Beatriz's claim, "It's more like being an object", reveals. Women in Cuban society may often lack the social organization, movement, and literal words to express their frustrations through a gendered prism; but this should not be read as a paucity of burgeoning feelings, or consciousness, in regards to gender-based oppression.

To extend my argument further, let us consider what Migdalis, who is completing a medical mission in Brazil, shared during her interview about her ex-husband:

> Interviewer: What do you think about feminism?
> Migdalis: [Silence] What do you mean?
> Interviewer: However you would like to answer the question.
> Migdalis: Well I think in Cuba we talk more about *machismo*. I think it depends on the man and on his culture. For example [the man] saying I can't do housework, or if his wife is a nurse saying she can't work the nightshift or work at night, or he feels inferior if his wife makes more money. But I think that is not common anymore. Of course, it was more common in earlier generations… My husband used to do the dishes, and if he got home first he would make dinner.

In the same way that Beatriz interpreted her personal experiences through objectification, Migdalis has made sense of sexism and gender-based inequality around her through the lens of *machismo*, culture, and historical setting. Her use of the word "machismo" speaks back to the centrality of male figures within Cuban society (CHASE, 2015), so much so that she interprets feminism as a problem of men's actions against women, instead of as a means for women's organization and empowerment to redress grievances and transform social practices. Furthermore, her use of the word "culture" is also telling of how feminism and gender inequality, like most other sensitive or troubling topics in Cuban society are typically addressed indirectly and with euphemisms. As Lutjens (2002, p. 221) writes, "In postrevolutionary Cuba, problems are often discussed with reference to cultural level, using

[15] This figure is based on Cuba's last election in 2013, where only the Communist Party was allowed to put candidates forth. At the level of provincial assemblies, women now claim 50.5% of seats. Although each seat only has one candidate slated for it, candidates must get at least 50% of the votes or the party chooses a new candidate (WHITNEY, 2013).

the standards of consciousness to replace both color and class in explaining the progress and problems that Cubans see".

During the course of my interviews, none of my respondents answered questions regarding feminism with post-colonial, queer, or intersectionality based underpinnings, which is not to suggest these types of reflections are absent in post-Soviet Cuba; but rather they have not yet entered mainstream feminist understandings in Cuba. All of my informants did answer in the affirmative when asked, "Do you agree with equality between men and women"? Feminism and its theoretical foundations, of course, can be difficult for many people to grasp, and even more so to present coherently during an interview. What I observed from my interviews, though, are the intricate ways in which these women understand and decode their gendered experiences through euphemisms, elaborate translations, and varying discourses of power.

In other words, to my participants, these experiences and their personal reflections are not automatically problematic, as they probably never framed them through a feminist theoretical lens. For them they are everyday experiences. Albeit coming from a very different research context, this is reminiscent of Fujii's (2010, p. 236) conclusion after conducting interviews in post-genocide Rwanda:

> What these women's denials taught me was that informants do not experience violence in the same neat, analytic packages that we researchers use in our fieldwork. Rather, people experience, remember, and recount violence through the lens of their own victimization.

Violence, here, could be replaced with sexism, feminism, or discrimination. I am not trying to label any individual research participant as a "good" or "bad" feminist or pass judgment on them for expressing what I interpret as a sexist claim or attitude. On the other hand, I simply call attention to the complexity of studying these topics and categories, because the variable one is analyzing is not necessarily identifiable by the research participant, which speaks back to Sabsay's (2016) claim about the problem of concept "translation" within the social sciences. Moreover, it is me (the author) with a university-level education who is identifying and "labeling" the above examples as sexist, in order to understand them within a greater feminist context. One could also posit that my research participants were hesitant to identify as feminists in the presence of a male interviewer, reflecting the negative semantic and social connotation feminism often carries.

Moreover, their mis-identification of feminism echoes the ways in which female Cuban doctors conceptualize their place within Cuban and international politics, regardless of the silences that exist surrounding feminist dialogues within Cuba. Since the early years of the

revolution, the Federation of Cuban Women (*Federación de Mujeres Cubanas*, FMC) has fulfilled many roles within Cuban society: mediating women's issues between civil society and the state, articulating the state's official position regarding gender equality, and holding a monopoly on feminist dialogues (FERNANDES, 2005; LUTJENS, 2002). However, what I contend is that despite this official relegation of gender-based issues to a specific institution, individual Cuban women still struggle with these issues and social processes in more nuanced ways than are apparent at first glance, as they form their own subjectivities; and this by extension affects the inner-workings of medical missions.

To exemplify this point let us reflect on what, Ana Clara, a doctor completing a mission in Venezuela expressed:

> Interviewer: What are the differences you see between men and women in Venezuela and in Cuba?
> Ana Clara: Well, women here [in Venezuela] govern the men. Here women are strong. Hysteria fits, in Cuba we see that among women. Here it's the men that come to the clinic with hysteria fits, who are 19, 20, 21, 22 years old because of their girlfriend.
> Interviewer: And what do you think about that?
> Ana Clara: Well you can imagine [rolls eyes and smiles] what would you say about that?

As the above example demonstrates, it is not only Cuban men who are capable of *machismo* or of expressing sexist thoughts and ideologies. Cuban women can also adopt culturally constructed narratives around gender roles and how men and women *should* act, and then repeat them, thus participating in sexist social structures that work towards their own oppression. Thus, examining the feminist consciousness and perceptions of Cuban women abroad also sheds light on relations of power within the international system, considering women from the Global South can express gendered perspectives of superiority towards other women and men from the Global South, which they might view as "inferior" through a gendered or racialized binary. Thus, Enloe's (2014, p. 40-7) analysis of women from the Global North travelling to the colonies and being able to exert traditionally male qualities through travel can also be extended to Global South women who participate in migratory patterns. International politics is not a one-way street whereby men exert power over women, it is more complex (ENLOE, 1996, p. 188). Gender binaries permeate both the domestic and international political arena and when Cuban female and male doctors travel abroad they carry these with them. Their conceptions of feminism, which were inculcated in them through socialization within Cuban civil society may also affect the ways they interpret and act within their host countries.

5.2 CUBAN MEDICAL INTERNATIONALISM AND FAMILY STRUCTURES

After questions about feminism and the differences they could observe between men and women in their host countries and Cuba, the interviews gravitated towards questions centered on personal family life. Many doctors who previously completed a medical mission in another country, and were now on their second or third, declared their marriage ended because of their participation in these medical programs abroad. As doctor Katia, who completed medical missions in Honduras and Venezuela shared:

> Interviewer: In what ways did your participation in these programs affect your family relations?
> Katia: Well terribly because my children really felt my absence, my mother had to go live there [her home] because who was going to take care of them? And my mother has different habits and it deteriorated my marriage to the point that we divorced. I gained material things, but I lost emotional things.

Or as another doctor Consuelo, who completed missions in Brazil and Nicaragua, explained:

> Interviewer: Who took care of them [her three children]?
> Consuelo: My family, my mom, my sister, my aunts, were who took turns caring for them. That was my case, but there are many who didn't have anyone to leave their children with and left them with neighbors…I left because my children honestly didn't have panties or shoes. You understand?... What leads us to all of these places is the economy, because you abandon your children, your husband, men leave their wives and all of this has brought a series of difficulties for the Ministry of Public Health where the majority of marriages have separated, in other words, it destroys us socially.

What these responses reveal are the complex outcomes that participating in these missions creates for every Cuban doctor. On the one hand, they gain material and economic empowerment they would otherwise not have access to on the island; while also taking on an immense interpersonal strain that affects not only them, but also encompasses their entire family. Following this line of reasoning, one can view Cuban medical internationalism from the point of view of the Cuban state or as a policy and remark on the impressive public health changes it creates, but as Brotherton (2012, p. 15-6) has also argued this ignores the tremendous human costs that are mainly shouldered by the doctors themselves. Through my interviews, I was able to appreciate how these missions result in both positive and negative consequences for Cuban doctors and the host communities where they work, as well as their extended families and communities back in Cuba. The line, however, between positive and negative is often difficult to draw. These mixed outcomes for female doctors recall Gold's arguments about how, "internationalism is an intricate part of [Cuban] revolutionary praxis";

but with time the Cuban revolution and state have opened up space for individual pursuits and agency within the folds and discourses of the revolution (2015, p. 105, 129).

Although I could hypothesize numerous reasons for why so many marriages among Cuban doctors who serve abroad end, it is probably a combination of many factors. Internet and phone service in Cuba are slow, expensive, and until recently inaccessible to most residents. The doctor abroad also becomes the main source of family income meaning they can dictate how this income is distributed, which can alter the gender roles within a specific marriage as a female doctor now decides how remittances should be spent. As Peggy Levitt (2001, p. 73) has shown through her fieldwork with Dominican immigrants to the USA, remittances can radically alter relations of power and strain family relations, as well as create resentment among recipients.

Spouses left in Cuba could also become resentful and not be able to relate to their significant other's exposure to new worldviews and material wealth. A reversal of gender roles whereby the female in the relationship becomes the "alpha" partner could cause an incompatibility with the gendered ordering of Cuban society that culminates in a divorce. This is one of the possible outcomes when men feel "inferior", as Doctor Migdalis explained in the previous section, to their spouse in a society where machismo and patriarchy are deeply rooted (NÚÑEZ SARMIENTO, 2010, 2005). My point here is not to intimate Cuban doctors divorcing is a *necessarily* negative occurrence, considering divorce could also be interpreted as a form of liberation, and that working abroad economically empowers Cuban female doctors. Instead, I propose that participation in these missions can affect the family arrangements and interpersonal relations of the individual participants, as doctor Carmen who participated in a medical mission in Venezuela explains:

> Interviewer: How did you time in Venezuela affect your relationship with your relatives back in Cuba?
> Carmen: Well obviously we leave and unhinge ourselves from our families. I left two small children in Cuba, a daughter of 9 and a son of 5, with my husband. And in that moment it was the only option that one finds to help your family economically… this inarguably is a big weight if you don't have a well-balanced family. In my family we never had any dysfunction because we are a truly well-geared family, well functioning. My husband, my children, my parents we lived in harmony and with good communication. But there are many families that fall into problems with conflicts.

As doctors go abroad, the other spouse, relatives, and even neighbors take on the responsibility of raising children and running households. For female doctors this means shifting their share of household burdens to other women, be it her mother, sister, and/or neighbor, in order to have access to foreign capital. Viewed from a different angle, we have one woman from the Global South shifting her gendered constraints onto another woman (or

women) to enhance her personal agency, as similarly observed by Chin (1998). Certainly, this is not a completely asymmetric power relationship as the doctor abroad then becomes socially indebted to the women who care for her family. The women in Cuba also benefit from the remittances and material goods that the doctor abroad sends home. This is a phenomenon we see with many women from the Global South who migrate for employment.

Medical missions are structured so that doctors spend two-year periods out of the country, however, they are typically given a vacation after their first year abroad where they can return to Cuba for about a month. This opportunity to return home after a year abroad creates a rather real encounter between female and male doctors with those whom they have left behind in Cuba, as they return with many material luxuries that their loved ones in Cuba do not have access to. They must also interact during a confined period of time, always with the background knowledge that they will shortly return for another year abroad. This "vacation" must create enormous psychological strain on the entire family as individuals strive to experience the most possible with their spouses, relatives, friends, and families.

It seems to me, from my interviews, that the rewards, financially speaking at least, from Cuban medical missions are structured so as to be high enough that they encourage recruitment and participation, while not being high enough so that they cause resentment within Cuba's socialist society. Stated differently, from their time abroad doctors may be able to purchase a car, build a house, or buy a computer, and return with a few thousand dollars – yet this is money which will quickly run out in Cuba's high inflation market. Doctors are then in a way trapped into maintaining the standard of living that their family, and themselves, gaining during their time abroad. This could create enormous social pressure for both female and male doctors, but in different ways, who must feel responsible for maintaining their families' acquired financial status. For men, it is probably a feeling of having to act within their traditional role as financial provider and head of household. For women, it is probably a double burden as they attempt to be financial provider for the family, as well as meet society's typical expectations of sentimental labor and duties from mothers, daughters, and wives.

Furthermore, many of my interviewees also revealed how their participation abroad affected their children's emotional and educational development and left them psychologically scarred. Children felt resentment and left behind by parents who sought better opportunities and income through participation in these programs. The access to foreign capital and improved living standards these missions bring do not come with impunity; on the contrary they come at a price to children, marriages, and families. The participation of any doctor in a medical mission alters the life and agency of everyone around them. Or as another

doctor, Gonzalo, who completed medical missions in Venezuela and Brazil, explains when reflecting on leaving his daughter behind with his now ex-wife:

> Interviewer: In what ways did your time abroad affect your family relations?
> Gonzalo: Of course it affects marriages, you know the separation for so many years, almost all of us spend 4, 5, 6 years away and the separation slowly deteriorates the relationship. And the kinds of things that occur inside of missions, which well, let's not even talk about that [laughs]. It affects us, not being there present for our children, to help them with their studies and guide them in life's matters. It affects the children.

This statement shows how women and men have their marriages and families affected by participating in the missions differently, following the gendered nature of power dynamics in the international system. Gonzalo's affirmation about, "things that occur inside of missions", is a euphemism for extra-marital affairs between mission participants, or with members of their host communities. As historian Christine Hatsky (2015, p. 256) presents through her fieldwork with Cuban veterans of the Angolan Civil War, it was very common for Cubans to engage in an "Angolan Marriage" to ease the loneliness and stress of separation from loved ones. As Hatsky (2015, p. 253) explains, the Angolan Marriages were often referred to indirectly or were difficult to get people to talk about during interviews. During my fieldwork, many male participants shared what could be called a "Venezuelan Marriage" or "Brazilian Marriage", whereby they had long-standing relationships with local women and some even fathered children. One of my, for example, participants is now married to his Brazilian significant other, after divorcing his first wife.

Furthermore, male interviewees admitted being away from home certainly affected them and their children and they felt sadness due to the separation, while remarking on how it must be even worse for women, considering women's important and "different" bond with children. These assertions reflect a deeper gender inequality whereby women working abroad are expected to miss their family back home and want to return, while it is more socially acceptable for men to marry a local woman and not return. I did interview Cuban women who arrived in Brazil single and not already mothers, then married Brazilian men and stayed. However, being a parent in Cuba or having a pre-existing marriage and then remarrying abroad seemed an almost exclusively male venture. Both men and women are able to participate in these foreign medical missions to enhance their agency and income, but even while abroad there are still different expectations for women. As my interview with Midgalis presents:

> Interviewer: How does being here affect your relationships in Cuba?
> Midgalis: My parents are very proud to have a daughter abroad doing a mission, for them it's a sign of pride. They tell everyone who visits the house about it.

> Interviewer: I understand, and did you ever face any judgment from any other Cuban women for leaving your son and coming here to Brazil?
> Midgalis: No, no, I think most people understand the reasons why we choose to go abroad. Which are for better opportunities and to help our relatives. [Eyes began to water]

Although the experiences of every Cuban doctor I interviewed are unique, most expressed economic opportunity as their primary rationale for joining medical missions, while travelling and helping others as secondary motives. Access to economic opportunity and career advancement though are not free – they come at a personal price. For Midgalis it was leaving her young son with her parents, which she misses dearly, as the tears brought to her eyes after being reminded of him would suggest. This is reminiscent of the sacrifices that both men and women who are employed internationally, or in internationally-oriented sectors, must make to pursue their careers or advance their social and economic positions, and that affect everybody around them. International politics depends on individuals' labor in order to function, but these individuals bear different burdens depending on their gender and gender roles. Likewise, the participation of women in international politics and labor markets creates a heightened opportunity to disrupt and alter gender roles within their families, which may consequently reshape patriarchal arrangements, at least at the personal level.

In this section, I have outlined the nuanced and complex ways in which participation in medical missions alters and affects the family structures and lives of Cuban doctors. More importantly, I have highlighted how these alterations and effects are manifested in strikingly different ways for both men and women. Certainly, the interactions highlighted here are not new within Cuban society, considering that from the early years of the revolution, family structures and dynamics were rearranged as many chose to leave Cuba and others chose to stay behind, or could not leave, and take part in the revolutionary process. Furthermore, Cuba's foreign policy involvements from Angola, to Nicaragua, to countless other countries, have created a historical precedent for how to "deal" with the family strains created by international involvement – and how to manage one's emotions towards the separation from loved ones. As soldiers around the world know, time abroad is interpreted as a heroic venture where one's time serves to further the causes of the motherland, and will be rewarded with glory afterwards. For Cuban doctors, it seems the same mentality is instituted, whereby their time abroad caring for thousands of sick people should one day by rewarded with the possibility of family reunification under improved financial conditions.

Yet, these propositions raise the question: to what extent has the Cuban revolutionary process and its foreign policy initiatives created (as an unintended consequence) a fractured,

fragmented, and disjointed notion of the Cuban family? The Cuban Diaspora around the world is perhaps one of the largest and most expansive ones in existence today, creating family networks that not only stretch across countries, but also across numerous continents as became apparent during my field research. Furthermore, as detailed in the introductory section, Cuba has been engaging in internationalism since the 1960s, therefore, perhaps the effects that I observed in my fieldwork are also part of a longer time sequence of effects caused by continued engagement in foreign affairs by the Cuban people since their revolution.

This suggestion is not meant to pass judgment on the choices or acts of, either the Cuban government, or the individual Cuban female and male doctors that go abroad to work within these medical missions. On the other hand, my point here would be to highlight the unintended consequences of internationalized labor, specifically women's labor, and the unexpected role it may play in the creation and expansion of the Cuban Diaspora. In other words, soldiers have been historically drawn to act within militarized conflicts through promises of protecting the motherland and of one day returning home. In Cuban society, with its high rate of immigration, and with the high divorce rate described by my interviewees, it seems almost necessary to ask: can Cuban doctors every truly return "home"?

This is overall, rather ironic, considering Western society's alleged care for and preoccupation with family and family structure, as a central component of civil society. Yet, what we see here is how family is put into jeopardy, or transformed, as international aims and objected are pursued usually in search of economic capital and improvement. Or returning to doctor Consuelo's words presented above, "it [working abroad] destroys us socially", is a statement with deeper meaning for our understanding of international politics than it appears to be a first glance. The destruction she speaks of can be seen as the trade-off Cuban doctors must make between continued participation in their family circles, or the possible rewards from work abroad. The social destruction she observes can also be drawn out beyond Cuban doctors, as it probably has ripple affects throughout all of Cuban society. This also shows the complex struggle that exists within societies between individual subjectivities and goals, government discourses and aims, and international political processes – all of which meet in a social field of force and result in an immensely varied and complicated set of power relations. Social destruction and construction then seem to work and emerge together, constituting social "realities" both within Cuban medical internationalism and beyond, and as agency manifests itself in convoluted ways throughout this process, as we will see in the next section.

5.3 RELATIONS OF POWER AND TRANSFORMATIVE EXPERIENCES

Another focus of my interview questions was attempting to gauge in what ways, if any, Cuban doctors affect and are affected by their host communities, and how their time abroad changes or transforms their world views. In order to obtain these insights, I asked my participants to detail their day-to-day activities, as well as memories that most stood out to them from their time abroad. From their responses, I observed how stepping outside of their native political and social communities created, for women and men, opportunities for personal reflection about their society, profession, and self that they had not had before. As the following excerpt from my interview with Antonio, a young doctor working in Brazil exemplifies:

> Interviewer: In what ways do you think that Cubans change Brazil, in other words, in what ways do you think that all of you affect the people with whom you interact?
> Antonio: Of course, look let me give you an example that I often use with people when that topic comes up. Cuban doctors are made to be family doctors, to touch and interact with the patient. I remember that when I arrived at the clinic for the first time my chair and the patient's chair were on opposite sides of the desk. I went in and immediately changed them, I want the patient here by my side [points at himself] so I can touch them and feel closer to them… From this alone the patient leaves the consultation feeling better, it's like a placebo, you know only Cuban doctors that are able to do that.

Doctor Antonio re-arranging the chairs in his clinic might seem like a miniscule act; but in reality, he is physically tampering with decades or centuries of pre-established Brazilian ethics on doctor-patient relations. Secondly, his awareness of the potential power he holds over his patients, in the way he treats them, even in his ability to "trick" them psychologically with a placebo affect demonstrates the inherent agency medical professionals hold in society. As Foucault (2003) argued, modern medical professionals are imbued with far-reaching agency and power over others through their ability to medicate, treat, and even construct dialogues about what is and is not illness. This power combined with the identity generally created around Cuban doctors, as benign international agents of soft power, results in a sizeable ability for them to affect their surrounding relations of power. The clinics, hospitals, and societies these doctors are sent to have a web of pre-established relations of power into which they become enmeshed. Cuban doctors, due to the combined social weight the identities of Cuban and doctor collectively carry, have considerable leverage to affect these power relations. That is not to say this is wholly positive or negative, but rather it is an outcome of this encounter.

Conversely, these power relations also affect Cuban doctors. Although they may arrive with pre-conceptualized notions of class, race, gender, and relations within their profession, all of that is subject to influence with time in their host communities. For instance, many of the doctors sent to the countryside of the Brazilian state of Rio Grande do Sul, which was colonized by German and Italian immigrants in rather closed off small villages, tended to remark on all of the cultural differences they noticed. Or as doctor Miranda also shared:

> I had a patient from Bahia [Northeastern Brazilian state] that hooked up with a German girl and she got pregnant and well they had to leave and move to Bahia. People here are very racist. There's also a black doctor that works at our clinic and patients who don't know her name arrive and are afraid to ask for the black doctor. They rather point to their skin before saying she's black, and I'm always like, "You're looking for the black [*emphatic intonation*] doctor".

This example reveals how time spent abroad challenges one to remark on cultural differences that would otherwise go unnoticed. Doctor Miranda is in a region of Brazil where she notices racialized acts considerably more than she noticed in Cuba. This opens her eyes to racist encounters she might never have identified before. Upon returning to Cuba, she may now identify racist acts, which would have previously gone unnoticed before her time in Brazil, and could cause her to radically (re)examine racial relations in her own country. The same can be said of other social structures, as interviewees shared numerous examples of the differences (positive and negative) they noticed between their host communities and Cuba.

For these individuals, their time abroad might be their first chance to critically reflect on social relations back in Cuba because they have an "other" against which to juxtapose their own cultural baggage and socialization. This returns to Lutjens' (2002, p. 221) claim that in contemporary Cuban society, class, race, and other taboo topics, are referenced to euphemistically as showing a lack of "culture". I did certainly receive a lot of these types of responses also, with allusions to "lack of culture" on the part of individuals in the stories they shared. From their interpretation of these stories one can sense, though, the beginning of a reflection on what a lack of culture *actually* implies, be it racism, machismo, etc. For my female research participants, and Cuban female doctors in these medical missions more generally, these encounters and reflections on foreign social systems and power relations might also lead towards a greater feminist or social consciousness, as well as personal subjectivity.

Asides from altering and being altered by relations of power, living abroad creates a generally transformative experience for Cuban doctors, both female and male, in multiple other ways. First of all, they are given access to economic capital, which introduces them to liberal ideas and a market system not familiar to their relatives back in Cuba. Living and

working within a capitalist system morphs the doctors' perception of income and labor, partially explaining why many choose to participate in multiple medical missions. The international reach of capital and the way it changes the lives of these doctors may hold deeper effects if Cuba ever transitions towards a market economy, since many of its medical professionals would have a thorough understanding of that system from their time abroad. In addition to economic capital, participation in foreign medical missions gives Cuban doctors access to new experiences retold during their interviews: travel, learning another language, being resourceful, etc. These experiences not only provide memories, but also work towards increasing the self-confidence and independence of these doctors, as they imbue them with an internationalized form of Bourdieu's social capital, which they can employ for the rest of their lives both in Cuba and abroad (see BASARAN; OLSSON, 2017).

For male doctors, these experiences might be "expected" of their gender, but for women who find themselves outside of Cuba's rigid patriarchal society these experiences have a deeper, more liberating, feeling. Female interviewees retold stories of crossing the border into Uruguay to shop while working in Brazil, or taking trips to Lake Titicaca on their own while working in Bolivia. This is reminiscent of Okin's (1998) argument that there exists a dichotomy within political theory between the private and public spheres, and women and their experiences are typically relegated to the private and domestic arena. Cuban medical missions give female doctors liberating and gender equalizing encounters as they step into the public and political sphere and engage in experiences typically reserved for men: travel, adventure, participation in the international. Stated differently, "equality between the sexes" here does *not* necessarily imply the experiences of the genders meeting at the middle, quite contrarily, what we observe here are the experiences of *select* women becoming closer to those of men. This is not to say Cuban civil society fails to provide women with empowering experiences within the public sphere, considering participation within the FMC allows women to become stakeholders in political conversations centered on women's issues. Likewise, the Cuban revolution has a long history of providing women with opportunities to participate in public political projects and reshape their personal identities, as the Literary Campaign well demonstrates (FAGAN, 1969). What I deduced from my qualitative fieldwork, though, is that medical missions provide a distinct and internationalized path for Cuban women to step into political and public projects, and further their agency and capital(s), in manifold ways.

Despite the mixture of positive and negative experiences these doctors have abroad and upon returning home, as I have detailed throughout the previous sections, I did not find any feelings or suggestions of victimization among my interviewees. On the other hand, most

of my participants remarked on how strong and self-assured they felt after participating in medical missions and overcoming the day-to-day obstacles of working abroad. Yamile, a doctor who completed missions in both Venezuela and Bolivia, expressed it as follows:

> After that I said, "Well now I can travel anywhere". Because in the end without ever having left Cuba before, Cubans sometimes think we know everything and it's not like that. Then you leave Cuba and you realize you don't even know half [of everything], and when you leave you realize that on the outside there is an endless amount of different things, that alone marks one.

Contact with the international is transformative; but it is transformative for every individual in different ways. Or as Perera Pintado (2005, p. 149) found during her fieldwork on the Cuban Diaspora in the USA, "We Cubans succeed wherever we are. We are intelligent, educated, hardworking, scrappy, and always inventive". Interviewees despite having to separate themselves from their families, working in oftentimes hostile environments, and navigating new cultural spheres managed to decipher their experiences and incorporate them into their psyche. Nevertheless, as I have described in this section only select women in Cuban society have access to these traditionally male experiences, which has secondary affects for them and their families. In short, medical missions present women with an additional, and internationalized, way of working within the field of high politics and action beyond those available on the island, while also positioning them at a distance from state, revolutionary, and familial bonds.

5.4 CONSLUSIONS

In 2012, The *New York Times* published an article titled, "Cuba May Be the Most Feminist Country in Latin American", (LOPEZ TORREGROSA, 2012) typical of the exaggerated binary constructed around feminism and women in Cuba as either a socialist utopia or dystopia. The purpose of this chapter has been to unpack and critically explore the lived and quotidian experiences of both Cuban men and women to better understand the nexus between gender and politics on the Caribbean island and abroad. Specifically, the previous discussion sections analyzed the routines and power relations of Cuban medical professionals living abroad and participating in numerous South-South cooperation missions through a gendered perspective. In my first discussion section, I outlined how numerous, plural, and oftentimes contrasting subjectivities and feminisms shape, and are shaped through, individual experiences in these medical missions. Then, I explored the negative and positive effects that international employment has on the doctors' interpersonal relations as they gain access to

economic opportunities, while simultaneously bearing strained family relations. Finally, my analysis turned towards the ways in which these internationalized experiences lead towards the (re)construction of self-images, and open up (or expand) spaces for personal agency.

Previous scholarly accounts of Cuban medical internationalism have largely ignored the ways in which gender can affect the daily and local implementation of these programmes, which employ the labor of thousands of Cuban women, while not directly addressing the unique issues they face both at home and abroad. Cuban medical internationalism, when interpreted through a critical lens, reflects the difficulty of using clear-cut pre-defined concepts in feminist methodologies. For instance, the terms "feminist" or "not feminist" lose their strength as classifications and labels in a context, such as Cuban civil society, where subjectivities are so varied, and individuals occupy a place of constant dispute and deliberation vis-à-vis the state and its official discourses. The FMC, non-state sanctioned civil organizing, international groups, individual female doctors, and so forth are all part of a sizeable web of both explicit and implicit social debate about the role of women within Cuban society and international political projects.

Cuban medical professionals are also representative of the millions of people who engage in global migration patterns each year, especially between Global South countries. The results and phenomena I have delineated here are ones which female soldiers, diplomats, and business leaders from both the Global North and South can relate to, but in different ways, considering the hierarchical configuration of global political processes. My research study encompassed the lives of both women and men to describe how contact with the international simultaneously alters social relations and capital acquisition at various points throughout the international arena. These shifts, however, come in different forms for every Cuban doctor, depending on their gender, and between individual women as well, depending on race, class, marital status, and other factors. Thus, this case study is one more example that reaffirms the work of previous feminist and postcolonial scholars, which argue that we cannot think of "women" – and certainly not Global South women – as monolithic and singular entities, instead we must work towards fully grasping and demystifying the place of individuals and identities within international politics.

6 DISCOURES, BODIES, AND BIOPOLITICS

On August 23, 2018, the *Zero Hora* newspaper, which is one of the most-read newspapers in the city of Porto Alegre, Brazil, published a news piece titled: "*Mais Médicos* completes 5 years, and the Ministry of Health promises to amplify the program". The news piece attempted to describe the status and accomplishments of the public policy and program half a decade after its implementation. What is amusing is that even within the short news piece, the acrimonious and oftentimes cacophonous socio-political battle that originally engulfed the introduction of the program comes to light, once again. For instance, the article quotes Fernando Matos, who is the president of the Rio Grande do Sul Regional Medical Council (CREMERS), as saying: "Even today, the medical councils do not know if the professionals from other countries that come for *Mais Médicos* are actually doctors or healthcare agents. Some cases of a lack of proper credentials for the job were proven" (MATOS, 2018, author's translation). The same news piece goes on to quote Erno Harzheim, who is the current Porto Alegre municipal Secretary of Health, "With these first pieces of research data, we can debunk any idea, which is probably a bit prejudiced, that the foreign doctors who came are of some inferior quality. They have the same quality as Brazilians [doctors]" (MATOS, 2018, author's translations). These quotes summarize the polarizing and discrepant social opinions and points of view that the *Mais Médicos* program, and the foreign doctors that work within it inspire, "even today", within Brazilian civil society.

In this chapter, I will problematize and nuance the controversy surrounding Cuban doctors within the *Mais Médicos* program in order to expand our understanding of these international medical missions and South-South cooperation programs, more broadly. Dialoguing with Foucauldian and post-modern perspectives, I argue that the arrival of Cuban doctors did *not* lead to a politicization of Brazilian healthcare or the creation of new discourses surrounding healthcare, because healthcare is already intrinsically politicized. On the other hand, I contend that pre-existing discourses were called upon to explain, support, or counter, the arrival of Cuban doctors and their possible effect on the country's healthcare system. What resulted was a polemic dispute over biopower and who has the right to yield it within Brazilian civil society and for what biopolitical ends.

Following Foucault's insights, as well as those of many other post-structuralists (see DERRIDA, 1997; DOTY, 1996), one could argue that the political and social worlds are full of multiple and varying discourses, which are created through both *langue* (language) and *parole* (speech), following Saussure's (1974) differentiation of the two (see FASSIN, 2016, p.

105-6; DOTY, 1997, p. 377-8). These discourses serve to create, amplify, and deliver power in a polyvalent way throughout social practices, or as Foucault writes, "Discourse transmits and produces power, it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it" (1978, p. 101). Likewise, "power" following Foucault's line of reasoning is a much more complex social force than traditional IR scholarship has been willing to engage with, considering its preoccupation with military weapons and financial forms of power (see FOUCAULT, 2001; KIERSEY; STOKES, 2011).

My objective in this chapter is to employ Foucault's previous insights about social discourses and power, as I attempt to understand how *Mais Médicos* activated various social discourses within Brazilian society at the time of its implementation. Specifically, how did the introduction of Cuban doctors within the matrix of Brazilian healthcare delivery and production affect these discourses, both positively and negatively? As Roxanne Doty states when she critiques Alexander Wendt's understanding of the agent-structure dilemma within IR: "discourses are inherently open, contingent and overlapping… To reiterate, the forms of fixation that establish identities and social order are always precarious" (1997, p. 385). Through this theoretical undertaking, I seek to contribute towards a post-structuralist reading not only of Cuban medical internationalism, but also of the ways in which encounters between different states create a shift, union, or clash between different discourses. Or as Joan Scott put it, "I understand discourse to refer to interpretation, to the imposition of meaning on phenomena in the world; it is mutable and contested, and so the stakes are high" (2007, p. 7).

Beyond Foucault, I also draw upon the insights of other scholars that added post-colonial (STOLER, 1995) and feminist (BUTLER, 1999, 1993) layers to Foucault's scholarly production on discourses and social power. Here, I analyze the production and functioning of biopolitics and biopower within a Global South context, distant from the Eurocentric setting, in which a work like *The History of Sexuality, Volume 1* is meant to be understood. By biopower I employ Foucault's definition of, "what brought life and its mechanisms into the realm of explicit calculation and made knowledge-power an agent of transformation of human life" (1978, p. 143), or as the power, "organized around the management of life" (see also CARRARA, 1996, p. 293-4; STOLER, 1995, p. 81-2). Through biopolitics, this study refers to the political processes and mechanisms that have arisen since the late 18th century either *to* manage biopower and its manifestations, or subsequently *from* the implementation of various biopower strategies. In the following sections, I will critically analyze this biopolitical process as performed through *Mais Médicos*, and attempt to unpack the nuances that surface when one examines the different conceptions of biopower the two societies hold.

Using Bourdieu's concept of "social capital", Feinsilver (1989) contends that participating in these medical missions provides the Cuban state with a formidable amount of symbolic capital, which it can use to further its foreign policy interests. This analysis raises the question: how do biopolitical consequences and factors fit into this creation of symbolic capital? As anthropologist P. Sean Brotherton (2012) advances, the post-revolutionary Cuban state has implanted an impressive set of biopolitical mechanism in order to legitimize itself before the Cuban people, create subjectivity, and further revolutionary discourses. Or as Brotherton posits, "the [Cuban] government expended considerable capital – financial, social, political, and symbolic – in strategically defining the terms and parameters of what constituted bodily health and physical well-being" (2012, p. 53). Through my discussions, I seek to outline how this process is complicated when Cuban medical practices are exported, along with Cuban doctors, through international medical cooperation programs.

As Laqueur (1990) and others have argued, medical professionals over the past few centuries have played a central role in redefining medical practices, reshaping our understanding of disease, and even reconceptualizing our understanding of "sex" as a social category and definition (see ACKERLY; STERN; TRUE, 2006; FAUSTO-STERLING, 2000, 1985; NICHOLSON, 1999; GILMAN, 1985). Or as Queer scholar Judith Butler has shown, bodies are discursively created and materialized through performative and reiterative acts, whereby, "'sex' not only functions as a norm, but is part of a regulatory practice that produces the bodies it governs, that is, whose regulatory force is made clear as a kind of productive power" (1993, p. 1). Thus, previous scholars have detailed how Cuban doctors abroad vaccinate children, prescribe medications, and alleviate illness, but they have *not* generally delved into how, if at all, Cuban doctors also contribute towards the *social* production of bodies and discourses of bodily regulation. These factors should be brought to light, considering the role doctors play in creating sex, bodies, illness, and the discourses which govern them, through their capacity to diagnose and medicate bodies (see DUMIT, 2012; BURRI; DUMIT, 2007; ROSENBERG, 2002; ROHDEN, 2001; CARRARA, 1996). By scrutinizing how Cuban doctors approach their overseas patients we seek to contribute to a further understanding of Rosenberg's assertion that, "The act of diagnosis structured practice, conferred social approval on particular sickness roles, and legitimated bureaucratic relationships" (2002, p. 239). Stated differently, Cuban doctors hold a convoluted form of power, and roles within numerous and overlapping power relations, which are in need of a closer examination, and are often overshadowed by Western academic approaches that

inherently place the state at the center of power operations (BUTLER, 2009, p. 149; SCOTT, 1986, p. 1067).

There is a vast preexisting production across many academic fields about the role of the medical professional within society and how they affect power dynamics and contribute towards materializing bodies within society. Secondly, there is also a lengthy scholarly production on how Cuban doctors, specifically since the revolution, have worked towards reducing disparities in access to healthcare both at home and abroad. My purpose in this chapter is to unite these two scholarly discussions and explore how Cuban doctors working abroad, in *Mais Médicos* and in other scenarios, participate in demarcating and differentiating bodies and bodily practices (NICHOLSON, 1999; BUTLER, 1993), and what this tells us about the international system. As feminist scholar Lauren Wilcox (2015) has argued, using Butler's line of reasoning, many of mainstream IR's scholarly endeavors focus on violence, security, and politics, while ignoring on *whom* these processes are actually inflicted. Through the scholarly discussions that follow, I aim to contribute towards the growing literature that challenges the place of bodies, emotions, and other often ignored variables within world politics (see SOLOMON, 2015; WILCOX, 2015; FIERKE, 2013; LOCK; FARQUHAR, 2007; BRAH, 1996).

6.1 CONFLICTING DISCOURSES AND INTERNATIONAL/NATIONAL HEALTHCARE

The Cuban doctors that were greeted at Brazil's airports by chants of "Slave", as Brazilian university medical students threw bananas at them, and then had their medical credentials questioned were stepping into a field of social relations and power dynamics far more complex than they might have anticipated during their airplane ride. As will be argued in this section, the foreign doctors that were included in *Mais Médicos* found themselves at the nexus of various contradictory discourses within Brazilian society about power/knowledge, and who has the right to make use of those dynamics to make truth claims about the human body. In other words, as the doctors stepped off the airplane they were, quite literally, stepping into a dense pre-existing web of racialized, gendered, sexualized, and classist discourses about medicine, the body, and biopolitics, that had been developing in Brazil over centuries.

Many observers, such as journalists, politicians, and other Brazilian civil society members, tend to describe *Mais Médicos* as a PT government program that was politicized

because it employed Cuban and other foreign doctors, which were quickly identified with leftist political ideologies and as an attempt on the part of the PT government to takeover medical care, and thus wield a larger portion of the country's biopower. One could contend, conversely, that there were many conflicting preexisting discourses and power struggles within Brazilian society over who should or could hold biopower, which were then projected through the *Mais Médicos* program. The inclusion of Cuban doctors in the program *neither* led to a politicization of healthcare in Brazil, *nor* to the introduction of racial, gendered, or other aspects into the South American country's healthcare arrangements. Rather, these discourses were multiple and manifold, and although "dormant" within the country's main political discussions before the introduction of the program, they found themselves at center-stage during the power/knowledge struggle that ensued over the program's implementation, assessment, and continuation.

For point of case, let us consider the following two contradictory viewpoints on the delivery of medical care within Brazilian civil society. First we have Sofia, a Brazilian gynecologist, who has worked in both public hospitals and private healthcare clinics:

> Interviewer: Why are there so many people [doctors] that do not want to work in the municipalities of Brazil's countryside?
> Sofia: Because municipalities typically default [*dão calote*] on paying doctors, they offer marvelous salaries, then people go and work there and after a time they stop paying, start paying late. That's happening here in Porto Alegre, the municipal government since half-way through last year started paying people late. That's here in Porto Alegre. Imagine in a small municipality. And also because of poor [working] conditions. We have a hard time here getting certain medical tests, and of being able to follow-up with patients, in rural municipalities that's ten times worse, maybe more.

Now let us remark on the comments of a mayor from a city who hosted numerous Cuban doctors, João Pedro, of the PT:

> Interviewer: Many of the Brazilian doctors that I have interviewed have spoken about the fear of working within the public healthcare system or in more rural municipalities, as a fear that they start to work and then after a certain time the municipal government starts to default on their payment.
> João Pedro: That's a lie, that is not true. Small municipal governments always pay their bills. Small municipalities that don't pay their bills are like poor people – poor people always pay their bills. It's the rich that don't pay their bills in Brazil. That is a lie, it's not true. It's a fallacy to justify the process of negating the arrival of [medical] professionals from other countries.

When juxtaposed one against the other, Doctor Sofia and Mayor João Pedro's comments are quite revealing on many points. First of all, it does not really matter for my purposes who is saying the "truth", rather what concerns us is the existence of these conflicting discourses on medical care which each side sees as its own truth. This is rather reminiscent of Ann Stoler's (1995, p. 69) argument, following Foucault's logic, that there is

no “scapegoat theory of race”. What this means is that racism does not emerge in moments of crisis to find a victim for its problems, but rather that racialized discourses are: “a manifestation of preserved possibilities, the expression of an underlying discourse of permanent social war, nurtured by the biopolitical technologies of ‘incessant purification’” (STOLER, 1995, p. 69). Read for *Mais Médicos*, one can infer the government program itself was not necessarily a “problem” that created resentment among certain Brazilian social groups, but rather a means through which preexisting discourses were articulated. Secondly, from the way in which discourses were articulated *through* and *around Mais Médicos* we can also see how the struggle was over the many power relations and social systems that compose Brazil’s social fabric. From Cuban doctors who were greeted with bananas thrown at them, a long-stranding trope that portrays one’s social opponents in a position of primitive racialized “other”, to the questioning of female doctors’ medical credentials, one can observe how political discourses centered on *Mais Médicos* were not only about race, or class, or gender – they were about all of these things at once. In other words, an intersectionality of oppressive and co-constitutive discourses surrounding biopower and biopolitics, which have shaped social relations and discussions surrounding healthcare in Brazil since long before the arrival of these doctors.

Curiously, every Brazilian doctor I interviewed cited the same rationale of poor infrastructure and fear of payment defaults as their primary objections towards working in the countryside, almost echoing Doctor Sofia’s words. Likewise, every PT politician I interviewed seemed to also follow Mayor João Pedro’s thinking about the “real” reasons why Brazilian doctors were opposed to the employment of foreign doctors in the *Mais Médicos* program. Interpreted along a Foucauldian line, this is telling of a long-standing struggle over biopower and the human body within Brazilian society. These contradictory discourses, which both sides seem to fervently hold onto and reiterate constantly show the way in which different political processes enact different discourses to advance desires for (bio)power and control within society.

Perhaps ingenuously, or underestimating their opponents, the PT government thought it could easily implement the program with little defiance from the medical professional class, since Cuban doctors would be sent to the countryside and more peripheral regions. The Rousseff administration failed to foresee how introducing foreign doctors throughout the country could awaken a deeper sense of peril within the medical professional class, which could then mount a sizable protest campaign against what they interpreted as a threat to their livelihoods, profession, and social status. Furthermore, the government did not anticipate how

quickly Brazilian doctors could employ and shift discourses to meet their political necessities in that moment. As the implementation of *Mais Médicos* once again exemplified, "where there is power – there is resistance" (FOUCAULT, 1978, p. 95), whether that be from the oppressed class against elites, or from elite professionals mobilizing against a government attempt to reshape medical discourses.

Utilizing Pierre Bourdieu's concept of *field of power*, we can see how the Brazilian federal government, Brazilian medical professionals, Cuban doctors within *Mais Médicos*, and Brazilians who use the public healthcare system, were each at different points within the same social field. Each group sought to maximize their benefits from the introduction of the program, or minimize their losses, and each was willing to employ and repeat certain discourses about medical knowledge and healthcare to protect their position within the field of power. This demonstrates how individuals act out and echo certain discourses to maintain their social privileges, vis-à-vis other social groups. As well as how the introduction of "international" elements within a field of power can work to create a rupture with pre-existing discourses, reaffirm discourses, awaken dormant discourses, or a combination of all three. As my discussion in the previous paragraphs has shown, a combination of all three of these discursive practices seems to have unfolded around *Mais Médicos*, as each group in the field of power attempted to defend itself from what they saw as an eminent threat from the others. Or as another mayor from the PT party, Paulo put it:

> For us it was a break in the patient-[medical]professional relationship paradigm because of the amount of time that was made available by these professionals in their wide set of activities at the public health clinic. Of course, at first, there was a foreseeable problem, which was people getting used to the Latin accent [of the Cuban doctors]. But soon that was surpassed and there was great acceptance of the work of these professionals…Before, we used to have a lot of complaints, in general, from the users of the [public health] system that – not all – but that some of our professionals from here [Brazil] had a different way of analyzing the patient, oftentimes already writing up the prescription without examining the patient.

It is rather revealing that Mayor Paulo chose to use the words, "break in paradigm", to describe the effect the arrival of Cuban doctors had on healthcare delivery and practices within his municipality. From his testimony and that of the Cuban doctors themselves, one can sense their belief that *Mais Médicos* led to a more democratic and equal healthcare system in Brazil, as well as a drastic redefinition of the doctor-patient relationship, claims I will better analyze in the following section. However, we can also ascertain that the introduction of Cuban doctors in any society leads to a politicization of their work and activities within the host country. That was true of Cuban involvement in Angola during the Cold War (see HATZKY, 2015), as well as in every country that Cuba sends medical professionals to, as

doctor Leticia who worked in a medical mission in Venezuela, and has since moved to the United States, revealed during her interview:

> We were required to tell them [our patients] the importance of voting for Chávez, that they had to keep the Bolivarian government, that they had to vote for the Chávez government because Chávez had brought healthcare and things like that. And they wanted us [Cuban doctors] somehow also to convince them, but that was not my function and because of that it did not interest me to speak about politics. Because when you brought up politics, they themselves would tell you, "You did not come here for that, you are not Venezuelan, that does not matter to you".

Cuban doctors regardless of geopolitical setting, always find themselves at the nexus of multiple and oftentimes competing discourses relating to race, class, gender, biopolitics, and so forth, which they must navigate as they are introduced into a foreign country's field of power.

As I have discussed in this section, Cuban doctors do not in and of themselves politicize medical care in any of the country's where they work; instead discourses surrounding medical care are always politicized, and the employment of foreign doctors only leads to a deepening of this process. Yet, the discourses and ways in which class, race, gender, and so forth, are articulated through them shift from country to country, and even within a single country. These processes are important to research and delineate considering the impressive growth in SSC programs and other migratory patterns one can see in the 21st century. The introduction of an "international" element into any pre-existing field of power leads to multiple ripple effects within a society, as different groups protect their position against a possible, "break in paradigm", to use Mayor Paulo's term. *Mais Médicos*, specifically, caused a sizeable mobilization of discourses because of its very medical nature, which threatened the ability of some within Brazilian society to make truth-claims about healthcare, and medicalize the body, as I will turn my discussions towards now.

6.2 BIOPOWER AND BODIES WITHIN MEDICAL INTERNATIONALISM

When one examines the day-to-day functioning of *Mais Médicos*, a strikingly nuanced image arises of how on the ground, at the local, and at the interpersonal level, the program resulted in a series of micro-struggles over how and who should enact biopower. Mayor Paulo's proclamation of a "break in paradigm" might seem like strong wording, until we contextualize his sentiment further, and what it meant to the average Brazilian to come into contact with, and be treated by, a Cuban doctor during the course of their quotidian existence. Or as a municipal Secretary of Health, Felipe, stated during his interview:

> Interviewer: What were the differences that you all noted, or that people told to you, between those doctors that come through *Mais Médicos* and Brazilian doctors?
> Felipe: The relationship bond [*relação de vinculo*] with a Cuban doctor is different than the relationship bond with our doctors, and the patients. To begin with, our doctors sit over there [points to other side of the desk] and the patient is over here. There exists a desk between them and its very probable that he will check the patient's pressure with the arm stretched over [the desk] to the other side and the patient on this side. A Cuban doctor is the opposite, he pushes the chair to where you are sitting and sits next to the patient and he checks the patient's pressure like this [points to his arm]. That was a surprise for the patient, having a doctor get up and come sit next to them, it gives a notion of being more proximate to the patient. It constructs a bond.

Certainly, this different treatment of patients by Cuban doctors could be attributed to revolutionary ideals, stemming from Che Guevara, Fidel, and others, on how communist doctors should be different than capitalist doctors, or to the different type of medical school training Cuban doctors receive (see KIRK, 2015; BROTHERTON, 2012; BUSTAMANTE; SWEIG, 2008). However, one could also posit that this different doctor-patient relationship, this different "paradigm", goes deeper: to a different understanding of biopower, the human body, and how to exercise one over the other. This is not to imply Cuban medicine is "better" or "more humane" than other types of medical approaches or cultures – instead I contend it is simply *different* because it has evolved within Cuba's own unique matrix of discourses surrounding medicine, race, gender, and so forth. Secondly, when transplanted from their original matrix, Cuban doctors inherently stand out because they represent a different pre-existing discursively constituted approach to medicine and to "acting like a doctor". To put it simply, Cuban medical professionals have a different way of treating, seeing, and defining the bodies of their patients, and of understanding their own bodies vis-à-vis their patients, or what Judith Butler calls "a process of materialization" (1993, p. 10).

Medicine and the medical profession are typically seen in a positivist light of pure reason, rationality, and truth. As historian Sander Gilman puts it, "The power of medicine, at least in the nineteenth century, lies in the rise of the status of science… In examining the conventions of medicine employed in other areas, we must not forget this power" (1985, p. 205-6). What we see here, when we juxtapose a Cuban doctor with a Brazilian doctor, is just how much of medicine, the medicinal profession, and the medical professional, are socially constituted and imbued with biopower, which is then used to: mould, gender, and racialize the body in myriad ways. During the course of my fieldwork it was not only Felipe who expressed this "difference" between Cuban and Brazilian doctors in how they treated and bonded with patients, considering Cuban doctors were also aware of these differences. Or returning to doctor Antonio's story that I presented in the previous chapter:

> Interviewer: In what ways do you think that Cubans change Brazil, in other words, in what ways do you think that all of you affect the people with whom you interact?
> Antonio: Of course, look let me give you an example that I often use with people when that topic comes up. Cuban doctors are made to be family doctors, to touch and interact with the patient. I remember that when I arrived at the clinic for the first time my chair and the patient's chair were on opposite sides of the desk. I went in and immediately changed them, I want the patient here by my side [points at himself] so I can touch them and feel closer to them… From this alone the patient leaves the consultation feeling better, it's like a placebo, you know only Cuban doctors that are able to do that.

What we see in both Doctor Antonio's answer, as well as in the municipal health official's, is that the arrival of Cuban doctors in Brazil led to a social re-evaluation of the doctor-patient relationship, perhaps for the first time, and the examination of that relationship in classist terms. Furthermore, as one can see in Antonio's answer, his awareness of his own biopower capabilities and ability to employ them to create a "placebo effect" on his patients, demonstrates that Cuban doctors, although imbued with a different sense of class, are still cognizant of the power they hold over the body, in both biological and cultural ways. This is what Rosenberg means when he writes about the "tyranny of diagnosis", stating:

> [Diagnosis] is a ritual that has always linked doctor and patient, the emotional and the cognitive, and, in doing so, has legitimated physicians' and the medical system's authority while facilitating particular clinical decisions and providing culturally agreed-upon meanings for individual experience (ROSENBERG, 2002, p. 240).

Moreover, Antonio's diagnosis abilities may also explain the fear of Brazilian doctors over employing Cuban doctors within the *Mais Médicos* program: a concern over new forms of biopower and diagnosis, both technological and cultural, being introduced within Brazilian civil society, and new methods for "materializing" the human body. This insight, when expanded, allows us to reinterpret SSC programs of a medical nature, at least (as well as North-South cooperation programs), as going beyond aid and development projects. Instead, they can be viewed as state-led attempts to introduce and superimpose new discourses and paradigms in an effort to subvert or weaken pre-existing ones within the state. In the case of *Mais Médicos*, the government attempted to do so by introducing new discourses about biopower in an attempt to redefine the medical profession and the ways in which medical care is delivered in Brazil.

Following Judith Butler's (1999, p. 171) insights about "gender performance" and applying them to my case study, one could argue Cuban doctors have a different way of "performing" their "doctorness", and this was immediately recognized by Brazilian patients. This is *not* to say their performance is automatically more humane, scientific, or correct – but to suggest it is as much a performance as that of other professionals. Moreover, although their performance might be different, or differentiated, from doctors trained within capitalist social

systems, it is still not free of the social processes and power relations that are articulated through the medical profession. To demonstrate this point, let us consider again this excerpt from my interview with a Cuban doctor, Ana Clara, who completed a medical mission in Venezuela:

> Interviewer: What are the differences you see between men and women in Venezuela and in Cuba?
> Ana Clara: Well, women here [in Venezuela] govern the men. Here women are strong. Hysteria fits, in Cuba we see that among women. Here it's the men that come to the clinic with hysteria fits, who are 19, 20, 21, 22 years old because of their girlfriend.
> Interviewer: And what do you think about that?
> Ana Clara: Well you can imagine [rolls eyes and smiles] what would you say about that?

From Ana Clara's response one can ascertain that as a Cuban woman, she held a different understanding of the male/female gender dichotomy, and resultantly, of how women and men should "act" during their interactions with each other. This revelation places her as an adherent of the western binary two-sex system, which since the late 18th century has replaced the ancient Greco-Roman system where only one sex existed, and women's bodies were viewed as imperfect male bodies, instead of as polar opposite bodies (LAQUEUR, 1990, p. 115). Her adherence to this model shows us how Cuban doctors – despite official government rhetoric and although they might have made great strides in treating patients in a more "attentive" manner – are still capable to repeating gendered, racialized, and other heteronormative interpretations of the human body. Post-Soviet Cuban medical practices might be "revolutionary" to a certain extent; but this does not mean they have fully challenged inherently classist, gendered, heteronormative, racial, or other social biases and premises.

Additionally, Doctor Ana Clara's reading of Venezuelan men "acting" in what she interprets as a feminine manner and pathological way, illustrates how these medical missions create an encounter between infinitely different ways of enacting and utilizing biopower. Following Butler's line of reasoning – Ana Clara "expects" men to perform their gender in a certain way, which means she also has an expectation for how she performs, as a woman, doctor, private citizen, etc. Read internationally, these medical missions create a clash between social systems, and how they are articulated by Cuban doctors within their host communities through biopower. This can have both positive and negative effects, depending on your position in the resultant power dynamics. Cuban doctors are well aware of their personal agency as medical professionals, and the resultant identity it entitles them to, and as Doctor Antonio's testimony validates, they are not hesitant to enact this biopower. Certainly, Doctor Ana Clara is just one individual, and this is only one statement she said among many

during her interview. The point here is not to criticize her or any other Cuban doctor, but instead to problematize the traditional "goodwill" discourse that is constituted around Cuban doctors, while presenting a more nuanced perspective on their international efforts.

From these short excerpts of conversations with Ana Clara and Antonio, as well as Brazilian officials, we can begin to perceive the international ramifications of these medical missions on biopower, discourses, and struggles over both. During the course of my interviews, in the same way that Ana Clara remarks on the Venezuelan men's "hysteria fits", other Cuban doctors also expressed bewilderment at various Brazilian tropical diseases and social norms they were exposed to for the first time during their time with *Mais Médicos*. For instance, one research participant was quick to list off various diseases that are not prevalent in Cuba and their causes, such as Brazilian *Gaúchos* (people from Rio Grande do Sul State) contracting specific intestinal diseases from eating too much rare meat, a dietary practice Cubans tend to avoid. Cuban doctors who have completed missions in many countries were also quick to remark on the differences between healthcare systems, for instance in Brazil they have access to better medications and equipment than they did in Venezuela. These memories reveal all of the personal and medical insights Cuban doctors gain during their time abroad, and how they then become a two-way bridge between medical practices in Cuba and their various host countries. As the documentary, *Vem de Cuba* (VEM…., 2017), about the experiences of two Cuban doctors working in *Mais Médicos* in Brazil's Rio Grande do Norte state well illustrates, in their efforts to integrate into and serve their host communities, Cuban doctors both change and are changed by them.

Taken to the international level, this process works to either reinforce or defeat pre-existing discourses and notions, depending on the situation. For instance, Laura, a Brazilian doctor, who was very critical of the *Mais Médicos* program, revealed the following:

> Better collegiate training I cannot judge because I do not know Cuban universities, but I can guarantee that today public universities, at least here in Brazil, have excellence in medical training… I cannot say that all medical training here in Brazil is better than that in Cuba, but I can guarantee, I couldn't tell you a percentage, but a large part of our universities train excellent professionals.

In a Foucauldian sense, this reveals the tense power struggle that the creation of the program incited, as each side fought over their right to have power work through them in order to accomplish greater social ends. The results of these struggles, however, as we have seen throughout this section, are more complex than can be perceived at surface-level. In summary, *Mais Médicos* presents us with numerous struggles over who, how, and for what

ends, is able to define and treat the human body – at both the inter-personal and international levels. Struggles that will continue to evolve across political arenas.

6.3 CONCLUSIONS

Throughout the two preceding discussion sections I have problematized conventional notions about Cuban doctors and their work abroad. As argued here, the arrival of Cuban doctors was not greeted by a scapegoatist racist reaction to their inclusion in the *Mais Médico*s program, by the PT government. Instead, Brazilian doctors and other civil society members rallied around and activated many pre-existing discourses concerning biopolitics, race, nation, and so forth, to counter what they saw as a biopolitical attack from the government through opposing discourses. What resulted was a heated struggle over discourses, whereby Brazilian medical doctors were afraid of: losing their privileged stance over the human body, having social hierarchies upended, and acquiring a passive international identity. As Cuban doctors began arriving they did indeed affect the inner-workings of biopower at the local and interpersonal level throughout Brazil. However, their affects and contributions were not a one-way street, as they were also affected by their time in Brazil, and all of the other countries where they complete medical missions.

Cuban medicine, and its doctors, may be revolutionary – but this does not mean they are entirely free of the racilaized, gendered, and other undertones that attempt to hide behind "*pure*" science. Cuban doctors might also have a different way of employing biopower than Brazilian or Venezuelan doctors; yet their methods can still be imbued with power imbalances, albeit more subtlety. Seen internationally, this cautions us against accepting SSC programs as inherently free of relations of power or dominance, and instead to critically analyze the day-to-day and interpersonal arrangements and exchanges that result from these ventures. Patients and bodies are not abstract or token variables within domestic political arenas, quite the opposite, they are oftentimes at the frontlines, as canvasses for many international political struggles over biopower.

7 FINAL CONSIDERATIONS AND FUTURE RESEARCH

The discussions advanced in the previous chapters have served, just as my title suggests, to "(re)imagine" Cuban medical internationalism – and to do so in a specific way. The predominant scholarly approach has been to take Cuban medical internationalism as a natural, unchallenged, and unproblematic process, and then to present it thusly to the academic community, as if power and the interpersonal could not in any way affect the delivery of healthcare across cultural and state borders. When included, the voices of the individual Cuban women and men who have comprised these countless missions to Angola, Timor-Leste, Haiti, Venezuela, Brazil, and to so many other places, have only served to reaffirm the pre-established narrative of Cuban medical internationalism and Cuba's internationalized place in the world. A form of self-fulfilling prophecy, whereby human services coming from Cuba must be intrinsically positive in their totality and must be presented as such. This study has focused its analysis on bringing other variables and factors to light, in an effort to expand our understanding of this political process.

Through the fieldwork findings presented here, I have demonstrated how the experience of a male Cuban doctor working in *Mais Médicos* is rather different from the experience of a female Cuban doctor also working in *Mais Médicos*. This process is only complicated when one considers the experience of a third female afro-descendent Cuban doctor working in Rio Grande do Sul state, with its predominantly German and Italian-descendent populations, which is also quite different from that of the first two doctors. Furthermore, the experience of these three doctors in Brazil is different from the experience of a Cuban doctor working and living in Venezuela or Bolivia. And lastly, the personal histories of all of these doctors in Latin American at the beginning of the 21st century is still differentiable from those of Cuban doctors who went to Angola, and other parts of Africa, during the midst of the Cold War in the 1970s and 1980s. These findings and insights, though, are *not* only important for historians, anthropologists, and sociologists – the areas to which they have been mainly confined within the academy – but are also fundamental to our understanding of the international and International Relations. What this research reveals to us is how the *stuff* of the international and substance of IR is created daily, on the ground, and through the quotidian. Likewise, these results demonstrate the importance of intersectionality for our understanding of global political processes.

All of the Cuban doctors whose experiences are retold throughout this study, as well as the 1.000s more that are out in the field currently working, do not simply ask patients about

their symptoms and ailments, and then prescribe medications in a robotic automated fashion. Quite contrarily, they are engaged throughout their daily interactions in a complex process of behaviors that presents to their host communities a doctor, a foreigner, and an international agent, all at once. These interactions are not free of class, race, gender, notions of the "other", or questions of a geopolitical or temporal nature, as has been explored here. Secondly, these interactions are all also centered on practices and systems of power, and power relations, that seek to define, order, and structure them. Power relations, as presented here, are hierarchical and not given *a priori* by nature or society – they are constituted through daily and interpersonal practice/contact. As the stories of Cuban doctors who suffered mild hostilities from certain members of their host communities, but are then in a superior position of power within an examination room reveal – power relations are not given and set, instead they are in constant flux. Hence, the primacy given here to questions of power, not only as a force; but also as a system of social discourses and practices, due to their utility as analytical means for understanding a phenomenon as complex as Cuban medical internationalism.

In chapter 3, I traced the origins of Cuban medical internationalism and how this contributed towards the creation of the "Cuban doctor" as an internationally recognized discourse with a certain identity and set of connotations and positive associations. This discussion revealed the diversity within and between these different South-South cooperation programs, and some of the effects they are currently having on national and personal identities. In chapter 4, I turned my attention towards race and hierarchy within these international medical missions and how these variables affect outcomes in rather unintended ways. A close reading was made of the narratives and discourses that state actors employ when they present and enact South-South cooperation schemes, which was then problematized when one studies the ways in which these programs play out at the interpersonal level.

In chapter 5, my analysis focused on questions of gender to underscore a variable that has been greatly omitted by Cuban histories, IR theorists, and scholars of Cuban medical internationalism. Through my fieldwork and discussions, I was able to delineate the difficulty of using terms such as "feminism", "agency", or "subjectivity", in a setting as complex as Cuban international development programs or civil society. Overall, this discussion shed light on the complexity of understanding and conceptualizing the international arena, especially when one employs feminist methodologies. In chapter 6, I conducted a close analysis of how the "Cuban doctor" discourse, whose creation was presented in chapter 3, plays out within current and daily practices by studying the different biopower and biopolitical practices that

Cuban doctors are enmeshed in, while participating in the *Mais Médicos* program. This chapter also presented a deeper look at discourses and how they constitute ways of looking at, representing, and defining both individuals and their bodies.

In all, my four discussion chapters can be taken as a close look into Cuban medical internationalism that goes beyond the official positioning of the state, or a clear-cut and rationalist analysis of the gains and losses of participation in these programs. On the other hand, what I have presented here is something that is somewhere in between, "living on Border Lines" to use Richard Ashley's description (ASHLEY, 1989) – on the borderlines between the individual/collective, domestic/international, negative/positive, oppression/agency. This reasoning makes us return to my original research question posed in our introduction: how does Cuban medical internationalism affect race, gender, and social discourses both in Cuba and in the host countries? The nuanced replies to that statement, given in the previous chapters, serve to highlight the complexity of conducting critical IR scholarship that goes beyond a reductionist view of state/national interest, or empirical results and hard data outcomes, or a search for one predominant variable/concept/theory to encapsulate all of one's messy fieldwork findings.

Why was, and is up until today, the *Mais Médicos* program so controversial in Brazil, giving way to such heated and polarizing social struggles and discussions? Perhaps because the program made apparent to a sizable portion of the Brazilian population various power relations, and medical discourses, which across time had been normalized, essentialized, and naturalized. Perhaps because it presented a marked alternative to the way in which healthcare has been traditionally delivered within Brazilian society, an alternative that is not necessarily superior or perfect, but one that challenges the perceived firmness of that which already exists. Perhaps because it placed Brazilian elites, white, male, and hypermasculinized, in a passive position within a domestic and international hierarchy of power relations whereby agents that they perceive(d) as inferior entered their political community as equals or superiors. Perhaps a combination of all of these factors and countless more – and all at the same time. The point being that all of these deductions reflect a fundamental connection with power and aspects of power relations operating within a negotiated space.

The same reading can be made on the other side for Cuban doctors and the Revolutionary regime, when we consider questions of why send so many doctors abroad and why have such care for the doctor's activities while abroad? This probably results from a fear of what unfettered contact between Cuban doctors abroad and other populations would bring in the long-term as these doctors return with ideas and experiences acquired abroad. Secondly,

the doctors' income while abroad, and upon returning home, must be closely calculated and watched lest it create resentment within the general population who do not have access to this form of income. Meanwhile, the doctors must appear to have gained something, socially and materially, from their participation in these programs in order to not effect future recruitment for these programs. Likewise, the image and behavior of Cuban doctors while abroad must be negotiated and managed to preserve the discourse of the good "Cuban doctor", and improve foreign public perception of the Cuban regime. Yet the doctors cannot appear either as being too controlled or too tied to the regime in Havana, lest they appear as communist agents. All of these considerations and intricate negotiations also reflect fundamental characteristics of power, agency, and subjectivity, which I have presented here as central to our understanding of Cuban medical internationalism.

Taking our analysis to the macro and international system level, when I envision Brazilian and Cuban foreign policy, I cannot help but be reminded of Frantz Fanon's (1986) classic, *Black Skin, White Masks*; but with a caveat. Fanon's work was written for and must be understood within an African racial and colonial context. As argued here previously, the way in which race and racism developed in Cuba and Brazil, and Latin America more broadly, is distinct. Across Latin America, for the most part, white elites still control the state, government, and its policies. On the other hand, convenient forms of blackness, for political purposes, are employed by these states through their national identity to further their own soft power and thirdworldist appeal. From this, the image of Latin American states' foreign policy in a way emerges as white skins, holding both a white and black mask, and switching between these masks depending on the occasion, venue, or which one will render them a larger position of power.

This image is further complicated when we examine if the figures conducting this convoluted game of whiteness/blackness/identity are men or women, but overall always actors caught within masculine narratives of assertion and dominance. In many ways, this dissertation has mapped out the effects and outcomes of encounters between different Latin American agents of foreign policy initiatives, and the differences that arise when those actors are women or men. Our focus, in a certain manner, has also been on highlighting the labor of women, afro-descendent Cubans, and/or migrants, to expose the specific problems and oppression they face while working abroad, while simultaneously finding avenues for enhancing or demonstrating their personal agency.

Certainly, this argument is not new – it is a point feminist, Marxist, and post-colonial thinkers have been making for decades. In a way though, my point has been to show how

these factors and issues persist, and how mainstream IR scholarship insists on folding these countless engagements and disruptive experiences, as well as complex plays of identity that do not fit easily into systemic-level theories, within unproblematic conceptual boxes and state-level accounts. IR scholarship continues to press for what is policy relevant, for what is politically useful, and for what is parsimoniously gathered and presented, in an almost obsessive persistence that this is what will solve international political problems. Variables such as, gender, race, discourse, time/place, and the individual experiences they foster, we are led to believe will not result in useful answers to larger problems. This dissertation has attempted to counter that narrative by presenting the lived experiences of Cuban medical doctors abroad, and their host communities, in an attempt to detail the various political processes in which they engage, and the effects this has on the international system. Moreover, these contemplations are of critical importance as the Cuban revolution turns 60 in 2019, and scholars reflect on its long-term legacies, both positive and negative, for individual advancement, state-level development, and global political outcomes.

Of the numerous interviews that were conducted during the fieldwork stage of this study, the one that stood out to me as most reflective and encompassing of the arguments being presented here is the response, presented and discussed earlier, from doctor Katia, who completed missions in Honduras and Venezuela:

> Interviewer: How was your experience in Honduras different from your time in Venezuela?
> Interviewee: In Honduras I was in a village that did not have electricity, and I was responsible for 28 villages, there were some villages that when I went to visit them it took me four hours on horseback. It was in the middle of the jungle, there was everything imaginable, snakes, everything. The people there were completely illiterate, very humble. There were days when we would see 102 patients. It was very difficult. They never attacked me. They used to say, "First God in Heaven and then the Cuban doctor"! They used to say that. In fact, they used to say I was *gringa*, because they thought that every Cuban, that we were all black.

The words, "First God in Heaven and then the Cuban doctor", stuck with me beyond my interview with her because of how succinctly they summarize the tensions and contradictions outlined in this study. Programs designed to help other countries and deliver healthcare can also work to constitute certain identities for a group of people in detriment of those they are trying to help. Furthermore, as Katia's recollection reveals, it is unsuitable to speak of Cuban medical internationalism and only focus on healthcare. Race, gender, geopolitics, class, religion, and numerous other variables, also enter into the picture or discourse.

This discussion is overall important to our understanding of politics across the Global South at the beginning of the 21st century. What we have seen here is that discourses, and

discursive practices, are out the outcome of social struggles over, say subjectivity, national identity, or biopower; but rather that they play an active role in the constitution of the discourse. Furthermore, this is not a distant and abstract process; but rather one in which actors and states from across the Global South are engaged in daily and constantly, through SSC, soft power, and other foreign policy tactics. The international discourse of the "Cuban doctor" runs deep, and it works to help reassert and contest the place of Cuba, and the Cuban people, within global politics. The way in which Global South states employ discourse to make up for deficits in military, financial, or other forms of power, is important towards our academic understanding of the dense web of interconnected power relations that collectively render the international system. The system though is tentative and fragile, because discourse almost necessarily implies *continuous* discursive struggle within social spheres. Our focus here has been on Cuba and Brazil, but further research is needed on how these processes play out throughout the Global South, and their impact on local, regional, and North-South relations.

On a more personal note, I myself came into contact with the "Cuban doctor" international discourse in February of 2015, at Rio de Janeiro's Galeão international airport, long before ever starting this research project, where I had the following exchange with an immigration officer:

> Immigration officer: How long will you stay here?
> Me: For nine months, my visa is a cultural one for a 9-month exchange program.
> Immigration officer: Are you a student? What are you studying here?
> Me: No, no, I'm not a student. I'm here with the Fulbright Program, I'm here doing a cultural exchange. I'll be working at a university for 9-months.
> Immigration officer: [Looks at my passport once again slowly] Oh, you're one of those Cuban doctors. [Quickly stamps passport, hands it back, and waves me away]

Although I was carrying a US passport, the fact that the passport read, "Place of birth: Cuba", immediately altered my identity and self before this immigration officer. Despite living in the US since I was four years old, to him, I was identifiable immediately only as Cuban, and more importantly, as a Cuban doctor.

Certainly this experience, and many other ones similar to it, as Brazilians struggled to understand "José Pérez" as a US citizen, who was somehow born in Cuba, have led me oftentimes to reflect on my identity and place within the grander workings of global politics. Specifically, why did this man immediately identify me as Cuban? Why did this association as a "Cuban doctor" immediately make me less threatening to him than if I were a US college student here for an exchange program? What did he personally think about *Mais Médicos* and

how did his encounter with me affirm or challenge that thinking? These are the types of questions and reflections that partially inspired and led me to carry out this research project.

Thus, the purpose of this undertaking has *not* been to bash or discredit the work of Cuban doctors abroad. As was well displayed in the previous chapters, Cuban doctors have a profoundly positive affect on their host communities, and are typically well reviewed by satisfaction surveys conducted with the populations they serve. The best example of their effectiveness, work ethic, and abilities, is probably the fact that President Michel Temer did not end the program in 2016 after assuming the presidency, replacing Dilma Rousseff (the creator of the *Mais Médicos* program), who was ousted following a highly politicized impeachment. Temer allowing the program to continue reflects the need that some municipalities have for these doctors and the positive impact they have had on their communities. Likewise, my argument is not meant to suggest that it is only Cuban medical internationalism which is subject to nuances resulting from racialized thinking, gender conceptions, geopolitical dissonances, etc. These are all variables that are present as well in Doctors Without Borders, the Red Cross, and every other international medical care program.

On the other hand, my purpose has been to look beyond these discourses and instead focus on that which is oftentimes overlooked, better yet naturalized, within these discourses. In other words, I have turned my analysis towards individuals and their experiences, the interpersonal, the quotidian as a means to understand the macro, the international, the political. The paradoxes and outcomes presented in this dissertation are likely to have far-reaching consequences (well beyond the timeline of this study) for these host communities and Brazil, considering that many of the Cuban doctors I interviewed (and many more in the program) have married Brazilian citizens, giving them a way to permanently stay in Brazil. As this project draws to a close, the medical partnership between the two countries appears to have ended for now, as Cuba announced at the end of 2018 that it would be exiting the *Mais Médicos* program, along with its doctors. This move is probably a result of the election of far-right candidate Jair Bolsonaro to the presidency of Brazil in 2018. These Cuban doctors who have left Brazil, though, will soon likely be delivering healthcare in new places across the Global South. In the meantime, their exit has affected the over 2.000 Brazilian municipalities that were still hosting over 8.000 Cuban doctors; and left 285 municipalities without any public doctors, 92 in the state of Rio Grande do Sul alone (PINHEIRO; COELHO, 2018). The Brazilian Ministry of Health has been forced to relocate existing medical professionals, and attempt to recruit Brazilian doctors, in an effort to reduce the negative side effects of Cuban professionals exiting the program.

There were of course oversights, like with any research endeavor, during this study that must be accounted for in this section. For instance, questions of sexuality and their affects on these programs is a theme that could have been better explored and analyzed. However, due to the sample that I as able to obtain, and because of the difficulty in bringing up those kinds of conversations during interviews, it was quite difficult to gain much insight into that variable and the role it plays within Cuban medical internationalism. Moreover, my sample size of 30 interviews is not a robust enough number to draw grand empirical findings or suggest drastic changes to the ways in which these policies are developed and implemented. Instead the force of my argument has been to detail the contradictions and tensions I observed during my fieldwork in hopes that future researchers will be able to reproduce these methodologies and see what insights they can obtain. For a longer research project of about four years, instead of this one which was only two, a larger sample size of about 50-60 fieldwork interviews and observations would certainly result in a much richer data set and opportunities for reflection and interpretation. This dissertation presents the results and observations that I was able to gleam during a two-year research cycle and invites other scholars to dialogue with these results in an effort to continue and enhance the conversation that was begun here. In no way is this meant as a definitive and comprehensive study of Cuban medical internationalism, especially considering that it is an ever-shifting and unstable concept, process, and identity.

"Cuba", as a place, state, idea, has gained a role within popular social and political discourse in Latin America that is unfortunately all too often fetishized as all to be emulated or avoided. Leftist leaders and thinkers within Latin America point to Cuba as the paramount example of that which is possible and within reach. Meanwhile, right-wing sympathizers and leaders also invoke a Cuban imaginary as the specter that haunts the region. My point here has been to defeat this binary conceptualization by exploring the density that lies behind domestic political processes in Cuban society, and within the island country's foreign political involvements. Said briefly, politics is convoluted. That might seem obvious at first glance, but it is a notion oftentimes abandoned by analysts in their search for explanations and answers.

When one considers "South-South cooperation" or "migrations in the global south", two themes under which this dissertation could be categorized, this process of reducing and flattening our understanding of political processes until they are easily digestible is typically the rule, not the exception. Both of these entities, as entities, are created by humans through human interactions, despite the appearance of inter-state politics often attributed to both. This dissertation has shown the complexity that exists within these projects as race, gender, and

other discursive means for producing difference alter and defy predetermined objectives. The migration of a Cuban woman from Havana to Maranhão state in Brazil affects her and her family in infinitely positive and negative ways. The participation of afro-descendent Cubans in South-South cooperation programs has the same effect. Focusing on these facts is not a preoccupation with minutia that blinds one from "what is really important", or leaves us in a field of "policy irrelevance". On the contrary, it gives us a firm grasp of how political processes do, in fact, play out on the ground. To understand Cuban medical internationalism one must be aware of the diversity within its confines, to then make sense of its outcomes and future possibilities.

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