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Cross-Continental Care: US and Cuban Medical Internationalism in Bolivia

Madeleine Blain
Macalester College, maddyblain@gmail.com

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Abstract

How can something as commonplace as going to the doctor influence international politics? In Bolivia, medicine is bound in politics. The political structure of a country both influences the approach to health care, and determines how that approach is most effectively implemented internationally. Building upon a framework of conceptual difference between capitalist and socialist health systems, this paper examines "effective" models of US and Cuban international health care on both a political and individual level. Drawing on fieldwork conducted in a Bolivian hospital, interviews with doctors working internationally, and current literature, I seek to discern what defines "effective" international health care, in terms of political goals, patient care, and sustainability. Bolivia's recent shift to the left enabled favorable political relations with socialist Cuba, and strained relations with the United States. By examining approaches to international health, the influence of national politics comes to light. Cuba's "medical diplomacy" is a means of solidifying trade relationships through the exchange of doctors. However, local doctors who do not share socialist ideology resent the loss of jobs. While tensions with Cuban doctors cast a shadow on international medicine, US doctors and organizations reported more successful operations. Given tense political relations with Bolivia, effective US medical programs seek to integrate their work into Bolivian society in order to avoid expulsion from the country. Understanding the interaction of politics and health care can aid in the design and implementation of effective public health projects, the world over.

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Introduction

Outside the big wooden doors, marked with "Pediatría Quemados" and posters showing visiting hours, the parents wait. The Hospital del Niño Manuel Asencio Villarroel Burn Center is far from the entrance of Cochabamba's Hospital Viedma complex. In front of the doors are benches where women in traditional dress and men in dusty rubber shoes sit. Children trailing bandages from their arms and legs cling to their mothers' skirts. They have been there since seven thirty in the morning, though it will be many more hours before they can enter. They come from the *campo*, from the city, from far away. And they come every day. Torn, discolored posters advise ways to avoid burns. For many of those who come to wait in front of these wooden doors, it is too late for warnings.

Inside the hospital, US doctors examine hundreds of children with severe burns, deciding which children will receive free reconstructive surgery, which will be flown to Boston, Massachusetts for intensive care, and which will remain in the hospital. Most of the children come from poor families in the department of Cochabamba. For some of them, their best hope for treatment comes from the US doctors.

In recent years, Bolivia has seen an increase in childhood burn victims. From 2010 to 2013, the number of reconstructive surgeries for burn treatment increased twenty percent (*La Estrella del Oriente,* 2013). The increase in burns follows a trend in urbanization of jobs that takes adults far from home, leaving children alone to cook for themselves and their siblings. There is a general lack of education of health risks, and

extreme poverty and geographical barriers make access to health care difficult (personal communication, B. Céspedes 2014). Because of the increasing number of childhood burns in and around Cochabamba, Hospital Viedma's pediatric burn center lacks the space to treat all burn injuries. Burn patients need about two square meters each for beds, braces, and bandages, but Hospital Viedma houses five patients in a room measuring four square meters, in an effort to treat as many children as possible (*Opinion* 1/20/2012). Many of the victims cannot afford the expensive treatments and reconstructive surgeries required for recovery. International medical aid thus plays a crucial role in the treatment of childhood burns in Cochabamba by providing surgeries free of charge.

Seeing the US doctors in action inspired me to examine the interaction of politics and health care on an international level. The US doctors I met in Bolivia represent one of many approaches to "medical internationalism," a term I use to refer to medical personnel—doctors, nurses, public health workers—who travel abroad to practice medicine or provide medical aid. I chose to use the term "medical internationalism" to describe both the US and Cuban approaches to medical aid, since it encompasses both the foreign policy motivations of internationalism and the humanitarian aspects of medical aid.

The literature on international medical programs uses a variety of terms to refer to what I call "medical internationalism." Most of the literature uses "medical internationalism" in reference to Cuban programs (Blue 2010; Harris 2009; Huish 2013; Kirk 2009). In contrast, a relatively new body of literature regarding "medical humanitarianism" has emerged, and most US international medicine programs are listed under this label (Good 2014; Abramowitz 2014). However, "medical humanitarianism" is usually used to describe "the delivery of health-related services in settings of crisis,"

including "contexts of violence, famine, natural disasters" (Good 2014:311). Extreme poverty is sometimes also considered among emergency situations, but because the programs I chose to analyze are established in non-crisis settings, I favor the term "medical internationalism." With this distinction, my research adds to the emerging field of study of international medicine.

The field of "medical internationalism" is largely devoted to Cuban programs. Cuba boasts a world-renowned international medicine program, in which Cuba trains and exports doctors around the world as a means of forging political relations and aiding in the treatment of medical emergencies. The unique aspect of political motivations in Cuba's medical internationalism led Julie Feinsilver (2006) to call the programs "medical diplomacy," distinguishing the political element from humanitarian efforts and from US programs.

The similarities and differences between Cuban and US medical internationalism prompted several questions about the nature of medical internationalism: What role do politics play in international health care? How do foreign policy and national politics affect the relationships between international doctors and their patients? How does Cuba's renowned medical internationalism program compare to US medical projects when implemented in Bolivia, especially in light of political alignment or tension? I argue that, while Cuba and the United States have different political and health care structures, their models of medical internationalism are similar. These models are influenced by Bolivian foreign policy, determining how US or Cuban programs are implemented in Bolivia.

For Bolivia, the most effective form of medical care is social, integrated medicine, given Morales's rhetorical commitment to indigenous identity and providing care for all

citizens. Cuba's medical diplomacy is thus effective in Bolivia through the political alliances and trade relationship it creates. Additionally, the social medicine model Cuba employs is successful in Bolivia given the similar health systems and focus on integrated health care. In contrast, US medical internationalism projects are most successful when they integrate directly into the Bolivian system. As Bolivian organizations or partners with Bolivians, US programs avoid Evo Morales's accusations of imperialist action. Integration into the local community requires three factors: culturally relative care, positive reception by the local community, and sustainability of medical efforts. To fully examine forms of health care and their relation to political structure, I turned to several frameworks of social medicine, cultural understandings of health, and political influence on health care system.

Theoretical Framework

My theoretical "framework" draws on research by medical doctor and sociologist Howard Waitzkin, his colleagues, and conceptual theories of social medicine. Waitzkin formed the basis for my research by theorizing a correlation between politics and health care in his book, *The Politics of Medical Encounters* (1991). I situate my research within Waitzkin's framework, but seek to add a dimension of internationalism. Waitzkin's various works on politics of health care deal only with political systems and their corresponding health care structure. Now, twenty years later, as ideas and people travel even more easily internationally, it is pertinent to ask what happens when different political and health care systems come into contact with each other in the context of medical internationalism.

Additional research by Waitzkin and his colleagues (2005) theorizes a fundamental difference in how US and Latin American health providers conceptualize health care. The

conceptualizations of medicine and health care further inform Waitzkin's (1991) theorized difference between US and Cuban health care. In following Waitzkin's various publications, the United States' and Cuba's health care systems and approaches ought to differ in both political form and health system implementation.

In his book (1991), Waitzkin suggests that, in the United States, and other capitalist societies, social class informs the interaction between doctor and patient. Doctors, as highly educated and typically from wealthier socioeconomic backgrounds, unintentionally reinforce structures of power. Because belonging to a higher social class is a privilege, doctors are not encouraged to challenge social class structure, nor "criticize the social structural roots of their clients' distress" (1991:22). Many doctors may view their own role as a limited one, meaning doctors believe they should not be expected to discuss potential social causes of pain because it is outside their scope of treatment. Waitzkin argues that classist politicoeconomic structures, like that of the United States, result in the over-medicalization of social problems, which contrasts the attention given to social causes of medical problems in socialist politicoeconomic systems, such as that of Cuba.

Cuba, Waitzkin writes, has significantly altered medical practice since the 1959 Cuban Revolution. By offering free health care to all, as well as free medical education, Cuba has diminished some of the barriers to health care and to medical education common in the United States. More women, Black Cubans, and students from poor socioeconomic backgrounds have been able to attend medical school (1991:265). By increasing participation of historically marginalized communities in health care, Cuba challenges the structures in place that have excluded certain populations from health care.

Cuba's health system shows positive outcomes for its citizens. Cuba's infant and maternal mortality rates radically decreased within the first 15 years after the revolution. They additionally eradicated malaria, polio, diphtheria and tetanus in the country. Cuba's health outcomes are possible through an "integrated" health care system.

Each medical encounter in Cuba now includes an "allied health worker" in addition to a doctor and nurse. This worker may come from one of many women's organizations, grandparent's circles, or trade unions, depending on the need of the patient. Waitzkin argues Cuba has privileged social intervention over medicalization. Cuba's medical system is therefore considered social medicine, integrating social and biomedical influences—the medical and the nonmedical—into the understanding of health, as defined by the authors of *The Social Medicine Reader* (2005).

One editor of *The Social Medicine Reader*, Jonathan Oberlander, offers an additional explanation for the difficulties facing the US health care system. Oberlander's theory focuses on access to health care in the United States' capitalist, competitive political structure. Like Waitzkin, Oberlander examines US health care from a politicoeconomic perspective, but emphasizes economic exclusion. Such exclusion adds to Waitzkin's class-based theory in order to more fully understand de facto exclusion from health care in the United States.

The United States spends more on medical care than any other country, but many Americans go without health care. Insured Americans have access to "the latest in sophisticated medical technology and innovative medical procedures", and yet more than 40 million Americans go without care (Oberlander 2005:5). Oberlander writes that, "the private market emerged as the engine of health care reform" in the 1990s, which would

supposedly combat cost inflation, while enhancing care quality and patient choice (Oberlander 2005:6). However, about 14.5% of the US population was uninsured in 2013 (ACS 2013), most of which is low-wage or small-business workers (Oberlander 2005:6).

Waitzkin also addresses this model of privatized health care in relation to Latin American health. In Latin America, Waitzkin and colleagues found a fundamental difference in conceptualizations of health from that of the United States. They found that "many governments in Latin America define health as a right and health services as a public good," and thus the government retains responsibility for providing care (Waitzkin et al. 2005:893). In contrast, the United States takes a market approach to health, assuming "that by expanding the private sector, improved economic conditions will improve overall health" and the government need not provide care (Waitzkin et al 2005:893). The US government does, however, sponsor health insurance programs, such as Medicaid. However, Oberlander argues that the US medical "system" lacks organization, rationale, and logic through its mixed public and private insurance structure, ultimately excluding much of the poor and minority population (Oberlander 2005:6, 7).

An understanding of the theory of social medicine is necessary for applying Waitzkin's framework of difference to actual health systems. Social medicine is based on the ideas that "medicine and medical practice have a profound influence on—and are influenced by—social, cultural, political, and economic forces" (Oberlander 2005:x). In the face of the increase in biomedical, molecular, and genetic understanding, the social medicine model contends that social factors also influence the occurrence and course of disease (Oberlander 2005:x). It further recognizes the effect medicine has on human kind's most basic understanding of experience: birth, maturation, sickness, healing, and death

(Oberlander 2005:x). The social medicine model expands on Waitzkin's concept of Cuban health care, placing the concept in a contemporary context. The *Social Medicine Reader* situates Waitzkin's theory of the relationship between class and health care in an examination of economic exclusion from health services in the United States.

While the frameworks outlined above offer insight into the relationship between health care structure and politico-economic structure, reality is messier. Since Waitzkin's writing in 1991, there have been significant medical advances—in technology and scientific understanding. In addition, political changes and shifts in the United States and Bolivia have affected relations in the hemisphere, with the advent of the "War on Drugs" and anti-terrorism campaigns. I suggest that my research modifies Waitzkin's theory of the politics of medical encounters.

Waitzkin lays a foundation for conceptualizing different health care models but he does not examine how either health care models or political structures might interact around international medicine. I thus propose a new model of analyzing health care and politics, through the lens of the society receiving care. Waitzkin suggests that political model defines structure of health care provision, and I ad to this to argue that local political structure determines the manner of implementing medical internationalism projects.

Methodology

My research for this paper comes in many forms. Investigations began with fieldwork in Bolivia. I spent a month working in the Pediatric Burn Center of Hospital Viedma in Cochabamba. There I practiced participant observation through shadowing nurses, attending to the patients and aiding in the bookkeeping system of the hospital. I

further conducted a series of formal and informal interviews with US volunteers and members of the Partners of the Americas organization. With the Partners of the Americas organization, I attended an annual meeting of the Cochabamba chapter and formally interviewed both the current president and the director of the health subcommittee. In the hospital I also had a series of informal interviews with a US volunteer in the pressure therapy center of the burn unit. These interviews proved to be an important source of cultural information, as well as cross-cultural observations from an outside perspective. My fieldwork and participant observation in the burn hospital led to continued investigation of the growing problem of burns in Bolivia, and the societal factors that contribute to the issue. This research took the form of literature review with scholarly articles and Bolivian newspapers.

Back in the United States, I continued with literature review of Bolivian politics and Bolivia's political relationship with both the United States and Cuba. I additionally consulted government documents and reports on health care, and World Bank and World Health Organization data. I conducted a series of interviews, both in person and via telephone and email, with doctors and international organizations that have worked in Latin America. Selection of these case studies aimed for a diverse array of experience. I gathered perspectives on international health care from individual doctors who spent time working in Latin America and other countries with similar levels of health access, as well as grassroots development organizations who conduct public health campaigns. Backgrounds of the doctors range from Christian missionaries to surgeons, to primary care doctors. The purpose of this diverse selection is to highlight the many different ways in which medical

aid flows internationally, and understand the positive and negative elements of each approach.

Much of my research was done with US organizations and doctors, leading to a lack of primary accounts from Cuban doctors. However, I chose to focus on the doctors sponsored and trained by the Cuban government in an effort to compare the political influence of both the United States and Cuba within Bolivia. Cuba's major export is medical personnel, which provided a large selection of secondary sources of information about medical training, programs, and Cuba's domestic social medicine system.

My analysis focused on themes of approaches to health care, efficacy, and sustainability. I compared health outcomes for Cuba's health system with those of Bolivia, and the outcomes of Cuba's medical programs abroad. Ethnographic data comprises much of the information on "effective" US programs, where I chose to center on what the doctors and organizations themselves saw as effective means of cross-cultural communication, medicine, and development.

In the following paper, I first examine the recent political history of Bolivia in order to lay the groundwork for understanding the current health care structure under President Evo Morales. I will explain the trajectory of neoliberalism to Evo Morales and the MAS, focusing on his reforms to the health care sector. Morales's election in 2006 marked an important shift in Bolivian politics and reformation of public services including health care. Morales's election came on the heels of the neoliberal era, which severely cut social spending for human services, such as health care. Running on a pro-indigenous platform, Morales has continued populist politics that cater to the indigenous community. His health

care policies highlight commitment to socialism and universal coverage that would provide access to the country's many poor and indigenous citizens. His socialist movement also relies on anti-United States rhetoric, exacerbating tensions in the hemisphere. In contrast, Morales's election solidified political relations with Cuba and similarities can be see between Cuban health care and Morales's health care reforms.

The second chapter examines the Cuban health care system and medical internationalism. The Cuban health care system shows positive health indicators, such as infant mortality and life expectancy, in part due to the integration of nonmedical influences into health care. Cuban physicians apply a similar approach abroad. Cuba's medical internationalism is often referred to a "medical diplomacy" because of its major role in Cuba's international relations. Cuba and Bolivia align politically following Evo Morales's election. Both are member nations of the Bolivarian Alternative for the Americas (ALBA) and have established a Peoples Trade Agreement as an alternative to NAFTA, which allows the trade of Cuban doctors for natural resources in Bolivia and Venezuela, notably. Despite the political alignment on a national level, conflicting ideologies between Cuban and Bolivian doctors sometimes results in resentment on the part of the Bolivian physicians. Cuban doctors are often seen as taking Bolivian jobs, in spite of the fact that the governments have arranged an agreement, and the similarities in health care structure. This chapter examines the tensions surrounding Cuba's political use of medicine, as well as the successes the Cuban approach has enabled.

The final chapter is comprised of information from interviews from US doctors and medical aid organizations. I compiled accounts from a variety of US medical internationalism projects, including grassroots development organizations, religious

missions, and volunteer medical aid workers. In light of recent political tensions in the region, and the United States' long history of intervention in Latin America, interaction with Bolivian government and society is a key theme. Despite these tensions, many doctors and organizations found effective ways to implement medical programs. I will compare several organizations on two levels: the political relations and the personal level, and the effectiveness in the cross-cultural encounter in Bolivian hospitals and clinics.

1 Decolonizing Health:
How Evo Morales changed the face of Bolivian health care

From Neoliberalism to *Vivir Bien*

The story of Bolivia' current health care situation is heavily influenced by the neoliberal era. Neoliberal policies in the 1980s ruptured Bolivia's political and social structures, and the subsequent rejection of neoliberalism sparked Bolivia's leftward shift. Bolivian president Evo Morales, elected in 2006, serves as an alternative to the neoliberal past and continues to promote Bolivia's path to socialism, changing Bolivia's political relations in the hemisphere as well as policies at home. Coming on the heels of a neoliberal regime in Bolivia, Evo Morales is positioned to reform health care along socialist lines. This interaction is crucial to understanding Bolivia's relationship with Cuba, which as of 2006, is based on political alignment. This chapter traces Bolivia's recent political history in order to examine the context for Evo Morales's political rhetoric and reforms, particularly in the health care sector. Given these reforms, I outline the burn problem in Bolivia as social in cause. The burn hospital offers a case study to analyze the models of health care examined in the next two chapters.

Spurred by high spending on oil in the early 1970s, a massive debt crisis erupted in 1982. Debtors were unable to pay, and creditors were unwilling to lend (Heenan 2002). Between 1983 and 1985, the Bolivian government attempted to cover for its debt by printing more money. The resulting inflation reached more than 20,000% per year in the mid-1980s. Three weeks after he was elected president in 1985, Victor Paz Estenssoro initiated a Structural Adjustment Program, designed by US economist Jeffrey Sachs, to end

hyperinflation through "shock therapy." The resulting Presidential Decree 21060 closed state mines, floated the boliviano against the US dollar, privatized state-owned enterprises, and increased foreign investment. Inflation plummeted from 20000% to 9% in a matter of weeks. The success in combating hyperinflation convinced much of the Bolivian population of the stability brought by neoliberal policies (Kohl and Farthing 2006).

Though it efficiently killed inflation, neoliberal policies had significant social repercussions. As Kohl writes, "neoliberalism as part of a global hegemonic project cannot effectively operate just on the level of government; it necessarily affects people's daily lives" (Kohl 2006:321). Impoverished by austerity measures and loss of social programs, the country's many poor began to mobilize to reject neoliberal policies. Neoliberalism simultaneously weakened social systems while providing new political opportunities for organization and opposition, resulting in popular mobilization against the neoliberal government (Postero 2005:79).

The two most infamous clashes came about in the water and gas wars. The *guerra del agua* erupted in 2000 in Cochabamba when a transnational corporation took over the water supply in Cochabamba, raising rates for poor neighborhoods and local farmers. The dissatisfied populace organized and defeated the transnational companies, reclaiming their water and marking a major victory against neoliberalism (Postero 2003:73). In 2003, another conflict over resources exploded. In his first term (1993-1997), Goni had already enacted many neoliberal policies, and his second term was also fraught with public opposition. The now famous October Uprising "was the culmination of tensions over neoliberal strategies, the right to meaningful political participation, and state violations of human rights" (Postero 2003:74). Tensions came to a head when the Sánchez de Lozada

administration proposed a natural gas pipeline across Chile to export Bolivian gas to the United States. The city of El Alto erupted in protests, blocking streets and fighting police officers. The conflict forced Goni to resign and board a flight to Miami, leaving Carlos Mesa Gisbert to fill the presidency (Postero 2003:75).

As the marginalized poor became increasingly unhappy with the failure of the government to recognize the rights of the indigenous, Mesa's politics shifted to the right, seeking support from the wealthy bourgeois bloc in the East. Protests from the indigenous bloc increased, and strikes and demonstrations erupted as the population grew more and more dissatisfied with the privatization of resources and cuts to social programs. Mesa's presidency ended when he found that he required force to maintain order. His legitimacy as president destroyed, Mesa resigned in June of 2005 (Kohl 2006; Webber 2010).

Through the destruction of legitimacy of previous leaders, mobilization of marginalized populations, and damage to crucial state services, neoliberalism brought about its own demise. The massive mobilizations against neoliberalism arose from political spaces guaranteed by neoliberal policies that ensured popular participation in elections. The increased participation of excluded groups suggests a "paradox" of neoliberalism: increased participation and exclusion from services.

Seeing democracy as the logical counterpart of market liberalization, neoliberal economists encouraged Bolivians' participation in their government through the Law of Popular Participation. The Law gave twenty percent of national government revenue to municipalities, and mandated participatory planning and citizen budget oversight, inadvertently creating "a training ground for indigenous political actors" (Kohl 2006:315). Håvard Haarstad, professor of geography at the University of Bergen, Norway, argues that

"popular mobilization is a direct and necessary response to exacerbated structures of exclusion and marginalization, of indigenous peoples in particular," (2009:4). The market structures that excluded the poor and marginalized were coupled with voting rights. Thus, the poor and indigenous sectors were able to find political power to act against the very structures that excluded them (Postero 2005).

In Bolivia, "indigeneity" replaced labor as the focus of popular movement. These indigenous groups, Haarstad posits, "were significantly empowered through the neoliberal decentralization and participation reforms of the 1990s" (Haarstad 2009:20). In addition to empowering indigenous groups, the subsequent rejection of neoliberalism paved the way for new forms of government in Bolivia. Richard Harris, political scientist and Professor Emeritus of Global Studies at California State University, Monterey Bay, argues that "neoliberal capitalism has had a devastating impact across the Americas," and has set the stage for a dramatic change in political trends (Harris 2009:40). The social damage neoliberalism caused led to a need for a new political system and reinstitution of social programs.

One area that suffered substantially under neoliberalism was the health care sector. In the 1980s, the World Bank gave many Latin American countries "recommendations" for repaying massive debts. These structural adjustment programs involved austere neoliberal economic policies, privatization of state resources and decentralization of the government and government services. Bolivia followed the World Bank's recommendations for 25 years, undergoing many changes to their health care system. The decentralization of government services, Silva and colleagues argue, fragmented health care delivery by separating "parallel subsystems with different modalities of financing, patient affiliation,

mentoring and service delivery" (Silva et al. 2011:27). Furthermore, decentralizing health care services transferred decision-making powers to local governments without strengthening the local governments' ability to direct and fund health care programs, leaving the poorer municipalities without access to health care.

Bolivia's health care system suffered greatly at the hands of neoliberal health care reforms. The decentralization of services left the system disjointed and with a barely-regulated market, the private sector filled the gaps. The World Bank only privatized the potentially profitable health services, such as contracting out private hospitalsand health insurance providers. These privatization measures only reached the middle and upper classes, who could afford care (Homedes & Ugalde 2005:85). In 2002, while Bolivia was still under neoliberal rule, a study by the Pan-American Health Organization (PAHO) reported that 77% of the poorest quintile did not have health insurance and only 4% was covered by social security. Following Mesa's presidency, Bolivia scored lowest in Latin America in health and equity indicators (Silva et al. 2011:23). By 2004, PAHO found that 30% of the population still had to no access to essential drugs, inequalities exacerbated by neoliberal privatization and inequalities (Silva et al. 2011:31).

Former cocalero union leader Evo Morales rode a wave of indigenous mobilization to the presidency in 2006. Morales's party, the Movimento a Socialismo (MAS; Movement Towards Socialism), framed itself as a break with past neoliberal agendas. Morales inherited a country scarred by neoliberal policies: the fragmented public services marginalized the numerous poor, protestors suffered violence as previous governments tried to quell the opposition, divides endured between the rich and poor, formerly state owned enterprises remained in the control of multinational corporations. In 2007, Morales

nationalized Bolivia's mines and oil fields, a show of his commitment to rejecting neoliberalism (Kohl 2006).

Morales's election is important because it forms the basis for two important shifts in Bolivian policy. First, Morales's rejection of neoliberalism and US economic restructuring politically aligned Bolivia with socialist countries in the region, namely Cuba and Venezuela, enabling trade alliances, which further strained relations with the United States. Second, the move towards socialism led to dramatic changes in Bolivia's health care landscape, including provision of health care for all Bolivians and the incorporation of indigenous modes of healing into health policy.

During the neoliberal era, health care structures were privatized as part of the market liberalization. Decentralized health care system caused fragmentation and dislocation of the health sector, excluding much of the population, particularly the poor. Most Latin American countries were forced to implement "truncated" versions of the neoliberal health reforms due to technical, logistical, political and financial difficulties. These abbreviated reforms resulted in wasted resources and ineffective practices. Further, the decentralization initiatives, as outlined above, forced the implementation of programs without the needed resources, particularly in the poorer municipalities, or without the necessary training for efficient use of available resources (Homedes & Ugalde 2005). Following the fragmentation and privatization of public sector services under neoliberalism, Evo Morales; administration seeks to return ownership of services to Bolivians.

A central tenet of Morales's presidency is his commitment to the indigenous heritage of Bolivia. Upon his election, Morales shifted political discourse to focus on pro-

indigenous concepts of "decolonization" and "interculturality"— which Brian B. Johnson, professor of sociomedical studies at Columbia University, argues have been effectively institutionalized by the Bolivian government (Johnson 2010:139). Johnson goes on to define interculturality as "integrated relationships between persons or social groups of diverse cultures or worldviews and, by extension, the attitudes or bearers of one culture toward the elemental norms of another," the goal of which is to open channels of exchange of power between different visions (141). Interculturality extends to health care through increased presence and acceptance of indigenous and traditional health practices. Relatedly, "decolonization" refers to "the intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation and/or exploitation of our minds, bodies, and lands" (Wilson 2005:2). Johnson argues that the MAS situates its policy changes within this framework, rendering decolonization "an experiment in national soul-searching and (re-)creation in a variety of aspects of daily life" (Johnson 2010:141).

Across the Andean region, the postneoliberal era has been characterized by a shift in thinking towards rights-focused development, known as *vivir bien*, which Morales has adapted to Bolivia. The concept draws on an originally indigenous concept that has taken on political power in the postneoliberal era, and stresses "a rights-based articulation of individual capacities and wellbeing, nature, and resource distribution" (Radcliffe 2011:240). *Vivir bien* (*Sumaj Kawsay* in Quechua and *Suma Qamaña* in Aymara) literally translates to "live well," and has been used as a slogan for Morales's policies, linking the socialism and modernity of the MAS with the idealized pre-colonial past integral to indigenous national identity (Johnson 2010:143).

Vivir bien, like interculturality, recognizes the intersections of diverse cultures while respecting their differences. In this model, rights of *vivir bien* are organized as differentiated citizenship: all citizens are not the same, but all different societies and cultures have important rights. This conception of human rights emphasizes health care as a right, rather than a commodity, and takes into consideration cultural differences in health beliefs. The inclusion of traditional and natural medicine into state health care acknowledges the importance of different cultural modes of healing, and like the Cuban social health model, strives to understand the social context of each patient (Radcliffe 2011).

In health care, *vivir bien* is used as a means of changing the thinking about rights and citizenship, with access to health care for all Bolivian and respect for traditional beliefs. Where neoliberal policies caused a decrease in the quality of life for many, as well as over-exploitation of natural resources, the primary goal of *vivir bien* is the increase in standard of living and respect and protection of natural resources. The main idea of living well extends to rights, abolishing the divide between collective rights and individual rights by "interweaving" the liberal focus on the individual and the pro-indigenous view of the collective, in order to acknowledge the rights of all Bolivian people (Radcliffe 2011:242). The change in thinking about rights corresponds to the desire for decolonized and state-provided health services, and the belief that health is integral to all areas of life. Good health is then necessary to "live well" in all areas of life.

The Morales administration uses *vivir bien* as a way of solidifying its connection with the indigenous population as well as a means of opposing Western imperial development and committing to decolonization. Juan Carlos Calvimontes, Bolivian Minister

of Health, claims the poor have been denied equality, dignified work, basic necessities, and the right of health by "development policies" ("las políticas de desarollo"). Under the new model of *vivir bien,* the Ministerio de Salud y Deportes (Ministry of Health and Sports; MSD) declares that "la salud ya no es privilegio de pocos es un derecho de todos" (Ministerio de Salud 2010). The Ministry of Health and Sports thus guarantees health care through the constitution.

The goal of the administration, in terms of restructured health care, is the implementation of the Ley del Sistema Único de Salud. This law would guarantee the right of health and universal access to all inhabitants of Bolivia. The Proyecto de Ley del Sistema Único de Salud, developed on 21 September 2010, uses language of "interculturality" and plans to include traditional medicine in coverage and definition of health care. The language of the project itself claims that "la salud es un derecho humano universal fundamental y social. Es un bien público inalienable garantizado por el Estado Plurinacional" (Government of Bolivia 2008). The Morales administration's plan for universal health care is what Morales calls "socialized medicine." Nila Heredia, the first minister of health under Morales, laid groundwork for a state-run, single-payer health service for the entire population that is sovereign and decolonized, free from private corporations (Johnson 2010:148).

The service builds upon previous attempts at maternal and infant health insurance. These previous programs, particularly for maternal and infant care, found only limited success. The Seguro Universal Materno Infantil (SUMI) was the most comprehensive health plan, according to a World Health Organization discussion paper. Implemented in 2003, while Bolivia was still under neoliberal rule, SUMI provides insurance for children until

they reach five years old, and for mothers until their infants reach six months (personal communication, B. Céspedes, 2014). In the first year of operation, infant mortality decreased from 52 to 49 deaths per 1000 live births. The scheme covers antenatal care, labor, delivery, and postnatal and newborn care. Funds come from central tax revenues (Silva et al 2010).

Central to Morales's plan for restructured healthcare is the Salud Familiar Comunitaria Intercultural (SAFCI). SAFCI, developed in 2006 and signed by Morales in 2008, is based on "social participation, intersectoral cooperation (between education, housing, agriculture, justice, etc.), interculturality, and the idea that health is integral to all other aspects of family and community life" (Johnson 2010:146). By including social participation in its health care plan, Bolivia comes a step closer to social medicine. Within SAFCI are Equipos Moviles, mobile health teams that, in addition to doctors and nurses include a sociologist or social worker. The social worker acts as a "cultural broker" with patients, in order to ease linguistic or cultural barriers to health care. In this way, SAFCI becomes an improved version of World Bank initiatives, which had similar mobile units, but without the cultural broker and emphasis on the local communities involved (Johnson 2010:147).

Interculturality also plays a role in decolonizing health care by returning indigenous ownership and identity to medical practices. The Bolivian government takes the intercultural elements of *vivir bien* into its comprehensive health care plan. In 2008, the Bolivian Government issued a Supreme Decree stating that "health facilities should deliver comprehensive care in relation to the family, the community, the nature and the spiritual world; assume both biomedical and traditional indigenous epistemological approaches;

pay family visits regularly and adapt their functioning schedule to the culture and dynamic of the community" (Silva et al. 2011:34). What Morales calls "decolonization" of health care encourages the ownership of health services by reclaiming them as Bolivian. This approach to ownership of health care suggests a contrast with the necessity of international care, but the theme of ownership and integration is key to successful international care, which is examined in detail in chapter three.

Poverty and Exclusion: The social causes of medical disasters

Given Bolivia's large rural population, even "universal" health programs encounter difficulties. Around sixty percent of the Bolivian population lives below the national poverty line, with as much as eighty percent of that in rural areas (Rural Poverty Portal 2014). According to US census data from 1998, the rural population of Bolivia was 58 (Reed 1998). In 2013, the World Bank reported the rural population at 32 percent, a decrease of 26 percent, indicating a general trend towards urbanization (World Bank 2013).

Rural populations tend to be the most in need of health services, since they tend to be elderly and poorer, due to internal migration of the working-age population to cities. UNICEF reports that "belts of economically depressed population have grown up around the cities" in Bolivia. Such urbanization is common as rural workers move to cities in search of work (UNICEF 2003). A report by the World Health Organization indicated that travel to and from the city is the main barrier to receiving care, especially because the populations surrounding cities tend to be very poor (UNICEF 2003). Doctor Betty Céspedes estimated that a day of travel to and from the city of Cochabamba from the campo could

cost up to 100 bolivianos (14.47USD) and may not even result in treatment (personal communication, B. Céspedes 2014).

Morales's rhetoric of *vivir bien* paints health care as a human right, but access to that health care remains difficult. A study by Howard Waitzkin, Rebeca Jasso-Aguilar, Angela Landwehr, and Carolyn Mountain found health as a human right to be a fundamental difference in perception of health between Latin American and US health providers. Waitzkin and colleagues concluded that, while many Latin American governments define health and health services as rights and public goods, the US providers tend to view health as for-profit (Waitzkin et al. 2005). Cuba, in contrast, claims health care is a universal right and has designed their health system to treat all patients free of charge. Morales's changed approach to health care parallels the Cuban socialized medicine structure. Morales, like Castro, has committed to universal health care, and with the aid of Cuban doctors and Cuban-trained Bolivian doctors, more and more rural Bolivians are receiving care.

Since Morales took office, health indicators have showed improvement. Common indicators include infant and child mortality rates, measured per 1000 live births. Bolivian census data from 2008 lists mortality rates in both urban and rural areas. In 2003, before Morales's election, urban infant mortality was 44 deaths, decreasing to 36 deaths in 2008. Interestingly, the rural infant mortality rate remained at 67 deaths between 2003 and 2008, suggesting that despite Morales's new health policies, barriers to health care continue in more rural areas. Child mortality, however, decreased in both urban and rural areas between 2003 and 2008. In urban areas, the rate decreased from 59 to 43 deaths per 1000, and in rural areas the rate decreased from 96 to 87 deaths. Both trends indicate

overall improvement in health services and access to those services, for both urban and rural populations (INE 2011).

The stories from the children in Hospital Viedma offer a different perspective on Morales's health care initiatives. The burn problem in Bolivia is social in cause: injuries result from lack of education, unsafe stoves in poor, and often rural, households, and increased urbanization of a "developing" nation (personal communication, Barbara 2014). The burn hospital provides an example of the need for international medical aid in Bolivia. Despite Morales's attempts at national health care, difficulties in access continue. Hospital Viedma's pediatric burn unit and the burn problem in Bolivia present a case study for examining barriers and approaches to international health.

Inside the burn hospital

One afternoon, thirteen-year-old Daniela[1] was cooking lunch for her younger brother. Her parents were not in the house, since they work in the city of Cochabamba. When Daniela lit the stove to heat the soup, the gas exploded, engulfing her in flame. Daniela's neighbor heard the screams of pain and ran inside to find Daniela covered in burns on her arms, legs, hands and face. The neighbor put out the fire and rushed Daniela to the hospital in a taxi. When I met her, she had been in the hospital for three weeks, her entire body and face still wrapped in bandages.

Daniela's story is not uncommon among burn victims in Cochabamba's Hospital Viedma. Hot liquids, such as soup, tea or water, cause the majority of burn injuries, followed by fires, and the most serious, electric burns (personal communication, L. Hidalgo

[1] Name has been changed to protect privacy

2014). Approximately eighty percent of burn patients are under five years old, and of them, eighty percent are under two. And the problem is growing.

Juana, a seamstress who sews pressure therapy clothing for burn treatment, records family statistics for each burn patient. She asks for both mother and father's employment status and where they work. She also asks about where each patient lives. These data can give the pressure therapy workers an idea of the financial situation of the family. Many of the patients come to the hospital from rural areas. The Cochabamba newspaper *Opinión* reported that "la situación es mucho más dificil para aquellos niños que vienen del campo" because they tend to be poorer (*Opinión* 2010).

Children in rural areas are at especially high risk of burn injuries. Poor households typically have ground-level stoves that present hazards for small children who may crawl into cooking fires. In addition, many rural Bolivians travel to cities to work, leaving children at home to care for one another, leading to tragedies like that of Daniela. A lack of education about burn risks increases the chance of injury from preventable causes.

Hot liquids also present a major risk for childhood burn injuries. Poor families often do not have water in their homes, and thus need to heat water for daily activities, such as drinking, bathing, and cooking. The most common burn injury is from hot liquids, stemming from poverty and increased amounts of hot water in poor households. In addition, hot liquids such as tea and soup are culturally important, also increasing the risk of a small child coming into contact with dangerously hot liquid (personal communication, Barbara 2014).

Treatment for burns, surgeries, medications, bandages, and physical therapy, costs an average of 85 bolivianos (12.50USD) per day. With children staying in the hospital for

months on end, these costs can be catastrophic for poor families (*Opinión* 2010). Because of the long recovery time, even within the largest hospital in Cochabamba, patients have only half of the space needed for proper rehabilitation due to overcrowding (Mercado 2012).

In addition, the pressure therapy clothes that Juana makes are crucial to proper burn care, but are very expensive to produce. The expense for the pressure garments come from parents' pockets (personal communication, Barbara 2014). The clothing fit tightly over burns and keep the skin flat to prevent the formation of keloid scars that can be very painful and disfiguring. Most of the materials are donated from a private US donor so that Juana can offer the clothing at dramatically reduced prices to poor patients (personal communication, Juana 2014).

The pediatric burn problem in Bolivian can be examined in two ways. First, burn injuries fall into a class of medical problems that necessitate international aid, as hospitals in Bolivia are poorly equipped to handle treatment. Second, the burn problem presents an opportunity for social and cultural change. Urbanization, lack of education, and poverty form the socioeconomic roots of the burn problem. Is it more effective for international medics to treat the social causes of the problem, or to perform surgeries that increase quality of life while doing nothing to change the number of burns? Given the two possibilities for international treatment, the burn hospital represents an ideal case study that roots concepts of international aid based in political alignment and social problems.

The final element necessary for understanding Bolivia's relationship with international health care is that of preventive medicine. The burn hospital offers a picture of the failings of preventive medicine in Bolivia. The American College of Preventive Medicine defines preventive medicine as having the goal to "protect, promote, and maintain

health and well-being and to prevent disease, disability and death" (American College of Preventive Medicine 2015). However, in a country facing the poverty of Bolivia, one of the poorest countries in the hemisphere, prevention proves extremely difficult. Doctor Oscar Romero, chief reconstructive surgeon and director of the pediatric burn center in Cochabamba, laughed when I asked him about preventive medicine in Bolivia. "No hay medicina preventiva," he told me, there is no preventive medicine (personal communication, O. Romero 2014).

The walls of the hospital are covered in posters instructing the viewer how to avoid electrical, liquid, and fire burns. The pressure therapy center in Hospital Viedma is affiliated with Burn Care International, Incorporated, which provides informational coloring books for patients. The books highlight burn risks around the house and include information about avoiding burns. By the time patients in the burn hospital color these books, many of which are printed in English, they are sitting in the hospital, their faces and arms bandaged. Not only are the attempts at educating children and parents about burn risks too late, they are also wildly inconsistent with the reality of many Bolivians. The lessons on the posters and in coloring books are meaningless to children who do not identify with the images printed there.

Eight-year-old Lucas and I spent hours coloring pages in Burn Care International activity books. I read in the hospital log that Lucas[2] had been burned by alcohol-fueled flames. I could barely see his eyes through the thick ointments and bandages on his face, but his creativity came through when he received a box of colored pencils and a Burn Care International coloring book. The scenes in the book showed teakettles and stoves and fire

[2] Name changed to protect privacy.

extinguishers, but Lucas showed no recognition of the objects or the captions printed in English.

Preventive medicine proves difficult to implement in the face of patients already suffering. The inability of the Bolivian government to provide comprehensive health care for all its citizens, and the ineffectiveness of prevention programs, leads to the need for international aid. Waitzkin advocates for a health care model that recognizes and treats social issues that become health problems—in effect advocating for preventive medicine that utilizes non-medicinal cures to prevent medical problems. In Bolivia, where catastrophic health problems stem from poverty, urbanization, and lack of education, international health care becomes necessary.

The example of the burn hospital and the types of care practiced there will inform the following two chapters, wherein I compare the Cuban model of medical internationalism with US approaches to international medicine work. I argue that the difficulties in achieving universal health care arise from economic and geographical exclusion. The burn hospital is an example of how social problems of poverty and lack of health education can result in medical conditions. The next two chapters will examine how medical internationalism programs attempt to implement such programs in Bolivia.

2 Where Politics and Health Intersect: Cuban Medical Diplomacy

When the Ebola virus crisis struck western Africa in the summer of 2014, Cuba demonstrated its medical prowess. Though a small country, Cuba initially sent 165 medical professionals to Sierra Leone, later followed by another 296. According to the World Health Organization, by early 2015 Cuba represented the largest contribution of any foreign nation, despite its population of just 11 million. By providing health care around the world, Cuba has made medical internationalism a focus of foreign policy, which has led to political alliances around the Latin American region and Venezuela and Bolivia in particular (Taylor 2014).

The following chapter examines the concept and implementation of Cuba's medical internationalism. Cuba's socialized medicine system leads to positive health outcomes, which it has been able to export to countries such as Venezuela and Bolivia through trade agreements. However, the ideology of free medical care and socialized medicine breeds resentment by local doctors. I argue that because of Cuba's medical internationalism is bound in politics, political ideology affects the reception of the Cuban programs by the local community.

Che Guevara, as a doctor and revolutionary, serves as inspiration for Cuba's medical internationalism. Castro's island has sent soldiers, teachers, doctors, nurses, technicians, and humanitarian workers across the world "armed with the ideals and convictions Che articulated" (Harris 2009:36). A massive earthquake in Chile in 1960 prompted the beginnings of Cuba's legendary medical presence around the world, "capturing the hearts

and minds of aid recipients" when Cuba sent doctors to treat victims of the disaster (Feinsilver 2008:216). Since the 1960s, Cuba's medical internationalism has come to parallel its domestic medical structure. Cuba provides free medical education to underrepresented populations at home and abroad, and trains local doctors as part of its international programs so as to encourage the host country to aid in the medical work (Feinsilver 2008). Howard Watizkin calls the Cuban health system the "most responsive and effective in all Latin America" (1991:265).

Watizkin's theory of medical encounters ties very closely with the political structure of the country in question, and he uses Cuba's integrated medicine model as an example of effective care. The capitalist economy of the United States situates health care in the free market, resulting in the general perception of health as a commodity, rather than a basic right (Waitzkin 1991). With the provision of Medicaid and President Obama's Affordable Care Act, medicine is becoming more accessible in the United States. However, given high costs of treatment, drugs, and insurance, health care in the United States cost much more compared with Cuba's costs. Waitzkin argues that political structure correlates with health care, and advocates for a social health care model that views health care as a right, as it is in Cuba.

Cuba's socialist economic structure, then, leads to two advantages. First, following Waitzkin's theory, Cuba's approach to medicine proves more effective at addressing medical needs without reinforcing socioeconomic class differences. Second, Cuba's socialist economy aligns with other left-leaning Latin American governments, particularly those of Venezuela and Bolivia. Establishing political relationships across the region is key to Cuba's survival as a socialist state, as it must acquire resources it cannot produce through trade

partnerships. Cuba uses its impressive medical education system to train doctors to export in such trade partnerships.

An important source of Cuba's medical internationalism comes from the Escuela Latinoamericana de Medicina (ELAM). Through ELAM, Cuba has increased its numbers of doctors from poor backgrounds, the racially disadvantaged and women**,** which Waitzkin argues empowers underrepresented population and creates Cuba's comprehensive and effective health care system. Since 1999, the ELAM has recruited students from poor socioeconomic backgrounds in Latin America, the Caribbean, Africa, Pakistan, East Timor, and the United States to study medicine in a six-year program in Cuba (Harris 2009:497). The school asks only that students make a moral commitment to serve in "vulnerable communities" after graduation, which functions to increase services in and access for the poor and rural populations (Huish 2009:301).

The school was created in response to the destruction caused by Hurricane Mitch in 1998. Initially, ELAM was designed for countries affected by the hurricane, so that graduates could go to work in their own devastated communities. However, the school later welcomed students from a broader reach of countries, including the United States. Huish calls this decision a "significant move that saw Cuba embrace capacity-building as part of its foreign policy of medical outreach" and marked a trend of medicine as foreign policy (Huish 2009:301).

The ELAM continues to train doctors in integrated family medicine, which includes community-oriented care and traditional medicine practices, which parallels the social medicine framework outlines in *The Social Medicine Reader.* Cuban family doctors typically take appointments in the morning and spend the afternoon making home visits in the

community. By integrating the community into health care, Cuban doctors and nurses take a more holistic and comprehensive approach to treating patients. Primary care teams include social works and psychiatrists as well as multiple internal medicine specialists (Dresang et al. 2005).

The Cuban health care model

The low cost of health care contributes to Cuba's successful health outcomes. In 2006, Cuba spent just 7.1% of its Gross Domestic Product on health expenses, compared with 15.3% spent in the United States (Drain et al. 2010). However, Drain and Barry examine other possibilities for Cuba's success, arguing that disease prevention and "one of the most proactive primary health care systems in the world" are to thank (Drain et al. 2010).

Even before ELAM was founded, Cuba maintained a commitment to community-oriented primary health care. In 1960, the Rural Social Medical Service began to encourage young physicians to work in rural areas. By 1974, the program had grown to expect all medical graduates to spend up to three years in a rural community. Today, about 97% of Cuba's doctors are trained in "integrated general medicine," which involves a three-year family medicine training residency after graduation. After three years of training, 65% of physicians continue to practice primary care (Drain et al. 2010). The focus on primary and family practice is the "foundation" of all medical care in Cuba, and contributes to Cuba's health outcomes (Dresang 2005:299).

Cuba achieves extensive primary and preventive care through the establishment of community and neighborhood level health posts. Since 1965, "community-based

polyclinics" have provided care, laboratory and diagnostic testing, and specialized care in 498 districts around the island. Each polyclinic tailors its medical care to the community it serves (Drain et al. 2010). Lee Dresang and colleagues address the practice of such community-oriented primary care (COPC) as contributing to Cuba's health outcomes. Dresang writes that "COPC is a systematic approach to health care based on principles derived from epidemiology, primary care, preventive medicine and health promotion" from which US family practitioners might benefit (2005:300). Dresang further complements Waitzkin's argument from more holistic social medicine, citing that "physicians are held accountable for health care outcome measures of the community members they serve" and doctors "are required to look at patients in the context of family and community," thus avoiding the unnecessary medicalization of social ills (Dresang 2005:300).

Community-orientated health further divides into "neighborhood-based family medicine" that takes an ever more careful look at community health on a micro-level. The neighborhood level of primary care began in 1984 with the formation of *consultorios* (clinics). A community level *policlinico* (polyclinic or specialty clinic) serves twenty to forty *consultorios* (Drain et al. 2010). Family doctors serve each *consultorio*, which are made up of about 600 patients or about 150 families. Doctors pair with a nurse and live adjacent to the *consultorio*, integrating them directly into the community they serve (Dresang et al. 2005: 298).

A third aspect of Cuba's medical approach is that of complementary and alternative medicine (CAM) and tradition and natural medicine (TNM). These practices lead to the distinction of "integrative medicine" through the use of non-allopathic medicine—either used alongside allopathic medicine (complementary) or instead of it (alternative), another

tenet of social medicine. In the first two years of medical school, Cuban medical students spend 200 hours on CAM rotations, learning "acupuncture, herbal medicine, trigger point injections, massage, heat therapy, transcutaneous electrical nerve stimulation, magnetic therapy, pyramid therapy, moxibustion, fangotherapy (mud), cupping, laser/photograph therapy, floral/essence therapy, homeopathy, yoga, meditation exercise training, and music and art therapy," underscoring the highly integrated and diverse model of health (Dresang et al. 2005:301).

Effectiveness of health care can be measured through health outcomes, which focus on the results of health care practices, and can be compared across nations. Lee Dresang, an MD at the University of Wisconsin, suggests that health outcomes are influenced by three factors: nonmedical determinants, social mediators, and health service determinants. Education, housing, clean air and water, nutrition and employment make up the nonmedical determinants, whereas health service determinants include accessibility, universality, comprehensiveness, quality, focus on health promotion, and integration of health across sectors (Dresang et al. 2005:299).

Cuba's health outcomes parallel those of the United States. The vast difference in gross domestic product (GDP) between the two countries renders this parallel even more striking. The World Bank reported Cuba's GDP in 2011 at about $68 billion. In contrast, the United States had a GDP of $16 trillion in 2011 (World Bank 2015). Despite the disparity in the countries' wealth, Cuba's health indicators have steadily improved since the Cuban Revolution of 1959.

Before the Cuban Revolution, Cuba's national health profile looked similar to an impoverished Third World Country (Dresang 2005:298). However, the revolution

"transformed both the context and the structure of medical encounters" (Waitzkin 1991:265). After the Cuban revolution and the implementation of the trade embargo by the United States, Cuba's health outcomes, life expectancy, infant and child mortality, and doctor-patient ratios, all improved. In the 1960s, Cuba's average life expectancy rose sharply to parallel that of the United States and Canada, hovering five to ten years above the average expectancy for the rest of Latin America and the Caribbean (Drain et al. 2010). In 2006, Cuba reported an average life expectancy of 78.6 years, 59 physicians per 10,000 people, and infant mortality of 5.0 deaths per 1,000 live births, the best among 33 Latin American and Caribbean countries, and on par with outcomes of the United States (Drain et al. 2010).

The Cuban model of care, Waitzkin argues, contrasts with the US approach to health. Cuba also spend a smaller percentage of its GDP on health services, leading Drain and Barry to suggest that the "emphasis on primary care medicine, community health care, community health literacy, universal coverage, and accessibility of health services may be how Cuba achieves developed-world health outcomes with a developing world budget" (Drain et al. 2010). The integrative, community-focused model employed by Cuba domestically parallels their actions abroad in countries with similar social structures, like Bolivia and Venezuela.

Evo Morales's new health care reforms mirror Cuba's integrated health care model. Cuban doctors trained at the Escuela Latinoamericana de Medicina bring a model of community-oriented primary care, in conjunction with alternative and traditional medical practices, to international medicine. The incorporation of traditional and complementary forms of treatment in Cuba mirrors Bolivia's shift towards "intercultural" health through

the respect and integration of indigenous health modalities into the national health system. Through employment of "decolonization" rhetoric, Bolivia further aligns with Cuba and distances itself from the US capitalist economic model in health care as well. The society-based, integrated model of health care employed in Cuba has shown positive results.

The model of health care employed in Cuba reflects the change in political ideology. The social mediators, including social cohesion, income disparities, and social structure inequalities, are of particular interest to Waitzkin's theory of the success of Cuban care (Dresang et al. 2005:299). As a socialist country, the relative lack of large income disparity in Cuba plays a role in their effective health care system. The same socialist structure that lessens income disparity also provides the social cohesion and integration across sectors that form Cuba's medical prowess. A small income gap, low health costs, and a primary care focus all contribute to Cuba's positive health outcomes.

Into the streets: Cuba's medical internationalism projects

Political alliances across the Latin American region facilitate Cuba's medical diplomacy. The Bolivarian Alternative for the Americas (ALBA) represents an alliance of socialist-leaning Latin American governments as an alternative to the hegemony of the United States. ALBA was designed to "unite and integrate Latin America in a social justice-oriented trade and aid block under Venezuela's lead" (Feinsilver 2008), and was signed in 2004 by Fidel Castro and Hugo Chávez. Castro used the alliance in conjunction with a commitment to internationalism in order to turn Cuba into a "world medical power" (Feinsilver 2008). ALBA further presents itself as an alternative to US hegemony in Latin

America and projects socialist ideals of exchanging talents and natural resources to help each other, directly opposing US legislation and establishing alliances (Kirk 2009:507).

Since the 1959 Cuban Revolution, Cuba's medical programs within Venezuela have become the largest ever established. Medical diplomacy represents Cuba's portion of trade agreements with Venezuela, signed by Chávez and Castro in 2000 and 2005 (Feinsilver 2008). The trade agreements guarantee "preferential pricing" of Cuban medical professionals in exchange for "a steady supply of Venezuelan oil, joint investments in strategically important sectors for both countries, and the provision of credit" (Feinsilver 2008). Celia Hart argues that the spread of revolution across the region is crucial to socialist survival: Venezuela gives Cuba preferential rates on oil to avoid energy crisis on the island, while Cuba provides doctors and teachers to aid poor Venezuelans (Harris 2009).

Economic cooperation between member countries of ALBA began as an alternative to free trade agreements, such as the North American Free Trade Agreement (NAFTA). NAFTA was signed in 1992 to lift tariffs on good produced in Canada, the United States, and Mexico, and remove barriers to investment and movement of goods across North America (Department of Homeland Security 2015). However, repercussions of "free trade" were felt around the region. Like NAFTA, free trade agreements in Latin America worsened economic disparities, "favoring corporations and US markets while destroying economies, worker rights, and the environment in Latin America (Dangl 2007:219). As an alternative to such agreements, Bolivia, Venezuela, and Cuba signed a People's Trade Agreement (PTA) that guaranteed Venezuelan and Cuban doctors and technicians would be sent to Bolivia, in addition to health care and scholarships for Bolivians (Dangl 2007:219). The PTA was a

first step in creating ALBA, the powerful political alliance that ensures socialist survival of all governments involved.

Cuba's first medical project in Venezuela, called Misión Barrio Adentro, exemplifies the cooperation between member countries of ALBA and the PTA. Developed in 2003, Misión Barrio Adentro sends Cuban doctors to the poorest neighborhoods (*barrios*) in Caracas. There, the doctors provide 24-hour free health care and dispense their own medications. The Cuban doctors in turn train Venezuelan doctors to continue the project. Between 2003 and 2006, MBA treated 17 million people. By 2011, MBA recorded 6.4 million consultations per month, which averages about 76.8 million a year. Between 1994 and 1998, there were not 70 million consultations in all of Venezuela (Huish 2013:67). While Huish writes of the massive success of Cuba's MBA program, Feinsilver points out that the program is not quite as effective as suggested. Significantly fewer health care facilities were built than were planned, and only 30 percent had doctors, insufficient to meet Venezuela's needs. However, the impact the Cuban programs continue to make in Venezuela is significant, if not enough to treat every person in need (Feinsilver 2008).

Political alliances between leftist Latin American governments prove crucial to political survival. ALBA aids Cuba in implemented aid programs by solidifying alliances between Cuba and other Latin American countries. In 2003, Fidel Cuba enacted "Operación Milagro," an ophthalmological program to restore sight to poor Venezuelans who otherwise could not afford the operation. Since its inception, more than one million Venezuelans have received treatment. The program was implemented with support from the ALBA alliance and in conjunction with Venezuelan president Hugo Chávez (Huish 2013:57).

Cuba's second-largest international medical program after Venezuela resides in Bolivia. In 2006, Castro withdrew four thousand Cuban doctors from Venezuela to begin an MBA offshoot program in Bolivia, as part of an ALBA initiative (Feinsilver 2008). Through cooperation with ALBA and Cuban doctors, Bolivia can now perform a minimum of 500,000 ophthalmologic surgeries each year, aiding the many poor who may otherwise have no means with which to pay for surgery (Feinsilver 2008). By 2006, 1,100 Cuban doctors worked in Bolivia, especially in rural areas, to provide free health care to those who are historically excluded from health services (Feinsilver 2008). Brian Johnson calls Cuba's work in Bolivia "socialist solidarity," emphasizing the alignment between the two governments that motivates medical cooperation. Cuba shows solidarity through medicine with many other countries "fighting to throw off the shackles of colonialism and imperialism" (Kirk 2009:500), and again echoing Morales's rhetoric of decolonizing Bolivia, moving away from historic imperial influence. In this way, Cuba's internationalism has also supported the survival of the socialist state, providing assistance to people in more than 90 countries, whether or not the governments are friendly with Cuba. In his commitment to internationalism, Castro's government maintains diplomatic relations with 178 countries, translating to international support (Harris 2009; Feinsilver 2008).

In 2013, 780 Cuban-trained Bolivian doctors returned to practice in their home country. Of 855 Bolivian doctors who graduated from Cuban medical schools in 2013, 780 of them attended ELAM. Morales's election to the presidency saw hundreds of Bolivians travel to Cuba in search of medical training, highlighting the "socialist solidarity" felt between Castro and Evo Morales. Many of the Cuban-trained doctors that return to Bolivia as part of their mandatory practice in vulnerable communities, work as part of Morales's

plan for universal health care, with as many as 125 working in El Alto as of June 2012 (Jamaicans in Solidarity 2013).

Cuba's medical internationalism in Bolivia and around the world parallels the approach to medicine taken "on the ground" in Cuba. The Escuela Latinoamericana de Medicina educates medical students from underprivileged backgrounds, encouraging them to return to their home communities and increase access to health care for those populations. The Misión Barrio Adentro and Operación Milagro initiatives show Cuba's commitment to socialized medicine, serving the underserved and training local doctors in the Cuban social medical philosophy. Bolivia has the structures in place, as well as hundreds of Cuban-trained Bolivian doctors, to enact a social medicine model.

For Cuba, the benefits of medical diplomacy are two-fold. Between 1961 and 2008, Cuba sent more than 113, 585 medical personnel abroad to one hundred and three countries, a tally that continues to grow as Cuba becomes a medical powerhouse. Julie Feinsilver argues that Cuba gains both symbolic and material capital through medical work abroad. Firstly, sending aid to disaster-struck nations gains Cuba "prestige and goodwill," which then translates to material capital through "diplomatic support and trade or aid" (Feinsilver 2008). Feinsilver parallels the importance of Cuba's increasingly popular international image to the story of David and Goliath. Cuba, a small country, works to project its image as "increasingly more developed and technologically sophisticated" as it struggles against "the Goliath of the United States" (Feinsilver 2008).

Cuba's medical internationalism goes beyond "socialist solidarity" to support on key issues in the United Nations. Particularly in light of cold relations with the United States, John M. Kirk argues that it "behooves Havana to make diplomatic and commercial

alliances wherever it can" (2009:504). As a result of such "symbolic capital," Cuba has gained significant backing in the United Nations, resulting in support for its condemnation of the US trade embargo. In November 2008, a vote on the trade embargo saw 185 nations in favor of lifting the embargo, and only three against (Kirk 2009:504). Cuba has further received recognition from the World Health Organization and many national governments for its medical work abroad.

Cuba also gains "material capital" from its medical internationalism. The export of doctors and medical services brought in about $2,312 million USD to Cuba, more than either nickel and copper exports or tourism. Feinsilver calls Cuba's export of medical services "the brightest spot on Cuba's economic horizon" (2008). While symbolic capitol and support in international issues are key advantages, economic gain represents a crucial motivator for international practice (Feinsilver 2008).

Given that Cuba's health outcomes parallel those of the United States and the island boasts excellent health care infrastructure and a robust medical internationalism program, one may assume that Cuba's model would be universally well-received and even desired. It would be natural to expect Bolivians—whose president enacted health care reforms resembling Cuba's—to welcome Cuba's medical internationalism program. However, the political aspect of Cuba's medical internationalism has created tensions with local doctors whose own jobs and salaries may suffer from the Cuban doctors' efforts. The next section examines the interaction of health care and politics as it relates to Cuba.

Ideological resentment: Tensions in medical diplomacy

Although Cuba may have achieved positive health outcomes at home, and gained international support for its medical aid, some doctors tell a different story. At first glance, Cuba's medical internationalism programs have found success: the Misión Barrio Adentro program reaches approximately 95% percent of the Venezuelan population, has conducted 278 million consultations and saved 74,000 lives, according to Health Minister Jesús Mantilla (Villanueva 2008). The MBA also reported that 260,000 Bolivians had undergone ophthalmological surgery since 2009 (Tockman 2014).

In spite of the statistics in favor of Cuba's actions, Dr. Douglas León Natera of the Venezuelan Medical Council "claimed recently that Cuban doctors are practicing illegally" (Villanueva 2008). He expressed concerns that the Cuban doctors are neither familiar with diseases in Venezuela nor properly trained to practice medicine at all. The Bolivian Medical College reiterated this concern, claiming the Cuban doctors are unqualified and do not understand Bolivian customs. Their statement also argued that Cuba's medical interventions deprive Bolivian doctors of jobs by providing free care (Tockman 2014).

A rupture between politics and health care becomes evident in the case of Cuban doctors in Venezuela. Legally, Cuban medical degrees are not recognized in Venezuela. In 2003, a tribunal ruled that Cuban doctors must pass an exam in order to practice in Venezuela. However, the Venezuelan government ignored the recommendation, choosing instead the favorable political relationship with Cuba. Dr. León Natera blames then-president Hugo Chávez for degrading the public health system in favor of political gain, saying "there is no promotion of health and the money from the oil business has been invested in political pacts" (Villanueva 2008). With Chávez's support of Cuban doctors,

Venezuelan doctors have become "second class doctors in their own country" who resort to menial and informal jobs. As taxi drivers and street vendors, Venezuela's doctors earn more than from medical practice (Villanueva 2008).

Local resentment of Cuban doctors is a theme reflected in Bolivia as well. Mano a Mano is a grassroots development organization that began with donations of medical supplies to poor Bolivian clinics. In an interview with founder Joan Velasquez, I asked about Cuban doctors working in Bolivia. She laughed and said, "The Cuba doctors are not welcome… [The Bolivian doctors] don't like them." Her staff in Bolivia, the local Bolivian doctors working for Mano a Mano's clinics, resent Cuban doctors "taking" jobs that could be done by the many trained physicians in Bolivia. Velasquez went on to explain:

> They feel insulted that Cuban doctors come in [and] they feel subordinated to them. They feel that there are so many doctors in Bolivia, why are we bringing doctors in from someplace else? Why aren't they (and this would be the Bolivian way of looking at it), why aren't they just giving us the money that they pay those doctors to pay our doctors, who speak Quechua, or Aymara, or whatever, and can work in these communities? (personal communication, J. Velasquez 2015).

As in Venezuela, the presence of the Cubans renders Bolivian doctors "second class" in their own communities. As a result of the tensions between local and Cuban doctors, Bolivian physicians of the Bolivian Medical College organized a strike to protest the presence of the Cubans. Like Chávez in Venezuela, President Morales ignored the protests and stated that the Cubans "would stay as long as he is in office" (Feinsilver 2006; Tockman 2014).

Julie Feinsilver takes a critical stance on the arguments against Cuban doctors. She contends that ideological differences between physicians' organizations and the national government bear responsibility for the tensions. The political benefits "to the host society far outweigh the costs to the local medical professions" which in both Bolivia and Venezuela are ideologically opposed to the government. Feinsilver also rejects the

legitimacy of arguments against the licensing of Cuban doctors. She writes that local doctors seek to discredit Cuban doctors because they "feel threatened by the competition of Cuban doctors willing to serve in areas they themselves would not go, let alone work" (Feinsilver 2006).

Bolivian and Venezuelan doctors who intend to discredit Cubans more likely disagree ideologically with their socialist governments. Feinsilver argues that the "current Cuban threat" is the threat of changing societal values and the structure and function of health systems, not endangering employment opportunities (Feinsilver 2006). Feinsilver suggests that the local doctors would not be willing to work in the areas where the Cuban doctors are stationed, and thus the argument is against the government, not the physicians. Cuba's "medical diplomacy" improves "the health of the less privileged in developing countries while improving relations with their governments," regardless of the stance of local doctors (Feinsilver 2006).

Not all Bolivian doctors resent the Cubans; rather tensions lie more along political lines. Doctor Godofredo Reinicke, the Ombudsman for the Chapare region of Bolivia, rejects the Bolivian Medical College's official position, saying, "For me, the presence of [Cuban] doctors in particular is aid of utmost importance. [They are] advancing the theme of solidarity for doctors and common citizens to see how people can work without the necessity of pressure, conditionality or money" (Tockman 2014). The arguments represent the differing ideologies of some Bolivian doctors. Debates over private care, lack of financial resources, and the privilege of biomedical practices over traditional remedies sit at odds with the Bolivian constitution's promise of "universal, free, equitable, intercultural" health care (Tockman 2014).

Cuba boasts a highly effective model of health care and its health outcomes have won acclaim. Cuba's integrated, community-oriented approach also shares many elements with Morales's health reforms along the lines of *vivir bien,* interculturality, and decolonization. However, Cuba's health care is predicated on political alliance, as seen through agreements such as ALBA and the PTA. Even within the structure of humanitarian action, Cuba still gains politically and economically from its medical internationalism. These additional benefits are gained through a socialist political structure often at odds with capitalist economics, inciting ideological disagreements.

Cuba's approach to medicine is effective, given impressive health outcomes, but the necessary politics that inspire the model of social health also cause its problems and result in resentment by local doctors. The next section examines a different ideological disagreement: political relations between the United States and Bolivia have grown colder since Evo Morales's election. Aid models employed by US international health workers are also affected by political alignments and misalignments, determining how US programs implement their health projects.

3 US Medical Internationalism: What is effective international health care?

On their last night in Bolivia, the local community held a farewell dance for Dr. David Baram's medical mission group. Besides the group of US Protestant missionaries, the clinic also welcomed a team of Cuban doctors. Divided by political, cultural, and religious tensions, the US doctors failed to establish a strong relationship with the Cubans. Dr. Baram remembers the US mission group standing across the room at the party, not interacting with the Cubans (personal communication, D. Baram 2015). The farewell party exemplified the cultural, ideological, and political dissonance between Cuba (and many other Latin American countries) and the United States that plagued the entire trip.

Political dissonance between Cuba and the United States permeates much of the discourse about Latin America, but less often examined is the relation the differing politics have on health care. Where political structure and alliances differ between the United States and Cuba, elements of effective health care are perhaps surprisingly similar. My comparison of US and Cuban medical internationalism leads to the examination of two interrelated elements: international politics and doctor-patient interactions. The political, cultural, and medical differences between the United States and Cuba allow for an examination of the intersection of politics and health care in a country like Bolivia, whose relatively recent leftist shift reflects a growing distrust of the United States.

This chapter examines different methods US doctors and organizations undertake in order to address medical concerns abroad. I argue that long-term US projects parallel Cuba's method of integrated health care, but with different implementation strategies. Due

to its capitalist—rather than socialist—politicoeconomic structure, the United States does not use doctors as tradable resources in the way Cuba does. This fundamental difference helps US organizations and medical initiatives integrate their projects in Bolivia, an otherwise contentious country for US aid.

In this chapter, I analyze information from US doctors and organizers who have worked abroad, largely in Latin America, though not exclusively. The comparison of their accounts with the Cuban models of medical internationalism stems from a historically fraught relations between the US and Cuba, which I discuss in the second section. I then compare the doctors' accounts across several dimensions: cultural relativity practices, reception by the local community, and sustainability. These three themes reflect US doctors' views of successful health care, as part of the integration of programs into the local community. I also discern two models of health care, which parallel Cuban programs: grassroots development and short-term "quick fixes." To conclude, I compare these models with Cuban medical internationalism.

US International Medicine Personnel

To collect information about the experience of practicing medicine internationally, I interviewed a variety of medical aid workers, including doctors, and organization leaders and administrators. I conducted interviews in order to gain insight into the experience of cross-cultural medicine and the influence of politics on international health actors. Each informant approached international medical aid slightly differently, but several themes were clear throughout: cultural relativity in health practices, acceptance of medical workers and projects by the local community, and sustainability or long-term effectiveness

of projects. These three factors contribute to integration of a medical program into the local community, diminish barriers to health care, and create successful programs, in the views of my informants.

I found my informants through a wide search for doctors in the Twin Cities area who had experience working abroad, as well as interviews conducted while studying abroad in Cochabamba, Bolivia in the spring of 2014. I spoke with five doctors who had experience practicing medicine abroad, in addition to the interviews I collected in Bolivia.

Doctor Rebecca Ratcliff is a family practice doctor, who also works in obstetrics. In the United States, she works primarily with Hispanic and Mongolian women, but she has worked extensively in Latin America. Her work has taken her to local community health organizations in Oaxaca, Mexico, to secondary and tertiary care centers and hospitals around Cusco, Peru. While she had not worked in Bolivia, her experience working with underserved populations in both Peru and Mexico offers insights in how one might treat Bolivian populations with similar difficulties of access to health care.

The second doctor I interviewed was Dr. Dave Klevan, a geriatric medicine specialist working with Health Partners in Minnesota, Dr. Klevan's international work is primarily in Tanzania, where he has worked through a partnership of Lutheran congregations for many years. While he does do clinical work in Tanzania, most of his efforts are focused on other health education and community development projects. His work in Tanzania provides information about the ways in which international health development organizations can promote health, health education, and treat patients in different cultural settings.

Doctor David Baram has travelled extensively as part of medical teams. Now retired, his work as a obstetrician-gynecologist has taken him on thirteen medical missions, many

through Medical Ministry International, a protestant aid organization. He has gone on seven trips to Guatemala, one to Bolivia, two to Ecuador, three to the Philippines. His repertoire of experience provides information on different contexts for international care, and specific examples from Bolivia.

Doctor James Hart is a professor of public health at the University of Minnesota. While his work is primarily in Africa (Uganda, Kenya, and Zambia), he shared a wealth of knowledge about the challenges of creating and implementing health programs internationally. As a public health worker and a medical doctor, his perspective corroborated much of the information I found on grassroots development organizations with preventive medicine components.

Finally, Doctor Alexia Knapp is a dermatologist who has worked in Tanzania. While not Latin America specific, case studies from Tanzania offer parallels to other third-world health conditions.

I also interviewed administrators from the Partners of the Americas and Mano a Mano organizations, both of which do development work in Bolivia, with medical subcommittees. The Minnesota-based organization "Mano a Mano" works in the department of Cochabamba, Bolivia, collecting medical supplies, building and equipping hospitals, in addition to development projects in other sectors, such as agriculture and infrastructure. Joan Velasquez and her husband, Segundo, founded Mano a Mano in 1994. Segundo Velasquez, a Bolivian, wanted to give back to his home country and aid the many Bolivians living in poverty in the department of Cochabamba.

Beginning with the initial goal of collecting excess medical supplies to send to Bolivian clinics, Mano a Mano grew quickly. Today, Mano a Mano exists as four distinct

organizations in Bolivia, all staffed completely by Bolivians. Mano a Mano's unique approach to grassroots development involves putting control of the organizations completely in the hands of their Bolivian counterparts (personal communication, J. Velasquez 2015).

While abroad I interviewed Mercado Vargas, the head of the health subcommittee of the Cochabamba chapter of the Partners of the Americas. The Partners of the Americas, designed as the "people to people" component of the Alliance for Progress, intended to bring US expertise to Latin American countries facing similar problems to those in the United States (Taffet 2007). Partnerships began between Idaho and Ecuador, Oregon and Costa Rica, Utah and Bolivia, Texas and Peru, and Arizona and Guatemala. Today, Bolivia has three chapters of the organization in Santa Cruz, La Paz, and Cochabamba (personal communication, M. Vargas 2014).

In 1984, Partners of the Americas, INC started a non-profit 501(c) organization under the same name. Today, the organization has sixty-six partnerships between the United States and Latin America. Each chapter consists of several subcommittees, each handling a different aspect of aid to Latin America, including youth, education and leadership, agriculture and environment, exchanges and fellowships, and health committees (Partners of the Americas 2013). While Partners of the Americas takes on many grassroots development projects in other areas, such as agriculture and education, the health sub-committee of the Cochabamba chapter stresses the surgeon exchange.

While varied in approach, specialty, and international experience, the doctors and organizations I interviewed all offered perspective on what successful health care means. I analyzed each doctor or organization's approach to conducting medical projects abroad,

and found correlations between duration of medical internationalism projects, sustainability of the aid, and conceptualizations of efficacy.

Aid and Expulsion: The United States in Latin America

The "tumultuous" relationship between the United States and Cuba has roots in the Cold War (Renwick 2015). Following the Cuban Revolution and Fidel Castro's socialist government, the United States initiated a trade embargo on Cuba. While at first only a partial embargo signed by President Eisenhower in 1960, all trade between the two nations ended in 1962 when President John F. Kennedy signed a full trade embargo proclamation (BBC News 2012). The fear of communism inspired by the Soviet Union spread through the United States and led to a mistrust of all things Cuban. Cuba became the image of communist force in the region, a force Washington sought to crush. Every year since 1992, the United Nations General Assembly has approved a resolution condemning the US embargo. In part thanks to Cuba's extensive medical diplomacy shown earlier, the resolution has been regularly supported by 188 nations. Only the United States and Israel continue to oppose it (Renwick 2015). [3]

Cuba is not the only Latin American nation to have tense relations with the United States. Since Morales began campaigning for the Bolivian presidency in 2005, tensions between the United States and Bolivia have also grown. The United States supported internal opposition to Evo Morales during the end of the Mesa administration, concentrated largely in the Eastern bourgeois bloc of Santa Cruz, Beni, Pando, and Tarija

[3] With President Obama's December 17, 2014 announcement of the release of Alan Gross and the opening of diplomatic relations with Cuba, this dynamic may change in the near future.

departments. Also called the Media Luna, the eastern departments represent the wealthy, conservative Bolivian elites, with whom Carlos Mesa sided during his split with the MAS in 2005. The US embassy also lent support to the Media Luna at the same time, hoping to prevent Morales's rise to power.

Initially, the United States Agency for International Development (USAID) was an additional source of opposition against the MAS and Morales's new health policies. USAID was active in Bolivia since 1964 (USAID). In 2007, USAID pulled all the health projects funded by the US government out of the Bolivian highlands, which generally align with Morales and the MAS. The agency further "prohibited any contact, let alone coordination, with 'foreign personnel' (i.e., Cuban physicians)" (Johnson 2010, 152).

In 2013, Morales's expelled USAID from Bolivia, claiming the agency was "meddling and conspiring against the government." The expulsion followed Morales's offense at being called the United States' "backyard" (Castillo 2013). The US agency denies the "baseless allegations made by the Bolivian government," while claiming that the agency has been dedicated to supporting Morales's National Development Plan and aiding Bolivian citizens (USAID 2013). The tensions indicate the continued distrust of aid programs that often attempt to influence policy. Dissatisfaction with these tactics led Bolivia away from US influence and desire to break with US influence and power. The United States' historical use of foreign aid as foreign policy in Latin America has engendered distrust in US aid in Bolivia, and presents difficulties for other medical aid organizations wishing to lend support to Bolivia's many poor.

By understanding the history of protecting US interest in Latin America and the pitfall of short-term medical projects, the US doctors and organizations I spoke with were

able to avoid ideological conflict with Bolivians and integrate their work directly into the Bolivian system. Given the rocky relations between the United States and Bolivia, the absence of politically motivated health care appears to necessitate the integration of long-term projects into Bolivia's health care system.

Fish out of Water: Barriers to Effective Care

In addition to tense political relations between the United States and Bolivia, interviews with doctors exposed barriers to effective health care in dealing directly with patients. I found that the most prominent health care obstacles are language and cultural barriers, a lack of preventive care, and distrust and lack of understanding of biomedicine, or Western practitioners. This section examines the challenges that doctors and organizers face working abroad.

Dr. Baram described his tight missionary group as a "fish out of water" in Bolivia. They faced a difference in ideology with their Cuban colleagues, and a clash with traditional Bolivian health modalities. Poverty and race also posed a challenge to Dr. Baram's group. He noted class differences that correspond to language, as many rural Bolivians speak indigenous languages and practice traditional medicine. A lack of education in the poor, rural community also prevented effective implementation of care due to an absence of trust in Western medicine. Even the trained Bolivian doctors contribute to the class difference, since many of them are of Spanish descent, which Dr. Baram contends, "introduces a racialized aspect to medicine." To combat this problem, Dr. Baram recommends increasing the number of indigenous people becoming doctors, through education and accessibility

programs (personal communication, D. Baram 2015), similar to Cuba's initiatives to increase underrepresented populations in health care.

On the other side, the American missionaries received very little cultural training. Dr. Baram says he had a small amount of cultural preparation training before working in the Philippines, and none before traveling to Bolivia. Dr. Ratcliff responded to my questions about cultural sensitivity training by saying what is more important than teaching doctors about "the other" was to "be open to hear the story. They'll tell you what to do, how to behave" (personal communication, R. Ratcliff 2015).

The language barrier was the most commonly expressed difficulty the doctors faced. Especially in the medical field, trained translators are "essential" says Dr. Alexia Knapp, "Language barriers can be a problem, especially when explaining precise information into another language that may not have a direct translation," which could lead to improper use of medicines or incomplete understanding of conditions or treatments (personal communication, A. Knapp 2015). Dr. Baram and Dr. Klevan noted the use of translators. In Guatemala, like Bolivia, Dr. Baram used a translator both from the indigenous languages to Spanish, and from Spanish to English. Dr. Klevan speaks through a translator to deliver his radio programs in the Swahili spoken in Tanzania.

Cultural barriers, as much as linguistic, pose complications for care. Dr. Knapp told a story of a particular instance of cultural misunderstanding. In Tanzania, it is common practice in some areas to change names after major life stages, such as after marriage. Many people also do not know their exact date of birth, and without consistent names or dates of birth record keeping can be very difficult. Dr. Knapp remembers one day realizing

doctors had kept up multiple medical charts all for the same patient, all under different names (personal communication, A. Knapp 2105).

Another difficulty in providing care is the lack of preventive medicine and the decision to prevent or to treat. Preventive medicine "is really lacking" in poor and rural areas, where lack of education and access to health care make preventive measures difficult (personal communication, D. Baram 2015). Rural Bolivian communities, like the one in which Dr. Baram worked, lack basic measures of preventive care, such as immunizations, stoves, and latrines. Childhood burns in Bolivia are most common among these poor, rural populations in part because of the living situation of many residents. Dr. Baram saw burns and respiratory problems in Guatemala and Ecuador as well, where houses are placed up on stilts, with tin roofs and shuttered windows. A campfire in the middle of house, with no protective structure and no ventilation, causes serious health problems (personal communication, D. Baram 2015).

The housing situation looks similar in rural Bolivia, where cooking fires lie at ground level and homes have very little ventilation. Many of the children I met in the burn hospital had crawled into these low fires, burning their hands and faces. In Bolivia, it is common practice for mothers to carry the youngest children on their backs, wrapped in colorful aguayos. While the mother is bending over to cook on a low fire, the babies slip from the wrap and fall into the flames (personal communication, Barbara 2014). Dr. Baram recognizes these risk factors as well, suggesting that building stoves in rural homes might prevent such injuries, as well as add ventilation to prevent respiratory disease. He mentioned an initiative in Boulder, Colorado, that builds stoves at ten US dollars apiece, in an effort for preventing injury and illness (personal communication, D. Baram 2015).

While some preventive measures, such as building stoves, appear simple to implement, such programs are not always so straightforward. Dr. Hart named access to vaccines and clean water as major determinants of health, in addition to income, education, and environment (personal communication, J. Hart 2015). However, programs to provide vaccines and clean water can be costly, and in catastrophic health situations, questions arise of where money is best spent. Dr. Hart remarked, "There is always another way to spend the money" (personal communication, J. Hart 2015). He also noted a "paradox"—spending large amounts of money on treatments robs other sectors that produce "more health," such as provision of sanitation or nutrition, but "you can't tell people who are sick, 'We only prevent,'" they must be treated (personal communication, J. Hart 2015).

Many of my informants have worked in Tanzania, where HIV and AIDS in rampant. While Tanzania's health landscape is different from that of Bolivia, and the countries are culturally and politically distinct, health concerns arising from widespread poverty and lack of health knowledge in both countries enable comparisons. Dr. Klevan estimated that as much as 15% of the population tests as HIV positive (personal communication, D. Klevan 2015). Like burn injuries, sexually transmitted infections can be prevented inexpensively, but with so many people already suffering, treatment must remain a priority. Both Dr. Klevan and Dr. Ratcliff noted the use of contraception as preventive care, but only after ther local community opened space to talk openly about traditionally taboo topics (personal communication, D. Klevan 2015; R. Ratcliff 2015).

Preventive medicine is also a focus in Mano a Mano's local clinics. Doctors and nurses have "individual health talks" with patients, bringing health care to the level of the patient. In addition, their clinics sponsor mothers' groups, men's groups, and children's

groups, all working for public health education. Mano a Mano further works on clean water, sanitation, and nutrition, including breastfeeding, and more recently, contraception. Joan Velasquez notes that the ability to speak about birth control is a recent development in Bolivia, which is a historically Catholic country and a staunch opponent of contraception. Now, Mano a Mano dispenses birth control in their clinics, though Velasquez says their preventive medicine is "a lot about hygiene and teaching people how they get sick, where their sicknesses come from," once again bringing preventive care to a very personal level (personal communication, J. Velasquez 2015).

Questions surrounding preventive care parallel the larger models of the "quick fix" and grassroots organizing. The short-term projects I observed that focus on surgery often do not involve preventive care projects. However, both US grassroots organizations and Cuban doctors emphasize prevention, in accordance with their holistic, community-based approach. Cuba's preventive health method involves examining the community has a whole and the patient's social context (Dresang 2005). Like the successful long-term US organizations analyzed here, the Cuban approach also focuses on integration into the community. However, for the Cubans, it is the doctors and nurses who assimilate into the community, whereas Mano a Mano works to integrate their entire program and put it fully under Bolivian ownership. Dr. Reinicke of the Bolivian Medical College suggests the same approach of "Bolivians treating Bolivians" as a solution to tensions with Cuban doctors (Tockman 2014). Cuba partially accomplishes the transfer of ownership through offering scholarships to train Bolivian doctors, which puts Bolivians in charge while maintaining Cuba's trade relationships (Tockman 2014).

In some cases, religious affiliation and mission structure presents a barrier to effective care. Medical Ministry International, with whom Dr. Baram traveled to Bolivia, brings religious ideology along on medical trips. A minister traveled with the group, and the work conducted in Bolivia involved "proselytizing" and saying prayers. While Dr. Baram acknowledged that religious organizations provide structure and money for trips, he found the religious affiliation polarizing. In particular, Dr. Baram observed a "cultural dissonance" between the Cuban staff also working in the hospital and the missionary team, in part because of the prominence of religion. Cuban doctors and Bolivian patients both found the religiosity of the group "offensive" (personal communication, D. Baram 2015). Dr. Baram felt a divide between the members of his mission group and their Bolivian patients. He conceptualized this as both a difference in religious ideology and a mistrust of allopathic medicine. He suggested the trip would have been more successful if it had not been associated with religion, as it thrust an additional divide between the US group and the Cuban doctors and Bolivian patients (personal communication, D. Baram 2015).

In contrast, Dr. Klevan's work incorporates an element of a faith-based "mission," but with more success. The Kwa Bega Kwa program began in 1987 as a synod to synod partnership between Evangelical Lutheran church congregations in Tanzania and the United States. Programs, including Radio Furaha, include an element of "proclaiming the Good News," to "inspire people and lift their hearts in praise and thanksgiving to God." The connection with the Lutheran Church has provided strong support for the projects in Tanzania. The relationship between the United States and Tanzania builds upon the community of a shared religious ideology, and eases the difficulties of cultural difference through a "ready-made" community (personal communication, D. Kelvan 2015).

In addition to cultural and ideological differences, religious missions also raise questions of sustainability and ethics. Dr. Ratcliff says missions are a "lovely paradigm" but often have side effects, especially from their short-term nature. Giving to a community, she argues, produces positive results, "But does it invest in long-term change?" (personal communication, R. Ratcliff 2015). Dr. Hart echoed Ratcliff, saying church groups who "go down with a bag of pills" do not effect lasting change (personal communication, J. Hart 2015). By acting on a short-term basis, missions run the risk of creating a dependency on the providers. Dr. Ratcliff urges international doctors to "look systematically" and analyze the institutions missions help to build. Christianity in particular may "cause a loss of the traditional" by forcing patients into an unfamiliar ideological system. She recommends acting as a "cultural in between" to negotiate and act as a resource between the United States and Latin America (personal communication, R. Ratcliff 2015).

Shut Up and Listen: Culturally appropriate care in cross-cultural situations

In order to overcome the many barriers to effective medicine, the doctors and leaders I interviewed expressed their views of successful health care in terms of integration and ownership of the medical program by locals. Integration returns ownership of the program into the hands of the local medical personnel and organizers. In Bolivia, the transfer of ownership from United States organizations to the Bolivian people functions to decolonize health care as an institution. In my interviews, "integration" as a concept was expressed through culturally appropriate health care practices, acceptance by the

community, and sustainability of the project. These three factors contribute to programs that acknowledge patients' views of suffering, increase trust and understanding of biomedicine, and create long-term projects that can eventually change structures of exclusion.

Integration into the local system represents an important tenet of Mano a Mano's approach to international health care. Joan Velasquez and her husband Segundo started four distinct organizations in Bolivia for different infrastructure projects, such as health, education, agriculture, or water issues. Ownership of the organizations belongs to the Bolivians, Velasquez stressed, saying, "so this is their water, it's their reservoir, it's their road, whatever it is" (personal communication, J. Velasquez 2015). Velasquez further emphasized the potential for political conflict between the Bolivian government and the US organization, but because of the ownership by the Bolivian community, Mano a Mano avoided expulsion:

> Now the Mano a Mano organizations in Bolivia, and there are four, they are seen as Bolivian organizations. They're incorporated in Bolivia. They might very well have been expelled if they hadn't been. And that was definitely part of our thinking when we did this. Latin American countries kind of like to kick people out and show that "we don't need you." As they did to USAID. So [USAID is] out of the country.

She went on to describe the fear of expulsion following the USAID case:

> An organization that we work very closely with, New Tribes Mission, they do aviation kinds of things. And we have an aviation program, so we used to interchange mechanics, for example, or maybe pilots. And New Tribes Mission has left Bolivia, because they were concerned that they were going to be expropriated. They were [expropriated] in Venezuela. And so they just left.

In contrast, Velasquez thinks the chances of the Bolivian government expelling Mano a Mano is "exceedingly unlikely" because "We are Bolivian organizations" (personal communication, J. Velasquez 2015). The threat of expulsion, following USAID, necessitates

the integration of the organization into the community, in contrast to the Cuban doctors, whose political alliances protect them from expulsion or expropriation.

Integration into the host community manifests in different ways. All of the doctors and organizers I interviewed conveyed that working cross-culturally requires listening. Dr. Hart's advice for effective cross-cultural medicine is "Just say 'We'd like to help,' and shut up and listen. That works." He emphasized the need for humility in understanding the needs of patients, stepping away from one's knowledge of medical "truth" to hear what the patient needs (personal communication, J. Hart 2015). Dr. Rebecca Ratcliff also addressed the need for humility and an understanding of patients' worldview and belief system. "What do they tell you?" she said, "It may not work in our paradigm, but it's their way of thinking and it's real to them." Listening to patients is crucial for Dr. Ratcliff, who underscored the limitations of allopathic medicine in other cultural paradigms. Treating patients with their own medicine is more effective for them. In her work in Mexico, patients complained of pain stemming from their ancestors, drinking bad water or an imbalance of hot and cold. She said, "Stand back and watch them," and learn how to treat conditions by listening to how patients view their world (personal communication, R. Ratcliff 2015).

Dr. Alexia Knapp noted that "adapting to the local circumstances without imposing too much of one's beliefs about how things "should" be done" was one of the most challenging aspects of working cross-culturally. Dr. Knapp shares the view of Dr. Hart and Dr. Ratcliff, that humility and acceptance of different worldviews is crucial to effective care (personal communication, A. Knapp 2015).

For Dr. Ratcliff, listening also requires creating a space for locals to speak openly about their concerns. In some cases, this task can be difficult given cultural taboos. She

suggested addressing difficult topics such as domestic violence by first discussing an acceptable subject, like nutrition. “Ask questions more and more until you get them talking about it,” she said, thus creating a culturally acceptable cultural space for women to talk about domestic violence, something generally considered taboo (personal communication, R. Ratcliff 2015).

The understanding and acceptance of diverse worldviews and conceptualizations of medicine require becoming integrated in the local culture. “It’s not enough to go in and out,” Dr. Ratcliff believes, “You have to be part of the system.” Dr. Klevan stressed the importance of “giving what we can” in creating an effective international medicine project. Saying, “don’t do that” or telling locals what they should or should not do will not produce positive results. Both Dr. Klevan and Dr. Ratcliff agree that short-term projects tend to be less effective than sustained efforts, although surgery-based work usually has an immediate positive impact (personal communication, D. Klevan 2015; R. Ratcliff 2015).

Another way of creating an appropriate and lasting health care program is through education. By teaching local doctors and medical personnel medical procedures or how to use equipment allows community health centers and hospitals to continue treating patients after international doctors leave. While in Peru visiting friends, Dr. Ratcliff walked past a *posta,* a secondary level Peruvian hospital, and saw overwhelmed doctors working inside. The Peruvian doctors learned Ratcliff was a doctor: “You’re a doctor? Can you help us?” they asked. Dr. Ratcliff taught the doctors to use their new ultrasound equipment and lessened the burden on the overworked staff. By teaching them to use the ultrasound equipment, “they can eventually know how to use it and teach others” (personal communication, R. Ratcliff 2015).

Mano a Mano also works directly with locals to increase their medical capabilities. While Velasquez is careful not to provide services unbidden, she said:

> What people do really want is further training. They want education, and they know that the US is more technologically advanced. So they will say, "Yes, you know things we don't know. Will you teach us?"

A key distinction is that teaching and training locals does not equate doing work for them. Velasquez added:

> "But they don't want us to come down there and do their work. And particularly in the health field because they train so many more physicians than there is paid work for." (Personal communication, J. Velasquez 2015)

By training doctors and not filling jobs with US employees, Mano a Mano attempts to avoid the inter-physician conflict that sometimes befalls Cuban doctors. Dr. Ratcliff also recommends treating the local system and local actors as allies. She recognizes the possibility of friction and resentment, but working as allies can lessen some of the tensions over employment (personal communication, R. Ratcliff 2015).

In underserved and often rural areas, the "barefoot doctor" model combines teaching and training with improving access and diminishing cultural barriers of distrust. Dr. Baram's mission trip to Bolivia placed him in a very rural community that was "incredibly poor." He related a story about a woman suffering from cervical cancer. The nearest health center equipped to treat cervical cancer was two hours away by bus, in the city of Santa Cruz. However, the woman was unable to afford the transportation to the city or food for the journey, let alone the treatment, and died of the disease. "Everyone deserves some care but they don't always get it," Dr. Baram said. The real development isn't in Western-style medicine, but in training people from villages. "It's not about surgery," he added, "It's about training barefoot doctors."

The barefoot doctor model began during China's Cultural Revolution under Chairman Mao in the 1950s. The model entails medical training for villagers, many of whom were barefoot from working in rice paddies (WHO 2008). Their training was short, from about three months to a year, allowing them to return to their home communities to practice primary and preventive medicine. The barefoot doctors enacted a "decentralized, deprofessionalized, grassroots-based, egalitarian, "low-tech," economically feasible, and culturally appropriate" approach to health care (White 1998:480).

The barefoot doctor model functions to decrease cultural barriers and mistrust, and increase access to medicine in rural areas. Similar to integrated family medicine in Cuba and intercultural health care in Bolivia, the barefoot doctors strived to practice "integrated Chinese and Western medicine," respecting traditional remedies alongside biomedical treatments (White 1998:482). The village-based health clinics staffed by barefoot doctors reported that 40-80% of prescriptions during the Cultural Revolution were herbal medicine, as clinicians placed "a strong priority on herbal medicine treatments," maintaining a culturally responsible model of health in rural China (White 1998:483).

The integration of biomedical and traditional practices seen in China's rural health initiatives sought to decrease the tensions and lack of trust in allopathic medicine. In his time in Bolivia, Dr. Baram noticed deep-seated distrust of Western medicine, stemming from the West's exploitive history in the Latin American region. The barefoot doctor model puts locals in positions of administering medicine, and "the locals will trust them" (personal communication, D. Baram 2015). Barefoot doctors provide primary care, not surgery, and the community still needs access to tertiary care centers, but "maybe what's

needed isn't a doctor or nurse, just a local person with local interest" (personal communication, D. Baram 2015).

A final component of culturally appropriate care comes from avoiding dependence on international organizations, and allowing the organization to be run by local hands. Mano a Mano is not economy-driven, a characteristic of many international development projects. Joan Velasquez claims Mano a Mano relies on good community organizing rather than economic theory because community organizing is "more effective." By approaching international development from a community standpoint, Mano a Mano integrates their work into the community and transfers ownership of the program to the Bolivians. This method eliminates dependence of the United States; says Velasquez, "It's a really good way, I think, that we've found of putting that all together and making it not depend on us. And all that they depend on us for is to keep extending to more and more communities" (personal communication, J. Velasquez 2015). By shifting the focus from economics, the health care model shifts from capitalist to resemble the integrated social medicine model, which mirrors Morales's health reforms.

Distrust and Acceptance: Reception by the local community

In Bolivia, President Evo Morales has made universal health care, along with integrated forms of care, a priority of his administration. Dr. Baram reported that the government runs the hospital in which he worked. Despite government ownership, the hospital lacked funding and other resources, and there simply were not enough hospitals or health centers available to treat the rural population. In 2011, the World Health Organization reported the number of physicians per 1000 patients at 0.473 in Bolivia. This

rate is lower than most other countries in Latin America, and most similar to statistics in sub-Saharan Africa (WHO 2014).

Dr. Baram also spoke of a "lack of government support and buy-in." The government, he says, lacks the will to make preventive medicine a priority, thus leading to widespread preventable diseases (personal communication, D. Baram 2015). The data indicate that, in spite of doctors claiming that Cubans are filling Bolivian jobs for free, not many doctors are working in rural areas. The lack of doctors in the *campo* leaves a large population underserved, driving down health indicators and outcomes.

Mano a Mano's interaction with the Bolivian government shows a degree of cooperation. Bolivian board members organize within the community to build health clinics and then attach them to the Bolivian government. Joan Velasquez reported that, "all of our Bolivian clinics are part of the Health Ministry's national health system" (personal communication, J. Velasquez 2015). By integrating their work deeply within local frameworks, and transferring ownership of the organizations to their Bolivian partners, the United States-based organization was able to access funds set aside by the World Bank and the IMF for health. Velasquez says they "were in the right place at the right time" to take advantage of the money set aside as a result of the forgiveness of Bolivia's debt (personal communication, J. Velasquez 2015).

In the beginning stages of founding Mano a Mano, Velasquez focused on making the organization sustainable by creating a "partnership of three" between the community, the government, and Mano a Mano's access to medical supplies and resources (personal communication, J. Velasquez 2015). Now Mano a Mano operates 154 clinics, and does not pay any of the staff salaries. Velasquez says, "they either come from the municipal

government… or they come from the Health Ministry's budget at a national level. Most of them are the Health Ministry's, but about 20% are the local government," which helps keep the community involved in its health (personal communication, J. Velasquez 2015).

Unlike the Cuban doctors and their connection with Castro, Mano a Mano is not affiliated with the US government. Mano a Mano is a non-governmental organization (NGO), meaning the money they receive from the Bolivian government is not due to political partnerships, but because Mano a Mano is a fully Bolivian organization:
"In other words, they're incorporated in Bolivia. They all have boards, they all have bylaws that are approved by the Bolivian government. They do all of that. They had to. They're incorporated completely into the Bolivian legal system. And they have a tie to us partly through their bylaws and partly through agreements with their finances" (personal communication, J. Velasquez 2015). This distinction is crucial in Bolivia, given growing distrust of US aid.

The United States historic use of aid as foreign policy has rendered political relationships tense in Latin America. With the recent expulsion of USAID from Bolivia, Evo Morales's intentions to dissociate from the United States are clear, and would complicate any medical programs that, like Cuba, attempted to use medical channels for political purposes. Cuban medical internationalism results in a mutually beneficial political relationship, which is not the goal of the US organizations and doctors I interviewed. Rather, political tensions necessitate that US organizations and doctors work alongside locals, instead of mandating actions. Integration into the local system also strives to overcome the history of hostility towards the United States for its role in exploitation and economic control in the Latin American region.

Another barrier to positive reception in the community is a lack of cross-cultural understanding and distrust of allopathic medicine. Dr. Baram reports that most of the people he interacted with abroad like Americans, who pay their own way to go abroad and "are not there to exploit the Bolivians" (personal communication, D. Baram 2015). A level of distrust of Western medicine, resulting from decades of exploitative policies, still exists for some patients, who "have a harder time buying into Western medicine fixes." The distrust was particularly evident to Dr. Baram when patients failed to come in to the clinic for surgeries. Patients often preferred to visit traditional healers and only by "the second or third time" would they come to the clinic. Because patients are treated for free, costs are not a major concern, and the major barrier is distrust in Western medicine, observes Dr. Baram (personal communication, D. Baram 2015).

The reception of religious-based programs differed between Dr. Klevan and Dr. Baram. A connection between Lutheran congregations in the Twin Cities and Tanzania helped assimilate Dr. Klevan's public health radio and medical programs into the community (personal communication, D. Klevan 2015). The common denominator of faith eased other cross-cultural disconnects. In contrast, as seen above, the religious aspect of Dr. Baram's group caused cultural dissonance with the local community and Cuban contingent.

While Dr. Baram had a difficult time integrating his program into the local community because of the religious aspect, he observed very positive interactions between the Bolivians and Cuban doctors. He said the doctors were "hardworking and passionate," and had built the hospital together. The area in which they were stationed "was so underserved that there weren't tensions," Dr. Baram remembers, but he has seen conflicts

between local and international doctors on other missions to the Philippines and Ecuador. International doctors tend to work for free, inciting conflict with local doctors who would otherwise be paid for the same work. However, in the community in Santa Cruz, all the doctors "have to care for those who can't pay," and they can find other income by treating paying patients on the weekends "as best they can" (personal communication, D. Baram 2015).

Mano a Mano's whole-community approach to development ensures positive reception in the community. After the first successful projects, Joan Velasquez said the organization "had a lot of requests for other kinds of infrastructure projects… a lot of the people said to us, 'if we had water to grow our own produce and a road to get it out of here on, we would have more money and we could build our own clinics'" (personal communication J. Velasquez 2015). A positive reception by the community facilitated Mano a Mano's total integration into the Bolivian system, constructing a sustainable model of international development. After building their first health clinic, Mano a Mano "then began to focus on the whole community and how can a community sustain itself and sustain the services it needs for its residents" (personal communication, J. Velasquez 2015). The organization focuses on sustainability on a community level, helping the community sustain itself and thus sustaining all infrastructure projects.

Sustainability: The Quick Fix vs. Grassroots Organizing as models for care

When I asked Dr. Rebecca Ratcliff what "effective" international health care might look like, she responded with two different possible models. She named obstetrics/gynecology or surgery as a way of making a positive impact, but without

enacting social change. Secondly, she considered social change within a given community to be effective if there is cultural space available to undertake social change. As I spoke to more doctors and organizations, their approaches to international health aid appeared to fall into one of these two categories: the first method is what I call the "quick fix," such as surgery; the second is grassroots and community-based health development, more similar to Cuba's approach to health.

Doctor James Hart highlighted the challenge of these two forms of health care. Like anything, the two approaches—grassroots development or "quick fix"—depend on financial resources. The difficulty comes from deciding which to choose: "there is always somewhere else to spend the money," Dr. Hart said (personal communication, J. Hart 2015). The choice becomes spending money on preventing health problems, such as burns or illnesses related to unsafe water, or spending money to treat those already sick. Both methods have successes and shortcomings, and I will examine how US doctors and organizations implement these approaches in order to evaluate the "effectiveness" of US medical internationalism.

The first method, the "quick fix," refers to aid organizations and groups of medical workers, who spend a short amount of time performing a high volume of treatments. Treatments tend to be surgical in nature, such as the Partners of the Americas organization that worked in Hospital Viedma in Cochabamba. The Partners organization coordinates a trip of about seven surgeons to travel to Bolivia every March. There, they provide reconstructive surgeries, free of charge, for burn patients in Hospital Viedma. The program began in 2006 with one surgeon, Bolivian native Dr. Carlos Vargas. He performed 37

surgeries. In 2013, six surgeons traveled to Bolivia and provided 100 surgeries for the most severe burn cases (North Carolina Partners 2015).

By 2013, the organization provided over 820 free surgeries. In 2014, the group added two introscopic gynecological surgeons. In addition to conducting surgeries, the surgeons bring with them expertise to teach Bolivia doctors, and instruments and supplies, such as bandages, that are difficult or expensive to purchase in Bolivia. The surgeons that travel as part of Partners of the Americas pay their own airfare and donate supplies, though the organization feeds and houses them during their stay (personal communication, R. Claros 2014). The aid these doctors provide, in expertise, donations of time, equipment, and labor, is critical for the treatment for the patients in the most need (personal communication, C. Vargas 2014).

Doctor Ratcliff echoed the mission of Partners of the Americas: "sometimes surgery makes sense," she said, adding that OBGYN medicine and surgeries "do good and make an impact," but do not enact social change. However, sometimes the medical situation necessitates the "quick fix" model (personal communication, R. Ratcliff 2015). In the example of the burn hospital, many patients live with painful and debilitating burn injuries. Rather than tackle the problem at the root cause and "enact social change," the Partners of the Americas surgeons save lives first. The surgical model thus does not attempt to change the system responsible for health problems, but nonetheless results in a relatively permanent "fix" for patients who need immediate care.

Another manifestation of the short-term "quick fix" method is the medical mission. Doctor David Baram, a semi-retired gynecologist, travelled to the department of Santa Cruz on a medical mission trip. His trip to Bolivia was organized through a protestant church

group and were there to, in his words, “save souls” as much as practice medicine in a rural Bolivian community. Though Dr. Baram does not share the religious ideology of the church group, he recognized the advantages to the short-term project: “It’s easy to go in and “fix” people in one shot. You don’t have to speak the language and it’s a relatively permanent fix” (personal communication, D. Baram 2015).

In contrast to the short-term model, the grassroots development model involves a more integrated approach to health, more closely resembling the Cuban model. The difference from the Cuban approach, however, is that the US organizations and doctors undertaking grassroots development are not associated with the government or national trade networks. The “grassroots” approach refers to a long-term project intending for systemic change. Where the focus of “quick fix” medicine is to treat those already sick or injured, the focus of grassroots organizations and doctors is preventive care and community-based development.

Mano a Mano works directly within the local community on projects, only undertaking projects requested by community members. Velasquez emphasized the community-based component, saying, “We have never done anything that someone in Bolivia did not ask us to do. And that’s a really, very principal part of the model we work with. We don’t do anything we’re not asked to do; we don’t go anywhere we’re not invited to go” (personal communication, J. Velasquez 2015).

Similarly, Dr. Dave Klevan emphasized the need for a “strong base,” a foundation in the community, for effective medical care. His work in Tanzania has focused on building a strong base for protecting health. For Dr. Klevan, a “strong base” means ownership by the community. One way of accomplishing this is the microbank project. The microbank sets up

loans that enable projects within the community. Money lent through microbanks often goes to agriculture projects, including effective planting and harvesting of crops. Dr. Klevan says the agriculture programs "go hand in hand" with the microbanks and produces a sustainable foundation for the community (personal communication, D. Kelvan 2015).

A second project to increase health awareness is a public health and education radio program, called Radio Furaha, in the Tanzanian community. The program hosts US specialists to give talks on health issues, and Dr. Klevan himself sometimes speaks. Because of a language barrier between local Swahili and English, the program is delivered through a translator (personal communication, D. Klevan 2015). These efforts build a "strong base" that keeps the community fed, educated, and aware of medical concerns. While a clinical component is often involved in such grassroots efforts, the main focus appears to be on preventing health problems and constructing strong community support for health care.

Both Velasquez and Dr. Klevan spoke of their models of health care as community development. An element of these grassroots models of US medical internationalism is the integration into the local community, compelled in part by the threat of expulsion in Bolivia. However, while Cuba's medical internationalism programs necessitate communication and cooperation between national governments through ALBA and the Peoples' Trade Agreement, most US programs do not involve political alliances. The "quick fix" efforts tend to have very little to no interaction with local governments, based on the information from doctors with whom I spoke. In contrast, the grassroots and development organizations tend to involve coordination with the local community. None of the organizations or doctors reported governmental-level alliances that characterize Cuba's medical diplomacy.

However, the "quick fix" and "grassroots" models parallel some of the Cuban approaches. Cuba's Operación Milagro program has provided free eye surgeries for millions of Venezuelans, following the short-term surgical approach. The Misión Barrio Adentro program, in contrast, stations doctors in neighborhood clinics to provide 24-hour care and medicine, with the goal of reaching underserved areas of cities. The MBA program more closely resembles the grassroots programs that increase number of physicians and provide primary care on a local and accessible level. In conjunction, these two programs treat millions of patients who may otherwise not get the care they need, either surgical or primary care. Table 1 shows a side-by-side comparison of these models.

In addition to paralleling elements of Cuba's medical model, grassroots US medical aid programs also support Evo Morales's health reforms and elements of social medicine. US organizations aid in the creation of intercultural medicine, by accepting and incorporating traditional and natural methods of healing. Further, the focus on integration of medical aid projects echoes Evo Morales's rhetoric of "decolonization" and ownership of health services for Bolivians. Integration into the community's existing system and the Bolivian health system in general, allowed Mano a Mano to avoid expulsion from the country, but also puts control back in the hands of the Bolivian people. With continued growth and financial aid from US donors and organizations, these projects might just fill the rural gaps Evo Morales's policies have trouble reaching.

Conclusions:
What structures and systems mean for Bolivia

This paper examines three health care systems, Bolivia, Cuba, and the United States, and the ways these three interact in medical internationalism projects. Austere neoliberal programs motivated Bolivia's shift to the left and the subsequent social medicine reforms. Following decades of exploitive projects and heavy-handed economic influence by the United States, President Evo Morales rhetorically committed to "decolonizing" Bolivia, including the health sector. His health reforms legislate intercultural health, integrating health modalities, societal factors, and biomedicine into the Bolivian concept of health. Bolivia's turn toward social medicine parallels Cuba's effective integrated health care system.

Cuba's health system, as Waitzkin has noted, coordinates across sectors of society and avoids a class-based approach to care. Through an extensive preventive and primary care program, Cuba avoids spending large amounts on health care while producing health outcomes on par with those in the United States. Cuba turns this effective model from the domestic sphere to the international as part of its medical diplomacy policy.

For Cuba, medical diplomacy is doubly effective. Since the Cuban Revolution, the establishment of ELAM, and Castro's commitment to becoming a world medical power, Cuba has gained significant support and diplomatic backing in the United Nations. In addition, health outcomes, such as infant and child mortality and life expectancy, improved drastically, indicating an effective "on the ground" approach to primary and preventive care. ELAM also works intentionally to increase the number of medical professionals from

traditionally underrepresented backgrounds, thus increasing access for patients from underserved populations, both physically and culturally.

In contrast, the United States maintains a more capitalist health system, spending huge amounts on health while still excluding many uninsured, poor and minority populations. However, the United States also has a variety of medical internationalism programs, ranging from missions to surgeries to grassroots development. Despite "fundamental" differences in conceptualizations of health, according to Waitzkin, the US and Cuban models show surprising similarities in approach and execution.

However, national politics *do* influence international health: for Cuba, political alignment creates alliances with governments and resentment of doctors who disagree ideologically. For the United States, political tensions necessitate integration of any long-term project into the community, ownership by Bolivians, and culturally appropriate health care to avoid the label of "imperial" or "espionage" and expulsion on political grounds. This integration runs counter to what Waitzkin calls the medicalization of social problems, as these US organizations also choose to focus on primary and preventive health care, education, and cooperation. I argue that while Cuba's political *alliance* with Bolivia facilitates successful medical internationalism programs such as Operación Milagro and Misión Barrio Adentro, it is precisely the political *tensions* between the United States and Bolivia that necessitate the integration of health programs that seek systemic change.

Combatting barriers to effective cross-cultural care comes in several forms. The barefoot doctor model offers insight into the advantages of integrated and community-based medicine to increase accessibility, and corroborates the success of Cuba's similar model of care. The barefoot doctor model established an effective rural health

infrastructure that provided health care to traditionally underserved populations in Mao's China. Cuba has implemented a similar program and Bolivia is currently laying groundwork for an analogous system. These models of socialized—or integrated—health care show a correlation of socialist governments and integrated health care that increases accessibility and decreases cultural clashes between doctors and patients. Bolivia under Morales has the structures and ideology in place to enact social medicine policies, following Cuba's lead.

Integration through culturally relative care and sustainable programs also serves to break barriers of distrust and resentment. A point of contention for the Cuban approach to medical diplomacy is the possibility of resentment by local doctors. While Cuba's aid and model of health care have produced positive outcomes in Bolivia, having Bolivians treating Bolivians would reduce potential ideological and cultural tensions, as well as further decolonizing Bolivia's health system through a transfer of ownership.

What can social medicine say about treatment in the burn hospital? Social medicine offers a picture of what effective care looks like: the intersection of culturally appropriate healing, social influences, and biomedicine, integrated within a local community. The burn hospital is the perfect example for implementation of this: undertaking the Cuban approach and increasing preventive measures will decrease the problem from the ground up. Education of local doctors and care givers and aiding in provision of equipment and supplies is effective resource-sharing on the part of the United States. The ultimate goal is for Bolivians to treat Bolivians. Until then, international doctors can continue to give what they can give.

Any aid, whether it's called humanitarianism, internationalism, or diplomacy, comes with strings attached. This paper has examined medical internationalism on political and

approach levels, and has avoided discussion of ethics of international aid. However, it must be acknowledged that within the discussion of *de*colonization is the concept of colonization and colonizing structures of aid from the Western perception of development. As a final consideration, I would like to acknowledge the contradiction of humanitarianism and the disparity between doctors who have the ability to move around the world, be mobile, and those who cannot leave, are stuck. While the ethics of international medicine are beyond the scope of this paper, they are important considerations in the broader study of medical internationalism.

Many barriers explored in this paper highlight the difficulties in implementation. Bolivia's large, poor, rural population often lacks access to care. Financial challenges of practicing preventive medicine translate to expensive treatments. Cultural barriers, even within a country, prevent effective care. However, Morales's new policies have changed Bolivia's political landscape, and by extension, the health system. With integrated medical internationalism, education and funds from US organizations and political alliances with Cuba and Venezuela, Bolivia may one day be able fully decolonize its own health system and truly care for all Bolivians, *para vivir bien.*

Table 1. Models of medical internationalism.

Model	Quick Fix	Grassroots development
Example Programs	Operación Milagro (Cuba) Partners of the Americas (USA) Mission trips	Misión Barrio Adentro (Cuba) Mano a Mano (USA)
Duration	Short-term	Long-term
Type of Care	Surgery (i.e., burns, cleft lip and palette) Obstetrics and gynecology	Primary care Preventive medicine programs Health education
Community Relationship	No intent for social change No extended stay of practitioners	Community-based development Coordination with local and/or national government

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