

Local Identity, Globalization, and Health in Cuba and the Dominican Republic

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Recently, I saw a photograph of a young Fidel Castro, beardless and in New York in the 1950s. It gave me pause and a chance to unravel a conceptual knot in the writing of this chapter. The central concept of this chapter is that history, politics, and economics intersect with cultural experiences to commodify health, and that the creation of local identities both reflect and augment that commodification process. To demonstrate this, I draw on my own research in the Dominican Republic and Cuba to show how local identities can impede or facilitate community-based health promotion campaigns to control, for example, dengue fever.

These local identities are associated with idioms, phrases, and even slogans that capture and reinforce lived experiences. In earlier work I have written about two of these idioms—*mala unión* in the Dominican Republic and *sembrando el futuro* from Cuba (Whiteford 1998a, 1998b). As I analyzed these idioms and the local identities they express in writing this chapter, I realized that the idioms of hope that *sembrando el futuro* held for Cubans in the 1980s may no longer be true, and that I, because of my own constructed identity, did not want to write that. I wanted the Fidel of promise still to be real. My own reluctance to acknowledge the waning of that promise made writing about Cuba and its social suffering at the end of the twentieth century difficult. I suspect that the idioms of hope that once brightened local identities of Cubans may have been replaced by more darkly colored sentiments similar to those expressed by Dominicans who spoke of powerlessness and lack of faith in their political authorities, or the *mala unión* between Dominicans and their government.

But this chapter no more speaks of the Cuban experiences in the last decade of the twentieth century than it refers to the young Fidel Castro in

New York in the 1950s. Instead it situates itself in the decade of the 1980s during a period of severe economic crisis yet, still, of possibilities.

The process of health commodification in the Dominican Republic and Cuba demonstrates how ideological seeds sown in national and global politics are transformed into local identities. Cuba is offered as a limited contrast with my more extensive experience and data from the Dominican Republic, to suggest the comparative utility of the analysis of globalization, the commodification of health, and local identities.

Cuba and the Dominican Republic can be seen as exemplifying how political history and global forces shape local rights, responsibilities, and obligations associated with individual, community, and national activities. These local responses reflect an ongoing process of negotiated cultural identities. In the arena of health, global forces, national responses, and local identities transform health experiences into forms of commodification, one consequence of which may be an increase in social suffering. Investigating these forms of commodification provides insight into the process of globalization, culturally negotiated identities, and the underpinning of the moral scarcity of health.

My use of the term *globalization* is based on Michael Kearney's definition of the "social, economic, cultural and demographic processes that take place within nations but also transcend them, such that attention limited to local processes, identities and units of analysis yields incomplete understandings of the local" (Kearney 1995:548). Conversely, exclusive attention to global processes blinds us to the national and local context particularly significant in understanding the nexus between local identity, social suffering, and health.

The commodification of experience, in this case of health, is the conceptualization of a particular type of occurrence in terms of its social and symbolic significance, as well as the economic and cultural conditions of contemporary global capitalism. Globalization, therefore, results in the capitalization of health. The analysis of contemporary health experiences in this context then takes on added significance as a reflection of the dispersion, decentering, interpretation, and general complexity of globalization (J. Fisher 1993; W. F. Fisher 1995, 1997; Ferguson 1996; Escobar 1995).

Mala unión and *sembrando el futuro*, idioms of hope and despair, were responses to ideological and economic strategies designed to combat global financial threats. In the 1980s, Dominicans used the phrase *mala unión* to refer to a "bad partnership" between ordinary citizens and their government (Whiteford et al. 1991; Whiteford 1997, 1998a, 1998b). The symbolic capital of such a phrase translates as a powerful deterrent to community-based activities like mosquito control, even though Dominicans suffer from a variety of debilitating, painful, and potentially fatal mosquito-borne diseases such as malaria and dengue fever (Salazar 1993;

Whiteford 1993, 1997), diseases that could be controlled through cooperative government-community response programs. In contrast, during the same period in Cuba, health was a central focus of postrevolutionary reforms, symbolized by the phrase *sembrando el futuro*, or sowing the seeds for the future, suggesting a relationship between current acts and future rewards.

Mala unión and *sembrando el futuro* are evocative phrases symbolizing identities imbued with differential expectations, reflecting distinctive social relations between citizens and their government, created from perceptions of material realities and social promises. The commodification of health, expressed in both symbolic and material forms, occurs in both contexts. In the Dominican Republic the commodification is played out in the loss of primary health care, the unequal distribution of human and fiscal resources, the increase in infectious disease, at the same time that the Dominican government continued to pay a relatively large percentage of its gross domestic product for the declining health of its people.

In Cuba, health was a symbolic public success both at home and abroad. Its success was also commodified for international distribution. And, as the following data show, health commodification for Cuba translated into more than symbolic successes.

On any summer day the fast beat and driving sound of merengue can be heard from New York to Paris, and all across the Caribbean. The music so loved in the Dominican Republic is part of the global transformation of music, images, and dance that fly across space with apparent disregard for geopolitical and cultural boundaries, erasing cultural histories and mixing local identities, shrinking the global world. But even in a world that appears to be shrinking, cultural identities powerfully root people in time and place. These identities, often changing and yet somehow enduring, shape how people feel about themselves, how they perceive their surroundings, and how they imagine their future.

In the arena of international policy, local identities are often overlooked as too amorphous, too changing, too ambiguous, and too great a complication in already complex processes. Yet local identities embody culturally constructed expectations that shape the ways transported music, for instance, is enjoyed, images understood, and dance interpreted. When music created in Africa is heard in the Andes, it is transformed by the listeners' Andean experiences. And so it is with all things, including health. Whereas health may be commodified by global economic and political forces, transformed through international health policies and programs, and interpreted by history and proximity, it is internalized in local idioms and identities.

Global processes are played out in the cultural, historical, and political contexts in which they occur, and they have distinct consequences for

the presentation and experience of health. Far too frequently international health policy planners attempt to standardize their programs in form and function, regardless of the historical/economic particularities of the country in which they will be applied. Sometimes health planners refer to this as the assumption that all countries are playing on the same level playing field, that is, that a health care program developed and administered from a central source such as the World Health Organization (WHO) can and will be applied in a standardized way, whether in Uganda or Bolivia.

In this chapter and others in this volume, we challenge that assumption and question the very efficacy of centralized health programs designed without attention to local identities and context, be they for the control of cholera, dengue fever, AIDS, or tuberculosis. Here I present some ideas about how local, national, and transnational histories shape local identities, citizens' perceptions of their rights and obligations, their expectations and exasperation, and their abilities to improve their own and others' health. My underlying argument is that local identities embody the perceived relations between sectors of the population and the officials charged with protecting the health of the community. These local identities, then, shape how health care programs are received and sustained. That is, the cultural construction of local identities, including citizens' rights and responsibilities for health, emerges from national historical and political experiences. Community willingness to participate, for instance, in community-based interventions such as those described in this chapter reflect constructed local identities. And, as this chapter demonstrates, those very identities unlevel the playing field. In short, there *is* no level playing field, and health programs developed and administered without cognizance of that at best will fail to maximize their effectiveness and, at worst, will contribute to the very suffering they seek to alleviate. The fallacy of the level playing field has implications beyond program ineffectiveness. Inattention to the disjuncture between globalizing discourses and localized social realities may actually increase the social suffering of the community and thereby multiply its losses. The following examples of local idioms and identities in Cuba and the Dominican Republic in the 1980s shows how they reflect distinctive realities and their consequences in the control of dengue fever.

Dengue Fever: A Vector-Borne Disease

The Pan American Health Organization (PAHO), the Americas' sister to the World Health Organization (WHO), declared war on *Aedes aegypti*, the mosquito vector of dengue fever (DF), in 1947. The program was ambitious, its aim no less than the eradication of *Aedes aegypti* from the Western

Hemisphere by "complete and thorough coverage of the infested areas with frequent treatment cycles" (Gubler and Kuno 1997:444). Opinions vary concerning the efficaciousness of the eradication campaigns (Gubler and Kuno 1997; Coreil et al. 1997), but there is no disagreement that dengue today is one of the most prevalent emerging diseases in the world, and that the public health consequences of dengue hemorrhagic fever (DHF) are no longer limited to the tropical countries of Asia, but now must be faced in the tropical areas of the Americas as well.

Since 1980 both the Dominican Republic and Cuba have experienced dengue fever epidemics, yet the countries' ability to respond to the epidemics has been fundamentally different. An analysis of these responses provides an opportunity to analyze how local identities shape what strategies were available to the Dominican and Cuban governments in their attempts to control dengue epidemics. During the period of the epidemics (between 1980 and 1990), both Cuba and the Dominican Republic were governed by strong-willed, independent, and isolated men—the last caudillos—Castro in Cuba and Balaguer in the Dominican Republic. Each had been in power for a prolonged period of time during which they came to be well known by the people they governed. Balaguer, almost blind and in his eighties, was supported by the United States. Castro, in power at that time for more than twenty years, relied on support from the Soviet Union. In both cases, the population on each island knew their caudillo—they had years of experience in dealing with him, his policies, and his programs; Cubans and Dominicans created local identities reflecting those experiences.

Vector-borne diseases are not new to the islands. Yellow fever, malaria, and dengue-like illnesses have been described in the Caribbean since 1635 (Gubler and Kuno 1997:5). According to Gubler and Kuno, as early as 1779 and 1780 there were reports of major epidemics of a dengue-like illness in Asia, Africa, and North America. Even earlier descriptions of a disease similar to dengue are found in a Chinese encyclopedia of disease symptoms and remedies first published during the Chin Dynasty (AD 265–420) (Nobuchi 1979, cited in Gubler and Kuno 1997:4). In 1635 an outbreak of a dengue-like disease occurred in the French West Indies, and later, in 1699, in Panama. The symptoms described during the Panama epidemic closely mirror those found in patients with classical dengue: acute pain in the joints and bones (giving rise to the name "bone-break fever," as dengue fever was sometimes known), rash, fever, headache, nausea, vomiting, pain behind the eyes, and prolonged exhaustion (Gubler and Kuno 1997:4). For most individuals, dengue fever is not fatal. However, since 1780 a new, more severe, and sometimes fatal hemorrhagic disease, dengue hemorrhagic fever, has been reported. DF and DHF now have reached a worldwide pandemic stage. Again according to Gubler and Kuno:

Epidemic DF/DHF has become one of the most important emergent global public health problems in tropical countries in the waning years of the twentieth century. In 1977, DF/DHF was the most important arbovirus disease of humans occurring in all major tropical areas of the world, with over 2.5 billion persons at risk of infections. Each year, an estimated 50 to 100 million cases of dengue fever and several hundred thousand cases of DHF occur. (1997:17)

Dengue is one of the leading causes of pediatric mortality and morbidity in the tropics (Halstead 1980) and is caused by a virus being injected by the mosquito into the human host. There are four antigenically related, but distinct, dengue virus serotypes (DEN-1, DEN-2, DEN-3, and DEN-4). Repeated infections can lead to conditions such as dengue hemorrhagic fever or dengue shock syndrome (DSS), particularly dangerous for children and the elderly. Even when people recover from DF/DHF, they are often in a weakened state for a prolonged period. Clearly, successful public health DF/DHF interventions need to be understood.

Dengue fever has much in common with yellow fever, although many people are more aware of the latter, perhaps because of its place in history books and its association with the construction of the Panama Canal. Both dengue fever and yellow fever are flavivirus infections in primates. They both have a zoonotic forest cycle and are present in urban and periurban settings. DF/DHF's principal urban and periurban vector in the Americas is the *Aedes aegypti* mosquito that breeds in domestic environments such as household containers (flowerpots, water-storage receptacles) and common trash like discarded old tires. Although today there is a yellow fever vaccine, there is no vaccine available for dengue fever, and therefore control of DF/DHF is dependent upon breaking its cycle of transmission.

Dengue Fever in Cuba

A number of dengue epidemics swept through the Caribbean during and immediately following World War II. Although between 1946 and 1963 there was no recorded evidence of epidemics (Gubler and Kuno 1997:13), by the 1980s the picture radically changed. Vector control spraying campaigns were active in the Americas until the 1970s, when concern about the long-term effects of the chemical agents ended the eradication campaigns, and in a few years the mosquitoes reinvaded the countries from which they had been banished in the previous decades. In addition, increased international travel allowed humans to transport various serotypes of the virus from one part of the world to another, spreading and then maintaining disease transmission. In short, the environmental conditions favored a resurgence of the *Aedes aegypti* mosquito at the same time that previous control activities failed (Kendall 1998).

According to Gubler and Kuno, the changing epidemiology of dengue in the Americas that took place in the decades of the 1970s and 1980s mirrors what was observed in Southeast Asia in the 1950s and 1960s (Gubler and Kuno 1997).

The reinvasion of Central and South America by *Ae. aegypti* in the 1970s and 1980s, combined with the increased movement of people and with them dengue viruses, resulted in most countries evolving from nonendemicity (no viruses present) or hypoendemicity (one virus present) to hyperendemicity (multiple virus serotypes cocirculating). This resulted in increased frequency of epidemic activity and the emergence of DHF as a major public health problem. (Gubler and Kuno 1997:15)

The environment was right and the mosquito was ready. In 1977 a dengue epidemic occurred in Jamaica and Cuba, and the following year another epidemic was identified in Puerto Rico and Venezuela. Within four years, the reinfestation was extensive. DF was found throughout the Caribbean, Mexico, Texas, Central America, and northern South America. These were the less dangerous classic dengue fever, DEN-1 serotype. But in 1981 a new and more deadly strain of DF (DEN-2) was identified in Cuba and resulted in the first dengue hemorrhagic fever epidemic in the Americas. The DEN-2 serotype found in Cuba may have been introduced from Southeast Asia, most likely from Vietnam (Gubler and Kuno 1997: 14) and resulted in a major epidemic with thousands of cases of severe hemorrhagic bleeding. It is estimated that 10,000 cases of DHF and dengue shock syndrome occurred in Cuba during a three-month period in 1981 (Kouri et al. 1986).

And yet, with more than 10,000 clinically diagnosed cases, and more than 116,000 people hospitalized, only 158 died. How did Cuba succeed in limiting mortality? What can we learn from an analysis of the successful Cuban campaign? The Cuban government's response to the 1981 DHF epidemic was massive and military in its execution. The military public health model was not rare; previous public health campaigns to eradicate yellow fever used a military model (used by Soper in the 1930s), a vertical, top-down program aimed at source reduction. In the 1981 epidemic, the Cuban government mobilized fifteen thousand health workers to conduct a house-to-house source reduction campaign during which disposal containers were treated with insecticides, malathion was sprayed from planes, portable blowers were used to fog inside dwellings, sanitary laws affecting disposal of containers were enforced, and health education intensified (Gessa and Gonzalez 1986; Kouri et al. 1986; Gubler and Kuno 1997). Massive resources were deployed, in both economic and human terms. Close to U.S.\$43 million was spent on the campaign, mostly on insecticides (Gubler and Kuno 1997), but human resources throughout the island were also mobilized, from top public health officials to individual householders and

community members. Much of the actual work of inspection of premises and removal of breeding grounds was conducted by community members who were organized into brigades, trained, supervised, and transformed into "vector controllers" (Gessa and Gonzalez 1986).

In May 1981 when the first cases were diagnosed, and between May and October when the Cuban epidemic ended, a total of 344,203 cases were reported. Two-thirds of the deaths reported occurred among children under the age of fifteen (101 cases); at the height of the epidemic on July 6 there were more than eleven thousand cases. In addition to environmental surveillance and insecticides, the Cuban government established mobile field hospitals and a liberal hospitalization policy, allowing more than 116,151 people (33.7 percent of all reported cases) to be admitted and treated (Kouri et al. 1986:26). Without doubt this policy reduced both morbidity and mortality rates significantly. As Kouri notes:

This policy appears to have played a significant role in reducing fatalities; in other epidemics elsewhere, where the index of hospitalization was typically much lower, patients were hospitalized when they were already in shock, and the indexes of mortality and lethality were higher. (1986, 26)

The Cuban case is remarkable not only for its low mortality rates, but also for the high level of sustainability the campaign engendered. The Cuban campaign against dengue fever and its *Aedes aegypti* vector enjoyed powerful governmental support, extensive personnel assigned to the campaign (15 provincial directors, 60 entomologists, 27 general supervisors, 729 team leaders, 3,801 inspectors, and 1,947 vector controllers), and a mass media health education campaign that built upon previous governmental activities to develop community-based prevention programs. The sustainability of these efforts draws extensively on the Cuban commitment to community-based primary care, and the successful experiences of health-based community participation programs.

The almost two thousand women vector control brigade members were responsible for many of the activities designed to reduce *Aedes aegypti* breeding places—a crucial element in any long-term reduction plan and one that needs broad community support to be effective. During the epidemic the government instituted a number of laws designed to reduce breeding places, such as banning the use of water-bearing containers in cemeteries, requiring that all water storage containers be covered with lids, and prohibiting the use of vehicle tires or tubes for animal feeding or as drinking troughs. Another common breeding place for *Aedes aegypti* is bromeliads; following the Cuban epidemic, planting bromeliads was banned. Vector controllers were authorized to fine people not in compliance with these regulations designed to reduce breeding sites (Kouri et al. 1986).¹

Dengue Fever in the Dominican Republic

Dengue fever is so common in the Dominican Republic that people accept it—along with the summer rains, heat, and humidity—as part of island life. For much of the Dominican population, life is lived outdoors, where evening breezes diminish the heat of the day. As the sun sets, people gather to recount the day and relax. Electrical power, often interrupted and always unreliable, makes houses hot and uncomfortable. Few houses without their own power supply have air conditioning, and most houses have no screens on the windows. In addition, the electrical power shortages mean that almost everyone stores water in buckets, tubs, and fifty-five-gallon drums for times when there is no running water (Whiteford 1997). The water storage containers and the lush foliage create perfect breeding receptacles in which *Aedes aegypti* flourishes.

Surveys conducted in the late 1970s showed that approximately 70 percent of children younger than ten years in some poor, urban neighborhoods of Santo Domingo had antibodies to dengue fever, and that dengue was endemic in the area (Tidwell et al. 1990). By 1988 approximately 40 percent of the blood samples from febrile children in Santo Domingo showed a positive screen for dengue fever, both DHF and DSS (Tidwell et al. 1990). These data underlie the grave concern that Tidwell et al. expressed in 1990 concerning the likely possibility of a serious dengue epidemic: "In view of the high population densities of *Aedes aegypti*, the endemicity of all four dengue serotypes, and the continuing use of essential water storage containers, it is probable that Santo Domingo will experience a serious epidemic of dengue hemorrhagic fever" (1990:521). How did this situation of endemicity come to pass, and given the extant data and documentation of the dengue problem, could the Dominican Republic undertake programs similar to those successfully employed in Cuba to control the vector and avoid an epidemic?

Between 1950 and 1960, the population of Santo Domingo increased sixfold; simultaneously, the percentage of the population living in urban centers doubled. The majority of that increase was due to rural migration to the capital city of Santo Domingo, resulting in 25 percent of the Dominican population living in 3.2 percent of the country's geographic area (Beestra 1984). By 1989 Santo Domingo had a population of 2.25 million inhabitants (Tadeu and Rauner 1989).

However, the increase in urban population crowding into the capital was not matched by an increase in the ability of the government to provide services for them, as shown in Table 3.1. Piped water and electricity, always in short supply, became even more difficult to secure, and as those necessities became harder to access legally, people became more adept at securing them through alternative means. One response to the capricious

Table 3.1 Access to Public Health Services (percentage)

	Cuba (1994)	Dominican Republic (1990)
Access to improved water		
Urban	96	82
Rural	85	45
Access to sanitation		
Urban	71	95
Rural	51	75

Source: Health Statistics Report, Center for International Health Information, December 1996.

provision of water was the Dominicans' constant concern with getting it and storing it. Another was the wide variety of ways people managed to obtain water: They tapped into city water pipes; they stood in line for hours to get water from public distribution points; they borrowed it from friends; they used communal standpipes. Wherever and whenever water was running, people collected and stored it.

In 1988–1990 I had the opportunity to study dengue fever in the Dominican Republic. The objectives of our research² were to conduct an ethnographic study of dengue fever, describe the household ecology of *Aedes aegypti*, identify constraints to community-participation activities, and propose means to overcome those constraints.

Integrated ethnographic methods were used to design and conduct a community study and small-scale survey to learn about people's knowledge of and behavior toward dengue fever. A walking survey and map of the community were drawn, and key informant interviews, structured observations of households, and in-depth interviews were conducted with a limited sample of men and women. In addition, school-based essay competitions provided access to families in the community.

Based on the qualitative data acquired through ethnographic techniques, a survey was constructed to elicit information concerning water-handling behavior, distribution of household tasks, the ethnoecology of dengue fever, knowledge about dengue fever and its causes, means of prevention, and perception of relative severity. The survey was administered to a random sample of one hundred adults living in the study neighborhood and was augmented by historical and ethnographic information. One individual per household was surveyed. Fifty-six males and forty-four females responded to the sixty-four-item interview schedule (Whiteford 1997).³

Following the ethnographic and survey components of the research, nine households were selected for structured direct observations. Day-long observations were designed to validate information provided during the survey concerning allocation of tasks, duration of tasks, and behavior

related to dengue fever. During the household observations, the project field director took special note of the physical and social environment of each household. Nine individuals were selected as key informants based on their knowledge of the history and population of the neighborhood. In addition, demographic and epidemiological data provided a national context in which to examine individual interviews and other qualitative data.

The Dominicans exposed to years of dengue eradication and control activities, including health education messages, understood the transmission cycle of dengue fever and the role of the mosquito in that process. However, they were unwilling to participate in the community-based prevention activities critical to control dengue transmission. Those activities did not necessitate large expenditures of time or money, but did require a community-based response. Water storage receptacles needed to be kept covered, refuse removed, and trash collected and disposed of. Dominicans explained the community's lack of willingness to engage in simple activities designed to control a potentially deadly disease as a result of the local identity of *mala unión*, lack of political will, lack of a viable partnership between the community and the government.

Idioms of Hope and Despair

Mala unión in the Dominican Republic and *sembrando el futuro* in Cuba are local idioms that reflect people's willingness to engage in community-based participatory activities. In the case of dengue fever, these activities are the control and prevention programs so necessary to the interruption of the cycle of transmission. The epidemiologic and ethnographic data from the Dominican Republic and Cuba contextualize these local identities from two Caribbean island countries so similar and dissimilar to each other. When Dominicans talk about *mala unión*, they evoke images of a partnership gone bad, of a relationship of trust soured. The identity is weighted with disappointment, failed expectations, and expectations of failure. It is a burden of knowledge borne from the past, carried into the future. *Mala unión* permeates Dominicans' explanations of past failures, and it predicts future outcomes. It surrounds their social suffering, explaining unemployment, power shortages, lack of teachers, powerlessness, and disease. While the Dominican idiom of *mala unión* looks backward as if at a failed marriage, the Cuban phrase *sembrando el futuro* is one of hope and expectation. The crop is planted for the future.

The Cuban phrase exemplifies a local identity defined by reciprocally achieved results in which participants and the government clearly have identified rights, responsibilities, and limitations. This identity includes a strong governmental role and equally strong community role, a cultural construction of health care surety played out against a backdrop of economic

hardship and political risk. Whereas the Cuban images look forward, the Dominican images suggest a local identity of failed expectations, loss of faith in health care rights, and community and governmental withdrawal from health obligations.

The Dominican Republic and Cuba share similar colonial histories: indigenous, diasporan, and colonial populations and physical environments. However, following the overthrow of Batista and Trujillo (the Cuban and Dominican leaders who controlled the islands during the middle third of this century), the political directions of the two islands diverged. As their political histories parted ways, in each country emerged the idioms of hope and despair grounded in individual political and economic realities and reflecting citizens' relations with their government and among themselves. The two countries exemplify distinctive national geopolitical and ideological identities and concomitant divergent global, political, and economic processes influencing the commodification of health.

In order to understand how health becomes commodified in local identities, national ideologies, and global pressures, I discuss some of the economic forces that prevailed upon the Dominican Republic and Cuba between 1980 and 1992, describe how responses to those pressures are expressed in changed health conditions, and analyze how accumulated symbolic and material capital are the result of both the process of globalization and its intersection with constructed identity.

Triggered by increases in world oil prices, the global recession of the late 1970s forced the Dominican Republic into a debt crisis from which every effort to extricate itself saddled it with crippling economic agreements. The International Monetary Fund imposed perilous structural adjustments on the Dominican economy as part of lending agreements, while simultaneously U.S. trade policies dealt a serious blow to Dominican sugar exports with the development of the U.S. Economic Recovery Act. In the early 1980s international economic policies resulted in the loss of Dominican revenue from sugar exports, a reduction of gross domestic product (GDP) that resulted in a severe decrease in government expenditures on health. Even when the percentage of the GDP dedicated to health increased in the mid-1980s, little was available for discretionary costs. Most was committed to the maintenance of the administrative and infrastructural fixed costs.

The economic crisis attacked the Dominican quality of health from several directions. For instance, loss of personal income led to increasingly crowded living conditions, deteriorating sanitation, declining nutritional status, and increased exposure to infectious disease. Simultaneously, as more women entered the workforce to supplement the decreased incomes of male wage earners, childcare became more problematic as it was more dispersed and less adequate. Meanwhile, at the very moment of increased health risk and need for services, the economic crisis forced the Dominican

government to withdraw support from its already ailing primary health system (Whiteford 1990).

In Cuba the thirty-year-old U.S. trade embargo not only continued, but also was strengthened (Santana 1992:1). The U.S. government continued its attempt to isolate Cuba economically through world trade by imposing sanctions against countries trading with Cuba. Of equal, if not greater, significance was the loss of the Soviet Union as both a trading partner and provider. Previous to 1989, the Soviet Union and its trading system had provided Cuba with food, medical supplies, and fuel; without this trade, the Cuban population suffered deficiencies in all three. Food shortages became so common in Cuba in the early 1990s that one could determine if a shop had food by the presence of a line of people waiting outside: "No line, no food." Bread, always a staple in the Cuban diet, became expensive and difficult to obtain; bakeries were unable to make enough because of the shortages in raw materials (Deere 1991:62).

Although almost all babies are born in hospitals in both the Dominican Republic and Cuba, and official statistics for each country suggest that most women receive prenatal care (Ubell 1983:438; Benjamin and Haendel 1991:4; Whiteford 1990), there is less similarity between the two countries than it first appears. Besides sharing an economic crisis, Cuba and the Dominican Republic share history, geography, and proximity to the United States. In terms of local identities, one of the greatest differences between the two islands is that Cuba transferred its vision of *sembrando el futuro* by creating an islandwide primary health care network and a community-based health care system, whereas the Dominican Republic allowed to lie fallow its rural primary care system and turned its resources instead to urban-based hospitals and clinics. Because of its emphasis on community and preventive health, the Cuban public health system appears to be withstanding the current economic challenges by relying on the accumulation of both symbolic and medical capital, whereas the Dominican commodification of health remains costly for its poor results.

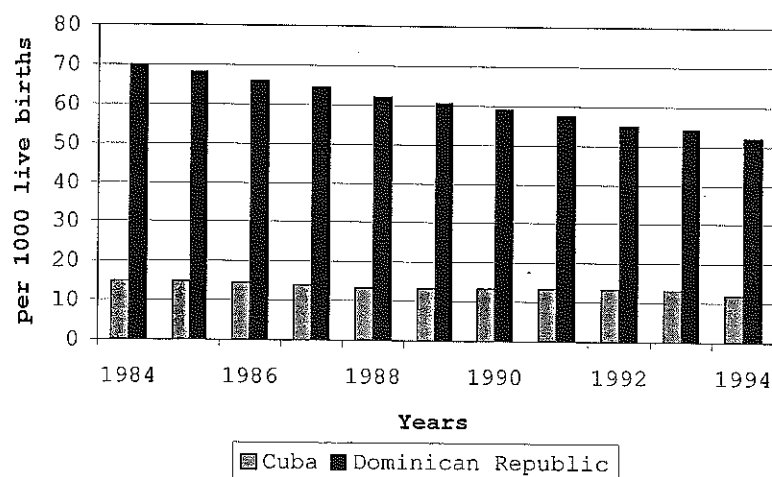
In the 1960s and 1970s, Cuba developed a system of community health centers, family health providers, public health education, potable water, and collection of human and solid wastes, each dependent on the central government and on the goodwill and participation of the community. Had the economic crisis not occurred, and had development continued according to Cuba's Public Health Plan, by 1995 Cuba would have been the first country to have comprehensive family practice coverage for 100 percent of its people (Nelson 1991). The economic crisis made that an impossible goal to achieve by 1995. Nevertheless, Cuba's health accomplishments are significant. In 1991 Cuba had thirty-eight thousand physicians and a physician-to-population ratio of 1:534, compared to the 1:2,320 physician-to-population ratio in the Dominican Republic, making total

coverage a realistic possibility (Nelson 1991). In addition, by 1992 Cuba had achieved a life expectancy rate within two years of that for the United States, and an infant mortality rate within one point of that in the United States, and had reduced low birth weights to within two percentage points of the United States' figure (*New York Times* 1994). Although the Cuban trends in infant mortality, birth weights, and deaths from infectious disease—each relatively sensitive indicators of changes in health status—show recent small increases in the number of low birth weight babies born and number of deaths from infectious disease, the overall infant mortality rate continues to drop (Figure 3.1).

In light of the economic restructuring that Cuba has endured, one must ask, How were they able to do so much? In the early 1960s, Cuba set four national health goals: "(1) increased emphasis on preventive medicine, (2) improvements of sanitation and related areas, (3) raising of nutritional levels for the disadvantaged social groups, and (4) education of the public regarding health matters" (Diaz-Briquets 1983:105–106). To accomplish those goals, the government provided free access to medical care; increased the number of trained health workers; increased the number of medical facilities in rural areas; increased chemical treatment of water; eradicated malaria; began food rationing to allocate food to those most in need; and began aggressive early intervention strategies to treat both problem pregnancies and diarrheal diseases (Diaz-Briquets 1983: 107–112).

In so doing, Cuba made equity and access a central focus of both its policy and practice. It accumulated symbolic and medical capital that

Figure 3.1 Infant Mortality Rates, 1984–1994



Source: *New York Times*, 1994.

serves the people during the economic crisis. Both Dominicans and Cubans face conditions that challenge their survival—shortages of food, housing, and medical supplies. However, Dominicans also struggle with the problems of little health education, restricted access to health care, inadequate services within the health system, a centralized, urban-based medical infrastructure, the lack of access to clean water and waste disposal, and the lack of political will to improve health.

Global and transnational economic pressures on the Dominican Republic resulted in increased external flows of capital and labor. Labor migration and remittances became increasingly significant as a survival strategy for Dominicans. More than seven hundred thousand Dominicans have emigrated since the 1970s, most of them during the decade of the 1980s, and especially since 1985 (PAHO 1996b). In the Dominican Republic, global pressures in the form of international lending institutions and their conditions for loan repayments, coupled with high unemployment, labor strife, and high levels of emigration, transformed health policies and, in so doing, commodified health away from the public good. During the financial crisis of the 1980s, provision of clean water and health policies directed toward improved sanitation and prevention were put aside as the commodification of health moved away from traditional public health themes and toward the provision of more centralized and curative practices. For many Dominicans, this turn away from community-based health programs was seen as a reflection of the global market in which one had to have money to purchase health at a time when the government was reducing the accumulated medical capital and restricting equity and access to public health programs. "The connection between income and health depends not only on current flows but on the stock of capital—including medical capital as well as safe water supplies and sanitation—accumulated from the past" (Musgrove 1987:421). As Musgrove points out, medical capital—like savings in a bank—continues to accumulate and reward the investor after the initial investment is made. Even with international pressures and high out-migration of labor, had the Dominican government maintained that initial commitment to public betterment through public health, that medical capital might well have changed local identities so antithetical to cooperation.

For the Dominican Republic the issue of accumulated capital is particularly critical because there was little medical capital previously accumulated, and what little there was does not serve to reverse community sentiment of *mala unión*. Cuba, on the other hand, showed real gains in accumulated and symbolic capital, particularly in the areas of public health, equity and access, and community identity.

These global pressures commodify Dominican health in "quick fix" immunization campaigns while ignoring the long-term health needs of

communities. This loss of support for communities further erodes the belief of Dominicans in their government, and even in their own abilities to participate in the alleviation of shared problems. *Mala unión* expands to permeate not only relations between the national government and individuals, but also between individuals, defeating community-based solutions.

The Dominican local identity of *mala unión* abrogates necessary government-community collaboration. Because the Dominican Republic, unlike Cuba, chose not to make prevention, health education, equity, and access to health care a major thrust of its public policy, Dominican health identity is one of failed campaign promises, hospitals without doctors, pharmacies without medicine, and rural health outposts without patients. In contrast to the constructed identity that places Dominicans in a *mala unión* with their government, the Cuban local identity of *sembrando el futuro* is one of promises fulfilled now and for the future.

Analysis and Conclusion

How do we measure the well-being of people in the 1980s living in these two countries? Standard health indicators such as maternal mortality, infant and child mortality, and total fertility rates suggest that health is more precarious in the Dominican Republic than in Cuba. By the mid-1990s, international agencies estimated 95 maternal deaths per 100,000 live births in Cuba, whereas in the Dominican Republic the rate was slightly higher at 110 (www.cihi.com, 1998). Infant mortality rates are more telling, reflecting the greater coverage of primary care doctors and family physicians in Cuba. Cuba's infant mortality rate was ten per one thousand live births, whereas in the Dominican Republic it was estimated that thirty-eight infants would die for every one thousand born live (www.cihi.com, 1998). Likewise, the death rate for children under the age of five was considerably higher in the Dominican Republic than in Cuba (fifty-two deaths per one thousand live births in the Dominican Republic as compared to thirteen in Cuba).

Other health indicators suggest that health coverage in Cuba is more equally distributed across the island than it is in the Dominican Republic. Measures of oral rehydration therapy (ORT) access rates in Cuba show 100 percent coverage, whereas in the Dominican Republic only 13 percent of the children have access. The use rate for ORT in Cuba is a remarkably high 80 percent, whereas in the Dominican Republic, only 29 percent of the population say that they use ORT (see Table 3.2).

A higher proportion of infants die in the Dominican Republic than in Cuba, perhaps a reflection of Cuba's emphasis on prevention and level of physician coverage. Access to sanitation, potable water, and education are

Table 3.2 Access to Health Services in Cuba and the Dominican Republic

	Cuba	Dominican Republic
Oral rehydration therapy (%)		
ORS access rate	100 ^a	13 ^b
ORT use rate ^a	80	29
HIV prevalence		
Adults (per 100,000) ^b	21	987

Source: *Health Statistics Report*, Center for International Health Information, December 1996.

Notes: a. 1991

b. 1989

also indicators of quality of life. If we consider only sanitation and access to "improved" (not necessarily potable) water—items that would improve the likelihood of survivability—96 percent of the urban households in Cuba have access to improved water, and 82 percent of the households in the urban areas of the Dominican Republic do (www.cihi.com, 1998). Both countries are undergoing serious economic crises, affecting the population's access to basic commodities, continuous electrical power, and basic sanitation. There is no doubt that social suffering exists in both countries in the form of a shortage of employment opportunities and the pressures of the global market—and, in Cuba, a lack of political freedom. The many similarities between the two countries, however, mask the importance of local identities. These local identities and the idioms that express them should be understood to mediate the unfolding of health programs and their local applications.

I have used the idioms *mala unión* and *sembrando el futuro* to suggest how two distinctive local identities could facilitate or impede health programs. These images are only two of the multiple identities that people have, only two of the many that people use at different times and in different contexts. Each identity is important in relation to the other identities in the community and serves to highlight the need to listen to the voices in the community, to learn their categories, and to fit health-program aims and objectives to local needs and identities—not to force local realities into global outcomes. The playing field will be more level only when its dimensions come from the users on the ground and in the communities. Until then, the idea of a level playing field is a fallacy.

In 1996 Kleinman and Kleinman wrote: "Existential processes of pain, death and mourning are metamorphosed by . . . historically shaped rationalities and technologies, which again all-too-regularly are inattentive to how the transformations they induce contribute to the suffering they seek to remedy" (1996:xii). Attention to local realities, constructed histories, and power differentials between funding agencies and recipient countries

can smooth out the craters and mountains on the playing field so that all players have equal opportunities to decrease social suffering and to improve their lives. Jean J. Schensul, past president of the Society for Applied Anthropology, suggested that applied anthropologists use their skills to level the playing field by equalizing the imbalance of power between funders and field sites, centralized programs and their field applications, globalized policies and in-country cultural contexts (personal communication, 1998). Attention to local identities and local realities can ground the social analyst in the application of programs shaped by politics and economics, thereby mediating the process of social transformation to reduce social suffering.

Even the semisacred cows of international health and development programs should be critically appraised to see how their local fit occurs. The three key concepts often employed in health and development projects, “empowerment,” “participation,” and “community” (Fisher 1997), may needlessly reify what Kleinman and Kleinman refer to as “routinized misery” because they are treated as processes whose outcomes are predetermined by funders (1996:xiii). That is, although community empowerment and participation are the cornerstones for many health and development programs (both in the United States and abroad), they are envisioned as processes for which planners have predetermined definitions (via funders) of acceptable outcomes. The process itself is rarely the outcome, and consequently the desired intervention outcome (increased immunizations, for instance) does nothing to alleviate the routinized social suffering of unemployment, lack of water and housing, and unequal social relations. In an era of globalization of international health programs, local realities—though often given lip service—are denied because they do not fit into predetermined categories. Local realities and identities are locally constructed, shaped by history and context, and often not globally generalizable. One consequence of this is the denial of the local because programs must fit into predetermined funding categories and their outcomes measured in units that are globally comparable—measures that may be locally inappropriate, meaningless, or even detrimental. Yet, as the Cuban and Dominican Republic examples show, local identities facilitate or prohibit types of interventions; those identities give contour to the playing field and define the rules of the game.

Perhaps it is time to throw out the idea of a “level playing field,” for without attention to local identities as well as national infrastructures, the globalization of health will only result in the globalization of social suffering. As Farmer (1996) and others have suggested, health policy and social policy are inseparable, and the discussion of social suffering brings a moral perspective to social analysis. It forces the social analyst to embed issues in a defined moral, political, and cultural space, reducing escapes into cultural relativity or global abstractions.

The Kleinmans suggest that routinized misery results from the lack of the level playing field, where local needs are not given weight and meaning comparable to the internationally generated agendas of funding sources. They draw our attention to the fact that even with the “miracles of modern medicine and public health measures, it is not nearly so apparent that the social suffering . . . is reduced” (1996:vii). We need to ask why this is the case. Could it be that we have too narrowly defined our roles as applied social scientists by confining our research foci to particular categories of physical health, thereby ignoring how suffering itself becomes reified as a process of social mediation and transformation (Kleinman and Kleinman 1996:xvii)? In an earlier work (Whiteford 1997), I suggested that dengue fever control projects in the Dominican Republic failed due to their inability to recognize and transform a local identity of powerlessness, that community participation failed because of historical circumstances. Now I wonder if even that explanation was too narrowly conceived, and in this chapter I have tried to expand my understanding of the social suffering embedded in the concept of *mala unión*, and explore the idea of local identities as keys to our understanding of the ways in which people interact with national health care systems. Social suffering “results from what political, economic, and institutional power does to people, and reciprocally, from how these forms of power themselves influence responses to social problems” (Kleinman and Kleinman 1996:xi). Although the Kleinmans include health as a possible indicator of social suffering, their concept is much wider than just health. They incorporate perspectives from economics, politics, social medicine, anthropology, and critical literature applied to levels of analysis stemming from the intersubjective connections of experience to localized social realities and global processes. Using the examples of the Dominican Republic and Cuba, I am suggesting that unexamined local identities become barriers to care, thereby increasing the social and physical suffering of people we work with and for. In a time of increasing globalization and commodification of health, it is time to understand how local realities transform people’s lives and their abilities to live them well.

Notes

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1. Fifteen years after the 1981 dengue fever epidemic, Cuba again experienced a reemergence of dengue. The 1998 epidemic was detected through an active

surveillance system. Early detection through active surveillance and ongoing detection through passive surveillance allowed for a rapid response to the threat. It appears that the vector control activities instituted following the 1981 epidemic made it possible to limit the transmission to one of 169 municipalities known to have *Aedes aegypti* mosquitoes, and that one municipality where dengue was found (Santiago) had a breakdown in vector control activities (wysiwyg:///106/http://www/cdc.gov/ncidod/EID/vol4no1/kouri.htm).

2. The research was funded by a grant from the Rockefeller Foundation and the International Center for Community-Based Health Research at Johns Hopkins University School of Hygiene and Public Health.

3. For more detailed information about research design and methodology, see Coreil and Whiteford 1997; Whiteford 1997.

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4

Health Care from the Perspectives of Minahasa Villagers, Indonesia

Peter van Eeuwijk

If the dream of postmodernism¹ and cosmopolitanism were to come true, world citizens would live in one big global village characterized by heterogeneity and cultural fragmentation. As Geertz (1995:140) states, "'modernity' may not exist as a unitary thing"; the interpretation of a particular culture as a monolithic body based on consensus, and on shared common values and modes of behavior, is untenable in a globalized world. We live in a paradoxical state in which global processes of transformation create uniformity and transnationalism on the one hand, but on the other, these processes lead to a strengthening of cultural differences within and between societies. The more people are interconnected, the greater the plurality of senses of belonging and modes of existence (Geertz 1996:24).² The popular slogan "think globally, act locally"³ puts into words the active protection of cultural difference as well as the carefully orchestrated transformation of "traditional" cultures. As Kearney's (1995) definition⁴ implies, present-day local processes and identities cannot be understood without understanding the ongoing global processes and their impact on local conditions. Conversely, local culture-specific circumstances always shape global processes. In this sense, the construction of cultural identity may function as a prerequisite for security, peace and well-being,⁵ but not as a shield against global influences. The simple oppositions of "the global versus the local" or "the universal versus the particular" are alleged contradictions that postmodernism overcomes with the concept of "glocalization"⁶ (Featherstone and Lash 1995:4), that is, global localization as "a global outlook adapted to local conditions" (Robertson 1995:28). For instance, worldwide local knowledge undergoes a process of hybridization⁷ resulting in "blurring distinctions between scientific and other knowledge