In this issue:

"Society is moved to compassion upon hearing of the kidnapping or murder of one child, but they are criminally indifferent to the mass murder of so many thousands of children who die every year from lack of facilities, agonizing with pain. Their innocent eyes, death already shining in them, seem to look into infinity as if entrusting forgiveness for human selfishness, as if asking God to stay his wrath. When the head of a family works only four months a year, with what can he purchase clothing and medicine for his children? They will grow up with rickets, with not a single good tooth in their mouths by the time they reach thirty; they will have heard ten million speeches and will finally die of misery and deception. Public hospitals, which are always full, accept only patients recommended by some powerful politician who, in turn, demands the electoral votes of the unfortunate one and his family so that Cuba may continue forever in the same or worse condition."

These words are from Fidel Castro's speech, "History Will Absolve Me." Given on October 16, 1963, as Fidel's own defense after leading the attack on the Moncada Barracks, this speech became the programmatic basis for Cuba's revolutionary struggle. It reflects the deep human concern for the health needs of the population that has been an integral part of the Cuban Revolution since its inception.

This issue of CUBA REVIEW describes the system that has been created to meet these needs. The successes of the system have been universally admired, even by those who are not in sympathy with the Revolution.

It is clear that the health care system of the United States, while producing technological triumphs and spending millions of dollars on exotic research, has failed to care for people's basic health needs. In recent years, the cost of health care has risen faster than any other item in the family budget. Increasingly, the family doctor is being replaced by overcrowded and understaffed hospital emergency rooms.

In the face of these problems, the North American doctors and medical workers who have written the articles of this issue—based on experiences in Cuba—describe a health care system that is much more than an example of a developing country's struggle to solve a major problem of underdevelopment. It is a model for the responsive health care system that is desperately needed by the people of our own country. What is today commonplace reality in Cuba can be a vision of the future that must be struggled for here in the United States.

Roberto Pereda Chavez, M.D., served as the Director of International Relations for the Ministry of Public Health in Cuba from 1966 to 1977. Dr. Pereda met a tragic and untimely death at age 48 in a traffic accident on February 15, 1977. He had been a member of the Cuban Communist Party since 1962 and held many positions of leadership in MINSAF from the triumph of the Revolution. Over the years he represented Cuba in governmental delegations and at many international organizations such as the World Health Organization of the United Nations. Dr. Pereda was elected President of the Executive Committee of the Pan-American Health Organization (PAHO), a position he held until 1976. In 1977 he was posthumously awarded the PAHO prize in Health Administration. In recognition of his revolutionary commitment he was awarded the Medal of the 20th Anniversary of Cuba. Dr. Pereda worked closely with U.S.-Cuba Health Exchange over the years and he became known, respected and loved by the people with whom he worked. His warm support and cooperation are deeply missed. We wish to pay tribute to his memory and dedicate this issue to his family, particularly his wife and two daughters.

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Looking at Health in a Healthy Way

By Margaret Gilpin and Helen Rodriguez-Trias

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We were eager to see Cuban health care in action when we set out under a broiling noonday sun in August, 1973, from the family health center in a suburb of Havana.

On that morning, Maria Fuentes, a public health nurse, had reviewed the medical charts of the children seen by the pediatrician during the previous week. Among others she selected for some visits was tiny Juana Marquez, who at six months of age was one pound below her normal weight.

We could not help contrasting the serious concern over this one baby's failure to gain weight with what we usually witnessed in the South Bronx where both of us have worked. There, underweight children go unnoticed or unattended.

Indeed, in that community only half the children get any pediatric care at all and most children lack even the regular and important childhood immunizations.

We stepped across the threshold of a small, very clean living room and not the baby's grandmother, Diana Fernandez, a grey-haired, stocky woman who greeted us warmly. Shyly, Rosa Marquez, came from the kitchen with her baby Juana in her arms. Perhaps seventeen or so, she had not completed high school before she married. Her husband was working out of town, and as so often happens in the Cuba of the extended family, Rosa lived in her mother's home.

Nurse Fuentes quickly established a conversation about feeding babies as she explained the purpose of the visit. As the talk progressed Rosa began to express her anxiety about feeding Juana. The more she tried to feed the baby, the more the baby seemed to be refusing solids and was taking only a little milk. Nurse Fuentes focused on teaching Rosa to let the baby's appetite guide her in the amount of food to be given, and on the importance of not trying to force the infant to eat. The nurse's second accomplishment was to route Juana into an on-going system of support and continuing education by scheduling further appointments.

We saw none of the accusatory style or condescension toward mothers which is all too frequent in pediatric circles in the United States. With her warm and supportive intervention, Nurse Fuentes averted what might well have become a serious problem for both mother and baby. We had witnessed preventive health care delivered in a caring way, and we wished to know more about the system that produced such health workers and services.

Then we wondered, what does it take to provide this concerned, at-home care for baby Juana and her mother Rosa Marquez? What are Cubans doing that is different from most places, certainly different from the United States where so many health problems go undetected until they are chronic or deadly?

A Crucial Difference

The principle factor, of course, is that in Cuba health and health care are integral parts of greater social change. The plagues of starvation, tuberculosis, diarrhea, prostitution,
child abandonment and the many diseases associated with poverty are gone. Cubans today are the healthiest people in Latin America.

One sensitive indicator of a nation's health is infant mortality. Whether children will live or die before they are a year old is determined by a complex interplay of biological and environmental factors such as nutrition, employment, income, housing, educational level, the age of the mother, the parents' health, etc. Health care provided for pregnant women, for women in childbirth and for newborn infants is critical in the prevention of illness and death among mothers and infants.

Recognizing that in pre-revolutionary Cuba at least five of fifty children like Juana Marquez died before their first birthday, health care for mothers and children was given high priority by the Revolution. Now only about one out of fifty babies dies, a remarkable accomplishment that even critics of the Cuban system have recognized.

The contribution of health care and health care workers like Maria Fuentes to this dramatic decrease in the death rate of infants was made possible by the creation of a new health care system beginning in 1959 after the revolutionary government took power.

The Old Story

Before 1959, privately owned clinics provided health care services for a few people who lived in the cities and who could afford it. "Mutual benefit societies" (hospital plans organized to serve descendents from specific geographic regions of Spain) ran hospitals which admitted the members enrolled in their health programs. The rest of the population depended on the few state-run services, which were so riddled by corruption that even admissions to hospitals were bestowed in exchange for favors or bribes to politicians. (If you could pay off an official or bribe a politician with a promise to deliver votes in the next election, you might gain admittance to a hospital when needed.) Physicians in private practice served the upper middle and upper classes in the cities.

More than 60 percent of the population of six and a half million in 1959 had virtually no access to health care. These were the people of rural Cuba and the majority of the urban poor. As in the United States today, the care that existed prior to the Revolution was fragmented, profit-oriented and focused on diagnosis and treatment of diseases rather than on their prevention. All these facts resulted in high rates of infant mortality, high rates of infectious and contagious diseases (such as polio, malaria, T.B., intestinal parasitism, diphtheria and tetanus—see Chart 1) and high rates of malnutrition, which caused enormous damage among millions of impoverished Cubans. Diarrheal diseases were one of the five leading causes of death in the general population of Cuba. (See Chart 2.) People lived under the constant threat of the most serious diseases and epidemics.

The New Way

We found the answers to our questions about how a health care system has come to provide progressive and comprehensive health care for infants and mothers in the founding principles on which the revolutionary Cuban health care system has been built. They are:
After preliminary introductions we explained to the Hernandezes that we were most interested in their perceptions of the differences in health care services before and after the Revolution. Luis looked down, indicating his useless left leg, and told us how it was injured in an agricultural accident many years before the Revolution. His wife found him in the field unable to walk. She rode to the nearest neighbor on horseback and brought help. The neighbor strapped Luis to his horse and took him to town, a two hour ride over rough trails. When they arrived the doctor was away and not expected to return until the next morning. A curandero (the local "healer") was called and he did what he could to help Luis rest comfortably through the night. The doctor came the next morning but it was too late to rescue Luis' leg--it was permanently paralyzed. It took him five years to pay the doctor's bill.

Luis' story was not an unusual one in Cuba before 1959. A serious challenge faced the new government of Cuba if all the Cuban people were to have equal access to health care.

The first task was to provide services and facilities in the rural areas for people like the Hernandezes. In remote districts all over the country construction began. In 1959 there was one rural hospital, in Oriente Province; by 1976 more than 57 new rural hospitals of at least 30 beds each had been rapidly constructed.

In 1958, 61.7 percent of hospital beds were in the province of Havana, with 38.3 percent in the rest of the country. By the 1970's the shift had been accomplished, not by eliminating urban facilities but by increasing those in rural areas. By 1973, 44.4 percent of hospital beds were in Havana, and those in the rest of the country had risen to 55.6 percent. (See Chart 3.) The overall increase in the number of hospital beds nationally from 1959 to 1976 was 18,638. By 1976, a total of 257 hospitals formed part of a nationwide network of facilities. (See Chart 4.)

Polyclinics, which are the facilities where Cubans get outpatient care, needed to be built. Between 1962 and 1970 the number of polyclinics in the country steadily rose, from 161 to 308. By 1976 there was a total of 345 fully staffed and operating polyclinics on the island (see Chart 5), and an additional 140 rural medical posts. The medical post at Valle de Picadura is about three blocks from the Hernandez' house. The Hernandezes are entitled to and encouraged to utilize full this health service at no cost to them.

In 1958 there was not one free dental clinic in all of Cuba. By 1976 there were 115 dental clinics scattered all over the country. (See Chart 6.) Blood banks, another indication of the increase of facilities available to all, had risen to 21 by 1976, as compared to one, in Havana, in 1958.

Chart 1, continued

1. The health of the people is the full responsibility of the state.
2. Universal coverage is guaranteed to all persons without discrimination.
3. The people must participate actively to assure and maintain high health levels.
4. Prevention is the primary goal of health care.

These principles focus on the needs of families and communities as well as individuals, and are designed with the understanding that the context in which people live is intimately connected with their health. The new system integrates good housing, sanitary conditions, education of the people and productive work as basic conditions for securing and maintaining high health levels for the population.

A single agency, the Ministry of Public Health (MINSAP), was established exclusively to coordinate everything pertaining to health and health care. It has been MINSAP's job to define a consistent national health policy for the whole country, and to develop national health plans for even the smallest rural community. Everything to do with health, from the production and distribution of medicine, medical equipment and supplies to the construction and staffing of health facilities--and including the quality and quantity of services available--falls under the auspices of MINSAP.

We rang the doorbell at a brand new apartment in Valle de Picadura, a dairy farm near Havana. Ana Maria Hernandez answered quickly and her husband, Luis, was not far behind despite his crutches. The parents of three grown daughters, the Hernandezes had moved to the new building only two years before. They came from a small bohio (a Cuban thatched-roof hut) where they had lived since they were married some 40 years before. Luis had been a farmer with a small plot of land which he had worked by himself with primitive equipment. We were greeted enthusiastically and invited to sit in the living room. Cups of Cuban expresso and glasses of iced water were passed around. The talk began.
see the harsh effects of the U.S. blockade as medical equipment lay unused and rusting because the Cubans could not get replacement parts. Precious foreign currency was used to purchase needed medical equipment from countries around the world. Equipment came from the Soviet Union, the German Democratic Republic, Sweden, Japan, England and many other nations. Today new equipment has been installed throughout the network of facilities from the smallest rural medical posts to high level national institutes. (Luis showed us the old crutches he had had to make for himself after his accident. He proudly compared them to the new crutches he was given free of charge in 1960.)

**Personnel**

Prior to the Revolution in Cuba, physicians, answering the seductive call of a more highly developed medical technology and higher salaries, left Cuba at the rate of about 15 percent a year. The impact of the Revolution on the availability of health personnel was dramatic. Cuban physicians increasingly emigrated, principally to the U.S. and Spain. On January 1, 1959, there were 6,500 physicians in Cuba, 65 percent of them working in Havana. During 1960 and 1961, 1,360 of them left the country. The exodus further depleted the numbers of working physicians to 4,325 by 1965, and by 1967 another 892 had requested permission to leave. Cuba faced serious problems in providing health care to previously unserved areas as well as maintaining and extending services in urban areas. In August, 1960, a scant 16 professors remained at the only medical school in the country, in Havana. The Revolution had to respond swiftly and vigorously if it was to fulfill its promise. Doctors from the socialist countries came to Cuba to help. Younger Cuban physicians were sent to other countries to complete their training. Intensive development of new faculty resulted in the upgrading of younger physician-instructors to help provide additional teachers in the medical school in Havana. Admissions to medical school were opened to all people in the country and a successful educational campaign about the need for doc-
tors resulted in more than enough applicants to expand the numbers of students. The Havana Medical School graduated 395 physicians in 1965. Ten years later, in 1975, the graduating class numbered 1,361 from Havana Medical School and the two new schools that had since been opened in Santiago de Cuba and Villa Clara. In order to help provide coverage to previously unserved areas the Cubans established a rural service experience. (In exchange for their completely free education, medical students agree that on completion of their training they will work for three years in an assigned rural area.)

Cuba now has over 9,000 working doctors. By 1980 its doctor-person ratio should be similar to that of the United States, one doctor per 750-790 people. The Cubans have achieved a more even distribution of physicians all over the country. Today in the U.S. there are many rural and poor urban communities where there is no doctor available or where there may be one doctor for several thousand people.

Of course, it takes more than doctors to staff a health care system. Cuba needed to train nurses and technicians of every kind: pharmacists, anesthetists, social workers, psychologists, X-ray technicians, laboratory assistants, physiotherapists, rehabilitation specialists, occupational therapists, medical librarians, sanitary workers, nutritionists, dieticians, blood bank technicians and so on. Goals were set by MINSAP for each occupation, specifying the numbers of graduates that would be needed. In areas of severe shortage of personnel the Cubans were quite inventive in meeting their needs by developing new health occupations. Good examples can be seen in dentistry and in the field of psychology, where the Cubans train a "psychometrist." In 1959, there were a total of only 32 graduates in all of the ancillary health occupations. Ten years later, in 1969, 3,750 graduated. The total number of graduates from 1959 to 1976 was an astounding 61,674. Most of the students in these health occupations are able to enter technical and professional training after completion of tenth grade. The length of their studies varies with the profession.

Mass Participation

And so we learned how two of the founding principles of the Cuban health care system have become a reality. The revolutionary government paid for and established facilities all over the island, equipped them and staffed them. This network of facilities provided health care for all the people of Cuba entirely free of charge.

We wondered about the third principle: how do the Cuban people participate directly in their new health care system to assure and maintain high health levels? What does participation mean in the everyday life of an ordinary Cuban citizen?

The answers to these questions have their roots in the philosophical principles of Marxism-Leninism. A defining characteristic of a true socialist country is the active participation of all the people in social and state activities. The vast majority of Cuban people are voluntary members of social and mass organizations. Indeed, over 80 percent of the entire Cuban population belongs to one or more of the following organizations: the Union of Pioneers of Cuba (UPC, 1,900,000 members); the Federation of Students of Middle Education (FEEM); the Federation of University Students (FEU, 40,000); the Federation of Cuban Women (FMC, 2,127,000); the Committees for the Defense of the Revolution (CDR, 4,800,000); the Central Organization of Cuban Trade Unions (CTC, 2,650,000), and the National Association of Small Farmers (ANAP, 232,568).

In addition to their central tasks and focus, all of these mass organizations are involved in some health activities. For example, the CDRs were originally formed in September, 1960, as vigilance committees to protect the Cuban people from counter revolutionary activity and U.S.-sponsored incursions. By 1961, when the United States invaded Cuba at the Bay of Pigs, there were thousands of CDR offices already functioning throughout the country. The national structure had been formed and CDRs were created on literally every block in urban areas and in defined districts in rural areas. By the time of the October Missile Crisis in 1962 the CDRs had already been involved in immunization campaigns against polio, tetanus, diphtheria and pertussis. The October Missile Crisis presented the CDRs with another task: in view of the threatened aggression, MINSAP needed to organize the people to give blood so they could have a sufficient reserve should it be needed. MINSAP turned to the CDRs for help. By holding meetings and explaining the needs, the CDRs mobilized 8,000 Cubans to give blood in less than 10 days. The visible success of their efforts in the anti-polio campaign and the blood donation campaign gave further impetus for the CDRs to expand their involvement in health work. For example, in 1963 they began to participate in a national campaign against gastroenteritis, which was one of the leading causes of death in the country, particularly for children. In 1962 it caused over 4,000 deaths, 90 percent of which occurred.
in children under 15. The concerted action of the CDRs, MINSAP and the other mass organizations was as successful with gastroenteritis as it was with polio. In 1976, only 569 patients died of gastroenteritis.

How did the people organize to do health work? The dramatic achievements typified by the successful fight against polio and gastroenteritis were clearly the result of the principle of mass participation, but people could not have accomplished such massive work without coordination. We found out that in 1961, within the organizational structure of MINSAP, Health Commissions were formed at national, provincial, regional and municipal levels. These Health Commissions were led by a worker from the MINSAP staff and were composed of voluntary health and hygiene representatives from each of the mass organizations. The work of these commissions concentrated on the planning, execution and control of all health activities. Goals set by the National Commission, such as the immunization of all children against polio, were planned and carried out at provincial, regional and municipal levels. Each commission analyzed the goals and created a plan to carry them out, taking into account any special characteristics of a province, region or municipality. The enthusiasm of the people involved in the work of the Health Commissions was enormous. The early anti-polio immunization campaigns were a good example of how they worked. The national goal of immunizing every child was first discussed at every level. A plan of action was developed that included educational meetings organized by each local CDR in every district to discuss the need for the campaign and the plans with all the neighbors. The FMC discussed the plan with mothers and children at the local day care centers and at their regular meetings. The CTC representatives posted announcements and discussed the importance of the campaign in all the work centers. Finally, the representa-

The use of the mass media was critical in increasing popular cooperation with the plans. Newspapers, television, radio and billboards were used to bring educational health material to the public. The plans for transportation, storage and distribution of the vaccine were completed. One small town decided that it was going to become famous for immunizing its at-risk population faster than any other. It did so by counting the number of children to be immunized, then by having one adult volunteer per child. At the appointed time, they lined up all the children in the central square. At the ringing of a bell the children opened their mouths and their corresponding adult partner popped in the candy vaccine. The total time for immunization was under two minutes. Cuba is now world-famous for its ability to immunize its entire at-risk population nationwide in eight hours.

As each goal was successfully reached and the numbers of cases or deaths from diseases decreased, the mass organizations expanded their health work within the Health Commissions and incorporated programmed activities in the following areas:

1. increasing the use of medical services for pre-natal patients;
2. seeing that newborn infants receive regular medical care;
3. controlling treatment for patients with tuberculosis;
4. motivating women to get pap smears to increase the early detection of uterine cancer;
5. making sure all people get needed immunizations;
6. continuing to assure sufficient supplies of food;
7. conducting literally millions of meetings over the years for public health education on innumerable topics;
8. carrying out campaigns against insects and vermin;
9. working towards the control of transmissible diseases;
10. trying to reduce the rate of industrial and home accidents;

11. detecting sanitation problems at the local level.

The role of the mass organizations, through their work in the Health Commissions, has been vital in developing a community-based system of health care that serves every single person in Cuba. It is through these structures that the health care services are organized and delivered. Cuba's ability to effectively interest and involve the people with the health care system is remarkable, particularly when one understands that the participation of the people in planning and decision making is real. Their input and suggestions are considered with the utmost seriousness and often are the determining factors in planning. This is dramatically unlike the ineffective participation of thousands of health consumers in the United States who regularly sit on health advisory boards and councils in clinics, hospitals and health systems agencies.

'Medicine-in-the-Community'

Several questions remained in our minds: How does the Cuban health care system in fact serve the people of Cuba? What activities take place to prevent illness and to cure disease? What happens to a Cuban citizen when s/he is sick? How is the health care system organized and structured to carry out its goals? How do all the new facilities relate to one another to provide systematic care?

The appropriate way to look at these questions is in today's context rather than from a historical viewpoint, since there have been far-reaching changes in the Cuban health care system which were a result of a serious analysis of the strengths and weaknesses of the system. This analysis was linked to political and administrative changes in the country which began in 1974 when the Cubans started an experiment in popular democracy in Matanzas province. This experiment included direct election by the people of delegates to municipal assemblies. All units of production and service within the municipality were and are now directly responsible to those municipal assemblies. Even small concerns, such as pharmacies, and services, such as polyclinics, are included.

By 1976, after thorough evaluation, this successful political structure, called People's Power, was extended to the whole country. At the local, regional and provincial levels this new structure transferred power and control of the state administration to democratically elected representatives of the people. A government that had been of the people and for the people is now, also, a government by the people. The elected representatives to the municipal assemblies, in turn, elect delegates from among their own ranks to provincial and national assemblies. The provincial assembly has control of such functions as teaching hospitals. The National Assembly controls the national institutes of health. At defined intervals, once every three months, the elected delegates to the municipal assemblies are required to report on their activities to the people in their districts. These delegates can be recalled at any time if the people are dissatisfied with their work. Recall is determined by a two-thirds vote of the people in the district.

The new organizational structure of MINSAP parallels directly that of the political-administrative structure. (See Chart 7.) Each municipality has a defined number of health areas, and each health area has a polyclinic in the urban centers or a rural hospital in rural areas. A health area is a defined geographic district with 25,000-30,000 people and the polyclinic is responsible for all the health activities in its defined health area. Prior to the reorganization of the health system (1959-1974), people went to the polyclinic in their health area and saw the appropriate primary care physician for complaints. Each polyclinic was staffed in the four primary care specialties (which in Cuba are designated as internal medicine, pediatrics, obstetrics-gynecology and dentistry), plus nurses and the necessary support staff. Before 1974, the polyclinics functioned much the same as out-patient clinics in the United States. There was no appointment system and people were seen on a first come, first served basis by the dispensarization: home visit to a prenatal patient.

doctor who was on duty. This system resulted in frequent long waits in the polyclinic and gave rise to a common complaint about the impossibility of establishing a personal on-going relationship with "your own doctor." These were two of the most serious problems health care planners had to solve in Cuba when they began their lengthy analysis in 1974. Another consequence of this system was that Cubans would sometimes bypass their polyclinic in favor of the emergency room at the regional hospital where they could often get quicker attention. This further complicated matters because information about a patient was often lost between the local polyclinic and the regional hospital. Although the same doctors often worked part of the week in the polyclinic and part in the regional hospital, there was no guarantee of seeing the same doctor in both places. Hence, continuity of care was interfered with. The other frequently encountered problem related to specialty referrals. For example, if a child saw a pediatrician and the doctor felt the child needed to consult an orthopedist for a bone problem, the pediatrician had to refer the child to orthopedics at the regional hospital where the specialty services were located, in much the same way as referrals are handled in the U.S.; there were no specialty services at the level of the polyclinic. Again, this frequently resulted in a lack of coordination in the care of the patient.

So, in 1974, even though their health care system was relatively new—and had outstanding triumphs to its credit—the Cubans began a profound re-evaluation in order to formulate improvements. The demands of the people for improvements in the quality of health care services were, to a large extent, a successful result of steadily increasing education regarding health
and health matters. In 1959 and the early sixties the vast majority of Cubans were getting health care service for the first time in their lives. To be able to see a doctor when needed, to be offered preventive services, to be hospitalized, all at no charge, were such enormous improvements over the way things had been before that the people were not so concerned about the more refined aspects of care. As Cuba's population became generally more educated, their consciousness grew, and their levels of expectations increased proportionately. They then expected to have a personal relationship with a physician who would get to know them and remain in a central coordinating position vis-a-vis their health care.

In the 1959-1974 system people were still referred inappropriately to specialists rather than having their problems managed at the local level. This was a result of a left-over attitude that treatment by a specialist was somehow better than that of a primary care physician. Additionally, inappropriate emphasis was still given to diagnosis and cure rather than prevention, and insufficient emphasis was given to the other aspects that make for total care, i.e., the psychological, environmental and social factors that intersect with health and illness. The turnover of doctors staffing the polyclinics was too high because of the continued emphasis on specialization. Doctors' training did not sufficiently prepare them to stay with a community-based primary care practice. The teaching of doctors remained based in hospitals and this was considered a key factor in the educational distortion leading to over-specialization. There was general agreement in Cuban health circles that in order for health care workers to effectively understand the psychological and social factors that affect health their practice had to be firmly based in the community where they were to practice.

It is astounding to us that a response to the criticisms and suggestions of the people would lead directly to a rapid restructuring of the whole health care system to overcome undesirable elements. But this, indeed, is what happened. From this all out effort, a new conceptual framework for the health care system was developed: it is called "medicine-in-the-community." In this view, health and illness are seen on a continuum and the individual is recognized as a bio-psycho-social being who needs harmonious equilibrium in all spheres of her/his being in order to be considered healthy. Therefore, health care has to be what the Cubans call integral, or holistic, and deal with all aspects of the individual in the full context of family and community.

Each health area is subdivided into health sectors, and the staff of each polyclinic divided into horizontal primary care teams, composed of one of the primary care specialists and a nurse. The team is then given full responsibility for a health sector, with a designated panel of patients to whom it relates. Every pediatrician has responsibility for 1,000 children, every internist for 2,000 adults and every obstetrician-gynecologist for 2,000 women over the age of 15. Each team has its own office in the polyclinic where it keeps the charts of all its patients. This means that all persons in the health sector have their own doctors to whom they relate in a continuing way.

In order to resolve the problem of the lack of coordination between the primary care physician and the medical specialist, the Cubans developed a new system they call "interconsultation." Representatives of the various medical and pediatric specialties (such as dermatology, psychiatry, orthopedics, ophthalmology, etc.) come to the clinic on a regular weekly schedule and are available for consultations. However, the primary care physician who makes the referral is required to attend the consultation with the patient and the specialist. In this way the problems of lack of coordination and lack of continuity in the area of specialist referrals have been resolved.

To insure the view of the patient as a 'whole' person the Cubans have emphasized the need for health care personnel to work in teams. The horizontal primary care team, discussed above, is but one example. There is also a vertical primary care team which functions in relation to specific problems a patient may have. The vertical primary care team is composed of the regular polyclinic staff including psychologists, sanitary workers, social assistance workers, epidemiologists, etc. These members work as a team with an individual or family when problems require the cooperation of the specialists in these areas. In a meta-
in the meeting, and the neighborhood health
and hygiene representative might agree to visit
the patient to find out what interfered with
the appointment. If it turned out that on her
visit she found the patient felt too sick to walk
to the polyclinic, but not too sick to call for
help, the worker might then arrange for a home
visit by the team or for transportation to bring
the patient to the polyclinic. These health care
teams are not only responsible for their health
sector but responsible for broader issues of
health within the sector. For example, the team
is responsible for follow-up and for health sur-
veillance in community facilities; the team
visits and cares for schools, work centers and
other community institutions within its bound-
daries.

A series of national health priorities have
been established by MINSAP that guide the work
of the polyclinic health care team. This system
in Cuba is called dispensarización. MINSAP has
defined certain target and high-risk groups in
the population which should receive special med-
ical attention. The target groups are children
from zero to four years of age and people over
65 years of age. The high risk groups include
hypertensives, asthmatics, diabetics, etc.
MINSAP has declared that persons in these cate-
gories shall have a fixed minimum number of visits
with a doctor per year. For example, in certain
categories the team is required to do a home visit
at least every six months. These home visits
are in addition to the regularly scheduled clinic
appointments. This system not only insures good
medical care, but also provides a system in
which the patient is viewed in context—that is,
at home. The home visits help the team to know
patients in their own environment and this con-
tact tends to increase the mutual relationship
of trust between the consumer and provider.

A qualitative change has also resulted from
the interrelationship between the health consumer
in the community and the health providers in the
polyclinic. To a large extent this has occurred
because of the establishment of People's Power.
The polyclinic staffs are now directly account-
able to the municipal assemblies. The municipal
assemblies have the power to request replacement
of a staff member should there be difficulties
between the member and persons in the health sec-
tor. We heard about a number of specific cases
where doctors were transferred out of a polyclinic
because a number of people in the community
were dissatisfied with their care.

On a visit to Cuba in 1977 one of us accom-
panied a primary health care team on a series of
home visits. We were impressed with the warm
familiarity with which people in the health sec-
tor greeted their team. One woman in the street
called a doctor over to ask a question about her
child. There was an air of intimacy between the
team and the members of the community, and the
team was clearly knowledgeable about its patients
and families.
The interrelationships of the various parts of the health care system is illustrated in the collection of national data on the incidence of diseases in the population. Data collection is a constant preoccupation of Cuban health personnel. Health surveillance by the polyclinic epidemiologist in the community aids the collection of data nationally. The results of an effective feedback information system between all these levels are quite astonishing and result in improved health status of the Cuban people. For example, in 1975, health planners decided that tetanus, a preventable disease, should be eliminated--91 cases in that year gave impetus to this concern. This could only be done if the Cubans could identify all people in the population who were not getting vaccinated. A careful analysis of these cases showed that 52 percent of the cases appeared in housewives. The analysts observed that housewives were not going to school, where all children are vaccinated, nor did they go to work, where control is established through the work center. The decision was made that the first step in the campaign would be to begin a national mobilization of housewives to make sure they got the needed immunization. The FMC was the logical mass organization to begin this effort. At the local level, 46,000 members of the FMC health brigades participated. They began by conducting a census to find out exactly how many women needed the immunization. First and second shots of tetanus toxoid were administered to 400,175 women and 86,744 women received booster shots for five-year protection. A total of 486,919 women were vaccinated, representing 96 percent of Cuban housewives.

In the actual delivery of health care in Cuba the application of "medicine-in-the-community" means that all Cubans are registered in their local health centers and have charts readily available to their doctors. Every person is cared for in accordance with standards which specify the minimum number of visits to doctors and whether those appointments should be in the health facility or at home. The home visits contribute to creating the assurance that people have caring, accessible doctors and nurses, and that the health team will work with the people in the milieu of the family or the community.

In summary, from 1959-1974 the Cubans constructed and staffed a nationwide system of health care providing universal ambulatory coverage through a network of polyclinics and rural facilities. In 1974 they reorganized the work within this ambulatory system to emphasize integrated primary care (rather than discontinuous out-patient visits), organized the staff into more effective health care teams, and linked those teams (and their work) to the community.
Hospital Care

In this new system the ties between the local community polyclinic and the more highly specialized hospital services could be strengthened too. Being hospitalized in Cuba is dramatically different from the experience of being hospitalized in the United States. Respect for the physical and emotional integrity of the patient, the need to include the person in every step, are the rule rather than the exception. Patients are part of decision-making at all stages of treatment. Surgery and other invasive treatment is never performed without full explanation to the patient about the procedure--its benefits and its possible side effects--nor without their "informed consent." In Cuba, unlike the United States, there is no need for a political movement to pressure for laws to force physicians to provide "informed consent" before performing a procedure. The system of accountability described previously insures that patients' rights are protected.

In all Cuban hospitals there are commissions charged with investigating and reviewing every death that occurs in the hospital. Posters in waiting rooms encourage patients to complain directly to the hospital administration if they feel they have not been treated with full dignity. There is an understanding that all workers contribute to the total functioning of the institution and that unless every group is fully involved, patient care will suffer. All workers (physicians, janitors, maintenance workers, laboratory workers, etc.) are on committees that review the way the institution functions.

All hospital care in Cuba is given within a regionalized system. Of the 257 hospitals in the country, 148 are general medical-surgical hospitals, 25 are maternity hospitals, 22 are pediatric hospitals, 31 are for maternal-infant care and 19 are psychiatric hospitals. Within this regionalized system there are five hospital beds for every 1,000 people in the country and the Cubans hope to increase this to 5.8 per 1,000 by 1980. Nationally, the distribution of hospital beds in 1976 was as follows: 27.2 percent in pediatrics, 18.4 percent in obstetrics-gynecology and 54.4 percent in other specialties. The unusually high percentage of younger people in the Cuban population has made this distribution pattern necessary. Total hospital bed utilization in Cuba in 1975 was 81.2 percent, with the highest utilization being in obstetrics-gynecology (due mostly to increased in-hospital delivery of infants) and the lowest in pediatrics with a utilization rate of 76.5 percent.

Role of Health Workers

Two other questions remained for us: how does the Cuban training system produce health workers who can fulfill newly defined roles, and what part are these Cuban health care workers playing in the world?

The most notable changes that have taken place in health education and training have been in the area of physician training, beginning with medical school. The new emphasis on training for primary care services parallels the changes in the delivery system already described. In the early years of the Revolution definitive changes took place in the medical school: students began participating in the running of the university and admissions were open to all people--income, racial or sexual discrimination were no longer barriers to entrance. The early years of reform saw changes in study plans and the institution of a six-year course, including a last year of rotating internship.

The purpose of these changes was to create a solid base of scientific training, including a balance of practical experience with theoretical learning. Time spent by medical students in various daily activities was rationalized to reflect these changes. For example, the implementation of a nationwide work-study program in all educational endeavors, including medicine, required a reorganization of the students' day to allow equal time for study and productive work. Analysis produced a new plan of integrated study which was established in 1970, after six years of development. The goals of socialist medical education were more clearly defined. Highlights of the new conceptual framework include:

1. a social conception of medicine;
2. the development of scientific thought;
3. new models of teaching which fully integrate practice and theory and are increasingly dependent on the use of multidisciplinary, collaborative team teaching as opposed to individual teaching;
4. integration of the basic and clinical sciences, and integration of the biomedical psycho-social and environmental factors involved in health;
5. familiarity with the organization and administration of public health;
6. emphasis on prevention and epidemiology;
7. emphasis on the general cultural development of students;
8. emphasis on the political and ideological development of students;
9. the practice of physical education and sports;
10. preparation for defense of the country in case of aggression or natural catastrophe.

Other significant factors in the recent transformation of Cuban medical education have been the growing decentralization of teaching, the participation of teaching personnel in service tasks, pre-professional practice of medical students in internship and the active incorporation of the medical student into the work of the local polyclinic and health area through the work-study plan. Currently, during the first two years of medical school a minimum of one day per week is spent by each student in a local polyclinic or health area. In the first year students work closely with a public health nurse or a community sanitary worker. In the second year they work with the horizontal primary health care team. By the third year the site for teaching shifts from the medical school to the hospital, and students continue to follow a minimum of one family from the polyclinic in which at least one member falls into a high-risk medical category. That student completes an "ecological study" of the family, emphasizing the family in its context and including a description of the interrelationship of the members with one another and with the community.

Students are expected to participate in health promotion activities as well. Throughout medical school the student continues in close and organized contact with the activities of health care in the community. Socialism transformation has thus created an organized, cooperative and coordinated base--the community-- within which training can be organically integrated. From the Cuban point of view, embedding these training activities in the life of the community is the way to create practitioners who possess the knowledge, motivation, skills and social and human attitudes to serve the people in a way that creates bonding between the health care team and the community at all levels.

Nursing education and the definition of the role and function of the nurse has thus far remained rather narrow and traditional. Expanded role functions such as the nurse practitioner, nurse educator and nurse midwife have not been incorporated as yet.

Cuban health care workers play a very special role in the world. We referred earlier to the role of the Cuban physician as an 'internationalist.' The Cubans are now implementing special training courses for Cuban health personnel who will go to other countries to give assistance in health. These special courses are designed to teach Cuban health personnel the diagnosis and management of illnesses no longer seen in Cuba, such as malaria and diphtheria. This small Caribbean island, with such severely limited natural resources and so little material wealth, has consistently provided medical aid to countries in times of crisis and ongoing medical assistance to countries in need throughout the world. During the long years of the Vietnam war, Cuban health teams worked and died alongside their Vietnamese comrades. Today, Cuban doctors staff the majority of provincial hospitals of that sister nation in Africa, Angola. It was Cuba who came to the rescue of the Peruvians after their massive earthquake, not only with on-the-spot medical teams but with massive blood donations. In the People's Democratic Republic of Yemen, Cuban health workers went to create a medical faculty at Aden. This medical school, the only one in the country, is now fully functioning for medical students in the first and second years of training, with participation of both Cuban and Yemenite professors. In 18 countries throughout the world Cuban medical teams are at work.

In addition to agreements with particular countries, MINSAP is involved in on-going collaboration with many international organizations such as the World Health Organization, the Pan-American Health Organization, the International Federation of Family Planning, UNICEF, the U.N. Development Program, etc. Cuba was elected to the Executive Council of the Pan-American Health Organization for a three-year term from 1973-1976, and a Cuban was elected president of the PAHO council.

So our eagerness to see Cuban health care in action was well rewarded. The outstanding accomplishments of the Cuban Revolution in all areas of human services are clear. The ability to respond decisively and quickly to peoples' needs is a unique feature. As presently conceived and carried out, the Cubans have indeed succeeded in creating a health care system which to us seems visionary. There is a unity of purpose and a dedication to improving the social, physical and mental well-being of the people: a dedication that is only possible in a socialistic context where competitive, material interests have been abolished.

The Cubans still have problems and will have problems in the future. What is striking and exciting is how they confront their problems directly and openly and how they work for solutions that benefit all their people, not just a privileged few. We certainly can learn a great deal from their experiences.
The Ministry: Planning for Health

Dr. Jose Molina Otero, the First Vice Minister of Public Health was interviewed for CRC by Margaret Gilpin in Havana, Cuba, July 1977.

CRC: How does MINSAP plan national health care? How is national health policy made?

Otero: The activities of MINSAP are innumerable, and therefore, cannot be left to spontaneity; they must be planned. Now, how are they planned? MINSAP has several types of plans, a long term plan, a medium term, and a short term plan. The short term plan is for one year, and the medium term plan, for five years. The long term plan is a future projection, and follows general national policy, in which all aspects of the state enter. Of course, these plans are made in accordance with the Party.

The First Party Congress held in December, 1975 laid out the general lines for the country's health policy. Based on these general lines, MINSAP forms its long term plans. Its five year plan, and the shorter plans, are constructed in accordance with this orientation and these directives. All the vice-ministries of MINSAP participate in the planning process, each contributing part of the plan. For example, the vice-ministry of education must plan human resources so that we know how many doctors, technicians, and dentists need to graduate each year nation wide, and then we can plan for their distribution by province.

Similarly, the pharmacy industry participates, because as the population grows and specialized human resources grow, there are needs for more instruments and medications. They must decide if these should be produced in Cuba or imported. The vice-ministry in charge of financing participates because we must plan the allocation of the state budget for human and material resources and modification of facilities. The vice-ministry of medical care participates because we must know, for example, how many polyclinics will be completed this year in the construction plan and how many new beds we will have. In this way the entire ministry participates in planning, designing the yearly health plan and meeting goals for different programs.

Five years ago, for example, in the maternal-infant care program we planned a 50 percent reduction of infant mortality in Cuba. We drew up a ten year plan. We have gone step by step, year by year, adjusting the program until we reached the current figure; our goal has practically been reached, well before the target date.

Additionally, all research institutions are included in planning so that their research is relevant to the national health goals. For instance, the infant mortality research program is geared to reduce the rate of infant mortality even further. Other research relates to maternal mortality, cardiovascular diseases--one of the primary causes of death in our country, and to cancer.

The national plan reflects the concerns of the people. Each provincial director brings all the concerns of the local people to the provincial level, and the province elaborates a plan. This plan moves to the ministry and to the national leadership of health planning. After formulating a national plan, all the ministry officials return again to the provinces, the regions, and the health areas where each must be committed to successfully complete the plan. The people participate in this process through the CDR's, and make a valuable contribution. The Federation of Cuban Women participates with its Sanitary Brigades, with the campaign of detection and prevention of cancer of the uterus, with blood donations, and the struggle against gastroenteritis. The mass organizations participate in creating the plan, and in its realization.

CRC: Can you explain in a little more detail the role of the Party in planning?
Otero: The role of the Party is fundamental. The Party directs our country, and is aware of all programs and plans. These programs and plans are not isolated, but must relate to the rest of the state's activities. For example, we cannot produce medications if the mechanical industry, metallurgy, and the chemical industry cannot meet our needs, and we cannot have hospital and polyclinics if the construction industry does not have a program to construct them, etc. Thus the Party has leadership of the entire state, and gives us general directives under which we work, indicating the paths down which we should travel. The government, however, controls all plans and orients us through the Council of Ministers, and the National Assembly of People's Power.

CRC: Does MINSA have responsibility for nutrition and medicine?

Otero: Yes, under the sanitary code we are responsible for control of nutrition from the importation of food stuffs to collective meals in schools. We have many problems rejecting food stuffs in bad condition. We have had to reject large quantities of stored grains. The economic blockade has made this situation difficult. Even in the face of food shortages the Ministry has had to say it was necessary to burn grain or rice and the government has had to accept this. The Ministry's decisions are totally respected, always. We also have control of medicines.

CRC: Are there programs in the country regarding cigarette smoking?

Otero: There has been much research, and much data has been produced about the effects of smoking. In Cuba's case specifically, this Ministry, the government and all state institutions have been enormously concerned with the dangers of smoking. MINSA took the first measures. At the beginning of the Revolution there was a large increase in cigarette consumption by young people. We analyzed this and saw that in the first place, the price of cigars and cigarettes was much too low. On the other hand, distribution of cigarettes, including free distribution, was common, for example, during student work periods and other occasions.

As a result a series of price regulations were instituted that practically eliminated the problem. Now a price of US$2.00 for a package of blond tobacco and, I believe, US$1.60 for black tobacco has been set. Blond is more expensive because it is more popular with young people. Before a package was 10¢ and any child whose parents gave him a dollar spent 20¢ on cigarettes. Now at parties you won't see any child smoking.

CRC: Can children get cigarettes on their ration cards?

Otero: No, only for adults over 18 years of age. What has happened? Since cigarettes are so expensive, children have stopped smoking. In addition, many adults have given up the vice too, because if you smoke a pack a day it's nearly $60.00 a month. So, many people have
given up smoking because of the pricing policy the government put into effect. The fundamental objective of the pricing policy was to prevent smoking for health reasons. There was no economic reason, this didn't represent any gain for the state. In addition, there are anti-smoking campaigns and on cigarette packs there is a warning about the danger of smoking. Great efforts are being made in this area, in the press, on television health and science programs, etc. All our gynecologists-obstetricians discourage pregnant women from smoking. In these ways we have a campaign to combat this problem.

**CRC: Can you explain the international programs of MINSAP?**

**Otero:** MINSAP has large international solidarity programs. We consider ourselves one of the state institutions that has most practiced proletarian internationalism seen in its broadest sense. We have not waited to resolve all of our problems to assist others who have these problems. Since the beginning of the Revolution it has been the policy of the Ministry to help those countries who have even greater needs than ours.

In 1962, we began to help Algeria, who had few doctors, and we have continued to send delegations every year up to this moment. Actually, internationalist medical assistance is given to 18 countries on three continents. In Asia, we help Laos and Vietnam. We aid South Yemen, where we have created a medical school. In Africa, we give help to Algeria, Equatorial Guinea, Guinea-Bissau, Sao Tome, Principe, Cape Verde, Angola, Mozambique, Benin, and Ethiopia. In America, to Jamaica and Guyana. This assistance consists of sending doctors, nurses, and technicians based on the requests and needs of these countries. The recipients don't pay for this assistance, Cuba pays completely. The countries provide the Cuban delegations with living space, and a part of food supplies like fresh foods; the rest is sent from Cuba. Generally delegations stay for one year, and then a new delegation is sent.

We believe that this aid has been very useful both for the recipients and for ourselves. Our doctors grow extraordinarily, it helps them grow ideologically and they can compare different pathologies and needs with ours.

**CRC: How is it possible for a developing country to supply aid to other countries?**

**Otero:** It is very easy because a socialist Revolution exists in Cuba. If there weren't a socialist Revolution we couldn't give this assistance. We are a poor country trying to develop ourselves. But considering that internationalism isn't just talking but doing, we consider that we cannot develop unless the entire world develops. We cannot be proud or feel good reducing our infant mortality rates, knowing that our infants do not die while infants die in the rest of the world and this could be avoided. The policy of our Party and our government is not to wait until we are totally developed to help others, but rather to help the other developing countries as we are developing.

**CRC: How do you select people to go overseas?**

**Otero:** We have problems at selection time because everyone would like to go and we cannot send everyone. If there are no more than two doctors in a unit however, we explain, "You cannot go, we are going to choose from this other hospital where there are four doctors, and from there we can take one."

**CRC: Are the doctors who go Party members?**

**Otero:** Some are members of the Party, some are not. They are all revolutionaries.

**CRC: Why does everyone wish to go?**

**Otero:** The majority of our doctors are young, educated within the Revolution and therefore have extraordinary revolutionary consciousness and are well prepared ideologically. They understand that it is not only important to maintain our people in good health but that the rest of the world needs to be in good health too. They consider they can help, and in this way they do help. And it is certain that they are succeeding because I have visited some countries where we have medical delegations and spoken with the people with whom they are working. I was in Algeria, the Congo, and Tanzania and I could see the feelings of the people of these countries who love and respect the Cuban doctors. In truth, they have done a great job, and, in addition to helping the people, they have been helped in their training as doctors and technicians.

**CRC: In the medical school we were told they are trying to develop a program to train for the work of internationalism**

**Otero:** Yes, because in Africa, for example, there exist a series of pathologies that are unknown in Cuba. Therefore, doctors who return to Cuba after duty abroad can give some training in foreign pathologies. So future doctors can be of more help and service to these peoples. The first doctors who went saw trachoma (a contagious eye infection), and later filariasis (a parasitic worm), which don't exist in Cuba. When they encountered these diseases, they had to go look them up in the books. There was no reason to train doctors for those illnesses which never existed in Cuba. Therefore, we must give seminars to doctors for all these pathologies that exist in Africa or in Asia. Courses are also given to technicians doing international service.
The Revolution Delivers

By Don Sloan

"How do you account for improvements in maternal and infant health in the U.S. over the past 20 years?" I recently asked a medical colleague whom I consider an authority in the care of mothers and children.

"Well, look around us," he said without hesitation. "We are in the electronic age of the monitor, the sonogram and the like—all invaluable aids to our clinical judgement. There are marked improvements in manufacturing processes of antibiotics. Surgical techniques are forever undergoing scrutiny so that operating and anesthesia times are shortened. And . . ."

He went on to laud the enormous technological gains which medical research has provided in recent years.

On a trip to Cuba last fall, I put the same question to a Cuban doctor equally involved in the maternal-infant health field.

"I guess one would start with the gradual elimination of the classes of society," he began. "Our people are raising their general standard of living. Our children are eating more nutritious foods. The importance of being a healthy person is being realized. In order to develop healthy minds and bodies you must eat well, sleep well and live well in general. And . . ."

Comparing these answers, I realized immediately that revolutionary Cuba has made enormous strides in health, not just because it exists in a world of modern medical technology, but because of its attitude toward health care and its place in society. When the triumph of the Cuban Revolution ushered in vast changes in the nation's entire health care system, maternal and infant health became a number one priority—and achievements in this field clearly demonstrate the importance in this new attitude toward health and medical care.

The pre-natal period and the earliest days and years after birth set the pattern for an individual's health status for a lifetime. The care of mothers and children is an area in which much public support and interest can be generated, and a good point to begin teaching the public that health is not just a question of medical care, but includes nutrition, housing, dental care, leisure time—indeed, all aspects of living.

All expectant mothers in Cuba make bi-weekly visits to an obstetric center until late in their pregnancies when weekly visits begin. Both emotional and physical aspects of pregnancy are emphasized by obstetric personnel. Classes in prepared childbirth are offered to all women and scheduled to meet the needs of those who work or have other children to care for. Husbands participate in the pre-partum classes as well as the infant care classes which follow the baby's birth. They are not yet permitted in the labor room, though some Cubans are pressuring for full partner participation in the birth experience.

Nearly 100 percent of Cuban infants are born in hospitals, a marked difference from pre-revolutionary times when maternity services were confined almost exclusively to Havana and a few other large cities. Post-delivery hospital stays average about five days. There appears to be no movement toward "safe alternative" birth settings, like birthing clinics or home delivery, which are gaining acceptance in the United States. Most Cubans, denied access to even the most elemental medical care before 1959, do not find the hospital an oppressive setting, nor do they feel that they are helpless in the hospital, with no control or understanding of what is happening to them there. Since all medical care is free and available to everyone, the enormous differences in the care of rich and poor have disappeared.

Breast-feeding, however, in contrast to the United States and Europe, is almost universal. Infant formula can be obtained only by prescription. Pregnant women are taught both the physical and emotional advantages of nursing—better nutrition and protection against infection on the one hand, closer emotional bonds between mother and child on the other. The Cuban Maternity Law guarantees working women a paid maternity leave.

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* It must be pointed out that these "safe alternatives" are, of course, only safe for those patients who come from that sector of the population which is economically sound, well-nourished and healthy, rather than poor and underprivileged.
of 18 weeks, 12 of them after birth. (New mothers may take another nine months of unpaid leave, after which they may return to work with no loss of seniority.) Arrangements may be made for nursing mothers who work to take time off from their jobs to feed their infants. Recognizing the important nutritional resource which mothers' milk offers, the Cubans are now beginning to establish "milk banks," where milk from lactating mothers can be stored and preserved for us by mothers who may not be able to breast-feed.

One of the most efficiently-run sections in Cuban hospitals are those devoted to newborn services. Despite shortages in other areas of medicine, newborn services are top priority for supplies, equipment and technology--reflecting the understanding that the earliest portion of life is vital to future good health. The death rate for Cuban newborns (during the first 28 days of life) is about 30 per 1,000 live births--about average for the developed world. (The rate is 26 per 1,000 in the United States.)

Revolutionary Cubans inherited a painful legacy of widespread infant and childhood diseases, many stemming from poor nutrition, sanitation and a general low level of health knowledge and conditions. Until 1970, it was still not uncommon to find entire children's wards in Cuban hospitals filled with youngsters of all ages suffering from a variety of intestinal tract infections labeled simply "the diarrheas." For centuries, these ailments were the leading causes of death in children. By 1976, these diseases had been all but eliminated: in that year, the Central Pediatric Hospital of Havana, which recorded over 200,000 patient visits, reported only six deaths from "the diarrheas."

Now Cuban children die at about the same rate and from the same types of diseases as do children in developed nations: malignancies, congenital defects, accidents.

Children from 15 days to 15 years of age receive medical treatment at pediatric centers offering general medical and dental care and acute trauma treatment. A full range of specialty services are available, including dermatology, surgery, nephrology and psychiatry. The infectious diseases so common among Cuban children two decades ago were attacked specifically in these pediatric centers. Antiseptic conditions and antibiotics won part of the battle, but improved nutrition and hygienic practices promoted in the centers played a crucial role.

Mothers are active in the care of their hospitalized children in revolutionary Cuba. In the U.S., a mother occasionally can be found "rooming in" with her sick child. In Cuba, "rooming in," or staying in another part of the hospital used exclusively for patients' mothers, is common. The mothers' role is particularly important in the children's feeding and recreation. Meal times are often communal affairs for patients and mothers. The Maternity Law provides for leave for working women who must attend sick children, and allows time for mothers to take their well children for regularly-scheduled pediatric checkups.

The care of mothers and children in Cuba reflects the attitude that health involves much more than isolated medical procedures and sophisticated hospital care. Health care in Cuba involves the entire community, from the local block organization to the highly-trained specialist. Housing, education, nutrition, work--all play a vital role in building a nation of healthy people, starting from the very beginning of life.
Putting Teeth in the Revolution

By Sam Siegel

A visitor to Cuba today will find fully staffed dental clinics in every urban and rural community. To equip these clinics was no mean feat. Before the Revolution, all equipment came from the United States. Because of the United States' economic blockade, the Ministry of Public Health had to seek other sources. Chairs were imported from Japan, dental units from Czechoslovakia, X-ray machines from West Germany and instruments, from the German Democratic Republic. England and the People's Republic of China were also represented with some sophisticated pieces of equipment.

In 1960 the Ministry Formulated plans to meet the enormous dental needs of the Cuban people. Prior to the Revolution there were no dental facilities at all in the rural areas; almost all dentists were in private practice, with the large majority of them concentrated in Havana. By 1962 the lack of services had become more acute because the great majority of dentists left Cuba. Dr. Ernesto Poussin, head of the orthodontic department at the University of Havana, when asked how he became the chairman of that department, jokingly replied, "There were two orthodontists left in Cuba and I was the oldest."

From the early years of the Revolution health clinics with dental facilities were opened in all sections of the country. These clinics were staffed by new graduates who, as part of their training, spent two years at a rural health center. By 1974 there were 104 dental clinics operating throughout the country with more planned or in construction. These new clinics provide complete dental care, including all the various specialties. The distribution of these clinics throughout the country has insured dental care for all the Cuban people. (See chart 6, page 7.)

New Dental Workers

By 1975 there were 2080 dentists working in public and teaching services, which meant one dentist for every 4600 people. The United States, compared with Cuba, has a most uneven distribution of dentists. There is, for example, one dentist for every 700 people in New York City, but in southern rural areas the ratio is probably one dentist to every three thousand people. In the United States, as in pre-revolutionary Cuba, dentists tend to be concentrated in large cities.

After completion of two years work in a rural area, the dentist, if s/he wishes, can enter one of the specialty graduate courses at the University. The study period for the different specialties, orthodontics (straightening teeth), periodontia (treatments of gums and bones that support teeth), endodontics (root canal), pedodontics (children's dentistry), etc., is two years. Maxilla-facial surgery, involving all surgery of the head and neck, requires three years of study.

Dental care improved steadily after the triumph of the Revolution as more and varied types of para-professional workers became part of the Cuban dental program. In 1961 a one-year course for dental assistants was started. A two-year course for prosthetic technicians was begun in 1972. These workers were particularly important as there were thousands of older people who for years were edentulous (toothless). Now they come to the clinics for false teeth, fabricated by the dental technicians. In 1968 a one-year course for dental equipment technicians was begun, to train workers for the important tasks of keeping the varied equipment in good working order.

A very important innovative step was taken in 1968 to rapidly increase the number of dental workers. A two-year course to train clinical dental technicians was set up using the New Zealand plan as a model. Women between the ages of 15 and 35 who have completed ten grades in school are eligible. (That men are not eligible is probably part of the residue of sexism that still exists in Cuba.) The training equips these women to do many dental procedures, such as fillings, simple extractions under local anesthesia, and prophylaxis. They are also involved in implementing the topical fluoride program (described below). The clinical technicians give school children dental health lectures and tooth brushing instructions. Such a plan would be most difficult to carry out in the United States since most of the above procedures are the "bread and butter" part of the private dental practitioner's income.

This plan allocates one dentist to supervise work with three clinical technicians. The implementation of this plan has further lowered the dental worker-patient ratio to one (dentist or clinical dental technician) for every 3500 people.

Problems and Programs

Solving Cuba's dental problems, if not the most serious of health needs, is still among the most difficult because the population is plagued with a high incidence of tooth decay due, in part,
to the high consumption of sugar. A program has been started to educate the people regarding the harmful effects of excessive sugar in the diet. One can recognize, though, the enormous difficulty of explaining this to a people whose diet has been so rich in this product.

Through the continued growth of the dental health program and the projected fluoridization of the water supply, the Ministry of Public Health hopes in time to effect a reduction in both the number of tooth fillings and of extractions. In 1960, at the beginning of the dental care program, there was a ratio of eight extractions for every filling among the general population; by 1975 the ratio had been reduced to one extraction to every filling. Although this seems like a dramatic improvement, it is in reality minor, since the number of fillings done has increased considerably, and the number of extractions has decreased very little. This means that there are still too many adults with too many missing teeth. This in turn puts an extra burden on the dental personnel to replace those missing teeth.

**Prevention—Hope for the Future**

Children, in particular, are the beneficiaries of the new dental plan as they are assured of dental care from nursery school on. For instance, I witnessed a professor in the endodontic (root canal) department at the dental school demonstrating to the students the finished procedure on an eight-year-old child. The procedure saved four badly infected upper front teeth. This incident is a microcosm of the difference between prerevolutionary Cuba and Cuba today. Before, this child probably would have been uncared for, unless she was part of the privileged minority, and would have lost the teeth at an early age—a tragic start toward "dental cripple" status. In today's Cuba this child was the recipient of the time and the sophisticated techniques necessary to save her teeth. There are dental clinics in most schools—certainly in all the new ones. In the rural areas, mobile clinics are used if a permanent clinic has not yet been established.

The orientation of the entire Cuban health system toward preventive medicine is seen in the topical sodium fluoride program for children. There are two such programs going on side by side. The first presently involves 270,000 children, aged three to five, who attend day care centers. Twice a year, the children's teeth are painted with "Duraphat," a sodium fluoride varnish made in the German Democratic Republic, where it is credited with reducing cavities by 25 percent. For the 900,000 children over five, a sodium fluoride mouthwash is used. So that this program does not interfere with the school day, the children line up in the school yard at 8:00 a.m. Each child is given a small paper cup filled with 0.2 percent sodium fluoride solution. At a signal from a teacher, they rinse with the solution for one minute. This procedure, which is used in Scandinavian countries, is carried out every fifteen days, at least fifteen times each school year. The program has been in use in Cuba for almost four year, resulting in a claimed 35 percent decrease in cavities.

In 1974, in a "curative" program for 240,000 primary school children, Cuban dental workers completed 417,000 fillings, 127,000 extractions and 60,000 cleanings. In 1975, the "curative" program was expanded to reach an even larger number of primary school children. A continuing need is seen for more fillings and cleanings and fewer extractions. Although the number of extractions done each year is still too high, a gradual reduction is a hopeful sign.

This children's dental health program, as it expands and improves, has the possibility of some day producing a generation of adults who will not be "dental cripples," but people with healthy sets of teeth. Preventive programs, that involve the children from an early age, hold the most hope for the future dental health of the Cuban people.

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Overcoming the Diseases of Poverty

By Evan Stark

It was in San Antonio del los Banos Polyclinic in Havana. Some 30 women met our small delegation of health professionals outside the clinic and led us through the crowded waiting room up a stairway to what was apparently the main meeting room for the medical staff. Several physicians were introduced. But during the next few hours, our excited dialogue was with the patients, medical and public health workers, and with the members of the Federation of Cuban Women (FMC) who filled every visible space. To the U.S. eye, schooled in the sharp social demarcations between physician, health worker and patient, the scene appeared chaotic. Actually, our reception symbolized the fact that the full participation of the Cuban people in health delivery and planning is the key to Cuban health care.

The Cubans' progress in health would be impossible were it not for the fact that health is a living priority for the Cubans about which there can be no compromise. This article will examine the connection between mass participation in health care and improvements in health and then take a brief look at the new health problems the Cubans must confront now that they have all but overcome the diseases of poverty and colonialism. There are no guarantees that the road chosen by socialist Cuba will lead miraculously to cures for cancer, heart disease or other so-called "diseases of progress." But if we in the United States have learned anything in the last decade from the failure of our medical system, it is that illness cannot be approached piecemeal, but only as a social problem requiring a social solution. By combining mass participation and the integration of health into overall social development, Cuba has come a long way towards such a solution.

The magnitude of the Cuban achievement can easily be underestimated. According to the official statistics of the Cuban Republic, in 1958 Cubans were well off, at least as compared to other Latins. Per capita income, somewhere around $500 a year, was higher only in Argentina and Venezuela, and Cubans had more telephones, TV's and cars than the vast majority of Latinos. This "average" prosperity was reflected in a decent level of "average" health. Average caloric intake seemed adequate. There had been no outbreak of smallpox or yellow fever since 1905. The main killers of the past, tetanus, typhoid and malaria, had declined substantially, and infant mortality, about 111 per 1000 live births during the depression years (1928-32), was down to 57, or about what it was for nonwhite Americans in 1970.

Like virtually all Batista statistics, however, these figures are suspect. Moreover, in highly stratified societies, the average is a statistical device that can easily hide the poverty of the vast majority. In fact, the real income of Cubans in 1958 was little more than it had been in 1920 and, proportionately, there were actually fewer youngsters in school. The relatively high caloric intake was mainly due to sugar and starch consumption and thousands of youngsters still died from acute diarrhea and malnutrition. Indeed, 40 percent of the population died before the age of 50 from gastroenteritis, tuberculosis, tetanus, diptheria, "accidents," typhoid fever, malaria, typhus, polio and influenza. And, though official statistics showed a doctor-patient ratio of one to 1000 (compared to one to 1900 in Mexico, for example), since these doctors were mainly in Havana and only available at fees beyond the means of most Cubans, the actual ratio is more closely approximated one to 15,000. The average Cuban's income was still only one-eighth that of U.S. residents.

Colonialism

Still, the statistics do make one point, namely that health problems in Batista's Cuba were due to something other than an inherent lack of economic and social resources. The fact is that in 1958 most Cubans died from diseases that had more to do with colonialism than with parasites, germs or environmental contaminants peculiar to the tropics. Or, to be more precise, it was the distorted pattern by which Cuba's human and economic resources had been developed and distributed, not lack of development per se, that made people unhealthy.

The needs of the multinational corporations determined the investment in health of the Cuban government and its business sector. The multi-
nationals in Cuba cared about the health of their most essential laborers, those in the middle classes—hence, hospitals were built in urban labor markets and few public health facilities were available for rural families. The multinationals were concerned with a high and speedy return on investment—hence, little was invested in preventive health, or in education, nutrition, housing or other services essential for the long-term improvement of the work force's health. In 1959, the population remained largely illiterate and wholly dependent for the most basic health information on local superstition and the official media of the comprador government.

The present U.S. trade embargo of Cuba prevents crucial medical supplies and research findings from reaching Cuban physicians, but it is far less effective than was U.S. domination of Cuba in denying the majority health benefits, which could have accompanied a just redistribution and reinvestment of the wealth their own labor produced. The pattern of disease in Cuba prior to 1958 reflected and supported the pattern of exploitation. And it is the reversal of this pattern of exploitation, more than any other factor, that has led to improved health in Cuba since 1958.

Today, 80 percent of the Cuban population live past the age of 50 and life expectancy at birth is 70 years. In African countries with the highest per capita income, life expectancy is little more than 50 years. And in Venezuela, with the highest "average" wealth in Latin America, average expectancy is only 64 years. Among Cuba's immediate neighbors, Mexico has a life expectancy of about 62 years, and Haiti's is only 45 years. In the U.S., meanwhile, average life expectancy is 71 years, though it is only 65 for men and far lower for nonwhite men.

The material basis for improved life expectancy has been provided by the equitable redistribution of social goods and services—e.g., food stuffs, housing, education, transportation and medicine—and by the integration of isolated communities and regions into overall economic and social development. In the past, the isolation of many segments of the population from the economic mainstream led to high rates of infant mortality—due particularly to malnutrition and a failure to identify potential problems early in pregnancy—and to excessive deaths from infections that could have been prevented or cured. The single most important change since 1958 is the decline in infant and childhood mortality caused by malnutrition, infection and inadequate medical attention. In addition, this decline reflects improved sanitation, domestic and institutional hygiene and post-natal maternal education.

In 1962, there were 6000 fetal deaths, that is 24 for every 1000 births. In 1976, there were just under 2100 fetal deaths (11.2 per 1000 live births).
Lowest Infant Mortality

Overall infant mortality in Cuba has dropped from approximately 37 per 1000 live births in 1958 to 23.6 in 1976, the lowest in Latin America. Again, in non-socialist countries the health gains associated with high per capita income are vastly unequal for rich and poor. While infant mortality on New York’s wealthy Park Avenue is far lower than Cuba’s—about 11 deaths per 1000 live births—among lower-class, non-white and inner city U.S. residents, infant deaths are higher than Cuba’s and in some cases, among Newark, New Jersey’s black population for example, twice as high. In Cuba, though small differences persist between city and countryside, the "average" approximates the norm.

In just a decade, gastroenteritis has changed from the number one cause of infant death (approximately six per 1000 live births) to 2.1 per 1000, the fifth leading cause. Throughout the rest of Latin America, Africa and Asia of course, rates for gastroenteritis are tragically higher.

The decline in childhood death has permitted the population to increase from approximately six million to nine million since the triumph of the Revolution.

Tuberculosis, the major killer of adults in 19th century Europe and the United States, is spread by poor nutrition, bad housing, urban crowding and unsafe working conditions, as well as by inadequate medical care and minimal public health. Not surprisingly, T.B. persists in virtually every poor country. In the U.S., the decline in the death rate from T.B. at the end of the 19th century accompanied the improved standard of urban living. And, by 1958 in Cuba, death from T.B. had been cut to 20 per 100,000, though among the poor, rates were far higher. It is a tribute to Cuba’s subsequent development as well as to the redistribution of gains that by 1976 the figure had been reduced by another 90 percent, to only 2.7 deaths per 100,000, approximately what it is in the U.S.

Malaria killed 3500 Cubans as recently as 1962. By 1968, however, the disease had been eliminated. In their attack on the anopheline mosquito, the Cubans combined widespread DDT spraying with a mass campaign to prevent a recurrence of the disease. In other countries such as Mexico and India, where the spray was employed without mass participation in followup, malaria has reappeared, carried by a mosquito that is immune to DDT.

Vaccination has been successfully used--again in combination with mass campaigns--to eliminate diphtheria, typhus and polio, health problems that are still endemic wherever there is poverty and colonial dependence.

For every death from tetanus today, there were 20 a decade ago. In 1959, there were 13 times as many Cubans killed by typhoid fever than there are today. And remarkable progress has been made against measles, whooping cough and maternal deaths in childbirth. By legalizing abortion and making it readily available, deaths during this procedure have been reduced by almost 90 percent, to just 15 a year.

By 1958, though the "average" health in Cuba was better than averages elsewhere in the Third World, the majority of deaths were still due to "the diseases of colonialism." Today, as Table I indicates, Cuba has the health profile of a "developed" country and Cubans die from the same diseases we do in the U.S. While this is hardly an unmitigated blessing, for Cuba it represents a major gain.

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*estimates

Social Solutions

Most writing about Cuban health has emphasized the relative contributions of medicine, public health and economic change (better housing, steady and safer work, redistribution of income etc.). And to an extent, this emphasis is well deserved. Early identification of disease and the use of vaccination were central to the

*The Cuban victory over malaria is even more remarkable when we realize that during this same period elsewhere in the Third World incidence of the disease increased dramatically. In India, for example, after a slow increase from 1962-69, it expanded from 349,000 cases (1969) to an incredible 4,200,000 in 1975. The decision by international health agencies and Third World governments to substitute "control" efforts for attempts to eradicate malaria reflects the impossibility of technologically conquering a disease whose spread is caused by poverty and malnutrition without, at the same time, ending poverty and malnutrition themselves.
struggle against polio, diphtheria, tetanus and typhus; and economic improvements, with their concomitant effects on nutrition and hygiene, contributed significantly to the reduction of fetal death, maternal and early childhood death and death from T.B., gastroenteritis, and so forth.

But we must remember too that much of the improvement in health took place before 1970, when the medical system was still in upheaval, when medical education was barely back on its feet, before maternal and child care had been rooted in efficient polyclinic programs and while the housing shortage was even worse than it is at present. To fully understand Cuba's health achievements, therefore, we must look at the most fundamental source of Cuba's gains since 1959, the revolutionary process itself.

The anti-polio campaigns illustrate how the revolutionary process links health to medical and economic development.

Mass Campaigns

As the most numerous and inclusive of the mass organizations in Cuba, the Committees for the Defense of the Revolution (CDRs)* were charged with the internal defense of the country and this has increasingly included its health. The first anti-polio campaign took place just before the April, 1961 Bay of Pigs invasion and was tied to internal defense in order to combat rumors spread by counter-revolutionaries that the intent of vaccination was to "brainwash Cubans to become Communists." But when mass participation was first discussed, many prominent officials were skeptical about the potential contribution of community-based organizations. Only when it became clear that a professionally administered, exclusively technical approach would fail was the reliance on the CDRs fully accepted.

At municipal, provincial and national levels, representatives from the Ministry of Public Health (MINSAP) met with CDR representatives and with technical representatives from the polyclinics. The doctors explained the intended vaccination procedure and defined the "at risk" population (those in greatest danger of getting polio) as all children under four. The CDR representatives determined how many children there were in their geographical areas and specified how many they hoped to reach and in what time period.

At a national meeting between MINSAP and the national leadership of the CDRs, specific dates for the campaign were set and the means of mass education were approved. Then preparation began, and the posters and slogans that had been approved were employed through every medium (including, of course, the other mass organizations)** to popularize the national goals. The polyclinics prepared the vaccine packages for distribution and the designated health representatives of the CDRs distributed the vaccine to their members. The original campaign took five days, with 85 percent of the target group vaccinated on the first day. Today, the entire at-risk population is vaccinated in just four hours and with an effectiveness that has been estimated by follow-up surveys (also carried out through the mass organizations) at 98 percent. To appreciate this achievement, remember the difficulty the U.S. Public Health Service had defining, let alone vaccinating, the at-risk population for the nonexistent swine flu epidemic of 1977.

The campaign succeeded only because it was accompanied by changes that went far beyond efficient distribution of medicine or coordination with the polyclinic teams. After the revolutionary government triumphed, there was a dearth of medical personnel, an absence of local leadership and widespread illiteracy. No effective program in preventive care was possible until these problems were confronted. Hence, the leadership shown by the CDRs during the anti-polio, anti-typhus, or anti-malaria campaigns was predicated on prior gains in literacy education and political participation.

The national goals in health could only be met in the process of overcoming the myriad of local inequities, particularly in the most backward areas, left over from pre-revolutionary days. Each "medical" problem was quickly shown to have a "social" solution. The paucity of laboratories and technical personnel in rural areas increased pressure to overcome rural/urban differences and to integrate rural workers in high-quality training programs. Horses were necessary to carry the polio vaccine into remote villages; when health representatives of the CDRs complained that these were in short supply, local representatives of the Party helped remedy the situation. To store vaccine, refrigerators were needed where before

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*The Committees for the Defense of the Revolution were founded in September, 1960, as vigilance committees when sabotage, terrorism, assassination attempts and military attacks were a constant threat. Today, the CDRs comprise the largest mass organization in Cuba, including 80 percent of the population over 14 years of age. Although they continue to have a security function, CDR activities range from neighborhood health campaigns and block beautification to organizing voluntary work brigades. (See "CDRs: Security and Service," CURA Review, Vol. VII, No. 3, Oct., 1977.)

**Cuba's other mass organizations are the Federation of Cuban Women (FMC), the Central Organization of Cuban Trade Unions (CTC), the Association of Small Farmers (ANAP), the Union of Pioneers (children), the Federation of University Students (FEU) and the Federation of Students of Intermediate (secondary) Education (FEEM).
Problems of Development

There is irony in the boast frequently heard from Cuban health planners that we can tell how much progress Cuba has made since the Revolution because Cubans now die from modern diseases.

For persons over 50, heart disease has become 15 percent more common as a cause of death just in the last four years. And cancer and stroke are taking their toll. Nor is this simply because more Cubans are living into old age. The so-called "chronic" diseases—heart diseases, cancer, hypertension, arthritis, etc.—are rising far more rapidly than the numbers reaching old age. And the age at which people are dying from hypertension and heart attacks is dropping.

We must quickly add that the entire industrialized world is experiencing these same trends and in most cases far more dramatically than is Cuba. In the U.S., for example, due primarily to deaths from alcoholism, accidents, suicide and homicide, the likelihood of a white male of 15 reaching his fiftieth birthday is about the same as it was 50 years ago. In Cuba, meanwhile, among young and middle-aged workers (15-49 years old), accidents are now the third major cause of death. And, among this same age group, the suicide rate has been climbing since 1970 (from 17.3 per 100,000 in 1972 to 22.1 in 1976) and the rate of venereal disease has risen sharply since 1972. And, perhaps the greatest irony of all, health planners estimate that 15-20 percent of all Cubans are now suffering from overweight!

The explanations for this pattern are not nearly so easily established as the figures themselves. To some extent, these increases are the result of more efficient systems for detecting and reporting health problems. The gynecological norms that govern the polyclinic require every woman to be regularly screened for cervical cancer. If a woman misses her annual checkup, she will be contacted by her CDR or FMC health representative. Through regular prevention-oriented checkups at the polyclinics, hypertensives can be identified early and, again with the help of the health representatives, monitored approximately every three months. In pre-revolutionary and traditionally Catholic Cuba, suicide and venereal disease, like mental illness, could, if publicly known, disgrace an entire family. Today, these are treated as social issues which need to be reported and carefully studied, not as "private."

Housing, Smoking, Stress

Other aspects of economic progress create social contradictions with implications for health. The increased percentage of young people in the population and their new sense of independence aggravates the housing shortage—preventing these young workers from living apart from their families prior to marriage—and threatens the three generational structure of the traditional Cuban family. The healthy desire for full sexual life—on the part of newly liberated women as well as men—is as yet unmatched by a vigorous national program for sex education. Liberal access to medicine in heretofore deprived districts contributes to an increase in accidental death and, perhaps, to suicide.

But, there are other factors which contribute to the new health profile as well. Increasing the domestic cost of cigars and cigarettes has not significantly reduced smoking in Cuba and smoking contributes directly to heart disease, cancer and a range of upper-respiratory ailments. The high sugar ("quick energy") diet has been implicated in heart disease and in a number of cancers. And reckless driving, self-inflicted violence and sexual irresponsibility all contain elements of traditional machismo.

Then there is "stress," an amorphous factor which many epidemiologists now believe may be a key to a host of high blood-pressure ailments (e.g., hypertension, stroke and heart disease) as well as to a number of persistent pathology-producing behaviors such as smoking, reckless driving, over-eating and carelessness on the job. The consequences of stress appear to be as diverse
as its roots. Pollution, over-crowding, urban noise, the disappearance of traditional rural communities due to urban migration, piece or time-work, individual competitiveness on the job, divorce, competition for grades in school—all these stress factors are prominent, and all persist, to some extent, in Cuba. Even such an obviously positive factor as the Cuban enthusiasm for socially productive work may, if it is allowed to extend beyond certain limits, create harmful stress, because of its effect on family and personal life, and result in illness.

Traditional medicine and public health measures, even when supplemented by the social service and mental health professions, have been largely ineffective against this modern array of health problems. At the very least, comprehensive changes in individual behavior and lifestyle are required. At most, the design of work and leisure and their relation to each other must be considered and modified.

In the capitalist world, the failure of technological medicine has led to "victim blaming," telling individual patients that their health problems derive from personal "irresponsibility." In Cuba, where widespread individual pathology is assumed to require a social solution, health planners are increasingly aware that the new health problems demand a new integration of medicine, public health, economic development, and the revolutionary process.

This new integration is already in its formative stages. Since MINSAP sets standards for caloric and nutritional intake, it can exert an important influence on nutrition as well as on the distribution of foods and medicines. The CDRs and FMCs are already involved in "mass" research on heart disease and hypertension. And, since the national health census is carried out through local chapters of the mass organizations, Cubans are aware of common health problems and discuss them, even before a national program has developed. Each polyclinic includes an epidemiologist on its staff and clinic data, presented at regular meetings to medical staff and health representatives from the community, can be acted on in a comprehensive rather than a piecemeal fashion. And, through the census, it is possible to learn if problems identified at the polyclinic level are specific to a single region or require a comprehensive redirection of national resources.

In the U.S., it may be decades between the discovery that a particular substance or occupation is hazardous to worker health and preventive action. Indeed, U.S. coal operators still deny the association between black lung disease and coal mining, and miners must be compensated on an individual-to-individual basis only after they are far too sick to enjoy life. In Cuba, once sufficient health information has accumulated to indict a specific occupation or work process, the facts can be speedily relayed to factory managers. Popular participation of the mass organizations in health care and in work helps insure rapid compliance.

Even with mass participation in the planning process, there is no guarantee that resources already invested elsewhere will be diverted to meeting pressing health needs. On the other hand, given the democratic nature of Cuba's health planning and maintenance process, it is impossible for MINSAP to ignore, as has the National Cancer Institute in the U.S., widely accepted links between social and economic conditions (the so-called "environmental determinants"), life-style and disease. Cuba has made health a priority and, on this point, it refuses to compromise.

In-patient pediatric care.

Now that the Cubans have all but eliminated the diseases of colonialism, they can turn their attention to the important nonmedical determinants of the modern afflications. In this area, where work satisfaction, community solidarity and social participation in all crucial decision-making processes have been held up even by U.S. epidemiologists as keys to improved health, Cuba's revolutionary process may make the difference between effective and ineffective prevention. That is to say that with the modern diseases, even more than with infant maladies and infections, the direct participation of the Cuban people may be the key that opens a door health researchers throughout the industrial world have been waiting to go through for some time.
By Manuel Gomez

Starting in 1959, the Revolution made a solid commitment to provide safe and healthful working conditions for all. This commitment has grown over time. Cuba's State Commission on Science and Technology (Conite Estatal de Ciencia y Tecnica), the country's top scientific policy advisory board, officially considers "the workplace environment and its relationship to health" as one of the government's eight priority biomedical areas. As a result, today Cuba is in the forefront among developing nations in occupational health and safety programs.

As in other public health areas, this emphasis hasn't always existed. Before the victory of the Revolution in 1959, private insurance programs covered only a small number of workers in the industrial and service sectors. Agricultural workers lacked any coverage. Although some minimal safety, health and compensation codes existed on the books, they were widely ignored by both corrupt government agencies and private industry. Social security programs to assist permanently disabled workers were splintered among countless agencies, highly disorganized, and notoriously deficient. The country had, in brief, no national health and safety policy or plan. Soon after 1959, basic changes began to take place when the MINSAP founded the Department of Occupational Medicine (Departamento de Medicina del Trabajo) under the Vice-Ministry of Preventive Medicine. The newly created Department began the gradual development of provincial and regional laboratories equipped to detect and measure toxic contaminants in samples of air collected in workplaces as well as in the blood and urine of workers exposed to such contaminants. These labs now operate throughout the country. The Department also directed its efforts to reorganize factory inspection services with an emphasis on better training for old and many new inspectors, for union representatives, and for specialized scientists who were practically nonexistent before the Revolution. As a result, inspections to detect health and safety hazards are now carried out monthly in all workplaces with more than 500 workers, and approximately every six months at smaller sites. They are conducted by sanitarians (technicians with three years of specialized training) from the area's polyclinic or health center, and/or by the safety and health representatives of the trade unions. In certain instances, more specialized workers with university training in the detection and evaluation of occupational health hazards, equivalent to industrial hygienists in the U.S., perform these inspections, although such specialists are still few in number. Most of the inspections are necessarily limited to walk-around type surveys because sampling equipment to measure health hazards such as dust, noise or radiation is still scarce.

Training For Safety

MINSAP also sought to increase the participation of workers and trade unions in the health and safety arena. By 1972 some 4500 workers had been trained to be health and safety representatives in their workplaces. When new technology is purchased from socialist countries, Cuban engineers and technicians often train in these countries to handle the new equipment. Union safety and health representatives accompany these trainers to learn the hazards of the new technology and how they can be prevented. For example, in early 1978, I visited a major cement plant under construction in Cienfuegos from which two trade union representatives had been sent to the German Democratic Republic to study the prevention of the hazards in a similar plant already in operation.

Toward the end of the 1960's, MINSAP began to develop a program of priority medical attention to certain groups of workers, choosing them according to three criteria: the number of workers in the workplace; the potential risks of working conditions, and the importance of the workplace in the country's economic development.

Workplaces designated as a priority number approximately 500, including mines, metallurgical industries, ports, and other important industrial sites. Each priority workplace is assigned a medical team by MINSAP's Medical Service of Industry and Work. The teams include a physician and other personnel with special training in preventative-curative occupational health services. Smaller workplaces are provided with proportionally fewer hours of direct medical attention, ranging from a part-time physician to a small first aid station.

Preventive medical practices are a major
thrust of MINSAP's occupational efforts. All Cuban workers receive a pre-employment physical exam, as well as periodic exams every six months or every year, according to the nature of their work. The exams include appropriate special tests. For example, agricultural workers exposed to lead and other toxic metals are monitored with special biological tests. In 1975, MINSAP laboratories performed nearly 70,000 determinations of various hazardous contaminants in biological fluids.

Many new hazards are now appearing in Cuba's agricultural industry. Increased mechanization creates dangers of serious injuries with powerful equipment, and the widespread use of fertilizers and pesticides exposes many workers to a variety of toxic substances. MINSAP consequently has devoted increasing attention to the health and safety of agricultural workers. In the sugar industry, for example, there were 68.2 accidents reported per million person-hours worked in 1967, with an average time loss of 50 days per accident. MINSAP together with the Ministry of Labor and the trade unions mounted a forceful campaign which reduced these figures to 16.5 and 17.5 days respectively in 1975. MINSAP also heads a National Commission on Pesticides (Comisión Nacional de Plaguicidas) composed of 25 different agencies. The Commission supervises the control of occupational risks involved in the use of pesticides, from application to harvesting, as well as environmental risks such as water pollution and hazardous residues.

The early 1970's also brought an increased interest in training a larger number of specialized scientists, including physicians, engineers, chemists, toxicologists (specialists in the study of toxic substances), psychologists and others. Many of them have been trained with the help of the socialist countries, especially in the Soviet Union, Bulgaria, and Romania. Cuba, however, has also developed its own training capabilities. The first two fully Cuban-trained specialists in occupational medicine graduated in 1976 and some 40 other physicians are now doing post-graduate training in the same specialty in medical school. By contrast, the U.S. has only about 30 physicians specializing in occupational medicine per year.

In 1976, MINSAP established the Institute of Occupational Medicine (Instituto de Medicina del Trabajo) to "study the most frequent risks of our working population and to establish the fundamental measures for their control." The Institute houses numerous scientists conducting research on Cuba's workplace hazards and providing consulting services to the entire country. The Institute also plans to develop a system of national record-keeping and statistics. It has already presented a number of research findings at international conferences. One of its most far-reaching steps, however, was the drafting of a new national Law on Occupational Safety and Health (ley de Proteccion e Higiene en el Trabajo), which Cuba's National Assembly adopted in late 1977. This legislation brings under one legal umbrella all matters of safety and health; it strengthens mechanisms for the participation and education of workers with regard to these issues, and it helps to define the responsibilities of different government sectors, or sectors of industry in occupational safety and health.

Cuba is a rapidly developing country. Tensions exist between industrialization and economic growth and the health and safety needs of the working population. The earlier example of accident rates in the sugar industry illustrates one such tension because the high rates coincided with a massive national drive to increase sugar production which culminated in 1970. The government recognized the problem and took measures which dramatically reduced accident rates in subsequent years.

Tensions are addressed in other ways. Cuban enterprises can lose the awards that go with productive successes if they show poor safety and health performance, indicating that moral incentives are used with the health and safety of the workers very much in mind. Cuba is now undergoing important changes in the organization of its economic system. How these changes will affect the manner in which safety and health performance is tied to moral and material incentives is uncertain. But it is clear that the Cubans are committed to providing safe and healthful working conditions for all.

### Cuban Constitution on Work

Article 45. All those who work have the right to rest, which is guaranteed by the eight-hour workday, a weekly rest period and annual paid vacations.

The state contributes to the development of vacation plans and facilities.

Article 46. By means of the Social Security System the state assures adequate protection to every worker who is unable to work because of age, illness or disability.

If the worker dies, this protection will be extended to his family.

Article 48. The state guarantees the rights to protection, safety and hygiene on the job by means of the adoption of adequate measures for the prevention of accidents at work and occupational diseases.

He who suffers an accident on the job or is affected by an occupational disease has the right to medical care and to compensation or retirement in those cases in which temporary or permanent work disability ensues.
Focus on Mental Health Care

This article was prepared by Margaret Gilpin with material provided by Lic. Lourdes García, Chief of the National Group in Psychology at MINSAP, Havana, Cuba and by Guillermo Barrientos, M.D., Chief of the National Group of Mental Health, MINSAP and Professor of Psychiatry at the University of Havana.

Q. How are mental health services related to the national health care system in Cuba?

A. Psychiatric and psychological services form an integral part of the national health care system under MINSAP. These services are connected to the system at several levels, through polyclinics in the community, through municipal and provincial hospitals, and through national research institutes. Psychology and psychiatry as disciplines have the same structures as the medical specialties. At the top, a national advisory group (the National Mental Health Group) establishes technical and professional standards. At the provincial level the application of those principles is designed according to the special features of each province. Then come municipalities within each province, and finally the local level where front line work is carried out. It is there that the shortage of personnel in the mental health disciplines, not all provinces have provincial groups or staff. At the local level there is also insufficient staff to form groups representing all the mental health disciplines. As a result, a single mental health professional rather than a multi-disciplinary team may act as the advisor.

The structural organization of the National Group in Psychology was instituted in 1968. At that time MINSAP employed only 15 graduate psychologists. There are now 225 psychologists working for MINSAP and an additional 208 psychiatrists. However, this is still not enough to provide universal coverage throughout the country.

Q. What kinds of services are available to people with psychosocial problems?

A. At the local level out-patient treatment is offered in the polyclinics. Other services available to the people of Cuba include emergency room services at the level of the municipality or the province. Many of these emergency rooms provide crisis intervention services as well. Short term psychiatric hospitalization is readily available through the Departments of Psychiatry in general hospitals. These departments also provide partial hospitalization programs. Psychiatric day-hospital programs are available in many localities. These are community based, rather than functioning out of general hospitals. Inpatient psychiatric hospitals provide short or long-term stays for patients. The psychiatric hospitals, in conjunction with inpatient services, run rehabilitation programs which, although they are located at different sites, provide services for discharged patients.

Fewer Admissions

Q. Has there been any change in the incidence of hospital admission for psychiatric patients since the Revolution?

A. The creation of short-term hospitalization, partial hospitalization programs, and day hospitals has produced a decrease in the number of patients requiring admission. We have instituted out-patient treatment for patients with "neurotic" conflict. The rate of readmission to psychiatric hospitals has been reduced as has the length of stay. The tendency toward admission of older people to psychiatric hospitals has also been reduced. On the other hand, there have been no changes in the numbers of admissions for persons labelled "schizophrenic." The prevalence of "schizophrenia" in Cuba approximates that of the rest of the world.

Q. How do people with problems get mental health services?

A. There are a variety of ways a person can enter the mental health system. The most common is self-referral, frequently through a primary care physician at the local polyclinic. This physician may then seek "interconsultation" for an identified problem with the staff psychologist at the polyclinic or with the psychiatrist who regularly attends the polyclinic from four to eight hours a week. Through this system of interconsultation a treatment plan will be developed. Generally speaking, the primary care physician will call for an interconsultation with the psychiatrist if s/he suspects organic involvement or psychosis; if the problem involves children or is "neurotic" s/he will call for an interconsultation with the psychologist. Psychologists tend to work more closely with pediatricians, and psychiatrists with internists.
In cases of psychiatric emergency, people can go to existing emergency psychiatric services in general hospitals. Any hospital service can refer patients directly to the psychiatry service.

Q. How does the community—and particularly the mass organizations—assist in the care of people with emotional problems?

A. Participation of the community occurs through the mass organizations which follow programs established and coordinated at provincial and municipal levels for health care in general. For the nation as a whole, however, no formal program exists and so there is no single model. Some municipalities have recently begun to establish programs in coordination with People's Power. At a more informal level, people from mass organizations frequently serve as a support system for people in need. For example, they may provide organized support for those suffering from the isolation that often results after a death in the family. Members of mass organizations also play a significant role in the rehabilitation of psychiatric patients when they return to the community from the hospital, and they help returnees from jail to re-adjust and re-incorporate into community life.

Q. What is the philosophy regarding the use of psychotropic drugs and medications for the mentally ill and for people with emotional problems?

A. We conceive the human being as a bio-psychosocial being and, in that context, mental illness is the same as any other illness that affects one or another aspect of the person. We accept the advances of bio-chemistry for all illnesses. It is therefore easy to determine the use of psychotropic drugs in the same way one would determine the uses for any medication (i.e., antibiotics or cortisone, etc.). In all of these regimes the principles of medical ethics, the principle of good or bad usage enters the question.

Q. What safeguards and protections exist for psychiatric patients regarding their rights with respect to admission and discharge from an in-patient psychiatric service?

A. With the exception of cases in which a serious crime had been committed (i.e., a felony) there is no compulsory psychiatric hospitalization in Cuba. In cases of a felony an expert judgment must be issued within a 30 day period. A person who is declared mentally incompetent falls under the jurisdiction of the psychiatric hospital where s/he is cared for. The hospital determines the time for discharge. In such cases the family of the mentally incompetent person can petition for release into their custody. If a person is functioning at the "neurotic" level and is considered responsible (for acts) before the law, s/he can solicit her/his own release. In both cases the doctor in charge of the patient must give an opinion and is required to explain that decision to the family and to the patient, even though the patient, if legally incompetent, cannot overturn the result.

Q. Will you describe training for mental health personnel, the kinds of training methods, schools of thought, etc.?

A. For the medical doctor, residency in psychiatry is defined as a time exclusively dedicated to psychiatry and the resident must go through a specific program of activities and basic materials. No single school of psychiatric thought is followed and individual professors set different standards for different services. Residency in psychiatry lasts for three years, with examinations at the end of each year. The resident is required to complete a thesis, and a state board examines this work at the end of the third year. In child psychiatry the graduating medical student does an internship in pediatrics and the rural service requirement in pediatrics as well.

Psychologists are trained at the Faculty of Psychology at the University of Havana in a five year course. Required subjects include: biology, neuroanatomy, physiology, the history of psychology, general psychology (motivation, cognition, learning theory), developmental psychology, social psychology, psychopathology, techniques of psychodiagnosis, research methodology, logic, statistics, political economy and psychotherapy. First and second year students work for two months in various institutions as research auxiliaries. In the last year they spend one session a day in a service in their area of specialization. All psychology students study the major schools of thought in the field, and they get solid training in Marxism. Areas of specialization in psychology include: clinical psychology, educational psychology, and social psychology. Psychometricians study for three years at the National Training Unit in Health. They are trained to work with groups, to gather data for research, to conduct psychological tests, and to do some statistical work. During their last year of training they do a practicum at the three levels of health care.

Q. What major problems still exist in the organization and delivery of mental health services?

A. We have not yet achieved equal coverage for all of the population, and we need better distribution of services within the 14 provinces. There are still only two training sites for psychologists, one in Havana, the other in Villa Clara, leaving the western provinces less well attended.
A Stay in a Day Hospital

By Bobby Salamanca

The following article appeared in the Cuban daily newspaper, Granma, on June 16, 1974. It recounts the experience of a well-known Cuban journalist who was treated for a time in a psychiatric day hospital.

"You need to be a day patient at our hospital," the doctor told me after listening to the synthesis of the psychological conflict that had taken me, for the first time in my 42 years, to see a psychiatrist.

Stated that way, without any preamble, the suggestion set me to shaking all over. "So he thinks I'm that bad," I thought, horrified. But my state of nerves didn't allow me to protest. I had gone to the Joaquin Albarran Department of Psychiatry, in Havana, to tell the doctor my troubles, that was all. I had thought my doing that would serve as a kind of cure-all. But I found it isn't all that easy.

"OK," I answered, somewhat dazedly.

Shortly afterward, we left his office and went along a passageway to the patio and then along a flower-bordered stone walkway past the inpatient ward to the rear of the hospital and the day patient ward, the "day hospital." It was 2:00 p.m. on December 20, 1973. There were around 15 people sitting in front of the ward, talking. Not all were in the main group (later I learned that this is generally done to analyze their respective conflicts). I was introduced to the nurse, who then introduced me to a comrade on the reception committee, which is composed of patients. This comrade told me the hospital's rules and how things were done there.

"You'll be here Monday through Friday, from 8:00 a.m. to 4:00 p.m. You can't enter the hospital after 8:00, and you can't be absent without a good reason. In the mornings we have two hours of productive work and two of sports or recreation. Lunch is at 12:00. Then we have two hours for resting, and group psychotherapy at 2:00."

"You can start tomorrow," the nurse answered when I went to ask when I should come in. And immediately added, "But if you want to get the feel of things, you can stay here this afternoon to observe a group psychotherapy session."

I agreed and she suggested that I go with the comrade from the reception committee to the little patio where the group was talking. I followed him as if I were being dragged along by the hair. My spirits sank a little. To be more exact, they plummeted like a stone. And it was at that moment that he, raising his voice so everyone could hear, told the group, "Comrades, here's a new patient, Juan Antonio Salamanca."

I went cold all over. Then my blood returned full force, racing hotter than ever, and my face turned red. Blushing and ashamed, I returned the collective's greeting and sat down a little apart from the others. It seemed to me they were whispering among themselves. Then one of the group got up and came toward me resolutely. Without any beating around the bush, he came right out with his question, like a slap: "Aren't you Bobby Salamanca, the sports commentator?"

I wished fervently that the earth would open and swallow me, chair and all. I wanted to tell him that I was my cousin, that we only looked alike or that it was simply a coincidence that we had the same last name. But I knew it was no use. I had to be accepted on my own merits.

So, "yes," I answered, wrapping the admission in a grimace that tried desperately to be a smile.

That first day, after taking part in the group therapy session, I decided not to come back. "I'm not going to sit there and talk about my problem in front of all those people," was the idea that kept going around and around in my head as I left the hospital that afternoon. I spent the night tossing and turning. Morning finally came. "I'm not going, I'm not going," I kept saying over and over. But, in spite of myself, I finally jumped out of bed, dressed in a flash, and in a matter of minutes I was on my way to the hospital.

The experiences I've gained during my two and a half months as a day patient will be of inestimable value to me for the rest of my life. You go into the hospital thinking that your real problem is your present conflict. And, in the majority of cases, this isn't so. The crisis is the result of the sum of all the problems you've accumulated throughout your life and that you thought you had solved. It's like a series of bombs that you thought had been deactivated and that now blow up all at once. Your present conflict isn't just the drop of water that makes the cup run over, but the drop that bursts the bottle....

First Experiences

Today it's Comrade X's turn to "make with psychotherapy," to use the terms of the initiate. Weeks before, we had had a similar welcome, and perhaps he, too, had decided not to come back. I sat down in the center of the group and told...
us the most important details of his life for about an hour and a half. In front of him were a psychiatrist; a psychologist; and the members of the group, which now numbered from 30 to 35 patients. Sometimes, a patient's story progresses chronologically; sometimes it jumps all over. In general, this depends on the patient's ability to express himself. When asked if he's finished, he often talks a little more. Often, he says, "Oh, I forgot to say that . . ."

And, in that detail, apparently "forgotten," we often find one of the true roots of his present conflict, of his crisis.

The patient isn't told when his turn for psychotherapy is going to come up. He wants to be cured, he wants to tell the whole truth. He knows from his weeks of experience that only by telling the truth can he be cured. He knows that the group has developed a capacity for analysis and is going to "get it all out of him." But he prepares himself; not to tell the whole truth but to see how he can skirt around it, how he can justify his weaknesses. He's afraid, as if the group were going to judge him. It's better to catch him off guard: "Today it's X's turn." And X hasn't spent the previous night preparing himself for it. All his conflicts, generally dormant in the subconscious since infancy, must be brought up and out. Only in that way will he understand his present state, whether depressive or anxious, his rejection of groups, his fear of failure, etc. Only in that way will he be able to return normally to society and be a sociable, useful, happy being--to live, in the purest sense of the word.

The person who goes to the psychiatrist and is sent to the hospital as a day patient is a person tormented by a conflict. He has the ability to think and discern and he should be ready to help himself and the comrades in his group. (On inquiring, I learned that the patients sent to this hospital have pathological levels that, technically, fall within the gamut of neurotic disorders.)

Great camaraderie is established between patients and therapists. Confidence in the latter and in one's fellow patients is of the utmost importance. We are in conflict, but we can overcome any quirk if we pull together. However, we must respect the discipline of the hospital. It is of great therapeutic importance since, in the first place, the individual must discipline himself. At times, indiscipline is a symptom of a psychic or nervous maladjustment. We must understand this and eliminate it. The hospital helps in this by enforcing strict discipline.

Group Psychotherapy

Appreciation of the importance of group psychotherapy grows on you as times goes on. The group steps in and helps the therapists in many ways. All sympathize with the comrade who has the floor. Often, you find a similarity between the comrade's conflicts and your own. Your analysis can be useful to the therapist and the patient. At other times, you "project yourself," which in psychotherapy means raising a question from the point of view of your own trauma. And this doesn't escape the attention of the doctor or of the group itself. The day it's your turn to talk, that expression, that concept that slipped out, will be resurrected to confront you.

In our experience, group psychotherapy covering from 30 to 35 people was the most effective. More contributions are made in such groups, and the "silent ones" are most moved to join in. The introvert is "extroverted," little by little. Without realizing it, you begin to slough off neurotic symptoms. Moreover, with collective psychotherapy, the idea that "mine is the worst problem in the world" starts to wear thin and actually disappears. And, in addition, your fixation on your own conflict begins to be shaken as soon as you put yourself in another comrade's shoes when he tells you about his problem. As long as you're trying to find the key to another person's problem there are minutes, hours and even days when you feel a beneficial relaxation which helps you break the vicious circle in which you're caught. In fact, it is of great help . . .

"Not For All The Gold In The World"

It's not necessary to be overly explicit about the difference between the psychiatric methods used before and those used after the Revolution. There's simply no comparison, not only as far as the methods are concerned but in the aims as well--let alone mentioning the possibility of even getting psychiatric help. The present-day aim of psychiatry is to succeed in incorporating a completely cured patient into his role in society and doing it with the greatest care possible: a completely rehabilitated person, to put it a better way. A new person he had never been before, with a new and true personality.

I can say that I couldn't have obtained rehabilitation of this kind "for all the gold in the world." Only a wealthy person could hope to get similar treatment in a capitalist society.

Not even then. The concept that a man is really man's best friend couldn't be established in a society where a dog is considered man's best friend and each man is out for himself. That's why I said "not for all the gold in the world," since, regardless of how we analyze it and because of the contradictions inherent in the capitalist social system, a patient there is nothing more than a client. He's a client above everything else. Private interests play a role. Perhaps there
are a few exceptions, but they do play a role. In a private clinic the complete rehabilitation of a patient is equivalent to the loss of a client.

Mental disorders are a rich man's illness in a capitalist society. The poor man in conflict can be on the brink of insanity and most likely be driven all the way by the very environment that is tormenting him.

Breaking With Taboo

Breaking with the taboo of mental illness is important. A mental patient gets cured just like any other kind of patient whether he's suffering from ulcers, a throat disease or a problem of the kidneys, to name just a few. The cure of a mental patient is up to him much more than in the case of any other kind of illness. His will power is a determining factor. The therapist provides the means for the patient's rehabilitation, so that he can solve his problem. But the patient must use these means resolutely.

Group psychotherapy reveals an affliction common to most patients: fear of facing a given situation. It's incredible how persons who have shown considerable courage in facing any kind of danger—even death—squarely, prove to be cowards when dealing with the causes of a conflict that's destroying them. I've seen them with my own eyes and heard them with my own ears. And perhaps the truth is that there's nothing more difficult than one's own self causing the destruction of one's distorted image. That's where one's determina
tion and willpower come into play. It's a necessary hurt, followed by one's stability. A person's willpower will triumph over his imagination in this struggle. Time will be his best ally, his best remedy.

I mentioned that breaking with the taboo of mental illness is important and decisive. When the psychiatric hospital releases the patient, he has to face "the street," the environment all around him. Without realizing it, he has become dependent on the hospital, and this too must be stopped. He must readjust himself to the life of the community. He returns to his work center, for example, with a certain degree of apprehension that he'll be considered mentally disturbed. This is also a matter of time. It's not easy to say, "I spent two and a half months in a psychiatric hospital." There's a kind of prejudice about this, which is nothing more than an underdeveloped attitude. It's not the same as saying that one underwent surgery for appendicitis or a cyst on the elbow. His fellow workers or classmates must help him at first in order to lessen his unavoidable "clash" with the environment. A comrade has returned after getting cured of a mental illness, just like another comrade who returned after having his tonsils out. And just as the latter isn't able to shout at the top of his lungs for the first few days, the former isn't able to use his intellectual capacity a hundred percent at first.

Of course, the healed patient must show by his attitude that he's completely rehabilitated or that he's much improved. It's not just a matter of replying, "I'm well," when asked how he feels. He must always use the pills prescribed by the doctor to help him during the entire rehabilitation process. But he must also realize that some day in the future he will have to do without them... forever.

When Should You Consult a Psychiatrist?

Leaving my hospital experience aside for a moment, I must explain that, just as no one should be afraid or prejudiced about seeking psychiatric help, the psychiatrist isn't a means for preventing mental illness. A mere upsetting situation brought about by a family problem that causes two sleepless nights, or a momentary emotional disturbance isn't sufficient to require psychiatric attention. Today we have radio and television programs, newspaper and magazine articles and books that fulfill the function of preventing mental illness. Naturally, if there's a real and lasting mental or emotional disorder, if the string gets too tangled up and there's no way of disentangling it, then the moment has come for seeking psychiatric help.

The psychiatric hospital for daytime patients doesn't just help the patient solve his conflict; it presents him with a more realistic picture of life. The patient learns to understand others a little bit better and to stop being so demanding with everyone else while being so tolerant with himself. Although sometimes it's just the other way around, which is another source of conflict. The patient gets to know himself, and, as a result, he's better able to understand others. To live with others. He finds out that he can cope with his problems and that he can tower above them.

Let's do away with the taboo of mental illnesses once and for all. I'm happy that a psychological conflict brought me to the Joaquin Albarron Psychiatric Day Hospital. Now I have many new friends, and my old ones are even closer to me. Roads that seemed closed when I was ill now open and broaden.

The Revolution is strengthened at each group psychotherapy session, in the mutual help and social motivation of each patient. A group functions for the good of a patient, and a patient functions for the good of a group. The essence of our new society is constantly shown at this daytime hospital. A dog is not man's best friend. Man's best friend is... man.
The Work of a Psychologist

Francis Figueroa is a practicing psychologist in the Nguyen Van Tron Polyclinic in Havana and a member of the Student Christian Movement of Cuba. CRC discussed her work with her in December, 1977.

CRC: What are your functions and responsibilities in the polyclinic? How do you relate to the other members of the polyclinic team?

Figueroa: I do consultations with children who present some problem, a behavior problem, bad formation of habits. I give "schools for parents" of children who have some kind of problem; or sometimes I conduct "preventive schools" for parents who wouldn't otherwise make an appointment because the child doesn't really present any problem, but the parents have some doubts about how to treat the child in a certain situation, so they're looking for some orientation. I also give therapy, such as psychotherapy, and lately we're doing sports therapy.

During the morning I have consultations. In the afternoons I go into the field, visiting schools, teachers and children with problems who have come in for consultation.

I also do some work with pregnant women. There are consultations, one session, or four hours, a week, for women who feel anxious or fearful about the birth. Along with these classes, we also have what are called "mothers' circles," a series of classes dealing with treatment of the baby, mental health of pregnant women, helping them understand that they don't only have to take care of themselves but that they also have to be concerned about the child. For instance, there are some pregnant women for whom diets are prescribed because they have anemia, or are overweight or because they have some heart problem or diabetes. Sometimes a woman doesn't want to follow the diet, she doesn't understand why it's important: that it's not just for her sake, but that it's for the baby—that the baby's health can be endangered or the birth can be made more difficult. So we, through psychology, emphasize this, so that she understands.

Also, there are talks for the polyclinic personnel about human relations. That's our responsibility in psychology, too. These human relations talks are given to all the polyclinic personnel in groups—to the administrative personnel, the technical personnel, the nurses. The human relations talks help them learn how to treat the patients, and how relations among all the personnel should be to best carry out the program of the polyclinic.

I work with a psychometrician, who's what we call a "middle-level technician"—that's a graduate of basic secondary school who hasn't pursued a pre-university program. After finishing basic secondary, which is compulsory in our country, the psychometrician takes a three-year training course.

CRC: When a child has a problem, can the parents or teacher come to consult with you, or refer the child to you?

Figueroa: Yes. Teachers may come themselves to present the problem, sometimes together with the mother. Or the teacher writes to me at the polyclinic, telling me, for example, about a child who doesn't participate, a very shy child who doesn't play with the other kids, and she doesn't know what to do with the child; she may tell me she's tried various things that she learned in her pedagogical training, but that the child doesn't react, and she wants my help. On my field work day, I go to the school; generally I need to see the child and I go to the classroom to see what the child is like, or sometimes the child, with the mother, comes out of the classroom to see me. Sometimes psychometric tests are done, which are evaluated together with the interview with the child. All this material is gathered to draw some conclusions and to see what treatment should be given the child, whether a group treatment, individual psychotherapy, it depends on the case.

Overcrowding

CRC: Can you describe the most common problems among children which you see in your work?

Figueroa: Well, the most common problems I've found are those involving family relationships. You know that in our country we still have a big problem with housing shortages. We often have situations where a married couple with children may live with grandparents, and perhaps a brother or sister-in-law with children too, and the problems become very difficult. There may not be uniform criteria about how the children should behave at home, how the children should be treated; that's one of the most frequent problems. So a whole series of children's behavior problems come from that. That's why we place so much emphasis on preventive medicine in this situation: talks at the block level, given by the Committees for the Defense of the Revolution.

CRC: Can you talk a little more about this? How do the CBDS and other mass organizations relate to the treatment of people who might have mental or emotional problems?
already a close relationship with the child and the parents.

CRC: And you can make all necessary consultations with other doctors?

Figueroa: Yes, in everything. Because it's not just a question of psychology alone, but of the general atmosphere, of the patient’s life, how the child has developed, where s/he lives, how s/he is treated, what methods have been used to train the child, where s/he attends school, how the child's doing with studies. All these things in the history can be gone over with the doctor. Things have worked this way since the implementation of medicine-in-the-community. That's one of its objectives, that there be a relationship among all the polyclinic personnel who are working with the patient.

The Goal: Reintegration

CRC: How has treatment of persons with mental health problems changed since the triumph of the Revolution?

Figueroa: One specific development has been the establishment of day hospitals. These are like homes where the patients go during the day, as if it were a work-day schedule. It can be a patient who's simply very exhausted, very tired, feels off-balance, nervous, and goes to the day hospital. Treatment can be individual psychotherapy, or group therapy, or other types such as sports therapy. The patient continues to live at home.

The psychiatric hospital before the triumph of the Revolution was a terrible place, disastrous; hygiene was awful, and patients were naked and isolated, it was as if they were in jail. They were abused terribly. Now tremendous strides have been made in personnel, in treatment, and the hospital has changed completely, in every way, and the therapy has changed also. The purpose of therapy is to re-integrate the patient, within the limits of his/her possibilities, into society, to make the patient a socially useful person. Now the patients work and earn a salary to support themselves; some can even support their families. They're incorporated into services and production. For example, they make dolls and crafts, and recently they began making shoes. They also work at cleaning the hospital area, the streets, inside the hospital; they plant flowers. Much of their therapy is therapy in which they carry out some kind of work. And this has a double objective: it's therapy, but it makes the patient a useful member of society at the same time. It's not only that s/he feels useful, but that s/he is so in reality. The effort is for the patients to be rehabilitated, to be re-incorporated into giving service to society and, at the same time, to recover.
Residents of Harlem Suffer Worst Health in New York

By MICHAEL STERN

Harlem residents suffer more from bad health than other New Yorkers and even more from residents of other predominantly black neighborhoods.

This hidden and little-known consequence of poverty means that Harlem's poor are victims more often than middle-class people, black or white, of high blood pressure, anemia, obesity, decaying teeth, malnutrition, pneumonia, diabetes, alcoholism and many other disfiguring ailments.

The results of these illnesses are higher death rates than in any other part of the city and a high degree of disablement.

"A man or a woman who is not well cannot hold a job, and too many Harlem people are far from well," said Dr. John W. Patrick Jr., who has been in practice in Harlem for 40 years. "That fact is so simple and self-evident it is hardly worth stating, except that people always seem to forget it when they talk about our high unemployment rates."

This picture of the poor state of health in Harlem emerged from an analysis of Health Department records and from interviews with physicians, health-service administrators and public-health officials. These authorities suggest three major causes for the persistence of so much illness in Harlem:

1. Inadequate diets and debilitating living conditions in the community's badly heated and maintained housing stock.
2. The unhealthy lifestyle followed by the section's large population of alcoholics, drug addicts and street people.
3. The absence of a good system of health care.

Health Department records show that in 1976, when the citywide death rate was 10.2 for each 1,000 population, the rate for the Central Harlem Health District was 14.5, almost 50 percent higher. In other predominantly black health districts, where there is a larger proportion of middle-class people, the death rates were significantly lower: 7.7 in Fort Greene, 7.6 in Bedford and 19.1 in East Jamaica.

The most commonly used index of a community's health is the infant mortality rate, and by that measure Harlem's health is catastrophically bad. It had 42.8 infant deaths for each 1,000 live births in 1976, compared to 19 per 1,000 in the city as a whole, 24.4 in Fort Greene, 27.8 in Bedford and 21.8 in East Jamaica.

Ironically, the gap between Harlem's rates and rates for other parts of New York have been widening over the last decade despite the introduction in 1968 of Medicaid and Medicare, which were designed to give poor people more nearly equal access to health care.

But many of Harlem's poor lead such unstructured lives that they never sign up for these programs, and many of those who do find that they cannot get in Harlem the kind of preventative services middle-class people use to maintain normal levels of well-being. With a shrinking roster of physicians, troubled and overcrowded hospitals and a decline in the number of city health centers caused by the fiscal crisis, preventive care is becoming less accessible while the need for it is growing.

Though New York City is well provided with doctors, with almost twice the national average of 1.8 for every 1,000 people, Harlem has far less than one per 1,000. By the estimates of Dr. Patrick and other Harlem physicians, there may be only 50 doctors in private practice to serve the Central Harlem population of 150,000 people, and most of them are thought to be old and close to retirement.

Harlem also has few pharmacies making it difficult for residents to get the medicines they need. This problem was made more acute last week when pharmacists in Harlem and other poor neighborhoods began refusing to fill Medicaid prescriptions in a dispute with the state over pricing policies.

Medical authorities say that Harlem residents do not benefit from those programs and that from the major advances in health care that have occurred over the last 150 years, prolonging life spans dramatically and lifting the burden of many debilitating illnesses.

The key health developments are improvements in diet-and-living conditions for most of the population, invention of immunization against contagious diseases, the discovery of wonder drugs to kill bacterial infections and the advent of sophisticated techniques to manage chronic illnesses.

Dr. Melvin S. Schwartz, an assistant commissioner of the Health Department, says: "If Harlem people do not share fully in any of these advances, but that their inability to share in American affluence may be the most devastating.

"Our studies show that poverty is the major factor that correlates with poor health," he said, citing a state mandate, by the department of critical health problems in Manhattan. The study, done by Mortimer S. Eisenstein, found that the worst health problems were in Harlem, which also was the area with the most welfare mothers with young children.

"Areas with disrupted families, low income and substantial black population," the study said, also were areas experiencing "more than their share of morbidity and mortality."

But Dr. Schwartz also pointed out that though health care was less available in Harlem than elsewhere in the city, it was equally true that many Harlem people did not take full advantage of the care that was available.

"The difficulty," Dr. Wasserman said, "is that though the vaccinations are available free, they may not be all that accessible to a mother who may have other children to look after, who may be sick herself or who may have to give a higher priority to providing food for her family. And it also is true that some mothers just don't recognize the importance of what they are denying their children."

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The Right to Health Care

THE CONSTITUTION OF THE REPUBLIC OF CUBA

Chapter VI: Fundamental rights, duties, and guarantees

Article 49. Everybody has the right to health protection and care. The state guarantees this right:

- by providing free medical and hospital care by means of the installations of

the rural medical service network, polyclinics, hospitals and preventive and specialized treatment centers;
- by providing free dental care;
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The committee can be contacted at:

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1) to provide religious communities with an accurate description of the Cuban Revolution

2) to promote communication between North Americans and Cubans

3) to counter United States and church policies which contribute to injustice with respect to Cuba and Latin America.

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