

The Island's Healthcare Legacy

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There is a little-known anecdote from Goiania City, Brazil, in 1987 that fittingly depicts Cuban medical internationalism. While Chernobyl burned itself into a global consciousness, another nuclear disaster was ignored and forgotten by most of the world. Two scavengers were searching through Goiania's abandoned private cancer clinic, when they discovered a canister containing Cesium-137. Unable to understand the word "radioactive," they opened the tube to find a blue stone, that "made everything it touch glow in the night." (Galeano, 2000) In their favela the blue stone was passed around. Children and adults alike rubbed pieces of the stone on their bodies and they began to illuminate. (Reuters, 2005) The radiation spread through the favela contaminating 244 persons. For a week the health authorities figured it as nothing more than food poisoning. Next to Chernobyl, Goiania City was the worst nuclear disaster in history, and is possibly the most forgotten. And yet alongside the victims of Chernobyl receiving treatment in Havana, were the children of Goiania City to whom Cuba provided free healthcare. While little attention is given to Goiania City, Cuba selflessly provided care to those in need.

This is a beseeching example of how Cuban medical internationalism treats health as a human right, especially in places loaded with too much inequality and too little understanding. Beyond a mere political stunt, this epistemology has endured through the Soviet years, during the special period, and continues today. Cuba routinely offers healthcare for Latin America's poor, and has benevolently forgotten to send on a bill.

To cynics, the goal of Cuba's medical internationalism must come down to political pork-barreling. But, did Cuba offer aid to victims of Chernobyl, or attempt to offer victims of Hurricane Katrina in New Orleans medical attention, just to get on the six o'clock news and receive laurels from ambas-

sadors? Belittling the Cuban human security approach to a publicity stunt is a disparaging and inane criticism. Cuban doctors, teachers and nurses routinely journey to attend to the most impoverished and forgotten regions of the South. They go to places where electricity and sanitation dare not tread, let alone television cameras; from Brazil's forgotten villages to Haiti's menacing countryside. Built on traditions of community-based care, person-to-person contact, and proven methods of primary care, Cuba's medical internationalism is first and foremost dedicated to saving lives. The success of this policy is in saving lives and empowering communities, before strategizing any sort of global political scheme. A commitment to save lives is what drives the doctors into the jungles. And yet, according to experts of political science, the ends of this extraordinary human security endeavor must be about gaining political allies, before the ability to save lives. Certainly the role of healthcare provision in Cuba's foreign policy will have some political capital. Is there any country today that crafts foreign policy in order to not gain some economic or political gain? But, to follow a cynic's logic, assuming that medical internationalism is a mere stunt, it's safe to assume that this policy would be abandoned with political change. But from the perspective of the actors in this production, the doctors, medical students and patients, is it really about political strategy? For the doctors who can check for broken bones without an x-ray and who deliver babies with little more than hot water and heaps of effort, how do they politically strategize? For the students who came to the Latin American School of Medicine (ELAM) without shoes on their feet, and left with white coats on their backs, where did they find time to formulate political grand strategy amid studying medicine in a six-year window that would take a North American student ten years to get through? And to the parents of newly born children who were not the one in 10 to die before their first birthday, where do their political allegiances lie (UNICEF, 2003: 110)?

I argue that in the Cuban context health and healthcare have been enabling expressions of self determination; bringing human security and empowerment to people who otherwise would go without. Instead of rationalizing Cuba's medical internationalism into broader political discourses, we can couch notions of transition, democratization and self determination into the health context. Perhaps it is time to consider good health as a means of self determination, before political gain rather than the other way around.

Social institutions and community health methodologies brought Cuba into the epidemiological transition, which is certainly one of the most successful social transitions in the history of the Americas. Current Cuban innovation in healthcare capacity building and accessibility may very well bring new health transitions at the community level in the South. Looking at pro-

grams like ELAM and Mission Miracle, it may be more fitting to ask what is Cuba's role in creating transitions rather than being in transition.

The epidemiological transition, and the institutions that made it possible, reveals that the nature of the programs, rather than assumed societal equality, plays a leading role in not only improving the quality of life, but empowering communities as well. While some critiques argue that inequalities in access to expensive pharmaceuticals, equipment, and other healthcare products, shows a failure of the Cuban model, they overlook that this is an endemic problem with all healthcare models. (Marchildon, 2006) What makes the Cuban approach unique is that consumption inequality poses little threat to the community focused primary care principles. Community care is not uniquely Cuban, but the fact that it costs next to nothing to create and even less to use is unique indeed. Accessibility to healthcare at the community level is not directly impacted by discrepancies in pharmaceutical distribution. Rather, human resource based healthcare, accessibility, and capacity building all remain unscathed by growing market influences. Indeed, the Cuban health legacy has already made tremendous social transitions through this human resource focused model, even in times of economic anarchy. It continues to do so as capacity-building programs expand into more dynamic dimensions and show little sign of collapse or retraction regardless of economic and political uncertainty. Perhaps the real crisis from inequality lies in a broader deficit of ideas of how the Cuban health paradox may continue to be a driver in social and community transitions throughout the Americas.

Imperialism, Self-determination and the Idea of Transition

I would like to discuss political philosophy and geographies of health, as I think it is necessary to understand how limited dialogue is in linking health, along with human security in general, to self determination in the Cuban case. To date, discussions of national health and national self determination remain strangers. Some studies acknowledge that national health is meant to provide well being to all those in the nation state, but they often fall far short in doing so. (Lightner, 2004) Hence the assumption that healthcare can be an enabling factor for an entire society is rarely considered. Perhaps as an unconscious consequence most chatter on self determination remains in high-political discourses of democratizing processes and political frameworks, which really have more to do with determination of an imagined nation state and not that of individuals and communities. (Anderson, 1991) Likewise, good health is seen as good thing, but is rarely acknowledged in political and legal frameworks as being a means of self determination beyond symbolic

capital. (Feinsilver, 1993) Still, Cuba's healthcare legacy has quite a lot to do with self determination by empowering individuals and communities alike. Overlooking the epidemiological experience in discussions of "Cuba in transition" omits important elements of autonomy gained through good health, and inherently constructs dialogues that bear narrow imperialist visions. In respect to the theme of this book, I would like to discuss some points made by James Tully on imperialist language and how it dominates the "Cuba in transition" question all the while omitting the other important social transitions.

If Cuba is only in transition now, then what was it before? Defining a Cuban transition on its relation into, or away from, the global system is a question that satisfies a hegemonic normative framework. Especially when considering that Cuba is a very active player in the U.N. and other global networks. Normative frameworks of democratization, reintegration and self determination have more to do with the country's so-called expected place in a system that is ridden with imperial traditions and hegemonic discourses; no less intrusive than in early twentieth-century Havana when school teachers thought it best to conduct lessons in English because of practical inevitability.

It is possible to consider discussions of national self determination to be a hegemonic language. For Tully, imperialist language flows through Kantian, and neo-Kantian understandings of the global order, but it remains, he argues, in the language of advocates of self determination. (Tully, 2005: 23-24) Tully uses Immanuel Kant's *Perpetual Peace: A Philosophical Sketch* to show that the so-called just and universal "post-colonial world of free and independent states under international law, [is] bound together by free trade, governed by a league of advanced states, [and is] the particular historical product of European colonial imperialism." (Tully, 2005: 25) Kant, among his many pearls of wisdom including his declaration that "Indians were incapable of civilization," (Galeano, 2000: 46) affirmed that the correct ordering of humanity is done through the establishment of European republican or constitutional states that are "formally equal and sovereign" and engage in their duty of free trade. (Kant, 1992: Tully, 2005: 25) Among other things, Kant believed that this league of nations has the right, if not obligation, to intervene into a society that was in any way different from the European norm. (Tully, 2005: 25)

The Kantian approach does not justify the use of imperialism to establish good constitutional states; it is taken as necessary and righteous. That said, participants of this system cannot recognize any other narratives, traditions or civilizations as equal yet different, as the European model state is the obligatory narrative. (Tully, 2005: 30) In the post-colonial world, the colonies dressed as nation states may be formally equal, but informally inequitable economic and historical exploitation doesn't skip a beat. The result is an

exemplary example of imperial relations through so-called non-imperial normative frameworks. (Tully, 2005).

For the Kantian and neo-Kantian perspectives, imperialism is an unavoidable necessary. Yet some argue that “the language and practice of political self determination of peoples and furthering of democracy offer a genuinely non-imperial and anti-imperial alternative.” (Tully, 2005: 34) The idea is that political self-determination from within, regardless if the leadership has been directly or indirectly influenced by foreign actors, will be a form of non-imperialism. Unfortunately this doesn't hold up. Democratic collectivisation does little to break imperial traditions, and it is unequipped to ward off intrusion from so-called “non-imperial actors” like multinational corporations, development agencies and such. Moreover the generally assumed form of democratic freedom is that of which Isaiah Berlin titled “negative freedom.” (Berlin, 1958) Being negatively free may remove repressive governors, but it makes no guarantee for working civic-democratic relations whereby the ruled and rulers are able to have open dialogue and speak frankly with each other. (Tully, 2003) All too often democratizing nations, especially those which have been aided into the process from Western powers, often with bombs and then ballots, experience the burden of the governed being too distraught to effectively communicate with their rulers, and governors being under equipped to meet the needs of the entire population. For Tully, this process is “not so much an alternative to contemporary imperialism but a move within the strategic-tactical logic of informal imperialism.” (Tully, 2005: 48) Kant's framework shows how the roots of imperialism transcend into modern dialogue between nation states, but it fails to handle informal imperialism. Tully argues that “changes in international law, the rise of powerful multinational corporations, and the role of soft-norm creation by non-governmental organizations” all play a role in redirecting power and control. (Tully, 2005: 32) These multi-dimensional sources of power and control are often presented as non-imperial, which, as Tully suggests, is as if to say that a centralized world empire is the only form of imperialism. (Tully, 2005)

If political self determination is more to do with imperial transformation of groups and nation states, then perhaps we should scale down the idea of self determination to the level of the individual? From the point of view of doctors who administer free vaccines, and newly born children who would not make it otherwise, health is a first step in self determination. What health and human security mean on the ground falls through the gaping holes of most political dialogues and with it tumble public imagination and awareness. Some say that “we have no alternative but to adapt to reality” of neo-liberalism and neo-conservatism. (Galeano, 2000) But what if that reality is about improving health at the community level, about training doctors who

heal instead of doctors who bill, and about educating mothers and children about the environmental and social determinants of health so that they can experience far more birthdays and far less funerals together? From this perspective can we consider political achievements to be subsequent to human achievements? We may in fact be able to entertain more sensitive and appreciative understandings of how health as a human right, an inkling that Hippocrates mentioned but modern society forgot to write down, can bring on self determination and transition.

*Domestic Success with health and healthcare,
showcase or spark?*

Healthcare provision during the Revolution has hardly been a static operation. Developments and successes have been matched by just as many perils and failures. Nevertheless, the ministry of health never wavered from two goals. The first was to ensure that every single Cuban had access to necessary medical services, and the second was to emphasize person-to-person care before investment in infrastructure and technology. Radical or reasonable? Tommy Douglas, a prairie farmer turned politician in Canada, came up with a similar idea during the 1960s. In the initial stages of the revolution the health issues were not difficult, and they did not necessarily require advanced medical science. Cubans mostly suffered from poverty-stricken parasitical diseases, and as such, the doctors of the revolution were mostly monitors and mentors of basic health. Doctors often administered basic antibiotics and promoted clean water usage, which relieved most juvenile intestinal disorders. (Danielson, 1985) Educating doctors in complex obstetrics as well as providing clean facilities for birth and neonatal care greatly reduced the infant mortality rate. By 1979, only 19 of every 1,000 live births died before the age of five, and by 1983, the figure dropped to 16 for each 1,000 (Feinsilver, 1993: 95). Today the figure is seven per thousand, a figure equal to the United States. (UNICEF, 2003: 110) Infant mortality was generally decreasing worldwide between 1960 and 1985, but compared to the 1979 Latin American average of 92 deaths per thousand live births, or neighboring Haiti of 127 per thousand, Cuba was far ahead. (Collins & Benjamin, 1985) As Collins and Benjamin point out, in 1982 the infant mortality rate of 18.1 per thousand for the black population in the United States was higher than Cuba. (Collins & Benjamin, 1985: 64)

By the 1980s, Cuba succeeded in removing diarrhea and tuberculosis from the top 10 causes of death, along with infectious and parasitic disease causing 13.3 percent of deaths in 1962 to only 2 percent in 1980. The life expectancy rate increased by nearly 20 years from 57 years in 1958 74 years

in 1980. (Collins & Benjamin, 1985) A slow process no doubt, but Cuba kept its promise to deliver effective health services that virtually eliminated the country's Third World health problems. The success came not in just creating health services, but through ensuring that the citizenry had access to them. In 1959, 1,800,000 medical visits were recorded, compared to 13,818,000 in 1979. (Danielson, 1985) The polyclinic was the entry point for most persons into the health system. (Feinsilver, 1993) These facilities provided health services for populations up to 25,000 persons. Teams of doctors operated in the clinics, with at least one obstetrician/gynecologist for every 3,000 women, and one pediatrician for every 3,000 children. (Gilpin & Rodríguez-Trias, 1979) At the polyclinic itself, doctors and nurses commonly held information sessions about hygiene and preventable activities while patients waited for their appointments. As Feinsilver notes, the polyclinic practiced "medicine in the community," not "community medicine." (Feinsilver, 1993)

Even today, the ministry of health continues to receive praise from the WHO and the PAHO for excellent monitoring systems, encouraging preventive treatments thorough data collection, and epidemiological tracking of major health issues. (Spiegel & Yassi, 2004) Critics of thorough record keeping in public health may employ Bashford's thesis to see it as more of a means of social control, and an instrument to reorder society. (Bashford, 2004) The most fatuous critiques have charged Cuba with micro-managing medical statistics in order to produce attractive health indicators for the WHO and the United Nations. Indeed, more appreciative studies done by Cooper and Spiegel and Yassi, clearly showed epidemiological tracking and data collection are integral parts of the Cuban health approach, as they act to take action on developing public health crisis, and monitor pattern changes in chronic and degenerative diseases within the society. (Spiegel & Yassi, 2004; Cooper, 2006) Indeed the sort of bio-medical imperialism that Bashford's case study deals with is non-existent in Cuba because the practice of health-care in Cuba actually improves the health and quality of life for those whom receive it.

Despite the epidemiological transition, Cuba doesn't give up the ghost on first world diseases. Prevention and education are employed as much as surgery in warding off cardiovascular disease and other such calamities. Cooper et al. claim that the data resources in Cuba allow for comprehensive descriptions and trends of advanced conditions like cardiovascular disease. Good knowledge of indicators and outbreaks allows for prevention in the community and preservation of the individual. (Cooper et al., 2006). Cuba's data collection and public health response mechanisms are well beyond the normalcy of the third world, and in some cases well past the first world. Cooper et al. show that diseases of the heart and suicide are just as common in other Carib-

bean countries, but accountable record keeping practices are not, and hence it is always Cuba that gets charged with having high heart disease and suicides when in fact it is such data that allows for not only taking account but taking action as well.

El pensamiento de salud para todos en Nuestra América

Dissatisfied with the short-term relief projects that are congruous with disaster management, the ministry of health's post-Mitch plan moved towards long-term capacity building strategy to empower locals to become active participants in their own health outcomes. The result was ELAM. Established in a former naval academy just to the west of Havana, the school accepted, at no charge, students who were from rural or under-serviced areas of Central America and South America. In 1999 ELAM accepted just fewer than 2,000 students from these regions, but since 2000 the school has welcomed students from Africa, the United States and even Europe. Students are selected on basis of merit, and special consideration is given to those from marginalized communities. During the six-year program, students are provided with free tuition, accommodation, books, sustenance, and are given a small monthly allowance to spend as they choose. Disease and poor health, despite homeland security's best efforts, do not stop at borders and neither does the Cuban approach. Building on a long-standing tradition of medical of offering medical aid, Cuba sent 1,300 doctors to Central American in 1998, to help cope with the aftermath of Hurricane Mitch. Despite cool diplomatic relations with Guatemala, Honduras and Nicaragua, and considering the domestic economic chaos of the Special Period, Cuba generously offered its services. (Cole, 1998; Kirk, 2000) Indeed the medical brigade's presence offered some immediate relief to the destitute, but it was shadowed by a sense of hopelessness, as these pillaged rural areas had skeletal healthcare infrastructure and almost no intersectoral support as a result of a decade of neo-liberal restructuring support. (Ugalde & Homedes, 2005a: 2005b) These two elements were vital for the success in the Cuban epidemiological transition, and indeed they are necessary for any resource strapped society to adapt in order to improve health at the local level. Frustrated by offering triage within a health framework that was as hollow as a gourd, Cuba revisited their post-Mitch strategy to put a great emphasis on capacity building and creating human resources for health, rather than continually sending their own doctors in to do patchwork healthcare within a crumbling system. (Sebastian et al., 2005) In order to cope with the cavernous void left from neo-liberal restructuring in the healthcare sector, the energy would have to turn towards capacity building and prevention within communities at the local level.

While most medical schools in the world are becoming more economically and socially exclusive, ELAM seeks those who would not have the fortune of attending medical schools in their home countries. (Jolly, 2005) Moreover, in order to be accepted into the program, the students agree to return to their home countries to offer their services where they are most needed. There is no written contract to enforce this pledge, and Cuba would be powerless to stop a graduate from practicing in the for-profit sector; it is simply a moral commitment for the graduates to do what they can for the forgotten ones who need it the most.

The life of a student is by no means a cakewalk. It is a challenging curriculum, covering in six-years what most North American medical students complete in eight to 10 years of training. Courses range from anatomy and molecular biology to physical education, and acupuncture and even disaster medicine. Working-level English is also taught so students may keep up with recent developments in medical literature, which is almost entirely published in English. In the early years of the program the challenges of this rigorous curriculum were compounded with a lack of up-to-date textbooks and adequate lab equipment. Students must also endure the challenges of Havana's erratic municipal services, which can leave students studying by candlelight for hours during a blackout. Nevertheless, such challenges will likely pale in comparison to those to be found on the ground when graduates return to their homes to practice in their over-burdened and under-serviced homes.

So far the program has received thousands of students from 29 countries in the Americas and Africa. Over 10,000 students were enrolled in the ELAM program in 2005. (Frank & Reed, 2005) Only about 4,000 of these students study at the school, while the remaining 6,000 study alongside Cuban students at medical schools throughout the country. The numbers are quite impressive indeed. By sheer volume alone, these graduating students, roughly 2,000 per year, will inevitably make a considerable impact on Latin America's anemic human resources for health landscape. While only a small percentage of students have dropped out of the program, others may be a flight risk to the United States or at least to the private sectors of their home countries. These young, bilingual and eager physicians could be seen as highly valued commodities in the healthcare marketplace. Indeed the demand for family physicians in the north, coupled with lucrative offers for foreign doctors to work in North America, may prove as the ultimate test for the moral commitment of ELAM graduates, and to the value-driven basis of Cuban medical internationalism.

While ELAM is a case in point of Cuba's approach to medical internationalism through long-term capacity building, other more short-term and collaborative medical initiatives are being undertaken. Mission Miracle is a

joint-venture project with Venezuela designed to restore sight at no cost to poor Latin Americans. The program offers free eye surgery (mainly on cataracts) to the poor and marginalized in Latin America and the Caribbean. To date over 122,000 patients from two dozen countries have been treated, although the vast majority are from Venezuela, which is offering the capital for the project. Cuba hopes to provide 1.5 million eye operations a year, and it plans to conduct 10.5 million procedures through this initiative. Cataract surgery is relatively cheap and quick to perform.

The gift of sight, the chance to learn, the ability to heal, is it a mere political move? Or is it unabashed human compassion? I am hard pressed to categorize life-saving practices as being one in the same as political payola. They are extensions of a sound ontology that provides care at the community level in addition to converting military and corporate edifices into hospitals and schools. (Spiegel & Yassi, 2004) Such projects directly aim to provide security, human security as defined by Axworthy, and well-being at the individual level, to empower individuals. (Axworthy, 2001) Indeed the success and uniqueness of these programs creates political capital on the world stage. Is there a country today that does not aim to gain some form of self-benefit from their foreign policy? Indeed Cuba is not out of line any more than any other nation-state in this regard, however, their approach is one that has just as many benefits for empowering people on the ground as it does in forums of high-level policy.

Conclusions

To conclude, the question of Cuba in transition should pay special attention to role of health and healthcare. Not only has Cuba made outstanding progress in the past, but it actively continues to do so in programs that are structured on sound knowledge of community health, social determinants of health, investment in human resources for health, and, above all, experience. Ensuring access to community-based primary care and attempting to extend this beyond its borders may indeed generate symbolic capital, but it ultimately empowers individuals and saves lives.

What better tool than good health do people need for self determination? Considering that so many of the south's functioning democracies, from Liberia to Bolivia, do not guarantee personal security and freedom from illness and want, we should ask how Cuba's approach to human security can better enable individuals to make choices at personal, community and national levels. As Ignatieff argues, an individual's priority is first to personal security, and then to the nation state. (Ignatieff, 1993) Cuba's human security is an integral part of a functioning civic nation state and it is certainly entrenched

into foreign policy that provides personal security first and national loyalty second. Understanding this experience as self determination, at the individual level, brings us into a dialogue that focuses less on imperialistic forecasts and more on seeking understanding to overcome inequalities. Perhaps its time to remove the painful burdens of misunderstanding and non-imagination and instead reflect not so much on how Cuba copes with political transition, but how its approach to good health enables transition and how it could enable us.

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