

**THE SICK REPUBLIC:
TUBERCULOSIS, PUBLIC HEALTH, AND POLITICS IN CUBA, 1925–1965**

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This dissertation explores the politics of disease control in Cuba during the mid-twentieth century, and uses tuberculosis as a lens to understand citizenship, state-building, and populism. By analyzing the popular press, health reports, medical journals, and official correspondence in U.S. and Cuban archives, it argues that ordinary citizens, public intellectuals, and civic actors in the interwar era—not the revolutionary government of 1959—introduced the concept of a “right to health” and invoked it to demand an efficient state healthcare sector. In response to these claims and in his quest to strengthen the state, Fulgencio Batista created the *Consejo Nacional de Tuberculosis* in 1936.

The heightened visibility of tuberculosis, achieved in part by the claims-making of citizens, channeled state attention towards a disease of the poor, but it also distorted the design of health projects, making them inefficient and openly political. Thus, although increased state attention to tuberculosis improved mortality rates and access to health services by the 1950s, the state proved unable to depoliticize the tuberculosis campaign and to uniformly implement the right to health care on the ground. The gap between the expectations of citizens and the performance of republican administrations influenced the growing de-legitimation of the state, the overthrow of Batista’s government, and the new regime’s priorities in health policy. Nonetheless, despite the revolutionary rhetoric of radical change, there were clear continuities in tuberculosis control policy before and after 1959, such as the new government’s reliance upon the resources and institutions developed by republican administrations.

By complementing health outcomes and statistics with a social and political history of tuberculosis, and by balancing attention between state health efforts and grassroots definitions of medical success, this dissertation shifts the frame of a decades-long debate in Cuban historiography that has sought to establish the objective quality of state health care before and after the 1959 revolution. Furthermore, it challenges the assumption of a weak Cuban state and insists that health projects constituted a fundamental arm of state formation. Finally, “The Sick Republic” points to the agency of citizens as they became health activists, shaped state-building efforts, and defined citizenship rights.

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1.0 INTRODUCTION

“This problem of tuberculosis has always been the Cinderella among governmental concerns.”

-Dr. Luis Ortega Bolaños, 1927.¹

“The 4th of September Revolution [of 1933] devoted intense and persevering effort to the protection of the people against the Koch bacillus...[The hospitals and dispensaries] we had built...represented an effort to eradicate tuberculosis unprecedented in Latin America.”

-Fulgencio Batista, 1964.²

One morning in 1926, a poor soldier hurried through the streets of Havana, his younger brother, Juan, in tow.³ Juan had travelled from the cane fields of eastern Cuba, where medical treatment was scarce, to the bustling metropolis where his brother was now stationed, in the hopes of gaining admittance to one of the capital’s public hospitals.⁴ At the tender age of twenty, Juan had contracted tuberculosis, one of Cuba’s deadliest infections.

For victims of the disease, the first harbinger of trouble, a deceptively mundane cough or strange aches, often arrived without notice. The next stage unnerved its victims, especially those

¹ “Consideraciones sobre algunos puntos importantes,” *Vida Nueva* 19, no. 5 (May 15, 1927): 201–2. All translations are mine, unless otherwise noted.

² *The Growth and Decline of the Cuban Republic* (New York: Devin-Adair Co., 1964), 98–99. Emphasis in original text.

³ The following narrative is derived from Fulgencio Batista, “Inauguración del Sanatorio ‘Topes de Collantes’,” May 9, 1954, 5, Box 1, Fulgencio Rubén Batista Papers, 1933–2007 (FRB Papers), Cuban Heritage Collection, University of Miami (CHC-UM). This speech was also published in José Manuel Cortina, Fulgencio Batista y Zaldívar, and Octavio Montoro, *Una historia en dos discursos y un artículo* (Havana: Editorial Echevarría, n.d.). Frank Argote-Freyre offers a similar narrative in *Fulgencio Batista: From Revolutionary to Strongman* (New Brunswick, NJ: Rutgers University Press, 2006), 30–32.

⁴ Argote-Freyre offers a slightly different account, in which Juan travelled from Camagüey, instead of from his father’s home in Banes. *Fulgencio Batista*, 30.

who knew what these symptoms portended. The cough was now more persistent, fevers and sweats became nightly companions, and then the cough turned bloody and violent. For other diseases, medical technologies seemed to advance every year, but defeating the tuberculosis bacillus remained an elusive goal for physicians and researchers. Contracting the white plague in the 1920s—when no sure cure existed—struck its victims with dread. To have the disease in Cuba was surely worse than to suffer from it in a country with a more developed health infrastructure, for the island had only 150 beds in one state sanatorium. Its waiting list numbered over 600; the wealthy often traveled to the U.S. or Europe to seek treatment.⁵ To be a poor Cuban and hear the diagnosis of tuberculosis must have been received with the same anguish as the pronouncement of a death sentence.⁶ Entering a public sanatorium or hospital was often the only chance of survival, and to achieve this end, ordinary men and women devoted substantial energy and time.

For weeks, the two brothers trekked along the well-worn path of what had become a ritual “pilgrimage” of the poor. With no political connections to gain admittance to a hospital and no money to travel overseas for medical care, they spent their days going from one hospital to another, hoping to arrive when a bed had been vacated.⁷ In December, Juan’s prayers were answered when he was admitted to the Calixto García General Hospital. With the exception of a brief hiatus in January, Juan stayed there for twenty-three long months. The elder brother first found himself frustrated with the scarcity of hospital beds and later, during his frequent visits to

⁵ “La lucha contra la funesta tuberculosis,” *Bohemia* 19, no. 51 (December 18, 1927): 29.

⁶ See, for example the story of Julián Acosta Rodríguez, *Havana Post*, April 27, 1932, 1, cited in Louis A. Pérez, Jr., *To Die in Cuba: Suicide and Society* (Chapel Hill: University of North Carolina Press, 2005), 201.

⁷ See, for example, “Editorial,” *Bohemia* 29, no. 48 (November 28, 1937): n.p.; “Triste odisea de una mujer que es abatida por el Mal de Koch,” *El País*, August 25, 1937, 8, leg. “Recortes de prensa,” expediente (exp.) “Maternidad e infancia,” 17/10/3/1-251, Fondo José Chelala Aguilera (JCA), Museo Histórico de las Ciencias “Carlos J. Finlay” (MHC). This experience seems to have been shared across borders, with one Argentinian calling it the “vía crucis.” Diego Armus, *The Ailing City: Health, Tuberculosis, and Culture in Buenos Aires, 1870–1950* (Durham: Duke University Press, 2011), 23.

provide company and food to Juan, disgusted with the quality of care. The small tuberculosis ward was “miserable and poor, neglected and dilapidated.”⁸ He believed that “more than devoting itself to the treatment of tuberculosis,” it served as a “repository of the sick.”⁹ Then, almost two years after Juan’s arrival in Havana, he took a turn for the worse. On the morning of November 5, 1928, he suffered a violent episode of hemoptysis. His elder brother was there, helplessly watching Juan choke on his own blood. “[H]e died...in my own arms,” the brother recounted, “bathing me in his almost adolescent blood.”¹⁰

This scene must have been repeated over and over in Cuba, where thousands died annually from the white plague, yet its recurrence surely made it no less tragic. The elder brother’s experience was ordinary, in the sense that he suffered a loss that hundreds of others had borne. But the brother was also as exceptional as the times in which he lived. This bloody morning would haunt the young soldier, never far from memory as he climbed the ranks to become the de facto ruler of Cuba following the 1933 revolution: the elder brother was none other than Fulgencio Batista, the central political figure of Cuba’s Second Republic.¹¹ Upon reaching power, he unexpectedly launched the largest national tuberculosis campaign the island had ever seen. Remembering his brother’s death in a conversation with a journalist in 1937, and laying blame on the insufficient tuberculosis facilities on the island, he brashly declared, “That will not happen again in Cuba.”¹²

Despite Batista’s declaration, the history of tuberculosis in Cuba does not originate from nor center on contributions from one of history’s “great men.” Poverty had woven tuberculosis

⁸ Batista, “Inauguración,” 2, Box 1, FRB Papers, CHC-UM.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Almost three decades after Juan’s death, Batista revealed that the loss was the second greatest of his life, the first being the death of his mother when he was a teenager. Ibid.

¹² Quentin Reynolds, “Otra entrevista con el Coronel Fulgencio Batista: El dictador sorprendido,” *Carteles* 29, no. 27 (July 4, 1937): 40.

into the fabric of Cuban society. When that fabric began to tear under the pressure of ordinary people demanding that their government act on their behalf, their frustration with the state's indifference toward those with the disease reached from rural *bohíos* and shantytown hovels, on the peripheries of the nation, into the halls of the presidential palace, the very center of power itself.

1.1 HISTORICAL OVERVIEW

The statesmen of the early republic, however, had prioritized other health issues. During the latter half of the nineteenth century, yellow fever had frequently traveled from the port of Havana to the gulf cities of the southern U.S., where epidemics exploded and spread into the surrounding countryside. Worried about the economic toll these events exacted, American authorities began to keep a close eye on Cuba's sanitary landscape. In 1898, when the island was drawing near to declaring victory against Spain in its final war for independence (1895–1898), the U.S. intervened, partially in response to worsening sanitary conditions in the midst of war.¹³ Under the U.S. occupation of the fledgling nation (1898–1902), military authorities spearheaded a massive sanitation campaign in its cities. The Americans made Cuban acceptance of the terms of the Platt Amendment a prerequisite for their departure in 1902.¹⁴ One of the Amendment's eight clauses linked Cuban sovereignty to the absence of epidemic diseases, namely yellow fever:

¹³ Mariola Espinosa, *Epidemic Invasions: Yellow Fever and the Limits of Cuban Independence, 1878–1930* (Chicago: The University of Chicago Press, 2009).

¹⁴ The text of the Platt Amendment was included as an appendix to the Cuban Constitution of 1901. Louis A. Pérez, Jr., *The War of 1898: The United States and Cuba in History and Historiography* (Chapel Hill: University of North Carolina Press, 1998), 34.

V. That the government of Cuba will execute, and as far as necessary extend, the plans already devised or other plans to be mutually agreed upon, for the sanitation of the cities of the island, to the end that a recurrence of epidemic and infectious diseases may be prevented, thereby assuring protection to the people and commerce of Cuba, as well as to the commerce of the southern ports of the United States and the people residing therein.¹⁵

If there were any doubt about the seriousness of the Americans in this matter, it dissipated in the first decade of independence when the U.S. occupied the island a second time (1906–1909), justified in part by the presence of yellow fever on the island.¹⁶

The looming threat of U.S. intervention shaped the national politics of disease. Cuban authorities directed the bulk of resources to keeping their streets clean and destroying mosquito-breeding grounds. While Cuban scientists had been renowned for medical advances and research innovation in the late nineteenth century, in the early twentieth century they instead spent their time doing routine work in order to prevent yellow fever outbreaks.¹⁷ Racial ideology also affected the distribution of resources. The virus ravaged white foreigners, especially Spaniards, so Spanish colonial authorities and Cuban scientists prioritized yellow fever research and control in pursuit of “whitening” their nation through immigration.¹⁸

Cubans died from yellow fever in smaller numbers, for most had built up immunity from mild childhood infections. Tuberculosis, on the other hand, was a disease highly fatal to the native-born population. Following the devastation unleashed by war, almost 3,000 Cubans died

¹⁵ Treaty Between the United States and the Republic of Cuba Embodying the Provisions Defining Their Future Relations as Contained in the Act of Congress Approved March 2, 1901, signed 05/22/1903; General Records of the United States Government, 1778–2006, RG 11, National Archives.

¹⁶ Espinosa, *Epidemic Invasions*, chapter 6.

¹⁷ Steven Palmer, “Shifting Sands of Cuban Science, 1875–1933,” in *State of Ambiguity: Civic Life and Culture in Cuba’s First Republic*, eds. Steven Palmer, José Antonio Piqueras, and Amparo Sánchez Cobos (Durham: Duke University Press, 2014), 55.

¹⁸ Nancy Stepan, “The Interplay between Socio-Economic Factors and Medical Science: Yellow Fever Research, Cuba and the United States,” *Social Studies of Science* 8, no. 4 (Nov. 1978): 400–1; José Amador, *Medicine and Nation Building in the Americas, 1890–1940* (Nashville: Vanderbilt University Press, 2015), chapter 2, “Beyond Yellow Fever Eradication: Nation and Racial Gatekeeping in Cuba.”

of tuberculosis in Havana alone in 1898; in contrast, yellow fever claimed 70% fewer lives.¹⁹ While 900 Cubans died of tuberculosis in Havana in 1901, only 18 died from yellow fever.²⁰ Two decades later, in 1919, tuberculosis mortality in Havana had dropped only slightly (from 360.8 to 344.1 deaths per 100,000 people) and was still the second highest cause of death.²¹ While Cuban officials did not completely neglect tuberculosis, it was far from a priority. Even with pressure from the Cuban Anti-Tuberculosis League, the proposal for a public tuberculosis sanatorium languished in Congress; construction began only when the authorities of the second U.S. military occupation pushed Cuban politicians to act.²²

The landscape of Cuba's public health sector began to change under president-turned-dictator Gerardo Machado (1925–1933). His administration prioritized the control of a host of diseases and health issues considered to be national problems, such as mental hygiene, infant mortality, eugenics, and tuberculosis.²³ Machado created an Anti-Tuberculosis Board, which increased epidemiological surveillance and expanded the infrastructure of tuberculosis services. These efforts were further expanded when military strongman Fulgencio Batista founded the autonomous *Consejo Nacional de Tuberculosis* (National Tuberculosis Council, CNT) in 1936. In its first years, the institution began construction on multiple sanatoriums, opened new dispensaries across the island, administered over 20,000 tuberculin tests in slums and schools, and widely disseminated educational propaganda. Once the CNT was established, tuberculosis

¹⁹ Espinosa, *Epidemic Invasions*, 69.

²⁰ “Defunciones ocurridas en la Ciudad de la Habana por las enfermedades que se expresan y mortalidad total por todas las causas,” *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* 1 (Havana: Secretaría de Sanidad y Beneficencia, 1909), 135.

²¹ Sergio Díaz-Briquets, *The Health Revolution in Cuba* (Austin: The University of Texas Press, 1983), 58–59.

²² John Gutiérrez, “Disease, Empire, and Modernity in the Caribbean: Tuberculosis in Cuba, 1899–1909” (PhD diss., The City University of New York, 2013), 191.

²³ Cuba, Secretaría de Sanidad y Beneficencia, *1926–1931: Cinco años de labor sanitaria y de beneficencia pública* (Havana: Imprenta y Librería La Propagandista, 1931). On Machado's reformist national platform, see Louis A. Pérez, Jr., *Cuba: Between Reform and Revolution*, 3rd ed. (New York: Oxford University Press, 2006), 187.

and politics became even more intricately interwoven: the issue shaped how people saw their government, and political processes affected the development of care on the island.

Tuberculosis persisted as a visible issue across all the changes of the mid-twentieth century in Cuba. This dissertation contends, then, that understanding the history of tuberculosis on the island is central to understanding modern Cuban history.²⁴ Building on recent literature on public health in Latin America, I also argue that disease eradication and public health efforts were key to processes of state formation in the region and became intertwined with debates about citizenship, race, and national belonging.

1.2 SCHOLARLY CONTEXT

Over the past three decades social and cultural historians have produced a large body of work on the politics of tuberculosis.²⁵ Taken as a whole, they have demonstrated that it remained a

²⁴ Frank Snowden made this argument for malaria in Italy in *The Conquest of Malaria: Italy, 1900–1962* (New Haven: Yale, 2006), 3.

²⁵ The literature includes Randall Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989); Linda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain* (New York: Oxford University Press, 1988), 95, 227; Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876–1938* (University of Pennsylvania Press, 1992); Barron H. Lerner, “New York City’s Tuberculosis Control Efforts: The Historical Limitations of the ‘War on Consumption’,” *American Journal of Public Health* 83, no. 5 (May 1993): 758–66; Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994); David S. Barnes, *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* (Berkeley: University of California Press, 1995); Georgina D. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick: Rutgers University Press, 1995); William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan* (Cambridge, MA: Council of East Asia Studies, Harvard University, 1995); Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, MA: Harvard University Press, 1996); Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900–1950* (Montreal: McGill-Queen’s University Press, 1999); Diego Armus, “Tango, Gender, and Tuberculosis in Buenos Aires, 1900–1940,” in *Disease in the History of Modern Latin America: From Malaria to AIDS*, ed. Diego Armus (Durham: Duke University Press, 2003), 101–29; Diego Armus, *La ciudad impura: Salud, tuberculosis y cultura en Buenos Aires, 1870–1950* (Buenos Aires: Edhasa, 2007), 279–80; Alison Bashford, “The Great White Plague Turns Alien: Tuberculosis and Immigration in Australia, 1901–2001,” in *Tuberculosis Then and Now: Perspectives on the History of an Infectious*

“Cinderella” disease throughout the early- to mid-twentieth century. Despite its demographic significance, tuberculosis often “lacked both the ‘glamour’ necessary to sustain political and scientific interest and the economic impact necessary to ensure official intervention.”²⁶ Its sufferers were often on the geographic, racial, and economic peripheries of nations or empires, and they faced a financially-strapped and insufficient public health infrastructure and encountered national governments that were reluctant to take on the burden of the disease.

Scholars propose varied reasons for the neglect of tuberculosis, including local social relations, attitudes toward the welfare state, and international norms of disease control. For instance, in many places, public figures and physicians placed blame for high mortality on the behavior and biology of non-white groups, and racial politics and science provided the language to block proposals for increased funding for the treatment of the disease.²⁷ Debates over the proper role of state intervention in health matters influenced many national governments’ refusal to accept responsibility for the ailment.²⁸ Tuberculosis constitutes a chronic disease, and historically, these have garnered less national visibility than the chaos-inducing epidemic crises.²⁹ Most national governments did not begin to fund and spearhead tuberculosis treatment, prevention, and diagnostic programs until the post-war period, when they were confronted with very high mortality and morbidity rates (induced by wartime conditions) and could take

Disease, eds. Flurin Condrau and Michael Worboys (Montreal: McGill-Queen’s University Press, 2010), 100–22; Armus, *The Ailing City*, 123–25.

²⁶ Mark Harrison and Michael Worboys, “A Disease of Civilisation: Tuberculosis in Britain, Africa and India, 1900–39,” in *Migrants, Minorities, and Health: Historical and Contemporary Studies*, eds. Lara Marks and Michael Worboys (London: Routledge, 1997), 116.

²⁷ Packard, *White Plague, Black*; Tera W. Hunter, *To ‘Joy My Freedom: Southern Black Women’s Lives and Labors after the Civil War* (Cambridge: Harvard University Press, 1997), 187–218; Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles* (New Brunswick: Rutgers University Press, 2007).

²⁸ McCuaig, *The Weariness, the Fever, and the Fret*; Feldberg, *Disease and Class*; Bryder, *Below the Magic Mountain*.

²⁹ Diego Armus, “Disease in the Historiography of Modern Latin America,” in *Disease in the History*, 8.

advantage of new technological tools that made mass campaigns more affordable (i.e., mass miniature X-ray radiography, outpatient antibiotic therapy).³⁰

The Cuban government's earlier and sustained interest in tuberculosis does not fit this chronological narrative. Cuba was one of several countries in the 1930s, including Italy, Brazil, Argentina, and Spain, whose national governments began to substantially expand the reach of their anti-tuberculosis efforts.³¹ Although historians have not interrogated this phenomenon, all these cases shared the rise of centralized states and new political formations, based on populist rhetoric, class politics and popular mobilization. This dissertation, then, adds complexity to the broader historiography of tuberculosis, using Cuba as a case study to explore the interaction between tuberculosis and authoritarian populism.

Cuban historiography offers few explanations for why the Cuban state pursued an early and aggressive anti-tuberculosis campaign. In decades past, scholars of Cuba produced an image of the republican state as weak: mediated by imperialism and infiltrated by corruption, its institutions and politicians were disinterested in or incapable of undertaking state-building endeavors. Scholars' focus on U.S. imperialism, especially during the First Republic (1902–1933), often obscured the decisions and projects of national actors. The revolution of 1959, which painted itself as the fulfillment of previous nationalist mobilizations (1898, 1933), has shaped an understanding of the entire republican period (1902–1958) “in terms of what did *not*

³⁰ See, for example, Lynda Bryder, “‘We Shall Not Find Salvation in Inoculation’: BCG Vaccination in Scandinavia, Britain, and the USA, 1921–1960,” *Social Science & Medicine* 49 (1999): 1157–67; McCuaig, *The Weariness, the Fever, and the Fret*.

³¹ Claudio Bertolli Filho, *História Social da Tuberculose e do Tuberculoso: 1900–1950* (Rio de Janeiro: Editora Fiocruz, 2001); Armus, *The Ailing City*; Jorge Molera Mesa, “Enfermedad y previsión social en España durante el primer franquismo (1936–1951): El frustrado seguro obligatorio contra la tuberculosis,” *Dynamis* 14 (1994): 199–225. I have found no secondary literature (in English) on tuberculosis in Italy, but Cubans in the 1930s referenced the tuberculosis insurance legislated by Mussolini in the late 1920s.

happen.”³² As several scholars of the early republican period write, “It is easy to see why the Cuban republic has become ‘el tiempo omitido’ (the ‘time that is left out’), as Marial Iglesias has put it.”³³ They continue, “Seen this way, the entire republican experience prior to 1959 is merely the antithesis of the Cuban revolution. It is a fifty-seven-year period of U.S. proxy rule studded with villains and martyrs and punctuated by political upheavals that prefigure the historical absolution of 1959.”³⁴

Undergirded by an assumption of state incapacity, scholarship on health in the republican period has mirrored these trends. Even those studies that attempt to provide an historical analysis of the public health sector in republican Cuba often paint a static, monochromatic picture.³⁵ As one anthropologist contends, “Between 1902 and 1959, the ‘state’ in Cuba was too contested, too parasitic, and too personalistic to coalesce into a viable authority that could enforce health codes and undertake crucial public works programs such as construction of water and sewer systems.”³⁶ Those who do attempt to add historical complexity to the period generally break it into two subperiods: until Machado, the island enjoyed medical advances and good sanitation; after Machado, Cuba’s health system entered a “stage of decay,” in which there was “an absence

³² Palmer et al., “Introduction,” in *State of Ambiguity*, 6–7. An early exception is Jorge I. Domínguez, *Cuba: Order and Revolution* (Cambridge, MA: Belknap Press of Harvard University Press, 1978). Works that use the republican period to explain the revolution of 1959 include Samuel Farber, *Revolution and Reaction in Cuba, 1930–60* (Middletown, CT: Wesleyan University Press, 1976); Marifeli Pérez-Stable, *The Cuban Revolution: Origins, Course, and Legacy*, 2nd ed. (New York: Oxford University Press, 1999); Samuel Farber, *The Origins of the Cuban Revolution Reconsidered* (Chapel Hill: University of North Carolina Press, 2006). Louis A. Pérez, Jr.’s superb body of scholarship has emphasized US-Cuban relations. See, for example, *Cuba: Between Reform and Revolution; Cuba under the Platt Amendment, 1902–1934* (Pittsburgh: University of Pittsburgh Press, 1986); *On Becoming Cuban: Identity, Nationality and Culture* (Chapel Hill: University of North Carolina Press, 1999); *The War of 1898*.

³³ Palmer et al., “Introduction,” in *State of Ambiguity*, 5.

³⁴ Ibid.

³⁵ One exception is Ross Danielson, *Cuban Medicine* (New Brunswick: Transaction Books, 1979).

³⁶ Katherine Hirschfeld, *Health, Politics, and Revolution in Cuba since 1898* (New Brunswick: Transaction Publishers, 2008), 14.

of state policies for addressing health problems.”³⁷ Other broad studies of health in Cuba simply omit the republican period, assuming the public health sector was unequivocally bad, which renders it as a nonissue for scholarly inquiry.³⁸

Over the last two decades, however, scholars of Cuba have begun to contend with the republican period on its own terms, analyzing the importance of the state and of domestic actors in shaping their own history (while still weighing the influence of outside actors, especially the U.S.).³⁹ Instead of continuing in the tradition of Cuban exceptionalism, many of these scholars locate Cuba within a Latin American context, drawing parallels with the nineteenth-century period of liberal nation-making and the mid-twentieth-century processes of populism, state-building, and class formation.

This framework has opened up new paths for junior scholars of Cuba, who have made health and medicine in the republic central to their research.⁴⁰ They are proving that there were efforts—however inadequate and flawed—to extend health services and improve national public

³⁷ José Ramón Ruíz Hernández, *La salud pública: Su desarrollo en el periodo revolucionario (1959–1980)* (Havana: Instituto de Desarrollo de la Salud, Ministerio de Salud Pública, 1986), 30.

³⁸ For instance, in one study of Cuban medicine and public health from 1840 to 1958, the work inexplicably stops in 1900; the section covering the twentieth century is an appendix of medical discoveries, conferences, and organizations, without any analysis. José A. Martínez-Fortún Foyo, *Historia de la Medicina en Cuba (1840–1958)*, Cuadernos de Historia de La Salud Pública 98 (Havana: Publicación del Consejo Nacional de Sociedades Científicas, 2005). Health, then, joins race relations as a “nonissue” after the revolution. Alejandro de la Fuente, *A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001), 3–4.

³⁹ De la Fuente, *A Nation for All*; Robert Whitney, *State and Revolution in Cuba: Mass Mobilization and Political Change, 1920–1940* (Chapel Hill: University of North Carolina Press, 2001); Alejandra Bronfman, *Measures of Equality: Social Science, Citizenship, and Race in Cuba, 1902–1940* (Chapel Hill: University of North Carolina Press, 2004); Rebecca J. Scott, *Degrees of Freedom: Louisiana and Cuba after Slavery* (Cambridge, MA: Belknap Press of Harvard University Press, 2005); Gillian McGillivray, *Blazing Cane: Sugar Communities, Class, and State Formation in Cuba, 1868–1959* (Durham: Duke University Press, 2009).

⁴⁰ Mariola Espinosa’s *Epidemic Invasions* was particularly influential in showing that U.S.-based scholars could pursue health histories of the republican period. Reinaldo Funes Monzote also opened up exciting avenues for those interested in the environmental aspects of disease. See, for example, “Slaughterhouses and Milk Consumption in the ‘Sick Republic’: Socio-Environmental Change and Sanitary Technology in Havana, 1890–1925,” in *State of Ambiguity*, 121–47.

health.⁴¹ This growing body of work also benefits from two scholarly communities. Under difficult conditions, historians in Cuba have done the painstaking work of writing institutional histories, medical biographies, and broad historical overviews of health and medicine in Cuba.⁴² Second, a burgeoning historiography of health and medicine in Latin America produced over the last two decades has established the value of using disease as a tool of social, political, and cultural analysis.⁴³

The broader international panorama of historical scholarship on public health and medicine has tended towards a certain bifurcation. In the 1970s and 1980s, historians were concerned with how health policies, ecological disruptions, and the political economy resulted in epidemiological changes.⁴⁴ They also sought to explain mortality transitions, sparking a debate over whether medical interventions or rising standards of living explained improvements in health indicators.⁴⁵

⁴¹ Gutiérrez, “Disease, Empire, and Modernity in the Caribbean”; Daniel Rodríguez, “‘A Blessed Formula for Progress’: The Politics of Health, Medicine, and Welfare in Havana, (1897–1935)” (PhD diss., New York University, 2013); Jennifer Lambe, “Baptism by Fire: The Making and Remaking of Madness in Cuba, 1899–1980” (PhD diss., Yale University, 2014); Daniel A. Rodríguez, “‘To Fight These Powerful Trusts and Free the Medical Profession’: Medicine, Class Formation, and Revolution in Cuba, 1925–1935,” *Hispanic American Historical Review* 95, no. 4 (2015): 595–629.

⁴² These scholars include César Rodríguez Expósito and Gregorio Delgado García, who have published prolifically in the *Cuadernos de Historia de la Salud Pública*. On the issue of tuberculosis, Enrique Beldarraín Chaple has produced excellent work. “Apuntes para la historia de la lucha antituberculosa en Cuba,” *Revista Cubana de Salud Pública* 24, no. 2 (1998): 97–105.

⁴³ For an overview of this literature, see Armus, “Disease in the Historiography,” 1–24.

⁴⁴ Thomas McKeown, *The Role of Medicine: Dream, Mirage or Nemesis?* (Princeton: Princeton University Press, 1979); Díaz-Briquets, *The Health Revolution in Cuba*; James J. Horn, “The Mexican Revolution and Health Care, or the Health of the Mexican Revolution,” *Latin American Perspectives* 10, no. 4 (1983): 24–39; Meredith Turshen, *The Political Ecology of Disease in Tanzania* (New Brunswick, NJ: Rutgers University Press, 1984); Packard, *White Plague, Black Labor*; Gilberto Hochman, *A era do saneamento: As bases da política de saúde pública no Brasil* (São Paulo: Editora Hucitec/ANPOCS, 1998).

⁴⁵ See, for example, Thomas McKeown and R.G. Record, “Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century,” *Population Studies* 16 (1962): 94–122; Thomas McKeown, *The Modern Rise of Population* (London: Edward Arnold, 1976); Leonard G. Wilson, “The Historical Decline of Tuberculosis in Europe and America: Its Causes and Significance,” *Journal of the History of Medicine and Allied Sciences* 45, no. 3 (1990): 366–96; James Colgrove, “The McKeown Thesis: A Historical Controversy and Its Enduring Influence,” *American Journal of Public Health* 92, no. 5 (May 2002): 725–29.

In response to the cultural/linguistic turn in the early 1990s, historians of medicine began to discard the quantitative tools of social history. This sociocultural approach instead utilized disease as a lens to explore broader topics, such as the growth of the welfare state, medical professionalization, and the construction of difference (e.g., race, gender). As historian Diego Armus notes, “This approach barely skims across the history of a given etiology; rarely is there any attempt to set up a dialogue between sociocultural history and the history of biomedical sciences.”⁴⁶ Many scholars of this new wave turned to the discursive insights of Foucault, foregrounding how medicine and health interventions relate to imperialism and internal colonialism within a nation-state. This culturalist approach critically analyzes the normalizing effects of medical discourses and how the state exercised power through biopolitical projects.⁴⁷

This dissertation argues that it is most productive to merge these two approaches, paying attention to both empirical health outcomes and cultural constructions of disease. This method means that both state health efforts and grassroots definitions of medical success must be part of the research agenda. When health statistics and institutional results are not considered, it becomes difficult to understand how health was experienced by people on the ground. However, tracing epidemiological outcomes alone cannot explain how historical actors (both ordinary citizens and medical professionals) defined medical success, how they evaluated the state’s

⁴⁶ Armus, “Disease in the Historiography,” 5.

⁴⁷ See, for example, Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993); Teresita Martínez-Vergne, *Shaping the Discourse on Space: Charity and Its Wards in Nineteenth-Century San Juan, Puerto Rico* (Austin: University of Texas Press, 1999); Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco’s Chinatown* (Berkeley: University of California Press, 2002); Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico* (Berkeley: University of California, 2002); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006).

performance on those metrics, and what the political outcomes of those evaluations were.⁴⁸ On the other hand, we will not be well-placed to interpret the frequently voluminous public discourse criticizing health projects and policies—sources generated by doctors, patients, and civic actors as they pushed the state for more resources to control diseases—unless we pair our reading of that critical discourse with attention to concrete trends in health outcomes. “The Sick Republic” thus advocates for adopting a “both-and” approach: paying attention to both empirical outcomes and the social construction of health and disease, from above and below.

By taking this approach, this dissertation uncovers key findings that make it possible to reconcile a decades-old debate in Cuban historiography. Since 1959, scholars from two very different political camps have attempted to prove that health was either better or worse following the revolution. Demographic analyses have shown that while the revolutionary government did make advances in health, the most radical drops in mortality and increases in life expectancy happened before 1959. In fact, by 1958, Cuba possessed some of the best health indicators in the Latin American region.⁴⁹ Another group of scholars have instead focused on the shortcomings of the republican administrations, primarily by emphasizing measures and issues other than national statistics (e.g., rural-urban disparities in doctor-to-patient ratios; absence of proper water sanitation; corruption).⁵⁰ This literature argues that Cubans were deeply unhappy with the quality

⁴⁸ As Flurin Condrau contends, “[U]nderstanding success as an objective rather than a historically shaped category appears ultimately to be an ahistoric notion.” “Urban Tuberculosis Patients and Sanatorium Treatment in the Early Twentieth Century,” in *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare in Britain, c. 1550–1950*, eds. Anne Borsay and Peter Shapely (Burlington, VT: Ashgate, 2007): 187.

⁴⁹ Those that emphasize mortality trends include Díaz-Briquets, *The Health Revolution in Cuba*; Leví Marrero, *Cuba en la década de 1950: Un país en desarrollo* (Santo Domingo: Editora Corripio, 1987); James W. McGuire and Laura B. Frankel, “Mortality Decline in Cuba, 1900–1959: Patterns, Comparisons, and Causes,” *Latin American Research Review* 40, no. 2 (2005): 83–116; Roberto M. González, “Infant Mortality in Cuba: Myth and Reality,” *Cuban Studies* 43 (2015): 19–39.

⁵⁰ Those that emphasize corruption include Carmen Arocha Mariño, “La economía y la salud pública en Cuba en la década de 1940,” *Revista Cubana de Salud Pública* 24, no. 2 (2000): 128–33; Hirschfeld, *Health, Politics, and Revolution in Cuba*. Sergio Díaz-Briquets represents an exception to this division of analytical labor: in the introduction to his superb book, he includes both trends. Additionally, he was careful to note that quantitative

of their health care before 1959, in ways that the revolutionary regime that followed sought actively to address.

This dissertation has proven that both sides in this debate are correct. On many counts, Cuba's health care system proved to be well developed and more advanced than regional neighbors, as the Cuban state pursued serious health initiatives (e.g., the CNT, experimentation with modern health units, and tuberculosis sanatorium construction). This system also produced significant successes, evidenced by mortality declines and good health indicators by Latin American standards. However, it was plagued by politics, and this resulted in citizens being dissatisfied with their health sector.

In tackling such questions, this dissertation also situates itself in a historiographical turn that offers a revisionist history of the Cuban revolution by questioning the assumption that 1959 was a definitive historical rupture. Scholars who have begun to cross the "great divide" have examined the victories of a social revolution, while also tracing its limitations and continuities with the republican period (what Alejandro de la Fuente has referred to, respectively, as the "yet" and the "still" in the revolution's discourse).⁵¹

Finally, this dissertation contributes to the literature on state-building in Latin America. Sociologists, political scientists, and historians have created a robust body of work on this subject, primarily measuring state formation through education; taxation; infrastructural development (e.g., railroads); and military participation and war.⁵² Social and cultural histories

national health indicators in Cuba have masked regional, racial, and other social inequalities. *The Health Revolution in Cuba*, 4.

⁵¹ "La Ventolera: Ruptures, Persistence and the Historiography of the Cuban Revolution," (paper presented at the conference on "New Histories of the Cuban Revolution," Yale University, October 3–4, 2014).

⁵² See, for example, Hendrik Kraay, *Race, State, and Armed Forces in Independence-Era Brazil: Bahia, 1790s–1840s* (Stanford: Stanford University Press, 2001); Miguel Angel Centeno, *Blood and Debt: War and the Nation-State in Latin America* (University Park: Pennsylvania State University Press, 2002); Marcus J. Kurtz, *Latin American State Building in Comparative Perspective: Social Foundations of Institutional Order* (New York:

of health and medicine in Latin America have flourished over the last two and a half decades;⁵³ however, few public health historians have explicitly considered the intersection of public health and state-building.⁵⁴ I contend that healthcare services, a crucial component of social citizenship by the mid-twentieth century, should be included in analyses of state formation processes.⁵⁵

This dissertation, then, pursues three main lines of inquiry: What can explain the precocious state attention paid to tuberculosis in Cuba, especially the 1936 initiative? If the Cuban state made the disease central to its state-building endeavors and efforts, resulting in the steady growth of health institutions and infrastructure, why did citizens perceive this project as inadequate at best and fundamentally flawed at worst? How did the tuberculosis programs implemented by the revolutionary government connect with or deviate from previous ones?

Cambridge University Press, 2013); Heidi Jane M. Smith, "State Building and Taxation in Latin America," *Latin American Research Review* 49, no. 3 (Summer 2014): 256–62; Miguel A. Centeno and Agustin Ferraro, eds., *State and Nation Making in Latin America and Spain: Republics of the Possible* (New York: Cambridge University Press, 2014); Hillel David Soifer, *State Building in Latin America* (Cambridge: Cambridge University Press, 2015).

⁵³ For an overview of this trend, see Marcos Cueto, "Introducción," in *Salud, cultura, y sociedad en América Latina*, ed. Marcos Cueto (Lima: IEP/Organización Panamericana de Salud, 1996), 13–30; Armus, "Disease in the Historiography," 1–24.

⁵⁴ Diego Armus states, "[I]ssues of state formation—a key topic among political scientists and sociologists—cannot be discussed ignoring public health problems, and the other way around. Something that, in the history of public health so far, I think that we don't have. Those people who are cultivating public health probably are not very into the idea that what we are discussing in the end is state formation." Interview with Steven Palmer, "Historiographical Reflections on Health and Medicine in Latin America: A Conversation with Diego Armus," *Canadian Journal of Latin American and Caribbean Studies* 35, no. 69 (2010): 34. A small, but growing, body of public health historians of Latin America has begun to address these issues. See, for example, Katherine Bliss, *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City* (University Park: Pennsylvania State University Press, 2001); Diana Obregón, "Building National Medicine: Leprosy and Power in Colombia, 1870–1910," *Social History of Medicine* 15, no. 1 (2002): 89–108; Steven Palmer, *From Popular Medicine to Medical Populism: Doctors, Healers, and Public Power in Costa Rica, 1800–1940* (Durham: Duke University Press, 2003); Ann Zulawski, *Unequal Cures: Public Health and Political Change in Bolivia, 1900–1950* (Durham: Duke University Press, 2007); Heather McCrea, *Diseased Relations: Epidemics, Public Health, and State-Building in Yucatán Mexico, 1847–1924* (Albuquerque: University of New Mexico Press, 2010); Nicole Pacino, "Prescription for a Nation: Public Health in Post-Revolutionary Bolivia, 1952–1965" (PhD diss., University of California, Santa Barbara, 2013).

⁵⁵ This dissertation will also contribute to medical historiography beyond Latin America. While political scientists and historians have generated an extensive body of work on citizenship, few medical historians have explored the intersection between health and citizenship, which has resulted in teleological narratives that have assumed that "the growing rapport between medicine and the state was both desirable and more or less foreordained." Harry Oosterhuis and Frank Huisman, "The Politics of Health and Citizenship: Historical and Contemporary Perspectives," in *Health and Citizenship: Political Cultures of Health in Modern Europe*, eds. Frank Huisman and Harry Oosterhuis (London: Pickering and Chatto Publishers, 2013), 5.

1.3 ARGUMENTS

As national politics shifted in Cuba in the 1920s, so too did the politics of disease, shaped by nascent labor organizations, surging nationalism, and disquiet over what many considered to be Cuba's sanitary decline. Tuberculosis had long plagued the *clases populares*, and their growing importance in Cuban politics propelled increased state attention to the disease. During the presidency of Gerardo Machado, his administration initiated a paternalistic and charity-based effort to expand tuberculosis services.

Concurrently, public debates about tuberculosis invoked an explosive mix of claims regarding race and nation; poverty and inequality; exclusion and inclusion; nationalism and immigration; citizen entitlements and hygienic responsibilities. Black politicians and public figures critiqued the limited state campaign and articulated the idea of citizen's right to health care. Physicians bolstered this call for an expanded state health care system, arguing that the Cuban government had the responsibility to scientifically fund and manage the campaign, replacing individuals active in anti-tuberculosis charities. In the following decades, other Cubans—including ordinary citizens, intellectuals, civic actors, and journalists—participated in defining the right to health and in demanding its implementation. I contend that it was these actors in the republican period, not the revolutionary government of 1959, who enshrined health as a cornerstone of state efficiency and citizenship.⁵⁶

When military strongman Fulgencio Batista launched a massive tuberculosis campaign in 1936, to be carried out by the new *Consejo Nacional de Tuberculosis* (CNT), he was responding

⁵⁶ Scholars of Cuba often say that the revolutionary government introduced the right to health care. It would be more appropriate to say that they came closer than any past government in fulfilling that right. Enrique Beldarraín Chaple, "La salud pública en Cuba y su experiencia internacional (1959–2005)," *História, Ciências, Saúde-Manguinhos* 13, no. 3 (July–September 2006): 710.

to the demands brought to the forefront by citizens themselves. The presidential hopeful's decision to extend the campaign's funding and scope promised high political dividends in a context of populist politics. Batista's well-known desire to be the "architect of the Cuban state" relied heavily upon the construction of a new social welfare edifice, and he made the CNT a pillar of this state-building effort. From 1936 on, the Cuban state—first under Batista and then under his successors—pursued a project that steadily expanded the infrastructure of tuberculosis surveillance and treatment for its citizens.

However, by the 1950s, while tuberculosis services had improved on many counts, citizens and physicians perceived the anti-tuberculosis campaign as an effort that had largely failed. The heightened visibility of tuberculosis, achieved in part by the claims-making of citizens, had channeled state attention towards a disease of the poor, but it had also distorted the design of health projects and policies, making them inefficient, openly political, and marred by corruption. Furthermore, over the previous three decades, in a number of spaces—from debates at international medical congresses held in far-away cities to agonizing experiences endured in the slums of Havana—citizens and medical professionals had formulated specific expectations of the public health sector. Despite the multiplication of dispensaries across the national territory and a declining mortality rate, the Cuban state had performed poorly on many of these issues. Cubans were concerned with the state's failure to remove patronage from hospital admissions and health personnel appointments; the state's inability to make available an adequate number of tuberculosis beds; the politicization of high profile projects; difficulties in accessing antibiotic therapy; and the absence of preventive health practices. These characteristics defined a "modern" public health sector, a distinction that Cubans felt could not be applied to their own nation.

On the eve of revolution, the gap between these expectations and the performance of republican administrations influenced the growing de-legitimation of the state, the overthrow of Batista's government, and the new regime's priorities in health policy. In their first years of governing, revolutionary health administrators deployed resources to respond to the shortcomings of the republican years. For instance, they carried out mass vaccination and sent trained personnel to peripheral areas that had never had access to medical care. For many Cubans, these campaigns signified a long-awaited wind of change sweeping through their tiny hamlets.

Nonetheless, continuities existed across 1959, obscured by the official rhetoric of all-consuming change. The new government relied upon what can be considered successes of the republican administrations, utilizing infrastructure, resources, and personnel developed before 1959. Furthermore, as the state initially prioritized magic bullet technologies and medical interventions, many of the poor continued to fall through the cracks of the welfare state, as they waited on legislation that would attend to the deep social roots and economic consequences of their disease.

1.4 CHAPTER OUTLINE

Chapter 2 traces the contours of the public debates surrounding tuberculosis in the late 1920s and 1930s. Medical professionals, volunteers in the tuberculosis campaign, and intellectuals all agreed that the state needed to do more to control tuberculosis, but questions of race, immigration, and social inequality created controversy. In this contested space, great tension existed between ideas of rights and responsibilities. Discourses of hygienic citizenship

emphasized that individual citizens should adhere to sanitary norms and behaviors to stem contagion. This language, which racialized the disease and depoliticized health inequalities, persisted as a durable language of blame throughout the Second Republic (1933–1958). Nonetheless, in the late 1920s, it also spurred black intellectuals and politicians to firmly articulate the idea of an individual’s right to health care on the basis of membership in the nation. This right had become firmly entrenched in the arsenal of citizenship demands by the mid-1930s (and codified in the 1940 Constitution), one that Cubans would draw from again and again throughout the republican period.

In response to this grassroots articulation of the right to health, and in his attempts to strengthen the state, Fulgencio Batista launched a wide-reaching tuberculosis campaign when he founded the *Consejo Nacional de Tuberculosis*. Chapter 3 follows the infrastructural expansion of this institution from 1936 to 1958, while also examining the critiques of citizens who continually sought a more extensive and geographically equal network of treatment services. The chapter continues this line of investigation into the revolutionary period: while the new government attended to marginalized spaces, it never fully rectified the concentration of medical resources in Havana. Furthermore, it continued to rely on the private actions of citizens to assist where the state could not, continuing a problematic tradition of charity in health that had existed under the Machado (1925–1933) and Auténtico (1944–1952) administrations.

The remaining chapters explore specific aspects of the tuberculosis campaign that illustrate the contradictions of a state-building project that was both expansive and widely maligned by citizens and medical professionals. At times, I expand the lens to consider issues that affected the public health sector at large. Chapter 4 analyzes the dense webs of patronage that permeated the Cuban public health system and public health officials’ attempts to replace

them with more technical and apolitical procedures. The first part of the chapter reconstructs the partnership of Cuba and the Rockefeller Foundation's International Health Division (RF), which sought to reform and modernize local public health units. The presence of the RF—and its highly-publicized exit from the country after its efforts were frustrated—served to accentuate the deeply rooted problem of patronage, so that by the late 1940s, in a context of worsening government corruption, citizens and physicians became acerbic in their criticism of the CNT. They accused it of unfair hospital admission procedures and of staffing its dependencies with unqualified, yet politically well-connected, appointees. The controversy dissipated in the wake of Batista's coup d'état in 1952, but the government never resolved the issue of patronage in the health sector.

Chapter 5 recounts the saga of the Topes de Collantes National Sanatorium, the premiere project of the CNT and a symbol of health during the republic that animates Cubans to this day. Batista governed as an authoritarian populist: appeasing the popular classes guided his decision to prioritize tuberculosis (and the authoritarian nature of his rule allowed him to freely dedicate resources to the disease); in contrast, advocates struggled to gain state attention to fight tuberculosis in many other countries. However, authoritarianism also made it possible for Batista to exercise undue influence over the conception and implementation of the project.⁵⁷ Guided by political objectives rather than technical advice, the project became a paragon of inefficiency and politicization. The poorly planned sanatorium cost millions and took seventeen years to open. Construction difficulties and political rivalries delayed its inauguration. Operating for less than five years, the sanatorium was quickly repurposed by the revolutionary government in 1959.

⁵⁷ Other works have highlighted how different ideological traditions and political systems have affected national health. See Werner Troesken, *The Pox of Liberty: How the Constitution Left Americans Rich, Free, and Prone to Infection* (Chicago: University of Chicago Press, 2015).

Chapter 6 examines the arrival of streptomycin—a widely known “cure” for tuberculosis—on the island in the late 1940s. By 1953, tuberculosis mortality had plummeted, suggesting that enough people had gained sufficient access to the drug to prevent or delay death. However, in the same period, citizens’ denunciations of the CNT and the Cuban state had never been more excoriating. Frustrated by their difficulties in accessing the expensive drug, the sick began to articulate (along with physicians) the right of the poor to free or state-subsidized medicine. Officials responded sluggishly, and private charities returned to plug gaps in the welfare system and help poor Cubans obtain the drug.

Chapter 7 turns to physicians’ demands for the protection of the healthy through preventive health measures, specifically the *Bacillus Calmette-Guérin* (BCG) vaccine.⁵⁸ By the 1950s, Cuba possessed a BCG Institute that produced (and exported) the vaccine, legislation that made vaccination obligatory, and significant funding to be used for mass vaccination. Nonetheless, the Institute continually fell far short of annual vaccination goals, due to an insufficient rural health network, lack of political will, and citizens’ resistance. When the revolutionary government came to power in 1959, they initiated a successful mass BCG vaccination campaign. The effort, however, owed part of its success to the vaccination infrastructure developed in the 1940s and 1950s.

⁵⁸ The BCG vaccine is made from an attenuated strain of the bovine tuberculosis bacillus and was first developed in France in 1921. Although its efficacy was the subject of intense international debates, many scientists (including a large portion of the Cuban medical community) believed that a series of BCG vaccinations could provide immunity against the disease, especially if children were vaccinated as early as possible. Simona Luca and Traian Mihaescu, “History of BCG Vaccine,” *Maedica (Buchar)* 8, no. 1 (March 2013): 53–58.

1.5 CUBA'S MEDICAL ORGANIZATION AND TERMINOLOGY

While this dissertation focuses almost exclusively on Cuba's public health sector, a brief note on the broader health care system is necessary. In the period under study, there were four categories of medical care: the public sector; the private sector (made up of fee-for-service practices); and the contributory sector, which had two separate systems: (1) a large, growing number of cooperative pre-paid medical plans and (2) "a small number of very large pre-paid medical plans" offered by the Spanish ethnic mutual-aid societies.⁵⁹ Overlap existed among these four categories: "The contributory sector served the middle classes, some organized workers, and many of the rich. The private sector, which was small by Latin American standards, served mainly the rich, although most people bought private medical services for some purposes. The purely public sector served mainly the poor, although many who were not poor used its services at one time or another."⁶⁰

Any study of health must confront the surprisingly difficult task of defining the term "public health." This category has changed over time and place and is "historically contingent and embedded in changing socio-political frames of thought, debate and practice, which not only reflect, but also shape their social realities."⁶¹ One historian summarizes, "'Public health' has at times been 'medical police,' 'state medicine,' 'public hygiene' (*hygiene publique*), or, most comprehensively, 'social medicine,' in which our 'public health' was only one division."⁶²

In Cuba during the mid-twentieth century, a subset of physicians sought to distinguish "public health" from clinical medicine, as a discipline and practice. For them, the former focused

⁵⁹ Danielson, *Cuban Medicine*, 101.

⁶⁰ McGuire and Frankel, "Mortality Decline in Cuba," 102.

⁶¹ Oosterhuis and Huisman, "The Politics of Health and Citizenship," 6.

⁶² Christopher Hamlin, "Public Health," in *The Oxford Handbook of the History of Medicine*, ed. Mark Jackson (Oxford: Oxford University Press, 2013): 412.

on the health of the collective, primarily through epidemiological surveillance and preventive health practices, and the latter was the purview of physicians focused on individuals and curing disease. They were supported by a growing corpus of public health officials in the Americas, who focused on preventive measures administered by local health units, considering medical care for the poor to be a separate issue to be administered by welfare departments.⁶³

However, other Cubans used the term “public health” broadly, referring to both state-sponsored health services for the poor and techniques to prevent disease. Unless otherwise noted, my dissertation uses the terms “public health” and “public health sector” in this comprehensive sense. One significant exception is the chapter on the Rockefeller Foundation, in which I am careful to delineate “public health” from the “public health sector,” as the very definition of “public health” was being disputed.

At the end of the twentieth century, tuberculosis “returned” with a vengeance throughout the world.⁶⁴ Pockets of rising incidence of the disease—now in multi-drug resistant and extremely drug-resistant forms—line up with spaces where inequality is worsening. The WHO has recently announced a campaign to end the tuberculosis epidemic by 2035. Cuba, which has been selected as part of the initiative, has declared its own intent to be the first country to eliminate the disease.⁶⁵ The goal is possible, the country insists, because of its drastic lowering of cases “over

⁶³ James Colgrove, *Epidemic City: The Politics of Public Health in New York* (New York: Russell Sage Foundation, 2011), 6. In the United States, for example, clinical medicine remained dominant, and public health suffered as a result. Elizabeth Fee, “Designing Schools of Public Health for the United States,” in *A History of Education in Public Health*, eds. Elizabeth Fee and Roy M. Acheson (Oxford: Oxford University Press, 1991): 155–94.

⁶⁴ Tuberculosis never left of course. Instead, it ceased to be a public health problem and receded into private spaces. With the explosive mix of homelessness, AIDS, and MDR-TB in the early 1990s, the disease returned to national and international visibility. Ott, *Fevered Lives*, 157.

⁶⁵ “OMS considera posible la eliminación de la tuberculosis en Cuba,” *Granma*, July 3, 2014, <http://www.granma.cu/salud/2014-07-03/oms-considera-posible-la-eliminacion-de-la-tuberculosis-en-cuba>, accessed March 30, 2016.

the past five decades, despite the U.S. blockade.”⁶⁶ However, in 2006, a specialist at the National School of Public Health in Cuba recognized that prior to the revolution “more had been done in our country in the struggle against tuberculosis than against any other disease.”⁶⁷ Understanding the path toward elimination demands an historical perspective, one that takes into account how a national disease was made: the process by which ordinary citizens, medical professionals, and health workers successfully pushed an unlikely disease to the forefront of national visibility. Considering the limitations and shortcomings of this endeavor is also crucial for offering lessons to those currently fighting for better health and “for better lives,” especially as debates about what constitutes “health” and the most effective way to achieve it are increasingly contentious in an age of neoliberalism.⁶⁸

⁶⁶ “Cuba Aims to Be 1st to Eliminate Tuberculosis in Latin America,” *Telesur*, March 26, 2016, <http://www.telesurtv.net/english/news/Cuba-Aims-to-Be-1st-to-Eliminate-Tuberculosis-in-Latin-America-20160326-0038.html>, accessed March 30, 2016.

⁶⁷ Beldarraín Chaple, “Apuntes para la historia de la lucha antituberculosa en Cuba,” 104.

⁶⁸ Hamlin, “Public Health,” 412.

2.0 TUBERCULOSIS AND CITIZENSHIP: COMPETING VISIONS OF HYGIENE AND HEALTH, 1925–1940

By the mid-1920s, physicians were vocally concerned about the changing panorama of national public health.⁶⁹ For over two decades, Cuba had enjoyed a reputation as a salubrious island, whose sanitation practices put it “on a plane with advanced nations.”⁷⁰ As economic conditions and political corruption worsened under the administration of Alfredo Zayas y Alfonso (1921–1925), however, public health officials had a more difficult time maintaining sanitary standards.⁷¹ The motif of a “sick republic” spread throughout the medical and popular presses, a sharp divergence from previous assessments.⁷²

⁶⁹ Portions of this chapter were originally published as Kelly Urban, “The ‘Black Plague’ in a Racial Democracy: Tuberculosis, Race, and Citizenship in Cuba, 1925–1945,” *Cuban Studies* 45 (January 2017): 319–39.

⁷⁰ “Medical Education and Public Health in Cuba,” 1927–1928, 25, Folder 1, Box 1, Series 315, Record Group 1.1, International Health Division records, Rockefeller Foundation records, Rockefeller Archive Center. Hereafter, the following abbreviations will be used for citing sources from the Rockefeller Archive Center: Folder (F); Box (B); Series (S); Record Group (RG); Rockefeller Foundation records, Rockefeller Archive Center (RF-RAC).

⁷¹ Alejandro de la Fuente, *A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001), 91.

⁷² Reinaldo Funes Monzote writes, “While the allegory of the polity as sick organism was common in the Latin American social essay and novel of the era, its appearance in Cuba was surprising, contrasting as it did with two decades of positive evaluations of the island’s progress in hygiene and public health starting with the first U.S. occupation...[I]n the 1920s new criticism emerged among scientists concerning the state of health and hygiene, and it became an important part of the enumeration of symptoms of republican decadence....From this perspective, the degeneration was a consequence as much of biological and social heritage or the influence of climate as it was of political corruption, bad public administration, and control over national resources by foreign interests.”

“Slaughterhouses and Milk Consumption in the ‘Sick Republic’: Socio-Environmental Change and Sanitary Technology in Havana, 1890–1925,” in *State of Ambiguity: Civic Life and Culture in Cuba’s First Republic*, eds. Steven Palmer, José Antonio Piqueras, and Amparo Sánchez Cobos (Durham: Duke University Press, 2014), 121–22.

Tuberculosis, “the great scourge of the capital,” loomed large in these evaluations of national health as one of the strongest indications of Havana’s sanitary decline.⁷³ After years of steadily decreasing, the tuberculosis mortality rate began to increase in 1924.⁷⁴ The persistence of the tuberculosis problem provided “a very painful contrast” to past sanitary achievements, as if the “conquests of modern hygiene and the renowned zeal of public health authorities shattered against it.”⁷⁵

While the situation was troubling for those concerned with Cuba’s reputation, it was felt most acutely by the poor struggling with the disease. The state-funded network of hospitals had expanded over the years, but not enough to keep “pace with the demands for care of the unfortunate.”⁷⁶ Tuberculosis and poverty became motifs in the popular arts.⁷⁷ In 1935, for example, both the prestigious Lyceum salon and popular news magazine *Bohemia* displayed the work of a new artist, Fidelio Ponce de León (1895–1949), whose work gained notoriety during this decade.⁷⁸ His painting *Tuberculosis* (1934) not only presented a chilling portrait of the often-fatal disease, but also critiqued Cuba’s social divisions and political economy through depictions of poverty and death.⁷⁹

⁷³ “Medical Education,” 18, F 1, B 1, S 315, RG 1.1, RF-RAC; Funes Monzote, “Slaughterhouses and Milk Consumption,” 128.

⁷⁴ It is unclear what caused this mortality increase, although it is possible that the economic crisis of the early 1920s, and a resultant decline in nutrition, played a role. Sergio Díaz-Briquets, *The Health Revolution in Cuba* (Austin: The University of Texas Press, 1983), 69–72.

⁷⁵ “Flagelo Social,” *Carteles* 14, no. 34 (August 25, 1929): 9.

⁷⁶ “Medical Education,” 36, F 1, B 1, S 315, RG 1.1, RF-RAC.

⁷⁷ See, for example, José Rico de Estasen, “La muerte de la tuberculosa,” *Bohemia* 19, no. 29 (July 17, 1927): 9.

⁷⁸ *Bohemia* 27, no. 48 (December 1, 1935): n.p.

⁷⁹ See Fidelio Ponce de León, *Tuberculosis*, 1934. Oil on canvas, 92cm X 122cm. Museo Nacional de Bellas Artes, Havana. For more on Ponce de León, see Juan Sánchez, *Fidelio Ponce* (Havana: Editorial Letras Cubanas, 1935), 123. Fidelio Ponce de León, an alcoholic, may have already contracted tuberculosis by 1934. La Esperanza Sanatorium admitted him as a patient in 1946, and he died of the disease in 1949.

Diseases like yellow fever, which had captured official attention in past decades, had “ceased to be real dangers, almost becoming ghosts.”⁸⁰ Instead, one public health official summarized, “Tuberculosis is the disease that causes the largest number of victims among us,” according it “an exceptional importance.”⁸¹ At the National Medical Congress in late 1927, one physician declared tuberculosis to be “the only health problem of momentous *national* importance, which is necessary to confront with decisiveness and energy.”⁸² The heightened visibility of tuberculosis across governmental and popular sectors reflected the growing nationalism and labor mobilization on the island.⁸³ In response to these changing politics of disease, the health administration of President Gerardo Machado y Morales (1925–1933) created a new anti-tuberculosis board, staffed by public officials and charitable volunteers, to alleviate the tuberculosis problem and gain political legitimacy.

Most medical professionals, volunteers in the tuberculosis campaign, and intellectuals agreed that the Machado administration had made significant progress in controlling the disease, but had also crafted a campaign with serious limitations. Physicians, overwhelmingly concerned with the health of the collective and epidemiological trends, petitioned the state to replace volunteers in charitable organizations with state-employed and scientifically-trained public health men. A number of public intellectuals, politicians, and civic groups also voiced criticisms, and their discussions generated influential debates about exactly how health and citizenship intersected.

⁸⁰ Cuba, Secretaría de Sanidad y Beneficencia, *1926–1931: Cinco años de labor sanitaria y de beneficencia pública* (Havana: Imprenta y Librería La Propagandista, 1931), 40.

⁸¹ Ibid.

⁸² Alberto Sánchez de Fuentes quoted in n.a., “Crónica del VII Congreso Médico Nacional (Habana, Diciembre, 1927),” *Revista Médica Cubana* 39 (1928): 96. Emphasis mine.

⁸³ For more on mobilization in the period, see Robert Whitney, *State and Revolution in Cuba: Mass Mobilization and Political Change, 1920–1940* (Chapel Hill: University of North Carolina Press, 2001).

Citizenship is a complex topic, with myriad competing theoretical definitions, but many scholars reference its dual nature: “equal rights to the enjoyment of collective goods provided by the political association” and “equal duties to promote and sustain them.”⁸⁴ The medical historiography on citizenship has also paid attention to this tension, noting “two contradictory forms of medical citizenship.”⁸⁵ Alex Nading writes, “In the first form, citizenship entails individual responsibilities, often of a hygienic nature.”⁸⁶ A number of scholars of medicine have referred to this as “hygienic citizenship”⁸⁷: around the turn of the century, various public health

⁸⁴ Richard Bellamy, *Citizenship: A Very Short Introduction* (Oxford: Oxford University Press, 2008), 17. The scholarship on citizenship is vast. Important works include Charles Tilly, ed., *Citizenship, Identity, and Social History* (Cambridge: Cambridge University Press, 1996); Frederick Cooper, Thomas C. Holt, and Rebecca J. Scott, *Beyond Slavery: Explorations of Race, Labor, and Citizenship in Postemancipation Societies* (Chapel Hill: University of North Carolina Press, 2000); Evelyn Nakano Glenn, *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor* (Cambridge, MA: Harvard University Press, 2002); Michael Hanagan and Charles Tilly, eds., *Extending Citizenship, Reconfiguring States* (Lanham, MD: Rowman & Littlefield Publishers, 1999); and Lara Putnam, “Citizenship from the Margins: Vernacular Theories of Rights and the State from the Interwar Caribbean,” *Journal of British Studies* 53, no. 1 (January 2014): 162–91. On citizenship in Latin America in the twentieth century, see Deborah Yashar, *Contesting Citizenship in Latin America: The Rise of Indigenous Movements and the Postliberal Challenge* (Cambridge: Cambridge University Press, 2005); and Brodwyn M. Fischer, *A Poverty of Rights: Citizenship and Inequality in Twentieth-Century Rio de Janeiro* (Stanford: Stanford University Press, 2010). On race and citizenship in Latin America, see George Reid Andrews, *Afro-Latin America* (Oxford: Oxford University Press, 2004). On citizenship in twentieth-century Cuba, see de la Fuente, *A Nation for All*.

⁸⁵ Alex M. Nading, “‘Love Isn’t There in Your Stomach’: A Moral Economy of Medical Citizenship among Nicaraguan Community Health Workers,” *Medical Anthropology Quarterly* 27, no. 1 (2013): 86. More scholarship on medical citizenship is needed, for two prominent medical historians write, “Whereas studies by historians and political scientists on citizenship are manifold, the concept has hardly been applied explicitly in medical history.” Harry Oosterhuis and Frank Huisman, “The Politics of Health and Citizenship: Historical and Contemporary Perspectives,” in *Health and Citizenship: Political Cultures of Health in Modern Europe*, eds. Frank Huisman and Harry Oosterhuis (London: Pickering & Chatto Publishers, 2013), 5.

⁸⁶ Nading, “‘Love Isn’t There,” 86.

⁸⁷ Historians of disease and colonialism have developed the term “hygienic citizenship,” using it to analyze how health, in discourse and practice, has been integral to the operation of power and domination. They have argued that in the tension between the rights and duties of citizenship, historical actors have determined that civically responsible hygienic behaviors should precede the granting of the privileges or rights of citizenship. These scholars have specifically focused on certain controlled micro-orders in colonial settings, like the leper colony or sanatorium, where colonizers employed the notion of hygienic or biomedical citizenship. By performing sanitary behaviors acceptable to the colonizers and learning “to be responsible about their habits of living both in their own interests and in the interests of the community,” the “contaminated” would become worthy of citizenship (eventually). Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (New York: Palgrave MacMillan, 2004), 77; Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006), 3. On hygienic citizenship in national contexts, see Diego Armus, *The Ailing City: Health, Tuberculosis, and Culture in Buenos Aires, 1870–1950* (Durham: Duke University Press, 2011), 50.

administrations and civic associations undertook projects to ensure that individuals followed the precepts of hygienic science; over time, these social engineers began to shift their attention from epidemic control and the social environment to the individual and his or her behavior.⁸⁸ These notions placed the blame for poor health on the individual, which often served to depoliticize these issues by decontextualizing social problems.⁸⁹

The second form of medical citizenship is guided by the idea of health as a civil right or as a central component of social citizenship, in which “citizenship entails the enumeration of health needs to which governments must respond.”⁹⁰ From the end of the nineteenth century through the mid-twentieth century, as electorates expanded, states in the Western hemisphere increasingly provided or subsidized health care for their constituents.⁹¹ Nonetheless, even in this period of social-democratic citizenship, in which the idea and practice of health as a social right gained dominance, various actors continued to espouse notions of hygienic citizenship.

In Cuba in the late 1920s, elite actors argued that tuberculosis’s presence among the poor grew out of their inability to adhere to sanitary norms and perform behaviors that would inhibit contagion. Afro-Cubans suffered from tuberculosis mortality rates that were higher than their white counterparts, and they also were overrepresented among the poor. Discourses of hygienic

⁸⁸ Oosterhuis and Huisman, “The Politics of Health,” 32.

⁸⁹ There is an entire body of sociological literature devoted to medicalization’s depoliticizing effects. See, for example, Cheryl Stults, “Medicalization,” in *Encyclopedia of Social Problems*, ed. Vincent N. Parrillo (Thousand Oaks, CA: Sage, 2008); and Paul Farmer, “Hidden Epidemics of Tuberculosis,” in *Infectious Diseases and Social Inequality in Latin America: From Hemispheric Insecurity to Global Cooperation*, Woodrow Wilson International Center for Scholars (Latin American Program), no. 239 (September 1999), 31–53. However, this depoliticizing phenomenon also occurs with other non-medical versions of citizenship. For example, one could apply Micol Seigel’s formulation of consumer citizenship to my own use of “hygienic citizenship”: it “has come to organize notions of who is a deserving member of society,” that is, those who perform sanitary responsibilities. And, just as Seigel argues that “assumptions regarding ‘good’ choices in the market divert attention from the structural factors that keep poor people poor,” so do discussions of choice regarding hygienic and sanitary behavior divert attention from socioeconomic factors and structures that keep poor people sick. Micol Seigel, *Uneven Encounters: Making Race and Nation in Brazil and the United States* (Durham: Duke University Press, 2009), 16.

⁹⁰ Nading, “‘Love Isn’t There,” 86.

⁹¹ Oosterhuis and Huisman, “The Politics of Health,” 32.

citizenship, then, often became racialized and racist. In response, however, black politicians and intellectuals began to articulate a more radical and popular notion of health citizenship, in which Afro-Cubans, a crucial part of the national body, deserved the right to state-funded health care. They turned the tables on Machado's limited and paternalistic tuberculosis endeavors, demanding the transformation and expansion of the state health care system. Their demands bolstered physicians' call for an end to the public-private hybrid nature of the campaign.

These dual discourses of rights and responsibilities continued to exist throughout the Second Republic. Elite actors and some medical professionals continued to blame the poor and Afro-Cubans, rather than discrimination and inequality in the health sector and larger society, for the persistent tuberculosis problem. Even more significant, however, were the assertions that access to health services constituted a critical ingredient of citizenship. By the end of the 1930s, this claim had become firmly entrenched in the arsenal of popular demands: delegates codified the idea of health as a right of citizenship in the influential and progressive 1940 Constitution. Furthermore, politicians serious about solidifying their legitimacy had to attend to the issue of health, especially tuberculosis.

2.1 TUBERCULOSIS POLICY UNDER MACHADO

Francisco María Fernández, Secretary of Sanitation under Machado, first intensified the state's tuberculosis control efforts in late 1927, expanding the existing small Tuberculosis Division to become the Bureau of Inspection, Statistics, Propaganda and Information. Its primary mandate included disease surveillance and popular education campaigns. Even treatment facilities were

primarily focused on changing individual behavior and producing disciplined citizens.⁹² Civic partners in the tuberculosis campaign sponsored lectures in a variety of private establishments inside and outside of Havana to teach workers and other targeted populations how to prevent contagion.

Despite this initial emphasis on popular education, the scope of the campaign gradually came to include the construction of hospitals and dispensaries. In 1928, Machado founded the National Anti-Tuberculosis Board (*Patronato Nacional contra la Tuberculosis*), which had the authority to tax luxury items to fund these projects. La Esperanza Sanatorium, on the outskirts of Havana, was Cuba's sole public tuberculosis treatment facility. From sixty beds in 1925, Fernández grew its capacity to 150 beds, and then to 300. By 1930, the administration had initiated a more serious transformation: the small, traditional cottage-style sanatorium was to become a modern, orderly health complex with the construction of a new surgical center, the Francisco María Fernández Hospital, which would make available 400 more beds.⁹³ Dispensary service increased marginally when the Board inaugurated the Elvira Machado de Machado Dispensary (named after the president's wife) in the Jesús del Monte working class suburb and re-opened the Hartmann Dispensary in Santiago de Cuba.⁹⁴ This extended state-funded outpatient therapy outside of Havana's central core, where there was one public dispensary (Furbush) and one private dispensary (run by the Cuban Anti-Tuberculosis League). Treatment

⁹² Cuba, Secretaría de Sanidad y Beneficencia, *Trabajos presentados por los médicos cubanos al Intercambio Sanitario de la Liga de Las Naciones* (Havana: Imprenta "El Siglo XX," 1925), 129; Alberto Sánchez de Fuentes, "Profilaxis de la tuberculosis en Cuba," *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* (1927): 543–44; Alberto Sánchez de Fuentes, "Nuestra ofensiva contra la tuberculosis," *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* (1930): 266.

⁹³ Secretaría de Sanidad y Beneficencia, 1926–1931, 334.

⁹⁴ Bartolomé Selva León, *Un año de lucha antituberculosa en Cuba, 1944–1945* (Havana: Consejo Nacional de Tuberculosis, 1946), 23.

and preventive services, however, remained overwhelmingly concentrated in Havana and failed to satisfy demand even in the capital.

The state also relied upon individuals active in anti-tuberculosis charities and other private resources to carry out this expanded campaign. Several associations assisted with the campaign, such as the Cuban Anti-Tuberculosis League and the National League against Childhood Tuberculosis, the latter comprised of some of the most elite women of the island, including “the noble daughters” of the President himself.⁹⁵ Most important, however, were the elite Catholic women of the Damas Isabelinas, who served as official members of Machado’s National Anti-Tuberculosis Board.⁹⁶ They were highly active in service provision, hospital construction, and fundraising.

The Damas Isabelinas spearheaded numerous popular education activities, which formed the bulk of the projects undertaken by the National Anti-Tuberculosis Board. In interactions with the general population and with patients at dispensaries and sanatoriums, these women emphasized how proper hygienic behavior on the part of the individual could limit contagion. Medical professionals also participated in these interactions, clinically treating patients while also prescribing advice to them about how to prevent their disease from worsening or spreading.

From the turn of the century through the 1930s, the language of tuberculosis educational efforts was heavily gendered and classed. Even though one of the most common refrains concerning the disease insisted that “[t]uberculosis is a transmissible, avoidable, and curable disease that does not respect sex, age, or race,” it continued with the commonly shared knowledge that tuberculosis “preferred to attack the weak, the licentious, and those that do not

⁹⁵ Secretaría de Sanidad y Beneficencia, *1926–1931*, 68.

⁹⁶ Reinaldo L. Román, *Governing Spirits: Religion, Miracles, and Spectacles in Cuba and Puerto Rico, 1898–1956* (Chapel Hill: University of North Carolina Press, 2007), 120. For more on the Damas’ activities, see Paula Coll y Núñez, *Memoria: 1925–1936* (Havana: Fernández Solana y Ca., 1938), n.p.

observe hygienic practices.”⁹⁷ As a result, tuberculosis specialists targeted those considered vulnerable, either from biology or behavior. They consistently organized their advice for disease prevention to three groups: children, women, and workers.⁹⁸

The burden of blame for high rates of disease often fell on women, for physicians believed their biological differences made them more susceptible to infection.⁹⁹ Furthermore, physicians emphasized their responsibility to keep the home free of disease.¹⁰⁰ The matriarch of every family was responsible for her own health, but more importantly, also that of her husband and her offspring (and thus, in a eugenic framework, the nation writ large). “Take care of your home as the best guarantee of the life of your child,” one pamphlet advised. “Make it comfortable, hygienic, happy.”¹⁰¹ Women were to prioritize childrearing before other activities, as the CNT warned, “Mothers who raise their children will ward off many illnesses.”¹⁰²

⁹⁷ J.A. López del Valle, *Lecciones populares sobre tuberculosis* (Havana: La Moderna Poesía, 1912), 3.

⁹⁸ Ibid.

⁹⁹ For example, Dr. Alberto Sánchez de Fuentes explained that women, in comparison to men, suffered greater “physical fatigue produced by...the work that they carry out in the home, which weakens them and puts them in a ‘defenseless’ situation.” M. Góngora Echenique, “El Dispensario Furbush,” *Carteles* 12, no. 30 (July 22, 1928): 43. By the 1930s, physicians asserted an increasingly biological understanding of tuberculosis in women, focused on “dangerous” or “vulnerable” hormonal stages. The textbook developed by the Tuberculosis Chair at the University Havana instructed, “Women suffer tuberculosis more often than men...their [the women’s] gender intervenes in a direct manner on the occasion of puberty, active sexual life, motherhood, lactation, and menopause. It is a biological—endocrinal—factor which determines this fact in the woman.” [Orfilio?] Suárez de Bustamante, *Lecciones de tuberculosis: De acuerdo con el programa desarrollado en cátedra durante el curso 1939–1940* (Havana: Instituto Nacional de Vías Respiratorias, n.a.), 7.

¹⁰⁰ Published statistics, however, show another trend from the 1920s through the 1940s: more men died than women in Havana. Nationwide, the total number of men who perished was roughly equivalent to the total number of women. In 1926, females accounted for 50.1% of total deaths, and males 49.9%; in Havana, the female percentage dropped to 42.9% and the male to 57.1%. In 1940, women’s deaths were 49.4% of tuberculosis deaths in Cuba, and 42.9% in Havana. “Informe anual sanitario y demográfico del Término Municipal de la Habana,” *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* (1927); “Informe anual sanitario de la República de Cuba,” *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* (1930); “Informe anual sanitario y demográfico de la República de Cuba, correspondiente al año del 1940,” *Boletín Oficial de Salubridad y Asistencia Social* 53, no. 1 (January–June 1950): 12 and n.p. (insert in bulletin). Despite the availability of this data, physicians continued to argue that women were more vulnerable to the disease.

¹⁰¹ Taboada and Ferrer, *La madre cubana ante el problema de la tuberculosis* (Havana: Carasa y Cía., 1936), 3.

¹⁰² Consejo Nacional de Tuberculosis, “¡Defiende a tus hijos contra la tuberculosis!” in “Collection of Publications” Box, National Library of Medicine, Bethesda, Maryland (NLM).

Educational efforts were primarily directed at spaces where the *clases populares* labored, such as factories and workshops. The Damas Isabelinas and other medical professionals visited these locales frequently to offer lectures on practices to ward off tuberculosis infection.¹⁰³ Public health workers were particularly adamant about convincing their audiences that tuberculosis was not hereditary, in order to dispel the belief that the disease was non-preventable. This belief may have been shared across individuals of all classes, but physicians directed their ire only at the poor. One dispensary director wrote, “How much we have to fight to uproot from the popular mentality the false idea of the heredity of tuberculosis!”¹⁰⁴

Paternalism, both in the form of Machado’s populist intentions and the elite’s charitable beneficence, undergirded this patchwork campaign.¹⁰⁵ Health services were not extended on the basis of any “right”—whether codified or implied—to health or health care. Machado revealed the logic guiding his wider reform efforts: “The people and especially the *campesinos* felt that they were being supported, they discovered prospects which they had not known before, and this made them show solidarity with my regime throughout its course...My adversaries therefore found no response from a social class that for the first time felt that it was tended to and part of the nation.”¹⁰⁶ The decision to place new tuberculosis facilities in poorer neighborhoods, supported by taxes on luxury goods, suggests the populist nature of the campaign, as Machado’s reference to “the people” makes clear. The administration publicized its “large-scale

¹⁰³ See, for example, “Conferencia antituberculosa de las Isabelinas en S.J de las Lajas,” *Diario de la Marina*, August 5, 1929: 12; “Conferencias antituberculosas, ayer, en la Cuban Telephone Company,” *Diario de la Marina*, August 15, 1929, 11; “Las Isabelinas visitan Bejucal,” *Diario de la Marina*, November 1, 1929, 19.

¹⁰⁴ Carlos Hernández Miyares, “Herencia y contagio!!” in “Collection of Publications” Box, NLM.

¹⁰⁵ Machado’s administration oversaw other public-private hybrid health campaigns, such as those against infant mortality and cancer. Daniel Rodríguez, “‘A Blessed Formula for Progress’: The Politics of Health, Medicine, and Welfare in Havana, (1897–1935)” (PhD diss., New York University, 2013), 182; Secretaría de Sanidad y Beneficencia, 1926–1931, 24.

¹⁰⁶ Gerardo Machado y Morales, *Ocho años de lucha* (Miami: Ediciones Históricas Cubanas, 1982), 28.

amplification of existing organizations and the creation of new services.”¹⁰⁷ Fernández emphasized that tuberculosis had “always been cause for concern for our illustrious President.”¹⁰⁸ Anti-tuberculosis efforts were praised by the press and “applauded by public opinion.”¹⁰⁹

2.2 CONTENDING NOTIONS OF HEALTH

By the late 1920s, then, the disease was becoming increasingly visible. Even though Machado had given more attention to tuberculosis than any previous Cuban president, his efforts made the campaign’s shortcomings more obvious and intensified demands for increased state intervention. Most Cubans agreed that the state needed to do more to counter the tuberculosis problem. However, in discussions about the campaign, physicians, elite charity workers, and more radical voices espoused differing visions of what good health entailed and who was primarily responsible for achieving it.

Physicians thought in primarily public-health terms (i.e., about the “collective well-being” to be achieved predominantly through preventive measures).¹¹⁰ Physicians’ concerns dovetailed with those of the state, for tuberculosis threatened the eugenic and economic

¹⁰⁷ Secretaría de Sanidad y Beneficencia, 1926–1931, 4.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid., 40. One foreigner residing in Havana reported that the press praised the Board’s formation. “Law Creating Special Taxes for Defraying Expense of Anti-Tuberculosis Hospital and Dispensary,” Harold L. Williamson to Secretary of State, no. 355, July 10, 1928, Records of the Department of State Relating to Internal Affairs of Cuba, 1910–29, General Records of the Department of State RG 59, Washington, D.C.: National Archives, National Archives and Records Service, General Services Administration, 1963.

¹¹⁰ Luis P. Romaguera, “Editorial: El problema de la vivienda en la lucha profiláctica contra la tuberculosis,” *Prensa Médica* 20, no. 11 (November 30, 1929): 18.

foundation of the country.¹¹¹ Secretary of Sanitation Fernández explained that the revamped tuberculosis department within the sanitation branch aimed “to achieve the moral and material betterment of the people of Cuba,” for most tuberculosis-related deaths “occurred among those people in full manhood, when their arms could still do much for the economic aggrandizement of the Nation.”¹¹² One medical editorial warned that 1,050 to 1,500 Cubans between the ages of nineteen and twenty-five died every year—a shame given the “efficiency of our current treatments” and the value of their lives to the social and economic future of the nation.¹¹³

Medical practitioners expressed two principal criticisms of the anti-tuberculosis effort: its reliance on charity and its failure to tackle the wider social problems influencing the spread of tuberculosis. The medical community declared the public health sector’s reliance on religious and civic philanthropy to be unscientific, archaic, and undependable. The fight against tuberculosis “cannot be constituted exclusively by private groups inspired by piety (we want to declare that upon affirming this, we do not deny the value or the disinterested spirit that any support implies),” one doctor claimed, “but instead, given its fundamental importance, the cost of the prophylactic campaign, the high mortality figure, the loss of fit individuals...it must be an infection that the sanitary authorities prevent in the interest of public health.”¹¹⁴ A more radical doctor found himself frustrated with the Damas Isabelinas’ involvement at La Esperanza Sanatorium. So many resources had been dedicated to the aesthetics of the buildings and the

¹¹¹ Sánchez de Fuentes, “Nuestra ofensiva,” 263–64. On the complicated case of Cuban eugenics, see Nancy Leys Stepan, *“The Hour of Eugenics”: Race, Gender, and Nation in Latin America* (Ithaca, NY: Cornell University Press, 1991); Armando García González and Raquel Álvarez Peláez, *En busca de la raza perfecta: Eugenesia e higiene en Cuba, 1898–1958* (Madrid: Consejo Superior de Investigaciones Científicas, 1996); Alejandra Bronfman, *Measures of Equality: Social Science, Citizenship, and Race in Cuba, 1902–1940* (Chapel Hill: University of North Carolina Press, 2004); Sarah Arvey, “Sex and the Ordinary Cuban: Cuban Eugenics, Physicians, and Marital Sexuality, 1933–1958,” *Journal of the History of Sexuality* 21, no. 1 (January 2012): 93–120.

¹¹² Secretaría de Sanidad y Beneficencia, 1926–1931, 40.

¹¹³ Luis Ortega Bolaños, “Consideraciones sobre algunos puntos importantes,” *Vida Nueva* 19, no. 5 (May 15, 1927): 200.

¹¹⁴ M. Peral, “Editorial: La tuberculosis y el estado,” *Prensa Médica* 21, no. 8 (August 31, 1930): 1–2.

grounds—the “pride of the sanatorium”—while the facility lacked the most basic medical equipment for surgery.¹¹⁵ He believed their motives to be guided primarily by the desire for notoriety instead of scientific excellence, for ceremonies where the Sanatorium’s avenues were named after elite charitable women were “well advertised by the social columns.”¹¹⁶

The second limitation of the campaign was its focus on epidemiological surveillance and the building of medical treatment centers. Physicians understood tuberculosis to be a quintessential social disease that required legislation to attend to its socioeconomic roots. Physicians believed this second weakness of the campaign to be intricately linked to their first criticism. Social problems undergirding high tuberculosis rates were so complex and far-reaching that they necessitated state legislation, stable resources, and scientifically-trained managers to attend to these problems; charitable institutions’ fundraising activities and educational lectures, while useful, could not attack the core of the tuberculosis problem.

Two major issues clearly evidenced the need for reformist legislation and the limits of elite charity: housing and immigration. By the late 1920s, increased migration to the capital had overwhelmed the existing housing supply, resulting in overcrowding and an overtaxed sanitation infrastructure. In response to this situation ripe for the spread of disease, physicians demanded that the state needed to build hygienic housing for workers, enforce sanitary regulations already on the books, and raise the minimum wage.¹¹⁷

Physicians and technocrats hoped to be employed by the state to create an orderly, salubrious urban environment. Havana’s suburbs and shantytowns were confirmation of an

¹¹⁵ Gustavo Aldereguía, “El Infierno y La Esperanza: Notas sobre un sanatorio desdichado,” in *Revolución y tuberculosis*, Cuadernos de Historia de la Salud Pública 68 (Havana: Central Nacional de Información de Ciencias Médicas, Ministerio de Salud Pública, 1984): 53, 56.

¹¹⁶ *Ibid.*, 56.

¹¹⁷ See, for example, Romaguera, “Editorial: El problema de la vivienda,” 19; Luis P. Romaguera, “Editorial,” *Prensa Médica* 20, no. 8 (August 31, 1929): 15; Peral, “Editorial: La tuberculosis y el estado,” 2.

unchecked and unregulated growth, which had not been guided by science but by necessity. For example, “the ugly barrio of Pogolotti, with narrow streets [and] little water,” was not to be emulated; “instead,” one publication advised, new neighborhoods should be “small cities with large parks, wide sidewalks, houses separated from adjoining ones, gardens and wide streets.”¹¹⁸ The issue of parks and green spaces, especially for children, came up continually, as they were slowly being eroded in the processes of urban expansion.¹¹⁹ One physician decried that “there are large zones of Havana with only a modest park (Jesús María, for example) and all know the phrase that parks are the lungs of the city.”¹²⁰ One physician favored the eradication of these “dens,” identifying them as “the seedbed of tuberculosis” and estimating that over 3,000 had the disease in Havana’s tenements (*casas de vecindad*) alone.¹²¹ These physicians argued that what the government was able to accomplish at the City of La Esperanza—the engineering and regulation of orderly spaces that adhered to the laws of sanitation and science—should be extended to the entire city of Havana.

Whatever their humanitarian motives, individuals active in anti-tuberculosis charities were not equipped to do any of these things, and the resources they raised paled in comparison to what the state was expected to bring to the campaign. “Improving housing cannot appear as the fruit of an altruistic spirit or of piety,” one editorial insisted, “but rather as the formidable foundation of collective well-being, of public health.”¹²² Medical doctors recognized that many workers earned only “a few cents a day” and thus concluded, “It is not possible to request,

¹¹⁸ Luis P. Romaguera, “Editorial: Algunas notas sobre campaña anti-tuberculosa,” *Prensa Médica* 21, no. 3 (March 30, 1930): 2.

¹¹⁹ Luis P. Romaguera, “Editorial,” *Prensa Médica* 20, no. 6 (June 30, 1929): 16.

¹²⁰ Romaguera, “Editorial: Algunas notas sobre campaña anti-tuberculosa,” 2.

¹²¹ Romaguera, “Editorial: El problema de la vivienda,” 17; “N.a., “Viviendas higiénicas,” *Diario de la Marina*, September 12, 1929, n.p.

¹²² Romaguera, “Editorial: El problema de la vivienda,” 18.

however many popular lectures are held, that they eat well or live in well-ventilated and cool places.”¹²³

On a second issue of even greater concern, physicians demanded state intervention in the immigration “crisis.” By the late 1920s, xenophobia ran rampant against black immigrants from Haiti and Jamaica, the *braceros* whose cheap labor was sought by a sugar industry that had been heavily Americanized following the U.S. occupation. In a context of broader debates about citizenship and economy security, medical professionals insisted that immigrants contributed to high tuberculosis rates.

A variety of actors wielded medicalized language as tools of exclusion against immigrants. The medical community in particular buttressed stereotypes about diseased “black” and “yellow” immigrants. Since the early 1920s, foreign black laborers had been construed as malaria carriers and were subject to quarantine while white immigrants were not. This discursive connection between disease and black bodies was not supported by statistics and instead drew upon commonly held racist beliefs.¹²⁴ As Marc McLeod asserts, “Cuban doctors and public health officials thus lent a seeming scientific authority, a medical imprimatur, to the notion—shared by much of the Cuban public—that Antillean immigrants were a biological threat to the nation.”¹²⁵

By the late 1920s, tuberculosis specialists insisted that immigrants constituted dangerous sources of tubercular contagion, even though no direct evidence was provided to substantiate the claim that the disease was present in higher quantities among them or that their habits were less

¹²³ Romaguera, “Editorial: Algunas notas,” 1.

¹²⁴ Marc McLeod, “‘We Cubans Are Obligated Like Cats to Have a Clean Face’: Malaria, Quarantine, and Race in Neocolonial Cuba, 1898–1940,” *The Americas* 67, no. 1 (July 2010): 58, 65.

¹²⁵ *Ibid.*, 59.

hygienic.¹²⁶ Instead these doctors called upon common “knowledge” about immigrants, which no doubt relied on any number of prejudices, and used vivid language to vilify them. For example, instead of citing data about what proportion of beds in state hospitals were occupied by immigrants, one physician claimed that these foreigners with tuberculosis drained the resources of the island’s health care system. He relied only on anecdotal or observational information to bolster his point, arguing, “[O]ur health clinics and hospitals have good proof of this.”¹²⁷ One editorial linked housing and immigration, imploring the state to prohibit “promiscuity or overcrowding” in slums, which were especially characteristic of immigrant living conditions during the period of the sugar harvest. These *braceros* were accused of “bringing us all of their baggage of vices and diseases, among which tuberculosis stands out.”¹²⁸ As the economic depression intensified, so did the xenophobic rhetoric. Haitians and Jamaicans were “landfills in our lands,” penned a physician, who then ascribed to them “barbarous customs, little hygiene, and multiple diseases.”¹²⁹

To help solve the problem of tuberculosis, physicians called on Congress to enact immigration quotas and to deport immigrants. “The prohibition of the Haitian exodus (without excluding the Jamaican) has been advised, on behalf of their poor conditions of hygiene, because they are individuals of a primitive economy and of a very inferior sense of life in relation to our *campesinos*.”¹³⁰ Benjamin Muñoz Ginarte—the author of the statement that Afro-Cubans were “between two great evils: foreigners in the cities and foreigners in the countryside”—used

¹²⁶ The rates of tuberculosis incidence among Jamaicans and Haitians in Cuba in the 1920s are unknown. The state did not publish tuberculosis morbidity rates, and it broke down total tuberculosis deaths only by race (*blancos* and *de color*) and by sex.

¹²⁷ Romaguera, “Editorial,” August 31, 1929, 15.

¹²⁸ *Ibid.*

¹²⁹ Luis P. Romaguera, “Editorial,” *Prensa Médica* 21, no. 1 (January 31, 1930), 2. Asian immigrants and Cubans of Asian descent were also discriminated against with medicalized language. See, for example, “Editorial: Inmigración y tuberculosis,” *Prensa Médica* 21, no. 6 (June 30, 1930): 2–3.

¹³⁰ Romaguera, “Editorial,” June 30, 1929, 15–16.

medical language and tuberculosis statistics to establish the economic perils of immigration and to call for the state to enact a scientific plan to manage immigration.¹³¹ As with malaria, physicians' claims about tuberculosis were considered reliable and, at least according to doctors, influenced the prohibition of immigration from Haiti and Jamaica in the early 1930s.¹³²

Popular debates about migrants and tuberculosis inevitably brought up questions about health and citizenship, for they took place in a broader context of the re-formulation of the relationship between race and nation (*cubanidad*) in the late 1920s. Whitening through immigration had failed, so public figures began to revalorize blackness and to downplay biological racial inferiority in order to champion *mestizaje* (racial mixing) as the national racial ideology. Physicians had previously used high tuberculosis rates as evidence of the dangers of miscegenation, but now began to explain those statistics as the consequence of primarily social factors instead of biological ones.¹³³

It was widely known that tuberculosis more intensely attacked non-whites than whites in Cuba. In 1926, while the former made up 27% of the population, they accounted for 38% of tuberculosis deaths.¹³⁴ Two decades later, these figures had changed little.¹³⁵ The disease, one

¹³¹ Benjamin Muñoz Ginarte, "Leyendo al Dr. Taboadela," *Diario de la Marina*, October 13, 1929, n.p.

¹³² M. Peral, "Editorial: Inmigración y tuberculosis," *Prensa Médica* 22, no. 11 (November 30, 1931): 1.

¹³³ De la Fuente, *A Nation for All*, 179–80. Nonetheless, medical professionals and popular audiences continued to include racial factors in their understandings of tuberculosis. Over the course of the 1920s and 1930s, virgin soil theory was dominant. Proponents of this theory believed that "[v]irgin soil epidemics are those in which the populations at risk have had no previous contact with the diseases that strike them and are therefore immunologically almost defenseless." Alfred Crosby quoted in David S. Jones, "Virgin Soils Revisited," *The William and Mary Quarterly* 60, no. 4 (October 2003): 703–4. This theory emphasized cultural racial differences over biological ones, but did not dispense entirely with the importance of biological racial explanations. For many Cubans, the social and the biological were not easily separated. For one popular (and Afro-Cuban) explanation of virgin soil, see Gustavo Urrutia, "La tuberculosis estudiada por la Dra. Shelton," *Diario de la Marina*, August 22, 1929, 10. For more on ideas of race and tuberculosis in Cuba in this period, see Urban, "The 'Black Plague'."

¹³⁴ Jorge Le-Roy, "Informe anual sanitario y demográfico del Término Municipal de Cuba, correspondiente al año 1926: Carta de remisión," *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* 35 (January–December 1930): 185; Cuba, Dirección General del Censo, *Informe general del censo de 1943* (Havana: P. Fernández y Cía, 1945), 741.

black politician warned, was “a terrible threat that...was continuously growing” in the black race. “[I]n this case and in relation to the Cuban population of color,” he suggested, “the odious white plague...may well be titled the black plague.”¹³⁶

Afro-Cubans’ experience with tuberculosis, then, raised important questions. If the dominant (though contested) national ideology declared that all Cubans, regardless of race, were equal members of the nation, then blatant differences in health indicators demanded an explanation. And, if elite physicians and politicians could use health as a means to exclude non-citizens, then citizens could urge the state to extend health services to them on the basis of this membership. Afro-Cubans began to articulate a different interpretation of health than that emphasized by physicians, insisting that they had rights as individual citizens to better access to health care. In order to remedy the tuberculosis problem in the black race, they argued, the state needed to expand its campaign and white elites needed to share resources.

At the same time and in contrast to this vision of health, a powerful counter-discourse operated. Motivated in part by the fear of material and discursive concessions to blacks, elites turned to the language of hygienic citizenship.¹³⁷ They shifted the blame for high tuberculosis mortality onto individuals and specific social groups: sometimes to the poor, but more often to Afro-Cubans. Elites and some medical professionals insisted that poor blacks needed to live more hygienically in order to improve their own health; they also urged middle-class Afro-Cubans to assist them in this effort.

¹³⁵ In 1944, for example, non-whites comprised 25.6% of the population and 34.5% of total tuberculosis deaths. Cuba, Ministerio de Salubridad y Asistencia Social, “Informe anual sanitario y demográfico de la República de Cuba, correspondiente al año de 1944,” *Boletín Oficial del Ministerio de Salubridad y Asistencia Social* 53, nos. 1–6 (January–June 1950): 46; Cuba, *Informe general del censo de 1943*, 741.

¹³⁶ Primitivo Ramírez Ros, “La tuberculosis en la raza negra,” *Diario de la Marina*, August 11, 1929, 11.

¹³⁷ De la Fuente, *A Nation for All*, 199.

In multiple medical and popular forums, these two competing ideas existed in tension with one another. With regards to tuberculosis, they were most clearly evidenced by a debate in *Diario de la Marina*, the nation's most widely read newspaper, in 1929. The polemic began when a young, (white) radical tuberculosis specialist, Dr. Gustavo Aldereguía, gave a workplace lecture to a group of cigar rollers. He had recently returned from a tour of tuberculosis facilities in the United States. Like Cuba, in the U.S. there was a discrepancy in mortality rates between black and white citizens; unlike Cuba, however, the U.S. health sector was segregated. As a result, Aldereguía noted that numerous black associations and hospitals had sprung up. Subsequently, he proposed that Afro-Cubans follow the example of North Americans by organizing a Black Anti-Tuberculosis League to attend to the problems particular to Afro-Cubans battling the disease. A committed communist, Aldereguía intended to critique the Machado administration's handling of the tuberculosis campaign and encourage popular mobilization toward rectifying social and racial biases in the distribution of the country's health resources. At a time of heightened racial anxiety, his proposal threw a spark into the powder keg, and soon Afro-Cuban and white intellectuals, legislators, physicians, economists, and private citizens joined the controversy, which quickly travelled from a local factory to the pages of *Diario de la Marina*.¹³⁸ Although this debate began with Cubans disputing the appropriateness of segregating the tuberculosis campaign, the tension between hygienic citizenship and the right to health soon dominated the conversation.

Everyone agreed that tuberculosis in the black race was a problem, but Aldereguía's thesis led to more contentious questions: who should take responsibility for solving the high mortality rate among Afro-Cubans—the state, white society, or blacks themselves? Afro-Cubans

¹³⁸ For an in-depth analysis of the changing conceptions of race and *cubanidad* in this period, see de la Fuente, *A Nation for All*.

espoused a variety of opinions, but all agreed that they, and especially poor black citizens, should not be expected to deal with the problem alone. To justify this, writers continually emphasized the socioeconomic roots of the disease and the visible inequality among blacks and whites in Cuba, which deprived most blacks of the organizational and economic resources to fight the disease. One of the most prominent black activist-intellectuals, Gustavo E. Urrutia, journalist and editor of the “Ideales de Una Raza” and “Armonías” columns in *Diario de la Marina*, looked abroad and concluded that tuberculosis was “fundamentally socioeconomic—to such an extreme that the sanitary authorities in London spend more money in building hygienic housing for the poor and bettering their standard of living than in constructing...preventoriums and hospitals.”¹³⁹

These intellectuals concluded, then, that blacks could not and should not act alone; instead, the state and elite (white) society needed to take the lead. Primitivo Ramírez Ros, a member of the black political elite, anticipated objections that this strategy was proof of Afro-Cuban helplessness and sloth. Afro-Cubans may have been at the bottom of the social order, but, he clarified, they were an active and vital force in building the nation.¹⁴⁰ Both Urrutia and Ramírez Ros, while demanding further state action, were pleased with Machado’s recent “patriotic” endeavors to lower tuberculosis and infant mortality among blacks.¹⁴¹ They both emphasized that with whites holding the lion’s share of economic and social resources, the burden of action in the current moment lay with them. Urrutia and Ros also mobilized the concept of contagion to convince readers of the necessity for white intervention in the problem. Any efforts to end tuberculosis in the white race, a much easier task than tackling the disease in the black race, “would be completely sterile, because...the black bacillus would continue

¹³⁹ Gustavo Urrutia, “Armonías: El busilis,” *Diario de la Marina*, September 1, 1929, n.p.

¹⁴⁰ Primitivo Ramírez Ros, “Sobre el mismo tema de la tuberculosis: Aclaración a la Señora Consuelo M. de Govantes,” *Diario de la Marina*, September 8, 1929, n.p.

¹⁴¹ Ramírez Ros, “La tuberculosis,” 11.

floating around, infecting the atmosphere, relentlessly spreading to the white.”¹⁴² While fears of infection and contagion from black spaces had been used in Cuba to discriminate against citizens and foreigners of color, these Afro-Cuban activists used the concept for a different end: to insist that the health of the national body depended on the vigor of both black and white citizens. The health of whites was linked, through shared physical space, to the health of blacks.¹⁴³

Afro-Cuban activists did not think that white clubs should act alone, and they urged elite associations to create cross-racial initiatives. Due to limited health resources, success in stemming contagion in Havana required intervention in the slums—white groups, these activists argued, needed the assistance of black societies to accomplish this.¹⁴⁴ While Ramírez acknowledged that the Damas Isabelinas treated those who came to them without racial bias, these women, he asserted, were “the cream of white Cuban society.” Therefore, they could “never know the true situation of tuberculosis in the black race,” for, unlike women of color, they could not “be led with efficacy...to the dens in which the black lives and where the white plague makes numerous victims.”¹⁴⁵

And black civic groups needed the assistance of white groups. Ramírez queried why the Damas Isabelinas had not collaborated with the *sociedades de color*, such as Club Atenas or La Union Fraternal, especially because the latter had a health dispensary. Even if the membership of all these societies remained racially exclusive, black intellectuals opined that cooperative

¹⁴² Ibid.

¹⁴³ In fact, a similar threat spurred public health action in the southern United States, when racist officials who often denied public services to African Americans provided sewer and water service to their communities in order to safeguard the health and sanitation of white communities. Werner Troesken, *Water, Race, and Disease* (Cambridge, MA: MIT Press, 2004).

¹⁴⁴ Afro-Cubans were denied service in the mutual aid organizations of the racially exclusive regional Spanish societies. The latter, according to Ramírez, “had inexhaustible economic resources.” Ramírez Ros, “La tuberculosis,” 11. Gustavo Aldereguía noted that black access to public health services was “difficult.” Gustavo Aldereguía, “La tuberculosis en la raza negra: Replica al Señor Gustavo E. Urrutia,” *Diario de la Marina*, September 15, 1929, n.p.

¹⁴⁵ Ramírez Ros, “La tuberculosis,” 11.

efforts would be beneficial for fighting tuberculosis. Urrutia argued that cross-racial, elite leadership of the tuberculosis campaign, with legislation “for the indigent class, in which blacks are the majority,” harmonized “with Cuban ideology” and social formation much more than Aldereguía’s suggestion to form a separate black anti-tuberculosis league.¹⁴⁶ These activists advocated a coalition of state and private elite mobilization, with legislation directed at raising both the poor white and black citizen out of wages of misery and tenements of filth.

Afro-Cuban activists blamed the insufficient reach of the public-private campaign for high mortality, pegging the latter to the government’s neglect of poor Cubans’ standard of living and on white society’s refusal to dedicate sufficient resources to supporting the campaign. Not all Cubans agreed, however, that the state needed to extend more services to the island’s marginalized citizens, and they placed the onus of blame on poor individuals rather than on the state and the elite. Several white physicians and key figures in the state anti-tuberculosis campaign turned to the tropes of laziness, inaction, and culpability on the part of the poor and/or poor blacks to explain away the limitations and failures in the tuberculosis campaign. This group argued that the Secretariat of Sanitation had already increased the scope of tuberculosis control, and many elite civic groups had joined the crusade as well. These actors agreed that the obligation now lay with the poor. “Every citizen, from the place he occupies, should be an enthusiastic cooperator,” the head of the Damas Isabelinas opined, “from the First Magistrate of the Nation, who gives the example, to the humblest day worker.”¹⁴⁷ This comment implied that it was now time for Cuba’s working classes and poor to take responsibility for their health and sanitary behavior.

¹⁴⁶ Urrutia, “Armonías: El busilis,” n.p.

¹⁴⁷ Consuelo Morillo de Govantes, “La tuberculosis en la raza negra: Contestando al Sr. Primitivo Ros,” *Diario de la Marina*, August 25, 1929, n.p.

This debate quickly provoked a shift in the classed vocabulary of hygienic citizenship: racialized understandings and racist assumptions about tuberculosis sprouted from the subsoil of private opinions into the open air of public debate. Writers argued that black mobilization was needed because Afro-Cubans had not taken appropriate action to fix their insalubrious circumstances; in essence, they were partially to blame. A number of white Cubans across the ideological spectrum, from radical mobilizers to representatives of the conservative elite, who vociferously disagreed on other political and economic tenets, embraced this view. Aldereguía suggested the creation of a Black Anti-Tuberculosis League that would be “capable of educating the masses, of popularizing the necessary knowledge, of creating a sanitary consciousness of the black race and in the black race” so they could contribute to “improving their conditions of life and health.”¹⁴⁸ He suggested the black Cubans form a sort of “class solidarity” against tuberculosis, from which “a sense of collective responsibility” would evolve and “an unwavering decision would be founded: the right to live in health.”¹⁴⁹ In short, citizen duty preceded citizen entitlement.

Notions of culpability often came in implicit and euphemistic terms, such as “lacking a sanitary consciousness.” The respected economist José Antonio Taboadela contributed to the *Diario de la Marina* debate by enumerating two kinds of measures needed to combat tuberculosis: the first, for the benefit of the entire working class, required the state to legislate solutions; the second (and in Taboadela’s opinion, the more important) referenced only the black section of the working class, which needed to work to improve itself. He addressed himself “to the individual awareness of black Cubans, and above all, to the black Cuban women,” for “if they were to achieve the creation of an animating spirit.... much could be hoped for in the sense

¹⁴⁸ Aldereguía, “La tuberculosis,” n.p.

¹⁴⁹ Ibid.

of social and economic betterment for our black population in the near future.”¹⁵⁰ While Urrutia disagreed with this second piece of advice and initially chose to suppress its publication, he eventually relented.¹⁵¹

Consuelo Morillo de Govantes, a governing member of the Damas Isabelinas, supported Dr. Aldereguía’s original call for mobilization by blaming black complacency. She wrote, “Doctor Aldereguía is right to plant in the spirit of the black race what he calls, with his wise and persuasive word, a seed of inquietude.” The latter would hopefully push black Cubans to act in their own interest, for she believed that “the black race, painfully destroyed by tuberculosis, should and can mobilize itself.”¹⁵² These three public figures—Aldereguía, Taboadela, and Morillo—all espoused the opinion that legislation was needed for the working class and urban poor. At the same time, they argued that high tuberculosis mortality among poor blacks was due to individual or group deficits—whether of mobilization, a spirit of concern, or a correct understanding of the disease.

The racist underpinnings of this “blame game” sometimes became more explicit, as evidenced in the passionate response of Consuelo Morillo de Govantes to the pointed commentary published by Primitivo Ramírez Ros. After Morillo emphatically insisted that the Damas Isabelinas administered care regardless of race or class—a point that Ramírez Ros did not dispute—she argued that it was time for blacks to act as well. The black race should “form mutual health societies, submit to the work of social education, and re-education when it is necessary. They should have their own health clinic.”¹⁵³ Furthermore, Morillo classified residing

¹⁵⁰ José Antonio Taboadela, “Nuevas consideraciones del Dr. Taboadela sobre la tuberculosis,” *Diario de la Marina*, October 6, 1929, n.p.

¹⁵¹ Ibid.

¹⁵² Morillo de Govantes, “La tuberculosis,” n.p.

¹⁵³ Ibid.

in dirty, unhealthy tenements as a choice, and, therefore, the poor black could be held responsible for the often-fatal consequences of living in these communities. “The black should leave the *solar*,” Morillo opined, “and take his offspring to the suburbs.”¹⁵⁴ Such a statement exhibits the power that racism had in informing notions of civic responsibility and public health, distracting from the disease’s socioeconomic roots, even when they were constantly acknowledged in the same debate. Even more telling is that Morillo was well aware of the housing problem in Cuba, having campaigned actively for housing legislation that had been submitted to Congress, but had not yet been discussed by legislators. “It is painfully true that economic housing for the poor is still not a reality,” she admitted.¹⁵⁵ Still, she claimed that blacks had the ability to move out of *solares* to the suburbs, where, she tellingly wrote, “there are some houses.”¹⁵⁶

Ramírez Ros responded to this article swiftly and forcefully. He chided Morillo for glossing over the cardinal issue. She had stated that the black race suffered tuberculosis at higher rates “for reasons we all know.” Ramírez called this a “pious euphemism” for the fact that blacks in Cuba were “economically impotent,” especially in comparison to whites. He rhetorically queried, “In what way are black Cubans going to build a health clinic, which white Cubans have failed to build for themselves?”¹⁵⁷ He claimed that Morillo had distracted readers from the central issue of inequality, which constituted and perpetuated the cycle of disease, contagion, and impoverishment. Ramírez was incredulous at Morillo de Govantes’ exhortations for poor blacks to pull themselves up by their bootstraps:

¹⁵⁴ Ibid.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

¹⁵⁷ Ramírez Ros, “Sobre el mismo,” n.p.

Ay, Señora de Govantes! If the black can hardly survive in the *solar*, how is it possible that he leave with his offspring to live in the suburbs [*repartos*]? But, does Señora de Govantes know how our suburbs are? I refer not to the suburbs of luxury, like Miramar, Almendares, Mendoza, Country Club, Havana Biltmore, and other similar ones, but instead to the modest ones, to those of San José, Juanelo, Pan con Timba, Llega y Pon, Berenguer, and others of that kind. Does she not know? It is necessary to buy the land parcel, provide an advance, pay the remaining term, and then... build the house! Then comes the problem of transport to the capital, where the job site is, and all that, ‘for reasons we all know,’ the black proletariat cannot do.¹⁵⁸

Morillo had written that “some houses” existed in the suburbs of which blacks could take advantage. Ramírez Ros warned her not to advertise her knowledge of their location; otherwise, he sardonically predicted, she would have to call upon the reserve police to not see her “elegant residence...invaded by a true Court of Miracles, asking for some of those available houses.”¹⁵⁹

Participants in this debate also evaluated the state campaign’s sufficiency and effectiveness. Some, like Aldereguía, were trenchant in their criticism, while others excused the state’s limited interventions in public health problems and the housing crisis. In answer to Ramírez’s critiques of the program and demands for more legislation, Morillo urged him to remember that the government’s anti-tuberculosis campaign had only existed for one year—construction of hospitals and other facilities was ongoing. “It is not possible,” she assured Ramírez, “to do more in less time.”¹⁶⁰ Others disagreed, claiming that the state, not blacks, needed to act to correct these problems.

As Morillo and other figures blamed blacks for high mortality and scant services, Afro-Cubans began to articulate more stringent demands on the basis of citizenship. The black race was not “indolent,” Ramírez insisted, for “[i]ts vigorous muscles and resistance to the climate were indispensable” in building the colony and the nation. He emphasized, “[T]he sweat of its

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ Morillo de Govantes, “La tuberculosis,” n.p.

forehead enriched the white Cuban patriciate.”¹⁶¹ Black participation in the wars of independence, a crucial experience for blacks demanding inclusion and suffrage in the early republic, continued to be a strong platform from which to make claims for state resources.¹⁶² “The contribution of blood in war cannot be exempted,” Ramírez continued. “[I]f the conditions of [the black race’s] standard of living are socially and economically inferior to the Chinese, the Syrian and the Polish, requesting that something be done for that is not to ask for a privilege. It is a social justice that is owed to it.”¹⁶³ Tuberculosis—and the wider context of inequality that allowed it to propagate—required state intervention, taken not on the basis of privileges and beneficence, but instead because its citizens were entitled to social equality.

These sorts of claims continued past the 1929 debate, as Afro-Cuban societies throughout the 1930s demanded state-subsidized health services. In a 1937 editorial on “Black Health,” the Afro-Cuban periodical *Adelante* linked blacks’ current poverty to their historical experience of slavery, when their labor made others rich. They implored the state for more health centers, especially as non-whites were barred from many of the private clinics and regional Spanish mutual societies.¹⁶⁴ And they expected a more efficient health sector. The editor urged, “Why don’t we demand with a unanimous voice...the careful attention that the hospitals, dispensaries, etc., require, every time that the State or the municipalities waver in service?”¹⁶⁵ Afro-Cuban

¹⁶¹ Ramírez Ros, “Sobre el mismo,” n.p.

¹⁶² De la Fuente, *A Nation for All*, 32–33. Also, see Ada Ferrer, *Insurgent Cuba: Race, Nation, and Revolution, 1868–1898* (Chapel Hill: University of North Carolina Press, 1999); Rebecca J. Scott, *Degrees of Freedom: Louisiana and Cuba After Slavery* (Cambridge, MA: The Belknap Press of Harvard University, 2005).

¹⁶³ Ramírez Ros, “Sobre el mismo,” n.p.

¹⁶⁴ “Salud negra,” *Adelante* 2, no. 20 (January 1937): n.p.

¹⁶⁵ Ibid.

writers also urged health institutions, and tuberculosis ones in particular, to tackle wider social issues—housing, hunger, and the minimum wage.¹⁶⁶

Despite the emergence of this rights discourse, the counter-discourse of hygienic citizenship continued to operate throughout the remainder of the Second Republic. Beliefs about racial difference, whether cultural or biological, were continually used to explain health differentials.¹⁶⁷ The University of Havana’s medical curriculum in the 1930s and 40s instructed medical students that “[t]he ethnic factor acquires considerable value in tuberculosis. The black race exhibits great susceptibility to suffer this disease, and more than that, these individuals that suffer it catch a more severe form.” The text continued, “Besides racial grounds, this is due to the lack of previous contagion, to economic status, and to the manner of life among the black race.”¹⁶⁸ The author of the text, Professor Suárez de Bustamante, abstained from explicating the exact mechanisms and significance of each of these variables, but students were left with an understanding that racialized cultural behaviors— “the manner of life among the black race”— were partially to blame for higher mortality rates among blacks.

Medical and popular texts also blamed women and the poor for contracting and spreading the disease through their lifestyle “choices.” For instance, Rosa Hilda Zell—the editor-in-chief of *Ellas*, union activist during the *machadato*, and recovered tuberculosis patient—castigated the non-elite for their unhygienic behavior. In one front-page essay in *Bohemia* in the 1940s, Zell disparaged a hypothetical *guajiro* family plagued by tuberculosis, who “lived poorly, not because

¹⁶⁶ “La lucha contra la tuberculosis,” *Adelante* 3, no. 26 (July 1937): n.p.; “Por el mejoramiento de la vivienda,” *Adelante* 3, no. 28 (September 1937): n.p.; Juan M. Chailloux Carmona, *Los horrores del solar habanero*, 2nd ed. (Havana: Editorial de Ciencias Sociales, 2005), 149, 151, 152.

¹⁶⁷ See Urban, “The ‘Black Plague’.”

¹⁶⁸ Suárez de Bustamante, *Lecciones de tuberculosis*, 7.

they were poor, because they were not, but because they were ignorant.”¹⁶⁹ Zell described their income as sufficient, but focused her ire on those familial behaviors and “typical” *guajiro* cultural “life habits” and “customs” she considered to be a result of free will and not structural poverty. She complained that they chose to live in an unsanitary fashion, and she despaired that the mother and father “had not submitted themselves to a medical exam.” According to Zell, these people preferred the *curandero* (unlicensed healer) to the physician, resulting in a “Middle Ages” of “hygiene” for Cuba.¹⁷⁰ Such a conceptualization of the struggle of the rural Cuban family to achieve good health turned a blind eye to their structural impediments to living a “sanitary life.”¹⁷¹ She also reprimanded poor mothers who chose to send their children to “*escuelitas del barrio*,” located in Havana’s *solares*, instead of to public schools. Outside the reach of formal state inspection, the teachers had “little culture” and conducted their classes in “anti-hygienic locales that were of doubtful health.”¹⁷²

Nonetheless, the idea of the right to health was an increasingly powerful one. By the 1940s, activists, including those involved in the 1929 *Diario de la Marina* debate, had netted significant results.¹⁷³ The progressive 1940 Constitution codified the right to health care for the poor. One of the five entitlements afforded to every Cuban citizen was the right “[t]o receive social assistance (*asistencia social*) and public benefits with, in the former case, prior affirmation of need.”¹⁷⁴ Historically and institutionally in Cuba, “social assistance” included health

¹⁶⁹ Rosa Hilda Zell, “La realidad en la tuberculosis,” *Bohemia* 38, no. 5 (February 3, 1946): 18.

¹⁷⁰ *Ibid.*

¹⁷¹ One historian calculated that in this period “[s]ixty percent of physicians, 62 percent of dentists, and 80 percent of hospital beds were in Havana. There was only one hospital in rural Cuba.” Marifeli Pérez-Stable, *The Cuban Revolution: Origins, Course, and Legacy*, 2nd ed. (New York: Oxford University Press, 1999), 29.

¹⁷² Zell, “La realidad,” 18.

¹⁷³ For more on the medical politics that shaped ideas about health rights, see Rodríguez, “A Blessed Formula,” especially 285–87.

¹⁷⁴ See Article 10 of Andrés Lazcano y Mazón, *Constitución de Cuba (con los debates sobre su articulado y transitorias, en la Convención constituyente)*, vol. 1 (Havana: Cultural, S.A., 1941).

services.¹⁷⁵ The Constitution also transformed the Secretariat of Sanitation and Charities (*Secretaria de Sanidad y Beneficencia*) into the new Ministry of Health and Social Assistance (*Ministerio de Salubridad y Asistencia Social*), in charge of public health measures and state hospitals. The switch from “charity” to “social assistance” (from “*beneficencia*” to “*asistencia social*”) represented more than a change in name; it revealed the desire of multiple groups to change the foundations of state health care on the island.¹⁷⁶ One delegate to the Constitutional Convention summarized that the state was now “require[d]...to protect citizens against all risks of disease and at the same time—as it says in the new Constitution—to give the citizen the right to receive the benefits of Public Assistance, previously proving their condition of poverty.”¹⁷⁷ No longer conceptualized as charity from the government, the poor had a legally enshrined right to medical care.

2.3 CONCLUSION

By the late 1920s, the changing landscape of politics and health had pushed medical professionals, volunteers in the tuberculosis campaign, and intellectuals to assert that the state

¹⁷⁵ The *Beneficencia* wing of the Secretariat of Sanitation and Charities managed public hospitals.

¹⁷⁶ Medical and public health reformers were adamant that the Cuban government replace (in name, concept, and practice) public charity with social assistance. One physician wrote to the president in the 1940s: “This aspect [*asistencia social*] of social-medicine has been constantly confused with public charity [*beneficencia pública*]. The latter began to disappear, as a scientific concept and as a type of state organization, from the moment that the State’s obligation...was recognized.” This obligation was “to give back public services to the individual—good health conditions, medical hospital care, institutes of preventive medicine, rigorous verification of the condition of foodstuffs, urban and rural sanitary legislation, etc.—which the individual invests for the sustenance, development and triumph of the ...NATION, in the form of work, compliance with legislation, and all that represents individual and social progress for the community. Social Assistance can be defined as the part of Social Medicine that is primarily concerned with preserving human life and health and....that strives to rebuild and improve the individual and the environment to ensure the possibility of a normal existence for all members of the collectivity.” José Chelala, “Asistencia Social,” July 1944, 41, leg. 24, exp. 845, Fondo Partido Revolucionario Cubano (Auténtico) (PRC-A), Archivo Nacional de la República de Cuba (ANC).

¹⁷⁷ Félix García Rodríguez, *Problemas de salubridad* (Havana: Imprenta Librería Nueva, 1940), 20.

needed to do more to control the disease. These claims provoked debates about exactly where individual responsibility ended and state responsibility began in solving the tuberculosis problem. Discourses of hygienic citizenship functioned in tension with grassroots demands for the state to recognize the right to health, although the latter steadily gained dominance.

Nonetheless, by the early 1930s, tuberculosis services were in shambles. The nation was enduring a devastating economic depression, and the government was crumbling under the pressure of popular mobilization and revolution. Within several years, however, the disease gained even greater visibility under military strongman Fulgencio Batista, who wrested control from private physicians and elite charitable women, positioning himself as the architect of the state, the father of the Cuban poor, and the author of an expansive tuberculosis campaign. One public health official argued that Batista's tuberculosis program represented the first "SOCIAL ASSISTANCE-based service" in Cuba, which was established in "recognition of the right that the poor sick have to receive the benefits of institutions created for their care."¹⁷⁸ It would be easy to misconstrue this grand health project as a top-down initiative, but Batista's decision to launch the *Consejo Nacional de Tuberculosis* was undoubtedly pushed from below, as citizens continued to demand better access to health care.

The right to health became firmly entrenched in the arsenal of citizenship demands by 1940, a right that Cubans would continually reference throughout the rest of the Second Republic. However, the process of working out what this right would mean in practice remained contentious. The remaining chapters chronicle the efforts of ordinary citizens, government actors, and physicians to implement their often-competing visions of health and citizenship.

¹⁷⁸ Juan J. Castillo, "Concepto, organización, funciones y resultados de los dispensarios del 'Consejo Nacional de Tuberculosis'," *Revista Cubana de Tuberculosis* 8, no. 1 (January–March 1944): 62. Emphasis in original text.

3.0 “A WIDE BATTLEFRONT AGAINST TUBERCULOSIS”: STATE-BUILDING AND HEALTH CARE, 1936–1965

In the years leading up to and following the revolution of 1933, the island’s tuberculosis facilities fell into disrepair. Dedicated staff struggled to care for patients with constrained budgets and credits that never arrived, and physicians at La Esperanza Sanatorium frequently went on strike as part of their struggle for improving the hospital and their working conditions.¹⁷⁹ On March 15, 1936, however, the Cuban press reported promising stirrings of activity in the sanitation branch. One day earlier, the directors of the tuberculosis dispensaries had called a meeting, in order to effect an “urgent reorganization of the anti-tuberculosis services in the Republic” and to open up facilities shuttered during the *machadato*.¹⁸⁰ Juan Castillo, director of the main Furbush dispensary, took the lead, reading a memo he had sent to the Secretary of Sanitation the year before concerning “our stunted anti-tuberculosis organization.”¹⁸¹ His frustration overflowed into

¹⁷⁹ On general conditions at La Esperanza Sanatorium, see Gustavo Aldereguía, “El Infierno y La Esperanza: Notas sobre un sanatorio desdichado,” in *Revolución y tuberculosis*, Cuadernos de Historia de la Salud Pública 68 (Havana: Central Nacional de Información de Ciencias Médicas, Ministerio de Salud Pública, 1984): 53–57. On physicians’ strikes at La Esperanza, see “Demandas de los médicos del Sanatorio ‘La Esperanza’,” *Tribuna Médica* 9, no. 230–31 (September 15 & 30, 1934): 259; “El triunfo de los médicos del Sanatorio La Esperanza,” *Tribuna Médica* 9, no. 232–33 (October 15 & 30, 1934): 347. For the wider context of medical politics and physician strikes, see Daniel A. Rodríguez, “‘To Fight These Powerful Trusts and Free the Medical Profession’: Medicine, Class Formation, and Revolution in Cuba, 1925–1935,” *Hispanic American Historical Review* 95, no. 4 (2015): 595–629.

¹⁸⁰ “Urgente reorganización de servicios antituberculosos en la República, se tiene en estudio por la S. de Sanidad,” *Diario de la Marina*, March 5, 1936, 15.

¹⁸¹ For text of the original memo, see Juan J. Castillo, “Males y remedios que reclaman inmediatamente una reorganización y mejoramiento de nuestras instituciones antituberculosas,” in *Dos años de trabajo contra la tuberculosis efectuados en el Dispensario “Furbush,”* ed. Secretaría de Sanidad y Beneficencia (Havana: Arellano y Cía., 1936): 52.

his writing, which was incredulous at the lack of concern shown by health authorities toward tuberculosis. Nevertheless, the directors decided to send the memo again to the Secretary of Sanitation.¹⁸²

Castillo must have been pleased and shocked when, a little more than a week later, *Diario de la Marina* announced the foundation of a new national institute, the Consejo Nacional de Tuberculosis (National Tuberculosis Council, CNT), dedicated solely to fighting the disease.¹⁸³ It was not the Secretary of Sanitation who had finally decided to act, however. Instead, one official told the paper, “Colonel Fulgencio Batista, Head of the Constitutional Army, has had a great influence in the discussion of these problems ... and has dedicated time and preferential attention to them, and there is no doubt that for this we contract one more debt of gratitude to this patriot.”¹⁸⁴ Within a month of its founding, the CNT was deemed as “one of the most beautiful humanitarian projects advocated by the Constitutional Army and in particular by its maximum leader.”¹⁸⁵

The move piqued foreign observers’ interest as well. In 1938, *TIME Magazine*, puzzled over Batista’s increasing intervention in social issues, remarked, “Fatherly Batista has...secured a firm Army grip on orphan asylums, tuberculosis sanatoriums and charitable institutions, administered by a group of seven Army-controlled corporations.”¹⁸⁶ In 1937, two Cornell physicians leading a group of medical students on an exchange program observed the activities of the CNT and praised its efforts: “Such an extensive program has never before been attempted,

¹⁸² “Urgente reorganización,” 15.

¹⁸³ “Se ha instituido el Consejo Nacional de Tuberculosis a fin de combatir esa dolencia,” *Diario de la Marina*, March 25, 1936, 3.

¹⁸⁴ “Hace declaraciones el Director de Sanidad acerca de cuatro leyes que tratan sobre la salubridad pública,” *Diario de la Marina*, April 2, 1936, 12.

¹⁸⁵ “Obsequeiaron al coronel Batista con una ambulancia modelo, que cedió a la Corporación Nacional de Tuberculosis,” *Diario de la Marina*, April 15, 1936, 3.

¹⁸⁶ “Foreign News: Cuba, Spring Fever,” *TIME Magazine* 29, no. 17 (April 26, 1937): n.p. Despite what this journalist wrote, there were five, not seven, corporations.

and it represents an advance in a new direction in public health control of tuberculosis.”¹⁸⁷ With few other exceptions, most nations across the globe did not prioritize tuberculosis control; Batista, Cuba’s military strongman, had not only dedicated a massive amount of funding to the disease, but also had explicitly declared its “eradication” as part of his policy platform.¹⁸⁸

The stakes were high for making such a claim—in 1936, no certain cure for tuberculosis existed—but perhaps Batista believed, like other populist leaders at the time, that “the enormous propaganda potential of the eradication campaign outweighed other political risks.”¹⁸⁹ On a return visit, those same two Cornell physicians surmised as much, writing, “If Colonel Batista frees Cuba from tuberculosis, he can be regarded as the savior of his country.”¹⁹⁰ Decades later, Batista himself recounted that his administration “[o]pened a wide battlefield against tuberculosis, because it was, and is, the social disease that threatens and decimates the poor the most.”¹⁹¹

Descriptions of the new tuberculosis program signaled that national politics—and the politics of disease—were changing yet again. The revolution of 1933 opened state agencies and officials to popular demands, and this chapter argues that the foundation of the CNT derived from and further cemented these political and social processes. As discussed in Chapter 2, during the 1920s Afro-Cuban activists had demanded that the state increase funding for tuberculosis services. This pressure, now emanating from a wider range of citizens and professionals, continued throughout the 1930s. In response, Fulgencio Batista made tuberculosis an important

¹⁸⁷ “Medics Study in Cuba,” *Cornell Alumni News* 41, no. 4 (October 20, 1938): 49.

¹⁸⁸ “Texto íntegro del Plan Trienal,” *Diario de la Marina*, July 25, 1937, n.p.

¹⁸⁹ Eric D. Carter, *Enemy in the Blood: Malaria, Environment, and Development in Argentina* (Tuscaloosa: University of Alabama Press, 2012), 153. Just like Batista, Juan Perón and his health advisor, Ramón Carrillo, aimed to “make political capital” out of a disease eradication campaign.

¹⁹⁰ Quoted in Arístides Sosa de Quesada, *El Consejo Corporativo de Educación, Sanidad y Beneficencia y sus instituciones filiales* (Havana: Instituto Cívico-Militar, 1937), 117.

¹⁹¹ Fulgencio Batista, “Inauguración del Sanatorio ‘Topes de Collantes’,” May 9, 1954, 3, Box 1, Fulgencio Rubén Batista Papers, 1933–2007 (FRB Papers), Cuban Heritage Collection, University of Miami (CHC-UM).

part of his statecraft and state-building designs. Batista hoped to garner political capital from the new tuberculosis projects. Presidential elections loomed in the near future, and Batista desperately needed to build popular legitimacy and an electoral base. Batista also desired to strengthen the reach of the state through the CNT and other army social welfare organizations.

Once institutionalized, the CNT constituted a significant arm of state formation, and it continued to function as such under succeeding administrations (1944–1952) and Batista’s dictatorship (1952–1958). Over the course of the Second Republic (1933–1958), the CNT oversaw the steady expansion of a tuberculosis treatment and diagnosis network across the island. As a result, by the 1950s, tuberculosis health indicators, access to tuberculosis services, and the number of tuberculosis beds had significantly improved from 1933.

However, this approach to state-building made state legitimacy conditional on performance, a process that was dependent not only on state capacity to respond to concrete problems, but on popular perceptions of the reach and effectiveness of government services.¹⁹² Since the late 1920s, tuberculosis specialists, health officials, and ordinary citizens had participated in a national dialogue about the appropriate form and scope of the tuberculosis campaign. By the time of Batista’s dictatorship, these expectations had crystallized, perhaps none more forcefully than the issues of an adequate number of hospital beds and citizens’ easy and fair access to them. Despite progress in the tuberculosis campaign, citizen complaints persisted, and they served not to highlight the achievements, but rather the shortcomings, of state efforts. On the eve of the revolution of 1959, the gap between popular expectations and the performance of public health under republican administrations influenced the growing de-

¹⁹² This argument about performance and legitimacy is central to Jorge I. Domínguez, *Cuba: Order and Revolution* (Cambridge, MA: Belknap Press of Harvard University Press, 1978).

legitimation of the state, the overthrow of Batista's government, and the fledgling revolutionary regime's priorities in health policy.

The revolutionary government funneled resources to address the limits of the CNT's decades-long campaign. The newly formed Tuberculosis Department within the Ministry of Public Health reported success in a number of areas, such as mass vaccination (the subject of Chapter 7) and mass X-ray examination. However, these early tuberculosis efforts (1959–1965) also reproduced some of the main features of republican programs. First, the government overstated its success in rectifying the shortage of beds dedicated to tuberculosis and their unequal geographic distribution. Second, in contrast to their rhetoric, health officials prioritized medical interventions over radical social legislation. As a result, those suffering from the disease continued to partially rely on the charitable activities of elite and middle class associations, a tradition in Cuban public health that physicians had adamantly denounced since the administration of Machado.

3.1 THE REVOLUTION OF 1933 AND THE CONSEJO NACIONAL DE TUBERCULOSIS

By September 1933, Machado fled the country, pushed out by mobilized sectors of the popular classes (*clases populares*), which included urban wage laborers, lower-rank soldiers, peasants, students, and middle-class professionals. The oligarchic state that had existed since 1902 was overthrown. Batista played a central, if complex, role in this process, rising through the ranks of the young sergeants revolting against their superiors. He originally threw his support behind Ramón Grau San Martín and other radical leaders, who abolished the Platt Amendment and

enacted a series of reformist laws during the “government of 100 days” (September 10, 1933–January 15, 1934). However, Batista soon turned against Grau, orchestrating his removal from power in early 1934. He then proceeded to crush all forms of mobilization and opposition, violently suppressing the very groups he had originally supported.¹⁹³ Among other measures, he declared all unions, including the Cuban Medical Federation, illegal and militarily occupied the University of Havana.¹⁹⁴ Until the elections held in 1940, Batista was the de facto ruler, maintaining order and governing the country behind the scenes of a string of civilian leaders, most of who were puppet presidents.

These processes of revolutionary mobilization and counter-revolutionary repression resulted in widespread violence, declining state legitimacy, and a breakdown of public services. By the end of 1935, however, the situation had stabilized, and Batista could turn to his long-term vision. Batista considered himself the leader of the 1933 revolution and the “architect of the Cuban state.”¹⁹⁵ He knew Cuban politics had changed irrevocably following the revolution, as the mobilized popular classes had gained greater weight in the political arena. As a brilliant strategist, Batista dedicated his efforts to building political support among the people.¹⁹⁶

During the first months of 1936, a provisional president was in office and Congress was out of session, to return in early April.¹⁹⁷ Cognizant of certain sectors’ discomfort with the increasing militarization of governmental services in Cuba, in the final days before Congress

¹⁹³ For more on this sequence of events, see Robert Whitney, *State and Revolution in Cuba: Mass Mobilization and Political Change, 1920–1940* (Chapel Hill: University of North Carolina Press, 2001).

¹⁹⁴ Rodríguez, “‘To Fight These Powerful Trusts’,” 625.

¹⁹⁵ Robert Whitney, “The Architect of the Cuban State: Fulgencio Batista and Populism in Cuba, 1937–1940,” *Journal of Latin American Studies* 32, no. 2 (May 2000): 435–59.

¹⁹⁶ Batista has been termed a “slippery populist,” for his ability to build alliances across ideological lines. Alan Knight, “Populism and Neo-Populism in Latin America, Especially Mexico,” *Journal of Latin American Studies* 30, no. 2 (May 1998): 231; Whitney, “The Architect,” 458–59.

¹⁹⁷ Frank Argote-Freyre, *Fulgencio Batista: From Revolutionary to Strongman* (New Brunswick: Rutgers University Press, 2006), 202. The Council of Secretaries, an advisory board to the President created in 1934, exercised legislative powers when Congress was not in session.

returned, Batista pushed a new platform of social services through the Council of Secretaries.¹⁹⁸ In what Frank Argote-Freyre has identified as a “power grab,” Batista founded five new institutions, all of which were to be managed by the army through the newly formed Corporate Council on Education, Health and Welfare (Consejo Corporativo de Educación, Sanidad y Beneficencia, CCESB).¹⁹⁹ While he created a general public health body (the Technical Institute of Public Health), he also founded a separate institute dedicated solely to tuberculosis control (CNT), institutionalizing the disease’s uniqueness and making it more important to domestic policy than ever before.²⁰⁰

The law that founded the CNT dissolved Machado’s Anti-Tuberculosis Board and transferred to the new agency control of tuberculosis hospitals, dispensaries, and administrative bodies previously under the purview of the Secretariat of Sanitation and Charities. The Cuban Anti-Tuberculosis League, active in the country since 1901, ceased to exist as a separate entity and was incorporated, along with its dispensary, into the CNT. The CNT rejected the participation of charities in the campaign, stripping the Damas Isabelinas of their mission by omitting them from the new governing board. Institutionally and financially autonomous from the sanitation branch, the vast majority of the CNT’s income was to come from a small percentage of the proceeds from the National Lottery.

¹⁹⁸ “Se ha instituido,” 3; “Decreto-Ley no. 706,” *Gaceta Oficial*, March 31, 1936, 13. Argote-Freyre writes, “There were early indications that President-Elect Gómez planned to make the curtailment of military power a central goal of his administration, and these social welfare laws were a preemptive strike against any such effort.” *Fulgencio Batista*, 204.

¹⁹⁹ Argote-Freyre, *Fulgencio Batista*, 203. The other four were the Technical Institute of Public Health, the National Corporation for Public Assistance, the Civic-Military Institute, and the Civic-Military Rural Schools. “Decreto-Ley no. 706,” 13.

²⁰⁰ Diana Obregón puts forth a similar argument for leprosy in twentieth-century Colombia: “[T]he government reinforced the uniqueness of the disease by setting up two public health agencies: one for leprosy and another for the rest of public health affairs.” “The State, Physicians, and Leprosy in Modern Colombia,” in *Disease in the History of Modern Latin America: From Malaria to Aids*, ed. Diego Armus (Durham: Duke University Press, 2003), 130.

Batista's decision to found the CNT was two-fold: he was hoping to expand the power and reach of the state, while responding to popular demands for more state health services. In the mid-1930s, Batista and other officials in the sanitation branch were aware of the growing politicization of the disease, as civilians and physicians made their critiques and complaints known. In the 1920s, Afro-Cuban figures had made the issue of tuberculosis visible to a national audience. After the fall of Machado, the push for reform continued, as middle-class and working-class Cubans formed associations, such as the National Workers Tuberculosis Cooperative (Cooperativa Nacional Obrera Pro-Anti-Tuberculoso), to address the poor state of tuberculosis care.²⁰¹ Newspapers featured the stories of ordinary citizens on "pilgrimage[s]" and "tragic odyssey[s]" to gain admittance to tuberculosis hospitals.²⁰²

Physicians petitioned the state to act by pointing to statistical evidence of the disease's import and the inadequacy of available funding. Specialists employed at public tuberculosis facilities and those in private practice proposed reforms in the medical press, published monographs for a broad readership, and wrote private correspondence to health officials. Juan Castillo, director of the Tuberculosis Section and the Furbush Dispensary, centrally located in Havana and overwhelmed with the needs of its district, sent off a string of memos to try to catch the attention of his superiors.²⁰³ In 1935, he declared tuberculosis to be Cuba's "most grave"

²⁰¹ "Cooperativa Nacional Obrera Pro-Antituberculoso," legajo (leg.) 206, expediente (no.) 4811, Fondo Registro de Asociaciones (RA), Archivo Nacional de la República de Cuba (ANC). Other groups formed included the Asociación Nacional Pro-Tuberculosos de Cuba (National Pro-Tubercular Association of Cuba). "Asociación Nacional Pro-Tuberculosos de Cuba," leg. 286, no. 8151, RA, ANC.

²⁰² "Triste odisea de una mujer que es abatida por el Mal de Koch," *El País*, August 25, 1937, 8, leg. "Recortes de prensa," expediente (exp.) "Maternidad e infancia," 17/10/3/1-251, Fondo José Chelala Aguilera (JCA), Museo Histórico de las Ciencias "Carlos J. Finlay" (MHC); "Editorial," *Bohemia* 29, no. 48 (November 28, 1937): n.p. Other accounts include "Hace falta un recio temple, para acometer el desempeño que exige cada cartera ministerial," *Bohemia* 27, no. 22 (May 31, 1936): 41; "Editorial," *Bohemia* 30, no. 30 (July 24, 1938): 38; Carlos E. Foment, "Los tuberculosos en los campos," *Bohemia* 30, no. 42 (October 16, 1938): 16; "Mueren millares de tuberculosos pobres en Cuba, desamparados del todo por los centros sanitarios," *La Palabra*, February 14, 1935, 1-2.

²⁰³ Juan J. Castillo, a doctor of "humble origin," who was one of only three mestizo professors in the University of Havana's School of Medicine, earned his doctorate in 1926 and was awarded the post of Graduate Assistant to the

disease and an “endemoepidemic problem,” bemoaning that the bases of the campaign had not been built on “technical knowledge.”²⁰⁴

Batista’s formation of the CNT responded to this groundswell of public opinion. While most scholars date Batista’s transition from military dictator to authoritarian populist to his alliance with the Communist Party in 1937, his first populist gestures occurred in 1936, through the programs of the CCESB.²⁰⁵ The propaganda that followed the CNT’s founding suggests how compelling popular and professional demands were in his decision.

Newspaper accounts and CNT materials painted a picture of a vibrant tuberculosis campaign, with Batista clearly identified as its patron. In his interactions with the press, Batista spoke frequently and energetically about his health projects, especially the CNT, which he referred to as “my anti-tuberculosis campaign.”²⁰⁶ He used tuberculosis as a bridge to connect with ordinary Cubans, many of whom knew the ravages of the disease firsthand. “I am very interested in tuberculosis,” he told one journalist, before revealing the story of his brother’s tragic death.²⁰⁷ Without giving firm numbers, barely a year after the CNT’s founding, Batista proclaimed in an interview, “I know that hundreds who would have died of tuberculosis five

Tuberculosis Chair in 1929 (which he held until he was named Associate Professor in 1937). During the revolutionary change of government in August 1933, he was appointed director of Havana’s main dispensary and immediately began to publish treatises in the medical press and to pen a series of interdepartmental memos to call attention to problems with the state’s tuberculosis organization. An insider within the Secretariat of Sanitation from the revolution of 1933 on, Castillo was one of the key figures in the tuberculosis campaign until the revolution of 1959, when he was one of 12 professors driven out in the first round of “purification” for “collaboration with the Batista dictatorship.” Gregorio Delgado García, “Cátedra de Patología, Clínica e Higiene Terapéutica de las Enfermedades Tuberculosas,” *Cuadernos de Historia de Salud Pública* 114 (2013): n.p.; Gregorio Delgado García, “Planes de estudios de la carrera de medicina de 1959 a 1966 y cambios en el profesorado,” *Cuadernos de Historia de la Salud Pública* 107 (2010): 299–300.

²⁰⁴ Castillo, “Males y remedios,” 49.

²⁰⁵ One exception is Domínguez, *Cuba*, 79.

²⁰⁶ Quentin Reynolds, “Otra entrevista con el Coronel Fulgencio Batista: El dictador sorprendido,” *Carteles* 29, no. 27 (July 4, 1937): 40.

²⁰⁷ *Ibid.*

years ago are now cured.”²⁰⁸ His administration distributed myriad photographs of Batista making publicized visits to hospital projects. The CNT touted a new children’s tuberculosis hospital as the initiative of Batista’s wife and routinely framed it as her gift to the Cuban people (see Figure 1).²⁰⁹



Figure 1. The First Lady presides over the Ángel Arturo Aballí Children’s Anti-Tuberculosis Hospital.²¹⁰

In preparation for the 1940 presidential election, Batista directly wove the accomplishments and goals of the CNT into his public speeches and campaign literature. He included the “eradication of tuberculosis” as one goal in his Three-Year Plan, the centerpiece of his platform.²¹¹ While campaigning, Batista promised to intensify the tuberculosis program and

²⁰⁸ Ibid.

²⁰⁹ See also Federico de Ibarzábal, *Lucha antituberculosa en Cuba* (Havana: Burgay y Cía, 1939), 24; “Visitando las obras del Sanatorio Infantil Antituberculoso,” *Boletín de información del Consejo Nacional de Tuberculosis* no. 14 (April 1939): 9, 18; “En marcha el proyecto de Hospital Infantil para niños tuberculosos, que auspicia la caritativa Señora Elisa Godínez de Batista,” *El Ejercito Constitucional: Revista oficial* 3, no. 26 (February 1938): 7.

²¹⁰ “Por la niñez enferma,” *El Ejercito Constitucional: Revista oficial* 3, no. 36 (December 1938): 9.

²¹¹ Whitney, *State and Revolution in Cuba*, 157–58; “Texto íntegro.”

construct more hospitals and dispensaries for the disease.²¹² “The crusade against tuberculosis is the exclusive work of Colonel Batista,” declared one campaign booklet, entitled “25 Reasons Why Batista Should be President.”²¹³ Two of those twenty-five reasons were dedicated to tuberculosis explicitly: he was credited for the national sanatorium (under construction) and for lowering tuberculosis morbidity and mortality rates.²¹⁴ Another brochure titled “The Eminently Constructive Inspired Work of President Batista” dedicated seven pages to photographs of Batista’s public works—three featured his tuberculosis projects.²¹⁵



Figure 2. Batista presides over the new Cuba under construction. Like other military propaganda, this image left no doubt as to who was to receive the glory for the social measures launched by the CCESB. The National Tuberculosis Council is pictured at bottom left.²¹⁶

²¹² “Plataforma presidencial de F. Batista,” 30, leg. 5, no. 231, Fondo Partido Revolucionario Cubano (Auténtico) (PRC-A), ANC.

²¹³ “25 razones por que Batista será Presidente,” 57, leg. 5, no. 231, PRC-A, ANC.

²¹⁴ Ibid. Osvaldo Valdés de la Paz, *La reconstrucción cubana realizada por Batista* (Havana: Talleres de Editorial, Guerrero, 1940), 131.

²¹⁵ “Inspiración obra eminentemente constructiva de Batista Presidente,” 85, leg. 5, no. 231, PRC-A, ANC.

²¹⁶ Sosa de Quesada, *El Consejo Corporativo*, n.p.

Batista also aimed to strengthen the Cuban state, which was to be accomplished initially by increasing the army's power. The five organizations of the CCESB represented "a series of bold initiatives that transformed the armed forces into the largest social-service provider on the island" (see Figure 2).²¹⁷ Batista stipulated that the CNT be an autonomous institution, removed from the oversight of the Secretariat of Sanitation. He and his supporters argued that this would protect the tuberculosis campaign from the corruption and politicking that plagued the sanitation branch. Some physicians agreed, like Luís P. Romaguera, a visiting physician at La Esperanza Sanatorium, who argued in 1935 that the nation needed a central tuberculosis board that "should be autonomous, untied from the partisan struggles of politics."²¹⁸ Romaguera had witnessed the influence of politics at work at the sanatorium and hoped the future of tuberculosis care might be depoliticized.²¹⁹

The CNT's creation, then, represented an indictment of Cuban state institutions: frequent political changes and patronage resulted in persistent personnel turnover, unstable funding, policy shifts and an inability to deliver efficient health services. Others, however, distrusted Batista's decision to make the CNT autonomous, fearing that it would allow him to have disproportionate influence over policy, further subjecting health programs to political objectives rather than medical ones.²²⁰ This controversy never went away, and the CNT remained autonomous throughout Batista's presidency (1940–1944). Over the course of the next several

²¹⁷ Argote-Freyre, *Fulgencio Batista*, 202. Although Argote-Freyre writes that the State Council passed this legislation, both *Gaceta Oficial* and *Diario de la Marina* indicate that it was the Council of Secretaries that did so. "Se ha instituido," 3; "Decreto-Ley no. 706," 13.

²¹⁸ Luís P. Romaguera, "Programa médico-social contra la tuberculosis," *Revista Médica Cubana* 46 (1935): 841.

²¹⁹ "Demandas de los Médicos del Sanatorio 'La Esperanza'," *Tribuna Médica* 9, nos. 230–32 (September 15 & 30, 1934): 259. In the fall of 1934, La Esperanza physicians had presented demands to the Secretary of Sanitation for better salaries, improved care of patients, and more scientific treatment methods. When they participated in the general medical strike of 1935, many of them were fired and replaced.

²²⁰ See, for example, "Informaciones médicas," *Medicina de Hoy* 1, no. 3 (April 1936): 103.

decades, tuberculosis programs became a key arm of state-building. The CNT, according to one insider, represented the first “SOCIAL ASSISTANCE-based service” in Cuba.²²¹

3.2 STATE GROWTH, STATE LIMITS

Following the March 1936 decree, the CNT launched “a formidable crusade against the white plague.”²²² Batista dedicated a sizable amount of funds to the disease by appropriating a percentage of the proceeds from the National Lottery. Citizens rarely knew the exact yearly budget of the CNT, with reports ranging from 1,200,000 to over 3,000,000 pesos, but the CNT reported that in seven and a half years (May 1936 to December 1943), they had expended 10,643,634 pesos on tuberculosis, a substantial increase from the first three decades of the twentieth century.²²³ The CNT embarked on many new endeavors: it opened new dispensaries in Havana and each provincial capital; constructed several hospitals; carried out an epidemiological survey in the slums and public schools of Havana; published a quarterly scientific journal; and established a Section of Social Action that distributed posters, brochures, and educational films.

The CNT prioritized the construction and expansion of treatment centers. It set about re-opening facilities that had lain dormant for years, finishing projects from the Machado era. By August 1936, the CNT had inaugurated the Lebrede Hospital (the previously uncompleted

²²¹ Juan J. Castillo, “Concepto, organización, funciones y resultados de los dispensarios del ‘Consejo Nacional de Tuberculosis’,” *Revista Cubana de Tuberculosis* 8, no. 1 (January–March 1944): 62. Emphasis in original text. Castillo was implicitly contrasting this term (“social assistance”) with prior forms of “public charity” (*beneficencia pública*).

²²² “Se ha instituido,” 3; “Se construirán sanatorios para los tuberculosos y 2 lazaretos para leprosos: Existe el propósito de iniciar una formidable cruzada contra la peste blanca,” *Diario de la Marina*, March 29, 1936, 3.

²²³ Demetrio E. Despaigne, *La lucha contra la tuberculosis en Cuba* (Havana, 1944), 94.

Francisco María Fernández Hospital begun in the late 1920s). Its opening more than doubled the capacity of the La Esperanza complex to just under 1,000 beds.

Construction projects began in the late 1930s on three more hospital projects. A children's tuberculosis hospital, A. A. Aballí, with 300 beds, was to be built next to the La Esperanza Sanatorium and Lebrede Hospital. Batista inaugurated the Aballí Sanatorium before leaving office in 1944. In Oriente, Cuba's most populous province, the CNT commenced work on Ambrosio Grillo Sanatorium, with almost 400 beds. This medium-sized facility was located on the outskirts of Santiago de Cuba, near the famous Basílica del Cobre. The administration of Ramón Grau San Martín (1944–1948) finished and inaugurated the Ambrosio Grillo facility during his first year as president. Several years later, Grau inaugurated a small, 70-bed sanatorium in his home province of Pinar del Río and named it after his mother, Pilar San Martín.

The massive Topes de Collantes National Sanatorium, located in the mountains of Las Villas Province, undoubtedly functioned as the CNT's premiere project with a slated capacity of 1,000 beds. Batista made this sanatorium (the subject of Chapter 5) a crucial part of his legacy and continually trumpeted it as one of his most important gifts to the Cuban people. Construction on the Topes de Collantes Sanatorium stalled during the Auténtico administrations (1944–1952), but Batista finally inaugurated the facility in late 1954.

Despite any controversies and criticisms surrounding these projects, one can trace the steady expansion of beds dedicated to tuberculosis treatment across the years of the Second Republic (see Table 1). Even when population growth is taken into account, the ratio of tuberculosis beds to people increased over time: in the early 1930s, there were approximately

1.14 beds per 10,000 inhabitants; in 1944, this number had increased to 2.51; by the late 1950s, this ratio had jumped to 3.83–4.45 beds per 10,000 inhabitants (see Table 4).²²⁴

Table 1. Bed Capacity of Tuberculosis Hospitals & Sanatoriums²²⁵

Year	1927	1933	1944	1948	1958
Number of TB Beds	150	450	1200	1630	2511–2911

Dispensaries proved even more vital for state-building efforts in public health. These facilities were open to the public and provided diagnostic services free of charge. Some had visiting nurses, who fulfilled important surveillance, educational, and therapeutic functions, fanning out from the dispensary to check on cases already registered or to raise awareness among those who had not visited the facility. Although in theory all dispensaries were to have these nurses, it appears that only two or three in Havana provided this service. Also, dispensaries were supposed to only provide diagnostic and educational services; however, the bed shortage in Cuba meant that in practice these facilities often provided therapeutic services, either by visiting patients' homes or by administering procedures inside the dispensary.

Table 2. Number of State Tuberculosis Dispensaries²²⁶

Year	1930	1944	1948	1958
Number of Dispensaries	3	10	28	28

²²⁴ See citation for Table 4.

²²⁵ Bed numbers come from “La lucha contra la funesta tuberculosis,” *Bohemia* 19, no. 51 (December 18, 1927): 42; Despaigne, *La lucha contra*; Bartolomé Selva León, *Un año de lucha antituberculosa en Cuba, 1944–1945* (Havana: Consejo Nacional de Tuberculosis, 1946); “Fórum nacional sobre ‘crisis médica’: Conclusiones y recomendaciones,” *Tribuna Médica* 27, nos. 430–31 (September–October 1956): 53; “Situación hospitalaria de Cuba en 1958 respecto de 1933 y 1944,” 1–4, Folder 75, Box 136, Fulgencio Batista Zaldívar Collection (FBZ Collection), CHC-UM. For the bed count in 1958: Both the National Medical College and the Batista administration reported that Topes de Collantes Sanatorium had 1000 beds, which brought the national total of tuberculosis beds to 2,911. Other sources reported that only 600 beds were made available, which would make the national bed count 2,511. “Fórum Nacional,” 53; “Situación Hospitalaria,” 1–4, Folder 75, Box 136, FBZ Collection, CHC-UM; Ministerio de Salud Pública del Gobierno Revolucionario de Cuba, *Desarrollo Económico y Salud en Cuba* (Havana: n.p., 1961), 124; Fulgencio Batista, *Piedras y Leyes* (Mexico: Imprenta M. León Sánchez, 1961), 120.

²²⁶ Dispensary numbers come from Selva León, *Un año de lucha*; Cuba, Consejo Nacional de Tuberculosis, *Un año de trabajo en el Consejo Nacional de Tuberculosis* (Marianao, 1957). These numbers do not include the municipal tuberculosis dispensary, which was managed by Havana’s municipal government.

The number of dispensaries increased over time (see Table 2). During the late 1930s, Havana's four pre-existing dispensaries were refurbished and/or reopened. The CNT inaugurated a new one in a poor Havana neighborhood and five in the capital cities of the remaining five provinces, delivering services to many who had had to travel to Havana for diagnosis and treatment in the past.²²⁷ Under Grau's presidency, the CNT turned its attention to increasing the geographic reach of these units. It added 18 dispensaries in a four-year period, paying particular attention to neglected regions (compare Figures 3 and 4).



Figure 3. CNT Tuberculosis Dispensaries, 1940. Under Batista, there were five dispensaries in metropolitan Havana, and five in each remaining provincial capital. Map made by author.



Figure 4. CNT Tuberculosis Dispensaries, 1948. To Batista's ten dispensaries (represented by the triangle and squares), Grau opened eighteen new centers (represented by circles). Map made by author.

²²⁷ While the director of Furbush Dispensary from August 1933 through August 1935, Castillo reported that his staff had served over 6,000 individuals, from 16 municipalities in Havana Province and 33 other municipalities of the island. Juan J. Castillo, "Informe al Sr. Secretario de Sanidad, de los trabajos realizados en la Sección de Tuberculosis (Dispensario Furbush y Negociado de Estadística e Información) bajo la dirección del Dr. Juan J. Castillo, in *Dos años*, 21.

The dispensaries, staffed by tuberculosis specialists, undertook important epidemiological work. Dispensary directors and nurses kept track of active cases in their district or region and attempted to secure admission to sanatoriums for these cases or to provide outpatient treatment. They often became aware of healthy children living in contagious homes and arranged their residency in one of Cuba's two preventorios (both located on the outskirts of Havana, in Cojimar and Luyanó).

The work of these CNT specialists intensified contacts between the state and its population, especially in marginalized areas. When one Havana dispensary opened its doors for a highly-publicized tuberculosis survey in July 1937, the staff was overwhelmed with the response. "Such was the influx of the public," the Survey's director reported, "as people flocked from the most remote places of the Capital, that it was decided to limit the services of the 'Survey'" to one district in Central Havana.²²⁸ In nine months, the survey staff had accomplished impressive results. They administered 21,414 tuberculin tests, recorded 13,523 positive tests (which indicates infection, but not active disease), and then gave 7,000 X-ray examinations to determine those who had an active case of tuberculosis. From these efforts, 466 cases of tuberculosis were found, logged in the dispensary's registry, and linked in to its network of surveillance and care.²²⁹

Within the first years of its existence, the CNT interacted with large numbers of people, especially compared to the early 1930s.²³⁰ From 1931 to 1933, for example, the Furbush

²²⁸ Cuba, Consejo Nacional de Tuberculosis, *Resumen general de los trabajos efectuados por el "Tuberculosis Survey de Cuba"* (Havana: Ciudad Militar, 1938), 18; Juan R. Mencia, Morton C. Kahn, and Edgar Mayer, "The Cuban National Case-Finding Campaign," *The American Review of Tuberculosis* 40 (July–December 1939): 523.

²²⁹ Consejo Nacional de Tuberculosis, *Resumen general*, 43–44.

²³⁰ People were tested primarily on a voluntary basis by visiting the dispensary during operating hours to be given a tuberculin test (and subsequent X-ray if necessary). However, visiting nurses also found cases by inspecting the homes of patients already registered and then convincing other family members to undergo testing. It is important to note that the CNT inherited the records of the dispensaries that were under the purview of the Secretariat of

Dispensary tested 4,126 individuals, of whom 1,326 were diagnosed with an active case of the disease.²³¹ Numbers are not available for Havana's other state dispensary, Jesús del Monte, but it is probable that they served a number equal to or lesser than Furbush Dispensary. In comparison, in 1937 alone, the CNT's five dispensaries in Havana tested 13,825 individuals, identifying 2,193 cases of active disease.²³² The provincial dispensaries tested a total of 14,570 people in that year, from which 1,665 cases were diagnosed.²³³

The total number of known cases increased over the course of the late 1930s, the 1940s, and the 1950s. In 1938, the CNT reported 15,352 registered cases; in 1942, 27,350 individuals with tuberculosis were on the dispensaries' registries.²³⁴ In four years, then, the CNT had diagnosed approximately 12,000 new cases. Although exact numbers are not given, this figure suggests that an extraordinary number of people had been administered a tuberculin test for the disease. Due to the limited numbers of visiting nurses, it is highly probable that the majority of these individuals came in to the dispensaries to be tested, evidence not only of citizens' concern for their health, but of the successful propaganda of the CNT campaign that heavily advertised its dispensaries' locations, hours, and free services. Although data are sparser in the late 1940s and 1950s, this trend appears to have continued. In 1956, 10 mobile units examined 12,439 people and dispensaries examined 49,854 people, amounting to 62,293 total people being tested.²³⁵ In

Sanitation and the Cuban Anti-Tuberculosis League before 1936, so the total cases known in 1936 include the cases diagnosed and registered by these dispensaries in 1935 in addition to new cases found in 1936. Furthermore, the total number of known cases downplays the larger number of individuals with whom the dispensaries were interacting, for it only reports those who had a positive reaction to the tuberculin skin test.

²³¹ Castillo, "Informe al Sr. Secretario de Sanidad," 15–16.

²³² Consejo Nacional de Tuberculosis, *Resumen general*, 12.

²³³ *Ibid.*

²³⁴ Cuba, Dirección General del Censo, *Informe general del censo de 1943* (Havana: P. Fernández y Cía, 1945), 528–29.

²³⁵ Consejo Nacional de Tuberculosis, *Un año de trabajo*, 3.

1952, two CNT doctors tested 70,598 persons in one campaign, in what can be considered the first national tuberculosis survey.²³⁶

The CNT also reported serving an increasing percentage of known cases over time. In 1938, the CNT claimed to have served 67.6% of the 15,352 cases known on the island. These percentages steadily increased in the years for which we have data: 72% (1939), 72.9% (1940), 74.5% (1941), and 75.2% (1942).²³⁷ This particular measurement is significant because it refers to a more sustained encounter between the dispensary and its population. It is unclear what “served” meant exactly: it might have been as brief as one follow-up visit to obtain access to some sort of medication, or it might have included a surgical or therapeutic intervention, such as pneumothorax, which entailed multiple procedures. Either way, the increase in the proportion of those served signifies that the state not only improved its epidemiological knowledge of its population (through diagnosis and registration), but also extended its governance by providing some sort of therapy to its citizenry.

Furthermore, the reach of the state, measured by the CNT’s interaction with citizens via its institutional network, was no longer limited to Havana. Absolute numbers of known cases also increased in the other provinces, from 6,850 in 1938 to 12,147 in 1942 (an increase of 5,297).²³⁸ Forty-four percent of the new cases found between 1938 and 1942 were from outside Havana Province. The CNT labored to rectify provincial disparities. In 1938, the percentages of known cases served by the CNT varied greatly by province, from a shockingly low 48.4% in

²³⁶ Rafael Ballesteros Sierra and José M. Hernández Pérez, “Contribución al estudio de los índices de infección tuberculosa en Cuba, en diversas edades,” *Revista Cubana de Tuberculosis* 16, nos. 3–4 (July–December 1952): 311–24. The figures being tested represent about 1% of the national population in that year (1952 and 1956). In comparison, by the 1940s, certain Canadian provincial governments had given X-ray examinations to their entire populations. The poorest performing province, Quebec, had tested one-third of its population. Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900–1950* (Montreal: McGill-Queen’s University Press, 1999), 189.

²³⁷ *Censo de 1943*, 528–29.

²³⁸ *Ibid.*

Oriente Province to a high of 74.2% in Havana Province; by 1942, that range had decreased, with the CNT serving 65.1% of known cases in Oriente Province and 77.3% in Havana Province. Oriente and Matanzas Provinces reported the highest increases in percentages of known cases being served: 48.4% to 65.1% and 52.3% to 72%, respectively. Finally, in 1938, the number of cases not served (the gap between the number of known cases and the number of served cases) was much smaller in Havana Province than in other provinces. In 1938, the CNT had not attended to 2,196 cases in Havana Province; in the other provinces, the CNT had not served 2,782 cases. By 1942, however, this gap between the number of cases not served in Havana and the rest of the provinces had closed, signifying an improvement in the number of cases served outside the capital (see Figure 5).

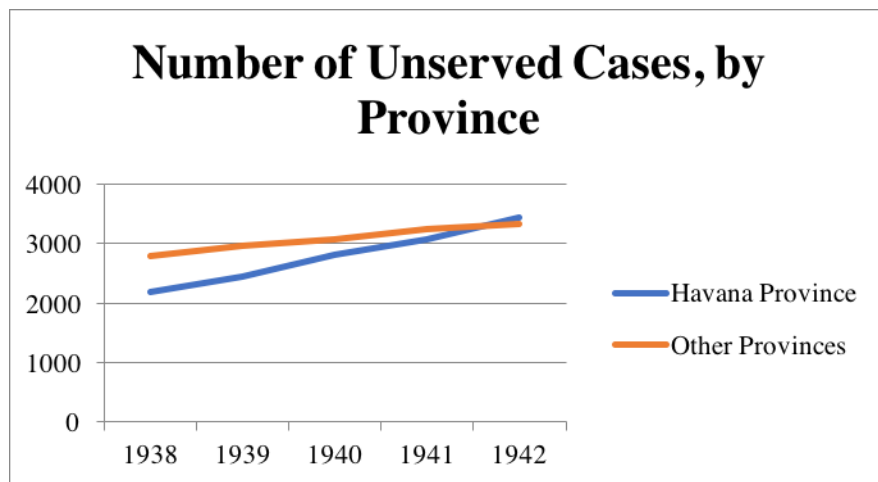


Figure 5. Unserved tuberculosis cases in Havana and other provinces. The gap had closed by 1942.²³⁹

Despite the improvements in the state tuberculosis campaign (e.g., cases served and the number of beds available), citizens continued to focus not on its progress but on its failures and shortcomings. The question of beds—their number and their geographical distribution—drew the

²³⁹ Ibid.

most energy, from citizens and medical professionals alike. By the mid-1930s, almost all physicians agreed that the state's primary responsibility was to provide more beds.²⁴⁰ (They disagreed over how to provide these beds, however, which is the subject of Chapter 5). Several physicians who joined the CNT soon after its founding were already painfully aware of the inadequacy of services and vocally pushed for an extension of beds. In 1935, Castillo, still head of the Furbush Dispensary, calculated that around 16,000 Cubans with tuberculosis were poor enough to qualify for state assistance; La Esperanza Sanatorium's 450 beds would not suffice.²⁴¹ Some tuberculosis specialists believed patients could be cured through residence in a sanatorium; others believed sanatoriums and hospitals served the dual purpose of isolating dangerous sources of contagion and improving the health of the patient. Physicians looked abroad and believed Cuba should emulate those "civilized" nations expending great sums of money on hospitals.²⁴² For physicians, then, providing sanatorium beds represented the linchpin of any effective tuberculosis control campaign.

More specifically, tuberculosis specialists believed that the CNT should endeavor to reach the standard recommended by the American National Tuberculosis Association (NTA): at

²⁴⁰ There were a few physicians who sought an alternative route, questioning the cost-intensive hospital plan. In 1935, Gustavo Aldereguía voiced concern that a hospitalization plan was not a sustainable project; however, due to the political climate of Batista's Cuba, Aldereguía, a fierce opponent and participant in the March 1935 strike, was shut out from the CNT despite being an excellent candidate for formulating tuberculosis policy. Aldereguía urged a campaign that was decentralized to the municipal level; focused on public health (i.e., preventive measures); and dependent upon the social work of visiting nurses, who would travel to the homes of the sick, provide supplies, instruct patients on how to recover, and monitor the hygiene and care of the patient to limit contagion. Some journalists and foreign experts endorsed his plan. Wilson G. Smillie, M.D. and Professor of Public Health Administration at Harvard, wrote, "The director of the National Tuberculosis Sanatorium has a clear conception of the magnitude of the tuberculosis problem of Cuba and has a very interesting plan of attack. It is obvious that a complete hospitalization plan for the island is prohibitive. We are in complete accord with this plan." Foreign Policy Association, Commission on Cuban Affairs, *Problems of the New Cuba: Report of the Commission on Cuban Affairs* (New York: Foreign Policy Association, 1935), 111; Antonio Penichet, "La tuberculosis y Dr. Aldereguía," *Bohemia* 27, no. 3 (January 20, 1935): 66. For more on Gustavo Aldereguía, see Dr. Gregorio Delgado García, "Doctor Gustavo Aldereguía Lima: luchador e higienista social," *Revista Cubana de Salud Pública* 38, no. 2 (April–June 2012): 183–91.

²⁴¹ Juan J. Castillo, "Males y remedios," 53.

²⁴² *Ibid.*, 50, 58.

a bare minimum, at least one bed (and preferably two) should exist for every annual death in the country. Luís Romaguera, for example, argued in 1937, “The urgent need of our country is to have a higher number of beds for the sick,” after which he cited the NTA standard of 4,000 beds for Cuba.²⁴³ This numerical goal of 4,000 beds, originally discussed in the medical press in the late 1930s, gathered broader consensus over the years, so that by the 1950s, it was also cited in the popular press.²⁴⁴ By the early 1950s, however, only 1600 beds were available. By the late 1950s, this number had jumped to approximately 2,900 (or possibly 2,500) with the opening of two new facilities (one outside of Trinidad and another outside of Havana), but the state had fallen short of the 4,000-bed goal (see Table 1).

The CNT’s constituents also expressed dissatisfaction with the geographic distribution of beds. Medical and health resources had long been concentrated in Havana, and the politicization of this unevenness grew over the course of the 1940s and 1950s. In 1935, Castillo penned, “The centralization of anti-tuberculosis services in the Capital of the Republic constitutes a fact of reprehensible magnitude.”²⁴⁵ He also argued that those with tuberculosis not only existed in all the corners of the island, but they also contributed to the national budget, and, therefore, “it is legal that they obtain and enjoy all the sanitary services” that had been centralized “arbitrarily” in Havana.²⁴⁶

Two geographic disparities were particularly disparaged. The first was the long-standing neglect of Oriente Province, Cuba’s most populous region. Foreign observers and domestic

²⁴³ Luis P. Romaguera, “Sanatorio para tuberculosos: Un estudio sobre esta materia de tanta importancia en una campaña contra la tuberculosis,” *Revista de Medicina y Cirugía de la Habana* (1937): 570.

²⁴⁴ For the medical press, see Castillo, “Males y remedios,” 58; Romaguera, “Sanatorio para tuberculosos,” 570. For the popular press, see “¿Topes de Collantes sirve para curar tuberculosos?” *Bohemia* 45, no. 18 (May 3, 1953): 23–24.

²⁴⁵ Castillo, “Males y remedios,” 59.

²⁴⁶ *Ibid.*

witnesses had recorded—and castigated—Santiago de Cuba’s “sanitary abandon” for decades.²⁴⁷ The second issue addressed the concentration of services in urban areas, and the difficulty that poor rural *campesinos* and sugar workers faced in gaining access to health care. “[T]he [sugar] barracks are hells,” one journalist revealed, “where tuberculosis has an important role of annihilation and destruction.”²⁴⁸ He continued, “[T]he inhabitants of the countryside are found lacking all protection, living a life of misery and slovenliness, a sphere ripe for all infections and epidemics.”²⁴⁹

While the CNT improved some regional disparities, as discussed above, citizens were never satisfied that they had adequately resolved either of these two geographic issues. In case-finding efforts, Havana’s denizens benefitted from a robust network of dispensaries, tuberculin-testing campaigns, and sanatoriums. In 1942, 55.6% of the total known cases came from Havana Province’s, even though only approximately 25% of the national population lived in Havana province.²⁵⁰ While Havana Province had the largest urban center on the island, it did not have the largest concentration of population. With 28% of the national population, only 11.4% of known tuberculosis cases came from Oriente.²⁵¹ Access to tuberculosis facilities and services continued to vary by regional location. In 1942, those in Havana accounted for approximately 57.2% of

²⁴⁷ See, for example, American Consul to Secretary of State, “Sanitary Condition in Santiago de Cuba and Vicinity,” March 4, 1918, no. 5; “Por patriotismo,” *Diario de Cuba*, March 11, 1918, translation not mine; American Consul to the Secretary of State, “Sanitary Conditions in Santiago de Cuba,” March 19, 1918, no. 12, Records of the Department of State Relating to Internal Affairs of Cuba, 1910–29, General Records of the Department of State RG 59, Washington, D.C.: National Archives, National Archives and Records Service, General Services Administration, 1963. “Lecturas amenas para el Consejo de Secretarios: Sgo. de Cuba vive en un abandono sanitario sólo comparable al que encontró el Gobierno Interventor,” *Bohemia* 27, no. 6 (February 10, 1935): 24–25, 51–52, 66; Gustavo Aldereguía, “Polémica: Sobre la tuberculosis en Oriente,” *Bohemia* 39, no. 11 (March 16, 1947): 20.

²⁴⁸ Foment, “Los tuberculosos en los campos,” 17.

²⁴⁹ *Ibid.*, 16.

²⁵⁰ Cuba, Oficina Nacional de los Censos Demográfico y Electoral, *Censo de población, viviendas y electoral, 1953* (Havana: P. Fernández y Cía, 1955), 1–2.

²⁵¹ *Ibid.* Some might counter that tuberculosis was an urban disease because of crowded living conditions. However, many contemporary scientists argued that the high case rate in Havana was actually a reflection of the superior surveillance and case-finding network and not a testament to the geographical distribution of the disease.

total cases served; Oriente Province (again, with 28% of the population), only accounted for 9.8% of cases served.

These disparities affected the experience of individuals with the disease. Even though provincial dispensaries had been established in the late 1930s, for those living far from their provincial capital, these medical services might be out of reach. In 1941, one physician from a provincial dispensary reported that his patients, 95% of whom were economically unable to support themselves, needed centers closer to them.²⁵² He told the story of one sick man who had to travel approximately seventy miles from Central Francisco to the dispensary. His journey consisted of a horse ride, then two car rides, and then a three-hour train. Six to seven hours after his departure, he would finally arrive at the dispensary for outpatient treatment.²⁵³

Grau's strategy of increasing provincial dispensaries ameliorated this situation by adding eighteen new dispensaries, and during the 1950s, ten mobile units were equipped to reach rural areas. These units carried out vaccination (including BCG), examined patients for parasites and tuberculosis, and administered some treatments.²⁵⁴ The Institute of Rural Health publicized Batista's concern with and increased attention to the "health of the *campesino* family."²⁵⁵ Nonetheless, the gap between rhetoric and experience remained wide; the politicized nature of rural health in the first years of the revolution suggests that while changes in tuberculosis policy in the 1940s and 1950s might have reduced the urban-rural disparity, it never resolved it.

Additionally, the provincial disparity in hospital beds was never resolved. Both medical professionals and citizens demanded a sanatorium in every province. One physician laboring in

²⁵² Dr. Ramón V. Tormo, "El neumotórax artificial en nuestro medio dispensarial," *Revista de Tuberculosis* 5, no. 1–4 (1941): 222.

²⁵³ *Ibid.*, 223.

²⁵⁴ Mercedes Chávez Arango, "Las nuevas unidades móviles rurales en Cuba," *Boletín Oficial de Salubridad y Asistencia Social* 53, nos. 1–6 (January–June 1950): 71–74; *Salubridad rural: Anhelos de un gobernante* (Havana: Mecalling, n.d.), n.p.

²⁵⁵ *Salubridad rural*, n.p.

Camagüey's dispensary, well acquainted with his clients' limited access to therapeutic services, recommended provincial sanatoriums to accommodate these citizens and more dispensaries to perform outpatient procedures for those who did not qualify or were wait-listed for the sanatorium.²⁵⁶ In 1937 a speaker at the Hermandad Ferroviaria of Camagüey praised the efforts of the CNT, thanking them for their dispensary, but then demanded a sanatorium. "In a town where 194–198 victims of tuberculosis die annually; in a town where in only two months 500 individuals are tested and 125, or 25%, of them are found to have tuberculosis...a sanatorium is needed!"²⁵⁷

Batista and the CNT, however, did not dedicate the majority of resources to providing small provincial sanatoriums. Instead, the CNT's energies went to a massive national sanatorium project (the subject of Chapter 5). Under Grau's presidency, a new CNT administration promised to add a sanatorium in those provinces that did not have one (Pinar del Río, Matanzas, Las Villas, and Camagüey), but they only built and opened one, a disappointingly small facility in Grau's home province of Pinar del Río. In the late 1950s, the CNT finally began construction on a sanatorium in Camagüey (Amalia Simoni), one of Cuba's largest cities. The project had come too late to satisfy Camagüey's citizens, who had to wait until the first years of the revolution for the sanatorium to be inaugurated. By the late 1950s, inequality in the provincial distribution of beds had not been resolved (see Figure 6). Havana, with roughly 26% of the population, had 48.1% of the island's tuberculosis beds. Matanzas and Camagüey had no sanatorium. Oriente, with over 30% of the population, had only 15% of the beds.

²⁵⁶ Tormo, "El neumotórax artificial," 226.

²⁵⁷ Ramiro Delgado Acosta, "Discurso pronunciado en la Hermandad Ferroviaria de Camagüey," *Revista de Tuberculosis* 1, no. 4 (1937): 640.

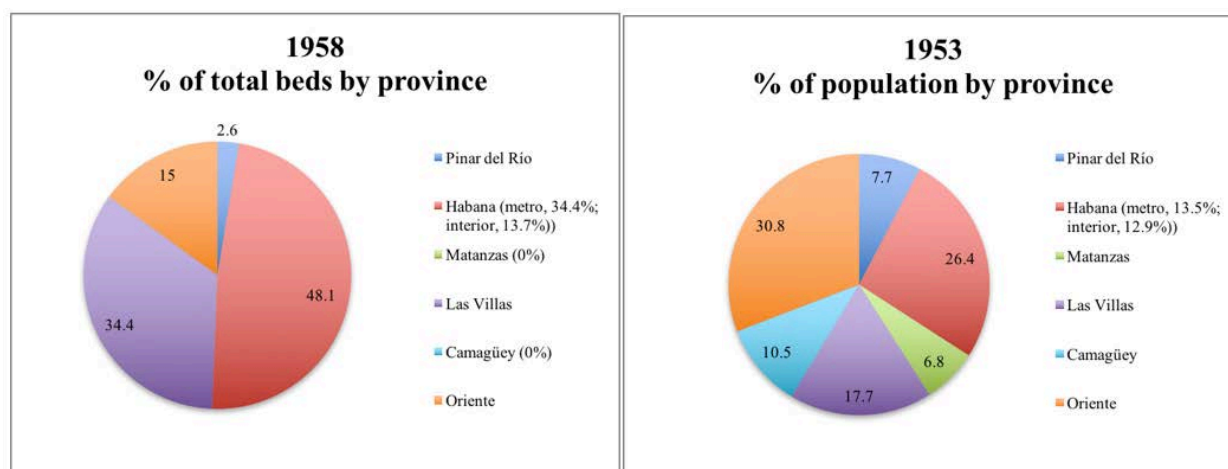


Figure 6. By the end of the Second Republic, the CNT had not distributed tuberculosis beds in a way that matched the geographic distribution of the population.²⁵⁸

Facing these inequalities and difficulties, Cubans sick with tuberculosis still tried to make their dreams for hospitalization become a reality. One strategy was writing to journalist Guido García Inclán, who published these letters in a weekly column in *Bohemia*, which provided a highly visible space for the poor to appeal for money or supplies for home treatment, plead for entrance into a medical facility, or to criticize the government's provision of health services. Many of these requests and complaints centered on tuberculosis, and they did not diminish despite the reported drop in tuberculosis mortality. García Inclán reported that he daily received letters, telegrams, and visits from tubercular patients, many of whom simply asked for "a bed in which to die."²⁵⁹

One such petitioner, Juana Meyrele Torres, a 35-year-old mother of six, wrote in desperation in March 1954. Though she had been admitted to La Esperanza Sanatorium previously, she was discharged before fully healed, and now spent her days prostrate in bed,

²⁵⁸ These percentages are based on the count of 1,000 beds in Topes de Collantes Sanatorium. If, as some alleged, only 600 were available, Las Villas' share of the beds would drop to 23.9% and Havana's would increase to 39.8%. There is no provincial population data for the late 1950s, so I rely on the 1953 provincial distribution. Oficina Nacional de los Censos Demográfico y Electoral, *Censo de población*, 3.

²⁵⁹ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 46 (November 14, 1954): 94.

unable to provide for her children, who were being “contaminated” by the disease. Health authorities advised her that there were not any available beds in the sanatorium, and hospitals would not admit tubercular patients. “I am dying, señor,” Meyrele declared, “and I leave my children with a similar ending as they are already infected. Please do whatever is in your reach to obtain entrance in a sanatorium for this mother who suffers and is dying.”²⁶⁰

During the same month, Pedro Luzardo Díaz wrote to García Inclán from Bejucal, outside of Havana. His son-in-law was afflicted with tuberculosis, and his daughter had passed away in a hospital, leaving the grandfather in charge of his nine grandchildren. On behalf of Luzardo, García Inclán begged for the children to be housed in a crèche, the father to be admitted to a sanatorium, and someone to give him a job—for the tubercular father was unable to provide income due to his weakened state. Luzardo despaired, “I do not know what I am going to do with all of these children...I am an old man, tired of struggling and working in the countryside...”²⁶¹ From these brief and often tragic letters, published weekly in García Inclán’s column, a portrait emerges in which the Cuban poor appeared to be desperate for more beds in sanatoriums.

In 1954, the CNT promised, “A bed for every tubercular and every tubercular in his bed.”²⁶² However, in citizens’ eyes, the CNT never provided enough beds nor made treatment easily and equally accessible to all.²⁶³ García Inclán opined that hospital service was “one of the most legitimate rights that a poor citizen has.”²⁶⁴ In Cuba, however, for an unknown reason, “the

²⁶⁰ García Inclán, “En la feria de la actualidad,” *Bohemia* 46 (March 14, 1954): 94.

²⁶¹ García Inclán, “En la feria de la actualidad,” *Bohemia* 46 (March 20, 1954): 92.

²⁶² “Nueve meses de una amplia y dinámica labor sanitaria,” *El Crisol*, March 19, 1954, n.p.

²⁶³ For more examples of citizen and professional discontent regarding beds, see “Insuficiente el número de centros para la curación de TB,” *Noticias de Hoy* (July 1944): n.p.; “Hay 30 solicitudes de ingreso por cada cama en el Sanatorio ‘La Esperanza’: Un grave problema,” *Boletín de lucha antituberculosa: Órgano oficial del Consejo Nacional de Tuberculosis* 1, no. 2 (July–August 1945): 18.

²⁶⁴ García Inclán, “En la feria de la actualidad,” *Bohemia* 46 (November 14, 1954): 94.

human rights of citizens” were being limited.²⁶⁵ In 1957, he decried that “6,000 poor tuberculars swarm through these streets...without finding refuge in a sanatorium.”²⁶⁶

Medical professionals agreed. In 1955, Castillo, then director of the CNT, visited the presidential palace to inform Batista that of the estimated 40,000 sick with tuberculosis in Cuba, only 12,000 were receiving hospital care.²⁶⁷ In 1956, the National Medical College’s Executive Committee demanded 4,000 more beds for tuberculosis patients.²⁶⁸ Later that year, they held a “National Forum on the Medical Crisis,” protesting the “anarchic distribution of beds” that negatively affected the health of the nation.²⁶⁹ By the late 1950s, then, a consensus had solidified among journalists, some health officials, and medical professionals that the state had improperly managed the public health sector and the tuberculosis campaign.

The CNT undoubtedly had flaws, but it is worth pausing to consider the nation’s performance in an international context. In 1958, in terms of tuberculosis hospital beds available per 10,000 inhabitants, Cuba placed seventh in the Americas, providing essentially the same ratio of beds as the United States.²⁷⁰ The country possessed an active national tuberculosis control campaign, which not all nations could boast. Consider, by comparison, Bolivia, which also

²⁶⁵ García Inclán, “En la feria de la actualidad,” *Bohemia* 48 (September 9, 1956): 112.

²⁶⁶ García Inclán, “En la feria de la actualidad,” *Bohemia* 49, no. 25 (June 23, 1957): 118.

²⁶⁷ “El Director del Consejo Nacional de Tuberculosis, Dr. Juan J. Castillo, visitó al Presidente de la República para informarle que el número de enfermos se eleva a 40 mil, de los que solamente 12 mil reciben atención hospitalaria y por lo tanto existente 28 mil casos que no están sometidos a tratamiento médico,” *El Médico* (October 15, 1955): A-1.

²⁶⁸ “Mejoramiento de los servicios hospitalarios de la nación,” *Tribuna Médica* 27, nos. 422–23 (January–February 1956): 5.

²⁶⁹ “Fórum nacional,” 39.

²⁷⁰ Canada had 8.87 beds per 10,000 inhabitants; Uruguay, 7.86; Chile, 6.39; Venezuela, 4.88; Argentina, 4.85; U.S., 4.73; and Cuba, 4.71. The next highest country was Paraguay, with 2.74 beds per 10,000 people. Calculations done by author from data published in Pan American Sanitary Bureau, *Summary of Four-Year Reports on Health Conditions in the Americas* (Washington, D.C.: Pan American Sanitary Bureau, 1958), 2, 105. Regardless of if a country reported a high or low tuberculosis mortality rate, international tuberculosis experts recommended 1–2 beds per annual death.

organized a tuberculosis department in 1936, but soon “its activities...reached a standstill.”²⁷¹ The Bolivian campaign offered no health services outside the capital of each of its provinces. In 1953, Bolivia had fewer than 600 beds available for treatment, a far cry from the Pan American Sanitary Bureau’s recommendation of 3,000 beds.²⁷² (It is important to note, however, that Cuba would not have wanted to compare itself to Bolivia, one of the poorest nations in the hemisphere. Instead, Cuban tuberculosis experts frequently compared their anti-tuberculosis campaign to programs in Western Europe and North America).

Cuba also performed well in the region on tuberculosis health indicators. Cuban physicians recognized their tuberculosis mortality rate was one of the best in the Americas. In the late 1940s, Castillo reported that Cuba had the third lowest tuberculosis mortality rate in the region. The U.S. and Canada reported, respectively, 46 deaths and 38 deaths per 100,000 people; Cuba reported 70. The next lowest mortality rate was Uruguay, with 110 deaths per 100,000 people.²⁷³ By comparison, Brazil reported over 300 deaths per 100,000 people. While Cuban physicians were aware that the national tuberculosis mortality rate was dropping, very few linked the declining trend to state intervention.²⁷⁴ In fact, they seemed only peripherally concerned with the mortality rate, worried more about the incidence of disease and the limited state network of facilities to isolate and cure those who were highly contagious.

²⁷¹ Pan American Sanitary Bureau, *Summary of Reports on the Health Conditions in the Americas, 1950–1953* (Washington, D.C., 1956), 76.

²⁷² Ibid.

²⁷³ Juan J. Castillo, “Epidemiología de la tuberculosis en Cuba y en América,” *Revista Americana de Tisiología* 2, no. 1 (October 1950): 11.

²⁷⁴ In 1949, physicians reported that from 1944 to 1947, there was a decline in mortality. Dres. Bartolomé Selva León et al., “Cuba,” in Congreso Panamericano de la Tuberculosis, *Memorias del VIII Congreso Panamericano de Tuberculosis U.L.A.S.T. y del III Congreso Nacional de Tuberculosis y Silicosis* (Mexico, 1949), 86. In 1953, tuberculosis specialists argued that in the last three decades, “mortality has decreased between 30 and 40 per 100,000 inhabitants, currently being much lower than the figure of 100 per 100,000.” Augusto Fernández Conde, “La lucha contra la tuberculosis en Cuba: Resumen cronológico,” *Revista Cubana de Tuberculosis* 17, no. 3 (July–September 1953): 164–65. One exception is a group of physicians who linked dropping mortality to the CNT’s interventions. Dr. Rafael Mañas et al., “Aspectos anatomopatológicos de la tuberculosis en Cuba,” *Revista Cubana de Tuberculosis* 17, no. 4 (October–December 1953): 380–81.

The very strength of the Cuban medical system seems to have made its weaknesses and shortcomings with respect to tuberculosis even more visible. Cuba's medical community was large, organized, and politically active. In 1957, Cuba had 10 doctors per 10,000 inhabitants (in the Americas, only Argentina, Canada, the United States, and Uruguay had a higher ratio).²⁷⁵ Some nations, like Bolivia, most of Central America, and Peru had fewer than 4 doctors per 10,000 people. Cuban physicians were highly mobilized as a labor group.²⁷⁶ They penned frequent critiques and recommendations for changes in the state health care sector in a large number of medical publications (as well as popular ones).²⁷⁷ Finally, some scholars have recently suggested that Cuba's excellent performance (relative to other Latin American nations) in health indicators by 1959 was partially due to the "relatively easy access to fairly high quality health care for an unusually large share of the population (by then-current Latin American standards)."²⁷⁸ In short, it is necessary to consider that Cuba's highly vocal and organized medical community—who had high standards for their state health care sector—made the picture of health care in the historical record seem more bleak than it was.

For those living in Cuba in the 1950s, their primary frame of reference does not seem to have been their performance in comparison with other Latin American countries.²⁷⁹ Medical practitioners and ordinary citizens had specific expectations of the CNT, influenced by local dialogue and international scientific tenets. These criteria were many (the subjects of Chapters 4–

²⁷⁵ Pan American Sanitary Bureau, *Summary of Four-Year Reports*, 78.

²⁷⁶ Ross Danielson, *Cuban Medicine* (New Brunswick: Transaction Books, 1979), 102. Danielson writes that physicians gained "considerable power" as a professional group in the 1940 Constitution (108).

²⁷⁷ One example of physicians actively engaging with the public on questions of health and medicine was José Chelala Aguilera, who penned a weekly column, "Problemas de Medicina Social," in *Bohemia* and hosted various radio shows.

²⁷⁸ James W. McGuire and Laura B. Frankel, "Mortality Decline in Cuba, 1900–1959: Patterns, Comparisons, and Causes," *Latin American Research Review* 40, no. 2 (2005): 100.

²⁷⁹ Alternately, Louis Pérez argues that Cuban expectations and national identity were influenced by American middle-class material and cultural norms. *On Becoming Cuban: Identity, Nationality, and Culture* (Chapel Hill: University of North Carolina Press, 1999).

7), but the inadequacy of hospital care was of crucial importance and became an issue of broad national political significance in the 1940s and 1950s. In one of his many calls for change on the island, in 1944 Guido García Inclán published a plea from Rosalina Marisy García, a poor woman living in Santiago de Cuba. Her letter testifies to the intersection of medicine, health and politics in republican Cuba. Suffering from tuberculosis, she could not “understand why in her country it is so difficult to find a [hospital] bed,” the columnist transcribed. She had written to functionaries in the previous government, but had “not received the consolation of even a few lines.” The consequence of the state’s failure to provide what was perceived as an adequate number of sanatorium beds was forcefully spelled out by García Inclán: “She wants to blame the rulers of her country for her fate.”²⁸⁰

In 1953, when Fidel Castro delivered his famous “History Will Absolve Me” legal defense, he identified health as one of the six problems plaguing Cuba: “Only death can liberate one from so much misery. In this respect, however, the state is most helpful—in providing early death for the people....Society is moved to compassion when it hears of the kidnapping or murder of one child, but it is criminally indifferent to the mass murder of so many thousands of children who die every year from lack of facilities, agonizing with pain.”²⁸¹ When the revolutionary *guerrillas* arrived triumphant in Havana in 1959, their new government declared the politicized issue of hospital beds as one of its most imperative priorities.²⁸²

²⁸⁰ García Inclán, “En la feria de la actualidad,” *Bohemia* 36, no. 45 (November 5, 1944): 42.

²⁸¹ Fidel Castro, “History Will Absolve Me,” in *The Cuba Reader: History, Culture, Politics*, eds. Aviva Chomsky, Barry Carr, and Pamela Maria Smorkaloff (Durham: Duke University Press, 2003), 310–11.

²⁸² In a 1959 national survey entitled, “Is there something that the Government still has not done that it should do as soon as possible?”, those line items categorized under “economic matters” reigned at 64.45%. Nonetheless, when looking at specific line item issues, 4.18% chose “creating hospitals, making them honest, sanitation, doctors, pharmacies.” This was the 10th most popular answer. Raúl Gutiérrez Serrano, “Survey nacional: El pueblo opina sobre el Gobierno de la Revolución,” *Bohemia* 51, no. 8 (February 22, 1959): 80.

3.3 REVOLUTION

In the weeks immediately following the revolution's triumph on New Year's Day, a handful of insiders of the new regime turned their attention to tuberculosis. The government appointed Gustavo Aldereguía as Director-General of the Anti-Tuberculosis Campaign. He had been active as a committed communist and tuberculosis expert since the 1920s and had vociferously criticized Batista's CNT as an expression of "tropical-fascism" since its inception.²⁸³ By 1960, the autonomous CNT had been dissolved, in favor of a Department of Tuberculosis within the new Ministry of Public Health (Ministerio de Salud Pública, MINSAP). With the exception of a brief period in the early 1960s, when he served in a diplomatic post, Aldereguía directed the campaign until his death in 1970.²⁸⁴

In the early stages of the revolution's tuberculosis program (1959–1965), public health officials tried to balance international standards of tuberculosis control with citizen demands and expectations. For the former, they dedicated extensive resources to mass testing and mass vaccination, finally wielding technologies on a national level, which physicians had long hoped the CNT would do. According to calculations made by the Batista regime, the average number of annual X-rays in the 1950s was 37,368.²⁸⁵ In 1956, however, the CNT reported only 17,745 X-rays.²⁸⁶ Opponents of Batista reported that from mid-1957 through the end of 1958, public health

²⁸³ Gustavo Aldereguía, "¡A luchar, tuberculosos de Cuba!: Contra el Consejo Nacional de Tuberculosis, Contra la tuberculosis," *Bohemia* 37, no. 37 (September 16, 1945).

²⁸⁴ Gustavo Aldereguía, "Papel de las comunidades en la lucha contra la tuberculosis," in *Estudios sobre tuberculosis pulmonar: Orientaciones para la lucha antituberculosa en Cuba* (Havana: Subsecretaría de Asistencia Médica, Dirección Nacional de Tuberculosis, 1963): 168.

²⁸⁵ Fulgencio Batista, "Realizaciones del Gobierno de FBZ: Salubridad y Asistencia Social," 18, Folder 124, Box 137, FBZ Collection, CHC-UM.

²⁸⁶ Consejo Nacional de Tuberculosis, *Un año*, 5, 9.

officials had only given 9,700 X-ray exams.²⁸⁷ After 1959, the revolutionary government made X-ray testing a priority. By 1965, MINSAP reported that it had reached its goal of a minimum of 1 million annual X-rays (see Table 3).

Table 3. X-ray Totals²⁸⁸

Year	Number of X-rays
1959	180,463
1960	274,785
1961	199,146
1962	170,508
1963	200,021
1964	548,695
1965	1,032,351

The government also claimed that the issue of beds was one of its highest priorities, and the evidence suggests that citizen expectations must have played a role in this decision.²⁸⁹ Beginning in the mid-1950s, sanatoriums around the world had begun to close down. Antibiotic therapy made outpatient treatment a possibility, which lessened the justification for running expensive tuberculosis hospitals.²⁹⁰ Since the 1930s, Gustavo Aldereguía had pushed for the state to pursue a project that rejected specialized tuberculosis hospitals. He hoped care could be

²⁸⁷ Cuba, Ministerio de Salud Pública, *Subdesarrollo económico, principal enemigo de la salud: Como combate la revolución cubano* (Havana: Departamento de Relaciones Públicas, Dirección de Docencia y Divulgación, 1960), 32.

²⁸⁸ “Información existente sobre tuberculosis humana en Cuba,” *Boletín de Higiene y Epidemiología* 5, no. 3 (December 31, 1967): 334.

²⁸⁹ The Cuban state’s prioritization of tuberculosis is evidenced by the fact that Cuba reported the highest number in the Americas for the percentage of total beds that were devoted to tuberculosis. Pan American Sanitary Bureau, *Summary of Four-Year Reports*, 80. As of 1962, 20% of Cuba’s hospital beds were for tuberculosis patients. Paraguay and Uruguay reported similar numbers. Argentina and the United States had much lower percentages, 10% and 4%, respectively.

²⁹⁰ By late 1954, the Trudeau sanatorium in New York, one of the most famous in the world, had closed; other sanatoriums were repurposed, suffered in quality due to lack of resources, or went bankrupt. Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), 249.

administered by visiting nurses in the homes of patients and by physicians in small tuberculosis wards in general hospitals.²⁹¹

However, throughout the 1960s, MINSAP claimed to be pursuing an expansive hospital building project.²⁹² In 1961, it reported to have already increased beds by 30% (to 3,219) and listed among its top priorities the creation of 1,200 more.²⁹³ Some tuberculosis specialists employed at MINSAP wanted to increase the national bed count to 6,000 total beds. One physician, who had lambasted the CNT in 1953 for not providing a bed count equivalent to the number of annual tuberculosis deaths, wrote in 1963 that 6,750 beds (25% of the active cases of tuberculosis in the nation) were needed “for carrying out an effective tuberculosis campaign.”²⁹⁴ In a sharp reversal of his past recommendation, Aldereguía estimated that 6,000 beds were “indispensable for successfully carrying out the anti-tuberculosis campaign.”²⁹⁵ Citizens, who had politicized the issue of hospitals, probably pushed the issue of hospital beds onto MINSAP’s agenda.

In order to demonstrate progress towards this goal, MINSAP distorted the data, claiming that only 2,196 tuberculosis beds had existed in 1958.²⁹⁶ In the early 1960s, much of the reported increase in beds literally built off of past republican projects: MINSAP finished and expanded sanatoriums begun under republican leaders, such as the Amalia Simoni Sanatorium in

²⁹¹ Foreign Policy Association, *Problems of the New Cuba*, 111.

²⁹² See, for example, Mercedes Rolo and Anselmo López Blanco, *La arquitectura de hospitales en la revolución cubana* (Havana: Ministerio de Desarrollo de Edificaciones Sociales y Agropecuarias, 1976), 9–10.

²⁹³ Ministerio de Salud Pública, *Subdesarrollo económico*, 32–33.

²⁹⁴ “¿Topes de Collantes sirve,” 23; Ricardo Sánchez Acosta, “Régimen de internamiento de adultos en los hospitales y sanatorios antituberculosos,” in *Estudios sobre tuberculosis pulmonar*, 299.

²⁹⁵ Gustavo Aldereguía and Luis Pascual, “Programa para el control de la Tuberculosis,” in *Estudios sobre tuberculosis pulmonar*, 128.

²⁹⁶ Ministerio de Salud Pública, *Subdesarrollo económico*, 32–33. Batista appears to have inflated the number of beds in 1958 (claiming that 3,740 tuberculosis beds existed when he left the country), while the revolution downplayed the number of beds in 1958. “Situación hospitalaria,” 1–4, Folder 75, Box 136, FBZ Collection, CHC-UM.

Camagüey and the Pilar San Martín hospital in Pinar del Río. By the mid-1960s, however, the government had added new facilities, increasing the national tuberculosis bed total to 4,080 in 1965 before contracting it to 3,473 in 1968 (from an estimated 2,911 in 1958, which represents a 40% and 19% increase, respectively).²⁹⁷ As of 1965, the revolutionary government had increased the bed to population ratio, to 5.35 from 3.84–4.45 in 1958 (see Table 4). By 1968, this proportion had declined to 4.38, comparable to the 1958 ratio. At no point in the 1960s did the government come close to providing the 6,000 beds originally envisioned by tuberculosis policy makers in the early 1960s.

Table 4. Beds & Population, 1931–1968²⁹⁸

	1931	1944	1958	1965	1968
Beds	450	1200	2511–2911	4080	3473
Population	3,962,344	4,778,583	6,548,300	7,630,700	7,937,200
Ratio (Beds per 10,000 population)	1.14	2.51	3.84–4.45	5.35	4.38

Rectifying the regional distribution of beds was important in the rhetoric of MINSAP (and the broader revolution), but the ministry achieved only partial success.²⁹⁹ By 1968, in Pinar del Río, Camagüey, and Matanzas, the government came close to providing a proportion of beds that matched the province’s representation in the national population (see Figure 7). However,

²⁹⁷ “Información existente,” 331; Julio Rodríguez Rodríguez, “Las camas de asistencia médica en el primer decenio revolucionario,” *Boletín de Higiene y Epidemiología* 7, nos. 1–3 (December 1969): 117

²⁹⁸ These are rough calculations based on the census data from 1931 and 1943. Oficina Nacional de los Censos Demográfico y Electoral, *Censo de población*, 1. The population estimates for Cuba in 1958, 1965, and 1967 are from Lowry Nelson, “Cuban Population Estimates, 1953–1970,” *Journal of Interamerican Studies and World Affairs* 12, no. 3 (July 1970): 395–96. Also, note that the population total listed under 1944 in Table 4 comes from the 1943 census and the population listed under 1968 comes from Lowry’s 1967 estimate. No census data is available for 1944 and 1968.

²⁹⁹ See, for example, F. Fernández Rubio, “El Hospital Nacional,” *Bohemia* 53, no. 23 (June 4, 1961): 44; “Salud pública,” *Bohemia* 53, no. 30 (July 23, 1961): 79–80; Frank Sarabia, “La salud del madre y del niño campesino,” *Bohemia* 53, no. 42 (October 15, 1961): 99–101; “En menos de tres años se ha hecho más por la salud del pueblo que en los 58 años anteriores: Discurso de Fidel en la Asamblea Médica,” *Bohemia* 53, no. 45 (November 5, 1961): 36–41, 79–81; Josefina Colli, “Más de 120 millones de pesos dedica el Gobierno Revolucionario a la salud al pueblo,” *Bohemia* 54, no. 17 (April 27, 1962): 27–29, 73; “Cárdenas: A la ofensiva de la revolución,” *Bohemia* 54, no. 26 (June 29, 1962): 52; “El porvenir será brillante para la salud de nuestro pueblo,” *Bohemia* 54, no. 43 (October 26, 1962): 32–37.

Havana's proportion of the nation's tuberculosis beds remained virtually unchanged from 1958. The province still had almost half of all beds, with only roughly a quarter of the total population. In fact, one of the first tuberculosis hospitals built by the government was a new surgical center (Julio Trigo Hospital) on the grounds of the La Esperanza-Lebreto complex.³⁰⁰ Finally, Oriente's access to tuberculosis services improved (from 15% to 21.8%), but still did not match its share of the national population (35%). With a dearth of popular sources in the period, it is unclear how Cubans, inside and outside of the medical community, reacted to these shortcomings regarding beds.

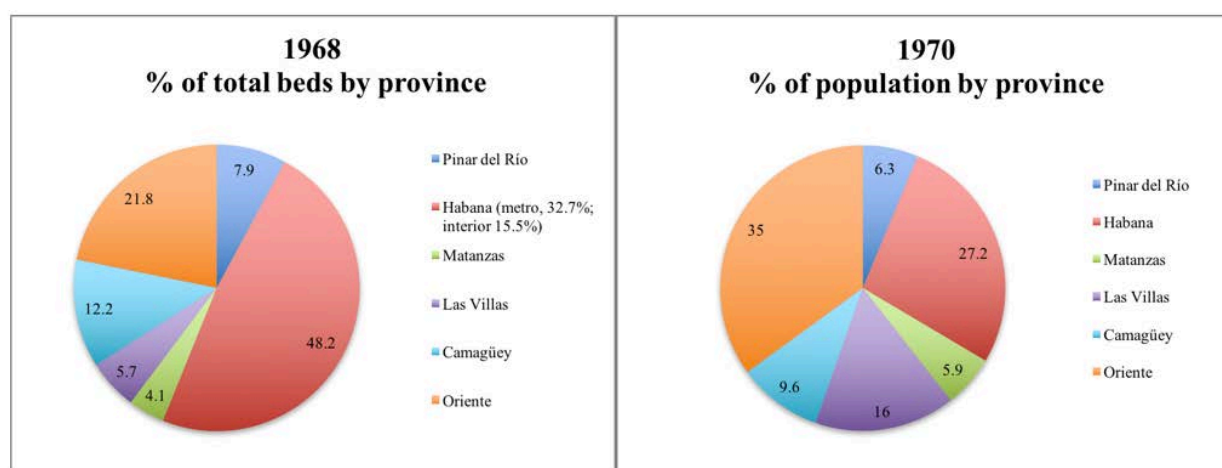


Figure 7. By 1968, MINSAP had rectified some provincial disparities in the tuberculosis bed count, but not all, especially in Oriente.³⁰¹

In 1963, the state announced a new Program of Tuberculosis Control, which aimed “to eliminate TB as a public health problem.”³⁰² To accomplish this, the Program prioritized a prevalence survey; mass BCG vaccination; chemoprophylaxis; mass X-ray examination; and

³⁰⁰ “Hospital Antituberculoso de la Habana ‘La Esperanza’,” *Bohemia* (n.d.): 92, Fondo Gustavo Aldereguía (GA), Archivo de la Oficina del Historiador del Ministerio de Salud Pública (AOH).

³⁰¹ Bed information from Rodríguez Rodríguez, “Las camas de asistencia médica,” 117. Census information is from Cuba, Dirección Central de Estadística, *Censo de Población y viviendas, 1970; 6 de Septiembre de 1970, datos preliminares sujetos a rectificación* (Havana, 1970): x.

³⁰² Aldereguía and Pascual, “Programa para el control de la Tuberculosis,” in *Estudios sobre tuberculosis pulmonar*, 124.

curative and prophylactic treatment with tuberculostatic drugs.³⁰³ All of these goals were medical in nature and did not attempt to deal with the social ramifications of the disease, yet another limitation of the tuberculosis programs of the early- to mid-1960s. The official rhetoric of the tuberculosis campaign mirrored that of broader politics. One MINSAP official insisted, “The labor of [the National Tuberculosis Council] did not remotely respond, neither in its conceptualizations or methods...to the profound social root of this disease.”³⁰⁴ Despite this critique, the program of the early 1960s did not pursue radical social or economic policies for tuberculosis sufferers.

Cubans with the disease could call on some new welfare agencies, however. In the early 1960s, the government formed a new Ministry of Social Welfare (Ministerio de Bienestar Social), which offered state resources to the “needy.”³⁰⁵ The ministry put tuberculars and “disabled” individuals (*impedidos*) under the Division of Social Work.³⁰⁶ Data are limited, but in one nine-month period, this Division registered 307 individuals who had tuberculosis or were disabled, which suggests that the Ministry did not have enough resources to deal with the thousands of Cubans infected with the disease.³⁰⁷

To answer this need, Gustavo Aldereguía hoped that the tuberculosis campaign might be one “from below,” involving local grassroots organizations, similar to the Committees for the Defense of the Revolution. These local tuberculosis leagues could influence policy, help identify cases, and care for sick neighbors.³⁰⁸ He organized these communities in a handful of towns, but

³⁰³ Enrique Beldarraín Chaple, “La lucha antituberculosa en la primera década de la salud pública revolucionaria,” *Revista Cubana de Salud Pública* 38, no. 12 (2012): 203.

³⁰⁴ Ministerio de Salud Pública, *Subdesarrollo económico*, 32.

³⁰⁵ Raquel Pérez González, “La función de bienestar social dentro de la revolución,” *Metas*, March 1960, 53.

³⁰⁶ Cuba, Ministerio de Bienestar Social, Departamento de Investigación y Estadísticas, “Informe estadístico preliminar: Enero–Marzo 1960,” 3–4, leg. 15, no. 290, Fondo Ministerio de Bienestar Social (MBS), ANC.

³⁰⁷ *Ibid.* The nine-month period included October 1960 to March 1961 and July to September 1961.

³⁰⁸ Gustavo Aldereguía, “Socialismo y tuberculosis,” *Bohemia* 54, no. 32 (August 10, 1962): 88.

during his absence as ambassador to Yugoslavia, his successors dropped the initiative.³⁰⁹ Instead, the state and the sick relied on a more traditional form of social assistance: that of middle-class and elite charities.³¹⁰

The Lyceum and Lawn Tennis Club of Havana was one such organization. The Club listed social assistance cases in their monthly bulletins, requesting that readers send in funds to help. For instance, in August 1959, the Club featured Gisela and Sergio as their “case of the month.” Both had been interned at a sanatorium, but had been recently discharged. Even though they were cured, Sergio could not return to his former job ironing clothes for fear that he would relapse. While the Ministry of Social Welfare was helping, it was not enough, and the couple requested \$100 to “restart their lives” and begin a new business.³¹¹ It is likely that the couple never received enough money, as the Club did not identify them in their published list of received donations.

In May of 1961, the Club featured the case of Esther and Luis, a family “well integrated” into the revolution.³¹² Luis still had tuberculosis, even though he was released from a sanatorium at the beginning of the year. Esther now found herself with tuberculosis in her kidney and needed to be on bed rest for three months while receiving a round of antibiotic therapy. Luis’ income could not cover the cost of rent, food, and medical treatment. In a situation that paralleled the case of the republican period, the hospital could not provide medicine, and the readers of the

³⁰⁹ Ibid.

³¹⁰ The Ministerio de Bienestar Social listed the social section of the Lyceum and Lawn Tennis Club Collection as one of the “resources of the community,” although it is unclear if there was any institutional relationship between them. República de Cuba, Ministerio de Bienestar Social, Oficina de Coordinación de Estadísticas e Investigaciones, “Recursos de la comunidad, agosto 1959,” 85, leg. 16, no. 319, MBS, ANC.

³¹¹ “Asistencia social,” August 1959, 7, Folder 11, Box 3, Lyceum and Lawn Tennis Club Collection, 1929–1986 (LLTC Collection), CHC-UM; “Asistencia social,” January 1960, 8, Folder 12, Box 3, LLTC Collection, CHC-UM.

³¹² “Asistencia social,” May 1961, 4, Folder 13, Box 3, LLTC Collection, CHC-UM.

bulletin sent in enough funds for Esther to be able to purchase these drugs.³¹³ Her medical treatment was secured, but it is unclear if the Club had received enough money to pay for the family's other basic necessities. As late as 1965, supplicants with tuberculosis requested money to pay rent and supplement their income; sewing machines to take in business; and extra beds so infected family members could sleep separately from those who were healthy.³¹⁴ In short, in the early 1960s, Cubans suffering the physical, financial, and emotional burdens of the disease continued to fall through cracks in the welfare state.

Machado's early tuberculosis program had also depended on elite, predominantly female, charitable associations to deliver health care services where the state could not, much to the chagrin of physicians who demanded scientific management of disease campaigns. Batista had originally shut charitable actors out of his new program, but civic associations had returned to aid the CNT in the late 1940s and 1950s.³¹⁵ The scarcity of data for the early 1960s makes it hard to find out what physician and citizens thought of the hybrid (public-private) nature of the early revolutionary campaign. Nonetheless, these programs suggest that early anti tuberculosis efforts under the revolution reproduced some of the main features of republican programs.

In 1968, perhaps as part of Fidel Castro's Revolutionary Offensive that nationalized remaining private small businesses, the government shut down the Lyceum and Lawn Tennis

³¹³ "Asistencia social," June 1961, 3, Folder 13, Box 3, LLTC Collection, CHC-UM.

³¹⁴ "Asistencia social," February 1959, 8, Folder 11, Box 3; "Asistencia social," August 1960, 6, Folder 12, Box 3; "Asistencia social," November 1960, 8, Folder 12, Box 3; "Asistencia social," December 1960, 4, Folder 12, Box 3; "Asistencia social," April 1961, 5, Folder 13, Box 3; "Asistencia social," November 1961, 4, Folder 13, Box 3; "Asistencia social," July 1962, 5, Folder 14, Box 3; "Asistencia social," August 1963, 4, Folder 15, Box 3; "Asistencia social," May 1965, 2, Folder 16, Box 3, LLTC Collection, CHC-UM.

³¹⁵ These organizations included the Liga Antituberculosa del Sanatorio La Esperanza; Comité de Damas del Sanatorio Infantil Antituberculoso Ángel A. Aballí; Liga Antituberculosa de Bauta; the Liga Antituberculosa de Isla de Pinos; and the Liga Antituberculosa de la CMQ. Lisandro Otero González, "Pan con una sonrisa para los desheredados de Cuba: Una batalla contra el bacilo de Koch," *Bohemia* 49, no. 43 (October 27, 1957). Also, in the Registro de Asociaciones Fondo in the ANC, see leg. 361, no. 10960; leg. 708, no. 18250; leg. 1205, no. 25219; leg. 192, no. 4218.

Club.³¹⁶ In the late 1960s, the state opened a new chapter of tuberculosis care by passing a law in 1969 that guaranteed patients 100% of their salaries while under treatment.³¹⁷ The government legislated this measure to guarantee that the sick complete all treatment regimens in full.³¹⁸ The late 1960s and early 1970s, then, represent a new stage in the policy and experience of state tuberculosis health care, one for which more research is needed to understand how programs, such as outpatient drug therapy, played out on the ground.

3.4 CONCLUSION

In the 1920s and 1930s, citizens and medical professionals made tuberculosis more visible to government leaders and pushed the idea of the right to health care onto the state agenda. In response, Batista founded the National Tuberculosis Council in 1936, which initiated an expansive state-building project throughout the republican period. It made great strides in increasing contacts with citizens, identifying previously undiagnosed cases, and providing medical treatment. By the 1950s, however, Cubans expressed great frustration with the CNT, most notably for its inability to provide an adequate number of beds and to make provincial sanatoriums a reality. On the eve of revolution, the gap between these expectations and the performance of republican administrations fed into the processes of political de-legitimation.

³¹⁶ Lillian Guerra, *Visions of Power in Cuba: Revolution, Redemption, and Resistance, 1959–1971* (Chapel Hill: University of North Carolina Press, 2012), 13. On the Club's closure, see "The Lyceum and Lawn Tennis Club Collection," University of Miami Libraries' Digital Collections, accessed October 3, 2016, <http://merrick.library.miami.edu/cubanHeritage/chc0124/>.

³¹⁷ Beldarraín Chaple, "La lucha antituberculosa," 211.

³¹⁸ Ibid. In 1971, the government initiated directly observed treatment, and, in 1982, they implemented DOTS (directly observed treatment, short course). E. González, L. Armas, M.J. Llanes, "Progress towards Tuberculosis Elimination in Cuba," *International Journal of Tuberculosis and Lung Disease* 11, no. 4 (2007): 405.

Whatever its rhetoric of radical change, the early stage of the revolution's tuberculosis program both connected with and deviated from the past campaign. In areas like mass X-ray testing, health officials made great strides. On the other hand, on the issue of hospital beds and reliance on charity, MINSAP's early tuberculosis programs did not depart significantly from the CNT's efforts.

Thus, instead of conceptualizing Cuba's tuberculosis programs as a series of distinct campaigns, this chapter suggests that they can be understood as part of one state-building project, beginning with Machado, intensifying under Batista, and being further developed during the early years of the revolution. Nonetheless, citizens and medical professionals roundly criticized the CNT, and the remaining chapters explore other aspects of the republican tuberculosis campaign to explain how and why this expansive effort failed to satisfy a large swath of the Cuban population.

4.0 “A SQUARE PEG IN A ROUND HOLE”: PATRONAGE, RIGHTS, AND REFORM IN THE HEALTH SECTOR

In the early 1930s, a number of transgressions took place behind the shuttered gates of La Esperanza Sanatorium, a microcosm of the broader public health sector.³¹⁹ When Gustavo Aldereguía took over as the facility’s director following the collapse of Machado’s government, he was dismayed by how poorly the sanatorium had been run. Beyond being unqualified for the job, the previous director had admitted patients who had brought him “the required letter” from a patron;³²⁰ that is, many of those who had gained access to treatment at the sanatorium had done so through political connections. Once interned, they were given preferential treatment based on “privileges that the Señor Director designated in order to satisfy his friends.”³²¹ The hospital lacked the most basic medical equipment and patients’ reclining chairs—central to the rest cure—had fallen into disrepair, while the director used La Esperanza’s carpenter to attend to his own private residence.³²² In short, the sanatorium did not operate as “a responsible and scientific organization, efficient and capable of setting standards.”³²³ La Esperanza was not an anomaly,

³¹⁹ Gustavo Aldereguía, “El Infierno y La Esperanza: Notas sobre un sanatorio desdichado,” in *Revolución y tuberculosis*, Cuadernos de Historia de la Salud Pública 68 (Havana: Central Nacional de Información de Ciencias Médicas, Ministerio de Salud Pública, 1984): 53.

³²⁰ Ibid., 55.

³²¹ Ibid.

³²² Ibid., 56.

³²³ Ibid., 53.

however. Under Machado, the sanitation branch had earned a reputation—both at home and abroad—of being “one of the most corrupt in the government.”³²⁴

The political ruptures of this period disrupted medical care at state facilities, but they also opened up a window for change, one that a cadre of Cuban physicians seized. They hoped to depoliticize the public health sector, making it technical and “modern.”³²⁵ In the mid-1930s, observing the energy for health reform in Cuba, one international agency proclaimed, “We believe that a real renaissance in public health work...is taking place in Cuba.”³²⁶ However, by the 1950s, these winds of change had stalled. In 1953, for example, Fidel Castro lambasted the pervasive interference of politics in the state health sector: “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.”³²⁷ The push for a modern, technical health sector had collided with a more traditional logic of power: patronage.

Defined as “granting protection, official positions, and other favors in exchange for political and personal loyalty,” patronage was widespread on the island.³²⁸ Alejandro de la Fuente has summarized:

Access to public employment depended on political connections. Victorious political parties and candidates distributed jobs and appointments through a complex system of patronage that started in the neighborhood and ended up in the presidential palace.

³²⁴ Raymond L. Buell to E.E. Day, July 23, 1934, Folder 788, Box 100, Series 315, Record Group 2, Rockefeller Foundation records, Rockefeller Archive Center. Hereafter, the following abbreviations will be used for citing sources from the Rockefeller Archive Center: Folder (F); Box (B); Series (S); Record Group (RG); Rockefeller Foundation records, Rockefeller Archive Center (RF-RAC). One historian suggests that the bombing of the archive of the Secretary of Sanitation in 1933 might have occurred because it was “infamous as an institution of corruption and graft.” Daniel Rodríguez, ““A Blessed Formula for Progress”: The Politics of Health, Medicine, and Welfare in Havana, (1897–1935)” (PhD diss., New York University, 2013), 18n26.

³²⁵ Cubans themselves employed the term “modern,” especially when referring to staffing state health posts with men who would be trained in public health methods and work full time.

³²⁶ “Comision de Malaria de Cuba: Annual Report,” 1935, 14, F 1639, B 139, S 315I, RG 5.3, RF-RAC.

³²⁷ Fidel Castro, “History Will Absolve Me,” in *The Cuba Reader: History, Culture, Politics*, eds. Aviva Chomsky, Barry Carr, and Pamela Maria Smorkaloff (Durham: Duke University Press, 2003), 311.

³²⁸ Richard Graham, *Patronage and Politics in Nineteenth-Century Brazil* (Stanford: Stanford University Press, 1990), 1.

Although no specific study has analyzed the operation of the system, the endless denunciations of favoritism and partisanship in the distribution of appointments permit at least a broad characterization of this process.³²⁹

Scholars of Cuba, however, have predominantly studied patronage in the early republic, at the national level, and/or its racial dynamics.³³⁰ Gillian McGillivray has argued that in the 1920s and 1930s “class-based mobilizations...pushed Cuban presidents to replace the client-based patronage politics with class-based populist politics.”³³¹ In weaving together the national and local dynamics of patronage, this chapter complicates that narrative, arguing for the deep-rooted nature of patronage during the Second Republic. It illuminates how patronage worked on the ground, the inefficiencies that it created in the state health sector, and the ways in which power was distributed within state structures.

Patronage shaped the public health sector in four important ways. First, health personnel were political appointees, which meant that national and regional political changes resulted in persistent turnover of national health officials (and, consequently, frequent shifts in health policy). For example, over the course of one eleven-year period, twenty-one different men served as the head of the national health ministry (see Appendix A). Second, these changes in personnel also took place at the local level, including the post of chief sanitary officer and the entire subordinate staff at municipal sanitation departments. Third, in a system of patronage, political

³²⁹ Alejandro de la Fuente, *A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001), 129.

³³⁰ Michael Zeuske, “Estructuras, movilización afrocubana y clientelas en un hinterland cubano: Cienfuegos, 1895–1906,” *Tiempos de América* 2 (1998): 93–116; Rebecca Scott, “Race, Labor, and Citizenship in Cuba: A View from the Sugar District of Cienfuegos, 1886–1909,” *Hispanic American Historical Review* 78, no. 4 (November 1998): 687–728; de la Fuente, *A Nation for All*; Gillian McGillivray, *Blazing Cane: Sugar Communities, Class, and State Formation in Cuba, 1868–1959* (Durham: Duke University Press, 2009); Melina Pappademos, *Black Political Activism and the Cuban Republic* (Chapel Hill: University of North Carolina Press, 2011).

³³¹ McGillivray, *Blazing Cane*, 9; Robert Whitney argues for a more nuanced view of the post-1940 period: “Caudillismo and caciquismo continued to plague Cuban politics, but they were no longer the only political mechanisms available to Cubans. Party politics, mass meetings, electoral campaigns, and constitutional legitimacy also mattered.” *State and Revolution in Cuba: Mass Mobilization and Political Change, 1920–1940* (Chapel Hill: University of North Carolina Press, 2001), 9.

needs and pressures trumped meritocratic qualification; as political appointees, health officials were frequently technically incompetent. Fourth, patronage connections influenced who was admitted to public health facilities and hospitals.

Public health reformers intended to combat these flaws of the patronage-ridden public health system, targeting not just national institutions such as the Ministry of Health but also local ones.³³² Particularly important were the local sanitation departments (*jefaturas de sanidad*), the government health structure with which ordinary Cubans interacted most directly (and, thus, Cubans were more aware of its shortcomings). From 1935 to 1942, the Rockefeller Foundation's International Health Division (RF) partnered with a group of Cuban health officials to modernize these local health departments and train a new body of public health men to manage them. The mechanics of patronage, however, complicated this reform effort. Parties and political bosses, key actors in patronage networks, controlled these local health posts; therefore, they opposed this project, for it challenged their authority. Frustrated by this seemingly insuperable resistance, the RF left Cuba in 1942.

After the RF's exit, Cuban physicians continued to press for reform, both of local health administration and hospital admittance procedures. They were driven by shared ideas of "best" health practices and the Constitution of 1940, which stipulated that a technical health sector should guarantee equal rights in accessing state health care.³³³ However, as they attempted to

³³² A brief note explaining the structure of Cuba's health organization: One Secretary, a physician appointed by the President and serving on his cabinet, ran the Secretariat of Sanitation and Charities. In addition, the Secretary appointed two directors to run the two departments of the Secretariat: the Department of Health and the Department of Charities. The National Board of Health, an advisory council of twelve men, supported the Secretary of Sanitation in formulating policy. Provincial governments had no health departments. Each of the 128 *municipios* had a local sanitation department (*jefatura de sanidad*), headed by a chief sanitary officer (*jefe de sanidad*).

³³³ Delegates to the Constitutional Convention of 1939 specifically stated in Article 160 of the Constitution that the newly reorganized Ministry of Health and Social Assistance "shall act exclusively as [a] technical organizatio[n]." See Article 160 of Andrés Lazcano y Mazón, *Constitución de Cuba (con los debates sobre su articulado y transitorias, en la Convención constituyente)*, vol. 3 (Havana: Cultural, S.A., 1941), 104.

untether the health sector from webs of patronage and favors, reformers faced resistance and achieved limited institutional results. In short, even though public health had become a privileged site for state-building efforts, it fell victim to patronage, which underpinned the functioning of the Cuban political system.

These thwarted projects heightened the visibility of patronage as a national problem. This led citizens to denounce the CNT, especially in a context of worsening governmental corruption under the Auténtico regimes (1942–1955). The National Tuberculosis Council was accused of staffing its dependencies with unqualified, yet politically well-connected, appointees and of using hospital admission as favors. While many of these public controversies receded in the wake of Batista’s coup d’état in 1952, physicians and citizens never were content with the political nature of the national health sector. Patronage and corruption, then, can help explain the disjuncture (discussed in chapter 3) between declining tuberculosis morbidity rates and worsening public perceptions of the CNT and the broader public health sector.

4.1 THE RF IN CUBA, 1935–1942

Discussions of international health in Latin America in the early- to mid-twentieth century invariably invoke the Rockefeller Foundation’s International Health Division (RF), for it was “arguably the most significant organization in public health in the international arena, with a special interest in Latin America.”³³⁴ Rapidly expanding from its national roots as the Rockefeller Sanitary Commission in the southern United States, the RF made its mandate

³³⁴ Nancy Leys Stepan, “The National and the International in Public Health: Carlos Chagas and the Rockefeller Foundation in Brazil, 1917–1930s,” *Hispanic American Historical Review* 91, no. 3 (2011): 470.

international in 1913 when it launched a series of cooperative projects in Central America and the Caribbean. The RF soon expanded from the Caribbean basin to the farthest reaches of the globe—to Paris, to Tokyo, to São Paulo—with its belief in the progressive impetus of modern medicine and public health as its driving force.³³⁵

In 1935, after years of negotiations, the Cuban government invited the RF to the island to lead a number of health initiatives. Cuba's Finlay Institute (FI), which had been founded in 1927 to carry out "communicable disease control, epidemiological investigation, and public health laboratory service, both diagnostic and research," served as the RF's institutional partner.³³⁶ When the Director of Scientific Research at the FI, Domingo Ramos, was appointed as Director of the National Department of Health in 1935, he successfully brokered the bilateral arrangement and then became one of the RF's primary liaisons.³³⁷

In May 1935, RF field officer Henry P. Carr arrived on the island and promptly formed a Malaria Commission to carry out a malaria survey and demonstration of control techniques. In 1936, the RF and the Cuban government decided to begin a second and more intense project, launching a new local public health unit to be headed by a physician trained in the science of public health. The Cubans and the RF agreed to place the health unit in Marianao, a municipality of Havana six miles southwest of the city's core and home to a diverse mix of residents; it

³³⁵ The International Health Division was first called the International Health Commission (1913–16) and then the International Health Board (1916–27). For an overview of its start in the Caribbean, see Steven Palmer, *Launching Global Health: The Caribbean Odyssey of the Rockefeller Foundation* (Ann Arbor: University of Michigan Press, 2010). For an overview of its activities beyond Latin America, see John Farley, *To Cast out Disease: A History of the International Health Division of the Rockefeller Foundation (1913–1951)* (Oxford: Oxford University Press, 2004).

³³⁶ Foreign Policy Association, *Problems of the New Cuba: Report of the Commission on Cuban Affairs* (New York: Foreign Policy Association, 1935), 110. For more information on the Finlay Institute, see Cuba, Secretaría de Sanidad y Beneficencia, *1926–1931: Cinco años de labor sanitaria y de beneficencia pública* (Havana: Imprenta y Librería La Propagandista, 1931), 102–22.

³³⁷ From a prominent family of physicians, Domingo Ramos occupies an important place in the history of Cuban health, predominantly for his work in eugenics alongside his mentor, Dr. Eusebio Hernández Pérez. Armando García González and Raquel Álvarez Peláez, *En busca de la raza perfecta: Eugenesia e higiene en Cuba (1898–1958)* (Madrid: Consejo Superior de Investigaciones Científicas, 1999).

included dilapidated public housing, rural areas, a military base, and more tony neighborhoods. The health center was to be a physical and highly visible demonstration (to both popular audiences and state officials) of the value of this type of modern local health institution. In time, the RF and its Cuban partners hoped to substantively overhaul existing local sanitation departments (*jefaturas de sanidad*) along the lines of the modern local health unit (*unidad sanitaria*) in Marianao.



Figure 8. The Marianao Health Unit began service in 1937 (courtesy of the Rockefeller Archive Center).³³⁸

In 1937, the Marianao Health Unit (MHU) opened its doors (Figure 8). Carr directed this project, and the RF provided training fellowships for his main Cuban assistants. Dr. Pedro Nogueira, for instance, who had served on the Malaria Commission, was selected to complete a three-month fellowship in Tennessee and Mexico and returned to serve as the assistant director of the MHU. By 1940, Carr and Nogueira were assisted by a local team of four public health

³³⁸ Carr wrote that it created “a most favorable impression upon the public mind.” Henry P. Carr (HPC), “Report of the Cooperative Public Health Work in Cuba During 1938,” n.p., F 1644, B 139, S 315I, RG 5.3, RF-RAC.

nurses, six sanitary inspectors, one laboratory technician, one office clerk, several laborers, a janitor and two chauffeurs.³³⁹

The MHU's services were wide in scope, including public health popular education; maternal and school hygiene; control of tuberculosis, malaria, and other communicable diseases; immunization; and supervision of mid-wives, night-soil disposal, water supply and home sanitation. The unit interacted with the community frequently, through a well-utilized playground, nighttime showings of motion pictures, visiting nurses that fanned out to local homes, and physician outings to a large number of public schools in the area. From 1937 through 1941, the MHU distributed over 650,000 popular health education bulletins (*Salud y Sanidad*), which were distributed to Marianao's schools and other educational facilities throughout the island.³⁴⁰

This model health unit was based on four principles, which the RF considered "best practices" and essential to its success: (1) its personnel had to be selected on the basis of their technical merit and "suitability to post," not political factors; (2) those personnel had to work full-time; (3) the area of the unit had to be large enough to achieve economies of scale, but small enough for the personnel to "know intimately all the health problems present"; (4) and the unit had to devote its limited time and resources to the "principal health problems" of the locale and

³³⁹ HPC, "Report of the Cooperative Public Health Work in Cuba During 1940," 15–16, F 2005, B 164, S 420, RG 5.3, RF-RAC.

³⁴⁰ My rough calculation of the number of bulletins distributed beyond the school system was 642,350. 31,118 copies of the bulletin were sent to families in 1937 and numbers continued to rise each year. In 1937, 94,493 bulletins were printed; by 1941, that number had skyrocketed to 360,000. Numbers of annual reports are taken from Malaria Commission of Cuba, "Annual Report, 1937," 27, F 1643, B 139, S 3151, RG 5.3; HPC, "Report of the Cooperative Public Health Work in Cuba During 1938," 5, F 1644, B 139, S 3151, RG 5.3; HPC, "Report of the Cooperative Public Health Work in Cuba During 1939," 9, F 2000, B 163, S 420, RG 5.3; HPC, "Report of the Cooperative Public Health Work in Cuba During 1940," 18, F 2005, B 164, S 420, RG 5.3; RBH, "Malaria Commission of Cuba, Annual Report, 1941," 10, F 2010, B 164, S 420, RG 5.3, RF-RAC.

“avoi[d] as much as possible over-specialization in the program.”³⁴¹ The RF emphasized preventive medicine over curative services.

This local health unit (*unidad sanitaria*), then, was to operate very differently from Cuba’s pre-existing local sanitation departments (*jefaturas de sanidad*), one of which operated in each of the island’s 128 municipalities.³⁴² Municipal authorities chose the chief sanitary officer of each sanitation department, which “resulted in the sanitary services being improperly performed or entirely omitted.... Not infrequently the offender [of a health code] is a municipal official and the sanitary officers are unwilling to bring him to account for fear of losing their places, or if they undertake to secure proper punishment, the local police and judiciary are indifferent or ineffective.”³⁴³ Local health officials received little to no training and worked only part-time (usually weekday mornings, 8 a.m.-12 p.m.). American observers were surprised to find that the majority of the departments’ appropriations went to street cleaning and garbage removal, functions that had already been moved to departments of public works in the United States, as they were understood to bear little direct relation to health. In short, these sanitation departments were antiquated and inefficient, although performance was uneven from one municipality to another. (Havana, for example, possessed a specialized and active municipal health department.)³⁴⁴

³⁴¹ Malaria Commission of Cuba, “Annual Report, 1937,” 2–5, 27, F 1643, B 139, S 315I, RG 5.3, RF-RAC.

³⁴² In this chapter, when I use the term (local) sanitation department, the original text referred to the “*jefatura (local) de sanidad*,” which was the pre-existing governmental organization tasked with health administration in the *municipio*. When I employ the term “health unit,” either the RF used this term in English, referencing their model local health institution, or the text in Spanish used the term “*unidad sanitaria*.” For Cubans, the former (*jefaturas locales*) were considered to be archaic, while “*unidades sanitarias*” were the modern model they hoped to implant throughout the island. And, in my source analysis, an author’s choice to use the designation “*unidad sanitaria*” was a political choice, for it referenced the work of the RF and/or critiqued the existing sanitation departments (*jefaturas de sanidad*).

³⁴³ Charles E. Magoon, *Report of Provisional Administration from October 13th, 1906 to December 1st, 1907* (Havana: Rambla and Bouza, 1908), 46.

³⁴⁴ Information in this paragraph is from Foreign Policy Association, *Problems of the New Cuba*, 95–128.

The Marianao Health Unit also provided a different kind of tuberculosis service than that offered by the CNT. Instead of a plan based around large hospital construction projects, the RF sought to institutionalize “pure” public health work, with major emphasis on case-finding, surveillance, education, and prevention.³⁴⁵ After the CNT adopted a bed-intensive strategy, members of the RF privately critiqued their approach. When writing to the RF Director in New York, Benjamin Washburn, a health officer in the Caribbean, reported “that the tuberculosis situation here in Cuba is hopeless as far as any cooperation on our part is concerned. The public health aspect of the disease is not realised and nothing worthwhile is being done to control it, while great sums are being spent in the provision of hospital beds as a method of treatment.”³⁴⁶

A small group of Cuban physicians had voiced this concern previously, none more vocal than Gustavo Aldereguía when he was director of La Esperanza Sanatorium.³⁴⁷ Aldereguía believed hospitalization to be cost-prohibitive and wanted to pursue outpatient therapy through trained public health nurses employed by the local sanitation department.³⁴⁸ Even though the CNT did not adhere to Aldereguía’s scheme and even though they operated in a different institutional network than that of the municipal sanitation departments, the RF’s broader goal of reforming these local health units throughout the island offered the possibility of synergies developing between the CNT’s dispensaries and local tuberculosis control efforts.³⁴⁹ If the RF

³⁴⁵ During this time, a growing corps of public health officials in the Americas dedicated themselves to preventive medicine administered by local health units. James Colgrove, *Epidemic City: The Politics of Public Health in New York* (New York: Russell Sage Foundation, 2011), 6.

³⁴⁶ Benjamin E. Washburn (BEW) to Wilbur A. Sawyer (WAS), July 6, 1938, F 11, B 2, S 315, RG 1.1, RF-RAC.

³⁴⁷ Oscar Jaime, “La lucha científica contra la tuberculosis: El dispensario como centro de tratamiento,” *Tuberculosis: Publicación científica mensual* 6, no. 6–8 (1934): 46–47; Antonio Penichet, “La tuberculosis y Dr. Aldereguía,” *Bohemia* 27, no. 3 (January 20, 1935): 66; Porter J. Crawford (PJC) Diary, 1940, 155, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁴⁸ Foreign Policy Association, *Problems of the New Cuba*, 111.

³⁴⁹ The RF did not interact formally or extensively with the CNT, as the RF had a policy to deal only with civilian administrations. Therefore, they interacted primarily with the Finlay Institute and the Secretariat of Sanitation (the Ministry of Health and Social Assistance after 1940). The CNT was autonomous from the Secretariat of Sanitation in the late 1930s and early 1940s.

were successful, a strong preventive health network might emerge, one that complemented the curative emphasis of the CNT's hospital projects. Before attempting to launch other local health centers, however, the RF had to first convince Cubans that the Marianao Health Unit was an effective and efficient form of local health care and disease control.

From the MHU's opening, local, national and international audiences considered it a resounding success and a model to emulate. Within four years of its inauguration, the MHU had been interwoven into the social fabric of Marianao. The Marianao paper praised the "zeal and perseverance" and the "magnificent labor" of the MHU.³⁵⁰ In 1942, after attending a Rotary Club luncheon celebrating the RF, its regional director boldly surmised, "The Marianao health unit continues to be the most popular activity in Cuba."³⁵¹ Physicians who had refused in 1937 to send in vital statistical information to Dr. Carr and Dr. Nogueira were doing so by 1939.³⁵² Throughout the RF's tenure in Cuba, its representatives reported that multiple Cuban municipalities pressed the national government to launch renovated local health units, and several of these requests explicitly referenced the MHU as a guide or model.³⁵³ Internationally the unit was well regarded, and the RF used it as a showcase and training site, for, as one official noted, "[N]eutral observers have declared it is the best in the Americas."³⁵⁴

³⁵⁰ "El Instituto Rockefeller: Desenvuelve una excelente labor sanitaria en Cuba," *El Sol*, April 8, 1939, 1.

³⁵¹ Rolla B. Hill (RBH) diary entry, January 22, 1942, 23, F 2, B 1, S 420, RG 1.1, RF-RAC.

³⁵² HPC, "Report of the Cooperative Public Health Work in Cuba during 1939," 27, F 2000, B 163, S 420, RG 5.3; HPC diary entry, May 28, 1939, B 58, RG 12, RF-RAC.

³⁵³ See for example, BEW diary entry, February 23, 1938, 2, B 493, RG 12; BEW to WAS, August 10, 1939, F 12, B 2, S 315, RG 1.1, RF-RAC. Crawford reported, "Other counties continue their requests for local health departments organized and conducted similar to the Marianao Health Unit." PJC, "Introduction: Annual Reports of Cooperative Work in the Caribbean Area – 1942," vol. 1, 3, F 2015, B 165, S 420, RG 5.3, RF-RAC.

³⁵⁴ PJC diary entry, December 1, 1943, 360, F 1, B 2, S 420, RG 1.1; "Notes on Preliminary Draft of Budget for 'Cuba-Marianao County Health Unit' – for the Year 1941," September 20, 1940, B1297, F 9, B 1, S 315, RG 1.1; PJC diary entry, June 26, 1943, 214, F 1, B 2, S 420, RG 1.1; RBH, "Cuba-Malaria Commission of Cuba, Annual Report, 1951," in "Caribbean Region Annual Reports, 1941," 3, F 2010, B 164, S 420, RG 5.3, RF-RAC.

In response, Cuban and RF officials tried to leverage the MHU's success into two further reform and institution-building efforts. The first endeavor was spearheaded by the Finlay Institute and other Cuban health authorities, who sought to modernize the existing sanitation departments by training their chief sanitary officers. The RF initiated the second project, a proposal to establish a second model health unit in Guantánamo. Both, however, encountered significant opposition from those involved in patronage networks.

When the Finlay Institute was created in the late 1920s, it was entrusted with forming a National Sanitary School to instruct the workers of the Department of Health in a number of practical and theoretical matters. Acknowledging that the study and practice of clinical medicine was not enough to adequately perform public health duties, medical students who took courses through the FI's training program at the University of Havana were to receive, in addition to their medical degree, the "certificate of Sanitary Doctor."³⁵⁵ Despite this original mandate, by the mid-1930s the Finlay Institute had survived economic and political chaos but its training program had not.

In the late 1930s, with unofficial and peripheral RF involvement (i.e., advice and very limited aid), Cuban officials led the drive to revitalize the FI's National Sanitary School. Part of the school's mission would be to train chief sanitary officers, with the broader goal of transforming existing sanitation departments into modern health units. In the spring of 1937, Dr. Ramos and a new Director of the Department of Health initiated a pilot training program, housing a small group of these local health officials from outside Havana at the FI. They

³⁵⁵ This "special training" included courses in "public hygiene, city and rural drainage; specific prophylaxis; eugenics; applied sanitary legislation; epidemiology; immunology, one course; maritime health, immigration, quarantine, one course; experimental pathology with laboratory work, one course; microbiology with laboratory work, one course; parasitology and parasitic diseases, half course; bromatology, half course; sanitary statistics, demography, half course; sanitary administration, one course; disinfection, disinfectants, insecticides, half course; biology, half course." "The Finlay Institute," 61, F 1, B 1, S 315, RG 1.1, RF-RAC.

attended courses on laboratory techniques, such as performing blood smears and staining them to diagnose for malaria. They also observed the RF and RF-trained Cuban personnel at the MHU to gain field experience in public health and preventive medicine.³⁵⁶ When the trained health workers returned to their posts, the goal was to begin the transition from part-time to full-time work. Then, another group would be selected for the program, and so on, until the entire corps of 128 chief sanitary officers had been professionalized.

The RF viewed this initiative very positively. Carr noted that this was “the first time employees have been given special training before being sent to do field work” in Cuba.³⁵⁷ Benjamin E. Washburn, the regional director of the RF’s Caribbean program, praised this effort: “Such a centre for training the subordinate personnel of the health department is the thing I should love very much to see in each of the countries of the Caribbean Region.” He continued, “The Training School for Health Officers, already organized by Dr. Ramos, has every prospect of succeeding since the budget of the Finlay Institute contains items providing for the board and lodging at the Institute of 10 students throughout the year.”³⁵⁸ The RF officials soon learned, however, that in Cuba the problem for state institutions was often not a shortage of money, and the National Sanitary School soon ran into more serious problems, despite Washburn’s cheerful forecast.

By the next summer, Washburn reported that the training program had been “discontinued” as of April 1938, after only two groups had graduated.³⁵⁹ When the trainees returned home, armed with an arsenal of new epidemiological techniques and administrative

³⁵⁶ HPC diary entry, October 4, 1939, B 58, RG 12; BEW to WAS, “Cuba,” September 1938, F 9, B 1, S 315, RG 1.1, RF-RAC.

³⁵⁷ BEW diary entry, April 5, 1937, 2, B 493, RG 12, RF-RAC.

³⁵⁸ BEW to WAS, May 20, 1937, 1, F 11, B 2, S 315, RG 1.1, RF-RAC. The RF representatives called the National Sanitary School a variety of names (The Training School for Health Offices, National School of Health, National School of Public Health, etc.), which points to its uncertain institutionalization.

³⁵⁹ BEW to WAS, July 6, 1938, 2, F 11, B 2, S 315, RG 1.1, RF-RAC.

guidelines, several found that their positions had been given away to other appointees. Even though the National Sanitary School, an arm of the national government, had invited these officers to come for public health training, and even though they were only absent for a few months, the FI found itself unable to extend its sphere of influence beyond Havana to the municipal outposts in other provinces to ensure that these public health officers would have a position when they returned.³⁶⁰ “In at least two instances,” Washburn summarized, “these health officers completed their training and returned home to find that their jobs had been given to political appointees.”³⁶¹ The ramifications were disastrous for the program’s appeal: “Needless to say, other health officers cannot be induced to take the course of training.”³⁶² Municipal authority and local patronage needs had trumped national designs.

The government’s ability to ensure a certain level of job security, that is, the prospect for a career in public health, was absolutely crucial for any future efforts to form a body of public health experts. Potential public health trainees were often loath to pursue the opportunities for professional advancement offered to them by the RF and the FI. For example, one potential RF fellowship recipient, the General Nursing Supervisor of the Health Department, demanded that a presidential decree be passed to ensure her position and salary upon her return from the United States.³⁶³ The Director of Health found this request unnecessary (and impossible), and the RF thus rescinded the fellowship offer. However far-fetched her request may have seemed, it persuasively illustrates how keenly Cubans in public posts experienced job insecurity. In reaction

³⁶⁰ One political scientist has argued that in several other Latin American countries, deployment of technocrats appointed by the national government to local posts led to successful state-building efforts. In contrast, delegating power to local elites in allowing them to fill local posts weakened state-building projects because local authorities were accountable to those who appointed them and not to the national state. Hillel David Soifer, *State Building in Latin America* (Cambridge: Cambridge University Press, 2015).

³⁶¹ BEW to WAS, July 6, 1938, 2, F 11, B 2, S 315, RG 1.1, RF-RAC.

³⁶² Ibid.

³⁶³ Fellowship File 36133, July 15, 1936, S IHD-TG Cuba, RG 10.2, RF-RAC.

to these developments, Washburn sensed that a tide was turning, but unfortunately in the direction opposite of what he and the RF had desired. “The conditions under which we are working at present are entirely different from those which existed three years ago when our cooperation began,” he bemoaned, “and, more and more, political conditions are affecting all the projects with which we are connected.”³⁶⁴

In the ensuing years, the Finlay Institute continued to make promises to the RF that they were serious about reopening the school, and government officials communicated their intentions to ensure the career prospects of those trained by the RF and the FI. In 1939 a competent and reform-minded Secretary of Sanitation, Dr. Juan de Moya, reopened the school, and the RF continued to support the small groups-in-training by offering malariology courses at the FI and practical fieldwork at the MHU.³⁶⁵ In 1939, de Moya arranged for six local health officers to be trained at the FI. He hoped to create six provincial health departments and to have the trainees direct these provincial units, which would “adopt the methods in use in Marianao.”³⁶⁶

Despite Ramos’ and others’ attempts to interest the RF in officially turning the National Sanitary School into a cooperative project, with resources and professors provided by the RF, Washburn was reluctant to participate. Dr. Ramos believed the RF’s institutional support would solve the problem of local authorities replacing trainees while on leave, perhaps because the RF possessed some kind of authority beyond what the national government did. The RF concurred

³⁶⁴ BEW to WAS, July 6, 1938, 5, F 11, B 2, S 315, RG 1.1, RF-RAC.

³⁶⁵ It is unclear from Cuban sources how many graduates there were and for how many years the school operated. Without giving sources or clear dates, one historian argues that the Institute’s National Sanitary School graduated twelve to fifteen students per year. In 1944, it became the School of Health and Tropical Medicine. Gregorio Delgado García, “La formación de médicos salubristas en Cuba: Algunos aspectos históricos,” *Cuadernos de Historia de Salud Pública* 99 (2006), http://bvs.sld.cu/revistas/his/his_99/his0199.pdf.

³⁶⁶ BEW to WAS, October 13, 1939, F 12, B 2, S 315, RG 1.1, RF-RAC. In 1939, de Moya also proposed that a second health unit be launched in Santiago, but the RF rejected this idea. They believed it would be forced to resemble a city sanitation department, and they expressed aversion to taking over duties such as street cleaning and garbage collection, which they no longer considered appropriate work for health departments.

that ensuring meritocratic and not political appointment was crucial for Cuba's public health future; however, as long as health officials only vaguely promised to remove politics from local health, the RF remained skeptical of any long-term change and declined to participate in the effort. The RF's doubts were confirmed when de Moya was removed from his post following the 1940 presidential election. The RF instead placed its hopes for permanent institutional change in launching a second local health unit. When this effort met the same obstacles as those encountered by the training program, RF officers began to understand even more clearly how Cuba's profoundly embedded political practices and institutional arrangements impeded efforts to reform public health institutions.

Within a few years of the MHU's operation, the RF determined that it had been successful enough that they could begin to broach the topic of establishing a second health unit. In 1939, the new regional director of the Caribbean, Porter J. Crawford, had met with a coterie of health authorities and reported, "The idea that the 'jefaturas' de sanidad (municipal health departments) could be gradually replaced by full-time health units with trained personnel, seems to be gaining ground in the minds of several important people."³⁶⁷ Washburn agreed that "such a programme is indispensable in the reorganization of public health work in Cuba...it is recognized that many of the municipal departments should be placed upon a more efficient basis in order to utilise modern methods of disease control."³⁶⁸

Both the Cubans and the RF turned their eyes eastward to Oriente, which in the RF's estimation was "the most important province of Cuba" in terms of size, population, and wealth.³⁶⁹ The RF presented a proposal for a second health unit in early 1941 when they believed

³⁶⁷ PJC diary entry, August 7, 1939, 90, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁶⁸ BEW to WAS, "Cuba," September 1938, F 9, B 1, S 315, RG 1.1, RF-RAC.

³⁶⁹ BEW to WAS, August 16, 1939, F 12, B 2, S 315, RG 1.1, RF-RAC.

that a new window of opportunity for reform had opened. The resumption of democratic national elections and the new constitution promised substantial and positive public health reforms on the island. Batista, for example, planned to rationalize the civilian and military health services into one new technical and modern health branch, baptized as the Ministry of Health and Social Assistance. The new director of health showed great interest in the idea of extending health units throughout the island.³⁷⁰ The RF hoped that after a brief and potentially unstable period of institutional reorganization, the government might successfully restructure the Health Ministry. The RF requested a continuation of funding for cooperative projects for two years from both the Cuban government and the RF board, which was granted.³⁷¹ The RF and their Cuban partners hoped their continued presence would ensure that as services were reorganized, the idea of extending health units and replacing sanitation departments would not be pushed to the back burner.

The RF urged that a second health unit be set up in Guantánamo, but the timing of the proposal was problematic.³⁷² First, treaty negotiations were underway between the U.S. Navy and the Cuban government to expand the size of the base at Guantánamo.³⁷³ Because its enlargement was prohibited under the Cuban Constitution, the American ambassador was reluctant to present the health unit project to the President while these negotiations were being worked out.

³⁷⁰ Much like the previous structure of the Secretariat of Sanitation and Charities, the Ministry of Health and Social Assistance was headed by one Minister. He appointed two directors to run the two departments of the Ministry: the Department of Health and the Department of Social Assistance.

³⁷¹ "Cuba-Malaria Commission," November 1, 1940, 40204, F 9, B 1, S 315, RG 1.1, RF-RAC.

³⁷² In comparison to the Marianao proposal in 1936, the intra-RF correspondence suggests that the RF might have been responding primarily to the Navy's concerns in choosing a location for the unit. This decision to appease the Navy, however, did not seem to be the factor that caused Cubans to not enthusiastically support the proposal.

³⁷³ Andrew J. Warren (AJW) to WAS, April 18, 1941, F 12, B 2, S 315, RG 1.1, RF-RAC.

More problematic, however, was the relationship between the RF and the new Health Minister. The RF had grown accustomed to the top health officials of the country frequently changing. In the course of eleven years, there were twenty-one secretaries of sanitation/ministers of health. (This, in itself, is evidence of the dysfunctional health system; see Appendix A.) In 1940, Batista appointed Colonel Demetrio Despaigne as the new Minister of Health; Despaigne had been the director of the CNT and continued in that position until 1944. Even though the Director of Health (Dr. Recio) supported the project, the RF soon learned that due to his close military connection to Batista, Despaigne held the power, and he soon began to put obstacles in the RF's path. Relations between Despaigne and the RF went back to at least December 1938, when Despaigne asked Washburn for a grant of money for the CNT's hospital building program. The RF did not believe in funding projects that in their view encouraged dependency, so Washburn told him that all RF budgets for the year had already been set, and that appropriations for tuberculosis control had been distributed to other Latin American countries. Washburn reported, "He was not satisfied with this reply."³⁷⁴

Now, as Minister of Health, Despaigne continued to try to assume control of the financial streams of the RF projects in order to redirect them to his ends. Carr had to seek an audience with Batista in early 1941 to stop Despaigne from taking over the Cuban government's appropriation to the Malaria Commission and the MHU. After talking to Carr, Andrew J. Warren, Assistant Director of the RF, reported, "Dr. Despaigne's only argument against the project was that with the money involved he would be able to provide an additional 200 political jobs."³⁷⁵ Furthermore, Despaigne was not the trained public health professional the RF would have preferred, and he often did not agree with the practices emphasized by the RF. In early

³⁷⁴ BEW to WAS, December 12, 1938, 1, F 11, B 2, S 315, RG 1.1, RF-RAC.

³⁷⁵ AJW diary entry, April 25, 1941, 51, B 491, RG 12, RF-RAC.

1941, Carr reported that Despaigne wanted to reassign the malaria funds to use them “for his own methods and personnel who would control malaria chiefly by the use of flame throwers. Doctor Carr has been unsuccessful in convincing the minister that the proved methods now in use should continue. He feels that further conferences would give negative results.”³⁷⁶ Warren was less tactful in his assessment of Despaigne, acerbically commenting, “[I]t is a good illustration of the intelligence and public health ideas of the present Minister of Health.”³⁷⁷

After the proposal for the Guantánamo unit had been sitting on the desks of Cuban officials for months, Warren finally took the issue to President Batista in April 1941 to see if he could push it forward. While Batista expressed interest, he said he needed to discuss it with his advisors because of the naval base negotiations underway.³⁷⁸ Two months later, in late June 1941, with no action taken on the part of the Cubans, the RF withdrew their proposal for the health unit.

At first, the RF interpreted authorities’ inaction as a lack of enthusiasm or desire for the project—that is, as a problem of attitude or knowledge. Crawford had “hope[d] that such a development would come from a desire of Government to extend the health unit idea.”³⁷⁹ The RF Director had cancelled the proposal because “the Cuban Government had shown little enthusiasm and had delayed acceptance.”³⁸⁰ However, after a few months’ deliberation, the RF began to realize that the root of the problem was political and not about a lack of appreciation for health reform. The proposal for a second health unit failed primarily because of Cuba’s existing

³⁷⁶ PJC diary entry, January 15, 1941, 7, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁷⁷ AJW diary entry, April 25, 1941, 51, B 491, RG 12, RF-RAC.

³⁷⁸ AJW diary entry, April 28, 1941, 52, B 491, RG 12, RF-RAC.

³⁷⁹ PJC to AJW, April 10, 1941, 2, F 12, B 2, S 315, RG 1.1, RF-RAC.

³⁸⁰ WAS to RBH, July 2, 1941, F 12, B 2, S 315, RG 1.1, RF-RAC.

patronage system, in which the distribution of health posts functioned as valuable currency, both for national politicians like Despaigne and local political bosses.

In the summer of 1941, a new RF representative arrived to replace Carr. Rolla B. Hill brought new eyes to the situation. After making a brief tour throughout the island to meet multiple health officials, he emphasized the political nature of Cuba's challenges. Hill explicitly observed that the root of the problem was not lack of money. Carr would have agreed. Speaking of Santiago in 1939, he opined, "There is no lack of funds for health work in places like that city."³⁸¹ He continued:

There are few municipalities in the Island where, on account of being sparsely settled and for other reasons, good health work cannot be carried on for a per capita cost of \$0.75 to \$1.00 and in the majority of them a per capita of \$0.50 would be sufficient even to include some permanent engineering work...Such figures, applied on an island-wide basis will be seen, when compared with the national health department budget, to leave ample funds for central administration.³⁸²

Based on his past experience in Latin America, Carr agreed, "This is rather an unusual situation."³⁸³ Cuban officials—both local officers and national ministers alike—often complained that they needed more money and credits from the government. It is probable that such complaints were used to distract from mismanagement of funds. Carr concluded that what was needed was not more funding but an "adjustment of program and personnel for increase in effectiveness."³⁸⁴

Hill argued that the patronage system in Cuba constituted the most important obstacle to reform. Cubans participating in regional and local political networks distributed jobs, including

³⁸¹ HPC diary entry, June 30, 1939, B 58, RG 12, RF-RAC.

³⁸² HPC, "Report of the Cooperative Public Health Work in Cuba During 1938," 4, F 1644, B 139, S 3151, RG 5.3, RF-RAC.

³⁸³ Ibid.

³⁸⁴ HPC, "Report of the Cooperative Public Health Work in Cuba During 1939," 4, 12–13, F 2000, B 163, S 420, RG 5.3, RF-RAC.

the chief sanitary officers of local sanitation departments. Carr had begun to understand this in late 1940, summarizing that “the greatest difficulty, and one which can hardly be overcome even by the highest officials, is the political type of local directors of health who on the whole aren’t suitable as directors of health units but are essential to the political (party) organization.”³⁸⁵ Hill echoed this in a report to Crawford within several months of arriving in Cuba: “Since the health officers are or may be changed with every political change, and the appointment of them and their subordinate employees is a fat political plum which local chiefs, that is senators, and others, consider natural perquisites, there will be a great deal to contend with.”³⁸⁶ Although the exact mechanics of job distribution remained unclear, RF men were convinced from their first-hand experience and second-hand reporting from Cuban interlocutors that a system of patronage stretched across different levels of government and appointments were made directly by municipal authorities and party figures, who were connected through patron-client ties to senators and national representatives. In terms of health reform, the most negative consequence of patronage was that it “discourage[d] the career of public health to physicians.”³⁸⁷ Any authority that came from training could not compete with the power of patron-client ties.

In short, the “best practices” espoused by RF representatives in Cuba, who (unrealistically) hoped to operate in complete independence from politics, butted up against entrenched local political networks.³⁸⁸ To launch a second health unit and then subsequent ones, the pre-existing sanitation department would have to be eliminated or combined with the new

³⁸⁵ PJC diary entry, November 23, 1940, 207, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁸⁶ PJC diary entry, August 22, 1941, 143, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁸⁷ PJC diary entry, December 11, 1941, 236, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁸⁸ The RF officers seemed to overlook the fact that politics affected public health everywhere, even in the US, albeit in differing modes and levels of intensity. In the United States, for example, clinical medicine remained dominant and public health suffered as a result. Elizabeth Fee, “Designing Schools of Public Health for the United States,” in *A History of Education in Public Health*, eds. Elizabeth Fee and Roy M. Acheson (Oxford: Oxford University Press, 1991): 155–94; Stepan, “The National and the International in Public Health,” 500–1.

organization. This threatened those who were distributing the health jobs, as well as those already employed in these positions. Those Cubans who understood the system suggested other tactics. In late 1941, for instance, Ramos proposed to Crawford that the RF accept and train fifty or sixty fellows, who then would be put to work in cooperative projects. He reasoned that after training “these men would demand full-time public health service and there would be much more progress.”³⁸⁹ Crawford balked at this suggestion, sticking to the RF’s established procedures, informing Ramos, “[F]ellowships are given at the request of Government to assist in plans involving development of public health...naturally fellowships cannot be just given in order to have numbers and hope that they will find positions later.”³⁹⁰

RF officials believed that the national government shouldered responsibility for making a career in public health possible. Carr wrote, “[F]ull-time work can only be secured when the Government is willing to give reasonable guarantees to the employee, who must not be removed from his position for political or other reasons not related to his capacity adequately to fulfill the duties of his post.”³⁹¹ The Spanish translation of this text (published by the Ministry of Health) removed the words “the government,” stating in passive voice that this “kind of work....can only be obtained when the employee is offered sufficient guarantees.”³⁹² One foreign health expert had observed in 1935 that there needed to be some mechanism to pull physicians, over-concentrated and underemployed in Havana, into rural areas: “Distribution of physicians in Cuba, as in many other countries, is not in accordance with the actual needs of the people, but in

³⁸⁹ PJC diary entry, September 17, 1941, 138, F 1, B 1, S 420, RG 1.1, RF-RAC. Politics in Cuba, during 1933–58, operated on the basis of interest groups, and Ramos understood these mechanics. Jorge I. Domínguez, *Cuba: Order and Revolution* (Cambridge, MA: Belknap Press of Harvard University Press, 1978), 57.

³⁹⁰ PJC diary entry, September 17, 1941, 138, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁹¹ HPC, “Report of the Cooperative Public Health Work in Cuba During 1940,” 15, F 2005, B 164, S 420, RG 5.3, RF-RAC.

³⁹² Comisión de Malaria de Cuba, “Informe anual – 1940,” *Boletín Oficial del Ministro de Salubridad y Asistencia Social* 44, no. 8 (August 1941): 301.

accordance with opportunities for the professional, social and financial advancement of the physician...A young, able physician must have a strong inducement to draw him to the interior.”³⁹³ The RF was convinced that if the Cuban government could ensure employment, physicians would take up public health posts throughout the island; Congress, however, never passed or enforced laws to make health work full-time; to take appointment power away from municipalities; to provide training to its sanitary workers; or to regulate qualifications for the job.³⁹⁴

Outside of Havana, local officials were especially powerful, and unlike Marianao where the local health officer had been unable to block the inauguration of the MHU, the health officers in Oriente would prove to be powerful foes. In this province, Hill summarized, “[t]he doctors are emphatic in saying that unless the Director of the Unit be given official authority, that is made Jefe Local de Sanidad, it will be nigh impossible to do effective work. In Guantanamo, even more than in Marianao, where much difficulty has been experienced in getting cooperation of the Jefe Local, the local officials can make or mar the work.”³⁹⁵

In light of all of these difficulties, the RF decided to turn over cooperative projects to the Cubans in 1942 and to pursue no new initiatives. The news of the RF’s departure sparked worry and outrage, providing one more indictment of the state and showcasing the vulnerability of the institutions started by the RF. Ramos, now Minister of Health, promised to pass a law reorganizing local health units, while insisting that he needed the backing of the RF to push this through. He told Crawford that the RF representative was “quite essential for holding together

³⁹³ Foreign Policy Association, *Problems of the New Cuba*, 117.

³⁹⁴ In fact, the 1940 Constitution gave the municipality the right to appoint municipal employees, which would include the sanitary officer, even though this was not explicitly stated. See Article 213 in Lazcano y Mazón, *Constitución de Cuba*, vol. 3. Dr. Recio (Director of Health) informed the RF that he had submitted a law for a full-time health department in 1940. The House had passed the bill, but the Senate had shelved it. PJC diary entry, April 21, 1943, 149, F 1, B 2, S 420, RG 1.1, RF-RAC.

³⁹⁵ RBH diary entry in PJC diary, August 22, 1941, 143, F 1, B 1, S 420, RG 1.1, RF-RAC.

advances in public health in Cuba.”³⁹⁶ Ramos highlighted that, unlike other countries in the region, the central public health problem of Cuba was not disease prevention, but one of institutions and administration. Crawford reported that Ramos “believes that as Colombia needs yellow fever work or Trinidad malaria studies, so does Cuba need most of all the stabilizing influence of the Rockefeller Foundation.”³⁹⁷

Unlike Hill, however, Crawford had grown immune to the promises of health change on the horizon. When Hill relayed the guarantees that Ramos had made, Crawford tiredly wrote that he had heard all of this before, “but nothing would please him more than that some of them would come true.”³⁹⁸ Crawford wrote to RF Director Sawyer, contending that two serious political issues would undermine any future efforts: the existing patronage system and Congress’s failure to pass a national budget for years. He recommended that projects be turned over in March 1942. Crawford identified the disjuncture in Cuba between those who desired public health reform and those who held power (over legislation, purse strings and/or appointments). Sawyer began to wonder if even the President had a strong grasp on what course of action Congress would take in passing reform laws.³⁹⁹ Crawford summarized, “[A]ll of those who wish to carry out a definite public health program so far do not have the laws, budget, and lack of political interference in order to accomplish their wishes.”⁴⁰⁰

The RF’s exit sparked protests and focused public ire on the shortcomings of the government. In the beginning of 1942, news that the RF was planning to turn over the Malaria Commission and the MHU to the FI leaked to the press. Crawford reported, “Articles and

³⁹⁶ PJC diary entry, April 21, 1941, 153, F 2, B 1, S 420, RG 1.1, RF-RAC.

³⁹⁷ PJC diary entry, July 22, 1943, 227, F 1, B 2, S 420, RG 1.1, RF-RAC.

³⁹⁸ PJC diary entry, September 17, 1941, 137, F 1, B 1, S 420, RG 1.1, RF-RAC.

³⁹⁹ PJC diary entry, May 5, 1942, 168, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴⁰⁰ PJC diary entry, June 4, 1942, 198, F 2, B 1, S 420, RG 1.1, RF-RAC.

editorials have now begun to appear every day saying that the RF intends to pull out, that we should not be allowed to leave, that something must be done about it.”⁴⁰¹ There was intense press coverage, and many (correctly) assumed that this meant that the RF was planning to no longer pursue cooperative work on the island.⁴⁰²

The outcry in Marianao reached a fever pitch, especially when citizens heard rumors that the MHU would be merged with the Marianao Sanitation Department.⁴⁰³ They had long benefitted from the MHU, and they feared what would happen if the RF relinquished control. On April 15th, Hill recorded the progression of events in his diary:

Last night there was another mass meeting in Marianao, with the Army represented, who offered to take a delegation to see the President. Present also was a Lyceum student with several hundred signatures of protest, thus united with the public school teachers. The merchants also in a signed statement, offered to close their stores for half a day in protest, or to unite with meeting in front of the Presidency. The Marianao paper came out 2 days ago with the whole front and back pages devoted to the question, with a picture of Dr. Ramos addressing the Marianao Rotary Club two months ago, in which he promised that the Health Unit would continue in Marianao to serve as an example to the whole country.⁴⁰⁴

This sort of unity across social class and professional sector seemed unusual to the Cuban press.

⁴⁰¹ PJC diary entry, January 3, 1942, 8, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴⁰² See, for example, “Se irán los delegados de la Rockefeller,” *El Mundo*, January 3, 1942, 1; “Sigue la Fundación Rockefeller aquí,” *El Mundo*, January 4, 1942, 4; “Prorrogará su permanencia en Cuba, cooperando con Sanidad, la ‘Institución Rockefeller’,” *Diario de la Marina*, January 4, 1942, 2; “La valiosa cooperación de la Fundación Rockefeller a la Sanidad de nuestro país,” *Alerta*, January 12, 1942, 5; “Consagraron los rotarios su sesión a tratar sobre la obra sanitaria que realiza la ‘Fundación Rockefeller’,” *Diario de la Marina*, January 23, 1942, 12; “Editoriales: La Institución Rockefeller,” *Diario de la Marina*, January 24, 1942, 4; “La Fundación Rockefeller brinda toda su cooperación a Salubridad para el saneamiento de la Isla,” *Diario de la Marina*, February 4, 1942, 3; “La. F. Rockefeller no nos abandona,” *Diario de la Marina*, February 12, 1942, 3.

⁴⁰³ “Protesta en Marianao por una fusión,” *El Crisol*, April 9, 1942, 5; “Interésase el Club Rotario de la Habana por la existencia autónoma de la Unidad Sanitaria de Marianao,” *Diario de la Marina*, April 10, 1942, 3; “Rotary Supports Continuation of Anti-Malaria Work,” *Havana Post*, April 12, 1942, 2. The MHU’s prestige among the Marianao community prompted rallies after the RF left. In May 1943, when the Ministry of Health tried to move the MHU to Oriente (according to the RF) and suspend the salaries of the Malaria Commission to use for other purposes (according to Cuban papers), once again civic organizations organized. The government dropped the matter in response. PJC diary entry, May 28, 1943, 189, F 1, B 2, S 420, RG 1.1, RF-RAC; “Marianao protesta enérgico,” *El Crisol*, May 28, 1943, 1, 5; “Marianao tendrá la debida atención por parte del Ministerio de Salubridad,” *El Crisol*, May 29, 1943, 1, 10.

⁴⁰⁴ RBH diary entry in PJC diary, April 15, 1942, 164, F 2, B 1, S 420, RG 1.1, RF-RAC.

“The Havana papers, including the weekly illustrated magazines,” Hill summarized, “continue to discuss the question, and some of them have stated that seldom if ever has such a unanimous protest, or conversely, such a demonstration of solidarity been shown for any cause.”⁴⁰⁵

The Cuban press alleged that the RF had become dissatisfied because the Cuban government had not paid for its share of the cooperative project.⁴⁰⁶ Even though the RF made concerted efforts to dispel this myth, this narrative prevailed in the public sphere. Privately, the RF tried to convince authorities that political problems prompted them to leave. Meeting with Wilfredo Albanés, a senator from Oriente, Hill “took occasion to point out that the Ministry of Health is still political, and that the employees work part-time and that under these conditions health work never will be satisfactory.” The senator told Hill that “now would be an extremely unfortunate time for the RF to pull out of Cuba, when the Government has a great many difficult problems confronting it, and when health work should be intensified rather than lessened.”⁴⁰⁷ Albanés continued to publicly malign the national government, which did not use the RF’s projects “as a guideline for application in other parts of the country.”⁴⁰⁸ Other health officials tried to calm public opinion by passing decrees promising more money for the sanitation departments.⁴⁰⁹

⁴⁰⁵ Ibid.

⁴⁰⁶ See, for example, “Editoriales: La Institución Rockefeller,” 4; “Work on Projects of Anti-Malaria Commission Stops,” *Havana Post*, April 5, 1942, 2; “Commerce Chamber Board Hears Talk on Sanitary Unit,” *Havana Post*, May 14, 1942, 6; “Coopera eficazmente con Sanidad la Comisión de Malaria de Cuba en su lucha contra las epidemias,” *Diario de la Marina*, May 23, 1942, 3.

⁴⁰⁷ RBH diary entry in PJC diary, January 21, 1942, 22, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴⁰⁸ “Si no actuamos con rapidez, pronto la Institución Rockefeller ha de retirarse de Cuba, declara Albanés,” *Diario de la Marina*, January 23, 1942, 3.

⁴⁰⁹ “Será resuelto el problema de los Jefaturas Locales de Salubridad de la Republica,” *Alerta*, February 2, 1942, 8; “El Ministerio de Salubridad está actuando para sanear las poblaciones de la Isla,” *Alerta*, February 9, 1942, 8; “La Fundación Rockefeller brinda,” 3; “Salubridad y la Fundación Rockefeller actuarán, conjuntamente, en la obra de saneamiento e inmunización de Oriente,” *Diario de la Marina*, February 11, 1942, 12; “La F. Rockefeller,” 3; “El gobierno facilitará un cuarto de millón de pesos para Jefaturas de Sanidad,” *Diario de la Marina*, February 19, 1942, 12; “Paulatinamente se dota a las Jefaturas Locales de Sanidad de los materiales necesarios,” *Diario de la Marina*, May 5, 1942, 12; “Salubridad y la Comisión de Malaria,” *Diario de la Marina*, May 24, 1942, 4; “Continua

Professionals employed in RF projects feared for their individual and institutional stability once the RF left. The Cuban staff of the cooperative projects read the press reports with dismay and told Hill that they would be “at the mercy of politicians.”⁴¹⁰ Several were so pessimistic that they planned to leave to find work in the U.S. Although the RF managed to get promises from three lead Cuban men to wait until the year finished to leave the work, Crawford was also cynical about their future: “There is no governmental full-time work in Cuba or the Finlay Institute and such a procedure is a very nice square peg, but it is in a very round hole.”⁴¹¹ Corroboration of these fears came when the press released a story in which the Marianao Sanitation Department had put forward a candidate for a job at the Malaria Commission, who stated, “I know nothing about malaria, but I can get 300 votes.”⁴¹² In the RF’s last months with the cooperative projects, “some higher ups” attempted to do what the RF and other Cubans had feared: taking over the MHU to redistribute valuable resources and jobs. These unnamed officials tried to incorporate the MHU into the Marianao Sanitation Department “for the purpose of securing more money to hire type [sic] of employees which assist party politics.”⁴¹³

In the face of these issues, Crawford and Hill remained committed to withdrawing from the island. They also laid out specific things the government could do to interest the RF in future work. Generally, health work needed to be technical, full-time, and not political. For instance, if they maintained the current health minister across the next presidential administration transition in 1944, it would be a good faith sign of moving toward a depoliticized bureaucracy. As one of

cooperando la Comisión de Malaria,” *Diario de la Marina*, May 29, 1942, 3. Crawford sarcastically wrote in his diary, “Dr. Ramos has been keeping me at his coattails all this time not because he thinks I am such a hell of a fellow, but to show everybody that the Foundation has not retired from Cuba, and to demonstrate that we are necessary and useful here.” PJC diary entry, June 4, 1942, 261, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴¹⁰ RBH diary entry in PJC diary, January 2, 1942, 8, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴¹¹ PJC diary entry, September 22, 1942, 328, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴¹² RBH diary entry in PJC diary, April 10, 1942, 147, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴¹³ PJC diary entry, April 2, 1942, 116, F 2, B 1, S 420, RG 1.1, RF-RAC.

his final communications with the Health Ministry, Hill penned a “strong” letter, advising that the government must evince a “sincere desire to raise the Health Dept. out of the mire.” He signed off with the admonition that cooperative aid might not be the answer to Cuba’s problems: “Any aid by a private organization can only be relatively small. In the final analysis, it is the people, their government and the technical men who must have the responsibility for their own health and their own institutions.”⁴¹⁴ In August 1942, Hill packed his belongings and left the island.

4.2 THE NATIONAL PUSH FOR REFORM

Throughout the 1940s, domestic actors initiated other reform efforts. Unsurprisingly, many physicians were concerned with restructuring local health administration and saw the MHU as a model to replicate. Félix García Rodríguez, who had been a delegate to the constitutional assembly, hoped that as the Health Ministry was restructured along the lines that the Constitution demanded, local sanitation departments would be replaced with health units.⁴¹⁵ The “archetype,” he contended, was the RF’s unit in Marianao.⁴¹⁶ After years of disappointment following the ratification of the 1940 Constitution, Cuban reformers saw another moment of possible change when President Grau prepared to assume office in 1944. Through the medical journals, popular press, and private letters, physicians submitted proposals for institutional change. They recommended a variety of administrative reforms and disease prevention or control programs,

⁴¹⁴ RBH diary entry in PJC diary, July 1, 1942, 264, F 2, B 1, S 420, RG 1.1, RF-RAC.

⁴¹⁵ The Constitution did not mention local health units, but Article 160 stipulated that the new Ministry of Health and Social Assistance “shall act exclusively as [a] technical organizatio[n].” Lazcano y Mazón, *Constitución de Cuba*, vol. 3, 104.

⁴¹⁶ Félix García Rodríguez, *Problemas de Salubridad* (Havana: Imprenta Librería Nueva, 1940), 24.

but all expressed two concerns: the Health Ministry needed to be modernized (i.e., made technical) and local health units in the style of the MHU needed to replace sanitation departments.

The physicians shared an understanding that the linchpin of health work, the local sanitation departments, were in disarray. José Chelala Aguilera, a well-known obstetrician and eugenicist, who published voluminously in the popular press and reached a large audience through a daily radio show in the 1940s, took the lead in pushing for this reform, publicizing his opinion pieces in *Bohemia* and a variety of professional journals.⁴¹⁷ Chelala recommended the “radical transformation” of the public health apparatus, noting that with the amount of money at the disposal of past ministers, Cuba should have had “a perfect sanitary state.”⁴¹⁸

He pinpointed the same central roadblock that the RF emphasized: the “sanitation departments dependent on political *caudillos* and unable to execute the most basic sanitary methods.”⁴¹⁹ Chelala maligned the system that made the chief sanitary officer a subordinate of the municipal mayor, which “ma[de] fragile all the means of public health.”⁴²⁰ Instead, Chelala advised the Minister of Health to establish public health as a career and call a conference with all Health Officers to determine who were “the...parasites of the Ministry” and who were “the true soldiers of the health policy that the country needs.”⁴²¹ Chelala was confident that the

⁴¹⁷ Sarah R. Arvey, “Sex and the Ordinary Cuban: Cuban Physicians, Eugenics, and Marital Sexuality, 1933–1958,” *Journal of the History of Sexuality* 21, no. 1 (January 2012): 100–1.

⁴¹⁸ José Chelala Aguilera, “Comoción sanitaria y acción,” *La Revolución en Marcha*, November 5, 1944, 3, Fondo de José Chelala Aguilera (JCA), Museo Histórico de las Ciencias “Carlos J. Finlay” (MHC).

⁴¹⁹ José Chelala Aguilera, “Hacia una política sanitaria,” *Prótesis Clínica* 5, no. 10 (October 1944): n.p., JCA, MHC.

⁴²⁰ José Chelala Aguilera, “Grau tendrá que iniciar la sanidad,” *Prótesis Clínica* 5, no. 9 (September 1944): n.p., JCA, MHC.

⁴²¹ *Ibid.*

reformation of the local health organization would have a cascading effect, ending a number of structural problems: rural migration, social diseases, and shantytowns.⁴²²

Chelala also contradicted claims about inadequate funding: while specific local sanitary departments might have required more credits from the central government, the Ministry of Health and Social Assistance had more than enough money to adequately run the public health sector.⁴²³ He had long lamented how party leaders and health officials had reduced the problems in the sector “to simple statements about lack of funds.”⁴²⁴ As citizens became increasingly frustrated with local health in the mid-1940s, Chelala queried, “With this awakening of the citizenry—slow but progressive—do they think they can indefinitely continue repeating the same excuse of ‘lack of credits’ ...?”⁴²⁵

Physicians appealed to the president-elect directly. Two doctors sent in lengthy reports that suggested how best to reform the health department. Both petitioned for sanitation departments to be replaced by health units and explicitly mentioned the Marianao Health Unit as a model. One of these reports outlined a gradual process, in which the “deficient current Local Services” would be transformed into “modern Units, constituting the most remarkable work of Public Health that could be carried out in Cuba. Only the incomparable work of Finlay and the American Commission against yellow fever could be considered as a superior work of national sanitation.”⁴²⁶ Through these structural changes, public health practices would finally reach the

⁴²² Chelala Aguilera, “Hacia una política,” n.p.

⁴²³ Chelala Aguilera, “Conmoción sanitaria,” 3.

⁴²⁴ José Chelala Aguilera to Ramón Grau San Martín, December 8, 1941, 15, legajo (leg.) 24, expediente (no.) 844, Fondo Partido Revolucionario Cubano (Auténtico) (PRC-A), Archivo Nacional de la República de Cuba (ANC). The letter contained the article, “Fracaso sanitaria e incapacidad política,” which was also published in *Bohemia*.

⁴²⁵ José Chelala Aguilera, “La Salubridad no admite improvisaciones,” *El Detallista*, August 28, 1944, n.p., JCA, MHC.

⁴²⁶ Dr. Alejandro Casuso, “Introducción a una reforma integral de nuestra Salubridad Pública (Memorándum al Dr. Ramón Grau San Martín, Presidente Electo de la República),” 10, leg. 21, no. 718, PRC-A, ANC.

rural countryside.⁴²⁷ In his message to Congress in 1944, Grau appeared to have adopted the reformers' goals. He argued, "The modernization (*tecnificación*) of the Ministry of Health and Social Assistance should begin with the transformation of the Local Sanitation Departments into true health units or centers."⁴²⁸

Despite these physicians' valiant efforts and Grau's promise to make the health ministry technical, little substantive reform occurred. Grau strategically deployed the name "*unidad sanitaria*" when, at the urging of the Ministry of Agriculture, he established nine rural health units in 1946 (at Guane, Bauta, Cardenas, Colón, Sagua la Grande, Sancti Spíritus, Ciego de Ávila, Holguín, and Guantánamo).⁴²⁹ A new Health Minister in 1947 promised to "modernize" the local sanitation departments, but it appears that any changes made, even into the 1950s, represented a transformation in name only (to "*unidad sanitaria*").⁴³⁰ From afar, the RF continued to lament that the health unit idea "did not seem to catch on in Cuba and that full-time health units were not expanded to other areas."⁴³¹ The net result was to exacerbate municipal unevenness. Chelala, for example, reported on the catastrophic state of the local sanitation department in Bayamo, while praising Havana's municipal sanitation department as resembling the ideal "modern Local Health Unit."⁴³²

⁴²⁷ Dr. Alberto Oteiza Setien, "Ministerio de Salubridad y Asistencia Social: Sus defectos," 81, leg. 21, no. 718, PRC-A, ANC.

⁴²⁸ Enrique Vignier and Guillermo Alonso, *La corrupción política administrativa en Cuba: 1944–1952* (Havana: Editorial de Ciencias Sociales, 1973), 43.

⁴²⁹ PJC diary entry, November 3–9, 1946, 86, F 2, B 3, S 420, RG 1.1, RF-RAC. The unit at Ciego de Ávila was featured in the first issue of the Bulletin of Public Works under Grau. "Hospital General y pequeños hospitales de Camagüey," *Boletín de Obras Públicas* 1, no. 1 (January 1946): 14. It is unclear if these health units were new or if they were simply restructured sanitation departments. Regardless, it seems that they did not gain the national renown that the Marianao Health Unit did.

⁴³⁰ "Modernizaran las Jefaturas de Salubridad," *Diario de la Marina*, January 12, 1947, 7; "Donde están las Unidades Sanitarias?" *Bohemia* 47 (July 24, 1955): 94.

⁴³¹ AJW to RBH, February 20, 1947, F 13, B 2, S 315, RG 1.1, RF-RAC.

⁴³² José Chelala Aguilera, "El Monumento Nacional de Bayamo," *Bohemia* 39, no. 3 (January 19, 1947), 20–22, 57–58; José Chelala Aguilera, "Veinticuatro horas en la vida de las Casas de Socorro," *Bohemia* 40 (December 26, 1948): 20.

Hospital admissions constituted a second subject that rankled physicians and citizens and catalyzed reform efforts. Patronage had long influenced the process of gaining access to free medical care at state hospitals. During the early republic, a lucky minority who had connections (through employers, for example) could ask their patrons to write letters to their cronies who ran hospitals and government health offices.⁴³³ For example, from 1935 to 1938, the Chief of Staff of the Presidency, Cristóbal Muñoz, penned letters from his official post to directors of various hospitals, requesting admittance for sick people that he knew directly or that friends had asked him to recommend. In June 1935, Muñoz wrote to Dr. Rufino Moreno, Director of La Esperanza Sanatorium, to request that he admit Vicente Falgueiras, the servant of Señor Rafael Pinetta (a friend of Muñoz). Pinetta could no longer allow the contagious Falgueiras to remain in his home. Later in the same month, Muñoz wrote again to Moreno to ask that he admit Teresa Ravelo y Machín to “oblige a good friend.”⁴³⁴ In several cases, there is archival evidence that Muñoz was successful, for he occasionally composed letters of appreciation to the hospital directors for their help.

Those without access to contacts in high places took to the hot, dusty streets, spending days in the crowded waiting rooms and chaotic halls of hospitals, going from one to another to beg for a bed. This was a “tragic odyssey,” an often-fruitless “pilgrimage” for many.⁴³⁵ After weeks and months of repeating the ritual, the only answer was to wait for the telegram that a

⁴³³ A number of these letters are held in the Secretaría de la Presidencia Fondo of the ANC. See, for example, leg. 17, no. 53; leg. 19, nos. 10, 30; leg. 34, nos. 20, 29; leg. 66, nos. 33, 76; leg. 67, no. 46; leg. 68, no. 34; leg. 71, no. 5; leg. 74, nos. 10, 23; leg. 75, nos. 18, 42; leg. 76, no. 32. Despite the limited number, time frame, and provenance of these letters, they still present a snapshot of how patronage operated in hospital admissions.

⁴³⁴ Cristóbal Muñoz to Rufino Moreno, May 22, 1935, leg. 18, no. 6, Fondo Secretaría de la Presidencia, ANC.

⁴³⁵ See, for example, “Triste odisea de una mujer que es abatida por el Mal de Koch,” *El País*, August 25, 1937, 8, leg. “Recortes de prensa,” expediente (exp.) “Maternidad e infancia,” 17/10/3/1-251, JCA, MHC; “Editorial,” *Bohemia* 29, no. 48 (November 28, 1937): n.p. Other accounts include “Hace falta un recio temple, para acometer el desempeño que exige cada cartera ministerial,” *Bohemia* 27, no. 22 (May 31, 1936): 41; “Editorial,” *Bohemia* 30, no. 30 (July 24, 1938): 38; Carlos E. Foment, “Los tuberculosos en los campos,” *Bohemia* 30, no. 42 (October 16, 1938): 16.

coveted spot had opened up at a state facility. The RF complained about this situation in the late 1930s, commenting, “Although Havana is well equipped with Tuberculosis Hospitals, it has not been possible to get any of these cases into an institution...[I]t seems necessary to have a recommendation from some official or influential political citizen to have a patient admitted.”⁴³⁶ The RF soon learned how to play the game, however. Although it had originally rejected the CNT’s request for nursing fellowships (probably because the request came from a military, not civilian, institution), in April 1939 Washburn reported that the MHU’s head nurse was training several nurses from the CNT in the tenets and practices of public health nursing.⁴³⁷ Not coincidentally, Washburn noted, “[P]atients referred by Dr. Nogueira to the Esperanza Hospital are now admitted.”⁴³⁸ In 1939, a total of 19 cases from the MHU were admitted to sanatorium. In the future, the MHU hoped to have a reserved two or three beds available to them monthly. By 1942, this “special arrangement” had been solidified, and the MHU had grafted itself into the CNT’s system of distributing sanatorium beds as favors.⁴³⁹ Rather than operating independently of politics, the RF ultimately succumbed to patronage practices.

The CNT had promised, however, that admissions would operate fairly, and specified the procedure for doing so.⁴⁴⁰ The CNT required a sick individual to visit a dispensary to be diagnosed, classified, and given a prognosis of whether the sanatorium cure was appropriate. Then the individual was to go to the headquarters of the CNT with paperwork from the dispensary to be put on a waiting list. The CNT alleged that no other factors, even severity of the case, would be considered. After obtaining the proper certification at the dispensary, the system

⁴³⁶ BEW diary entry, July 15, 1938, 5, B 493, RG 12, RF-RAC.

⁴³⁷ BEW to WAS, April 14, 1939, 1, F 12, B 2, S 315, RG 1.1, RF-RAC.

⁴³⁸ BEW diary entry, April 4, 1939, 1, B 493, RG 12, RF-RAC.

⁴³⁹ RBH, “Semi-Annual Report,” June 1942, 7, F 2013, B 165, S 420, RG 5.3, RF-RAC.

⁴⁴⁰ “¿Qué se necesita para que un tuberculoso, residente en la Habana, ingrese en el Hospital-Sanatorio?” *Suplemento a la Revista de Tuberculosis* 1, no. 3 (July 1937): n.p.

operated on a strict first-come, first-serve basis.⁴⁴¹ In practice, however, an informal system of bed distribution existed, in which decisions were less technical. In 1941, at a meeting of CNT-employed tuberculosis specialists, a physician in the audience commented that one of the most pressing problems for dispensaries was that “private action” interfered in the process of sanatorium admission.⁴⁴²

Juan Castillo, a CNT insider, envisioned a different system, one in which medical classification would reign. As a dispensary director, he pushed for admissions procedures to be transferred from the CNT central administration to a committee composed of CNT dispensary and hospital directors. The former distributed beds with little regard for patients’ clinical history; therefore, patients in an advanced state of the disease, for whom surgery and medical treatments could do little good, overran facilities.⁴⁴³ Castillo estimated that approximately 75% of patients in CNT institutions presented such advanced cases of the disease that they were essentially incurable. He noted that some had been admitted without ever having been diagnosed at a state dispensary, and he suspected many of them suffered from something other than tuberculosis.⁴⁴⁴ In articles in the *Revista Cubana de Tuberculosis*, he insisted that the social and clinical history of each patient, determined locally at the dispensary, should determine admission; no other factors should intervene. Castillo argued that this approach was “[s]o logical” and “so evident...that it is not contested or supplanted in any anti-tuberculosis organization in the world,

⁴⁴¹ Ibid.

⁴⁴² Alberto Sánchez de Fuentes and Julio Morera Carbonell, “Aspecto médico-social de la población tuberculosa del Dispensario ‘JL Jacobsen’,” *Revista de Tuberculosis* 5, nos. 1–4 (1941): 72.

⁴⁴³ Gustavo Aldereguía, “Mi visita al Sanatorio Hospital Ambrosio Grillo,” in *Revolución y tuberculosis*, 61–62.

⁴⁴⁴ Juan J. Castillo, “Concepto, organización, funciones y resultados de los dispensarios del ‘Consejo Nacional de Tuberculosis’,” *Revista Cubana de Tuberculosis* 8, no. 1 (January–March 1944): 48.

except in Cuba.”⁴⁴⁵ Castillo also confirmed the “traditionalism” of “political interference” in the admissions process.⁴⁴⁶

On a surprise investigative visit to La Esperanza Sanatorium in 1948, José Chelala Aguilera asked Director Francisco Núñez Llanes if he, the directors of dispensaries, or any other physicians played a role in admitting patients to the hospital. Núñez Llanes answered that he only communicated to the CNT the number of vacancies at the hospital and then the latter “ordered admittances.”⁴⁴⁷ Chelala then asked Núñez Llanes to comment upon the common understanding that in most public hospitals political influence was necessary for admittance; he followed this question with a particular rumor about La Esperanza:

The issue I want to investigate is even more serious. Based on the information that I have, the beds of the Sanatorium are divided into three parts: one part is at the disposal of the Ministry of Health and Social Assistance, another part is at the disposition of the First Lady of the Republic, Sra. Paulina Alsina...and a third part is at the disposition of the Consejo Nacional. And only these people can authorize an entry or not.⁴⁴⁸

Surely aware of his coveted public post, Núñez Llanes diplomatically repeated his answer to the previous question, perhaps feigning ignorance of the mechanics of admission. In his published report, Chelala confirmed the existence at the sanatorium of two supervisors who “did nothing more than fulfill the orders of the people from above who control the beds of La Esperanza Sanatorium.”⁴⁴⁹ Other reports corroborated the existence of these two functionaries.⁴⁵⁰

One former patient and activist reported on the influence of patronage at the hospital. Rosa Hilda Zell penned, “Remember that whoever obtains a bed in the Sanatorium proves, with

⁴⁴⁵ Ibid.

⁴⁴⁶ Ibid.

⁴⁴⁷ José A Chelala, “Reportaje sobre ‘La Esperanza’: Una acusación contra el Consejo Nacional de Tuberculosis,” *Bohemia* 40, no. 17 (April 25, 1948): 66.

⁴⁴⁸ Ibid.

⁴⁴⁹ Ibid.

⁴⁵⁰ Rosa Hilda Zell, “En torno a una iniciativa de ‘Bohemia’,” *Bohemia* 40, no. 20 (May 16, 1948): 3.

this fact alone, to be a person with *influencias*.” She continued, “When a patient is set to have a thoracoplasty, and he does not desire to submit to the operation, he goes to his *influencias* so that, in place of an operation, he is injected with gold salts, or they leave him in absolute rest.”⁴⁵¹ Based on the science of the time, serious cases that required surgery or intensive treatment were to be sent to a hospital, such as Lebrede, while those who had less grave cases and required less intensive therapy such as the rest cure were to be sent to the more comfortable and private cottages of La Esperanza Sanatorium. Nonetheless, connections, not medical diagnosis, dictated the categorization and placement of patients. Zell observed, “Those who have *influencias* are in the *casetas*....those who do not have, or have fewer, influences, although they come ‘almost’ healthy, go to the rooms of Lebrede.”⁴⁵²

A new form of patronage had developed by the mid-1940s, one that reflected the populist politics at the time. In columns in *Bohemia* and *Prensa Libre*, journalist Guido García Inclán provided a medium to link the masses who did not have political connections to potential patrons in the government. For example, in April 1944, a woman from Chaparra wrote to García Inclán about her two young daughters. They were unable to walk, with a vaguely identified “sickness...in the spine.” The woman begged “the First Lady of the Republic, Sra. Elisa Godínez de Batista, [to] please admit her two children to the Children’s Tuberculosis Hospital.” García Inclán seemed optimistic because he knew that the President of the Republic “regularly rea[d] this section” and hopefully would “pass on this plea to his wife.”⁴⁵³ In 1945, another woman wrote from her bed in a rickety shack in remote Calimete, asking to be admitted to La Esperanza. She had already written a letter to the First Lady of the Republic (Grau’s sister-in-law), who had

⁴⁵¹ Ibid.

⁴⁵² Ibid.

⁴⁵³ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 36, no. 16 (April 16, 1944): 42.

“offered to let [her] know when there was a vacant bed.”⁴⁵⁴ The woman had become desperate, writing to García Inclán: “Remote hope! The days pass....and I am dying!”⁴⁵⁵

For certain cases, this strategy worked. In May 1946, García Inclán reported that CNT Director Bartolomé Selva León had read his column about a sick man and arranged his entrance to La Esperanza, for he “strives to please the poor.”⁴⁵⁶ Health officials seemed to respond to the more heart-wrenching cases. In September 1946, Selva León responded again, this time for a young child who needed to be admitted to Aballí Sanatorium.⁴⁵⁷ The columnist penned, “Our profound thanks to Dr. Selva León...who...fulfill[s] each need, without political influence mattering.”⁴⁵⁸ In 1949, the director of the CNT under President Prío, Santiago Rodríguez, heard about two stories published in *Bohemia*. He sent “two urgent telegrams” to the paper, advising them that he had admitted “the little girl” to Aballí and another individual to La Esperanza.⁴⁵⁹ García Inclán summarized, “When the rulers are attentive to the beat of the fourth estate [the press], the citizen feels more protected.”⁴⁶⁰ However, for many others letter writers, officials high in the government never responded to them or García Inclán did not publish their pleas. This was not an ideal or efficient way to secure hospital admission. García Inclán himself admitted as much, writing, “They do not know what to do! Without political influence, without

⁴⁵⁴ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 37, no. 36 (September 9, 1945): 26.

⁴⁵⁵ Ibid.

⁴⁵⁶ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 38 (May 5, 1946): 26; Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 28 (May 19, 1946): 26.

⁴⁵⁷ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 38 (September 29, 1946): 26.

⁴⁵⁸ Ibid.

⁴⁵⁹ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 41 (November 6, 1949): 120; Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 41 (November 20, 1949): 120.

⁴⁶⁰ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 41 (November 20, 1949): 120.

leverage...the poor, they turn to me, as a last resort.”⁴⁶¹ This process satisfied neither the sick nor physicians.⁴⁶²

Citizen discontent over patronage in the CNT only worsened in the late 1940s, exacerbated by the increase in corruption under the Auténticos. Beyond hospital admissions problems, one major theme in denunciations of the CNT centered on the issue of incompetent or “dirty” administrators. Their internecine battles served as entertaining fodder for political magazines, but they were also worrying signs of the time.⁴⁶³ CNT Director Selva León stood at the center of a maelstrom of highly public struggles over credits and jobs. From the beginning of his tenure, critics were quick to point out that he was not a tuberculosis specialist, but instead was a political appointee. Newspapers alleged that he increased his own personal fortune by accumulating surpluses that were supposed to go to personnel who were fired or resigned and by charging a 20% commission to suppliers, which he then skimmed off the top. He also stood accused of placing a variety of people from his kinship network into positions in the CNT.⁴⁶⁴ The latter resulted in a ministerial resolution cancelling these commissions in 1948.⁴⁶⁵

Exposés about *botelleros*—physicians who were paid full salaries to occupy a post for which they never did any work—were particularly inflammatory, and the public’s awareness of

⁴⁶¹ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 38 (May 23, 1946): 26.

⁴⁶² On the other hand, two scholars have argued, “Patronage is a suboptimal way to allocate health care access, but it may have benefited the Cuban poor more than the obvious alternative mechanism, ability to pay.” James W. McGuire and Laura B. Frankel, “Mortality Decline in Cuba, 1900–1959: Patterns, Comparisons, and Causes,” *Latin American Research Review* 40, no. 2 (2005): 109.

⁴⁶³ See, for example, “En Cuba: Incidente,” *Bohemia* 38, no. 26 (June 30, 1946): 38; Gustavo Aldereguía, “Polémica: Sobre la tuberculosis en Oriente,” 39, no. 11 (March 16, 1947): 20, 39, 65–66; “En Cuba: Salubridad: Ni pediatra ni tisiólogo,” *Bohemia* 40, no. 31 (August 1, 1948): 55–56; “En Cuba: Salubridad: Ni Salubridad ni Asistencia Social,” *Bohemia* (October 1948): 46–47; “En Cuba: Salubridad: ‘Espera a que te boten...’,” *Bohemia* 40, no. 49 (December 5, 1948): 62–63. In Selva León’s memoirs, he decried, “My primary and most painful problems were those created by the Havana press.” Bartolomé Selva León, *Memorias de un viejo médico* (Miami: Ediciones Selle, 1981), 122.

⁴⁶⁴ There is archival evidence that when the Auténticos first came to power, those who kept their positions or were promoted at La Esperanza were “Auténtico 100 X 100.” “Relación en orden alfabético del personal de plantilla del Hospital-Sanatorio ‘La Esperanza’ (copia),” leg. 27, no. 1041, PRC-A, ANC.

⁴⁶⁵ “En Cuba: Salubridad: ‘Espera,’ 62–63.

botellas increased under the Auténticos. Selva León leveraged the pejorative nature of the term to allege that one legitimately employed scientist had been a *botellero* of the CNT under Batista. He then revoked his funding and created a new allergy department within the CNT.⁴⁶⁶ At the Pilar San Martín Sanatorium in Pinar del Río, regional papers published observations of malfeasance at the facility. A local paper reported that even before tubercular patients were housed at the facilities, one hundred people were on the payroll. Six months after new patients had been transferred from other hospitals, only forty of those one hundred employees actually worked at the facility.⁴⁶⁷ This was not simply mismanagement but a “cruel deceit.”⁴⁶⁸

Following Batista’s coup and the overthrow of the Auténticos, these issues receded from the public spotlight, but they continued to simmer beneath the surface. Citizens were well aware that patronage and corruption were widespread in the health sector. Whether hand delivered to a sanatorium director or published for a national audience, the practice of using letters and political connections to enter a hospital carried on through the end of the republican period.⁴⁶⁹ Decades later, citizens would remember the politics of admittance as a key characteristic of the late republic. “Of course it’s true,” one woman recalled, “that...during Batista’s rule, there were not hospital beds available, and my father had to talk with a politician he’d voted for before he could get my brother into the Calixto García Hospital.”⁴⁷⁰

⁴⁶⁶ Juan Govea, “La triste y gloriosa historia del ‘botellero’ del Consejo Nacional de Tuberculosis,” *Bohemia* 38, no. 1 (April 7, 1946): 52, 66.

⁴⁶⁷ Efraín Martínez Andreu, *Extra del Lunes*, November 27, 1950, cited in Milagros Fernández Vera, Olga Alarcón Ulloa y Jesús R. Contreras Cué, “Apuntes históricos de la Salud Pública en Pinar del Río (1819–1958),” *Cuadernos de Historia de la Salud Pública* no. 77 (1992): 95.

⁴⁶⁸ *Ibid.*, 94. The problems of the Pinar del Río Sanatorium were also fodder for the national press. See, for example, “En Cuba: Salubridad: Galimatías sanitario,” *Bohemia* 40, no. 29 (July 18, 1948): 60.

⁴⁶⁹ See, for example, Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 49 (April 7, 1957): 118; Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 49 (August 18, 1957): 118.

⁴⁷⁰ Oscar Lewis, Ruth Lewis, and Susan Rigdon, *Four Women: Living the Revolution* (Chicago: University of Illinois Press, 1977), 245. This team conducted interviews from 1969–70.

Health units in the structure and style of the Marianao Health Unit also remained an unrealized goal. By the late 1950s, physicians were still calling for the modernization of sanitation departments.⁴⁷¹ Pedro Nogueira, who had been promoted to Director of Health under Grau, reflected years later that although “there was an attempt to reproduce this type of unit in all the country...the circumstances that prevailed in health care at the time relegated it to a utopian plane.”⁴⁷² Many Cubans continued to live in what medical anthropologist Paul Farmer has termed “public health deserts”; the presence of the Marianao Health Unit only served to heighten that fact.⁴⁷³

4.3 CONCLUSION

By the 1930s, patronage had come to undergird the operation of the health sector, the CNT, and the admissions offices of hospitals. Unsatisfied with this, Cubans pushed for a constitutional provision to make the health sector technical; they also spearheaded domestic initiatives and partnered with international agencies to make this law a reality. Despite the efforts of this dedicated and diverse group of physicians and civic actors, by the end of the 1950s, the health sector had not been modernized. Merit and training often did not determine health posts, nor did medical diagnosis or a waiting list transparently govern admission to state hospitals. The publicized tenure and exit of the RF had national importance, not primarily for its disease control

⁴⁷¹ “Donde están las Unidades Sanitarias?” 94.

⁴⁷² Silvia Martínez Calvo, “El Doctor Pedro Nogueira Rivero: Un salubrista cubano,” *Revista Cubana de Salud Pública* 30, no. 2 (April–June 2004).

⁴⁷³ Paul Farmer, “Who Lives and Who Dies? The Most Important Lessons from Decades of Global Health Care,” *Slate*, March 15, 2015, accessed April 1, 2015, http://www.slate.com/articles/health_and_science/medical_examiner/2015/03/global_public_health_development_goals_paul_farmer_on_who_lives_and_who.single.html.

efforts but because it highlighted the politicized nature of the Cuban public health sector, especially its deeply rooted problem of patronage. By the end of Batista's dictatorship, this had become one more issue on which the government had failed in citizens' eyes.

The vision of a modern health sector and the importance of reforming local health departments informed the health policy of the revolutionary government. In 1960, the Ministry of Public Health integrated multiple municipal health organizations (like the *casas de socorro*, sanitation departments, and various dispensaries) into one local health unit, called *unidades sanitarias* (like the Marianao Health Unit).⁴⁷⁴ MINSAP called these bodies "the cornerstone of the public health work of the Cuban Revolution."⁴⁷⁵ While governmental administrators might have been ignorant of the fact that what they called "perhaps the most characteristic innovation" in public health had already been tried at the MHU (an American-Cuban partnership), Nogueira boldly asserted decades later that the Marianao Health Unit "had been the first center in which the problems of the health of the community had been analyzed."⁴⁷⁶

During the Second Republic, the influence of politics in state health care, a lightning rod of national debate, was not limited to the issue of patronage. Chapter 5 examines the story of the Topes de Collantes National Sanatorium, one of Batista's most important health projects and a cogent example of how the prioritization of political objectives hindered the achievement of public health goals.

⁴⁷⁴ José Ramón Ruíz Hernández, *La Salud Pública: Su desarrollo en el periodo revolucionario (1959–1980)* (Havana: Instituto de Desarrollo de la Salud, Ministerio de Salud Pública, 1985), 39.

⁴⁷⁵ Cuba, Ministerio de Salud Pública, *Subdesarrollo económico, principal enemigo de la salud: Como combate la revolución cubano* (Havana: Departamento de Relaciones Públicas, Dirección de Docencia y Divulgación, 1960), 2.

⁴⁷⁶ Ibid.; Martínez Calvo, "El Doctor Pedro." More research is needed to understand how the revolutionary government dealt with patronage. One historian has suggested that the revolution's political culture, "despite radical departures, refused to move beyond traditional logics and networks of patronage." Alejandro de la Fuente, "La Ventolera: Ruptures, Persistence and the Historiography of the Cuban Revolution," (paper presented at the conference on "New Histories of the Cuban Revolution," Yale University, October 3–4, 2014).

5.0 “A TEMPLE OF HEALTH”: THE TOPES DE COLLANTES NATIONAL SANATORIUM PROJECT, 1936–1964

In January 1937, high in the mountains of central Cuba, a delegation of military and civilian authorities gathered.⁴⁷⁷ After being greeted at the train station by “a large audience, in which all the social classes were represented,” Fulgencio Batista and other Cuban officials inspected the site he had recently chosen for the construction of Cuba’s first modern, high-altitude tuberculosis sanatorium. As cool breezes flowed through the pine and eucalyptus trees, he declared to a reporter that in “these rugged mountains...the best Sanatorium in the Americas will rise.”⁴⁷⁸

Almost twenty years later, in 1955, *Washington Post* columnist Drew Pearson arrived at the sanatorium, after making the steep and winding drive through the mountain range. As he climbed out of the car, he was struck by the grandiosity of the edifice, which Batista had recently inaugurated. After a tour, he concluded, “The sanitarium was modern and beautiful. It had the latest American equipment, from operating rooms to laundries.”⁴⁷⁹ One of Batista’s most publicized projects, the Topes de Collantes Sanatorium was described as “the miracle on the mountain” by its admirers.⁴⁸⁰ Its pleasing aesthetics and “unexcelled construction,” however,

⁴⁷⁷ An earlier version of this chapter was originally published as Kelly Urban, “Plagued by Politics: Cuba’s National Sanatorium Project, 1936–1959,” *Bulletin of the History of Medicine* 91, no. 4 (Winter 2017).

⁴⁷⁸ “Laredo-Brú y Batista en Topes de Collantes,” *El Ejército Constitucional: Revista oficial* 2, no. 13 (January 1937): 14.

⁴⁷⁹ Drew Pearson, “Batista Proves He’s Still Popular,” *Washington Post*, September 17, 1955, 43.

⁴⁸⁰ “Fórum cubano,” September 1996, 22, Box 3, Fulgencio Rubén Batista Papers, 1933–2007 (FRB Papers), Cuban Heritage Collection, University of Miami (CHC-UM).

were not the hospital's most salient characteristics.⁴⁸¹ As Pearson noted: "Its significance was the part it played in Cuban politics."⁴⁸² Labeled by detractors as the "whim of a dictator," the contested history of the sanatorium illustrates how tuberculosis control operated in republican Cuba, a parable of health care under authoritarian populism.⁴⁸³

From its conceptualization in 1936 to its closing and repurposing in the early 1960s, the Topes de Collantes Sanatorium revealed a contradiction of how politics and health concerns intersected in Cuba. Batista governed as an authoritarian populist: appeasing the popular classes guided his decision to prioritize tuberculosis (and the authoritarian nature of his rule allowed him to freely dedicate resources to the disease); in contrast, advocates struggled to gain state attention to fight tuberculosis in many other countries. However, authoritarianism also made it possible for Batista to exercise undue influence over the conception and implementation of the project. Batista had filled the CNT's governing board with appointees, many of who were military men, deferential to his opinions. To the dismay of a number of technocrats who proffered scientific advice, the CNT followed a political and propagandistic logic in designing the hospital project. As a result, the sanatorium was inefficient, plagued by logistical setbacks, and especially vulnerable to changes in political leadership. As Frank Snowden has argued for Mussolini, fascism, and malaria in Italy, Batista was able to "pursu[e] political objectives," which "led to heavy costs in the field of public health."⁴⁸⁴ In short, even though tuberculosis was taken seriously in Cuba, politics undermined efforts to control the disease.

⁴⁸¹ "A Dream that Has Become a Reality," *Gente de la Semana*, January 5, 1958, 51, Box 1, FRB Papers, CHC-UM.

⁴⁸² Pearson, "Batista Proves," 43.

⁴⁸³ "Los centros de atracción turística: Trinidad," *Bohemia* 54, no. 2 (January 14, 1962): 111.

⁴⁸⁴ Frank Snowden, *The Conquest of Malaria: Italy, 1900–1962* (New Haven: Yale University Press, 2006), 177, 179.

The Topes de Collantes Sanatorium represented another major public health endeavor of the republican period; however, similar to the RF's effort to remove patronage from the public health sector and reform local health units, the sanatorium fell victim to politics and became a highly visible marker of the failures of the republican state, most notably its inefficiency and corruption. In the late 1930s, the public widely approved of the sanatorium. By the 1950s, however, after years of watching a string of governmental administrations mismanage the project, citizens reacted to its inauguration in late 1954 with mixed opinions. After 1959, the revolutionary government repurposed the facility, but its salience in national politics (and also, by this point, in the politics of the exile community) endured, as opposed political factions continued to wield the sanatorium as a symbol of health care in the republic.

5.1 CONTESTED CONSTRUCTION

From its founding in 1936, the CNT made the Topes de Collantes Sanatorium its premiere project. One of the provisions of the law that created the CNT stipulated that the "first funds that the National Tuberculosis Council collects will be dedicated to the construction of a sanatorium in the hills of Trinidad."⁴⁸⁵ It occupied the largest line item in the organization's budget, it filled the pages of popular and state publications, and it held a central place in Batista's presidential campaign literature. One military publication identified the sanatorium as "the most definitive step in eradicating the deadly white plague from Cuba."⁴⁸⁶ Batista envisioned that the sanatorium

⁴⁸⁵ "Se ha instituido el Consejo Nacional de Tuberculosis a fin de combatir esa dolencia," *Diario de la Marina*, March 25, 1936, 3; "Decreto-Ley no. 706," *Gaceta Oficial*, March 31, 1936, 13.

⁴⁸⁶ "La lucha contra la peste blanca," *El Ejército Constitucional: Revista oficial* 2, no. 15 (March 1937): 12.

would be concrete evidence of his state-building project and of his concern for the health of the poor.

Popular demands and physician recommendations shaped Batista's decision to make the sanatorium a cornerstone of the anti-tuberculosis campaign. In a context of populism, the expectations of the masses could not be ignored. Editorial after editorial in the mid- to late-1930s called for more beds, specifically in sanatoriums.⁴⁸⁷ One article in *Bohemia* described "the pilgrimage of tuberculosis sufferers, who do not have sanatoriums in which they are received."⁴⁸⁸ *El País* featured the "sad odyssey of a women crushed by the 'illness of Koch'." She pursued a "tragic pilgrimage from hospital to hospital without resources, with no relief from the terrible disease."⁴⁸⁹ The repeated use of the word "pilgrimage" by journalists to describe the plight of those with the disease in Cuba suggested that the search for a bed was a ritual shared by many, recurring over the course of many days, months, and even years.

Physicians also influenced Batista to prioritize the construction of sanatoriums over other disease-control methods. Although a minority of medical professionals supported other models of disease control (such as prevention and home care), the majority of Cuban physicians, and especially those employed in the state health bureaucracy, endorsed a tuberculosis program that centered on isolation and/or cure through sanatorium beds.⁴⁹⁰ As discussed in Chapter 3, Cuban

⁴⁸⁷ "Hace falta un recio temple, para acometer el desempeño que exige cada cartera ministerial," *Bohemia* 27, no. 22 (May 31, 1936): 41; "Editorial," *Bohemia* 30, no. 30 (July 24, 1938): 38; Carlos E. Foment, "Los tuberculosos en los campos," *Bohemia* 30, no. 42 (October 16, 1938): 16.

⁴⁸⁸ "Editorial," *Bohemia* 29, no. 48 (November 28, 1937): n.p.

⁴⁸⁹ "Triste odisea de una mujer que es abatida por el Mal de Koch," *El País*, August 25, 1937, 8, leg. "Recortes de prensa," expediente (exp.) "Maternidad e infancia," 17/10/3/1-251, Fondo José Chelala Aguilera (JCA), Museo Histórico de las Ciencias "Carlos J. Finlay" (MHC).

⁴⁹⁰ Antonio Penichet, "La tuberculosis y Dr. Aldereguía," *Bohemia* 27, no. 3 (January 20, 1935): 66; Foreign Policy Association, Commission on Cuban Affairs, *Problems of the New Cuba: Report of the Commission on Cuban Affairs* (New York: Foreign Policy Association, 1935), 110–11.

tuberculosis specialists declared that the CNT needed to dedicate 4,000 beds to tuberculosis treatment.

Batista and his appointees on the CNT Board of Governors (Consejo Superior de Tuberculosis) determined the specific manner in which tuberculosis beds would be provided. This Board acted as an authoritarian, top-down policy-making apparatus, impervious to pressures from technocrats. The concentration of policy-making power in this board was intentional: as seen in Chapter 3, Batista pushed through the legislation of the CNT, which determined the governing board's composition, during an interim period of government. It was a moment when the militarization of social services faced no serious opposition as Congress was not in session and civilian leadership was in transition.⁴⁹¹ The Board was composed not of tuberculosis experts, but of individuals that Batista had approved. The eight members were the Public Prosecutor of the Supreme Court, a senior official of the Army, a professor at the University of Havana, the Director of Public Health, and one representative from the College of Architects, the National Red Cross, the Economic Society of Friends of the Country, and the Medical Services of the National Police.⁴⁹²

Medical professionals expressed concern about the CNT's failure to include a sufficient number of tuberculosis specialists on its governing board. The initial composition of the CNT administration was telling: the police and military were overrepresented and the University of Havana representative did not have to be a specialist on tuberculosis. Even though the university appointee was Dr. Oscar Jaime, a long-standing member of the Cuban Anti-Tuberculosis League

⁴⁹¹ Frank Argote-Freyre, *Fulgencio Batista: From Revolutionary to Strongman* (New Brunswick, NJ: Rutgers University Press, 2006), 202.

⁴⁹² "Decreto-Ley no. 706," 13; "Miembros del ejército y de la Cruz Roja Nacional, dirigirán los destinos del Consejo Nacional de Tuberculosis," *Diario de la Marina*, April 8, 1936, 18; Demetrio E. Despaigne and Arturo Andrial Colas, *Desarrollo y evolución de la lucha antituberculosa en Cuba* (Havana: Carasa, 1940), 27; Demetrio E. Despaigne, *La lucha contra la tuberculosis en Cuba* (Havana, 1944), 33–35.

and director of its dispensary, the medical community did not believe this to be sufficient. The editors of the underground journal of the recently outlawed Cuban Medical Federation wrote, “[I]t would have been just and of great utility to have formed this Council with physicians trained in tuberculosis and directors or officers of the diverse sanatoriums and anti-tuberculosis dispensaries since they are the ones who through their scientific and technical capacity and through their experience with the problems that the organization is going to tackle...can rapidly support and contribute...to the quickest organization of this center that is so necessary in our country.”⁴⁹³ Although more tuberculosis specialists were added to a technical subcommittee of the CNT after a few months, the structure of the governing board (whose president was appointed by Batista) facilitated loyalty and deference to Batista’s public health plans.

Professional groups had been writing extensively about the ideal size, architecture and geographical distribution of sanatoriums in the years preceding the foundation of the CNT, and they continued to do so after March 1936. Following a global trend, Cuban medical professionals insisted that what was of paramount importance was providing as many beds as possible as quickly as possible, which determined the particular specifications of sanatoriums and hospitals. For these facilities, the architecture needed to be simple and their physical size small (200 to 400 beds) to allow for rapid construction and inauguration. Also, they needed to be located close to centers of population, so as to make movement of construction materials, access to medical professionals, and the travel of patients—many of whom were poor—as convenient as possible.⁴⁹⁴ In sum, the majority of Cuban physicians urged the following schema: a small,

⁴⁹³ “Informaciones médicas,” *Medicina de Hoy* 1, no. 3 (April 1936): 103.

⁴⁹⁴ Luis P. Romaguera, “Sanatorio para tuberculosos: Un estudio sobre esta materia de tanta importancia en una campaña contra la tuberculosis,” *Revista de Medicina y Cirugía de la Habana* (1937): 571.

simple sanatorium near every provincial capital (or, alternatively, specialized tuberculosis wards in existing provincial hospitals).⁴⁹⁵

The Board of Governors, however, ignored this corpus of knowledge produced by medical professionals and pursued a project diametrically opposed to these treatises. In short, they were guided by political objectives that often were executed against technical, scientific, or medical advice.⁴⁹⁶ Batista mandated that the CNT's first project respond to the public rhetoric of a bed shortage: a massive facility for 1,000 patients, equipped with the best surgical equipment, displaying the most modern architecture, nestled in Cuba's Sierra del Escambray mountain range. Thus, when Batista's plans for a new national sanatorium became public knowledge, physicians began to write numerous editorials, published mainly in the medical press, in an attempt to critique and re-orient the fundamental bases of the project.

While the therapeutic effectiveness of the local climate at Topes de Collantes was not a subject of debate, its location in terms of topography and proximity to a large population center raised considerable concern. Topes de Collantes was closest to the municipality of Trinidad, but Cienfuegos, Sancti Spíritus, or Santa Clara, all with double or triple the population of Trinidad, would have been more appropriate. Furthermore, there was no highway or railway in the mountains to connect to the existing transportation system. Luís Romaguera argued in 1937 that the most important factor for any sanatorium was its accessibility to a population center, so that

⁴⁹⁵ Juan J. Castillo, "Males y remedios que reclaman inmediatamente una reorganización y mejoramiento de nuestras instituciones antituberculosas," in *Dos años de trabajo contra la tuberculosis efectuados en el Dispensario "Furbush,"* ed. Secretaría de Sanidad y Beneficencia (Havana: Arellano y Cía., 1936); Dr. Ramón V. Tormo, "El neumotórax artificial en nuestro medio dispensarial," *Revista de Tuberculosis* 5, nos. 1–4 (1941): 226; Romaguera, "Sanatorio para tuberculosos," 570; Alfredo Vivar Antonetti, "Lesson 29," *Lecciones de tuberculosis* ([Havana?], [1937?]), 1–3; "¿Topes de Collantes sirve para curar tuberculosos?" *Bohemia* 45, no. 18 (May 3, 1953): 23–24.

⁴⁹⁶ Scholars may critique the simplified dichotomization of scientific/technical/medical knowledge and politics, for these factors are all mutually constitutive. However, for Cubans in this period, this distinction between technical knowledge and politics was a very important one, as they continually struggled to reform politicized, "archaic" health structures into modern units that were run based on technical knowledge.

patients, their families and medical personnel could easily access the facilities.⁴⁹⁷ He advised that the CNT consider building sanatoriums that were in the plains (*sanatorio de llanura*) instead of mountains (*sanatorio de altura*) since all population centers in Cuba were located in the former.⁴⁹⁸ The professor occupying the University of Havana's Tuberculosis Chair, arguably one of the most relevant figures with whom the state should have consulted, Dr. Alfredo Antonetti, found himself shut out of the CNT's original deliberations because of the estrangement between Batista and the university. Nonetheless, he publicly opposed the project, concurring with the call for sanatoriums on the outskirts of each provincial capital.⁴⁹⁹

Doctors also expressed serious concern about the size and grandiosity of the sanatorium design. One physician estimated that the anti-tuberculosis campaign, if effectively carried out, would last at most twenty or twenty-five years; therefore, the sanatoriums and hospitals constructed for tuberculosis treatment should be cheap and plentiful, not made to last longer than that period.⁵⁰⁰ These physicians based their recommendations on programs in other countries that were not economically wealthy and that championed a decentralized network of sanatoriums instead of large centralized institutions.⁵⁰¹ "We will start by saying as has been said before that we are enemies of large sanatoriums with capacities for hundreds of sick," Romaguera opined, "logical near N.Y. or Chicago, where the land is expensive, but incomprehensible in Cuba where the land is not valuable and there are small centers of population."⁵⁰² After visiting several mid-western American states to tour their facilities, Romaguera concluded, "[W]e understand that in Cuba they should not return to building establishments similar to La Esperanza Sanatorium with

⁴⁹⁷ Romaguera, "Sanatorio para tuberculosos," 572.

⁴⁹⁸ Ibid., 576.

⁴⁹⁹ "¿Topes de Collantes sirve?" 23–24.

⁵⁰⁰ Francisco Núñez Llanes, "Algunas consideraciones sobre la lucha antituberculosa," *Medicina de Hoy* 1, no. 10 (November 1936): 473.

⁵⁰¹ Romaguera, "Sanatorio para tuberculosos," 571.

⁵⁰² Ibid., 596.

a capacity for 1,000 patients, whose difficulties of government, etc., are all known, but instead, on the contrary, they should be small sanatorium units of 100, 200 or 300 beds, as the Americans have done in Puerto Rico.”⁵⁰³

The CNT also disregarded the advice of architects, the other technocratic group involved in the initial planning process. The CNT announced a national design competition for the sanatorium to the College of Architects in Havana in 1936. As the deadline for turning in drafts and blueprints drew near, the members of the College met to discuss their concerns, where they decided it was necessary to send a letter to the president of the CNT’s Board of Governors, Dr. Maximiliano Smith, to request modification of the building design requirements (set by the CNT) that they found most worrisome. Echoing the doctors’ concerns, they proffered two central recommendations: (1) that the sanatorium be built at a lower altitude; and (2) that the sanatorium’s size be capped at 400 patients.

The first recommendation would allow the sanatorium to be constructed along a pre-existing highway between Trinidad and the mountains. As it stood, before the supplies for the sanatorium could even reach the construction site, a twenty-three-kilometer highway would have to be laid through the mountainous terrain of Las Villas province, a difficult task in and of itself. The second recommendation would ensure the sanatorium’s “efficient and economic service,” based on “what was advised in the whole world by specialists.”⁵⁰⁴ Using the standards of the American National Tuberculosis Association (which quantified factors such as accessibility, ease of construction, the psychological value of scenery, and protection from the north wind), the College of Architects gave the existing sanatorium plan a 40% acceptance mark and cautioned

⁵⁰³ Ibid., 572.

⁵⁰⁴ Joaquín A. Weiss, “Proyecto del sanatorio de tuberculosos en Trinidad,” *Arquitectura y Urbanismo* 5, no. 44 (March 1937): 10.

that a new site with a value above 75% should be found in order to avoid future complications and criticism.⁵⁰⁵ The CNT Board, however, denied the College's request to modify the stipulations of the sanatorium design.⁵⁰⁶

Even those professionals who were insiders at the CNT and formally represented in the sub-committee that was tasked with evaluating the technical bases of projects found their voices marginalized when they expressed worries or doubts about the specifications of the sanatorium. Within the first year of the CNT's existence, Juan J. Castillo had been drafted into the CNT's Technical-Administrative Board as the lead technical advisor (and one of three medical experts responsible for advising the Board of Governors).⁵⁰⁷ When he was called upon to enumerate the advantages and disadvantages of the Topes de Collantes project, he emphasized its high cost, the necessity of a new highway, the engineering difficulty of leveling the peak to pour the foundation, and its distance from population centers. These factors did not seem to sway Batista or his appointees on the CNT board, who disregarded the advice of their own lead expert. Castillo recalled that despite his counsel, the CNT proceeded to build the sanatorium, arguing that the law that founded the CNT also required that a sanatorium be built in Trinidad.

Castillo, who had risen to be an integral player in Batista's anti-tuberculosis campaign, was then given "the honor of drafting the medical bases of the sanatorium."⁵⁰⁸ Only a few months earlier, when he outlined his plan for national tuberculosis policy to the Secretary of Sanitation, Castillo explicitly rejected the appropriateness of large sanatoriums for the country. Considering Cuba's scant financial resources and the danger posed to society by the large number of contagious poor who were not hospitalized, Castillo believed that even small

⁵⁰⁵ Ibid., 11.

⁵⁰⁶ "Comité Ejecutivo," *Arquitectura y Urbanismo* 5, no. 46 (May 1937): 24.

⁵⁰⁷ Cuba, Ejército, *Ejército Constitucional de Cuba* (Havana: Ucar, García, y Cía., 1937), n.p.

⁵⁰⁸ "¿Topes de Collantes sirve?" 98.

provincial sanatoriums would be too costly and take too long to inaugurate, so he recommended specialized tuberculosis wings within existing hospitals.⁵⁰⁹ In 1936, however, he abruptly changed his position on large sanatoriums from less than a year earlier and published an article in the medical press that extolled the “fundamental medical bases” of the new sanatorium. He focused exclusively on the climatic justifications of the sanatorium, which were not disputed by medical professionals, without mentioning the drawbacks of its location and size.⁵¹⁰

One of the other physicians on the technical board, Dr. Joaquín Martos, also published his praise of the project, declaring it to be a “technical work.”⁵¹¹ Two months prior to his appointment to the board, he had been named as director of La Esperanza Sanatorium, replacing a politically ostracized administrator. Dr. Oscar Jaime, the university representative on the CNT and the third member of the technical committee, also did not criticize the plan, even though a year earlier he had told members of the Anti-Tuberculosis League that “[s]cience and charity do not need palaces nor expensive equipment.”⁵¹² All of these professionals held positions within the CNT bureaucracy in a period when physicians were politically repressed and experienced difficulty in securing jobs, and they probably had little freedom to express a dissenting view without professional repercussions.

That the CNT Board of Governors heeded none of the technocrats’ advice illustrates the top-down, inflexible nature of the campaign, which was undergirded by political imperatives over scientific tenets. While the technocrats were attuned to the consensus about “best practices” in their international communities of expertise, national and local politics followed another logic.

⁵⁰⁹ Castillo, “Males y remedios,” 61.

⁵¹⁰ Juan J. Castillo, “Bases médicas fundamentales que deben de orientar la construcción del Sanatorio Nacional para tuberculosos que se levantará en Trinidad,” *Medicina de Hoy* 1, no. 8 (September 1936): 319–22.

⁵¹¹ Joaquín Martos Vallhonrat, “Sanatorio: Funciones y organización,” *Revista de Tuberculosis* 1, no. 4 (1937): 539.

⁵¹² “Discurso del Dr. Oscar Jaime,” *Tuberculosis: Publicación científica mensual* 6, nos. 9–12 (1935): 71.

Batista was hoping to gain political capital through the CNT's endeavors, and nowhere was that more clear than in this hospital project: a monumental facility that served the masses, among which there existed strong demand for beds and a cure.

The CNT designed the sanatorium to inspire awe. The sanatorium was grandiose in its conceptualization and promised to be breathtaking in its implementation: constructed at a height of 800 meters above sea level, the structure was set to have eight floors and a basement. Each floor was to have a dining area, an artificial pneumothorax room, and dormitories. The sanatorium would boast a modern operating room; departments for dentistry, cardiology, and gastroenterology; offices for administration, management, and accounting; a complex heating system; a solarium on the roof; an X-ray department; and a library.⁵¹³

Political imperatives also influenced the region chosen for the sanatorium, for Batista picked a site that was popularly regarded as therapeutic for those suffering tuberculosis. As early as the 1890s, a renowned Cuban tuberculosis physician, applying global medical science that extolled the high-altitude cure, recommended the construction of a sanatorium in the Topes de Collantes region.⁵¹⁴ While doctors had come to believe by the 1930s that each climate type benefitted different types of tuberculosis, popular knowledge continued to insist that a high-altitude climate (which Topes de Collantes could provide) was unparalleled in its effectiveness in curing all forms of the disease.⁵¹⁵ Tellingly, Cuban companies often tried to sell tuberculosis

⁵¹³ Federico de Ibarzábal, *Lucha antituberculosa en Cuba* (Havana: Burgay y Cía, 1939), 19–20; Despaigne, *La lucha contra*, 228–29.

⁵¹⁴ John Gutiérrez, "Disease, Empire, and Modernity in the Caribbean: Tuberculosis in Cuba, 1899–1909" (PhD diss., The City University of New York, 2013), 126n30.

⁵¹⁵ Francisco Núñez Llanes, "Valor de la cura sanatorial en la tuberculosis pulmonar," *Revista Médica Cubana* 47 (1936): 1019; Luis Romaguera, "Programa médico-social contra la tuberculosis," *Revista Médica Cubana* 46 (1935): 847; Luis Romaguera, "Clima y tuberculosis," *Revista Médica Cubana* 48 (1937): 134–46; Osvaldo Valdés de la Paz, *La reconstrucción cubana realizada por Batista* (Havana: Talleres de Editorial Guerrero, 1940), 123.

tonics by using pictures of sanatoriums in the snowy Alps.⁵¹⁶ Erecting the sanatorium in a popularly esteemed location would secure public approval. Indeed, while doctors and architects criticized the project, it was initially well received in the press, as journalists detailed the curative properties of the mountain climate.⁵¹⁷ While nothing had been done in past years to exploit the region's climatic advantages, one reporter rejoiced that due to the "praiseworthy initiative of Colonel Batista," the government was finally doing so for the good of the Cuban nation.⁵¹⁸ The CNT's Director testified, "The construction of a tuberculosis sanatorium in Trinidad was always a national desire."⁵¹⁹

The CNT heavily publicized the selection of the particular site for the sanatorium, and it served as a performance of Batista's centrality to the project. In 1937, followed by a retinue of military men and his medical advisors, Batista trekked through the mountains on horseback to personally choose the land on which the hospital would be erected (see Figure 9). Photographs were taken of the journey and distributed to the press, along with stories of sensationalized danger and divine intervention as Batista pointed to the mountain peak upon which the sanatorium would be built.⁵²⁰

⁵¹⁶ See, for example, Jarabe Roche's advertisements in *Carteles* 25, no. 5 (February 2, 1936); *Carteles* 27, no. 27 (July 5, 1936); *Carteles* 27, no. 29 (July 19, 1936).

⁵¹⁷ "Carteleras," *Carteles* 26, no. 25 (June 21, 1936): 24; "Obsequiaron al Coronel Batista con una ambulancia modelo, que cedió a la Corporación Nacional de Tuberculosis," *Diario de la Marina*, April 15, 1936, 3.

⁵¹⁸ "Carteleras," 24.

⁵¹⁹ Despaigne, *La lucha contra la tuberculosis en Cuba*, 40.

⁵²⁰ Fulgencio Batista, "Inauguración del Sanatorio 'Topes de Collantes'," May 9, 1954, 5, Box 1, FRB Papers, CHC-UM.



Figure 9. Batista (left) on horseback with his retinue of military and medical men, crossing a river in the Escambray Mountains, on their 1937 journey to select a site for Topes de Collantes Sanatorium.⁵²¹

The CNT also advertised the sanatorium's progress, recognizing its value as propaganda. One military publication included articles on Topes de Collantes in almost every monthly issue.⁵²² Images, stories, and poems emphasized Batista's beneficence in providing medical interventions for many Cubans sick with the disease. Batista declared that this project was going to bring the "procedures of modern medical science" to the Cuban people, in a hospital that could rival the "most notable sanatoriums in Europe."⁵²³ One pamphlet from Batista's presidential campaign even went as far as to say that the hospital offered a "guarantee for the cure of tuberculosis."⁵²⁴ Part and parcel of Batista's plan to use the military to construct a new

⁵²¹ Box 1, FRB Papers, CHC-UM.

⁵²² See, for example, "El Sanatorio de Topes de Collantes," *El Ejército Constitucional: Revista oficial* 2, no. 17 (May 1937): 26; "El Sanatorio de Topes de Collantes," *El Ejército Constitucional: Revista oficial* 2, no. 18 (June 1937): 19; "Cómo será el Sanatorio de Topes de Collantes," *El Ejército Constitucional: Revista oficial* 2, no. 20 (August 1937): 7; "En marcha la obra de Topes de Collantes," *El Ejército Constitucional: Revista oficial* 2, no. 23 (November 1937): 30–35; "Topes de Collantes," *El Ejército Constitucional: Revista oficial* 3, no. 26 (February 1938): 31; "Topes de Collantes: Un gran sanatorio para tuberculosos," *El Ejército Constitucional: Revista oficial* 3, no. 27 (March 1938): 24.

⁵²³ "25 razones por que Batista será Presidente," 1940, 58, legajo (leg.) 5, expediente (no.) 231, Fondo Partido Revolucionario Cubano (Auténtico) (PRC-A), Archivo Nacional de la República de Cuba (ANC).

⁵²⁴ *Ibid.*

Cuba, the sanatorium being built in the “rugged mountains” represented an effort “to locate civilization among the virgin countryside.”⁵²⁵

Discussions about the sanatorium often became a forum for political contention. Topes de Collantes featured centrally in Batista’s 1940 bid for the presidency.⁵²⁶ When his opponent, Ramón Grau San Martín, accused Batista of building schools and hospitals for personal enrichment on the campaign trail, Batista retorted that Grau, who allegedly suffered from tuberculosis, travelled to Saranac, New York, for medical treatment. Batista maligned Grau’s action—seeking treatment in a foreign “millionaire’s clinic”—as an option only available to a select few.⁵²⁷ One journalist defended Batista’s hospital program, sardonically reporting that it seemed that “Dr. Grau believes that he [Batista] should have made tents for tuberculars” instead.⁵²⁸

In spite of warnings from bureaucratic insiders and outsiders, construction of the monumental structure—one journalist baptized it “the skyscraper of health”—proceeded when Batista symbolically laid the first brick on November 14, 1937.⁵²⁹ The CNT estimated that construction would last less than three years and that the sanatorium could be inaugurated in September 1940, with an approximate budget of one and a half million pesos.⁵³⁰ However, despite Batista’s support, the hospital’s construction moved sluggishly and easily passed the inauguration deadline. Foreign correspondents reported as early as 1939 that a “[l]ack of money has bogged down Batista’s three-year plan.” Only with “grim determination” was Batista “driving” the two projects most precious to him: rural education and the anti-tuberculosis

⁵²⁵ “Laredo-Brú y Batista,” 14.

⁵²⁶ See, for example, “25 razones,” 57, leg. 5, no. 231, PRC-A, ANC.

⁵²⁷ June 20, 1940, State Department Files.

⁵²⁸ Ibid.

⁵²⁹ Valdés de la Paz, *La reconstrucción cubana*, 122, 126.

⁵³⁰ Ibid., 123.

campaign, specifically, the “huge ultra-modern plant in the Trinidad mountains.”⁵³¹ Wartime economic contraction, which affected the movement and cost of construction materials in the western hemisphere, slowed the hospital’s progress.⁵³² Undoubtedly, this situation was made more difficult by the inaccessibility of the construction site in Cuba. Although historical evidence concerning the sanatorium in the early 1940s is sparse, it seems that the very factors that medical professionals predicted would cause construction difficulties and increase financial outlays did complicate the project’s progress.

Determining the status of the project in 1944, when a new presidential administration came to power, remains difficult, but photographic evidence and published reports point to the project being nearer to completion than the incoming administration tried to argue. According to Batista, the building was almost ready for inauguration in 1944, with even the “kitchen utensils” in place.⁵³³ Batista was possibly exaggerating the hospitals’ readiness, for his own CNT director reported in 1944 that 1,650,000 pesos had already been spent and that expenditures would reach three million pesos by the time the hospital was equipped and furnished.⁵³⁴ Photographs of the exterior of the sanatorium show a structure close to completion, so perhaps only the internal appliances and medical apparatuses had not yet been purchased (see Figure 10). Batista futilely rushed to finish the sanatorium in the month preceding Ramón Grau San Martín’s inauguration.⁵³⁵ Nonetheless, seven years after the first stone was laid on the facility and as a new ruling party came to power, the future of the Topes de Collantes Sanatorium remained far from certain.

⁵³¹ J.P. McEnvoy, “Not all Rum and Rumba,” *The Saturday Evening Post*, May 20, 1939, 81.

⁵³² José Manuel Cortina, Fulgencio Batista y Zaldívar, and Octavio Montoro, *Una historia en dos discursos y un artículo* (Havana: Editorial Echevarría, n.d.), 25.

⁵³³ Fulgencio Batista, *Piedras y leyes* (México: Imprenta M. León Sánchez, 1961), 119.

⁵³⁴ Despaigne, *La lucha contra*, 91.

⁵³⁵ “Esfuerzos para que terminen la carretera a Topes de Collantes antes de octubre 10,” *Acción*, September 10, 1944, 7.



Figure 10. By the early to mid-1940s, the exterior of the Topes de Collantes Sanatorium was close to completion.⁵³⁶

5.2 ABANDONMENT OF THE PROJECT

During the new administration's first months, Grau appointed Dr. Bartolomé Selva León as CNT Director and reoriented the national anti-tuberculosis campaign. The CNT announced it would build more dispensaries in smaller cities, and in lieu of "luxury" sanatoriums, it promised a small, simple tuberculosis sanatorium to every province. By the end of 1945, the CNT governing board had decided to stop construction on Topes de Collantes and was attempting to interest private companies in its purchase.⁵³⁷

The newly formulated strategy—more dispensaries and smaller provincial sanatoriums—had been the approach originally advocated by medical and technical advisers less than a decade

⁵³⁶ Bartolomé Selva León, *Un año de lucha antituberculosa en Cuba, 1944–1945* (Havana: Consejo Nacional de Tuberculosis, 1946), 320.

⁵³⁷ Selva León, *Un año de lucha*, 319.

before. Furthermore, many international and national experts continued to recommend that countries should build sanatoriums according to their national economic resources. Writing for a Cuban audience and drawing upon his experience with the large Santa María sanatorium in his own country, one highly respected Argentinian tuberculosis specialist summarized, “It is an error, then, in countries such as ours, in which there is not one-tenth of the beds for tuberculosis patients that would be necessary, to constantly demand...more expensive sanatoriums in the mountains.”⁵³⁸ This expert and others argued that financial considerations were more important than the therapeutic value of certain climates.

Despite the new strategy’s congruence with international standards, political objectives primarily influenced President Grau and Selva León’s decision to not finish the national sanatorium. The hospital was, after all, and without question, a Batista project, and Grau had been involved in bitter political battles with Batista since the early 1930s. The structure of the CNT, highly dependent on presidential approval and appointment, continued to allow the executive to exercise considerable influence over tuberculosis policy and to disregard public health advice. Medical professionals hired by the new administration who had expressed certain views under the Batista regime now changed their opinion to fall in line with the national executive’s strategy. Most strikingly, Selva León had once supported the Topes de Collantes project based on its climatological properties, exuberantly proclaiming that the sanatorium promised to be “one of the best in the Americas.”⁵³⁹ However, after Grau appointed Selva León as CNT Director, his support for the national sanatorium put him into conflict with other pro-

⁵³⁸ Gumersindo Sayago quoted in Gregorio Aráoz Alfaro, “El clima de las montañas está lejos de ser indispensable,” *Boletín de lucha antituberculosa* 1, no. 2 (July–August 1945): 9.

⁵³⁹ Antonio Penichet, “Cuba es una fábrica de tuberculosis,” *Bohemia* 37, no. 26 (July 1, 1945): 50.

Grau physicians.⁵⁴⁰ In the end, the pro-Grau faction overrode Selva León, claiming that the high altitude cure was not paramount and that with the amount of money it would take to finish the sanatorium, five other provincial sanatoriums could be constructed.⁵⁴¹

Divergent financial estimates across administrations also point to the influence of politics in the evaluation of health projects. While the previous administration had published much smaller figures, Selva León argued that an extraordinary 4.5 million pesos had already gone into the project (in comparison to Despaigne's 1.5 million estimate), and 2 million more would need to be expended before its opening.⁵⁴² According to Selva León, the sanatorium's price per bed had reached an "excessive amount of \$4,000"; in no other country had the "cost of construction...reached this amount per bed."⁵⁴³

The Grau administration finished other tuberculosis projects begun under Batista that had not been as heavily publicized and were not as closely associated with his rule. For instance, within a year of taking office, Grau's administration approved another 500,000-peso credit to complete the Ambrosio Grillo Sanatorium, a facility on the eastern side of the island. Batista had initiated its construction, but the facility was not as tightly linked to his name in the national imaginary.

In response to the news that construction on the Topes de Collantes project had stalled, the national sanatorium exploded as a topic of contention in the popular press. Many journalists and physicians were in double outrage—first, over what was considered initial poor planning, and second, over the possibility that the sanatorium would not be opened after so much money had already been spent. General consensus held that although a different location should have

⁵⁴⁰ Ibid.

⁵⁴¹ Ibid.

⁵⁴² Despaigne, *La lucha contra*, 91; Selva León, *Un año de lucha*, 162.

⁵⁴³ Selva León, *Un año de lucha*, 162.

been chosen originally, it was a larger crime to back away from the project after years of construction. “There is no government that thinks of the poor,” one journalist bemoaned, when he reported that the “palace” of Topes de Collantes had been abandoned “to its skeleton of steel, as if the money of the people could be thrown out.”⁵⁴⁴ The University of Havana’s Associate Professor of Tuberculosis commented that the “moment of debate over Topes de Collantes has already passed,” and the goal should be to open it as soon as possible.⁵⁴⁵ Even one of the most vocal opponents of the projects, Gustavo Aldereguía, stated plainly that the sanatorium “is there, in front of us, and also in front of us is this bloody reality: Cuba needs 4,000 beds for attending to its tubercular sick, and [they] demand urgent attention...It must be opened, then.”⁵⁴⁶

The press closely covered the controversy over whether the Grau administration would finish the project. The writers of *Noticias de Hoy* disagreed with the CNT’s claims that there were not enough funds to finish the project. One editor had visited the facility three months earlier, alleging that it lacked only the “final touches.”⁵⁴⁷ They had hoped it would open in only a few weeks. The paper also reported that a socialist legislator had presented a bill to the Congress to demand that the government finish Topes de Collantes. He told his readers that based on Grau’s extensive public works plan, it was doubtful that lack of money was the problem.⁵⁴⁸ Perhaps in response to popular pressure, the Health Minister told *Noticias de Hoy* in mid-1945 that the government would finish the sanatorium project, and it would be dedicated to tuberculosis treatment.⁵⁴⁹ While this may have quelled public outrage for a few months, by the end of 1945, the administration had made a final decision. The CNT would not complete the

⁵⁴⁴ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 37, no. 40 (October 7, 1945): 26.

⁵⁴⁵ Penichet, “Cuba es una fábrica,” 50.

⁵⁴⁶ Gustavo Aldereguía, “El Escorial de Topes de Batista,” *Bohemia* 37, no. 40 (October 7, 1945): 42.

⁵⁴⁷ “En su punto: Topes de Collantes,” *Noticias de Hoy*, November 18, 1944, 2.

⁵⁴⁸ *Ibid.*

⁵⁴⁹ “Seguirán las obras de Topes de Collantes,” *Noticias de Hoy*, May 31, 1945, 1.

Topes de Collantes Sanatorium and would instead try to sell it and use the funds for other provincial sanatoriums.

In the midst of public alarm over the termination of the sanatorium's construction, Grau's CNT quickly opened new institutions to show their dedication to the disease: thirteen dispensaries were opened by the end of 1946, bringing the island's total to twenty-three; the 400-bed sanatorium, Ambrosio Grillo, was promptly finished and functioning by 1945; and construction was commenced on a small provincial sanatorium, Pilar San Martín, on the western side of the island. Nonetheless, the projects initiated and put into operation by the CNT in this period paled in comparison to the promise that had been made to build five provincial sanatoriums.⁵⁵⁰ While the Ambrosio Grillo sanatorium adhered to medical and technical requirements, Pilar San Martín's seventy beds fell short of the recommended bed-per-sanatorium minimum that Cuban physicians had espoused. More disappointingly, no new sanatoriums were built in the three remaining provinces. Grau's successor, Carlos Prío Socarrás (1948–1952) (who was less attentive to tuberculosis than his predecessors were) continued to ignore the Topes de Collantes Sanatorium. The project receded from public attention, abandoned in the isolated hills of central Cuba.

5.3 THE GENERAL BATISTA SANATORIUM

In 1952, in anticipation of elections he was expected to lose, Fulgencio Batista orchestrated a military coup. As in the late 1930s, he rhetorically deployed tuberculosis to emphasize past

⁵⁵⁰ "Serán construidos seis sanatorios antituberculosos," *El País*, October 27, 1944, 1, 6.

government failures and to offer promises of material improvement to the Cuban people under his rule. In 1951, Batista reflected bitterly on the state of Cuban affairs.

From all the Nation we frequently receive letters from men and women who live over in the mountains or in the valleys, parents and children who long for and hope for the continuation of the work that official *autenticismo* paralyzed or destroyed. Misery, tuberculosis, parasitism, and ignorance have returned to a gallop, like hellish apocalyptic horsemen.⁵⁵¹

One of Batista's first actions once he returned to power was to recommence the Topes de Collantes Sanatorium project. The press covered the visits of the Minister of Public Works and the Minister of Health to the facility. They reported that the sanatorium had been greatly neglected, with its steel structure damaged and much of its equipment stolen, but the government would soon begin work.⁵⁵² The CNT promised to complete it "at an accelerated rhythm that will allow us to properly deal with the sick of the interior."⁵⁵³

In light of changing medical practices, the decision to devote significant funding to a high-altitude sanatorium seems incongruous. Due to the discovery and distribution of antibiotics in the 1940s, mortality rates began to fall throughout the world, including in Havana.⁵⁵⁴ Renowned tuberculosis specialists, such as those in the United States, believed that streptomycin and the handful of other effective antibiotics promised to fundamentally alter how they treated tuberculosis, for it made possible effective outpatient therapy in lieu of long and costly stays in

⁵⁵¹ "Autenticismo" refers to the Auténtico party, to which Grau and Prío both belonged. Fulgencio Batista, "'Mensaje' político de Cuba," *El Diario de Nueva York*, 1951, Box 3, FRB Papers, CHC-UM.

⁵⁵² "Inspección al Topes de Collantes," *El Crisol*, March 26, 1952, 1; "Grave daño ha sufrido la estructura de acero de Topes de Collantes," *El Crisol*, March 31, 1952, 1, 18; "Main Body of Topes De Collantes Building Seen Still Sound," *Havana Post*, April 1, 1952.

⁵⁵³ Esteban Reyes, "Unos minutos con el Director del Consejo Nacional de Tuberculosis: Entrevista," *Boletín Oficial del Consejo Nacional de Tuberculosis* (October 15, 1952): n.p.

⁵⁵⁴ Sergio Díaz-Briquets calculated that the mortality rate declined in Havana from 177.0 (per 100,000 population) in 1943 to 41.3 (per 100,000 population) in 1953. *The Health Revolution in Cuba* (Austin: The University of Texas Press, 1983), 58, 69.

closed institutions.⁵⁵⁵ As sanatoriums throughout the world began to close, such as the famous Trudeau sanatorium in New York, Batista and the CNT chose to resurrect the project instead of initiating an antibiotic distribution campaign.⁵⁵⁶ Cuban physicians, drawing on local notions of success in controlling tuberculosis, supported Batista's decision; however, Batista's political objectives were the most important rationale for reviving the project.⁵⁵⁷

In contrast to the medical community's consensus in past decades, in the early 1950s Cuban physicians roundly endorsed the opening of Topes de Collantes Sanatorium.⁵⁵⁸ Even though they knew that the mortality rate was falling, they argued that the state's provision of adequate beds remained the most important measure of success in the tuberculosis campaign. They continued to envision a metastasizing seedbed of contagion on the island, even after the arrival and distribution of antibiotic therapy.⁵⁵⁹ When *Bohemia* interviewed a number of tuberculosis specialists in 1953, asking if "Topes de Collantes will serve to cure tuberculosis," all fully supported the completion of the project (even though some of them had opposed the project in the late 1930s). They insisted that the country found itself in a precarious situation, with a bed shortage that previous administrations had not resolved. Alfredo Antonetti, a past critic of the project and the Chair in Tuberculosis at the University of Havana, estimated that 6,000 beds were needed, and only 2,000 were available: the completion of the sanatorium would raise the

⁵⁵⁵ John Geiger, "La verdad sobre la tuberculosis," *Bohemia* (April 19, 1953): 20–21.

⁵⁵⁶ Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), 249; "Así va la ciencia," *Bohemia* 46 (August 8, 1954): 18.

⁵⁵⁷ Also, shifting approaches to disease often do not lead immediately to institutional changes. Flurin Condrau, "'Who Is the Captain of All These Men of Death': The Social Structure of a Tuberculosis Sanatorium in Postwar Germany," *Journal of Interdisciplinary History* 32, no. 3 (Autumn 2001): 245.

⁵⁵⁸ One exception was, unsurprisingly, Gustavo Aldereguía, who continued to lambaste the project, primarily for its inflated cost, claiming that it would cost around 5,000,000 pesos, not the original 1,000,000 budgeted. Gustavo Aldereguía, "Topes de Collantes vuelve al camino," *La Última Hora*, April 16, 1952.

⁵⁵⁹ "Sobre la tuberculosis en Cuba disertó el Doctor Arnaldo Coro," *Diario de la Marina*, September 12, 1951, 2.

count to 3,000 beds.⁵⁶⁰ Dr. Reinaldo Gómez Ortega argued that “a sufficient number of beds” represented “the vital issue” of any tuberculosis campaign, and therefore, Topes de Collantes should be opened as soon as possible.⁵⁶¹ The physicians used the language of “scarcity of beds” and opined that the sanatorium would save 6,000 lives in six years alone.⁵⁶² One doctor contended that there were 4,500 Cubans who could not be cured by surgery or antibiotics and instead needed the climate cure; several others emphasized that the sanatorium would be a site where new and old therapies (e.g., streptomycin and the climate cure) could co-exist.⁵⁶³

Batista’s primary objective in reviving the Topes de Collantes Sanatorium project, however, was political. As part of his strategy to rule once again as a populist, he needed to legitimize his coup and build support for his openly illegal administration. The popular classes still demanded adequate beds. Throughout the early 1950s, requests for admission to a sanatorium came from all parts of the island. Guido García Inclán’s column in *Bohemia* provides a valuable window into the desperation for admittance to a hospital. Many of these requests and complaints centered on tuberculosis, and they did not diminish despite the reported drop in tuberculosis mortality. When one of García Inclán’s letter writers passed away “without any governmental help,” the journalist claimed the death represented “another painful and dreadful...charge” against the government.⁵⁶⁴

With his eye on these constituencies, Batista (and the CNT) publicized the project as his gift to the Cuban people. Pro-Batista literature declared that the sanatorium was located in a “true

⁵⁶⁰ “Topes de Collantes sirve?” 24.

⁵⁶¹ Ibid., 23.

⁵⁶² Ibid., 22–23.

⁵⁶³ Ibid., 98.

⁵⁶⁴ García Inclán, “En la feria de la actualidad,” *Bohemia* 43 (August 5, 1951): 116.

paradise” and was the “white elephant” of the Grau administration.⁵⁶⁵ In a book detailing the achievements of Batista’s rule, one of its seven chapters was devoted entirely to the Topes de Collantes Sanatorium.⁵⁶⁶ Both the press and CNT officials increasingly referred to the facility as the General Batista Anti-Tuberculosis Sanatorium.⁵⁶⁷ In the grand atrium of the sanatorium, carved in large letters on one of the walls, was the statement, “The ‘General Batista’ Sanatorium is and will be a beacon of hope for the sick.”⁵⁶⁸ Batista’s name was now explicitly linked to the sanatorium, a strategy undoubtedly utilized because the project still represented fertile ground for building legitimacy.

Batista attempted to create a popular base of support as he had done in the late 1930s; however, politics in Cuba had shifted fundamentally by the 1950s. The governmental attack on unions had begun in the late 1940s in an international context of anticommunism. When Batista staged his coup d’état, which was not backed by popular mobilization, he deepened the process of emptying out the “populist compact.”⁵⁶⁹ In response, he increasingly relied on violence and bribes to garner support, and the decision to resume construction on the sanatorium must be placed in this broader political context. Batista used public works programs to deal with

⁵⁶⁵ Edelmira González, *Martha Fernández Miranda de Batista* (Havana, 1954), 205, 208.

⁵⁶⁶ Ulpiano Vega Cobiellas, *Batista y Cuba: Crónica política y realizaciones* (Havana: Publicaciones Cultural, S.A., 1955), 147–90.

⁵⁶⁷ Aníbal Hernández, “Como es el Sanatorio Antituberculoso ‘General Batista’ de Topes de Collantes,” *Bohemia* 46 (May 9, 1954): n.p.; “Topes de Collantes,” *Carteles* 35, no. 20 (May 16, 1954): 43; “Batista y Topes de Collantes,” *Bohemia* 46 (May 16, 1954): 68–69. During the 1950s, critical accounts of the CNT and Topes de Collantes are hard to find, perhaps due to the fact that Batista and his wife paid a number of journalists for their support. Gillian McGillivray, *Blazing Cane: Sugar Communities, Class, and State Formation in Cuba, 1868–1959* (Durham: Duke University Press, 2009), 257.

⁵⁶⁸ Hernández, “Como es el Sanatorio,” n.p.

⁵⁶⁹ Gillian McGillivray identifies three “compacts,” or periods of socio-political negotiation, in Cuban history. The third, “the populist compact,” stretched from 1933 to 1959 and was “forged” by “workers, farmers, and sugarmill owners” who functioned as “lobby groups” and “created a more class-based system of ruledemand[ing] social-democratic ‘rights’ and ‘protection’ from the state.” This compact broke apart in the 1950s as Batista “us[ed] too much military force and favoritism for individuals and not enough political inclusion for organized groups such as workers’ unions and associations of cane farmers, industrialists, professionals, and mill owners.” *Blazing Cane*, 6, 9, 253–57, 274.

unemployment, build legitimacy and handle money.⁵⁷⁰ One scholar notes that during the 1950s, only 50% of public works expenditures (which exceeded one billion pesos) covered the actual costs of the projects; the other half went to “commissions and profit margins.”⁵⁷¹ The sanatorium was no doubt a project from which state officials and many of their supporters were making a large profit.

In the late 1930s, the sanatorium project created a debate about the medical and technical bases of the project; in the mid-1950s, the controversy surrounding Topes de Collantes revolved instead around government incompetence and corruption. Although Batista hoped to use the national sanatorium to gain legitimacy, the project fell victim to the politics of embezzlement. The press reported on how corruption had tainted the government’s management of the sanatorium, with political cronies benefitting from the funds dedicated to the project. In the 1950s, the protest song “Ya Tenemos Hospital” (“Now We Have a Hospital”) used the symbol of Topes de Collantes to criticize the Batista regime for its “rampant corruption...and apparent disinterest.”⁵⁷² In 1953, Batista made the Sanatorium’s administration autonomous from the CNT. The regime claimed that it had created the “Autonomous Jurisdiction of Topes de Collantes” so that the project could run more efficiently.⁵⁷³ Others believed that this was a ruse of “rubbish and figures,” used to facilitate corruption.⁵⁷⁴

⁵⁷⁰ Samuel Farber, *Revolution and Reaction in Cuba, 1930–60* (Middletown, CT: Wesleyan University Press, 1976), 154–55; Marifeli Pérez-Stable, *The Cuban Revolution: Origins, Course, and Legacy*, 2nd ed. (New York: Oxford University Press, 1999), 54; Jorge I. Domínguez, *Cuba: Order and Revolution* (Cambridge, MA: Belknap Press of Harvard University Press, 1978), 93–95.

⁵⁷¹ Pérez-Stable, *The Cuban Revolution*, 54.

⁵⁷² Robin D. Moore, *Music and Revolution: Cultural Change in Socialist Cuba* (Berkeley: University of California Press, 2006), 59–60.

⁵⁷³ Batista, *Piedras y leyes*, 120.

⁵⁷⁴ Gustavo Aldereguía, “La lucha antituberculosa en Cuba: Crítica histórica y examen político del problema y endemia,” in *Revolución y tuberculosis*, Cuadernos de Historia de la Salud Pública 68 (Havana: Central Nacional de Información de Ciencias Médicas, Ministerio de Salud Pública, 1984): 105.

Another journalist, writing for *Bohemia* in 1954, claimed that 8,000,000 pesos had been spent on the sanatorium, an extraordinary sum in comparison with the smaller figures from the mid-1940s.⁵⁷⁵ Even though his article dealt with the sanatorium specifically, the journalist then referenced the anti-tuberculosis stamp campaign in the early 1940s in which funds were allegedly not put towards their intended target (the construction of the children's tuberculosis hospital). What promise was there now, he queried, that funds would be funneled to the national sanatorium? One pro-Batista figure, Dr. Montoro, defended Batista and the sanatorium project (based on its climatological properties) in the conservative press, to which another journalist sardonically replied, "Is it possible that Dr. Montoro has not understood that the political-social problem of Cuba is, first of all, a problem of faith and confidence in the government authorities?"⁵⁷⁶

Despite these scandals, construction proceeded on the project, and its grand opening took place amidst fanfare and pomp. On May 9, 1954, almost seventeen years after the first brick had been laid, Batista inaugurated the sanatorium (see Figure 11). Prior to his departure to Las Villas, he told the press, "Topes de Collantes is the culmination of one of the greatest desires that I have nurtured for years."⁵⁷⁷ Over 1,500 individuals traveled to the province for a banquet to celebrate the hospital. The public inauguration ceremony was attended by national, provincial, and municipal officials; clergy; leaders of industry, business, and the arts; and representatives of labor unions. In a lengthy speech, Batista recounted his personal experience with tuberculosis in his own family, his arduous journey to create the sanatorium, and the obstacles faced along the

⁵⁷⁵ Previous figures ranged from 1.5 million to 4.5 million pesos, according to the Batista and Grau administrations, respectively.

⁵⁷⁶ Octavio Montoro, "Justificación de Topes de Collantes," *Diario de la Marina*, May 23, 1954, 47; Pedro Iglesias Betancourt, "No justificación de Topes de Collantes," *Bohemia* 46 (June 20, 1954): 92.

⁵⁷⁷ Ramón Vasconcelos, "Entreactos: Topes de Collantes," *Alerta*, May 10, 1954, 1.

way, which in his estimation were posed primarily by his political adversaries. It was a paragon of political theater, although Batista denied claims of politicking by arguing that Topes de Collantes Sanatorium “was not—it is not!—a Sanatorium for Batista, a work for Batista, but instead for the poor sick ones and for Cuba.”⁵⁷⁸ He was met with sustained applause.



Figure 11. Topes de Collantes Sanatorium, 1954.⁵⁷⁹

The press closely covered the event, and many wrote positively about the facility (see Figure 12).⁵⁸⁰ One journalist dubbed it a “temple of health” and asserted that, like the pyramids of Egypt, it would have “immortality sown into its walls.”⁵⁸¹ Another claimed that the sanatorium would redeem the island’s sanitary reputation. “Topes de Collantes should be a symbol,” penned one editor, “of hospital and welfare service.” It promised to elevate Cuba’s

⁵⁷⁸ Batista, “Inauguración del Sanatorio,” 7, Box 1, FRB Papers, CHC-UM.

⁵⁷⁹ N.a., *Topes de Collantes (Collantes Hilltop), an immensely large edifice built as a hospital*, 1954, Postcard, 14 x 9 cm, From: Author’s Collection.

⁵⁸⁰ “Después del homenaje al Presidente en Topes de Collantes podrá ser visitado durante tres días el gran sanatorio,” *Avance Criollo*, April 14, 1954, 1, 14.

⁵⁸¹ “Un templo de salud a 2,642 pies de altura,” *Alerta*, May 1954, n.p.

reputation “to the highest [level] of scientific...efficiency.”⁵⁸² Architects wrote that the hospital constituted a “model in its class to the world.”⁵⁸³ Past problems with the project were blamed on the Auténtico administrations, which “wanted no medical monument to Batista, no matter how much it might help the sick and the poor.”⁵⁸⁴



Figure 12. Batista, “the man who had the will to conceive and execute it,” stands in front of “the pride of Cuba and of America.”⁵⁸⁵

Shortly after these exuberant celebrations, problems with the project surfaced again. The inauguration ceremony had been orchestrated to coincide with several important dates on the political calendar. Most significantly, 1954 was an election year for Batista. The ceremony took place on the national “Day of the Hospitals,” but in reality, the sanatorium was not opened until six months later in November 1954, and journalists critical of Batista fumed about this deception and delay. Furthermore, instead of the promised 1,000 beds, the CNT made available only 400–600.⁵⁸⁶ Reports indicate that many of the remaining beds were necessary for housing medical

⁵⁸² Vasconcelos, “Entre actos,” 1.

⁵⁸³ “Topes de Collantes,” *Alerta*, May 15, 1954, 11.

⁵⁸⁴ Pearson, “Batista Proves,” 43.

⁵⁸⁵ “El gobierno constructivo del General Fulgencio Batista al servicio de Cuba,” *El Crisol*, March 19, 1954, n.p.

⁵⁸⁶ Batista, *Piedras y leyes*, 120.

personnel, who were not from Las Villas province; professionals had warned the CNT about this complication in the late 1930s.⁵⁸⁷

The Topes de Collantes Sanatorium, then, fell short of the quantity of beds promised, a highly-politicized metric in the 1950s (as discussed in Chapter 3). In September 1956, Guido García Inclán wrote of the young Manuel Mayo, who had been seeking entry into a sanatorium for four years. García Inclán lambasted the government:

One hears talk of new drugs....of the majestic Topes de Collantes....All that is heard and read, but he [Manuel] has to wait for death, in his hovel, without further consequence! How sad is all this, Cubans. In other nations of the Universe, when one is attacked by a sickness of such contagion but now of possible cure, it is pursued and isolated in a charitable center. Here in the fatherland of Martí, it is necessary to beg humbly for it, to pray for it, to request it, and to PUBLISH IT, to see if someone will pity the sick and achieve entry into a sanatorium for them.⁵⁸⁸

As physicians and citizens reflected on the history of the sanatorium project and the broader bed shortage, they increasingly expressed the view that their state health care sector was fundamentally flawed. Governmental administrations had failed to accomplish certain medical goals, and the roots of these failures were interpreted as political ills ailing the nation. This had political consequences, contributing to the decline of Batista's legitimacy in the 1950s and the advent of revolution.

5.4 **REVOLUTION AND REDEMPTION**

The new regime in 1959 was immediately concerned with the Topes de Collantes Sanatorium. Less than two weeks after taking power, they passed a decree to rename the facility after a fallen

⁵⁸⁷ Betancourt, "No justificación," 70.

⁵⁸⁸ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 48 (September 9, 1956): 112–13.

guerrilla leader, Comandante Enrique Villegas. In 1961, Gustavo Aldereguía exclaimed, “Already Topes—the General Batista Sanatorium A.M.D.G. (*a la mayor gloria del general*) [to the greater glory of the general]—is closed forever...in hopes that Fidel will assign it another function.”⁵⁸⁹ In 1964, Castro announced that the sanatorium would become a teacher training school. Such a move was political gold: he took a project that had upset different constituencies, for different reasons, and repurposed it to address educational deficiencies. Like public health, education and educational services were deeply politicized in the 1950s and used by the revolutionary government for legitimation in the 1960s. When discussing the change, one journalist wrote that although the hospital had been a form of “criminal business,” the revolution had put an end to all that: “Immediately, the hospital underwent a radical change...Simply, it has been converted into a school, in which 4000 youth, funded by the Revolutionary Government, will be trained as teachers, prepared to serve the Country....”⁵⁹⁰

Throughout the early 1960s, the Sanatorium continued to serve as a space for political contention. Insiders of the new regime and anti-Batista factions wrote about the hospital frequently. The Cuban press lambasted the sanatorium. One popular magazine recounted, “Trinidad counts among its greatest attractions the most beautiful panoramic highway of Cuba, a rugged passage that winds through the mountains...until reaching the top of Topes de Collantes above the clouds, crowned by the Sanatorium, an immense pile of concrete that alters the magnificence of the changing landscape.” It was a “kind of a *criollo* Escorial, which a vain tyranny raised with the intention of perpetuating its hated name.”⁵⁹¹

⁵⁸⁹ Aldereguía, “La lucha antituberculosa,” 105.

⁵⁹⁰ Ricardo Bernal Mora, “Topes de Collantes: Escandaloso negocio ayer, una esperanza hoy,” *Noticias de Hoy*, August 6, 1964, 4.

⁵⁹¹ “Los centros de atracción,” 111.

Batista and his supporters vociferously defended his health projects and especially the sanatorium. The U.S. State Department's 1961 *White Paper on Cuba* cited Batista's "indifference" to "medical care" and other social issues as "an open invitation to revolution."⁵⁹² In response, pro-Batista elements summoned the image of Topes de Collantes Sanatorium as concrete proof that he had not been unconcerned with health matters. The sanatorium, for these actors, represented modernity and scientific achievement for the Cuban people, and a source of national pride on the international stage. One pro-Batista magazine published a bevy of accomplishments of Batista's dictatorship in 1958 as his regime crumbled. The Topes de Collantes Sanatorium featured centrally, its photograph occupying a two-page spread. The author wrote:

The hospital is, without a doubt, a source of pride for the whole hemisphere. It was constructed with the most modern methods and equipped with the best facilities available to treat respiratory disease. In addition to its unexcelled construction and equipment, the hospital is also endowed with a highly unusual and extremely beneficial natural location that in itself is of considerable aid to its numerous patients. In effect, Topes de Collantes is a dream that has become a reality. It is a medical center that is helping Cubans fight tuberculosis with all the care and aid that modern science and nature can provide.⁵⁹³

In 1972, one group argued, "Batista propelled education, communications, [and] public health. The sanatorium in Topes de Collantes, constructed by Batista in an adequate place for the treatment of tuberculosis, was in its time the most modern and advanced tuberculosis sanatorium in America."⁵⁹⁴ Another newspaper, in 1963, featured a picture of the hospital, calling it a "stupendous work of the enormous labor of the Government of President Batista," even stating

⁵⁹² U.S. State Department, *White Paper on Cuba*, April 3, 1961, quoted in Fulgencio Batista, *The Growth and Decline of the Cuban Republic* (New York: Devin-Adair Co., 1964), 103.

⁵⁹³ "A Dream," 51, Box 1, FRB Papers, CHC-UM.

⁵⁹⁴ Justo LeFranc, "Habla Fulgencio Batista sobre las causas de su renuncia a la Presidencia de Cuba y sobre la situación de su país," *Defensa Institucional Cubana* 10, no. 120 (September 1972): 14, Box 3, FRB Papers, CHC-UM.

that it “overcame the terrible illness of the white plague.”⁵⁹⁵ As late as 1996, a radio station in Miami hosted a program about Batista’s rule and called Topes de Collantes Sanatorium the “number one” of its kind “in the world,” deeming it “the miracle on the mountain.”⁵⁹⁶

The sanatorium was used to contrast Batista’s rule with that of Fidel Castro. In 1963, one exile group claimed that tuberculosis was once again a threat in Cuba, “thanks to the other PLAGUE...of the *Castrocidades*.”⁵⁹⁷ Conversely, many decades later, Batista’s son Rubén claimed that Topes de Collantes was “before a model hospital for the poor, and today is utilized [as a hotel] for the rich foreigners who pay in dollars.”⁵⁹⁸

From the late 1950s on, Batista obsessively published statistics and compiled the accomplishments of his administrations. Batista argued that his hospital projects “offered silent, but conclusive, testimony to the interest which I shared with my associates in the health of Cubans in general and in medical assistance to the needy, the aged, the children, the disabled and the underprivileged in particular.”⁵⁹⁹ Of the Topes de Collantes Sanatorium and the Children’s Anti-Tuberculosis Hospital, Batista wrote, “These hospitals and the other facilities....gave the National Council for Tuberculosis the tools it needed. They represented an effort to eradicate tuberculosis unprecedented in Latin America.”⁶⁰⁰ Batista looked back on his reign much differently than his detractors and selected the Civic-Military Institute, the Civic-Military Schools, and the Topes de Collantes Sanatorium as his most essential and important works.⁶⁰¹ When Batista passed away in 1973, textual descriptions and visual representations of the

⁵⁹⁵ “Cuba en 1.958,” *La Voz del Cauto (en el exilio)*, February 11, 1963, 1, Box 3, FRB Papers, CHC-UM.

⁵⁹⁶ “Fórum cubano,” 22, 29–30, Box 3, FRB Papers, CHC-UM.

⁵⁹⁷ “Cuba en 1.958,” 1, Box 3, FRB Papers, CHC-UM.

⁵⁹⁸ Ariel Remos, “Emotiva conmemoración del Instituto Cívico-Militar,” *Diario Las Américas* (January 20, 2004): 2B, FRB Papers, CHC-UM.

⁵⁹⁹ Batista, *The Growth and Decline*, 109.

⁶⁰⁰ *Ibid.*, 99.

⁶⁰¹ Batista, *Piedras y leyes*, 97.

sanatorium were pervasive, with poems dedicated to the facility appearing in his funereal literature. One piece of poetry proclaimed, “[T]here are a thousand important works/*campesinos* and students/they are grateful to you/like the sick secluded at Topes de Collantes.”⁶⁰² Images of the sanatorium and of Batista in Las Villas were published as well (see Figure 13).



Figure 13. An exile bulletin from 1978 featured a painting of Batista choosing the site for Topes de Collantes Sanatorium.⁶⁰³

Batista and his supporters failed to grasp the resentment associated with the sanatorium. By focusing on the modernity of the sanatorium as the exemplar for public health achievement in republican Cuba, they overlooked two key processes. First, the emphasis on the sanatorium’s grandiosity and modernity ignored the medically- and popularly-formulated conceptions of “success,” namely the provision of an adequate number of beds. In March 1954, when *El Crisol* printed an anniversary edition of Batista’s regime, the subtitle of the page devoted to public

⁶⁰² Juan Mujica Gálvez, “Decimas al General Fulgencio Batista,” 130, Box 3, FRB Papers, CHC-UM.

⁶⁰³ This painting also hung in the lobby of the sanatorium. Ernesto Montaner, “Llanto General,” *Lealtad* 1, no. 1 (October 1978), Box 3, FRB Papers, CHC-UM.

health announced, “A bed for every tubercular and every tubercular in his bed.”⁶⁰⁴ The state had not made this a reality. Batista envisioned the sanatorium as a gift to the Cuban people, but over the years, citizens had come to expect access to hospital care as one of their rights, and Batista’s regime (and all republican administrations) had fallen far short of this goal.

Second, although Batista conceded that the sanatorium had had a “dramatic history,” he seemed blind to the fact that this drama might represent a tragedy to the people. This had been caused by the detrimental interference of crude political calculations in health policy: republican administrations had disregarded medical advice, which had hindered construction and delayed the sanatorium’s opening.⁶⁰⁵ While Batista had made claims about the beneficence, modernity, and therapeutic effectiveness of the Topes de Collantes project, medical professionals and citizens evaluated the performance of the government in providing something that they had been promised—a sufficient number of beds in state facilities.

Fidel Castro’s use of the sanatorium is also telling. The new government was quick to publicly emphasize the sanatorium’s scientific inadequacy and its history of corruption. The ultimate goal, however, seems to have been to erase it from historical memory. By the mid-1960s, once the facility was repurposed, references to the sanatorium in the censored press disappeared. In 1969, for example, one article noted that Topes de Collantes [it is unclear if the article was referencing the location or the building] had been transformed and was now a site of a magnificent teacher-training program.⁶⁰⁶ The text did not mention from what it had been converted. Of course, most people would have known of the sanatorium, but it is an interesting

⁶⁰⁴ “Nueve meses de una amplia y dinámica labor sanitaria,” *El Crisol*, March 19, 1954, n.p.

⁶⁰⁵ “Realizaciones del Gobierno de FBZ: Salubridad y Asistencia Social,” 17, Box 137, Folder 124, Fulgencio Batista Zaldívar Collection (FBZ Collection), CHC-UM. If Batista ever acknowledged any problems about the project and/or the facility, he attributed it to the obstruction of his political foes, namely the Auténtico administrations (1944–1952).

⁶⁰⁶ “Topes de Collantes, en el corazón del Escambray, se transforma,” *Granma*, November 27, 1969, 2. Also, see “Fidel en Topes de Collantes,” *Juventud Rebelde*, July 19, 1966, 19.

discursive shift from the vitriolic invocation of the sanatorium in documents in the first years of the revolutionary government. It is possible that in order for the socialist regime to continue its narrative that virtually no health care had existed in rural areas before 1959, the Topes de Collantes Sanatorium, a visible sign of health intervention, no matter how problematic, needed to be forgotten or downplayed.⁶⁰⁷

5.5 CONCLUSION

The history of the Topes de Collantes Sanatorium illustrates the contradictions of health policy in populist Cuba. Compared to many other nations in the interwar period, the Cuban state prioritized a disease of the marginalized masses and devoted considerable resources to its cure. However, these efforts, such as the Topes de Collantes project, were mediated, marred, and erratically executed due to the political objectives and needs of succeeding administrations.

The project was, from its origins, crafted to support Batista's political ambitions. Then the Grau administration abandoned the project, even though construction was nearly finished. This served Grau's own political agenda, as he did not want to complete a public health project that would be credited to his political opponent. However, this made the project more expensive

⁶⁰⁷ Also, in the early 1960s, while a civil war raged in the region, patients were transferred out of Topes de Collantes Sanatorium, which was then used as a "military fort" and possibly as a prison for counter-revolutionaries. The government probably did not want to draw attention to this phase of the sanatorium's history. On this civil war, see Lillian Guerra, *Visions of Power in Cuba: Revolution, Redemption, and Resistance, 1959–1971* (Chapel Hill: University of North Carolina Press, 2012). On the use of the hospital as a military fort, see Gustavo Alderreguía, *Camaguey y su tuberculosis* (N.p.: Editorial Cenit, 1959), 29. On the use of the facility as a prison, see Michael Sallah and Mitch Weiss, *The Yankee Comandante: The Untold Story of Courage, Passion, and One American's Fight to Liberate Cuba* (Guilford, CT: Lyons Press, 2015). The hospital itself was caught up in the conflict. The forces of the revolutionary government arrested the ex-chef (*jefe de cocina*) of the Topes de Collantes Sanatorium in 1961, for putting "himself in the service of imperialism." "Limpieza en el Escambray: Capturados 381 traidores y 945 armas," *Bohemia* 53, no. 12 (March 19, 1961): 57. Also, see Richard Eder, "Former Sanatorium in Cuba is School for Teachers," *New York Times*, July 8, 1964.

than it should have been, heightening the frustration of Cubans, who increasingly perceived their public health sector as inadequate and inefficient. By the time the sanatorium was finally inaugurated, then, it was already considered a failure in many Cubans' eyes. The decision to follow political objectives rather than technical advice in the conceptualization of the project also meant that the sanatorium fell short on the quantity of promised beds, the one metric that many physicians and citizens considered the definition of "success" for the facility.

By 1959, to some observers, the sanatorium represented an achievement of the state, with modern architecture, a conquering of the physical landscape, and the provision of medical care for hundreds of Cubans who received surgical interventions, antibiotic therapy and the rest cure. For others, however, the sanatorium symbolized the role of graft, the politicization of health projects, and inefficiency in health management.

Sick Cubans, tuberculosis specialists, and politicians had long been concerned with making the sanatorium cure more accessible. However, by the late 1940s, another cure had materialized with the discovery of streptomycin, an antibiotic that ignited the hope of those dying from the disease. The next chapter takes us inside the walls of Cuba's sanatoriums, pharmacies, and homes, as the poor endeavored to get their hands on the precious substance and demanded new rights in the process.

6.0 “NO OTHER REMEDY”: STREPTOMYCIN AND THE POLITICAL ILLS OF THE CNT, 1945–1952

In 1943, as construction workers toiled away on Batista’s “temple[s] of health,” hundreds of miles away a researcher witnessed something under his microscope that would make sanatoriums obsolete within several decades.⁶⁰⁸ At the Department of Soil Microbiology of the Rutgers University Agricultural Experimental Station, Albert Schatz, a graduate student under the direction of Dr. Selman Waksman, isolated an active strain of the bacteria *Streptomyces griseus*, which produced an antibiotic named streptomycin.⁶⁰⁹ Waksman’s team knew that they were on the verge of something momentous: most significantly, streptomycin mounted a formidable assault against the tuberculosis bacillus in *in vitro* tests, and human trials would soon prove that the antibiotic did so without fatally toxic effects in its host.⁶¹⁰

Many presumed that an uncomplicated scientific conquest of the disease would soon follow the breakthrough in the laboratory, and the press published optimistic declarations throughout the 1940s.⁶¹¹ Waksman graced the cover of *TIME Magazine* for his contribution; the

⁶⁰⁸ “Un templo de salud a 2,642 pies de altura,” *Alerta*, May 1954, n.p.

⁶⁰⁹ T.M. Daniel, “Selman Abraham Waksman and the Discovery of Streptomycin,” *The International Journal of Tuberculosis and Lung Disease* 9, no. 2 (February 2005): 120–21; Helen Bynum, *Spitting Blood: The History of Tuberculosis* (Oxford: Oxford University Press, 2012), 192–94.

⁶¹⁰ American Chemical Society National Historic Chemical Landmarks, “Selman Waksman and Antibiotics,” 2005, accessed March 8, 2016, <http://www.acs.org/content/acs/en/education/whatischemistry/landmarks/selmanwaksman.html>.

⁶¹¹ Many historians of tuberculosis reproduce the understanding that antibiotics represented a rupture, ending their narratives around 1950. See, for example, Adrián Carbonetti, *Enfermedad y sociedad: La tuberculosis en la Ciudad*

New York Times claimed that “the preliminary performances, in tests with laboratory animals, are almost sensational” and that “we may be standing on the threshold of one of science’s greatest achievements”; and, in the fall of 1947, the WHO reported that “it will be possible to bring tuberculosis under international control within a reasonable period of time.”⁶¹² Indeed, the discovery, manufacture, and distribution of streptomycin forever altered the history of tuberculosis on a global scale, but it did so unevenly, for the advent of a new disease technology has rarely meant easy and equitable access to it across political and social borders.⁶¹³

During the 1940s, streptomycin production remained exclusively in the United States. Consumption remained there, too, until 1946, when pharmaceutical companies had sufficiently increased output, and the U.S. Streptomycin Control Board set quotas and exported the precious substance for sale in foreign countries. Cubans became aware of streptomycin very early on due to the country’s proximity to the United States, the shared networks of American and Cuban medical practitioners, and a well-developed Cuban media, with a high national readership. As knowledge of the drug spread in Cuba, so too did demand for streptomycin.

Cubans first had to contend with material scarcity of the drug. As that problem was solved, however, they confronted a new issue: the price of a full streptomycin treatment remained beyond the reach of many poor Cubans, the very population that was

de Córdoba, 1906–1947 (Córdoba: Editorial de la Municipalidad de Córdoba, 1998); Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900–1950* (Montreal: McGill-Queen’s University Press, 1999); Claudio Bertolli Filho, *História Social da Tuberculose e do Tuberculoso: 1900–1950* (Rio de Janeiro: Editora Fiocruz, 2001); Diego Armus, *The Ailing City: Health, Tuberculosis, and Culture in Buenos Aires, 1870–1950* (Durham: Duke University Press, 2011).

⁶¹² “Microbiologist Waksman,” *TIME Magazine* 54, no. 19 (November 7, 1949), cover page; “Streptomycin as Supplement to Penicillin, is Under Study for Use Where Other Fails,” *New York Times*, August 16, 1945, 20; “What are We Willing to Pay for Health?” *New York Times*, November 18, 1945, 86; “Tuberculosis Fight Gains,” *New York Times*, September 10, 1947, 4.

⁶¹³ As Julia Ross Cummiskey has recently argued for tuberculosis control efforts in Baltimore, “The history of these efforts is part of the larger global history of TB control in the antibiotic era and developments in Baltimore were both shaped by and contributed to this wider history.... Yet, it is also a history that was profoundly shaped by local social and political conditions in Baltimore.” “Drugs, Race, and Tuberculosis Control in Baltimore, 1950–1958,” *Social History of Medicine* 27, no. 4 (2014): 730.

disproportionately afflicted by the “Koch bacillus.” Frustrated by their difficulties in accessing the expensive drug, the sick, physicians, and activists began to articulate the right of the poor to free or state-subsidized medicine. Demanding that the Health Ministry and the CNT guarantee a free and regular supply of the antibiotic to its poor constituents meant that questions of access to the drug became enmeshed in debates about public health performance, and streptomycin became politicized as an issue of national importance. As state institutions attempted to deliver streptomycin to patients, distribution fell victim to the politics of the Cuban state, evidenced by irregular payments, the need for patronage connections to gain access to the drug, and government officials’ (illegal) profit from its sale.

As a result, citizens took action, and their perceptions of the state worsened. As health authorities inadequately responded to grassroots demands for subsidized antibiotic therapy, patients in sanatoriums began to organize and strike, finding allies in the media and politically organized groups such as the Popular Socialist Party (PSP) and the Federation of University Students (FEU). Middle-class charities also returned to the anti-tuberculosis campaign, plugging gaps in the welfare system by helping poor Cubans obtain the drug. These efforts and episodes made the issue of government incompetence regarding streptomycin highly visible to a national audience. Thus, even though by 1953 tuberculosis mortality had plummeted (suggesting that enough people had gained sufficient access to antibiotic treatment to prevent or delay death), citizens’ denunciations of the CNT and the state health care sector intensified as they became convinced that Cuba’s health bureaucracy was hopelessly politicized and inefficient.

The history of streptomycin in Cuba, like that of the Topes de Collantes Sanatorium and the effort to reform Cuba’s local sanitation departments, serves to explain the disjuncture between good health indicators and highly critical citizen perceptions of the public health sector.

The discovery and distribution of an effective treatment (evidenced by the dropping tuberculosis mortality rate) represents a story of at least partial success. However, streptomycin also served as another highly visible marker of the problems of the republican state. Combined with the other condemnations of the Cuban health sector in the late 1940s—patronage, corruption, the abandonment of Topes de Collantes Sanatorium, and poor hospital management—the state’s failure to meet citizens’ expectations of access to streptomycin contributed to the unraveling of the consensus that the Cuban state could effectively lead the tuberculosis campaign.⁶¹⁴

6.1 “THE MARVELOUS DRUG”

In early 1945, Havana proudly served as host to the Sixth Pan-American Tuberculosis Congress; it was here, in his role as president of the meeting, that CNT insider Juan Castillo first heard stories that American scientists were testing a new antibiotic in animal and human experiments. As director of Havana’s main tuberculosis dispensary since 1933, the news piqued Castillo’s curiosity, and he packed his bags and headed to meet with Dr. Emerson, head of the American National Tuberculosis Association, where he was informed of “the great hopes that North American tuberculosis specialists were putting on that drug.”⁶¹⁵

⁶¹⁴ This consensus coalesced in the late 1920s and 1930s among physicians who pushed for one central anti-tuberculosis organization, to be managed and/or funded by the state. See, for example, Luís P. Romaguera, “Programa médico-social contra la tuberculosis,” *Revista Médica Cubana* 46 (1935): 841; Juan J. Castillo, “De la necesidad de reorganizar los servicios antituberculosos y creación de un comité director responsable,” in *Dos años de trabajo contra la tuberculosis efectuados en el Dispensario “Furbush,”* ed. Secretaría de Sanidad y Beneficencia (Havana: Arellano y Cía., 1936), 25; Rafael Sentmanat, *Una nueva organización sanitaria en Cuba* (Havana: M. Paredes, 1936), 1.

⁶¹⁵ Juan J. Castillo, “Nuestra experiencia streptomycinoterápica en Tuberculosis,” *Revista Cubana de Tuberculosis* 12, no. 1 (January 1948): 45.

The Cuban press soon printed the rumors of a new panacea for one of Cuba's most vexing illnesses. "Keep Your Eye on Streptomycin!" screamed one headline in June 1945.⁶¹⁶ Its subtitle must have immediately grabbed the attention of the thousands of readers who suffered from TB: "Tuberculosis, infant paralysis, leprosy, and other diseases may fall rapidly, shot down by this new drug."⁶¹⁷ In November 1946, through injections of streptomycin, a New York physician saved the life of a fifteen-year-old who had tubercular meningitis, a previously fatal form of the infection.⁶¹⁸ In January 1947, *Diario de la Marina*, Cuba's newspaper with the highest readership, reprinted the results of a Mayo Clinic study that corroborated the efficacy of streptomycin in fighting tuberculosis.⁶¹⁹ These vignettes from abroad echoed loudly in Cuba, and press outlets continuously featured them in medicine and science columns. Soon stories of antibiotic success in Cuba's own hospitals began to appear.⁶²⁰ Pharmaceutical companies in Cuba crafted advertisements to overcome any lingering doubts, announcing messages like "[t]uberculosis CAN be defeated."⁶²¹ Facilitated by the tightly linked information channels between North America and Cuba, the medical community and lay public in Cuba became aware of streptomycin in the mid-1940s, and such knowledge generated widespread expectations of access to streptomycin, which many were calling the "miracle drug."⁶²²

⁶¹⁶ J.D. Ratcliff, "¡Atención al Estreptomicin!" *Bohemia* 30, no. 37 (July 29, 1945): 16, 26, 48–49, 65, translated and reprinted from J.D. Ratcliff, "Keep Your Eye on Streptomycin," *Liberty* 22, no. 26 (June 30, 1945): 24–25, 72.

⁶¹⁷ *Ibid.*, 16.

⁶¹⁸ "Así va la ciencia," *Bohemia* 38, no. 46 (November 17, 1946): 15. The *New York Times* reported that the patient had outlived any other cases of tubercular meningitis that had been previously "cured." "New 'Cure' is Reported," *New York Times*, September 1, 1947, 21.

⁶¹⁹ Armando Chardiet, "La estreptomicina abre brecha en la tuberculosis," *Diario de la Marina*, January 26, 1947, 46. This article reprinted the widely known findings of Corwin Hinshaw, William H. Feldman, and Karl H. Pfuetze, "Treatment of Tuberculosis with Streptomycin: A Summary of Observations on One Hundred Cases," *Journal of the American Medical Association* 132, no. 13 (November 30, 1946): 778–82.

⁶²⁰ "Así va la ciencia," *Bohemia* 38, no. 52 (December 29, 1946): 15; "Así va la ciencia," *Bohemia* 39, no. 35 (August 31, 1947): 16.

⁶²¹ *Bohemia* 39, no. 32 (August 10, 1947): 25.

⁶²² The earliest printed reference to streptomycin in Cuba that I have found is the June 1945 *Bohemia* article (this American-authored article reported on the potential of streptomycin, which was unclear even in the U.S.). By early

Those expectations of access to the drug only intensified in December 1946, when the Cuban press reported that streptomycin had finally arrived on the island. In practice, however, access would be mediated by several factors: (1) availability (streptomycin's material existence on the island, which was determined by U.S. production and its quota system), (2) the Cuban Health Ministry's controlled distribution of the antibiotic, and (3) the cost of the drug (and the state's role in controlling and/or subsidizing that cost). This section considers each of these variables in order, arguing that until the end of 1947, severe scarcity plagued the streptomycin market, as a result of restricted American export of the drug. As 1947 came to a close, the drug began to arrive in adequate quantities to Cuba, and as a result, availability in material terms ceased to be a serious problem, and the Cuban government ended its control over distribution. However, into the 1950s, even though the price of the drug had dropped radically, the price of multiple doses and especially a full streptomycin treatment remained prohibitive for many.

The available supply of streptomycin was quickly outstripped by demand—though by precisely how much is unclear. Data on import totals exists for certain months or weeks in the late 1940s, but I have found no data on the number of individuals who received the drug.⁶²³ And, trying to translate aggregate data into an estimate of how many individuals accessed streptomycin would be problematic. In 1947, Cuban physicians prescribed a range of 40 to 360 grams per person for a total treatment (usually administered over three months).⁶²⁴ It is probable

1947, *Diario de la Marina* ran at least several stories a month regarding the drug. For references to the “miracle drug,” see, for example, “La estreptomicina hace ‘milagros’ en el tratamiento de la tuberculosis,” *Diario de la Marina*, February 1, 1947, 10; Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 41, no. 12 (March 26, 1949): 34.

⁶²³ Consistent and comprehensive data on Cuba's changing quota and its monthly import amounts does not exist. The U.S. did not provide annual streptomycin-specific export information until 1951.

⁶²⁴ There are many reasons for such a wide difference in total grams for treatment. First of all, the drug was still in an experimental stage, and physicians were attempting to standardize dosage amounts. This differed across nations, with North American physicians more aggressively injecting their patients in the mid-1940s, and then decreasing the daily and total dosage amounts by the late 1940s. In comparison to U.S. physicians, the CNT-employed doctors used

that most prescribed 3–4 grams per day, over the course of “several months,” thus, totaling anywhere from 180–360 grams. Even with this range in mind, however, it remains difficult to ascertain how many people obtained the drug. One cannot simply divide an import total by the total number of grams considered necessary to complete a regimen because the Cuban government did not distribute streptomycin in this manner, at least not in the first half of 1947. Instead, it allocated several doses to as many supplicants as possible (instead of distributing a complete treatment to fewer patients).⁶²⁵ Even if the aggregate data cannot be plausibly converted into a number of individuals who would have received streptomycin from Cuba’s pharmacies and hospitals, knowing the standard dosage helps to provide a sense of how inadequate imports were (keeping in mind that the government calculated that 40,000 people in Cuba had the disease).⁶²⁶

The drug’s material availability on the island was determined primarily by U.S. pharmaceutical production and the U.S. government’s control over streptomycin exports. In the United States, the Civilian Production Board, a holdover from the Second World War, continued to strictly regulate the domestic distribution of the drug through a newly created Streptomycin Control Board (SCB).⁶²⁷ When production finally satisfied enough of the U.S.’s domestic need

fewer grams (a range of 40–125 grams in a 1947 CNT experiment, versus the approximate 360 grams used in the pioneering Mayo Clinic trials the year before.) There were also differences within national medical communities, however, and it is probable that on average, Cuban physicians prescribed 3–4 grams per day. There were also differences even within a single study: the total grams applied varied from person to person, depending on factors such as age, type of tuberculosis, and severity of the disease. Chardiet, “La estreptomicina abre,” 46; Castillo, “Nuestra experiencia streptomycinoterápica,” 47; Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 39, no. 41 (October 12, 1947): 18; Luis de la Cruz Muñoz et al., “Estreptomicina en el tratamiento de la tuberculosis pulmonar,” *Revista Cubana de Tuberculosis* 15–16, nos. 1–4, 1 (1951–1952): 8.

⁶²⁵ The Health Director, Dr. Pedro Nogueira, reported on February 15, 1947 that 130 *expedientes* had been initiated, and the official in charge of streptomycin’s distribution made a delivery of at least two doses in each case.

“Actualidad nacional: Salubridad: La liberación de la streptomicina,” *Diario de la Marina*, February 15, 1947, 2.

⁶²⁶ Pedro Domingo, “Puede erradicarse la tuberculosis de Cuba?” *Revista Cubana de Tuberculosis* 9, nos. 2–4 (April–December 1945): 170.

⁶²⁷ “The Nation: Streptomycin,” *New York Times*, April 21, 1946, 76. In March 1946, eleven companies produced 28,000 grams of streptomycin: 19,000 went to the military and government agencies, leaving only 9,000 for use in

in the fall of 1946, the government announced that streptomycin could be exported, but only under license and with a specific quota set for each country, each established by the SCB.⁶²⁸ In December 1946, the Cuban press announced that the head of the SCB had informed Cuba's Health Ministry that they would begin receiving a monthly quota of 25 grams, a trivial amount that had increased more than tenfold by January 1947, undoubtedly due to rapidly expanding production of the substance in the U.S.⁶²⁹ Spurred by the mounting national and international publicity in response to promising streptomycin trials in 1945 and 1946, American pharmaceutical companies geared up to satisfy the demand; within several years, they had exponentially increased production of the drug for clinical use.⁶³⁰ Table 5 presents periodic monthly outputs by American pharmaceutical companies, the sole producers of the drug during this period. While the table demonstrates a steadily accelerating growth in streptomycin production, for those on the ground in Cuba, the shortage of the drug in 1947, partially due to the restrictions set in place by the U.S. quota system, seemed anything but short-lived.

Table 5. American Production of Streptomycin⁶³¹

Date	Grams produced
September 1945	3,000
March 1946	28,000
September 1946	140,000

clinical medicine. Physicians had to offer sufficient burden of proof that their patients had urgent cases of specific forms of the disease.

⁶²⁸ This system continued until December 1948, when the U.S. Commerce Department ended licensing requirements for the export of streptomycin. "Streptomycin May Now Be Exported without License Except to Europe," *New York Times*, December 25, 1948, 21.

⁶²⁹ "Enviarán 25 gramos mensuales de estreptomicina a Cuba," *Boletín del Consejo Nacional de Tuberculosis* (December 1946): 20; "Drug is Effective for Tuberculosis," *New York Times*, December 1, 1946, 60; "Aumenta el envío de estreptomicina," *Diario de la Marina*, January 10, 1947, 12.

⁶³⁰ For instance, in August 1946, Merck & Co. dedicated two new plants exclusively to streptomycin production. "Drug Production Begun," *New York Times*, August 21, 1946, 33.

⁶³¹ Numbers calculated from "The Nation: Streptomycin," 76; "Streptomycin Wonders," *TIME Magazine* 48, no. 12 (September 16, 1945): 56; "Streptomycin Released," *New York Times*, July 4, 1947, 9; "Streptomycin Output Jumps," *New York Times*, January 1, 1948, 40; "Streptomycin Output Sets Mark," *New York Times*, August 24, 1949, 27.

Table 5 (continued)	
Date	Grams produced
July 1947	550,000
December 1947	1,660,000
June 1949	7,300,000

In the first seven months of 1947, the U.S.-determined quota for Cuba hovered around 3,000 grams before rapidly increasing in the fall. In certain moments, this amount was increased when the Cuban Health Ministry successfully leveraged Cuba's ambassador in Washington D.C. to petition for special shipments of streptomycin. Moreover, the drug could enter the country outside of both U.S. and Cuban governmental channels, creating a black market.⁶³² As the stream of requests for streptomycin began to pick up, the Cuban government declared a crisis in the summer of 1947. They reported on July 8th, for example, that only 12 grams existed in the country. As a result, the Cuban government petitioned the U.S. government, which raised Cuba's monthly quota to 4,000 grams in August and sent an emergency shipment of the drug to quell the chaos. By the early fall of 1947, as a function of increased pharmaceutical output in the U.S., streptomycin began to enter the country in an ever-increasing stream (see Table 6).

Table 6. Grams of Streptomycin Imported into Cuba, 1947⁶³³

Dates	Total (g)	Daily average
July 5–August 27 (54 days)	11,675	216.2 g
August 28–October 16 (50 days)	17,178	343.6 g
November 5–17 (13 days)	6,900	530.8 g

⁶³² For instance, in June 1949, the U.S. Department of Commerce suspended the export license of Milton Berk for violating the export control regulations for a streptomycin shipment to Cuba. "Export License Suspended," *New York Times*, June 4, 1949, 19.

⁶³³ No monthly aggregate data on imports was reported prior to July 1947. For speculative comparative purposes, if the country received only its quota amount of 3,000 grams, we can assume that the daily average in the spring and early summer of 1947 was 100 grams. "11.675 gramos de streptomicina distribuidos en 52 días," *Diario de la Marina*, August 28, 1947, 13; "Gastan \$178.544 los cubanos en streptomicina," *Diario de la Marina*, October 17, 1947, 16; "La estreptomicina será rescatada de los especuladores," *Diario de la Marina*, November 19, 1947, 16.

The Cuban government's controlled distribution of the drug constituted the second barrier to accessing streptomycin. Considering the drug's scarcity and possible toxicity if taken outside of medical supervision (and the U.S.'s similar procedure of regulating domestic distribution), the Cuban Health Minister, Dr. Andreu, and the National Health Director, Dr. Nogueira, appointed one official (Dr. Ilisátegui) to control the sale of the antibiotic from a new post within the Health Ministry.⁶³⁴ Scarcity meant that the Cuban government would approve the purchase of the drug "only in cases of emergency and upon proof of critical need."⁶³⁵

The sick and their relatives had to traverse several bureaucratic steps to gain access to the drug: first, a physician had to determine that streptomycin would indeed be efficacious for the patient's particular form of tuberculosis. If the physician deemed it so, he wrote a prescription. With that sheet of paper, the patient and/or his relatives filed a request for the drug from the Health Ministry. Finally, weighing the particulars of the case and with a register of all the streptomycin stock in the country by pharmacy, Ilisátegui determined which patients could receive what amount of the drug. These fortunate few then received from the Health Ministry a license to purchase the drug from a specific pharmacy. By the fall of 1947, *Diario de la Marina* provided daily reports of the amount of streptomycin disbursal approved by the government, and the pharmacy that filled them, evidence not only of intense citizen interest in the drug, but also of the government's need to publicly satisfy that escalating demand.⁶³⁶ The Cuban government retained control over the drug's distribution until November 1947, when American production and export to Cuba had increased sufficiently. The Health Ministry continued to exert some

⁶³⁴ "Enviarán 25 gramos," 20.

⁶³⁵ Ibid. It is no surprise then that in Cuba and throughout the Western hemisphere, a black market for the drug quickly grew up, so that people with enough resources could spend exorbitant amounts to receive the drug outside of governmental control.

⁶³⁶ See, for example, Rogelio Franchi de Alfaro, "Misceláneas de Salubridad: Control de la estreptomicina," *Diario de la Marina*, October 15, 1947, 18.

control over the process, requiring pharmacies to freeze and store 20% of all imports, which could be thawed in case of emergency. This reserve seemed to have been at the disposal of the government, to ensure that stocks never ran out and to distribute licenses to certain individuals to purchase the drug at specific, controlled prices.⁶³⁷

The third and final impediment to accessing the drug concerned its price. One aspect of Cuban governmental control of streptomycin included an agreement on price limits between the Ministry of Commerce and importers of the drug, which were predominantly foreign-owned enterprises.⁶³⁸ Despite this agreement on paper, Cubans encountered great variation in price when attempting to buy the drug, and the Cuban government's control over the cost of the drug seems to have been tenuous. For example, the government asked the public to assist them in November 1947 when they ended total control over the drug's distribution: if an individual encountered a price higher than that set by the Ministry of Commerce at a pharmacy, they were asked to not purchase the drug, but to go to the Health Ministry to obtain documents to buy it at the indicated price.⁶³⁹ Additionally, a black market soon developed for the drug. The price inflation in this parallel market skyrocketed in the interior of the island, which often remained beyond the reach of the Health Ministry. *Diario de la Marina* confirmed that some citizens in these areas paid \$20 for a gram of streptomycin while others in Havana were paying approximately \$5 a gram.⁶⁴⁰

⁶³⁷ "De nuevo a control la estreptomicina de venta al público," *Diario de la Marina*, November 22, 1947, 16.

⁶³⁸ Prior to the 1959 revolution, 70% of the Cuban pharmaceutical market was foreign-owned. José Ramón Ruíz Hernández, *La salud pública: Su desarrollo en el periodo revolucionario (1959–1980)* (Havana: Instituto de Desarrollo de la Salud, Ministerio de Salud Pública, 1986), 25–28.

⁶³⁹ "De nuevo a control," 16.

⁶⁴⁰ "Se está pagando a \$20.00 el gramo de la estreptomicina," *Diario de la Marina*, November 13, 1947, 16.

Despite this variation and exploitation, throughout 1947, the price of the drug slowly decreased. In February 1947, the government set the price at \$7.50 per gram.⁶⁴¹ In October 1947, *Diario de la Marina* reported that since July, Cubans had spent, on average, \$6.50 per gram.⁶⁴² By November of 1947, the average price had fallen to \$4.75 per gram.⁶⁴³ When the government ended controlled distribution, the cost of the drug briefly jumped (\$5.95 per gram), but by late December, U.S production and exports had increased so much that the average price paid for the drug had fallen to \$3.70 per gram.⁶⁴⁴

Despite the trend of decreasing cost, for many people, paying for a complete drug regimen remained prohibitively expensive. Although a few exceptions existed, overall, individuals bore the cost of the drug on their own, for the Cuban government declared that it could not afford to subsidize large amounts of the drug, especially in 1947.⁶⁴⁵ In June 1947, *Diario de la Marina* estimated the total cost of treatment to be \$800.⁶⁴⁶ Even when the price dropped in the fall to around \$4 a gram, one journalist noted that treatment remained simply “too expensive.”⁶⁴⁷ Another physician reported that one of his poor *habanero* clients would have to pay \$200 to cure her daughter.⁶⁴⁸ While the cost of the treatment was now a quarter of the estimate from June 1947, the physician was painfully aware that the mother, a cook, only earned

⁶⁴¹ “Declara Salubridad la venta libre de la droga llamada streptomycin,” *Noticias de Hoy*, February 12, 1947, 6.

⁶⁴² “Gastan \$178.544,” 16.

⁶⁴³ “Se está pagando,” 16.

⁶⁴⁴ “De nuevo a control,” 16; “Desde ayer se puede adquirir el gramo de estreptomycin a \$3.70 con permiso de Sanidad,” *Diario de la Marina*, December 2, 1947, 16; “Resumen de las actividades oficiales durante el año 1947: Salubridad,” *Diario de la Marina*, January 2, 1948, 20.

⁶⁴⁵ One exception was the CNT streptomycin experiment on 100 patients (at La Esperanza Sanatorium), led by Juan Castillo over the course of 1947.

⁶⁴⁶ “Solo cura dos variantes de la tuberculosis la streptomycin,” *Diario de la Marina*, June 17, 1947, 30.

⁶⁴⁷ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 39, no. 41 (October 12, 1947): 18.

⁶⁴⁸ Arnaldo Coro del Pozo, *Usted y la tuberculosis* (Havana, 1957), 31. Unfortunately, Coro does not provide a specific date for this observation; it was sometime between December 1946 and November 1948.

\$20 a month. At \$200, the total treatment regimen would consume over 80% of the family's yearly income.

Each of these variables that affected access—availability; governmental distribution; and cost—fluctuated in importance across time. Throughout 1947, material scarcity of the drug, shaped first and foremost by American production and distribution, channeled the public's focus onto the issue of availability of the drug on the island and the U.S. quota. For instance, Guido García Inclán first addressed streptomycin in late April 1947: "A good *criollo*, a good husband writes me wanting his words to jump from the paper." The man's wife was "wasting away," and he feared being left alone with their four children, and begged for streptomycin. "In Cienfuegos," he continued, "it has not been possible to find the medicine that she needs," even with the prescription of their physician.⁶⁴⁹ Other press outlets focused on the Cuban government's efforts to get more of the drug into the country. Aware of material shortages, very few critiqued the performance of the Cuban state or even the U.S government at this stage.

The government was not unaware of the potential political effects of scarcity, however, and they carefully crafted messages to the public to emphasize the limits and disadvantages of the drug. Not coincidentally, in June 1947, at the beginning of a crisis of extreme scarcity, *Diario de la Marina* announced that "The Government Cannot Acquire Streptomycin," and the CNT made the following warnings to the public: the drug was still in an experimental phase, and if applied without attention to contraindications, the toxicity of the drug could create serious problems. Most significantly, the CNT director summarized, "It is a drug that is highly costly and beyond the financial reach of the CNT."⁶⁵⁰ He concluded that he could not "wantonly

⁶⁴⁹ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 39, no. 16 (April 20, 1947): 26.

⁶⁵⁰ "El gobierno no puede adquirir streptomicina," *Diario de la Marina*, June 4, 1947, 3; "Hacen aclaraciones respecto al uso de la streptomicina en los casos de tuberculosis," *Noticias de Hoy*, June 4, 1947, 5.

recommend its acquisition to the Government until they have the assuredness that it will really work, since this would mean wasting money that could serve other needs.”⁶⁵¹ In August, the Health Minister formally recommended to the President to not procure large quantities of the drug, based on the decisions of the CNT’s Board of Governors. Instead, he recommended the purchase of a limited amount of the drug for the CNT to use in human trials.⁶⁵² For the moment, the government could refuse to buy large stocks of the drug, shielded by scarcity and the need for more experimentation.

There was at least one important exception to the tempered response of the citizenry to the drug shortage, a foreshadowing of the politicization of the drug to come. On July 10, 1947, in the midst of a national crisis of streptomycin scarcity (only twelve grams remained in the country), the family members of patients in La Esperanza Sanatorium planned to stage a demonstration in the centrally located *Parque de la Fraternidad* to demand “that the Government acquire a sufficient quantity of the drug called streptomycin so that they will apply this treatment to all the sick of the Republic, since the efficacy of this medicine has been proven in the treatment of this terrible sickness.”⁶⁵³ Five days later, the patients at Ambrosio Grillo Sanatorium also issued a manifesto, which demanded the “shipment of streptomycin to that center, so that the patients can radically and immediately improve.”⁶⁵⁴ Rejecting the CNT’s

⁶⁵¹ “El gobierno no puede,” 3.

⁶⁵² “No comparan streptomicina en cantidades,” *Diario de la Marina*, August 1, 1947, 2.

⁶⁵³ “Concentración el día 24 de los familiares de los tuberculosos,” *Noticias de Hoy*, July 10, 1947, 5. This brings up one other source of friction that developed between the government and the popular sector regarding the efficacy of the drug. Physicians expressed concern about the drug’s safety and efficacy until the end of 1947. And, after that, they continued to recommend the drug in moderate amounts for certain forms of the disease, while preferring other interventions (e.g., sanatorium residence, surgery) for others. However, popular audiences, especially the sick and their families, crafted their own understanding of the drug. They believed it to be a “cure-all” or a “miracle drug” despite governmental and medical warnings to not do so. Juan J. Castillo, “Demuestra un tisiólogo todas las ventajas y perjuicio de la estreptomicina hasta ahora,” *Diario de la Marina*, December 24, 1947, 3. In this article, Castillo reported the results of a streptomycin trial done at La Esperanza Sanatorium, in which the drug showed promising results for some forms of tuberculosis and no improvement for other forms.

⁶⁵⁴ “Enfermos del Hospital ‘Ambrosio Grillo’ piden estreptomicina,” *Noticias de Hoy*, July 15, 1947, 6.

admonition to not treat the medicine as some miracle cure, the patients demanded their immediate access to the drug.

The Health Minister's promise to visit La Esperanza Sanatorium to investigate its daily operations and his announcement that the U.S. government had granted Cuba a special quota of 8,000 grams of streptomycin, to arrive by the first week of August, quelled the agitation as the family members cancelled the planned demonstration. Nonetheless, by the next summer this initial ripple of discontent would turn into more powerful waves against government performance, driven by a shift in the discourse throughout 1948: with the problem of extreme scarcity solved, citizens began to put the blame for difficulty in purchasing the drug squarely at the feet of the government.

Based on a broad interpretation of laws and past practices, many Cubans expected the state (whether national or municipal) to provide medicines free of charge to the poor.⁶⁵⁵ However, even after streptomycin's price plummeted, it stretched the limited resources of the Health Ministry's and the CNT's dependencies, which were already having trouble paying their bills. The extant evidence points to the very limited role of the government in subsidizing or purchasing the antibiotic for its poor citizens in the late 1940s.⁶⁵⁶ The CNT director had

⁶⁵⁵ Since 1909, several municipal health departments, especially those in the larger cities, provided medicines to poor citizens, undoubtedly in limited quantities and usually in external dispensaries attached to municipal hospitals. While only the revolutionary government of 1933–34 explicitly declared that it was the duty of municipalities to provide medicine for the poor, in the 1940s, hospitals, including tuberculosis sanatoriums, dedicated part of their budgets to medicine. Foreign Policy Association, *Problems of the New Cuba: Report of the Commission on Cuban Affairs* (New York: Foreign Policy Association, 1935), 107, 165; Dr. Juan M. Pla, "La Dirección de Beneficencia," *Boletín Oficial de la Secretaría de Sanidad y Beneficencia* 1, no. 1 (April–June 1909): 33; "Fondos municipales para los pobres; Decreto 2435," 14, legajo (leg.) 23, expediente (no.) 791, Fondo Partido Revolucionario Cubano (Auténtico) (PRC-A), Archivo Nacional de la República de Cuba (ANC). In 1944, 1945, and 1946, respectively, the budget of La Esperanza Sanatorium dedicated \$8,000; \$12,000; and \$43,274 to "drugs of all kinds." See leg. 22, no. 749, PRC-A, ANC; Bartolomé Selva León, *Un año de lucha antituberculosa en Cuba, 1944-1945* (Havana: Consejo Nacional de Tuberculosis, 1946), 315.

⁶⁵⁶ The municipal government also played a role, however small, in funding antibiotic therapy. Throughout 1947, the Municipal Respiratory Dispensary, funded by Havana's municipal government, reported that it had "freely administered" penicillin and streptomycin "to the population, and this dispensary is acquiring an adequate number of

promised in 1947 that if the drug proved effective in experiments, “we will be the first to obtain all the quantity necessary for our sanatoriums since we consider it our duty to serve the sick in everything.”⁶⁵⁷

However, the CNT had little room in its existing budget to buy the costly drug, as its operating budget devoted most of its funds to personnel salaries and new facilities (i.e., research institutions, sanatoriums, dispensaries). These constraints forced the CNT to rely upon special credits issued from the central government to purchase the drug. In April 1948 and August 1948, for example, the CNT director reported that the CNT received credits of \$6,000 and \$10,000, respectively, to purchase the drug to distribute to its patients.⁶⁵⁸ In August 1948, the CNT claimed to have distributed (to date) 15,000 grams free of charge.⁶⁵⁹ CNT Director Bartolomé Selva León attempted to spin this investment positively, claiming (incorrectly) that Cuba was the only country in the world to distribute streptomycin without cost to its poor population.⁶⁶⁰ When a new CNT director took over in late 1948, he spent \$20,000 on streptomycin in his first three months of office; it is unclear, however, if he continued to spend at that level over the course of

units and grams of these for clinical application every month” (158). However, it spent approximately \$3,860 in 1947 on streptomycin, which in no way could have served the many citizens in Havana who needed the drug (160). *Anuario de Sanidad Municipal, 1947–1948* (Havana: Alcaldía de la Habana, Departamento de Sanidad Municipal, 1948).

⁶⁵⁷ “El gobierno no puede,” 3; “Hacen aclaraciones,” 5.

⁶⁵⁸ “El Sanatorio ‘La Esperanza’,” *Diario de la Marina*, April 8, 1948, n.p.; “Unos 15,000 gramos de estreptomicina distribuidos gratis,” *Diario de la Marina*, August 4, 1948, 28.

⁶⁵⁹ Although the CNT did not reveal how many people had been treated, using the CNT standard range of dosages (40–125 grams), 120–375 individuals could have received a complete treatment (although it is more likely that more people were served, but only given partial treatment through small amounts of the drugs).

⁶⁶⁰ “Unos 15,000 gramos,” 28. By 1948, some municipal health departments in the United States, such as the one in Baltimore, had begun very small-scale funding of the drug in their public hospitals. Between 1952 and 1953, they started offering antibiotic therapy free of charge to all patients. City of Baltimore, Health Department, *One Hundred and Thirty-Fourth Annual Report of the Department of Health* ([Baltimore?], 1948): 27, <http://health.baltimorecity.gov/sites/default/files/City%20of%20Baltimore%20134th%20Annual%20Report%20of%20The%20Department%20of%20Health.pdf>; Samuel K. Roberts, *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill: University of North Carolina Press, 2009), 201–2.

his tenure.⁶⁶¹ By the early 1950s, a paltry 200 grams of streptomycin were given monthly to each CNT dispensary (along with a number of tablets of a new hydrazide drug).⁶⁶²

Beyond the issue of subsidization, the CNT hospitals could not adequately stock the drug in their pharmacies for patients to purchase, reflective of the broader situation of scarcity (e.g., food, instruments) plaguing hospitals. When streptomycin was not materially available in the sanatoriums, patients' relatives had to search out the drug in pharmacies outside the medical facilities.⁶⁶³ The system, then, was experienced by patients and their relatives as ineffective. The CNT could not ensure a steady supply of antibiotics for the poor patients in its facilities, nor could they finance a regular distribution of the drug. Furthermore, the historical evidence also suggests that the system was plagued by more than inefficiency: the press published convincing allegations that the poor constituents of the CNT saw little if any of the special credits issued expressly for streptomycin purchase, as patients reported that they had to pay for any doses administered (an allegation discussed in greater detail below).⁶⁶⁴ While some of Cuba's poor may have received free or subsidized streptomycin in certain moments, the evidence persuasively suggests that most patients had to draw on their own meager resources to purchase the drug from state hospitals or private-sector pharmacies.

Traditional mechanisms of health care in the republic (charity and patronage) emerged to answer this crisis of Cubans unable to afford the antibiotic. The Cuban media broadcast urgent appeals for the drug and/or cash donations. Guido García Inclán hoped to appeal to the charity of middle-class and wealthy Cubans and, in particularly egregious cases, public officials. Indeed,

⁶⁶¹ Pedro Díaz y Rodríguez, *La lucha antituberculosa en Cuba* (Havana, 1949), 2.

⁶⁶² The dispensaries also received "3 to 5,000 tablets of hydrazide" every month, but I am unsure of how many tablets were prescribed for a daily dose or total regimen. Pedro Iglesias Betancourt, "No justificación de Topes de Collantes," *Bohemia* 46 (June 20, 1954): 91.

⁶⁶³ "Cínica propaganda en torno al Sanatorio 'La Esperanza'," *Noticias de Hoy*, April 17, 1948, 1, 6.

⁶⁶⁴ "De pésima calidad la comida que se sirve en el Sanatorio La Esperanza: Grave situación confrontan los hospitalizados," *Noticias de Hoy*, August 11, 1948, 5.

for certain cases, the columnist reported that the CNT Director or the First Lady of the Republic had intervened to resolve the plight of a letter writer. García Inclán had to request that his readers not send in their electoral *cédulas*. He knew they hoped that they would receive money or streptomycin in return, but he emphasized that he was not seeking political office.⁶⁶⁵

By 1948, letters concerning streptomycin began to pour into García Inclán's office. He despaired, "Every day there are more people that come to us in supplication for streptomycin. The marvelous drug is prescribed by physicians, but...the poor cannot buy it!...and anguish and desperation begin."⁶⁶⁶ In August, the columnist begged his readers for patience, reporting that he received an "average of 40 letters a day," asking for help. When the CNT reported a recent purchase of the drug, García Inclán directed the letter-writers to CNT headquarters for assistance, but this does not seem to have happened frequently.⁶⁶⁷ In 1949, the situation had not let up, and García Inclán prefaced his column with the following admonition: "IMPORTANT NOTE: Every day the letters that we receive asking for streptomycin are more numerous."⁶⁶⁸

These requests emanated from all corners of the island, from the metropolitan centers of Havana and Santiago, as well as from tiny hamlets like Los Arabos, Rodas, and Camajuaní. In one *Bohemia* issue alone, requests for the drug were published on behalf of Cubans from Las Villas, Luyanó, Velasco, Havana, Santiago de Cuba, Central "Francisco," and Camagüey.⁶⁶⁹ Many of the letters came from patients already interned at one of the island's three state

⁶⁶⁵ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 42, no. 14 (April 2, 1950): 120.

⁶⁶⁶ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 13 (March 28, 1948): 26.

⁶⁶⁷ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 31 (August 1, 1948): 26.

⁶⁶⁸ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 41, no. 18 (May 1, 1949): 26.

⁶⁶⁹ Guido García Inclán, "En la feria de la actualidad," *Bohemia* (November 5, 1950): 120. Many published letters requesting streptomycin originated from outside of Havana. Although an imperfect measure, I tracked every letter requesting medicine published in the "En la feria de la actualidad" column between 1947 and 1952 that made known the geographic origin of each person. Of the 32 cases where the letter's provenance was identified, none came from Pinar del Río province; 21.8% came from Havana Province; 6.3% from Matanzas; 43.8% from Las Villas; 12.5% from Camaguey; and 15.6% from Oriente.

sanatoriums, and patients at La Esperanza were even given certificates, presumably from the sanatorium staff, to fill out and send to acquaintances to request donations so that they could buy the antibiotic.⁶⁷⁰ The CNT's patients, who had already fought against great odds to be granted admission to a tuberculosis facility, had to work to raise the money needed to buy the drugs before the hospital staff could administer them.

Even though García Inclán, other allies, and the sick leveraged traditional mechanisms of patronage and charity, most hoped for a more bureaucratic, technical and fair distribution of the drug, and in the process, they began to articulate a grassroots definition of the state's duty to subsidize antibiotic therapy for the poor. Some spoke generally of vague humanistic concerns and governmental duties. These citizens demanded that the government fulfill its responsibility of "protection."⁶⁷¹ When the Health Ministry and CNT did not provide antibiotic therapy, many alleged that they were committing "crimes against humanity."⁶⁷² Others explicitly used the language of patients' "right to recover their health."⁶⁷³

Many civic actors wanted some version of a government-run and -funded streptomycin bank to provide free access to the drug for the poor. García Inclán considered the absence of a National Streptomycin Bank to be a glaring fault. He wrote, "It is incredible that the Government of LOVE, with so many millions in income, is not capable of having a Streptomycin Bank, for these desperate cases. Turning its back on the people is committing a crime against humanity."⁶⁷⁴ He considered such a bank "the most fundamental thing."⁶⁷⁵ Aware that streptomycin worked

⁶⁷⁰ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 7 (February 15, 1948): 26; Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 21 (May 23, 1948): 26.

⁶⁷¹ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 42, no. 35 (August 27, 1950): 120.

⁶⁷² Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 13 (March 28, 1948): 26; Guido García Inclán, "En la feria de la actualidad," *Bohemia* 44 (May 4, 1952): 86.

⁶⁷³ Gustavo Aldereguía, "Mensaje a los enfermos tuberculosos," *Bohemia* 40, no. 34 (August 22, 1948): 50.

⁶⁷⁴ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 13 (March 28, 1948): 26.

⁶⁷⁵ Guido García Inclán, "En la feria de la actualidad," *Bohemia* 40, no. 21 (May 23, 1948): 26.

better for some forms of the disease than others, García Inclán fumed that the government did not ensure that the drug was furnished for these patients. He opined, “Streptomycin is the savior of this specific form of tuberculosis. But...the Government does not listen to this.”⁶⁷⁶ In another case, he wrote, “It seems impossible that our Government does not have a Streptomycin Bank for these cases, where the drug operates in a direct and efficient manner.”⁶⁷⁷

Cubans interpreted the government’s reticence to fund a streptomycin bank in divergent ways, few of them positive. Some citizens criticized North American pharmaceutical companies’ greed. However, most critiques concerned the Cuban government’s inability, indifference, or malfeasance concerning streptomycin.⁶⁷⁸ Citizens and journalists blamed Cuban politicians for the privileges granted to the U.S. pharmaceutical industry in the 1930s, to the detriment of the Cuban people.⁶⁷⁹ In the late 1930s, government officials had established regulations over the price of medicine, and many press outlets reported that many concessions had been granted to

⁶⁷⁶ Ibid.

⁶⁷⁷ Guido García Inclán, “En la feria de la actualidad,” *Bohemia* 40, no. 20 (May 16, 1948): 26.

⁶⁷⁸ In the United States, in comparison, there were more measured responses to the scarcity and/or high costs of the drug. Many citizens considered it normal and a stage that would soon be ameliorated with time, state control, and increased production by pharmaceutical companies. For example, the *New York Times* explained the existence of a black market for streptomycin in a matter of fact manner: while every gram was theoretically accounted for, “some of the drug so allocated may have found its way to the black market through inefficient handling in the agencies.” “Inquiry Is Started in Drug Sale Gouge,” *New York Times*, April 14, 1946, 36. This was the response, even though in the U.S., like Cuba, newspapers “were featuring swallow-hard stories about babies wasting away from want of streptomycin.” “Report on Streptomycin,” *TIME Magazine* 47, no. 21 (May 27, 1946): 51. Similarly, in Britain, the government found itself “besieged” by streptomycin requests, and the BBC “broadcast many emergency appeals for the drug.” The medical community, however, was able to create a toxicity scare to decrease demand for the drug and avoid the potentially politically destabilizing effects of unmet antibiotic demand. Alan Yoshioka, “Use of Randomisation in the Medical Research Council’s Clinical Trial of Streptomycin in Pulmonary Tuberculosis in the 1940s,” *British Medical Journal* 317, no. 7167 (October 1998): 1222; Alan Yoshioka, “Streptomycin in Postwar Britain: A Cultural History of a Miracle Drug,” *Clio Medica* 66 (2002): 203–27.

⁶⁷⁹ By 1952, the price of streptomycin had dropped radically in the United States (both in cost of production and price of consumption), but the pharmacies in Cuba continued to charge inflated prices. One report put the cost of streptomycin at over one peso a gram; the drug was being exported from the United States for only 15 to 25 cents a gram. As late as 1957, García Inclán continued to indict foreign exporters of drugs, for the cure for tuberculosis remained expensive. “El abusivo negocio de las medicinas,” *Bohemia*, February 24, 1952, in Enrique de la Osa, *En Cuba: Segundo tiempo, 1948–1952* (Havana: Editorial de Ciencias Sociales, 2005), 473; U.S. Department of Commerce, *United States Exports of Domestic and Foreign Merchandise: Commodity by Country of Destination* (1952): 160; Guido García Inclán, “¡Arriba corazones!” *Bohemia* 49 (September 8, 1957): 118.

the magnates of the “Trust del Dolor,” the caustic appellation by which Cubans indicted the industry. The critical press alleged that the “Trust del Dolor” and the CNT were involved with specific abuses regarding streptomycin. At the end of 1948, *Bohemia* journalist Enrique de la Osa accused CNT Director Selva León of directly profiting from the sale of streptomycin. “The Director had organized a true racket with streptomycin.” He clarified, “When an influential politician requested the saving substance, the request was made for quantities much higher than what was required, and the surplus thus accumulated was resold...to the laboratories.”⁶⁸⁰ As late as 1952, de la Osa continued to rail against the “abusive business of drugs,” arguing that while the nation was “one of the countries with the highest medicinal consumption in relation to its population—50 million pesos sold in 1951—it was, also, the center of the most scandalous speculation with the price of medicine.”⁶⁸¹

When news of streptomycin’s discovery reached the press in 1945, in both Cuba and the United States, headlines optimistically presaged scientific conquest. By the late 1940s, these narratives had unraveled in Cuba, replaced by a more critical assessment of Cuba’s public health sector. In many citizens’ eyes, the government had performed poorly in the first years of streptomycin’s arrival in Cuba, and the inability of patients to gain access to the drug served as a material measure of state incompetence or complicity. In response, patients began to mobilize for change.

⁶⁸⁰ “En Cuba: Salubridad,” *Bohemia* 40, no. 49 (December 5, 1948): 62–63.

⁶⁸¹ “El abusivo negocio,” 472.

6.2 GRASSROOTS MOBILIZATION

Tuberculosis may have enervated their bodies, but those who had secured a bed at one of Cuba's public tuberculosis hospitals did not react passively to what they perceived as the CNT's mounting indifference. Unlike sanatoriums in other urban metropolises in Latin America, patient strikes in Cuba did not seem to be the norm (or at least did not receive national coverage) in the 1920s and 1930s.⁶⁸² However, beginning in 1946, strikes organized within sanatoriums erupted sporadically in Cuba. Some were in reaction to the practices of individual institutions, and others sought to build on the momentum of strikes that had begun in hospitals in other cities. This cycle persisted until the presidential administration of Carlos Prío Socarrás aggressively quelled a highly-publicized strike at La Esperanza Sanatorium in 1951.

One strike in August 1948 is illustrative of the motivations, methods, and objectives of tuberculosis patients who mobilized in the late 1940s. On August 5th, a large group of angry patients exited Ambrosio Grillo Sanatorium, outside of Santiago de Cuba. They purposefully blocked vehicles on the central highway, "paralyzing the flow of traffic in protest of the bad quality and quantity of food, screaming that they were hungry, that their clothes were dirty..."⁶⁸³ The doctors at Ambrosio Grillo admitted that the patients had every reason to be upset: for the past several months, the sanatorium administrators had fallen significantly behind on paying the food vendors and had resorted to watering down milk, replacing butter with a poor quality oil (which irritated the patients' stomachs), and serving lower quality and smaller portions of

⁶⁸² Historians have analyzed sanatorium strikes, for instance, in Argentina and Uruguay, from the 1920s through the 1940s. Armus, *The Ailing City*, 88–91; José Pedro Barrán, *La ortopedia de los pobres*, vol. 2 of *Medicina y sociedad en el Uruguay del novecientos* (Montevideo: Ediciones de la Banda Oriental, 1993), 199–203.

⁶⁸³ "Abandonan un hospital sus 398 enfermos," *El Crisol*, August 6, 1948, 1, 10. See also, "Enérgica protesta de los enfermos en el Ambrosio Grillo," *Diario de la Marina*, August 6, 1948, 28.

meat—some of which had worms, according to patient allegations.⁶⁸⁴ A contingent of the armed forces was called out to convince the patients to leave the highway and return to the sanatorium, but they did so only on several conditions, the most important of which was that CNT Director Selva León visit the sanatorium in person to hear their list of demands.

When Selva León arrived, he did his best to dispel the patients' anger, promising that he had checks to (partially) pay suppliers; what was still owed would be paid by September 15th.⁶⁸⁵ Selva León spent most of his time passing the buck, but his maneuverings served only to illustrate the fractious, chaotic, and politicized nature of the Cuban government. Selva León reported that he had to visit the Minister of the Treasury in person in order to get a check to pay the sanatorium's debts. While the facility owed 50,000 pesos to suppliers, Selva León received enough only to liquidate 15,000 pesos of that debt. He then revealed that the Treasury owed more than 40 million pesos to suppliers throughout the island.⁶⁸⁶ As would be repeated in press coverage of future strikes, government officials' public acknowledgment of the dysfunctional operation of state institutions encouraged a growing perception that the public health sector was inadequate and a national embarrassment.

Reports of this strike and subsequent sanatorium rebellions also indicated that antibiotics—or lack thereof—functioned as a spark to mobilization. One *Bohemia* journalist who interviewed the patients at Ambrosio Grillo disclosed, “[T]he new drug...has been taken as the pennant of the patients' upheaval.”⁶⁸⁷ Physicians also expressed frustration concerning this issue.

⁶⁸⁴ “Comida con gusanos sirven a los enfermos recluidos en el Hospital Ambrosio Grillo,” *Noticias de Hoy*, August 8, 1948, 1, 8; “Trucidan muertos en ‘Ambrosio Grillo’,” *Noticias de Hoy*, August 13, 1948, 1, 6.

⁶⁸⁵ With this, *Diario de la Marina* considered the issue to be closed, even if other newspapers did not agree. “Con el pago a los suministradores del Hospital ‘Ambrosio Grillo’, se estima resuelto el problema de los enfermos,” *Diario de la Marina*, August 7, 1948, 3.

⁶⁸⁶ “De pésima calidad,” 1; “Acusan médicos del Hospital Ambrosio Grillo a Selva León,” *Noticias de Hoy*, August 7, 1948, 1, 5.

⁶⁸⁷ Carlos González Palacios, “Rebelión en el ‘Ambrosio Grillo’,” *Bohemia* 40, no. 33 (August 15, 1948): 73.

With Selva León present, “Doctor Venzant, distinguished Doctor of the sanatorium, made a careful presentation about the problem of streptomycin.” In response, “Dr. Selva defended himself against the charges. He signaled the very high price of the drug; its scarcity; and highlighted his doubt about its efficacy in many cases.”⁶⁸⁸ When the press, mostly based in Havana, heard about Ambrosio Grillo, they turned to La Esperanza in their backyard to ascertain if the patients’ demands in Santiago had any validity. Despite the two facilities being on opposite ends of the island, with one on the periphery and the other in the medical and governmental core, the reporters confirmed that they shared many worrying problems, and streptomycin constituted a top concern.⁶⁸⁹

Discontent in the sanatoriums was aggravated by news reports that the CNT had purchased streptomycin, while the patients still had to pay for the drug out of their own pockets. One journalist reported, “Right now there is a muffled protest over what is happening with Streptomycin, which it has been said has been acquired by the CNT. According to Señor Selva León, 10,000 pesos have been invested in the drug, but the sick have to pay with their own money for the doses that they need.”⁶⁹⁰ When *Diario de la Marina* reported in April 1948 that the CNT had spent around \$6,000 on streptomycin for its patients in the first several months of the year, *Noticias de Hoy* responded with incredulity.⁶⁹¹ They were disgusted with this “criminal lie,” which was disputed by the fact that many relatives had to “anxiously journey” to try to find the drug for their interned family members.⁶⁹² An outraged journalist bemoaned that the hospital did not have “credits available to cover this fundamental aspect of public health care!” And,

⁶⁸⁸ Ibid. Also, see “Acusan médicos,” 1, 5.

⁶⁸⁹ “No se atiende la higiene pública en La Esperanza,” *Noticias de Hoy*, August 13, 1948, 7; “Ratifican denuncia contra el director de ‘La Esperanza’,” *Noticias de Hoy*, August 22, 1948, 12.

⁶⁹⁰ “De pésima calidad,” 6.

⁶⁹¹ “El Sanatorio ‘La Esperanza’,” *Diario de la Marina*, April 8, 1948, n.p.

⁶⁹² “Cínica propaganda,” 1, 6.

perhaps more importantly, he alleged, “And if there are, they steal them.”⁶⁹³ When the hospital did have stocks of streptomycin, the paper reported that it did not sell the drug at low prices, and patients and relatives had to make “great sacrifices” to purchase the prescribed grams.⁶⁹⁴ To add insult to injury, in Lebrede Hospital, the patients had to even buy the syringe to inject streptomycin; in one hall of the hospital, with 28 patients, there was only one syringe supplied.⁶⁹⁵

Once patients began to be interviewed, journalists discovered that racketeering, favoritism, and patronage characterized the distribution of the drug within state sanatoriums. In Ambrosio Grillo, one journalist reported, “[W]hile streptomycin is scarce, a favored patient has received almost 200 grams of the drug for his personal use from the official sphere. All of this echoes and disorders the morale of the establishment.”⁶⁹⁶ An exposé on La Esperanza in *Noticias de Hoy* demanded to know how the CNT had spent the credit expressly issued for purchasing the drug: “Where has the streptomycin, that should be handed out [*distribuido*] among the sick of La Esperanza Sanatorium who need it, gone to? Could it be that Dr. Selva León distributes it exclusively among some protected ones (*algunos protegidos*)?”⁶⁹⁷ Earlier in the month, *Noticias de Hoy* had already alleged, “Dr. Selva León carries with him ‘some grams of streptomycin’ to give to the sick who have requested them in advance.”⁶⁹⁸ *Prensa Libre* connected the corruption concerning medicine to a broader web of problems: “The credits for medicine vanish. Supplies are trafficked, which is like trafficking in the blood, pain and flesh of the unfortunate compatriots who, without resources for the expensive treatment required for the disease that has taken hold in their bodies, go to that hill [La Esperanza] seeking relief, to be equipped with supplies to battle

⁶⁹³ Ibid., 6.

⁶⁹⁴ “Miente el ‘Diario de la Marina’ en lo publicado sobre ‘La Esperanza’,” *Noticias de Hoy*, April 20, 1948, 5; “Cínica propaganda,” 6.

⁶⁹⁵ “Miente el ‘Diario de la Marina’,” 5.

⁶⁹⁶ González Palacios, “Rebelión en el ‘Ambrosio Grillo’,” 74.

⁶⁹⁷ “De pésima calidad,” 6.

⁶⁹⁸ “Acusan médicos,” 1, 5.

against death.”⁶⁹⁹ Unfortunately, admission did not guarantee that one would “be equipped with supplies.”

When Selva León returned from Santiago to Havana, he attempted to dispute many of the patients’ and journalists’ reports. He thanked the director of the conservative *Diario de la Marina* for his “sensible editorials” about the influence of “poisonous communism” within Cuba, and by extension, the halls of the CNT hospitals.⁷⁰⁰ Selva León insisted, “[T]he patients never lack anything.” Instead he alleged that “[w]hat happened in the ‘Ambrosio Grillo’ Sanatorium is a display of what communism, trying to mislead public opinion, can cause.” According to Selva León, communist patients within the sanatorium had fomented anarchy in the facility. When hearing about the failure to pay suppliers, “[a] group of 5 or 6 communists took advantage of the opportunity.”⁷⁰¹ In a political climate of staunch anti-communism, Selva León tried to discredit the movement by attributing it solely to communist agitation.⁷⁰² One *Bohemia* journalist partially agreed, observing that the leaders of the strike “spoke a communist and pseudo-revolutionary language.”⁷⁰³

When Selva León publicly undermined the patients’ demands, the director of Ambrosio Grillo retaliated against the strikers by expelling two of the protest leaders from the sanatorium, citing indiscipline. *Noticias de Hoy* reported that Luis Felipe Rivero and Benito Suárez “were criminally thrown out,” without being given any money for transportation. Felipe Rivero was seriously ill but was refused entrance into Santiago’s general hospital, which did not admit

⁶⁹⁹ Raúl Lorenzo, “¡Aquí estamos, Aldereguía!” *Prensa Libre*, n.d., Fondo de Gustavo Aldereguía (GA), Archivo de la Oficina del Historiador del Ministerio de Salud Pública (AOH).

⁷⁰⁰ “Una felicitación al ‘Diario’ del Dr. B. Selva León,” *Diario de la Marina*, August 13, 1948, 23. Also, see “Una entrevista con Bartolomé Selva León,” *Diario de la Marina*, August 11, 1948, 10.

⁷⁰¹ “Una felicitación,” 23.

⁷⁰² Alejandro de la Fuente, *A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001), 224.

⁷⁰³ González Palacios, “Rebelión en el ‘Ambrosio Grillo’,” 45.

tubercular patients. One paper alleged, “The ‘Ambrosio Grillo’ Hospital has been converted into a concentration camp. More than twenty soldiers, under the command of a lieutenant, surround the sanatorium to prevent any protest movement of the patients. The patients continue to totally lack food.”⁷⁰⁴

While some journalists considered some of the patient claims about abuse at the sanatorium to be patently false, almost every newspaper agreed that the patients had a right to be upset about other issues and that the central governing board of the CNT was to blame. For instance, while one reporter remained skeptical about the claims against the sanatorium’s *mayordomo*, he conceded that the “politicking attached to almost of all the institutions of our State permeates the organization of this center too much.”⁷⁰⁵ He condemned the highest authorities for failing to exert authority. “[T]here is no other remedy,” he concluded, “but to find the governmental system guilty.”⁷⁰⁶ In the end, allegations of serious administrative malfeasance at Ambrosio Grillo Sanatorium could not be denied, and Selva León had to designate an investigator for the sanatorium in late August 1948, in order to probe for “anomalies.”⁷⁰⁷ Even though the chaos at Ambrosio Grillo had died down, strikes and protests continued to plague the tenure of the Auténtico CNT directors. Strikes took place at Ambrosio Grillo and/or La Esperanza in February 1946, August 1948, November 1948, October 1949, November 1949, February 1950, and August 1951.

In the wake of these sanatorium strikes, Gustavo Aldereguía attempted to leverage national discontent, proposing the organization of those with tuberculosis into a union: the

⁷⁰⁴ “Echan del ‘Ambrosio Grillo’ a los enfermos que denunciaron los inmoralidades de allí,” *Noticias de Hoy*, August 11, 1948, 5.

⁷⁰⁵ González Palacios, “Rebelión en el ‘Ambrosio Grillo’,” 74.

⁷⁰⁶ *Ibid.*, 44.

⁷⁰⁷ “Se ve obligado Selva León a reconocer las anomalías del Hospital ‘Ambrosio Grillo’,” *Noticias de Hoy*, August 20, 1948, 5; “Investigador para Ambrosio Grillo,” *El Mundo*, August 20, 1948, 7.

National Union of Tuberculosis Patients and Ex-Patients (*Unión de Enfermos Tuberculosos y Ex-Enfermos*) (UNETE).⁷⁰⁸ Patients and physicians like Aldereguía understood the mechanics of the political system, which was particularly responsive to organized groups.⁷⁰⁹ Efforts to create a union illustrate how medical care (and drug availability and distribution in particular) had fallen prey to the logic of the Cuban state. Aldereguía used *Bohemia* as a platform to call for registration, which resulted in “hundreds of letters, all responses lit by fever and faith.”⁷¹⁰ According to historians, UNETE even published a monthly journal, but the union’s efforts appear to have been short-lived.⁷¹¹ Reports on strikes from the early 1950s, including ones authored by Aldereguía, make no reference to UNETE.

Even without a national organizing body, patients persisted in taking matters into their own hands, and streptomycin continued to function as a material motivator for mobilization. In the October 1949 strike at La Esperanza, patients “were united in their petition to secure better care,” and they presented a memorandum to the President, asking for “sufficient credits to be allocated to the Sanatorium...for the nutrition of the patients and the provision of medicine.”⁷¹² Later that month, the patients at Ambrosio Grillo followed the example of the La Esperanza patients and organized a strike again, “asking for improvement in food, medicine, and care in general.”⁷¹³ By the end of the month, Selva León dispatched by air 1,300 grams of streptomycin to the sanatorium in Santiago, to be distributed free of charge; this effectively subdued the

⁷⁰⁸ Aldereguía, “Mensaje a los enfermos,” 50–51, 71; Gustavo Aldereguía, “Polémica ante el espejo: Con motivo del mensaje a los tuberculosos,” *Bohemia* 40, no. 36 (September 5, 1948): 37, 74, 97; Gustavo Aldereguía, “Llamado a los médicos: Con motivo del mensaje a los tuberculosos,” *Bohemia* 40, no. 37 (September 12, 1948): 36, 73–74.

⁷⁰⁹ Jorge I. Domínguez, *Cuba: Order and Revolution* (Cambridge, MA: Belknap Press of Harvard University Press, 1978).

⁷¹⁰ Gustavo Aldereguía, “Cama y paréntesis,” *Bohemia* 40, no. 45 (November 7, 1948): 27.

⁷¹¹ Gregorio Delgado García, “Aldereguía Lima, Gustavo (1895–1970),” *Revista de Ciencias Médicas de la Habana* 20, no. 2 (2014): 287. It is unclear when and why the union ceased to exist.

⁷¹² “Prometan dar atención a los enfermos de ‘La Esperanza’,” *Diario de la Marina*, October 13, 1949, 28.

⁷¹³ “Remediaran la situación del Hospt. Grillo,” *Diario de la Marina*, October 21, 1949, 28; “Informaran al Presidente de la crisis del Sanatorio ‘A. Grillo’,” *Diario de la Marina*, October 26, 1949, 13.

upheaval.⁷¹⁴ These piecemeal responses, which provided streptomycin only in the aftermath of nationally publicized episodes of patient mobilization (in contrast to a more organized and regular bureaucratic distribution), point to the lack of efficiency in the public health system.

These strikes were motivated primarily by the streptomycin issue, but also by broader dissatisfaction with the CNT in the late 1940s. During almost every month of 1948, *Bohemia* ran lengthy editorials and small opinion pieces on the problems plaguing the CNT. That 1948 was an election year illuminates how politically contentious and salient tuberculosis had become. Allegations swirled around multiple issues: the “abandoned” state of tuberculosis facilities; the politically-motivated decision to not finish Topes de Collantes sanatorium; corruption and favoritism among administrators; continued practices of patronage in admission process; and gross negligence. Gustavo Aldereguía branded the CNT as the “Consejo Nacional de Politicosis,” an organization infected by the political ills affecting many health institutions.⁷¹⁵

Patients who initiated strikes believed CNT and hospital administrators were mismanaging sanatoriums. Problems with antibiotics went hand in hand with other difficulties of daily life in the sanatoriums, as José Chelala Aguilera observed when he made a surprise visit to La Esperanza Sanatorium in March 1948. This investigative report was prompted by the dozens of letters that *Bohemia*’s editorial board had received about the state of affairs in the nation’s premiere tuberculosis treatment center.⁷¹⁶ Chelala reported on a severe disconnect between the needs of the facility (articulated by the medical faculty), and the budget and distribution networks set up by the CNT, whose representatives rarely visited the hospital complex. For

⁷¹⁴ “Estreptomicina para enfermos del ‘A. Grillo’,” *Diario de la Marina*, October 29, 1949, 8.

⁷¹⁵ Gustavo Aldereguía, “El escándalo de ‘La Esperanza’ y la Novena Convención de Tisiología,” *Bohemia* 40, no. 47 (November 21, 1948): 75.

⁷¹⁶ José A. Chelala, “Reportaje sobre ‘La Esperanza’: Una acusación contra el Consejo Nacional de Tuberculosis,” *Bohemia* 40, no. 17 (April 25, 1948): 64.

instance, the budget allocated 45 cents per person for food daily, while one hospital administrator reported needing to spend 71–73 cents.⁷¹⁷ Admission decisions were made not by dispensary or hospital doctors but “from above,” issuing down from somewhere in the CNT’s central administration. While the number of patients kept increasing, the quantity of medical personnel decreased.⁷¹⁸ Like other hospitals in the republic, La Esperanza ran a monthly deficit, and Chelala advised health officials and private donors to act fast, for “[a]lready the moment is arriving in which the hospitals will have to close their doors.”⁷¹⁹

While Chelala praised some of the more orderly and hygienic sections of the sanatorium, he also stumbled upon several makeshift living quarters, many of which were in the basement, informally thrown together to house numerous servants and low-paid employees (see Figure 14). He concluded that these rooms represented a real hazard for the health of these employees. “The environment and the furniture,” Chelala penned, “denounced an extraordinary misery and an adequate source for cultivating and spreading the Koch bacillus.”⁷²⁰ Chelala could not “comprehend that such a room existed in La Esperanza Sanatorium—our principal and best surgical-medical center for the treatment of tuberculosis.”⁷²¹ Other reports corroborated the horrific conditions of the island’s sanatoriums.⁷²² One journalist, for instance, described Ambrosio Grillo as a “tomb of living men.”⁷²³

⁷¹⁷ Ibid., 65.

⁷¹⁸ Ibid., 66.

⁷¹⁹ Ibid., 67.

⁷²⁰ Ibid., 90.

⁷²¹ Ibid.

⁷²² “Cínica propaganda,” 1, 6; “Miente el ‘Diario de la Marina,’” 5; Gustavo Aldereguía, “Mi visita al Sanatorio Hospital Ambrosio Grillo,” *Bohemia* 41, no. 5 (January 30, 1949): 24–25, 89.

⁷²³ “Cunde la rebeldía entre los enfermos abandonados del Hospital ‘Ambrosio Grillo,’” *Alerta*, August 29, 1951, 16.



Figure 14. A photograph published with Dr. Chelala's exposé at La Esperanza Sanatorium. It featured beds “whose rusty racks held up discolored mattresses.”⁷²⁴

Past scholarship has often described the pre-revolutionary period's public health sector in static terms of corruption and inefficiency.⁷²⁵ A closer analysis of these decades, however, reveals a significant intensification of these practices during the Auténtico years. The political designs of Machado and Batista in launching tuberculosis initiatives had been transparent to many Cubans. Journalists and physicians had publicly discussed them from their respective dates of inception. Nonetheless, the severity and scope of the critiques of the CNT in the late 1940s constituted a departure from previous forms of criticism.⁷²⁶

All of this frustration culminated in the most disruptive and infamous sanatorium strike in republican Cuba, which burst out of the gates of La Esperanza Sanatorium in the late summer of 1951. Trouble had been brewing in the months leading up to the strike. Tensions increased as patient expectations were continually not met: the CNT's apparent disinterest and mismanagement meant the hard-working sanatorium staff often did not have the resources to

⁷²⁴ Chelala, “Reportaje sobre ‘La Esperanza’,” 65.

⁷²⁵ See, for example Katherine Hirschfeld, *Health, Politics, and Revolution in Cuba since 1898* (New Brunswick: Transaction Publishers, 2008), 14.

⁷²⁶ Although critics accused Batista for using the CNT to build political legitimacy and for making decisions first and foremost on political and not scientific objectives, I have uncovered no claims in the press during the late 1930s and early 1940s that Batista or his cronies embezzled CNT funds.

adequately care for patients. On August 7th, when the male patients were served lunch, they refused to eat it on the grounds of its poor quality. Later in the afternoon, patients at the adjoining Lebrede Hospital created more disorder, “throwing plates, glasses, and spoons into the street, at the same time exhorting their *compañeros* who left for the public road to make ‘demonstrations on the street’.”⁷²⁷ The disorder turned from local to national: the patients at Ambrosio Grillo, “[l]ost in the eastern extreme of the island, at the mercy of official charity,” began to protest against their own situation at the same time of the La Esperanza strike.⁷²⁸



Figure 15. The patients march to the theater of the sanatorium.⁷²⁹

In response to the growing disorder, La Esperanza Director Dr. Carlos Guerrero ordered the gates of the sanatorium to be closed. Meanwhile, representatives of the Federation of University Students (FEU) and the press came to the scene, as well as family members of patients, who had heard about the situation. When the director refused to open the doors, several

⁷²⁷ “Plantearon un nuevo conflicto los enfermos de ‘La Esperanza’,” *Diario de la Marina*, August 8, 1951, 32.

⁷²⁸ “Cunde la rebeldía,” 16; “Actitud rebelde de los recluidos en el Hospital ‘Ambrosio Grillo’,” *El Mundo*, August 5, 1948, 1, 12; “Portador Selva León de la solución de grave problema,” *El Mundo*, August 7, 1948, 6.

⁷²⁹ “Enfermos hacia el teatro del Sanatorio,” *El Mundo*, August 8, 1951, 26.

patients and FEU students proceeded to open one of the gates, and all headed to the theater of the sanatorium where they “improvised various acts of protest” (see Figure 15).⁷³⁰

The patients at La Esperanza were denouncing lack of food, overcrowding, unsanitary conditions, and, of course, insufficient antibiotics. They insisted that they had not seen the effects of the 30,000-peso credit that the government had given to La Esperanza in response to intensifying patient complaints in the summer months.⁷³¹ Instead of attempting to pacify the patients and focus on funneling more resources into the hospital, the government’s response to the protest came swiftly and aggressively. The sanatorium staff decided to call the police, who rounded up 115 patients, five of who were women, and transferred them, “as detainees” for their indiscipline, to a police station in Havana.⁷³² Two days after the event, President Prío named Col. Dr. José Randin Vergara, previously director of the Police Hospital, as military supervisor of the sanatorium.⁷³³ The *Havana Post* noted that this was necessary as “[t]hroughout the morning yesterday, the patients still remaining in the hospital maintained their protest, which grew more violent after the expulsions Tuesday. The patients spent the morning throwing bottles, plates and other objects into the streets of the Sanatorium and the doctors declared they could not restore order.”⁷³⁴

The public response to this episode echoed widely and loudly. The visual record of the event proved shocking—weakened tuberculosis patients were treated as criminals and lay across the floor of the police station (see Figure 16). The papers featured stories of suffering at the

⁷³⁰ “Refúgíanse los enfermos en el Recinto Universitario,” *El Mundo*, August 8, 1951, 8. See also, “Tratan de imponer el orden en el Hospital,” *El País*, August 8, 1951, 1, 8.

⁷³¹ “Refúgíanse los enfermos,” 1.

⁷³² *Ibid.*, 1, 8.

⁷³³ “Designan supervisor para La ‘Esperanza’,” *Havana Post*, August 9, 1951, 1; “Normalidad en ‘La Esperanza’,” *El País*, August 9, 1951, 1, 8; “Trabaja el supervisor militar de La Esperanza,” *El País*, August 13, 1951, 1, 8; “Con amplios poderes designaron al Cnal. Randin en La Esperanza,” *Diario de la Marina*, August 9, 1951, 16.

⁷³⁴ “La Esperanza Sanatorium Re-Admits Ousted Patients,” *Havana Post*, August 9, 1951, 1.

station, with one striker, for instance, experiencing an episode of hemoptysis. In response, the FEU opened the University Stadium to the expelled patients, neighbors brought food and milk, and doctors from the nearby Calixto García Hospital treated them. The day following the expulsion, the FEU demanded better food and medicine for patients at La Esperanza, the readmittance of the strikers, and “the resignation of the Minister of Health for his ‘unjust and inhumane’ attitude in ordering the patients out of La Esperanza.”⁷³⁵ The active involvement of the FEU in these conflicts speaks to the growing political importance of the disease. Other politically prominent figures, even those not directly connected with the health sector, condemned the conditions in La Esperanza. For example, Juan Marinello, head of the PSP, deemed the strike a “just protest.”⁷³⁶



Figure 16. *Bohemia* published photographs of the arrested patients on the floor of the police station.⁷³⁷

⁷³⁵ “TB Patients Ousted; FEU Protests,” *Havana Post*, August 8, 1951, 10.

⁷³⁶ Juan Marinello Vidaurrete, “El arte y la paz: Sigue el escándalo de La Esperanza,” September 10, 1951, 2, Marinello Manuscript Collection, no. 130, Colección de Manuscritos (CM), Biblioteca Nacional de Cuba José Martí (BNJM).

⁷³⁷ “Escena de abuso, miseria y dolor en el Sanatorio ‘La Esperanza’,” *Bohemia* 43, no. 32 (August 12, 1951): 90–91.

The pressure grew to be so great that the Health Minister and the CNT promised to make changes. Labor leaders, including CTC leader Eusebio Mujal, and the student leaders of the FEU, met with Prío and secured the re-admittance of the strikers to La Esperanza.⁷³⁸ The new administration of the sanatorium reported immediate improvements in the management and infrastructure of the facility.⁷³⁹ The critical press, however, reported that in the aftermath of the strike, the new administration exerted a firm grasp over La Esperanza, and despite Prío's promises, within weeks all had returned to normal and the scope of changes were limited.⁷⁴⁰

Respected national figures, such as Guido García Inclán, Gustavo Aldereguía, and Juan Marinello, wrote throughout 1951 about the failed promises of the Prío administration regarding the strike.⁷⁴¹ Roughly a month after the strike, based on a patient's letter, Marinello informed the audience of *La Última Hora*, "[T]he promises have not been fulfilled, the money has not arrived to the sanatorium and the situation is practically the same as that which caused the loud and justified protest."⁷⁴² By the end of the year, Marinello penned:

Never have things gone very well in the official service to tuberculars nor in the internal management of La Esperanza Sanatorium. But the situation of this sanatorium has reached such a point that it would not be an exaggeration to call it a national shame. It could not be otherwise, the predatory and lazy plague of the *Prista* bureaucracy having fallen on the important center of treatment. For a long time, waste and dishonesty have been vast in the management of La Esperanza. In this each administration has surpassed the previous one. But the criminal neglect and the absence of all scientific standards have

⁷³⁸ "Reintegran al Sanatorio a los enfermos que se trasladaron al stadium," *Diario de la Marina*, August 9, 1951, 32; "La Esperanza Sanatorium Re-Admits," 1; "Reingresan todos los enfermos al Sanatorio," *El Mundo*, August 9, 1951, 1, 8. These leaders also continued to meet with health officials throughout August. "Visitó al M. de Sanidad, al Ejecutivo de la FEU: Trataron del problema del Sanatorio 'La Esperanza'," *El País*, August 23, 1951, 1, 8.

⁷³⁹ "Mejora comida en 'La Esperanza'," *El Mundo*, August 14, 1951, 5; "Informa a Prío el Supervisor de La Esperanza," *El Mundo*, August 21, 1951, 12; "Reorganización de La Esperanza," *El Mundo*, August 22, 1951, 7; "Aclaraciones en torno al caso de La Esperanza," *El Mundo*, August 24, 1951, 4.

⁷⁴⁰ "Incumplidas por el gobierno las demandas de los enfermos de 'La Esperanza'," *Alerta*, September 15, 1951, 8.

⁷⁴¹ See, for example, Gustavo Aldereguía, "Yo estuve en el Stadium Universitario, Carlos Prío," *Alerta*, September 4, 1951, n.p. in GA, AOH; Gustavo Aldereguía, "Yo estuve en el Stadium Universitario, Carlos Prío: II," *Alerta*, September 6, 1951, 4, 7; Gustavo Aldereguía, "Yo estuve en el Stadium Universitario, Carlos Prío: III," *Alerta*, September 7, 1951, 4.

⁷⁴² Marinello Vidaurrete, "El arte y la paz," 2, Marinello Manuscript Collection, no. 130, CM, BNJM.

never been so absolute as now. Place of theft and deaths. That is La Esperanza. Good image of the government that serves it and destroys it.⁷⁴³

Despite these reports, by mid-1952, the chapter of this “crisis” had been declared closed by the CNT. Its journal reported on all of the improvements made at the sanatorium by Col. Randin, alleging that discipline had been restored for the benefit of the hospital.⁷⁴⁴

Taken as a whole, the episodic strikes reveal how desperate the situation had become for those lucky enough to have secured one of Cuba’s scarce sanatorium beds. In 1949, one reporter conjectured that tuberculosis sanatoriums were “one of the gravest problems, and perhaps the sharpest of all, created by the sanitary policy of the Auténticos.”⁷⁴⁵ The internal management of sanatoriums was seen as a microcosm of Cuba’s national politics. Reporting on the 1948 Ambrosio Grillo strike, another journalist concluded, ““Ambrosio Grillo is not an exception...In any zone of the State, the situation is the same. The government has lost credit; has ignored its own program; has disrupted its authority; has twisted the Constitution and laws to its whim; has allowed excesses, plunder, and crime.”⁷⁴⁶

⁷⁴³ Juan Marinello Vidaurrete, “Lo del Quetzal: Final previsto. El escándalo de La Esperanza,” December 27, 1951, 2, Marinello Manuscript Collection, no. 113, CM, BNJM. Other papers confirmed that conditions remained poor in La Esperanza. See, for example, “Es campo de concentración el Sanatorio ‘La Esperanza’,” *Alerta*, December 15, 1951, 12.

⁷⁴⁴ “Informaciones: Sección del Hospital-Sanatorio ‘La Esperanza’,” *Revista Cubana de Tuberculosis* 16, no. 2 (April–June 1952): 253–63.

⁷⁴⁵ “Protesta en el Sanatorio La Esperanza por la falta total de la comida y medicamentos,” *Noticias de Hoy*, November 12, 1948, 1, 5.

⁷⁴⁶ González Palacios, “Rebelión en el ‘Ambrosio Grillo’,” 74.

6.3 THE RETURN OF CHARITIES

Running parallel to this cycle of radical protest, upper- and middle-class citizens began to mobilize to deal with the urgent issue of tuberculosis care. Unlike strikers' disgust with the material shortcomings of a corrupt administration, these citizens hoped to supplement the CNT's work, drawing upon traditional notions of charity and humanitarian philanthropy.⁷⁴⁷ In the late 1940s, physicians and civic figures formed private voluntary associations, which, among other goals, sought to facilitate access to streptomycin. With the advent of antibiotic drugs for the disease, treatment, while still costly, was no longer prohibitive for wealthy individuals or groups of middle-class citizens. In short, antibiotics had the potential to decentralize state-provided health care. Private citizens providing health services to the poor worked against the principles undergirding Batista's design for a welfare state and used traditional mechanisms of class-based charity to provide health services.

Dr. Arnaldo Coro del Pozo, a tuberculosis specialist, was the architect behind this new wave of associational activity. In his narration of the origins of the new organizations, class and racial power dynamics are clearly evidenced:

In 1946 the discovery of Streptomycin by professor Wassman [*sic*] was officially announced....We decided to go to the Mayo Clinic to observe the results and learn the application of Streptomycin under the expert direction of Drs. Feldmann and Hinshaw. A few weeks after our return, Streptomycin was already for sale in Cuba, but at a soaring price....Then we saw *una muchacha de color*, 15 years old, who presented with a form of pulmonary tuberculosis that I had already seen evolve towards cure with streptomycin treatment at the Mayo Clinic, but this case was in the Laennec Dispensary [in a neighborhood of Havana], which translated means that the patient was poor, and poor *de qué manera*; her mother was a cook and earned \$20 a month, they lived in one room in a

⁷⁴⁷ See the regulations of the anti-tuberculosis leagues, which emphasized that they were to "[m]ake propaganda for the anti-tuberculosis campaign, according to the guidelines of the Consejo Nacional de Tuberculosis."

"Reglamento," *Liga Antituberculosa de Regla*, 7, leg. 1194, no. 24928, Fondo Registro de Asociaciones (RA), ANC; "Reglamento," *Liga Antituberculosa de Bauta*, leg. 708, no. 18250, RA, ANC.

solar, in the picture of misery that can be imagined. It was not possible to propose to this mother that she needed to obtain, by any means, the approximately \$200 needed for the cure of her daughter; I thought about it various times but it was impossible for me to put the dagger in the chest of this Cuban mother, and I simply asked God for help.⁷⁴⁸

The next day, still distraught, Coro ran into a friend, a fellow member in the local Rotary Club. He explained his despondency, and his friend abruptly drove him to the exclusive Biltmore Club. There, his colleague “directed himself to a group of peers from the Club and he requested from each one a quantity of money, five, ten and twenty pesos.” After his rounds, he told him, “Coro, smile a little, change your face, for already your patient is going to be saved. Here is the money so that you can buy Streptomycin.”⁷⁴⁹

From this experience, Coro and his Rotary companions realized the potential of fundraising for the drug, and they drew from the far-reaching social connections of the Rotary Clubs to launch a network of streptomycin banks.⁷⁵⁰ At first, they grafted onto the existing state infrastructure, forming a bank at the Laennec dispensary, in the heart of central Havana; however, by 1949, they began to form independent municipal anti-tuberculosis leagues with streptomycin banks. Leagues sprang up in Bauta, Regla, Punta Brava, Guanabacoa, Isla de Pinos, and at the CMQ radio station. These leagues relied on subscriptions from individual and associational members; donations and special deals from laboratories (e.g., Pfizer, Squibb); and fundraising events. The local leagues vetted patients based on access to economic resources: those who were very poor received streptomycin free of charge, while others were given loans that they had to pay back in easy installments.

⁷⁴⁸ Coro del Pozo, *Usted y la tuberculosis*, 31.

⁷⁴⁹ Ibid., 32.

⁷⁵⁰ For more on Rotary clubs in Cuba, see Maikel Fariñas Borrego, “District 25: Rotary Clubs and Regional Civic Power in Cuba, 1916–1940,” in *State of Ambiguity: Civic Life and Culture in Cuba’s First Republic*, eds. Steven Palmer, José Antonio Piqueras, and Amparo Sánchez Cobos (Durham: Duke University Press, 2014), 231–50. He reports, “Rotary clubs in Cuba were essentially made up of the urban middle class, composed of three subgroups: small industrialists, businessmen, and university professionals” (247).

Philanthropic intentions surely played a central role in this story, as Coro himself recounted. The network of leagues partially filled a gap in a critical arena in which the state was failing. However, the system that ensued possessed fundamental flaws. The first concerns the coverage that such associations provided. The municipal leagues popped up predominantly in the greater metropolitan area of Havana. Citizens in rural areas and eastern cities had fewer resources to call upon, and efforts to raise money for the drug were spontaneous and transitory. For example, before what was perceived as “the passivity of the government,” a group in Cienfuegos organized to raise money to save the life of a fellow resident of the city.⁷⁵¹ While admirable and resourceful, such piecemeal responses could not answer the great need of the large pool of tuberculosis victims in the country. The quantity of people that the leagues could serve was also limited. For example, in the course of approximately nine years, the Bauta League supplied only forty residents with medicine (135 total were assisted more generally). In Punta Brava, in six years, nineteen citizens received medicine.⁷⁵² Several of the clubs sought to run their own dispensaries, but soon found themselves physically and financially exhausted, and redirected these populations to CNT dispensaries.

Second, the leagues contributed to the maintenance of ideas about traditional charity and did not base their actions on any notion of a right to health care. Batista’s CNT had been a key part of the effort to build a welfare state, one built on “the recognition of the right that the poor sick have to receive the benefits of institutions created for their aid, without having to use the clout of recommendations, nor receiving it through gifts or alms, as happens when they solicit a

⁷⁵¹ García Inclán, “En la feria de la actualidad,” *Bohemia* 40, no. 10 (March 7, 1948): 26.

⁷⁵² Coro del Pozo, *Usted y la tuberculosis*, 46.

service in the other institutions for the poor.”⁷⁵³ Instead, in the late 1950s, Coro sang the praises of these municipal banks, for not only “were many lives saved,” but “the poor family did not have to resort to public charity nor to moneylenders to obtain Streptomycin.”⁷⁵⁴ While he denigrated public charity, models of private charity were implicitly deemed beneficial. Instead of insisting that the state use their money efficiently and effectively, Coro argued that the onus lay with civilians, asking them to make charitable donations.⁷⁵⁵

Efforts to create a parallel private, charity-based health system accompanied the weakening of the consensus that the Cuban state could lead the tuberculosis campaign (even if many continued to believe that theoretically a state should do so). These efforts also contributed to that consensus by highlighting the shortcomings of the public health sector. Throughout the 1940s, politically active physicians exhibited disillusionment with the state for not endorsing and carrying out their professional projects.⁷⁵⁶ When *Bohemia* announced its own streptomycin bank, with intentions of eventually turning it over to the government once off the ground, one activist responded quickly and fiercely, begging that *Bohemia* not put the bank in the hands of the government: “Because, if they control it, we will be buying streptomycin for ‘them,’ those who sell it for votes, as they sell beds at ‘La Esperanza.’ Streptomycin would not arrive to those most in need, but instead to those most addicted to the regime.”⁷⁵⁷ She insisted that this was not a matter of which party was in power, but a fundamental flaw of Cuba’s system of governance: “It

⁷⁵³ Juan J. Castillo, “Concepto, organización, funciones y resultados de los dispensarios del ‘Consejo Nacional de Tuberculosis,’” *Revista Cubana de Tuberculosis* 8, no. 1 (January–March 1944): 62.

⁷⁵⁴ Coro del Pozo, *Usted y la tuberculosis*, 33.

⁷⁵⁵ For instance, he recommended the formation of a municipal anti-tuberculosis league in each of the 126 municipalities, which were to “collect no less than 500 thousand pesos (\$500,000.00) every year.” Coro del Pozo, *Usted y la tuberculosis*, 51.

⁷⁵⁶ For example, Chelala’s professional trajectory illustrated a “turning point after which a new type of Cuban eugenicist emerged who held faith in the public instead of the state.” Sarah Arvey, “Sex and the Ordinary Cuban: Cuban Eugenics, Physicians, and Marital Sexuality, 1933–1958,” *Journal of the History of Sexuality* 21, no. 1 (January 2012): 105.

⁷⁵⁷ Rosa Hilda Zell, “En torno a una iniciativa de ‘Bohemia,’” *Bohemia* 40, no. 20 (May 16, 1948): 3.

matters little if the President is named Juan or Pedro, if the First Lady is Panchita or Mariquita, if in the high administration of the CNT figure the politicians...of the Orthodox, the Liberal, or the Auténtico Party; whatever the case, it will be the same.”⁷⁵⁸ She concluded that under governmental control, “streptomycin would not be distributed by scientific criteria”; therefore, “we cannot allow *our* streptomycin bank to be placed under its subvention.”⁷⁵⁹

6.4 CONCLUSION

In May 1947, choreographer Alberto Alonso unveiled his latest work at the Teatro Auditorium in Havana. The ballet, titled *Antes del Alba* (*Before the Dawn*), represented a significant break from traditional ballet compositions, not least of all for placing social critique at the heart of the performance.⁷⁶⁰ Its protagonist, played by Alicia Alonso, was a woman sick with tuberculosis, residing in one of Havana’s notorious *solares*; the ballet’s central motifs were suffocating poverty, eviction, and sickness. Haunted by the loss of love, the police, her landlord, hallucinations, and the all-consuming symptoms of tuberculosis, the widow metaphorically brought down the curtain by committing suicide by fire, her only ticket out of her predicament of impoverishment and disease.

The ballet debuted in the very moment that foreign news reports were broadcasting the great hope that streptomycin might pose for those with tuberculosis. While the well-to-do and art critics lambasted the ballet, “representatives of the progressive intelligentsia, university students, professionals and the humble sectors of the population...understood the validity of its

⁷⁵⁸ Ibid.

⁷⁵⁹ Ibid., emphasis in original text.

⁷⁶⁰ Dino Carrera, “A cuarenta años de Antes del Alba,” *Cuba en el Ballet* 6, no. 2 (April–June 1987): 10.

audacity.”⁷⁶¹ Many Cubans found Chela’s decision to commit suicide to be plausible, reflective of the ways in which poverty and disease had become interlocked for many of Cuba’s citizens. The narrative of triumph over tuberculosis would take root much later in Cuba than in the United States.

Streptomycin, as a curative drug technology, possessed the potential to help the government achieve many of its goals. It was not a panacea, as streptomycin cured only certain forms of the disease; however, its use in outpatient care and surgery resulted in a remarkable and swift drop in disease incidence in certain corners of the globe (including Cuba). But the Auténtico administrations’ governance over the issue proved tenuous and fragile, and the issue further contributed to citizen discontent with government authorities and the public health sector.

At first, Cubans were concerned with the issue of scarcity and poorly managed distribution by the government; however, by 1948, the state ended controlled distribution in response to increased production. Nonetheless, a streptomycin regimen remained prohibitively expensive for ordinary Cubans. In response, the poor and their allies articulated the right to free or state-subsidized medicine. The CNT and the Health Ministry proved incapable not only of paying for the drug, but of regularizing its distribution in a fair and efficient way; patronage, inefficiency, and corruption undermined the process. As the poor mobilized with the help of student groups and labor unions, they politicized the issue further and made their negative experiences in trying to access what they believed to be a “miracle drug” visible to the nation. By the 1950s, many Cubans had become convinced that their state was not capable of effectively

⁷⁶¹ Miguel Cabrera, *El ballet en Cuba: Nacimiento de una escuela en el siglo XX* (Buenos Aires: Balletin Dance Ediciones, 2010), 30. The ballet “caused something of a scandal in Havana’s elegant society,” who did not believe the story, setting, and African-based dance was suitable for their tony theater. Victor Fowler, “Some Dance Scenes from Cuban Cinema, 1959–2012,” in *The Oxford Handbook of Dance and the Popular Screen*, ed. Melissa Blanco Borelli (Oxford: Oxford University Press, 2014), 354. Facing this critical reception, the ballet was shown only on one day, with two performances.

managing the tuberculosis campaign, and charities returned to assist the state, a telling indictment of the Cuban public health sector.

While the issue of antibiotic therapy energized the poor, physicians found themselves equally concerned with the BCG vaccine, a technology that prevented tuberculosis infection and, if used on a mass scale, could lower Cuba's morbidity rate. In the 1950s, the CNT changed its motto to "For the Cure of the Sick and Defense of Healthy."⁷⁶² While the CNT had not met citizen expectations on the first count, physicians hoped that the state would effectively wield the vaccine in the 1950s to ensure the health of its population.

⁷⁶² Cuba, Consejo Nacional de Tuberculosis, *Un año de trabajo en el Consejo Nacional de Tuberculosis* (Marianao, 1957), 3.

7.0 “IN DEFENSE OF THE HEALTHY”: BCG VACCINATION IN CUBA, 1927–1965

In May 1950, Dr. Edward J. O. Brien, president of the American Tuberculosis Sanatorium Commission, embarked on an international journey, where he “studied the conditions of various countries regarding tuberculosis.” He came back convinced that “the only hope of ending the disease is mass vaccination with the BCG...vaccine.”⁷⁶³ *Bohemia* reported on his trip, acknowledging that although the vaccine did not help those who already had tuberculosis, “if all the children of the world were vaccinated with BCG, the disease would be completely eliminated in a few generations.”⁷⁶⁴ One year earlier a columnist at *Prensa Libre* penned, “The World Health Organization of the United Nations just reported that around five million children in different areas of Europe have been examined and vaccinated against tuberculosis.”⁷⁶⁵ He posed a question to his readers: “And why does Cuba not bring that famous vaccine to save us so much horror and so much pain?”⁷⁶⁶

Researchers at the Pasteur Institute in Paris discovered BCG (Bacillus Calmette-Guérin), an attenuated strain of the bovine tuberculosis bacillus, in 1908 and developed it into a successful vaccine by 1921.⁷⁶⁷ In the decade that followed, the vaccine was implemented on a wide scale in

⁷⁶³ “Así va la ciencia,” *Bohemia* 42 (May 7, 1950): n.p.

⁷⁶⁴ Ibid.

⁷⁶⁵ Guido García Inclán, “Trinchera del deber,” *Prensa Libre*, August 4, 1949, 3.

⁷⁶⁶ Ibid.

⁷⁶⁷ Simona Luca and Traian Mihaescu, “History of BCG Vaccine,” *Maedica (Buchar)* 8, no. 1 (March 2013): 53–58.

France, and to a lesser degree in Germany.⁷⁶⁸ In the wake of World War II, during which tuberculosis morbidity and mortality surged, many countries turned to the BCG vaccine to control the disease, for it was more cost-efficient than sanatorium construction. In the late 1940s and accelerating in the 1950s, various international organizations initiated mass BCG vaccination campaigns in places as diverse as India, Yugoslavia, Poland, Jamaica, and Mexico.⁷⁶⁹

In Cuba, after a brief and experimental phase with BCG vaccination in the late 1920s, the state neglected this method of disease control, focusing instead on sanatorium projects. Reflective of the CNT's tendency to ignore the advice of technocrats, they took action regarding BCG vaccination only when physicians' reform efforts coincided with foreign scientists' interest in Cuba's BCG program. As a result of this pressure, in 1942, the CNT founded a BCG Laboratory to produce the vaccine and conduct experimentation on a small scale. In 1950, the government elevated the Laboratory to an Institute, with the goal of carrying out mass vaccination across the national territory.

By the mid-1950s, Cuba possessed an institute that produced the vaccine, legislation that made vaccination obligatory, and significant funding to be used for mass vaccination. Nonetheless, the BCG Institute fell short of annual vaccination goals, due to an insufficient rural health network, lack of political will, and citizens' resistance. While the CNT achieved medical success in its production and export of the BCG vaccine by the 1940s, it experienced failure in the field of public health in the 1950s by continually underperforming in the practice of vaccination.

⁷⁶⁸ Linda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain* (New York: Oxford University Press, 1988), 138.

⁷⁶⁹ See, for example, Niels Brimnes, "Vikings Against Tuberculosis: The International Tuberculosis Campaign in India, 1948–1951," *Bulletin of the History of Medicine* 81, no. 2 (2007): 407–30; Henrice Altink, "'Fight TB with BCG': Mass Vaccination Campaigns in the British Caribbean, 1951–6," *Medical History* 58, no. 4 (October 2014): 475–97.

When the revolutionary government came to power in 1959, they initiated a successful mass BCG vaccination campaign. By making adjustments to correct for past failures in the CNT's immunization program, MINSAP vaccinated large numbers of Cubans throughout the 1960s. Tuberculosis policy makers dedicated resources to popular education; they forged cross-institutional partnerships with non-health-related organizations; and they adjusted to on-the-ground limitations by simplifying vaccination procedures. In short, during the 1960s, political will bolstered the vaccination campaign. The effort, however, owed part of its success to the excellent vaccination resources developed by republican administrators in the 1940s and 1950s.

BCG vaccination has encouraged scholarly interest, but much of it has been concerned with understanding which nations widely used the vaccine and why. While the vaccine invoked acrimonious controversies about its safety and efficacy (the latter continues to be the subject of debate in international health circles), scholars have argued that ideological orientation, and more specifically a country's attitude toward social welfare, is the variable that most adequately explains why western European countries and the United States adopted or did not adopt the vaccine.⁷⁷⁰ The case of Cuba complicates this narrative. Even though government and public health officials were firmly in the pro-vaccine camp by the late 1940s and were even producing the vaccine domestically, Cuba never carried out mass vaccination until the 1960s. This chapter argues that variables such as political will, state capacity, and citizens' reception should be included when comparing national vaccination efforts.

⁷⁷⁰ Georgina Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, N.J.: Rutgers University Press, 1995); Linda Bryder, "'We Shall Not Find Salvation in Inoculation': BCG Vaccination in Scandinavia, Britain, and the USA, 1921–1960," *Social Science & Medicine* 49 (1999): 1157–67; Niels Brimnes, "BCG Vaccination and WHO's Global Strategy for Tuberculosis Control 1948–1983," *Social Science & Medicine* 67 (2008): 863–73. Bryder argues that Scandinavia adopted the vaccine and other preventive measures because of their socialistic policies. The USA and Britain, on the other hand, showed resistance towards social welfare and preferred a curative/institutional approach to tuberculosis control.

By analyzing a preventive health measure, this chapter considers a different aspect of Cuba's tuberculosis campaign than those discussed in previous chapters. With the arrival of antibiotic therapy, the number of tuberculosis-related deaths decreased; however, physicians observed that the number of Cubans who contracted the disease, representing dangerous sources of contagion, did not diminish. In response, doctors began to take a greater interest in BCG vaccination, for it promised to protect many Cubans, especially children, against the tenacious and ever-present threat of infection by the tuberculosis bacillus. In their view, any effective tuberculosis campaign should pursue vaccination, for it prevented illness and controlled disease, the fundamental purpose of a public health sector. The CNT's inability to vaccinate en masse influenced physicians' view of the state and informed the vaccination program that the new regime adopted. BCG vaccination, then, is yet another example of a national medical success (i.e., the local production of the BCG vaccine) that was experienced as a failure.

7.1 FIRST STEPS, 1927–1951

Developed in France in the 1920s, the BCG vaccine produces immunity against tuberculosis, although the effectiveness of the vaccine and the duration of immunity have always been debated in scientific circles.⁷⁷¹ Compared to other forms of vaccination, BCG was fairly complex, usually requiring at least three interactions with a medical professional. First, a Mantoux tuberculin skin test was performed, in which a tuberculin purified protein derivative was injected into the forearm. After a short period of time (usually 48 hours), the individual would return for a

⁷⁷¹ Currently, "[t]he BCG vaccine is thought to protect up to 80% of people for up to 15 years." "BCG TB Vaccine: Frequently Asked Questions," *National Health Service*, accessed October 1, 2016, <http://www.nhs.uk/Conditions/vaccinations/Pages/bcg-tb-vaccine-questions-answers.aspx>.

reading. Those who showed serious reactions (such as raised, swollen, or hardened skin at the injection site) had already developed resistance to the disease (from an earlier infection) and would not be vaccinated. The non-reactors were given a stronger dose of tuberculin and asked to return in a few days. If they still showed no reaction to the skin test, they would then be vaccinated.⁷⁷² BCG was administered orally or via intradermal injection. Because the vaccine did not offer lifelong immunity, the medical community advised that individuals, especially children, submit to re-vaccination at specific intervals.

Facilitated by their scientific connections with France, Cuba began a small-scale human trial of BCG very soon after the vaccine's development. Receiving a donation from Calmette himself and authorization from the Secretariat of Sanitation in 1927, Dr. Alberto Sánchez de Fuentes and Dr. Clemente Inclán immunized 126 children in different hospitals with the oral BCG vaccine. Many of the children selected had parents with tuberculosis and were therefore at a high risk for contracting the disease.⁷⁷³ If, however, these children did not become ill, the researchers could report data that supported the vaccine's efficacy. The trial showed promising results, but its timing was not fortuitous.

In 1930, disaster struck. In Lübeck, Germany, seventy-two infants died (27% of those vaccinated) when they were administered a virulent human strain of BCG (instead of an attenuated, bovine strain). This disaster echoed widely and “set back the vaccination program all over the world.”⁷⁷⁴ When news of Lübeck arrived in Cuba, Cuban pediatricians launched a

⁷⁷² This procedure is described in Brimnes, “Vikings Against Tuberculosis,” 420–21.

⁷⁷³ Cuba, Secretaría de Sanidad y Beneficencia, *1926–1931: Cinco años de labor sanitaria y de beneficencia pública* (Havana: Imprenta y Librería La Propagandista, 1931), 48.

⁷⁷⁴ Donna Harsch, “Medicalized Social Hygiene? Tuberculosis Policy in the German Democratic Republic,” *Bulletin of the History of Medicine* 86 (2012): 415. Attenuated vaccines are “[l]ive vaccines prepared from microorganisms which have undergone physical adaptation (e.g., by radiation or temperature conditions) or serial passage in laboratory animal hosts or infected tissue/cell cultures, in order to produce avirulent mutant strains capable of inducing protective immunity.” “Attenuated Vaccines,” *Online Medical Dictionary*, accessed August 15, 2016,

campaign to oppose the vaccine. Tuberculosis specialists, on the other hand, still supported it.⁷⁷⁵ The social struggles that characterized the late years of the Machado government, which interrupted the regular functioning of many aspects of the sanitation branch's tuberculosis service, also created problems for the pro-vaccination camp, and the vaccination experiment fizzled out in the tumultuous and uncertain years of the early 1930s.⁷⁷⁶

Despite these circumstances, throughout the 1930s and 1940s, a small group of physicians, primarily tuberculosis specialists, persistently asked the government and the CNT to devote increased funding and resources to this prophylactic measure. They hoped that the founding of the CNT would allow them to re-insert vaccination as a cornerstone of the revived and expanded national tuberculosis campaign. One year after the CNT's founding, the clinical chief at La Esperanza Sanatorium, Dr. Francisco Nuñez Llanes, wrote, "So important is the Calmette Vaccine in these moments, that a serious anti-tuberculosis campaign" without "said vaccine is inconceivable."⁷⁷⁷ Alberto Sánchez de Fuentes, who had co-led the vaccination studies under Machado and who still occupied a position of prominence as director of the Jacobsen Dispensary in a poor Havana suburb, published frequently on the topic in the late 1930s and early 1940s.⁷⁷⁸ To those eminent pediatricians who continued to express reservations about the

<http://www.online-medical-dictionary.org/definitions-a/attenuated-vaccines.html>.

⁷⁷⁵ José María Hernández Aquino, "BCG: Trabajos experimentales, técnica de vacunación, estado actual de la vacunación BCG en el mundo y Cuba" (thesis, University of Havana, 1954), 26, TC-2325, University of Havana Medical Student Thesis Collection (UHTC), Museo Histórico de las Ciencias "Carlos J. Finlay" (MHC).

⁷⁷⁶ Ibid.

⁷⁷⁷ Francisco Nuñez Llanes, "Algunas consideraciones sobre lucha antituberculosa," *Medicina de Hoy* 1, no. 10 (November 1936): 473

⁷⁷⁸ See, for example, Alberto Sánchez de Fuentes, "La inmunización preventiva en la lucha contra la tuberculosis," *Revista de Tuberculosis* 1, no. 3 (1937): 370–83; Alberto Sánchez de Fuentes, "Vacunación Calmette," *Revista de Tuberculosis* 1, no. 4 (1937): 507–21; Alberto Sánchez de Fuentes, "Informe científico sobre la conveniencia de re-implantar en Cuba la vacunación por BCG," *Revista de Tuberculosis* 4, no. 1 (1940): 64–76.

vaccine, this cadre of tuberculosis experts pointed to the earlier vaccination experiment: of the 126 children vaccinated in the late 1920s, only four had tuberculosis by 1939.⁷⁷⁹

Once it became clear that the CNT did not plan to pursue vaccination as part of its campaign, these physicians employed a stronger and more critical tone in their articles. They insisted that any effective tuberculosis campaign had to include BCG vaccination.⁷⁸⁰ One BCG vaccine specialist, Dr. Rita Shelton, claimed that the delay in vaccinating had already cost lives. She argued that if Cuba had continued vaccination during the 1930s, it would have experienced mortality drops on par with Sweden and Holland, two countries that vaccinated widely and reported very low rates of the disease.⁷⁸¹

Reflective of the CNT's tendency to ignore the advice of technocrats in their employ (and especially outside of it), they took significant action regarding BCG vaccination only when physicians' reform efforts coincided with the pressure of international scientific attention. One of these moments arrived in the early 1940s, when the CNT founded a national BCG Laboratory. At the 1940 Pan-American Tuberculosis Congress held in Buenos Aires, delegates selected Havana as seat and Juan Castillo (of the CNT) as president of the next Congress. Latin American tuberculosis specialists had overwhelmingly embraced the vaccine (in contrast to Britain and the

⁷⁷⁹ José Francisco Ferrer, "Resultados lejanos de la vacunación Calmette," *Revista de Tuberculosis* 3, no. 3 (1939): 367. On the opposition of pediatricians, see Pedro Domingo, "La vacunación B.C.G. y su aplicación en Cuba," *Revista Cubana de Tuberculosis* 17, no. 3 (July–September 1953): 187; Gustavo L.P. Estévez Berriz, "Importancia del BCG en pediatría" (thesis, University of Havana, 1954), 16, TC-1735, UHTC, MHC. Physicians would continue to reference this experiment throughout the 1940s and 1950s to gain support for the vaccine. For example, in 1953, Domingo claimed that the morality rate for those children in the trial who were vaccinated was 5%; for those in the trial who were not vaccinated, their mortality rate was 14.7%. Pedro Domingo, *La vacunación B.C.G. y su aplicación en Cuba* (Havana, 1953), 22.

⁷⁸⁰ Carlos Taboada and José F. Ferrer, "Lo que falta hacer en nuestra campaña antituberculosa," *Revista de Tuberculosis* 3, no. 3 (1939): 360–63.

⁷⁸¹ Dr. Rita Shelton, "Estado actual de la vacunación antituberculosa de Calmette Guérin," *Revista de Tuberculosis* 6, no. 4 (October–December 1942): 182.

United States), and they selected BCG as one of the central themes of the next meeting, to be held in 1942.

A number of Cuban physicians, including Castillo, seized this opportunity to push the CNT to act. They argued that it would be a source of national embarrassment if the international congress met in Havana to discuss BCG, and delegates realized that the country practiced no vaccination. With “new urgency” given to the issue, the CNT responded promptly.⁷⁸² In 1942, one Rockefeller Foundation official noted, “It appears that a Latin-American tuberculosis meeting is to be held in Havana in June, and the Tuberculosis Association [the CNT] wished to show the meeting that they too are doing something about BCG.”⁷⁸³

In late 1942, the CNT inaugurated the BCG Laboratory and appointed Dr. Pedro Domingo Sanjuan, a Spanish tuberculosis expert living in exile, to head its operations. The laboratory focused on the production of the vaccine, while also engaging in small-scale human trials of the vaccine (see Table 7 for numbers). In March 1944, the Laboratory set up a service at the Jacobsen Dispensary. This center represented a prime spot from which to begin vaccination. Sánchez de Fuentes, one of the vaccine’s primary proponents who had experience with BCG in 1927, directed this unit. Furthermore, the population of the dispensary reported high tuberculosis rates: located in the Jesús del Monte neighborhood, near the large Las Yaguas shantytown, it served an overwhelmingly poor and indigent population.

⁷⁸² Hernández Aquino, “BCG,” 26; Domingo, “La vacunación B.C.G.,” 187.

⁷⁸³ Porter J. Crawford (PJC) diary entry, March 27, 1942, 133, Folder 2, Box 1, Series 420, Record Group 1.1, Rockefeller Foundation records, Rockefeller Archive Center. Hereafter, the following abbreviations will be used for citing sources from the Rockefeller Archive Center: Folder (F); Box (B); Series (S); Record Group (RG); Rockefeller Foundation records, Rockefeller Archive Center (RF-RAC). Due to the war, the 5th Pan-American Tuberculosis Congress was postponed until 1945.

Throughout the 1940s, the BCG Laboratory earned a certain level of regional notoriety.⁷⁸⁴ Pedro Domingo and colleagues developed EBCG (an extract of BCG) as a new method for tuberculosis testing, arguing that it was more effective than the protein derivative used in the traditional Mantoux tuberculin test. By the late 1940s, Cuba exported the BCG vaccine to Mexico, Colombia, El Salvador, Panama and Guatemala.⁷⁸⁵ The Laboratory also sent their employees overseas or invited foreign medical practitioners to Cuba to train personnel from these countries in proper vaccination techniques.⁷⁸⁶

Despite these accomplishments, Cuban physicians were not satisfied with the scope of vaccination within Cuba. During the 1940s, the highest annual vaccination number was just under 4,000 children. CNT employees pointed to other countries in an attempt to interest the CNT Board of Governors in funding more widespread vaccination. In a report on the 1945 Pan-American Tuberculosis Congress, Castillo noted that Cuba possessed “more limited experience” in vaccinating than Brazil and Argentina.⁷⁸⁷ From 1925 to 1945, Castillo reported, Uruguay had vaccinated 115,000 people; Argentina, 200,000; and Brazil 330,000.⁷⁸⁸ At this point, Cuba had vaccinated less than 3,000 in the previous twenty years.⁷⁸⁹ Pedro Domingo published an article in the CNT’s scientific journal, observing that Cuba lagged behind other national vaccination programs. In Brazil, for instance, “vaccination with BCG had reached better development” than

⁷⁸⁴ Pedro Iglesias Betancourt, “No justificación de Topes de Collantes,” *Bohemia* 46 (June 20, 1954): 91.

⁷⁸⁵ Rolla B. Hill (RBH) diary entry, February 20, 1947, 17, B 219, RG 12, RF-RAC; “Empleara Panamá las vacunas BCG, hechas en Cuba,” *Diario de la Marina*, October 16, 1947, 16.

⁷⁸⁶ Carlos Hernández Miyares, “Informe sobre el Segundo Congreso Mexicano de pediatría,” *Revista Cubana de Tuberculosis* 8, no. 3 (July–September 1944): 522–35; “Inauguró el Presidente Prío el Instituto BCG de nueva creación,” *Diario de la Marina*, May 30, 1950, 34.

⁷⁸⁷ Héctor Madariaga Escobar, “Sexto Congreso Panamericano de la Tuberculosis,” *Revista Cubana de Tuberculosis* 9, no. 1 (January–March 1945): 124.

⁷⁸⁸ *Ibid.*, 118–19.

⁷⁸⁹ I calculated this estimate from the numbers in Table 7, plus the approximately 100 children who were vaccinated in the 1927–1930 experiment.

in Cuba.⁷⁹⁰ Domingo noted that 27,000 (not a paltry 3,000) should have already been vaccinated if Cuba wanted to match the percentage of the population that Brazil had vaccinated.⁷⁹¹ Also, the Uruguayan government vaccinated four times more people than Cuba did every year.⁷⁹²

In the late 1940s, physicians once again referenced the precariousness of Cuba's reputation on an international stage to push for more BCG funding. In the post-war period, mass X-ray examination and mass vaccination gained greater acceptance as tools to eliminate tuberculosis. In 1950, Domingo pronounced, "In the period in which all civilized countries of the world are implementing vaccination; when France, Belgium, the Scandinavian countries, Brazil, and others make it obligatory; in the moment in which the World Health Organization is developing in Europe a vaccination campaign intended to immunize more than 15 million children, freeing them from the torment of the white plague, we would be guilty of being insensible if we did not cry out for Cuba to achieve the benefits that the others are getting."⁷⁹³

These physicians argued that foreign medical figures were already noting the contradiction of Cuba's vaccination policy: it produced an effective vaccine and trained non-Cubans in vaccination techniques, yet did not widely immunize its own population. *Diario de la Marina* reported that the CNT Director "witnessed the spectacle of scholarship students from different countries coming to Cuba to receive training in anti-tuberculosis vaccination who left saying: Cuba is a marvelous country, studying and preparing the best BCG vaccine in the world; they give it to other countries that implement it with magnificent results, but they do not

⁷⁹⁰ Pedro Domingo, "Síntesis de las observaciones efectuadas en tres países de América Latina, en relación con las directrices dadas por los mismos a la lucha antituberculosa," *Revista Cubana de Tuberculosis* 9, nos. 2–4 (April–December 1945): 288.

⁷⁹¹ *Ibid.*, 279–80.

⁷⁹² *Ibid.*, 288.

⁷⁹³ "Informaciones al día," *Revista Cubana de Tuberculosis* 12–13, nos. 2–4 (April 1948–December 1949): 199–200.

vaccinate anyone.”⁷⁹⁴ Domingo noted, “Our attendance at international Congresses and constant publications about this theme...in medical journals of different nations gave us great international importance.” When compared with the practice of vaccination, however, he opined, “It is not hard to understand that we had already left the sphere of neglect and entered into one of ridicule.”⁷⁹⁵

Unsatisfied with this situation, in late 1948, a BCG committee formed within the CNT, who went to the Board of Governors to push for mass vaccination.⁷⁹⁶ On May 29, 1950, the Health Ministry elevated the BCG Laboratory to become the BCG Institute, and the President called for the expansion of vaccination. A year later, Congress appropriated a credit of \$100,000 to support the Institute.⁷⁹⁷ Marianao served as the seat of the Central Vaccination Dispensary (annexed to the BCG Institute and the headquarters of the CNT). With the objective of making vaccination truly national in scope, each provincial capital was slated to receive a vaccination dispensary, with a doctor, nurse, and visiting doctor at each unit. Domingo pronounced, “With the inauguration of the BCG Institute in 1950, one stage of vaccination in Cuba closed. During it, tuberculosis specialists had been carrying out the toughest work, in waking up the interest of responsible authorities and the public.”⁷⁹⁸

This legislation coincided with physicians’ growing fears of contagion in the late 1940s and early 1950s. With the arrival of antibiotic therapy, mortality began to drop, but morbidity did not. In fact, physicians were concerned about those individuals who did not die (due to antibiotic therapy), but were still not completely cured and therefore represented a dangerous source of

⁷⁹⁴ “Inauguró el Presidente,” 34.

⁷⁹⁵ Ibid.

⁷⁹⁶ Ibid.

⁷⁹⁷ Domingo, “La vacunación B.C.G.,” 189. The regular operating budget of the BCG Laboratory is unclear in the historical record and was likely to have been different each year as it drew from the sale of the annual anti-tuberculosis campaign stamp.

⁷⁹⁸ Domingo, *La vacunación B.C.G.*, 36.

contagion. In 1951, one BCG advocate spoke publicly about “the impetuous advance of the terrible disease,” warning of the threat posed to the “great majority of the Cuban population” of “the most imminent contamination.”⁷⁹⁹ Juan Castillo believed that Cuba, “because of its high morbidity,” had entered into a phase that he termed “Tuberculous Intensification.”⁸⁰⁰ To combat this, what was especially important were “preventive instruments, like BCG vaccination.”⁸⁰¹

Physicians had finally achieved their goal of garnering adequate state funding for vaccination. They hoped that the CNT would correct the fundamental contradiction of BCG vaccination in Cuba: the Laboratory had achieved great success in medical research and vaccine production, yet the public health sector had not extended the vaccine to benefit the Cuban people. The government had legislated a new stage of mass vaccination; it remained to be seen if they could immunize large numbers of people throughout the island or if BCG vaccination would serve as yet another example of the shortcomings of the public health system.

7.2 NATIONAL VACCINATION, 1950S

The foundation of the BCG Institute increased the number of annual vaccinations. After providing 7,400 vaccinations in 1950, health workers employed by the BCG Institute administered over 20,500 vaccines in 1951 (see Table 7). Although the data is hard to parse, it appears that the state measured number of vaccines administered, not the number of individuals who were vaccinated (no data is available in the 1950s that breaks the total vaccination count

⁷⁹⁹ “Sobre la tuberculosis en Cuba disertó el Doctor Arnaldo Coro,” *Diario de la Marina*, September 12, 1951, 2.

⁸⁰⁰ Juan J. Castillo, “Epidemiología en la tuberculosis en Cuba y en América: Su relación con el diagnóstico precoz y el B.C.G.,” *Revista Americana de Tisiología* 2, no. 1 (October 1950): 9.

⁸⁰¹ *Ibid.*

into first vaccinations and re-vaccinations.). By 1956, the number of vaccinations had more than doubled from 1951, reaching over 45,000. By 1958, however, vaccinations dropped to under 20,000, probably a result of the political chaos engulfing the country.

Table 7. Annual Number of Vaccines, 1943–1958⁸⁰²

Year	Vaccinations
1943	522
1944	922
1945	1,398
1946	2,243
1947	3,741
1948	3,413
1949	3,975
1950	7,359
1951	20,521
1952	28,891
1953	N/A
1954	N/A
1955	N/A
1956	45,739
1957	N/A
1958	17,154

Despite this improvement in vaccination across the 1950s (and in comparison with the low numbers of the 1940s), the campaign underperformed on two central measures. The BCG Institute aimed to implement a mass vaccination campaign that extended across the national territory. On the first count, the BCG Institute fell far short of its own goals. In 1950, Dr. Pedro

⁸⁰² Rafael Ballesteros Sierra, “Extensión de la vacunación antituberculosa con BCG, en Cuba durante el año 1952,” *Revista Cubana de Tuberculosis* 17, no. 2 (April–June 1953): 131. The estimate for 1956 comes from Cuba, Consejo Nacional de Tuberculosis, *Un año de trabajo en el Consejo Nacional de Tuberculosis* (Marianao, 1957), 17. They list the vaccinations as 45,769, but when adding up their raw data, the correct number is 45,739. The estimate for 1958 comes from “Realizaciones del Gobierno de FBZ: Salubridad y Asistencia Social,” 19, Folder 124, Box 137, Fulgencio Batista Zaldívar Collection (FBZ Collection), Cuban Heritage Collection, University of Miami (CHC-UM).

Domingo, head of the BCG Institute, declared that Cuba should be “annually vaccinating 150,000 newborns in the urban and rural areas of the country.”⁸⁰³ He also noted that the Institute should conduct more than 650,000 exams annually, to identify those children and adults who needed to be re-vaccinated.⁸⁰⁴ Several years later, another high-ranking BCG Institute official modified the annual goal to be 380,000 vaccinations (80,000 newborns; 200,000 children older than 3 months; and 100,000 re-vaccinations).⁸⁰⁵

The BCG Institute never vaccinated in numbers that would qualify it as a “mass” campaign. In 1953, the Director of the Central Vaccination Dispensary of the BCG Institute, Dr. Rafael Ballesterro Sierra, summarized, “Although the number of BCG vaccinations carried out in Cuba is growing significantly from year to year, nevertheless it has not arrived at the minimum necessary for achieving the optimal results that it can produce in the prophylaxis of tuberculosis.”⁸⁰⁶ The number of vaccines administered to infants in 1952 (19,224) was “frankly insufficient, since they barely represent one quarter of those necessary for a very efficient prophylaxis.”⁸⁰⁷ By the end of the 1950s, even though the number of annual vaccinations had increased, the highest annual total was 45,769 vaccinations, a far cry from the 380,000 recommended.⁸⁰⁸

The BCG Institute also underperformed on the second issue of importance: a vaccination campaign that extended across the national territory (see Figure 17). In the provinces of Matanzas, Las Villas, and Camagüey, the BCG Institute managed to immunize in numbers proportional to the provincial population. On the other hand, Oriente Province—Cuba’s most

⁸⁰³ “Informaciones al día,” 199.

⁸⁰⁴ Ibid.

⁸⁰⁵ Ballesterro Sierra, “Extensión de la vacunación,” 133.

⁸⁰⁶ Ibid.

⁸⁰⁷ Ibid.

⁸⁰⁸ One scholar notes that from 1954–1959, the annual average vaccination rate was 43,245, of which 10,000 were given to children. Nelson P. Valdés, “Health and Revolution in Cuba,” *Science & Society* 35, no. 3 (1971): 335.

populous province with 30.8% of the national population—accounted for only 6.25% of the vaccines administered in 1953.⁸⁰⁹ By 1956, this had improved slightly, with the province receiving 12.8% of vaccines. By contrast, 47.4% of vaccines were administered in the Province of Havana (with approximately 26.4% of the national population).⁸¹⁰

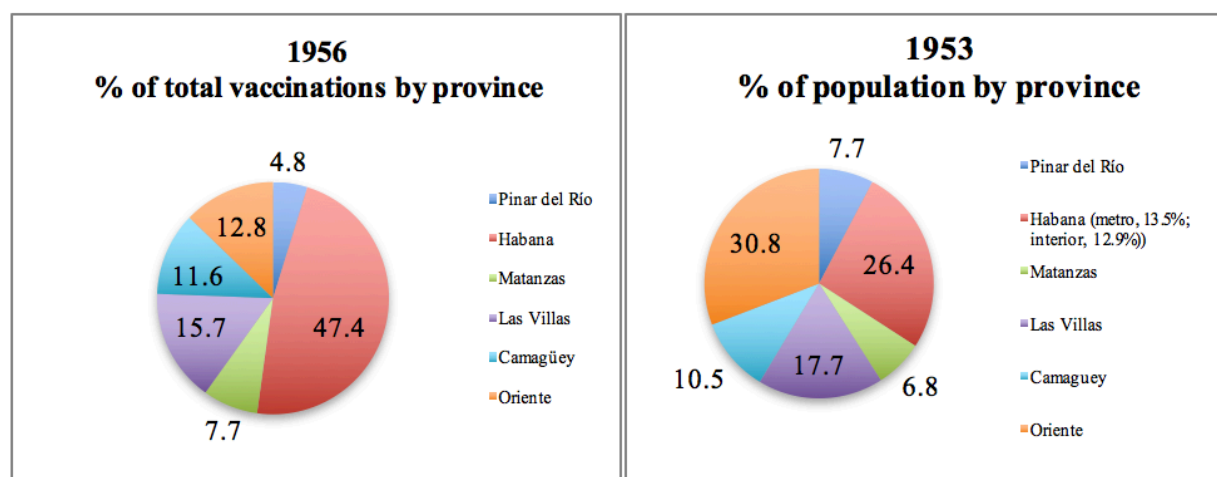


Figure 17. As with other medical resources, the largest percentage of total vaccinations took place in Havana Province and Oriente was particularly neglected.

Physicians took note of this disparity and petitioned the state for a change. The director of the Central Vaccination Dispensary published a report in the CNT's journal, pressing them to allocate more vaccinations to Oriente. He pointed out that not only was this the most populous section of the country, but it also reported the highest tuberculosis incidence.⁸¹¹ During a national tuberculosis conference held in Santiago de Cuba in 1953, a cadre of physicians took the opportunity to highlight this problem. In the presence of members of the Cuban Society of Phthysiology, the National Tuberculosis Council, the Society of Clinical Studies, the Society of

⁸⁰⁹ Rafael Ballester Sierra et al., "Vacunación antituberculosa en la Provincia de Oriente," *Revista Cubana de Tuberculosis* 17, no. 3 (July–September 1953): 364. Population numbers from Cuba, Oficina Nacional de los Censos Demográfico y Electoral, *Censo de población, viviendas y electoral, 1953* (Havana: P. Fernández y Cía, 1955), 1–3.

⁸¹⁰ Vaccine numbers from Consejo Nacional de Tuberculosis, *Un año de trabajo*, 17. Population numbers from *Censo de población*, 1–2.

⁸¹¹ Ballester Sierra et al., "Vacunación antituberculosa," 364–65, 368.

Surgery, the Santiago de Cuba Society of Pediatricians, and the Santiago de Cuba chapter of the Medical College, these physicians demanded better and expanded vaccination in the region. One of the specific problems they noted was that Holguín, the third largest municipality in the republic, merited its own vaccination center and should not have to rely on the services located in Oriente's provincial capital (Santiago de Cuba).⁸¹²

The BCG Institute also underperformed in an international context. While Cuba reported mortality data and health indicators on par with the most developed regions in the Americas, they could not match their vaccination rates. Brazil and Chile, both reporting good health statistics and possessing a relatively well developed public health sector, vaccinated 4.1% and 5.67% of their populations, respectively, in 1956.⁸¹³ While Cuba performed better than those Latin American countries with notoriously insufficient health ministries (e.g., Bolivia, which vaccinated 0.07% of its population), it only vaccinated 0.73% of its national population in 1956.⁸¹⁴

By the mid-1950s, health officials and tuberculosis specialists reported concern with these low vaccination numbers. Octavio Montoro, an eminent Cuban physician, served on Batista's Advisory Council (Consejo Consultivo), where he introduced an initiative in 1954 to make BCG vaccination compulsory and to increase funding for the Institute. The Council approved the legislation and sent it on to Congress.⁸¹⁵ Passed in 1955, the law required a number of institutions to vaccinate newborn children: municipal, provincial, and state hospitals; private and mutual aid health centers; and other dispensaries, crèches, and clinics. Those who birthed

⁸¹² "Tercera Jornada Tisiológica de Santiago de Cuba," *Revista Cubana de Tuberculosis* 17, no. 4 (October–December 1953): 537, 542.

⁸¹³ Numbers calculated from Pan American Sanitary Bureau, *Summary of Four-Year Reports on Health Conditions in the Americas* (Washington, D.C.: Pan American Sanitary Bureau, 1958), 2, 63.

⁸¹⁴ *Ibid.*

⁸¹⁵ "Sesión del día: 6 de Abril de 1954," 4B, legajo (leg.) 890, expediente (no.) 3, Fondo Secretaría de la Presidencia, Archivo Nacional de la República de Cuba (ANC).

children outside of these institutions were required to vaccinate them within three months of their birth. The law mandated that two years after its passage, families would have to show a certificate of vaccination before schools admitted them. The Ministry of Education was asked for its cooperation in this matter.⁸¹⁶ Certificates would also be required for those working in the public sector, domestic service, or the armed forces.⁸¹⁷

The legislation noted that “more resources and a more adequate organization” were needed to achieve immunization of the largest possible number of Cuban children. Funding was increased to 360,000 pesos.⁸¹⁸ These efforts seem to have improved vaccination, as the number of vaccines climbed to roughly 45,000 in the year following the passage of the law, but total vaccination still did not come close to the number desired by tuberculosis specialists. In an international comparative context, the BCG vaccination campaign in Cuba seems to have been well funded. The decree in 1951 appropriated \$300,000 annually to the BCG Institute. By comparison, in India from 1948–1951, the International Tuberculosis Campaign tested 4 million individuals for only \$448,000.⁸¹⁹ In short, it is unlikely that lack of money handicapped the Cuban campaign.

Instead, I argue that three factors stunted vaccination efforts: lack of political will behind the issue, citizen resistance, and an inadequate rural health infrastructure. Even though the CNT formed the BCG Institute in 1950, the topic of vaccination seems to have not captured the attention of the population or of important governmental leaders. The press infrequently discussed vaccination, and following Batista’s return to power, publicity and attention shifted

⁸¹⁶ It is unclear if these measures were ever enforced, and the low vaccination numbers suggest that they were not.

⁸¹⁷ “Sesión del día,” 3.

⁸¹⁸ *Ibid.*, 1.

⁸¹⁹ Brimnes, “Vikings Against Tuberculosis,” 408. Brimnes does not provide the number of vaccinations administered in this campaign, but it was certainly higher than Cuba’s total vaccinations. Also, note that until 1960, the Cuban peso was pegged to the U.S. dollar.

even more to hospital projects, especially the Topes de Collantes Sanatorium. In early 1954, as Batista rushed to finish and inaugurate the facility in time for the National Hospital Day ceremony in May, the BCG Institute reported that it had to stop production of the vaccine “for lack of material” and for “not having paid its suppliers.”⁸²⁰ It is likely that in early 1954 the CNT diverted money away from the BCG Institute in order to finish construction on Topes de Collantes. In the situation of “irregularities” in which the CNT found itself, one journalist doubted that the “excellent [compulsory vaccination] proposal of the Advisory Council will culminate in a practical reality.”⁸²¹

The significance of political will is highlighted by episodes in which the government carried out mass vaccination. For example, in 1949, the Ministry of Health feared an outbreak of smallpox, when a case was reported after a young Cuban returned from Mexico. In a very short period of time, the Health Ministry initiated a campaign of vaccination in Havana and planned a campaign outside of the capital.⁸²² After two weeks, 800,000 Cubans had been vaccinated.⁸²³ When political will and public concern coalesced, the Cuban state was very capable of mass vaccination.⁸²⁴ The BCG vaccine, on the other hand, prevented a chronic disease; it did not capture the attention and resources of the state like vaccinations against epidemic diseases.

A second factor hindering the campaign was resistance to vaccination. Opposition to vaccination has a long history, crossing borders and centuries.⁸²⁵ The case of resistance to BCG

⁸²⁰ Iglesias Betancourt, “No justificación,” 91.

⁸²¹ Ibid.

⁸²² “Se activará en toda la República la vacunación contra la viruela,” *Diario de la Marina*, April 1, 1949, 15.

⁸²³ Rolla B. Hill (RBH) diary entry, April 9–April 15, 1949, 56, B 219, RG 12, RF-RAC.

⁸²⁴ Niels Brimnes notes that BCG vaccination “lacked the drama and urgency of smallpox and BCG vaccination campaigns suffered more from recruitment problems than did the more ‘heroic’ smallpox eradication campaign.” “Another Vaccine, Another Story: BCG Vaccination against Tuberculosis in India, 1948 to 1960,” *Ciência & Saúde Coletiva* 16, no. 2 (2011): 397. The simplicity of smallpox vaccination probably also facilitated this effort.

⁸²⁵ See, for example, Jeffrey Needell, “The Revolta Contra Vacina of 1904: The Revolt against ‘Modernization’ in Belle-Époque Rio de Janeiro,” *Hispanic American Historical Review* 67, no. 2 (May 1987): 233–69; Nadja Durbach,

vaccination in Cuba, however, had a specific historical precedent, one that directly increased fears of the BCG vaccine and accusations of the Cuban state's incompetence. In the spring of 1948, the press published an account of "the strange case of Public School No. 40." In late 1947, the Ministry of Education carried out an epidemiological survey in several Havana public schools, including one in Jesús del Monte, a working-class Havana neighborhood. They tested for many diseases, including tuberculosis, and physicians administered EBCG tests in order to determine the index of tubercular infection at each school. (This was purely a survey, and they were not vaccinating the children with the BCG vaccine).

Several days after these tests had been given, a large number of female pupils began to present severe and disturbing reactions. For some, the abrasion caused by the test did not scar over (as was the normal reaction); instead, tumor-like eruptions formed at the site, the scar remained open, and the wound began to ooze.⁸²⁶ Even more serious and bizarre symptoms were reported: loss of appetite and weight; general weakness; pain in the legs and arms; high fever; and even one case of facial paralysis.⁸²⁷

Then, panic broke out when the doctor who had administered these tests could not return to the school to answer parents' questions because he had been hospitalized. The Ministry of Education downplayed the incident, not taking the parents' understandable distress into account. The Ministry sent another physician to the school, who declared that the "matter lacked importance."⁸²⁸ He recommended only that parents feed their children a nutritious diet and

"'They Might as Well Brand Us': Working-Class Resistance to Compulsory Vaccination in Victorian England," *Social History of Medicine* 13, no. 1 (April 2000): 45–63.

⁸²⁶ Isaac Astudillo, ¿Error científico o negligencia oficial? ¿Qué ha pasado en la Escuela Pública no. 40?," *Bohemia* 40, no. 11 (March 14, 1948): 45–46.

⁸²⁷ *Ibid.*, 45.; "El extraño caso de la Escuela Número 40," *Bohemia* 40, no. 17 (April 25, 1948): 41.

⁸²⁸ Astudillo, "¿Error científico," 46.

provide them with vitamins. In response, the parents brought a lawsuit against the government.⁸²⁹

In March 1948, the incident gained national attention when *Bohemia* brought the “strange case” to light, asking a myriad of questions that it believed needed to be answered. The inflammatory language of *Bohemia* served to broaden the ire and anxiety surrounding the situation. In its first article, the magazine asked its readers: “What has happened? Has the...doctor committed some error, injecting the girls with another virus? Is it due to an error or deficiency in the preparation of the vaccine that is made in the laboratory of the National Tuberculosis Council? Why has this event been kept a secret for three months? Have these 156 girls contracted the terrible illness [TB]?” In the late 1940s, distrust of the state and the CNT was at an all-time high, and the author concluded, “[I]t would be nothing unusual if we were in the presence of a typical case of negligence or criminal ineptitude.”⁸³⁰ Much like the strikes in Cuba’s sanatoriums, this incident—covered over the course of several months by the national press—contributed to citizens’ critical perceptions of the public health system and its institutions.

The language and photographs published by *Bohemia* stoked public fear. For instance, one journalist spoke to a tuberculosis researcher, Dr. Pulido, who did not hesitate to claim that many of the children had tuberculosis (without adequately emphasizing that they might have been infected *before* the skin test). When *Bohemia* asked him if the situation might be similar to what happened at Lübeck, he replied, “Anything is possible.” He continued by stating how easy

⁸²⁹ “Lo ocurrido en la Escuela Pública No. 40: Informe de la Asociación de Profesionales de Higiene Escolar,” *Bohemia* 40, no. 13 (March 28, 1948): 38.

⁸³⁰ Astudillo, “¿Error científico,” 46.

it was for germs to turn virulent, a claim with which many physicians took issue.⁸³¹ This specialist also had questionable motives, for he was developing a serum he claimed would cure tuberculosis.⁸³² In the interview with *Bohemia*, he offered to treat the girls with this substance.⁸³³ The photographs published by the magazine also contributed to panic (see Figure 18).



Figure 18. *Bohemia* published many photographs of the afflicted schoolchildren. Pictured above is a group of girls showing the “pustules” that remained at the site of injection.⁸³⁴

The government responded slowly and with little transparency. When confronted with the incident in late 1947, the government did not proactively try to understand what went wrong, assign blame, and provide explanations (and medical treatment) to the parents and school children of Public School No. 40. In March, in response to *Bohemia*’s first exposé, the Cuban Society of Tuberculosis Specialists (the CNT’s scientific society) publicized the safety of EBCG.

⁸³¹ “Otra vez el caso de la Escuela Pública Número 40: Al Colegio Médico de la Habana,” *Bohemia* 40, no. 35 (August 29, 1948): 111.

⁸³² In 1949, *Bohemia* published Pulido’s “cure” for tuberculosis, which ignited a two-month debate in the magazine among Pulido, Chelala Aguilera, and Gustavo Aldereguía.

⁸³³ “Otra vez el caso,” 4.

⁸³⁴ “El extraño caso,” 40.

This was an inadequate response, for many had already begun to suspect that BCG, not EBCG, had been administered.⁸³⁵ In April 1948, governmental ministries began passing the buck. For example, Health Minister Riva said the incident was not his or the Ministry of Health's fault.⁸³⁶ The "responsible sanitary organizations" had not been conscientious, and *Bohemia* felt the need to safeguard the reputation of the BCG vaccine, something that all government organizations involved—the CNT, the Health Ministry, and the Ministry of Education—should have been doing.⁸³⁷

The exposé—and recurrent follow-up essays—pushed the government and the medical community to act. Six months later, *Bohemia* published the findings of the investigation that the Medical College of Havana had conducted. Instead of being administered the EBCG skin test (which could determine past exposure to the tuberculosis bacillus), the health workers of the Ministry of Education had administered the actual BCG vaccine. It was unclear, however, who had made the mistake of supplying BCG vaccines instead of EBCG, although the Ministry of Education blamed it on the CNT.⁸³⁸

Like the tuberculin skin test, EBCG tests were given prior to the BCG vaccine for two primary reasons. First, if a health worker vaccinated someone who had been previously been infected with tuberculosis, the reaction at the site of vaccination could be severe and scar the person who had been vaccinated. Second, physicians wanted to avoid claims that the BCG vaccine had directly infected people. Giving a skin test first would determine if someone had the disease or not. While the international medical community had reached the consensus that it was

⁸³⁵ "Estiman los tisiólogos infundada la alarma en la Escuela Número 40," *El Mundo*, March 31, 1948, 1, 12.

⁸³⁶ "Miscelánea de Salubridad: Virus inoculado a niños de la Escuela No. 40," *Diario de la Marina*, April 3, 1948, 19.

⁸³⁷ "Punto final: El Colegio Médico de la Habana y el caso de la Escuela No. 40," *Bohemia* 40, no. 37 (September 12, 1948): 47.

⁸³⁸ "Lo ocurrido," 61.

not possible for the BCG vaccine to cause the disease, large numbers of civilians still believed this to be a risk. The Medical College insisted to readers that even in the case where BCG vaccine was accidentally administered, local reactions would have no long-term effects. Their thorough investigation (though the use of pre-existing medical records) determined that those children who reported more severe symptoms—facial paralysis, tuberculosis infection—had been diagnosed with these conditions *before* the BCG incident. The report also ascertained that the doctor who had administered the vaccines and then had been hospitalized had suffered from a medical condition not related to the BCG incident.⁸³⁹

Havana's physicians tried to reframe the controversy, pointing to the high tubercular infection rates that the epidemiological survey had uncovered (50–80% of children in Havana's public schools were infected with "virulent tuberculosis.")⁸⁴⁰ They recommended "systematic anti-tuberculosis vaccination whenever possible," and ironically concluded that the children of Public School No. 40 had been done a favor—unlike other schoolchildren of the republic, they had been immunized against a terrible disease.⁸⁴¹

Despite this measured and convincing report, the damage to the BCG vaccine's reputation had been done. The Medical College of Havana explicitly rejected Pulido's comparison to Lübeck in their report, but perhaps they had not convinced the public. One medical student recounted, "The case was talked about throughout the island; all the doctors received inquiries from their clients on their opinion on the matter...The anti-tuberculosis vaccine was confused with tuberculosis, Lübeck was remembered, and the problem was greatly

⁸³⁹ "Punto final," 47.

⁸⁴⁰ Ibid., 76. Tuberculosis infection does not mean one has an active case of the disease but rather that they have been exposed to the bacillus.

⁸⁴¹ Ibid.

exaggerated.”⁸⁴² In the month following the first *Bohemia* exposé, the Ministry of Education changed its policy to require parental consent before giving any medical tests, vaccinations, or medications in schools.⁸⁴³

It is highly likely that by the early 1950s, parents throughout the island, and especially in Havana, remembered this incident and refused vaccination. The compulsory legislation of 1955 may have been prompted in part by citizen resistance or ambivalence about the vaccine. As late as 1957, one tuberculosis specialist trying to promote BCG vaccination felt the need to insist in a popular health bulletin, “We can inform parents that our BCG Vaccine is as good as the best, that it has all the guarantees of creating true immunity in our children without producing any damage...”⁸⁴⁴

One final issue that handicapped the mass vaccination effort concerns Cuba’s insufficient rural health network. BCG vaccination procedures were, in comparative terms, complex; the methods developed by Cuba’s BCG Institute were especially intense. The Institute required five “contacts” between medical personnel and the individual being vaccinated. In addition to the three contacts mentioned at the beginning of the chapter, the Institute also required follow-ups after the vaccine had been injected. Five days later, a nurse or physician would check the injection site: if a nodule formed, then the individual had already been infected (he or she was thus considered to not be vaccinated). Ten to thirty days after the injection, the site would be read a final time: if a nodule formed (considered normal), the individual had been successfully

⁸⁴² Ricardo Álvarez Alegre, “Vacunación antituberculosa con el B.C.G.,” (thesis, University of Havana, 1948), 22–23, TC-13, UHTC, MHC.

⁸⁴³ “Pide la educacional que se consulte a los padres para las vacunaciones,” *El Mundo*, April 3, 1948, 1, 12.

⁸⁴⁴ Arnaldo Coro del Pozo, *Usted y la tuberculosis* (Havana, 1957), 25.

vaccinated.⁸⁴⁵ Medical personnel were not only to perform all of these steps, but also to keep detailed records to give to the BCG Institute, which would serve as an epidemiological clearinghouse. One could see how such a complex process could be difficult to maintain even in an area like Havana, which was saturated with physicians and medical infrastructure; in rural areas, even one trip to a vaccination center might be prohibitive (and five visits certainly were).

In order to carry out vaccination, the BCG Institute had been endowed with funds to create vaccination dispensaries in provincial capitals and mobile units for traveling to more isolated areas. By the early 1950s, ten mobile units were functioning, and they provided typhoid, smallpox, and BCG vaccines to the communities they visited.⁸⁴⁶ The Central Vaccination Dispensary (in Marianao, a municipality of Havana) quickly opened, and by the mid-1950s, five provincial vaccination centers were in operation.⁸⁴⁷ This institutional design made sense in Cuba's political system, where health posts were distributed as a crucial part of the patronage system. The BCG Institute and its vaccination dispensaries constituted "yet another vertical structure" in Cuba's public health sector.⁸⁴⁸ The decision to not decentralize vaccination, integrating it into general local health units followed the logic of Cuban politics, but it also spoke to the stunted effort to reform Cuba's *unidades sanitarias* (the subject of Chapter 4). During the 1950s, these health posts remained wedded to local politics, were often manned by unqualified candidates, functioned only part-time, and struggled to keep up with their duties. The BCG Institute, even if it had wanted to, could not graft onto a pre-existing adequate rural health infrastructure to carry out local vaccination campaigns.

⁸⁴⁵ José María Hernández Pérez, "Necesidad de la vacunación BCG extendida a toda la República," *Revista Cubana de Tuberculosis* 15–16, nos. 1–4, no. 1 (1951–1952): 86–87.

⁸⁴⁶ Mercedes Chávez Arango, "Unidades sanitarias móviles rurales en Cuba," *Boletín Oficial del Ministerio de Salubridad y Asistencia Social* 53, nos. 1–6 (January–June 1950): 71–74.

⁸⁴⁷ Consejo Nacional de Tuberculosis, *Un año de trabajo*, 17.

⁸⁴⁸ Ross Danielson, *Cuban Medicine* (New Brunswick, N.J.: Transaction Books, 1979), 118.

One final note is the curious trend of the BCG Institute to not alter its vaccination procedures in response to these logistical difficulties and limits. During the first international BCG vaccination drive, when the Scandinavian-led International Tuberculosis Campaign moved from Europe to India in 1947, they were forced to simplify BCG vaccination practices. Confronted with India's massive population and stunted health infrastructure, a "simplified technique" developed, in which only one test was administered; keeping epidemiological records fell by the wayside; and lay vaccinators were employed.⁸⁴⁹

For unknown reasons, Cuban health officials did not adopt these sorts of adjustments. Perhaps politicians, nurses and physicians balked at giving up the economically and politically valuable posts. By May 1950, officials had already begun to appoint nurses and physicians to fill these posts, even though the vaccination centers were not yet constructed.⁸⁵⁰ The Cuban BCG Institute themselves recognized that there would be cases where "for not having adequate resources or technical personnel," more convenient methods of administration would be necessary: in these situations, they deemed that the oral form of vaccination would be most feasible.⁸⁵¹ However, even with this recognition, the Cubans seemed to have relied little on oral BCG. In 1952, for example, only 3% of vaccinations were oral, and they were administered only in Havana, which arguably was the easiest region to follow the complex five-contact procedure.⁸⁵² The records of the BCG Institute offer no explanation for this discrepancy, so it is unclear if a rigid commitment to the most modern methods of vaccination or if poor central planning was to blame.

⁸⁴⁹ Brimnes, "Vikings Against Tuberculosis," 420–21.

⁸⁵⁰ Domingo, *La vacunación B.C.G.*, 26.

⁸⁵¹ Ballester Sierra, "Extensión de la vacunación," 125.

⁸⁵² *Ibid.*, 127–30.

In sum, then, a variety of factors coalesced in the 1950s that limited the BCG campaign effort, even though it had been endowed with significant funding, compulsory legislation, and an infrastructure capable of producing the EBCG test and the BCG vaccine. In the final years of the 1950s, political chaos interrupted vaccination, which plummeted to levels similar to those preceding the formation of the BCG Institute. As the guerrilla army fought its way across the island, a number of medical personnel accompanying them began to note that tuberculosis—the “*gusanera real*” —was causing “casualties in their ranks.”⁸⁵³ When these same individuals were appointed as health officials after 1959, they would make significant changes in vaccination policy and practice.

7.3 MASS VACCINATION

The health administration of the new revolutionary government made mass BCG vaccination one of its top priorities. In comparison to the performance of the republican state in the 1950s, the data from the early 1960s is impressive. Several Cuban physicians reported that in nine years of the 1950s (1950–1958), 277,380 vaccines were administered.⁸⁵⁴ From January 1959–June 1962 (three and a half years), the government had already more than tripled this number to 927,043.⁸⁵⁵ In 1964, 1965, and 1966, the Health Ministry administered 289,917; 368,873; and 338,107

⁸⁵³ Gustavo Aldereguía, “Papel de las comunidades en la lucha contra la tuberculosis,” in *Revolución y tuberculosis*, Cuadernos de Historia de la Salud Pública 68 (Havana: Central Nacional de Información de Ciencias Médicas, Ministerio de Salud Pública, 1984): 143. “Gusanera” translates to a “breeding ground of maggots or worms.” This is an interesting and early use of the politically-charged word that would later be applied to the exile community in Miami.

⁸⁵⁴ José Losada Betancourt, “Vacunación B.C.G. y quimioprofilaxis de la tuberculosis,” in *Estudios sobre tuberculosis pulmonar: Orientaciones para la lucha antituberculosa en Cuba*, ed. Ministerio de Salud Pública (Havana: Subsecretaría de Asistencia Médica, Dirección Nacional de Tuberculosis, 1963): 174.

⁸⁵⁵ *Ibid.*

doses.⁸⁵⁶ In 1952, a CNT physician lamented that the state had not vaccinated even a quarter of the number of newborns that needed to be vaccination.⁸⁵⁷ By 1964, MINSAP had vaccinated almost 93% of institutional births and 62% of total births; by 1966, they administered the BCG vaccine to approximately 70% of the newborn population.

The government was able to achieve these figures by making a number of significant changes to the BCG vaccination campaign. The first concerns political will: this was a public health effort supported not only by tuberculosis specialists, but also by the authorities of the Health Ministry and even the Prime Minister (Fidel Castro). When new administrators began to make tuberculosis policy, they elevated BCG vaccination to be one of the cornerstones of the public health campaign to control the disease. In 1960, “intensifying BCG vaccination,” especially in the “urban and rural schools” was listed first among the priorities of the anti-tuberculosis campaign.⁸⁵⁸ When MINSAP formed the Program of Tuberculosis Control in 1963, mass BCG vaccination figured among its five central methods of disease control.⁸⁵⁹

Governmental officials also integrated BCG vaccination into several highly publicized public health efforts to reach previously marginalized populations. In early 1960, as droves of young Cubans headed to Varadero Beach to be trained for the literacy campaign, health workers tested them for tuberculosis and vaccinated them against the disease. During “Operation Varadero,” 15,000 literacy *brigadistas* were given oral BCG vaccines.⁸⁶⁰ A similar campaign took place among the civilian population of Zapata Swamp in the summer of 1961. Dubbed

⁸⁵⁶ Edilberto González Ochoa, “Breve revisión de los aspectos fundamentales en el control de la tuberculosis,” *Boletín de Higiene y Epidemiología* 6, no. 3 (December 31, 1968): 219.

⁸⁵⁷ Ballester Sierra, “Extensión de la vacunación,” 133.

⁸⁵⁸ Cuba, Ministerio de Salud Pública, *Subdesarrollo económico, principal enemigo de la salud: Como combate la revolución cubano* (Havana: Departamento de Relaciones Públicas, Dirección de Docencia y Divulgación, 1960), 32.

⁸⁵⁹ Enrique Beldarraín Chaple, “La lucha antituberculosa en la primera década de la salud pública revolucionaria,” *Revista Cubana de Salud Pública* 38, no. 2 (2012): 203.

⁸⁶⁰ “Operación Varadero,” *Bohemia* 53, no. 35 (August 27, 1961): 30–31, 87.

“Operation Ciénaga de Zapata,” health workers and volunteers traveled around the region in mobile units, vaccinating the population against four diseases (tuberculosis, typhoid, tetanus and polio), while also giving X-ray examinations and hospitalizing active cases of the disease. During this five-week health operation, 30,000 BCG vaccinations were administered, a number that surpassed many of the annual totals of the 1950s.⁸⁶¹

At the end of this health campaign, Fidel Castro traveled to the area, which was dubbed the “most unhealthy and forgotten region” in all of Cuba. On the sands of Playa Girón, where the failed Bay of Pigs invasion had taken place only three months earlier, Castro declared the region the “first territory free of tuberculosis.”⁸⁶² One journalist present penned, “In a period of five weeks the Cuban Revolution carried out what no government has ever attempted in fifty-eight years of subordination to imperialism.”⁸⁶³ Politicking about tuberculosis had long been a feature of national politics; in the early 1960s, this tradition took on an anti-imperialist cast. Furthermore, it began to involve vaccination, which had been little emphasized by Batista and other political leaders, who chose to focus the biggest share of their resources and speeches on hospital projects and other institutions.

MINSAP began a popular education campaign concerning vaccination, a second major adjustment from previous vaccination efforts. They secured advertising space in major national publications that had a wide readership, including *Bohemia* and *Zig Zag* (see Figure 19). Fears about vaccination were taken seriously, and MINSAP instructed physicians to convince patients of the safety and efficacy of vaccination. This was considered part of physicians’ broader

⁸⁶¹ Gustavo Aldereguía, “La lucha antituberculosa en Cuba: Crítica histórica y examen político del problema y endemia” in *Revolución y tuberculosis*, 113.

⁸⁶² “¡Primer territorio libre de tuberculosis!” *Bohemia* 53, no. 32 (August 6, 1961): 48.

⁸⁶³ *Ibid.*

mandate to “mobilize the *campesinos* to bring their children to the vaccination sites.”⁸⁶⁴ One physician employed with the Rural Medical Service (discussed more below) held educational talks in the neighborhoods he served. He recalled, “A very lively discussion among the *campesinos* followed, since none of them had been vaccinated against any disease, and they were worried about the reactions that could occur and the way in which vaccination is carried out.”⁸⁶⁵ The topic also generated “a hectic campaign” in his clinic, where he conversed with mothers privately about the benefits of immunizing their children, themselves and their spouses.



Figure 19. MINSAP promoted BCG vaccination by publishing advertisements in popular magazines.⁸⁶⁶

The physician was careful to emphasize that vaccines were innocuous; furthermore, by ensuring the community that he would be the vaccinator, he was able to build trust. While it is unclear how such efforts played out in other municipalities, this physician happily reported that

⁸⁶⁴ Gabriel Toledo Curbelo, “Recuerdos del Servicio Médico Social Rural,” *Cuadernos de Historia de la Salud Pública* 109 (2011).

⁸⁶⁵ Ibid.

⁸⁶⁶ Advertisements are from: *Zig Zag* 21, no. 1083 (September 9, 1959): 20; *Bohemia* 53, no. 35 (August 27, 1961): 99; *Bohemia* 51, no. 35 (August 30, 1959): 31.

on the first Saturday that vaccinations were offered, the community members had formed a long line to be immunized.⁸⁶⁷

MINSAP also leveraged cross-institutional partnerships to build synergies and share the burden of vaccination efforts. Operation Varadero drew on the resources of multiple organizations: the National Literacy Commission, the National Institute of Tourism, the National Agrarian Reform Institute, and the Ministry of Public Health. These same four institutions also collaborated to carry out the work in Operation Ciénaga de Zapata, for they recognized “the binding links between the development of human life and activity and the protection of health.”⁸⁶⁸

Beyond special vaccination campaigns, officials integrated vaccination into general health units (versus the specialized tuberculosis vaccination centers created in the 1950s). In response to the politicized absence of medical care in rural areas, by 1960, the government had created the Rural Medical Service (Servicio Médico Social Rural), which put recent medical graduates to work in the countryside for at least six months (in 1960, 318 were employed by the state).⁸⁶⁹ These rural doctors, sent to posts in isolated areas, worked in conjunction with municipal health units that were simultaneously being set up throughout the island. These physicians provided vaccination to many who had had little to no interaction with formal medical services in the past.

The revolutionary government anticipated and adjusted policy for on-the-ground difficulties that had stunted vaccination efforts in the previous decade. Related to cross-institutional partnerships, MINSAP employed a number of laypersons to help with vaccination

⁸⁶⁷ Toledo Curbelo, “Recuerdos del Servicio.”

⁸⁶⁸ “¡Primer territorio,” 48.

⁸⁶⁹ Francisco Rojas Ochoa, “Origins of Primary Health Care in Cuba,” *Medicc Review*, accessed August 18, 2016, http://www.medicc.org/publications/medicc_review/1104/pages/cuban_medical_literature.html.

efforts. As part of more mass involvement in public health matters, during Operation Varadero more than one hundred professionals, employees, and workers participated in defining how the health operation would play out. Daily meetings were held, where all employees—from the highest trained medical professional to the most menial laborer—were called upon to voice concerns and suggestions. *Bohemia* noted that, in fact, many of the initiatives were offered by those less qualified workers, whose suggestions were “incorporated consciously into the process” of what was being deemed a “mass sanitary activity.”⁸⁷⁰ Literacy *brigadistas* were also instructed in their own revolutionary duty to participate in popular health campaigns.

In Operation Ciénaga de Zapata, literacy campaign members worked alongside medical professionals to administer vaccines. The exodus of medical professionals from Cuba in the early 1960s necessitated this action, but the government framed the use of non-technical personnel as more fitting for a social revolution. *Bohemia* triumphantly concluded, “Operation Varadero has been revealed as a new technical modality, a revolutionary sanitary specialty, in which collective work has played an important role and for which it is necessary to assign a large part of the achieved success.”⁸⁷¹

Finally, the revolutionary government made the decision to utilize the oral form of BCG vaccine. For those children under 45 days old, the campaign still administered the vaccine via intradermal injection. However, the oral form was used in settings with older children and adults. Pedro Domingo developed this vaccine, which was suspended in ice cream (Glacivacuna). This strategy was pursued for several reasons. First, auxiliary personnel with little training could

⁸⁷⁰ “Operación Varadero,” 87.

⁸⁷¹ Ibid.

easily administer the vaccine.⁸⁷² Second, based on tests done by Pedro Domingo, Glacivacuna could be given indiscriminately without posing danger—that is, no prior tuberculin testing was needed.⁸⁷³ Instead of administering a tuberculin test, sending the patient away, and then asking them to return a few days later for a reading and vaccination, large groups of children could be vaccinated in a short time, requiring only one contact with medical personnel. In 1952, only 3% of vaccines administered by the BCG Institute were oral;⁸⁷⁴ by comparison, from July 1960–December 1961, 76.5% of vaccine doses administered were oral.⁸⁷⁵ Although MINSAP transitioned back to the intradermic method by the end of the 1960s, for the early years of the revolution, many mass campaigns relied on oral BCG (see Figure 20).⁸⁷⁶



Figure 20. The BCG vaccine was mixed with vanilla ice cream and distributed to children.⁸⁷⁷

⁸⁷² Departamento Nacional de Tuberculosis, “Informe final del seminario regional de tuberculosis,” *Boletín de Higiene y Epidemiología* 4, no. 2 (1966): 41–42.

⁸⁷³ Pedro Domingo, “La Glacivacuna B.C.G.,” in *Estudios sobre tuberculosis pulmonar*, 189.

⁸⁷⁴ Ballesteros Sierra, “Extensión de la vacunación,” 127–30.

⁸⁷⁵ “Vacunación,” *Boletín de Higiene y Epidemiología* 1, no. 1 (1963): 7.

⁸⁷⁶ Beldarraín Chaple, “La lucha antituberculosa,” 211.

⁸⁷⁷ Published in *Bohemia*, the caption of this image read, “An industrious volunteer teacher encourages them to try the delicious bite. This is a tasty vanilla ice cream—many have tried it for the first time—where the BCG vaccine is mixed in, which will immunize them against the terrible white plague.” Vicente Cubillas, “Vacunación infantil en zonas rurales,” *Bohemia* 54, no. 6 (February 11, 1962): 70.

The success of the mass vaccination campaign, however, cannot be linked only to the policies and efforts of health officials in the 1960s. The campaign owed part of its success to the medical infrastructure developed during the 1940s and 1950s, specifically the informational, infrastructural and human resources developed at the BCG Laboratory and BCG Institute. Due to strained economic relations with the U.S., Cuba experienced severe pharmaceutical shortages in the early 1960s. In fact, the negotiations over Americans imprisoned after the Bay of Pigs debacle took the form of a hostages-for-drugs exchange.⁸⁷⁸ Cuba, however, was not dependent on the U.S. or any other foreign country for the production of the BCG vaccine, and Cuba continued to produce the vaccine. Pedro Domingo, who had headed the BCG Laboratory since the early 1940s, stayed on during the revolution to develop and produce Glacivacuna.⁸⁷⁹

This combination of factors led to successful mass vaccination campaigns throughout the 1960s.⁸⁸⁰ These efforts had long-term epidemiological consequences, protecting large numbers of the population and lowering tuberculosis morbidity. The short-term effects of these efforts are harder to measure. The letters sent to the Lyceum and Lawn Tennis Club, discussed in Chapter 3, point to the continued economic and social hardship of those suffering from the disease. On a microhistorical scale, vaccination seems to have played little role in alleviating their suffering—they still needed money to pay for medicine, admission to hospitals, and additional economic assistance for paying bills while they could not work. By the late 1960s, the Cuban government recognized many of these issues and began to pass legislation to soften the economic blow of

⁸⁷⁸ Jennifer Lambe, “Drug Wars: Revolution, Embargo, and the Politics of Scarcity in Cuba, 1959–1964,” *Journal of Latin American Studies* (2016): 1–28.

⁸⁷⁹ Domingo, “La Glacivacuna B.C.G.,” 185–96.

⁸⁸⁰ Despite its increased coverage of the population, the state’s vaccination campaign had limits, although these are harder to find in the historical record. The Cuban Refugee Medical Program, based in Florida, tested incoming child refugees for tuberculosis. Of those who tested positive from July 1962–June 1963, “50%...did not receive oral BCG in Cuba.” “A Report on the Development and Activities of the Cuban Refugee Medical Program: Dade County Department of Public Health, Miami, Florida,” 22, Folder 160, Box 7, Cuban Refugee Center Records, CHC-UM.

contracting tuberculosis, but during the early years of the revolution, even if they had more health resources to call upon, many of the poor who were sick continued to struggle, leveraging state resources and older forms of charity to try to scrape by.

7.4 CONCLUSION

Across the globe, in the anti-tuberculosis campaigns of the mid-twentieth century, BCG vaccination represented a crucial weapon in fighting the disease, as it held the promise of immunizing children at a relatively low cost (versus expensive curative interventions like the sanatorium cure, antibiotic therapy, and lung surgery). Cuba's experience with this vaccine illustrates some of the strengths, weaknesses, and contradictions of its health sector. Reflective of the CNT's tendency to ignore the advice of technocrats in the pursuit of political objectives, they took significant action regarding BCG vaccination only when physicians' reform efforts coincided with the pressure of international scientific attention.

Vaccination represented another area (like sanatoriums and streptomycin) in which the state made significant steps towards improving the public health sector, and yet citizens and physicians perceived the effort as a failure. Cuba achieved medical success in developing and exporting both EBCG and the BCG vaccine. However, despite the passage of legislation, increases in funding, and new vaccination dispensaries in the 1950s, the CNT and other public health institutions never adequately or effectively implemented this technology that was central to the control of the disease. Lack of political will and an insufficient rural health network thwarted widespread vaccination. Citizens in the republic took an active role in demanding certain rights and shaping their public health sector, pushing the state to fund more sanatoriums

and streptomycin treatment. And, in the case of vaccination, citizen resistance to BCG probably played a role in hampering the immunization campaign.

After 1959, MINSAP launched a new vaccination campaign, one that health administrators considered to be one of their top priorities in eliminating tuberculosis as a public health problem. They took popular education seriously, sought out cross-institutional connections, and simplified the operation of the campaign by using a different form of the vaccine and by training non-medical personnel to administer it. The campaign, however, drew on past resources that had been developed under republican administrators.

By 1965, MINSAP's tuberculosis policies seemed to have stabilized. They had institutionalized a new public health network, which continued to carry out mass X-ray examination and BCG vaccination. Sources report that the mortality rate began to drop every year after 1963 and the total number of new tuberculosis cases began to decline after 1965.⁸⁸¹ The state opened a new chapter of tuberculosis care by passing a law in 1969 that guaranteed patients 100% of their salaries while under treatment.⁸⁸² In 1971, the government initiated directly observed treatment, and, in 1982, they implemented DOTS (directly observed treatment, short course).⁸⁸³

These promising epidemiological trends have been lauded as major achievements, one more aspect supporting the general assessment of the socialist Cuban public health sector as a model to emulate. However, a number of questions remain that need to be explored, especially regarding how these changes and policies were experienced on the ground, across racial, class,

⁸⁸¹ Antonio Marrero, José A. Caminero, Rodolfo Rodríguez, and Nils E. Billo, "Towards Elimination of Tuberculosis in a Low Income Country: The Experience of Cuba, 1962–97," *Thorax* 55 (2000): 40–41; Mercedes Rolo and Anselmo López Blanco, *La arquitectura de hospitales en la revolución cubana* (Havana: Ministerio de Desarrollo de Edificaciones Sociales y Agropecuarias, 1976), 82.

⁸⁸² Beldarraín Chaple, "La lucha antituberculosa," 211.

⁸⁸³ E. González, L. Armas, and M.J. Llanes, "Progress Towards Tuberculosis Elimination in Cuba," *International Journal of Tuberculosis and Lung Disease* 11, no. 4 (2007): 405.

gender and geographical boundaries, differences that historians have proven continued to matter in daily life, despite the revolution's rhetoric.⁸⁸⁴

⁸⁸⁴ See, for example, see Alejandro de la Fuente, *A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001); Devyn Spence Benson, *Antiracism in Cuba: The Unfinished Revolution* (Chapel Hill: University of North Carolina Press, 2016); Lillian Guerra, "Gender Policing, Homosexuality and the New Patriarchy of the Cuban Revolution, 1965–70," *Social History* 35, no. 3 (July 2010): 268–89.

8.0 CONCLUSION

Almost eighty years after workers laid the first brick on the Topes de Collantes Sanatorium and over sixty years after its inauguration, the formidable structure still stands, a jarring juxtaposition of human engineering in the midst of a dense forest, a historical text made of concrete that demands to be deciphered. What was this strange building? What does the effort to erect it tell us about the not-so-distant past? What human dramas swirled inside and outside of its walls? Once the focus of the revolution's condemnation and then redemptive refashioning, the facility eventually faded from national importance. However, questions about it continue to be asked and to be answered. Throughout the years, elements of the story of the building in Topes de Collantes have been dissembled, invented, and recombined, part of the slippery process of historical memory.

Tourists still trek to the isolated region, a respite from the sweltering heat and cacophonous bustle in the island's cities. Those who research the area before arriving will find a revisionist history of the eponymous (former) hospital, a structure that continues to evoke strong emotion in its observers. One travel writer, for instance, chronicles, "The park takes its name from its largest settlement, an ugly health resort founded in 1937 by dictator Fulgencio Batista to placate his sick wife, for whom he built a quaint rural cottage. The architecture went downhill thereafter with the construction of an architecturally grotesque tuberculosis sanatorium (now a

health ‘resort’) begun in the late ‘30s but not opened until 1954.”⁸⁸⁵ *Wikipedia* repeats a similar narrative, but shifts the characters slightly; in this account, it is Batista’s second wife who was sick: “Coffee growers were living in the area when president Fulgencio Batista ordered the construction of a massive battleship-like Art Deco sanatorium for tuberculosis patients in 1954. Rumor has it that his wife Martha was battling against this illness and once there she fell in love for [sic] the place. As a result, she persuaded Batista to build her a cottage in the zone as well.”⁸⁸⁶

There is historical evidence to dispute the veracity of both of these stories, but they are instructive for revealing how the public continues to remember Topes de Collantes Sanatorium—and health care before 1959 writ large. Even in the absence of state propaganda and scholarly works, popular knowledge insists that the former tuberculosis sanatorium—one embodiment of Fulgencio Batista’s policies—reveals something nefarious about republican public health.⁸⁸⁷ The two narratives above merge both periods of Batista’s rule into one monochromatic interval and elide the eight-year-reign of the Auténticos. The intricate twists and turns of the sanatorium’s history have been forgotten. Instead, Cubans have assumed that the well-known corruption, graft and patronage that ran through many state projects by the 1950s must also have defined and poisoned this particular structure.⁸⁸⁸ Unaware of the facility’s popular reception in the 1930s, the critique of its abandonment in the 1940s, and demands for its resumption in the early 1950s, contemporary voices repeat “rumors” that collapse the building’s history into a narrative of

⁸⁸⁵ Brendan Sainsbury, *Lonely Planet Cuba*, 7th ed. (Hawthorn, Australia: Lonely Planet Publications, 2013), 303.

⁸⁸⁶ “Topes de Collantes,” *Wikipedia*, accessed April 28, 2016, https://en.wikipedia.org/wiki/Topes_de_Collantes.

⁸⁸⁷ Historians in Cuba have produced many excellent histories of the island’s public health and medical institutions. The absence of Topes de Collantes Sanatorium in this literature is striking, for the facility was central to national politics in the republican period.

⁸⁸⁸ It is possible that the contemporary narrative of Topes de Collantes Sanatorium has resulted from what historian Rosalind Shaw calls “palimpsest memories,” where “memories may combine events and processes from different historical moments.” *Memories of the Slave Trade: Ritual and the Historical Imagination in Sierra Leone* (Chicago: Chicago University Press, 2002), 15.

extreme nepotism, in which a sanatorium was built and funded on the public's dime, on the self-interested whim of the First Lady. However, a careful historical reconstruction of Topes de Collantes Sanatorium reveals a more complicated story about health before 1959.

Other health programs and institutions—not as strongly tied to Batista's legacy and with less sensational backgrounds—have simply been forgotten. Residents, especially those born before the revolution, might be able to tell you what the often-abandoned buildings near their neighborhoods once were. But, for decades, the history of the health sector before 1959 has been reduced in the national imaginary to a string of egregious errors. For many scholars, the revolution solved the public health problems that the republican government had created; therefore, the topic has been considered a nonissue, not worthy of research and analysis.⁸⁸⁹

However, as this dissertation argues, republican political leaders and health officials did attempt to control tuberculosis through serious state-building efforts prior to 1959. In the early 1900s, tuberculosis specialists persistently pushed the national government to attend to tuberculosis, which they believed to be one of the nation's primary public health problems. The state, however, proved mostly deaf to these requests. By the 1920s, however, politics had shifted in Cuba, and the reformist and populist-leaning government of Machado finally began to allocate resources towards “national” diseases, among which tuberculosis figured centrally.

State attention, in turn, heightened the visibility of the disease, and a number of public and medical debates highlighted the limits of Machado's anti-tuberculosis campaign. Of particular importance were Afro-Cuban figures who widened the meaning of citizenship to include the right to health, a concept that challenged elite discourses of hygienic citizenship.

⁸⁸⁹ After 1959, “the racial problem” was also considered a nonissue as the revolution had “solved” it. Alejandro de la Fuente, *A Nation for All: Race, Inequality, and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001), 4.

Physicians also critiqued the Machado administration's reliance on private charities for managing and funding anti-tuberculosis efforts. By the end of the 1930s, these activists achieved a measure of success: the right of the poor to health services was codified in the 1940 Constitution, and Fulgencio Batista launched a massive, state-led anti-tuberculosis campaign to deal with one of the deadliest diseases to Cuba's poor and working classes.

Batista hoped to satisfy physicians, public figures, and ordinary citizens' demands for better health care when he founded the Consejo Nacional de Tuberculosis. From 1936 on, the Cuban state expanded the tuberculosis diagnostic and therapeutic infrastructure throughout the island. The campaign not only erected large hospitals but also set up a string of provincial and municipal dispensaries, sent out mobile units to reach rural areas, and disseminated health education materials. By the late 1950s, national tuberculosis health indicators had improved from the 1920s, partially as a result of easier access to medical services.⁸⁹⁰

Nonetheless, citizens raised a number of damning critiques of this project and the wider public health sector. The heightened visibility of tuberculosis, achieved in part by the claims-making of citizens, channeled state attention towards a disease of the poor, but it also distorted the design of projects, making them inefficient and openly political. Frustrated by their difficulties in accessing antibiotics, the sick began to articulate the right of the poor to free or state-subsidized medicine, which the state proved unable to provide. Transnational efforts to reform the local health system could not uproot the dense web of traditional patronage politics. Physicians expressed discontent with the state's neglect of preventive methods of tuberculosis

⁸⁹⁰ Several scholars have recently suggested that Cuba's excellent performance (relative to other Latin American nations) in health indicators by 1959 was partially due to the "relatively easy access to fairly high quality health care for an unusually large share of the population (by then-current Latin American standards)." James W. McGuire and Laura B. Frankel, "Mortality Decline in Cuba, 1900–1959: Patterns, Comparisons, and Causes," *Latin American Research Review* 40, no. 2 (2005): 100.

control, namely the stunted effort to immunize the population with BCG. And, the state's inability to provide the popularly- and medically-formulated goal of a specific number of tuberculosis beds delegitimized the CNT in many constituents' eyes. Even if academics convincingly argue that Cuba had relatively advanced health indicators by 1958, many Cubans perceived the tuberculosis campaign as an effort that had largely failed.

These discontents fed into the broader processes of revolution and regime change. As a result, the socialist government oriented its tuberculosis programs to respond to the failures of the CNT. Nonetheless, their own campaign was marked by certain shortcomings, such as the fact that tuberculosis resources remained over-concentrated in Havana and under-concentrated in Oriente. Moreover, some of their successes, such as mass BCG vaccination, relied on resources developed under republican administrations. The revolution, however, more successfully attended to the health of its population, an achievement that marked the perceptions and experiences of Cuban citizens and facilitated the erasure of past tuberculosis control efforts.

8.1 HEALTH & CITIZENSHIP

This dissertation speaks to issues beyond Cuba, to the broader relationship between health(care) and citizenship. Medical historiography has employed teleological explanations and/or Foucauldian frameworks to explain the “growing rapport between medicine and the state” in the

twentieth century.⁸⁹¹ Two leading scholars in the field have recently pointed out the limits of this approach:

Medical knowledge, which has increasingly multiplied in a large diversity of scientific and popular viewpoints on health and illness, was not only deployed to further the power of the medical profession, insurance companies, pharmaceutical industries, state agencies and welfare bureaucracies. Information about health and illness has also increasingly been used by voluntary associations, social interest groups, patient organizations and individual citizens for their own purposes...Citizens may play an active role in defining health and illness and in utilizing regular or alternative health care services.⁸⁹²

In the republican period, ordinary citizens, public intellectuals, civic actors, and journalists became health activists, making the plight of tuberculosis sufferers nationally visible, pushing for the codification of health care as a right, and demanding that tuberculosis treatment and medical services be available to all, especially the poor. In the 1920s, black politicians and intellectuals insisted that access to state health care constituted a crucial component of citizenship. In the following decades, other Cubans participated in defining the right to health and in demanding its implementation. They did so by mobilizing sanatorium patients, writing letters to the First Lady, and publishing newspaper exposés. Such efforts contradict politicians' claims that they bequeathed the expanding network of health services to the people. "On the question of tuberculosis," Batista may have "had an extraordinary obsession," but physicians and intellectuals had previously catapulted the disease to national attention.⁸⁹³ Others have suggested that the revolutionary government introduced the principle that "health is a right of the

⁸⁹¹ Harry Oosterhuis and Frank Huisman, "The Politics of Health and Citizenship: Historical and Contemporary Perspectives," in *Health and Citizenship: Political Cultures of Health in Modern Europe*, eds. Frank Huisman and Harry Oosterhuis (London: Pickering and Chatto Publishers, 2013), 5.

⁸⁹² *Ibid.*, 6.

⁸⁹³ "Fórum cubano," September 1996, 22, Box 3, Fulgencio Rubén Batista Papers, 1933–2007 (FRB Papers), Cuban Heritage Collection, University of Miami (CHC-UM).

population.”⁸⁹⁴ Instead, I argue that it was citizens themselves, and often those with the least power, who played fundamental roles in shaping state-building efforts and in defining citizenship and rights in republican Cuba.

8.2 STATE-BUILDING IN LATIN AMERICA & THE CARIBBEAN

Once those health rights were articulated, the struggle to make them a reality on the ground became tied to national politics. This dissertation contends that in the 1930s and beyond, health care became a privileged site for state-building in Cuba. And, as Jorge Domínguez has argued for other state institutions in Cuba, health care became tied to the performance of the republican state.⁸⁹⁵ Political objectives influenced health policy, and tuberculosis programs and projects informed the processes of political legitimation. This dissertation contends, then, that to understand the modern Cuban state and populism, studying health care is as essential as the analysis of labor unions or the economy.

Freeze the frame, for instance, on the mountaintop on which Topes de Collantes Sanatorium sits. In the early decades of the republic, the pristine landscape remained untouched by the reach of the Cuban government. To take advantage of its climate, small numbers of individuals sick with tuberculosis ventured to the region and set up tents.⁸⁹⁶ Here, at their own expense and in harsh conditions, they sought their cure.

⁸⁹⁴ Enrique Beldarraín Chaple, “La salud pública en Cuba y su experiencia internacional (1959–2005),” *História, Ciências, Saúde-Manguinhos* 13, no. 3 (July–September 2006): 710.

⁸⁹⁵ Jorge I. Domínguez, *Cuba: Order and Revolution* (Cambridge, MA: Belknap Press of Harvard University Press, 1978).

⁸⁹⁶ “Carteleras,” *Carteles* 26, no. 25 (June 21, 1936): 24. In 1894, renowned tuberculosis specialist Joaquin Jacobsen pushed for the creation of a sanatorium in the Escambray Mountains to take advantage of the climate. This

In the late 1930s, the mountains began to come alive, buzzing with the visits of men in military uniforms, architects and senators, and construction lorries. Reflective of the rise of a new kind of state, Batista's government had brought its arm to the once-ignored region. As workers poured a foundation and hoisted steel beams, Batista's designs for a welfare state began to be realized.

In certain periods after 1936, reflecting the Second Republic's political divisiveness and inefficiency, construction came to a standstill and workers emptied out of the region, leaving behind an unfinished frame. By the mid-1950s, however, the region bustled once again with construction activity and then with the arrival of weakened yet hopeful patients. The Cuban state had finally conquered the mountainous terrain, raised a hospital, and provided medical care to a number of citizens suffering from the white plague.

When the revolution took power in 1959, they quickly changed the name of the facility, but the building's purpose remained in question. While the regime pushed an official narrative of unopposed revolutionary change, the hospital quietly transitioned, first into a military fort and then into a prison for counter-revolutionaries, as a little-known civil war raged in the Escambray Mountains.⁸⁹⁷ In 1964, Cuba's Communist newspaper announced that the government had repurposed the tuberculosis sanatorium. Redeeming a relic of "the tyranny of Batista," the revolution renamed the building Manuel Ascunce, repurposing it to house scores of teacher-

speech was based on "a number of cases of tubercular patients whose condition was improved by exposure to the climate of the sierra between Trinidad and Cienfuegos." John Gutiérrez, "Disease, Empire, and Modernity in the Caribbean: Tuberculosis in Cuba, 1899–1909" (PhD diss., The City University of New York, 2013), 126n30.

⁸⁹⁷ On this civil war, see Lillian Guerra, *Visions of Power in Cuba: Revolution, Redemption, and Resistance, 1959–1971* (Chapel Hill: University of North Carolina Press, 2012). Gustavo Aldereguía, *Camaguey y su tuberculosis* (N.p.: Editorial Cenit, 1959), 29. On the use of the facility as a prison, see Michael Sallah and Mitch Weiss, *The Yankee Comandante: The Untold Story of Courage, Passion, and One American's Fight to Liberate Cuba* (Guilford, CT: Lyons Press, 2015). The hospital itself was caught up in the conflict. The forces of the revolutionary government arrested, among other individuals, the ex-head chef of the Topes de Collantes Sanatorium in 1961, for putting "himself in the service of imperialism." "Limpieza en el Escambray: Capturados 381 traidores y 945 armas," *Bohemia* 53, no. 12 (March 19, 1961): 57.

trainees who spent several years at the school, in austere accommodations, in preparation for their careers.⁸⁹⁸



Figure 21. Kurhotel Escambray in 2014. Photograph by author.

Sometime after the mid-1970s, the government discontinued the training program at Manuel Ascunce and the building became a hotel. Reflective of tourism's increasing weight in the island's economy, the hotel (Kurhotel Escambray) is now owned by the "military's tourism wing, Gaviota" (see Figure 21).⁸⁹⁹ It caters to tourists seeking ecological immersion and the health benefits of the region; the hotel continues to be fully staffed with medical professionals for health tourists.⁹⁰⁰ Opponents of the socialist state disparage what they consider to be one more betrayal by the revolution, as it caters to "the rich foreigners who pay in dollars."⁹⁰¹ Throughout the years of the twentieth century, then, the activity on this plot of land has reflected, and at times even influenced, the island's politics and political economy.

⁸⁹⁸ Ricardo Bernal Mora, "Topes de Collantes: Escandaloso negocio ayer, una esperanza hoy," *Noticias de Hoy*, August 6, 1964, 4.

⁸⁹⁹ Martha Honey, *Ecotourism and Sustainable Development: Who Owns Paradise?* (Washington, D.C.: Island Press, 1999), 218n66.

⁹⁰⁰ "Kurhotel Escambray," *Gaviota Grupo*, accessed October 15, 2016, http://www.gaviota-grupo.com/sites/default/files/kurhotel_escambray_factsheet.pdf.

⁹⁰¹ Ariel Remos, "Emotiva conmemoración del Instituto Cívico-Militar," *Diario Las Américas* (January 20, 2004): 2B, FRB Papers, CHC-UM.

8.3 HEALTH IN CUBA

Since the 1960s, scholars have engaged in an unresolved debate about health care in Cuba prior to 1959. Demographers and political scientists have persuasively contended that Cuba achieved impressive advances in health statistics before 1959, strong evidence of prerevolutionary modernity.⁹⁰² For example, the tuberculosis mortality rate in Havana declined from 360.8 deaths (per 100,000 population) in 1901 to 41.3 deaths (per 100,000 population) in 1953.⁹⁰³ Others have argued that health care was disastrous in the republican period, extolling the virtues of the revolution that they believe created a successful health care system for the people.⁹⁰⁴

This dissertation has similarly demonstrated a striking disjuncture in the republican period between “modern” health statistics and highly critical popular perceptions of health care on the island (on the basis of vernacular metrics of good health care).⁹⁰⁵ By complementing health outcomes and statistics with a multifaceted social and political history of tuberculosis in the period, and by balancing attention between state health efforts and grassroots definitions of medical success, this dissertation has proven that both sides in this debate are correct. On many counts, Cuba’s health care system proved to be well developed and more advanced than regional

⁹⁰² Those that emphasize mortality trends include Sergio Díaz-Briquets, *The Health Revolution in Cuba* (Austin: The University of Texas Press, 1983); Leví Marrero, *Cuba en la década de 1950: Un país en desarrollo* (Santo Domingo: Editora Corripio, 1987); McGuire and Frankel, “Mortality Decline”; Roberto M. González, “Infant Mortality in Cuba: Myth and Reality,” *Cuban Studies* 43 (2015): 19–39.

⁹⁰³ Díaz-Briquets, *The Health Revolution in Cuba*, 58.

⁹⁰⁴ See, for example, Julie Feinsilver, *Healing the Masses: Cuban Health Politics at Home and Abroad* (Berkeley: University of California Press, 1993); Aviva Chomsky, “‘The Threat of a Good Example’: Health and Revolution in Cuba,” in *Dying for Growth: Global Inequality and the Health of the Poor*, eds. Jim Yong Kim, Joyce V. Millen, Alec Irwin, and John Gershman (Monroe, ME: Common Courage Press, 2000), 330–57; Paul Farmer and Arachu Castro, “Pearls of the Antilles? Public Health in Haiti and Cuba,” in *Unhealthy Health Policy: A Critical Anthropological Examination*, eds. Arachu Castro and Merrill Singer (Walnut Creek: AltaMira Press, 2004), 3–28; Beldarraín Chaple, “La salud pública en Cuba,” 710.

⁹⁰⁵ On the importance of “vernacular” theorizations of rights and expectations, see Lara Putnam, “Citizenship from the Margins: Vernacular Theories of Rights and the State from the Interwar Caribbean,” *Journal of British Studies* 53, no. 1 (January 2014): 162–91.

neighbors, as the Cuban state pursued serious health initiatives: the CNT, experimentation with modern health units, tuberculosis sanatorium construction, new drug therapy, and BCG vaccination. This system also produced significant successes, evidenced by mortality declines and good health indicators by Latin American standards.

Yet, ordinary Cubans had negative experiences in interacting with health institutions. Heightened claims-making and increased state attention to the disease made it a visible issue of national political significance throughout the Second Republic. While national politics favored attention to tuberculosis and state-building efforts in the public health sector, they also undermined efforts to control the disease. The projects of the CNT and other health institutions became marred by corruption, patronage, and inefficiency. The politicization of these programs also meant that they were subordinated to changing political priorities and non-technical bureaucracies, rather than the modern, technical organizations that physicians and citizens desired.

After 1959, a new government introduced many changes in Cuba's public health sector and tuberculosis control and treatment programs. Health continued to be a politicized issue after 1959 and an arena in which the revolution was legitimized and institutionalized. In response to the republican state's failures, the revolutionary government made the extension of efficient health services throughout the island one of its central goals. This made disease control and health care even more visible, encouraged a bio-medicalization of its population, and increased citizen expectations. As anthropologist Sean Brotherton has recently argued, "The socialist health care doxa has saturated people's everyday lives and mundane practices," while also "producing state-fostered expectations and feelings of entitlement to a particular form of

biomedical health care.”⁹⁰⁶ The long-term consequences of this biopolitical project are not yet clear, although the historical narrative suggests that they could be politically problematic in the current period, as state performance in the health sector falters.

8.4 EPILOGUE

Beginning in the 1990s, as the Cuban government instituted economic reform to deal with the crisis of the fall of the Soviet Union, resources have been shifted away from certain medical services on the island. For instance, through the Family Physician and Nurse Program (Programa del Médico y la Enfermera de la Familia), Cubans had access to a doctor and a nurse on their block or in their community. By the early years of the 2000s, many of these doctors had been sent to work in Venezuela’s Misión Barrio Adentro program (part of the oil-for-aid agreement between Castro and Chávez).⁹⁰⁷

There are other signs pointing to the deterioration of medical services on the island. Although it is unclear how trustworthy these reports are, a subgenre of political propaganda against Castro’s regime documents the medical horrors on the island. The *On Cuba* website, for instance, provides photographic evidence of the Pilar San Martín tuberculosis sanatorium (turned psychiatric hospital) that now sits “abandoned in the mountains.”⁹⁰⁸ The once-modern Lebrede Hospital became a well-regarded maternity hospital after 1959. It has since been deserted and fallen into disrepair, hidden behind the still-functioning units at the former La Esperanza

⁹⁰⁶ P. Sean Brotherton, *Revolutionary Medicine: Health and the Body in Post-Soviet Cuba* (Durham: Duke University Press, 2012), 6.

⁹⁰⁷ Ibid.

⁹⁰⁸ Eduardo González Martínez, “Un manicomio abandonado en las montañas,” *On Cuba*, February 13, 2016, accessed September 14, 2016, <http://oncubamagazine.com/sociedad/un-manicomio-abandonado-en-la-montana/>.

complex (see Figures 22–23).⁹⁰⁹ Many Cubans, both on and off the island, are unhappy with the hospital's closure, for they now have to travel farther to seek medical attention.⁹¹⁰



Figure 22. Lebrede Hospital during the Second Republic.⁹¹¹



Figure 23. Lebrede Hospital in 2014. Photograph by author.

⁹⁰⁹ The cottages at La Esperanza are also not in use, although Julio Trigo Hospital still operates as a surgical center.

⁹¹⁰ See, for example, “How the Best Maternity-Infant Hospital in Cuba Looks Now,” *El Blog de Medicina Cubana*, February 14, 2007, accessed October 14, 2014, <http://medicinacubana.blogspot.com/2007/02/how-best-maternity-infant-hospital-in.html>; Eriberto Liranza Romero, “Párraga pierde su patrimonio,” *Misceláneas de Cuba*, August 26, 2010, accessed October 28, 2016, http://www.miscelaneasdecuba.net/web/Article/Index/518129d93a682e0f88c50bc_b#.WBzq4-ErKRs. Also, see the following clip, which features interviews with the residents who live near the Lebrede Hospital: https://www.youtube.com/watch?v=NKynty_F1Jc.

⁹¹¹ Photograph from FC (Col), *Hospitales, Sobre 1* (48), 29, Fototeca, Biblioteca Nacional de Cuba José Martí (BNJM).

Pointing to a number of derelict hospitals that have fallen from glory, however, does not provide an adequate measure of national health care. Cuba continues to report promising health indicators. The WHO recently certified Cuba as the first country to eliminate mother-to-child HIV transmission;⁹¹² it is also in the running to become the first country to eliminate tuberculosis. Despite recent changes in the health sector, the state insists that it is using the funds generated by its booming medical tourist industry to maintain its renowned primary health care system. Nonetheless, evidence suggests that citizens have increasingly negative perceptions of their health care system. Sean Brotherton writes, “The período especial called into question the moral legitimacy of the state, and it had indelible social and political consequences for both the revolutionary government and the popular support citizens and health professionals gave it.”⁹¹³

The history of Cuba’s anti-tuberculosis campaign might be instructive for the future of health care and politics on the island, for contemporary conditions bear striking similarities to the 1950s. At that time, Cuba had achieved modern health indicators, but its citizens’ subjective experiences with the health care sector were deteriorating. For decades, they had presented demands to the state, but their expectations had not been met. A host of Cubans believed that only serious political change could improve the public health sector, which gave many citizens another reason to welcome the revolution when it arrived in 1959. The future of Cuba remains uncertain on many measures, but the deeply political nature of health on the island suggests that the state’s ability to continue to fulfill the obligations of health citizenship will play a role in shaping the path that is taken.

⁹¹² Donald G. McNeil, Jr., “Cuba Wins W.H.O. Certification It Ended Mother-to-Child H.I.V. Transmission,” *New York Times*, June 30, 2015, accessed October 14, 2015, http://www.nytimes.com/2015/07/01/health/who-certifies-end-of-mother-to-child-transmission-of-hiv-in-cuba.html?_r=0.

⁹¹³ Brotherton, *Revolutionary Medicine*, 20.

APPENDIX A

SECRETARIES OF SANITATION/MINISTERS OF HEALTH

Dr. Santiago Verdeja Neyra: January 24, 1934–August 19, 1934

Dr. Rafael Lorié Marín: August 20, 1934–March 10, 1935

Dr. Aurelio Ituarte Gutiérrez: March 11, 1935–November 6, 1935

Dr. Leonardo Anaya Murillo, Interim: November 7, 1935–January 12, 1936

Dr. Emilio Martínez Martínez: January 13, 1936–May 19, 1936

Dr. Manuel Mencía y García: May 20, 1936–November 11, 1936

Dr. Carlos Peláez y Cossío, Interim: November 12, 1936–December 7, 1936

Dr. Manuel Mencía y García: December 8, 1936–December 24, 1936

Dr. Zenón Zamora y García: December 24, 1936–August 10, 1938

Dr. Manuel Costales Latutú: August 11, 1938–May 16, 1939

Dr. Domingo F. Ramos Delgado, Interim: May 17, 1939–May 26, 1939

Dr. Juan de Moya y Flamand: May 27, 1939–May 13, 1940

Dr. Joaquín Ochotorena, Interim: May 14, 1940–May 20, 1940

Dr. Juan de Moya y Flamand: May 21, 1940–October 9, 1940

Dr. Demetrio Despaigne y Grave de Peralta: October 10, 1940–July 17, 1941

Dr. Sergio García Marruz: July 18, 1941–February 1, 1942

Dr. Domingo F. Ramos y Delgado: February 2, 1942–June 21, 1942

Dr. Gustavo Adolfo Bock y Jorge: June 22, 1942–August 17, 1942

Dr. Juan M. Portuondo Domenech: August 18, 1942–March 6, 1944

Dr. Alberto Recio Forns: March 7, 1944–October 9, 1944

Dr. José A. Presno Bastioni, October 10, 1944–April 16, 1945

Dr. Octavio Rivero Partagás, April 17, 1945–June 2, 1947

Dr. José R. Andreu Martínez, June 3, 1947–December 4, 1947

Dr. Ramiro de la Riva y Domínguez, December 5, 1947–October 9, 1948

Dr. Alberto Oteiza Setién, October 10, 1948–June 23, 1949

Dr. Carlos Ramírez Corría, June 24, 1949–September 27, 1950

Dr. José Antonio Rubio Padilla, September 28, 1950–April 3, 1951

Dr. Jose R. Andreu Martínez, April 4, 1951–March 10, 1952

Dr. Enrique Saladrigas y Zayas, March 11, 1952–August 9, 1953

Dr. José Elías Olivella Lastra, August 10, 1953–August 4, 1954

Dr. Carlos Salas Humara, August 5, 1954–February 23, 1955

Dr. Armando J. Coro y de la Cruz, February 24, 1955–July 18, 1955

Dr. Alberto Recio y Forns, July 19, 1955–January 29, 1956

Dr. Carlos Salas Humara, January 30, 1956–March 5, 1958

Dr. Octavio Montoro y Saladrigas, March 6, 1958–March 12, 1958

Dr. Manuel Ampudia González, March 13, 1958–January 5, 1959⁹¹⁴

⁹¹⁴ Information from César Rodríguez Expósito, *La primera Secretaria de Sanidad del mundo se creó en Cuba*, Cuadernos de Historia de la Salud Pública 25 (Havana: Ministerio de Salud Pública, 1964), 142, 144.

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Secretaría de la Presidencia

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