

# Affective relatedness, temporalities, and the politics of care in a medical South-South partnership The Cuban mission in Brazil

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*Abstract:* For more than 50 years, Cuba has been one of the most important players in the field of international medical care in the Global South. Between 2013 and 2018, Cuba sent nearly 18,000 Cuban health professionals to Brazil within the framework of the More Doctors Program to assist during the Brazilian public health care system's state of emergency. This article focuses on local encounters and emergent socialities between Cuban physicians and Brazilian patients and medical staff. Their sensitive moments of interaction—with their embodied, emplaced, and political dimensions of past and present—hold the possibility of a fragile intersubjectivity that creates its own temporal and affective dynamics, undermining, for a moment, the prevalent care regimes.

*Keywords:* affective relations, care regime, Cuban internationalism, More Doctors Program, temporalities of care

As we left the clinic and entered the narrow alleys of one of Rio de Janeiro's northern favelas, we were stopped over and over by residents. People asked Dr. Emanuel—whose white coat identified him from a distance as a clinician—to address minor health issues right there on the street. He measured pulses, felt foreheads for fever, and briefly examined aching body parts, offering basic medical advice and promising that he would stop by to see sick relatives on our way back to the clinic. Rose, a community health worker (CHW), became anxious; the requests were not emergencies, and the team had a busy schedule of home calls until noon. Still, Dr. Emanuel took his time, and we reached the first patient's home with considerable delay.

This was a common occurrence when Dr. Emanuel,<sup>1</sup> a Cuban family doctor, went to the *morro* (favela hill) for domiciliary visits, which he did approximately twice per week. It took a couple months until residents recognized and approached Dr. Emanuel as the local family clinic's new GP. Despite being Cuban, his brown skin differentiated him from both the Brazilian and international doctors, who had sporadically attended the favela in previous times. Dr. Emanuel was one of more than 18,000 Cuban health professionals who arrived in Brazil between 2013 and 2018 as part of the More Doctors for Brazil (*Programa Mais Médicos para o Brasil*, or PMM) initiated in 2013 by the then Labor Party government to dispatch physicians to medi-



cally underserved areas of Brazil (OPAS 2018). In response to massive protests throughout the country, then President Dilma Rousseff had previously proclaimed a state of emergency in the Brazilian health care system and declared the PMM as a call for international help. The treaty with Cuba at the very heart of the program was one of the biggest South-South partnerships at the time. Moreover, Cuban physicians like Dr. Emanuel referred to their three-year assignments in Brazil as an act of international solidarity with people in need and emphasized the humanitarian nature of their work.

These introductory remarks reveal some of the peculiarities and tensions that emerge in the context of international medical aid. Focusing on the example of the Cuban-Brazilian cooperation, I will show how the coincidence of divergent care regimes and their underlying temporal horizons and affective arrangements affect medical care and subjectivities in this particular constellation within a South-South partnership.

South-South partnerships blur apparently clear-cut lines in the postcolonial framing of give-and-take in the humanitarian and development imaginary (Fiddian-Qasmiyeh 2015). As the introduction to this theme section makes clear, these seemingly alternative forms of aid provision have garnered increased political and academic attention in the last few years for the supposed challenge they pose to established principles of Western humanitarianism (see also Cesarino 2012). However, the differing social, political, and cultural complexities and hierarchies within the postcolonial humanitarian care social order have so far received less attention in the debate about these new actors in the Global South<sup>2</sup> (Fiddian-Qasmiyeh 2015; Six 2009). Similarly, the debate has lacked a more nuanced perspective on emergent socialities and interactions among those on-site, as well as the affective relations and politics of emotion involved.

This article engages deeply with the implementation of the medical treaty between Cuba and Brazil established by the PMM, wherein

divergent care regimes—Cuban, Brazilian, and humanitarian—become entangled. I focus on the temporal and affective dimension of local encounters and emergent socialities between Cuban physicians and Brazilian patients in urban socioeconomic peripheries, where these regimes not only materialized in and through interaction but also became questioned and challenged. The term care regimes, as I use it here, refers to the dominant structural arrangement of care and its politics, discourses, and power relations, as well as policies and protocols, standardized practices, and dominant imaginaries (cf. Ticktin 2011). Within an international setting like the PMM, my approach demands a transnational perspective on gender, class, and race relations as constituting and constitutive of care, along with the symbolic dimension of nationality. As Heike Drotbohm and Hansjörg Dilger show in the introduction to this theme section, affect is another integral element of care and care regimes, as these regimes entail intersecting or conflicting social and political imaginaries, norms, and practices of care; the underlying politics of emotion and the sentiments, affective attitudes, experiences, and expectations evoked or enhanced therein; and individuals' emotions and perceptions in intimate caring interactions. I argue that time matters in shaping the affective arrangements in care regimes and the emergent socialities in caring interactions. I will address time as temporality in a threefold way: as relational practice, manifest in the timely duration of its performance; as embodied experience of past and present everyday life and the politics of living (Feldman 2017); and as narrative and discursive projection of temporal horizons of care practices and care regimes.

My discussion draws on ethnographic research I conducted between 2014 and 2016 in urban socioeconomic peripheries of Rio de Janeiro. The core of the research involved a 12-month period of fieldwork in two primary health care family clinics in northern Rio de Janeiro that participated in the PMM. Through the lens of sensory ethnography (Pink 2009),

I carried out participant observation focusing on the everyday working routines of all clinical staff (including Cuban and Brazilian physicians, nurses, pharmacists, and CHWs) within and outside the clinics, as well as in the surrounding communities. Within the clinic walls, I witnessed innumerable (Brazilian and Cuban) doctor-patient encounters in the treatment rooms and dwelled at will in the waiting rooms, staff meeting rooms, clinic-intern pharmacies, and casualty stations. This also provided me with rich insight into medical practices along with clinic staff members and patients' views on health, care, and care politics. On a regular basis, I participated in the clinic's community actions for the provision of public health (e.g., in primary schools and kindergartens, precarious collective housing arrangements, and weekly meetings with special focus groups such as teen mothers or traumatized elderly women) and in home visits, accompanying not only Cuban doctors but also Brazilian nurses and nurse auxiliaries, social workers, and, above all, CHWs.

I complemented my ethnography with a range of interviews and informal conversations with Cuban physicians participating in the PMM in other parts of Rio de Janeiro, as well as sporadic participation in their work routines over the months. I compared my ethnographic data with the findings of the Brazilian CNPq Research Group on International Health and Cooperation, which examined Cuban participation in the PMM in three other Brazilian cities (cf. Terra et al. 2016). I also performed literature and database reviews in leading Brazilian health-related institutions, including FIOCRUZ and ABRASCO.

In the following, I first provide background information on Cuban medical internationalism and Brazil's health care crisis to contextualize the PMM. Then, I focus on physician-patient relationships in different ethnographic settings within family clinics in Rio de Janeiro's socio-economic peripheries that exemplify the divergent politics, temporalities, and affective relations of care. Subsequently, I discuss these ethnographic examples against a set of theoret-

ical concepts concerning affective relations and temporalities in postcolonial and humanitarian care regimes.

### **Cuba's medical internationalism, Brazil's health care crisis, and the temporal horizons of humanitarian care**

For over 50 years, Cuba has been an important player in the field of international humanitarian aid and an important advocate in international forums for solidarity and cooperation among countries of the Global South. To date, Cuba has sent more than 135,000 professionals to provide medical help to over 100 countries, especially in Latin America and Africa (Kirk et al. 2016). The history of these aid missions is closely entangled with the Cuban Revolution. Initially part of an internationalist solidarity between countries in need, medical aid was long considered the more human flank of Cuba's anti-colonialist and anti-imperialist strategy (Kirk and Erisman 2009). However, the overemphasis on the socialist mission of its international medical assistance gave way to a more impartial framing of Cuba's official discourse over the years, with an acknowledgment that these missions had formed the country's most important grounds for diplomatic international agency since the mid-1970s (Feinsilver 2010). Medical collaborations also became an economic necessity for the highly isolated country after its *período especial*; while Cuba continued providing unconditional, immediate medical aid in settings of humanitarian emergencies, they also expanded into structural, long-term foreign missions operating alongside the public health care of the recipient country in exchange for financial support or other compensatory measures (Feinsilver 2008). Regardless of the context, medical partnerships have earned Cuba respect worldwide (Huish 2014; Kirk and Erisman 2009). Leading countries in the UNDP's Special Unit for South-South Cooperation refer to such partnerships as an "inspiration" (Malik 2013: iv) and an "alternative" (108) to international aid programs from the

North. These reports point to the significance of shared experiences of the postcolonial social order and neocolonial dependency as the basis for a more horizontal solidarity rather than a privilege-adherent compassion as the driving force to act (Reality of Aid 2010).

In this spirit, the Cuban government has referred to its international medical assistance over the decades as an act of humanism, helping distant (but not-so-different) “others” in need. Since the early 1960s, Fidel Castro himself emphasized international solidarity—especially with the countries of the Global South—in his public speeches, referring to Cuba’s internationalism as driven by love (see Castro 1983). While Castro tied this love to noble sentiments like altruism and appealed to the Cuban people’s capacity for sensibility and identification with those in need, he did not refer solely to emotions and empathy as the impetus for Cuban internationalism. Rather, he also addressed each Cuban’s moral debt to humanity, which could be paid by becoming an *internacionalista*, as suggested by one of his most famous phrases (“Ser internacionalistas es saldar nuestra propia deuda con la humanidad”) in 1978 (see Castro 1988). The underlying politics of emotion of these discursive figurations of solidarity, debt, and duty have since become an integral part of public consciousness-raising, which Castro and other state officials repeated in innumerable speeches to medical graduation classes from the 1970s through the 2000s (*Infomed* 2023). Through their iterant and permeant presence in the Cuban internationalist solidarity *dispositif*, these politics of emotion shaped and bolstered collective sentiments among a large part of the Cuban population toward countries in need, especially in the Global South. These politics also affected the professional subjectivities of the medical *internacionalistas*.

Parallel to the international political, economic, and symbolic significance of these medical missions, health care has been a major battleground for social change in Cuban domestic politics and a driving force of Cuba’s socialist revolutionary enterprise (cf. Brotherton

2013; Feinsilver 2010). From its beginning, the Castro regime approached public health and health care as a domain in which capitalism and colonialism’s inhuman injustices and social differentiations (on the basis of class, gender, and race) play out. The popularization of medicine therefore became an integral part of building a socialist society (Guevara 1977). Ernesto “Che” Guevara’s (1969) manifesto for a “revolutionary medicine”—which remains part of the Cuban Ministry of Public Health training manual (cf. Brotherton 2013: 130)—addressed medical performance; Guevara, himself a trained physician, encouraged medical professionals to have a humble, solidary, and empathetic attitude toward their patients. Revolutionary medicine also promoted equal access to medical care and medical training for any person, regardless of social background, region of origin, gender, or race (Blue 2010).

Several political and infrastructural measures undertaken in the 1960s and 1970s led to largely equal access to both health care and the medical profession for Black and low-income populations and especially for women in Cuba. As a result, Black and women doctors have become a significant presence in Cuban medicine and consequently have been well-represented in international work assignments (Blue 2010), including for the PMM. But while these *internacionalistas* diversify the trope of the “valiant family physician as revolutionary hero” abroad, the Cuban population’s life in permanent crisis mode since the *período especial* has slowly turned into a health crisis for the population at home (Brotherton 2013: 130).

In contrast to recent Cuban history, the Brazilian health care landscape has clung strongly to its postcolonial legacy. Access to medical university training is structured in ways that favor the (white) upper class. According to Brazil’s 2010 census, only 18 percent of all physicians belonged to a racial category other than white (LAESER 2014). (Bio)medicine has been, and continues to be, perceived as a “white” field by all social and racial segments of the Brazilian population. With regard to health care, large

parts of the Brazilian population—especially poor and Black Brazilians—have long had little access to adequate medical care (Bertolli 1996). Although considerable efforts and improvements were made to include these marginalized populations after Brazil’s democratization in the late 1980s, the public health sector has since suffered from a constant scarcity of resources and professionals and an unequal distribution of medical infrastructure throughout the country (cf. Scheffer 2015), fueling collective sentiments of inequality and negligence among these populations.

Long-term experiences with a precarious public health care system were especially salient in urban socioeconomic peripheries like favelas, where they fit into a wider trend of social suffering. As a common local trope, favela residents considered public health part of an ongoing crisis and the epitome of political disregard. In June 2013, nationwide protests against political and social ills arose throughout the country. Protesters demanded improvements in the public sector—above all, in public health care. In this moment of political turmoil, the then Working Party government officially recognized an emergency in the public health sector. Shortly after, the government initiated the PMM in order to meet these demands. In this context of the affective dissatisfaction of large parts of the Brazilian population with the prevailing care regime, Cuban physicians arrived in Brazil in September 2013.

The PMM aimed to guarantee access to primary health care especially for “the socially most vulnerable population” (OPAS 2018: 5, my translation) by investing in and improving both the quantity and quality of the personal and technical infrastructure. The program also acted as an emergency measure to fill vacant job positions by immediately assigning over 18,000 physicians to public health facilities in underserved urban and rural regions. The program’s core was the treaty with Cuba, which enabled more than 11,400 Cuban medical professionals to work in Brazil for a period of at least three years (OPAS 2018). Interim President Michel

Temer renewed the treaty between the two countries in 2016, a few months after the impeachment of Dilma Rousseff. Although President Jair Bolsonaro resumed the PMM in 2019, the Cuban government canceled the treaty with Brazil in November 2018 and recalled the more than 8,500 health professionals still working in Brazil at that time.

Brazil’s call for medical help and the Cuban solidarity-based response entered but also contested the temporal horizons of humanitarian care regimes. Institutions involved in humanitarian aid assistance consider their assistance primarily an exception occurring in moments of crisis, with crisis long conceived as a “rupture in the order of things” (Vigh 2008: 8), “separating two states of normality” (Redfield 2005: 335). The urgency to act (Calhoun 2004: 376) focuses mostly on present biological survival at the expense of enduring (dignified) living (Feldman 2017). Through immediate, short-term action (Feldman 2017: 44), the crisis is addressed and becomes manageable through selective measures—that is, minimalist biopolitics (Redfield 2005: 344)—and, consequently, normality can be reestablished. These tropes of exception, immediacy, and urgency tie the humanitarian care regime to particular politics of time (Brun 2016: 406).

What differentiates the PMM from such conceptions is that for both Cuba and Brazil, crisis is not sudden and exceptional but rather an enduring condition and the context of most people’s lives. This case is far from exceptional: humanitarian entities across the globe have long paid attention to the persisting, “broad landscape of insufficient care, services, and opportunities” (Feldman 2017: 44), where basic survival—despite conflict and poverty—has already been secured but still depends on the continuing provision of humanitarian care. By contrast, Brazil’s sudden political recognition of its health care crisis and Cuba’s transformation of its medical internationalism into a political act that simultaneously recognized the country’s extraordinary political and economic situation was exceptional. Rather than offering

short-term, selective action to save lives, the PMM envisioned from the start a medium-term engagement that also aimed for long-lasting structural improvements in the health care sector. However, the Brazilian government acknowledged the urgency to act at a moment of governmental instability during which social suffering had become a political issue expressed through street protests. This renders the PMM not only a needed and urgent health care measure but also a political act.

Similarly, Cuba's framing of its international medical assistance is also political, transcending compassion as a shared emotional commitment and a driving force to act (Bornstein and Redfield 2011). Cuban political discourses include compassion and love as crucial aspects of mobilizing international solidarity, which is rendered as a horizontal bulwark against postcolonial inequalities and neocolonial dependencies. Thus, as the introduction to this theme section makes clear, commitment is actively evoked by a "politics of emotion," that is, the mobilization of emotions as an instrument and motor of the political (Bargetz 2014: 119). In the following I explore how these political, affective, and temporal dimensions of divergent care regimes materialize and become contested in local encounters and emergent socialities in caring interactions between Cuban physicians and Brazilian patients and medical professionals in the context of the PMM.

### **Entanglements of politics and temporalities of care: On (not) being the appropriate giver**

The small waiting room of the family clinic in one of my fieldwork settings was crowded, as it always was on workday afternoons. Patients sat or stood wherever they could find space, some chatting with each other or typing on their smartphones, while others commented on the news playing on the television on the wall above and children played on the tiled floor. Some people complained about pain; others coughed,

gasped, or wiped sweat from their faces. Most patients had been waiting for more than two hours, and some started pacing impatiently up and down the small clinic's corridor, complaining of yet another doctor's visit full of delays and waiting. The tense atmosphere was regularly cut by nurses, doctors, or CHWs calling for a patient.

Amid this noisy chaos, Dr. Rodrigo—a Brazilian and one of the clinic's four family doctors—dismissed his patient Dona Bianca from the treatment room, when she suddenly turned and begged him not to leave the clinic, knowing of his plans to move to another hospital in the more attractive southern zone of the city. Dr. Rodrigo assured her that, in addition to the other doctors already at the clinic, two more doctors were set to arrive that month. The old lady corrected him, pointing out that, "except for the little white one" (referring to one of the clinic's physicians), one of the other two doctors rarely visited the clinic, while the other (who was Black) was not a "proper doctor" because he was "from Cuba." She added that the new doctors would surely be "only from Cuba again." Slightly embarrassed by her remarks, Dr. Rodrigo interrupted her, telling her in a low voice that the Cuban doctor at the clinic had been a medical professional for much longer than he himself had been and that, by the way, "the little white one" was also Cuban. "A Cuban?" interrupted Dona Bianca, raising her voice again. That couldn't be right, she insisted, because "Cubans are really black." Rubbing her left forearm with her right index finger, she added, "They're even blacker than us."

I witnessed this episode in April 2014, eight months after the arrival of the first Cuban physicians in Brazil at a general medicine family clinic in a favela complex in northern Rio de Janeiro. A routine state of being for favela residents in public health care, waiting symbolized the temporal permanence of living in crisis, which most people wearily endured as part of a wider pattern of disregard by public services (cf. Auyero 2012). Waiting thereby epitomized the merging temporal antipodes of urgency and

chronicity related to crisis and under-care in the Brazilian public health care system; it revealed the underlying inequality of the Brazilian care regime and disclosed the shortage of medical professionals in public facilities in marginalized areas due to fewer well-paid opportunities and often adverse working conditions. In one of our conversations, the committed Dr. Rodrigo justified his leave by revealing, sadly, that “even if you want to, you just manage to stay in these areas for only a couple of years and then you are burnt out.” Patients, therefore, were used to a high turnover of medical staff, impeding the establishment of longer-lasting doctor-patient relationships. This also affected their forms of sociality, as I show below.

Moreover, this episode emblematically captures the controversial manner in which Brazilian medical personnel and local populations initially received the Cuban PMM participants. Dona Bianca’s reaction points to the importance of racialized ascriptions and their connection to nationality in patients’ initial judgments of the Cuban physicians’ professional skills. She doubted that the Cuban to whom she referred was a “proper” doctor, which she indirectly connected to both skin color and nationality. This is further evidenced by her surprise that one of the “whites” was also a Cuban, as she perceived all Cubans to be “black,” even “blacker” than herself. Dona Bianca’s apparent confusion about whom she could or could not trust to possess appropriate medical skills pointed to deep-seated prejudices, which can be viewed as the continuing social legacy of a colonial past and a reflection of current racialized inequalities in Brazil. Patients like Dona Bianca do not associate specialized skills in medicine—a field perceived as “white”—with Black people, a disconnect maintained by the minimal presence of Black physicians in Brazil. In conversations in clinics at the beginning of the PMM, patients repeatedly expressed their skepticism about “the Cubans.” Due to favela residents’ fairly sporadic contact with medical care throughout their lives, such an attitude at first seemed surprising. Television and social media plat-

forms, however, were brought to my attention as important sources for the justification of such doubts and resentments.

As with previous international medical enterprises (e.g., in Venezuela, Honduras and Bolivia; cf. Huish 2014: 272), the Cuban mission in Brazil became the subject of nationwide public controversies (Kirk et al. 2016), echoed in local settings like the one described above. At the beginning of the PMM’s implementation, Cuban physicians faced reservations and hostility from Brazilian professional medical associations as well as from more conservative political circles. Leading conservative media provided a platform for the latter to express their doubts regarding Cuban physicians’ moral commitment to their medical work, pointing to past Cuban political engagements and socialist interventions in the Global South (e.g., Moura Brasil 2013; cf. Emerich et al. 2018). Brazilian doctors and medical organizations based their rejection of their Cuban colleagues on their allegedly inadequate language skills and insufficient medical knowledge (*Globo* 2013).

Disrespect and professional discrimination from Brazilian colleagues and patients shaped the first work experiences of many Cuban physicians, especially in urban settings. Black Cuban physicians mentioned racial prejudice as a reason for rejection and a factor that impeded recognition of their medical competence. Yet, all Cubans with whom I spoke identified their nationality as the major reason for discriminatory practices. Supporting this perception, physicians from Europe and other Latin American countries participating in the PMM or working in philanthropic or humanitarian contexts in the same local settings did not have their professional knowledge questioned at all. By contrast, opposing voices portrayed Cuba as a country in need, not least due to previous economic treaties between the two countries wherein Brazil was positioned as the donor.<sup>3</sup> That Cubans referred to their mission as humanitarian was even more problematic, as it challenged the globalized imaginary of the “appropriate” humanitarian worker as white and European.

Cubans interpreted the mistrust regarding their medical competence as an improper negation of Cuba's national achievements in public health and medical training, not to mention the international reputation of the country's medical internationalism. They were supported by family doctors like Dr. Rodrigo and other proponents of the PMM, who constantly pointed to Cuba's medical reputation. Ana Paula, a supervisor for Cuban *internacionalistas* working in Rio de Janeiro's northern districts, even inverted the accusations: "We have plenty of trained physicians in Brazil. But most of them don't want to work here but prefer the private sector. So, it is their lack of professional responsibility that has caused and maintains the crisis in the public sector. It is also due to them that we have to ask for help."

Cubans also saw the resentment against them as an inappropriate negation of their personal educational and professional achievements. As Cuban doctor Roselia pointed out (referring to a patient who refused to be treated because of Dr. Roselia's skin color and nationality), "At first, it hit me a lot. Never would I have imagined that someone of the same color as me would refuse my attendance. I am as much a doctor as all the others." While she tried to explain this type of patient reaction as a symptom of an afflicted society in particular need of help (a common trope in Cuban official solidarity discourse), she also struggled with her own unmet expectations of a modern, multiracial Brazil. Others, in turn, used their disappointment to confront these resentments. For example, Cuban doctor Elena ("the little white one" mentioned by Dona Bianca), participating in her fourth international mission, echoed discursive figurations of personal debt to her country and solidarity with people in need but also referred to her own medical expertise: "My country provided me the opportunity to graduate in medicine and to obtain two specialized *postgrados*, and I have spent more than eight years in *misiónes*. So, I think that I don't have to prove to anyone that I know what I am doing, except my patients." Instead, she stressed comparisons between Cuban public health and the new work environment

in Brazil. She criticized a lack of knowledge among the local population about improving their own lives, despite their poverty. She then commented in Spanish, while treating a little girl with a severe skin rash, "No wonder that diseases that are long eradicated in Cuba flourish so readily here. Here, neither the state nor the people themselves seem to care about their well-being. We literally have to educate them on the good of health and well-being." Statements like this sought to justify Cuban medical aid to Brazil, and such observations and the precarious state of medical care facilities in the favelas supported the Cuban narrative of the medical progressiveness of Cuba, which was viewed in stark contrast to the health and living conditions in some of Rio de Janeiro's favelas, despite the shared problem of living in poverty. Cuban doctors used these same observations to legitimate the humanitarian impetus of their mission in Brazil, in the context of which Dr. Elena and others constantly emphasized the "help" (*ayuda*) that they provided and the fact that it was not limited to "mere" medical work.

In summary, divergent sentiments materialized in local settings at the beginning of the PMM. This can be read in a broader affective framework of entangled politics and temporalities of care of and between these two countries: public health in Brazil demonstrates long-lasting, insufficient care—and disregard—for certain segments of its population based on race- and class-related inequalities, which affects favela residents in particular and engenders both resignation and anger among them over time. These emotional responses transcend the boundaries between bodily feelings and inner sensations: disregard and neglect are also experienced on a collective level, where emotional responses are socially shared and made meaningful. As social-relational phenomena, these sentiments also have a temporal dimension. They "travel with great historical depth" (Bens and Zenker 2019: 97), whereby affective collective histories and memories of under-care merge with individual experiences and biographies that structure affective sense-making of present experiences.

Sentiments are not only meaningful as a response to a collectively experienced denial of being a deserving care receiver (cf. Ticktin 2011: 11–12). They also affect emerging socialities in physician-patient relationships. Within the entanglement of postcolonial and humanitarian care regimes, this structuring effect also addresses the recognition of legitimated agents of care. The long-lasting postcolonial imaginary about the appropriate medical professional as white was deep-seated among favela residents despite their rather sporadic contact with physicians in the past. Cubans, who did not match this imaginary due to their skin color, were initially not recognized as doctors. Their nationality, however, provoked the most resentment, as a result of the politicization of the PMM in conservative media and political circles—a resentment that Cubans, in turn, could not comprehend due to the long-standing international acknowledgment of their country’s achievements in domestic and international public health and medicine. Cuban doctors also felt attacked on a personal level by Brazilians’ disregard for their extensive professional expertise and work experience in medicine and international commitments. Some Cubans responded to these resentments with pride, but they also referred to their debt and duty to help people in need and compared the long-term experience of crisis in Brazil with that in Cuba. However, this particular comparison, closely linked to the political past in Cuba and its international aid, fueled resentment in Brazilian conservative media and politics, which enabled the politicization of Cuba’s humanitarian help in the present and questioned the appropriateness of Cuba’s role as a provider of aid. Against this background, I now focus on emerging socialities through temporalizing practices of care.

### **Entanglements of temporalizing practices and emerging socialities beyond regimes of care**

From the beginning, Cubans stressed the care aspect of their medical work, which had a sub-

stantial effect on the emergent sociality between Brazilian patients and Cuban physicians. The Brazilian public health care crisis was defined not only in terms of scarcity and the unequal distribution of medical facilities and staff. People who depend on public health facilities have bemoaned in particular the lack of a caring dimension. Patients’ narratives characterized doctors’ behavior toward them as arrogant, ignorant, or indifferent, reflecting the effect of Brazil’s social and racial hierarchies on patient-physician relationships and pointing to a negated appellation and recognition regarding the patient’s subjectivity. Although efforts have been made to implement a more “humanized” approach, especially via the primary health-care-based Community and Family Health Program (Puccini and Cecílio 2004), concrete medical praxis was different. For most marginalized people, medical encounters remained something special, for which patients had to wait in crowded clinics. When access to a medical professional was finally granted, the patient was expected to behave appropriately—that is, in a grateful, humble and disciplined way. Nonetheless, like others (Boccolini et al. 2015), I encountered narratives from disappointed patients describing not being listened to, examined carefully, or even touched; not being understood or respectfully talked to; and not being cared for or cared about. Furthermore, almost no Brazilian family doctor I met during this time left the clinic on a regular basis for home visits or community activities; these were instead left to the subordinated medical staff (nurses, nurse auxiliaries, and CHWs).

Brazilian family doctors in particular identified insufficient time as a major problem, although they were highly encouraged to apply a more humanizing approach. The scarcity of medical staff—resulting in patients far outnumbering patient-physician ratio as recommended by the Brazilian Health Ministry—and the pressure put on the clinics to achieve efficiency in economic terms led to a rationalized scheduling of attendance in the family clinics, leaving little time to engage with patients’ individual needs.

In contrast, the newly arrived Cubans sought to provide adequate time to their patients, using this as a strategy to gain the trust of the local population. This started with attendance in the clinic's treatment room. I had the opportunity to regularly assist Cuban doctors such as Dr. Alejandra, who had been part of the Cuban mission "Barrio Adentro" in Venezuela before embarking for Brazil with her husband. Before examining her patients, she started with small talk, asking about their families, their personal matters, and how they had spent the previous days or weeks. Everyone in the treatment room was asked to sit, and she took the time to listen to even the longest of patients' accounts without interrupting. When treating her patients, she touched them in a gentle, careful way, inclining or squatting down to her patients' level and explaining every movement and touch she was going to perform on their bodies. Her explanations included detailed explanations of diagnoses, illnesses, and treatments, and she relied on the strong inclusion of the CHWs, who bridged language-related misunderstandings (e.g., translating the Cubans' initial "Portonhol" into Portuguese) and translated patients' local slang and intended meanings. She also paid attention to the other team members. Barbara, her team's auxiliary nurse, told me that Dr. Alejandra advised her, for example, to warm the stethoscope before applying it to patients' bodies, especially when treating children and older people. "Through [Dr. Alejandra]," Barbara told me, "I started to understand what a humanizing approach means in practice."

These time-consuming activities affected the emerging socialites between Cuban doctors, their patients, and their subordinate staff. Hence, time was actively targeted as an agent that worked on their affective relations. Taking time, together with a modest and caring attitude toward patients and staff, helped create trusting relationships. This "humanizing approach," to use Barbara's words, recognized the subjectivity on both sides—medical professionals and care-deserving patients—as creating a "sociality of with-ness" (cf. Ahmed 2000: 48) during sen-

sitive encounters in the treatment room. This countered patients' long-time experiences as objects of medicalization and with the race- and class-based "sociality as differentiation" (ibid.) of their past experiences in doctor-patient relationships. By contrast, Dr. Alejandra, a white Cuban, turned toward her mostly Black and lower-class patients and actively sought communication and mutual understanding.

Through her performance, Dr. Alejandra also embodied a political statement by indirectly criticizing and undermining the prevalent care regime in Brazil. She proudly recalled that Fidel Castro, who gave the commencement speech to her graduating medical school class, had always emphasized that Cubans should feel love, not pity, for the neediest people and that her profession obliged her to offer the dignified treatment that these people deserve as humans, regardless of race or class, as "el Che" had demanded.

Cubans' time-consuming practices contrasted strongly with the economized scheduling in the family clinics. They justified this initially by pointing to the necessity of getting to know their new field of work and the profiles of their patients. However, they maintained this time-intensive attendance throughout their three-year service. Dr. Elena once made the slightly petulant statement that "I take the time that I need for properly attending my patients. If they [clinic management] don't accept the way I attend to my patients, then let them send me back home to Cuba." Several Cuban doctors echoed this sentiment in similar forms during my research, showing that they were highly aware of their indispensable on-site services. The urgency of the Brazilian health care system's crisis was countered by time-intensive caregiving and affectionate caring about, which worked against the resentment of the patients, medical staff, and Cubans alike. Temporalizing—that is, time-taking—practices not only created trusting relationships within the timely, determined moments of sensitive encounters in the treatment rooms but also exposed the divergent politics of care in the two national contexts.

The most time-intensive endeavors were regular home visits, conducted once or twice a week. Most family clinics I came to know during my research were at the outskirts of the favelas for which they were responsible. Visiting the community thus meant, first, “climbing up the hill” (*subir o morro*) to the houses where the patients lived. *Subir o morro* is an intensive physical and sensory activity, embedded in the affective *Erleben* of heat, dust, smells and, frequently, insecurity. It is also time intensive, as these were seldom straightforward walks to the patients’ houses; instead, they were often marked by calls from the local population in the street. When stopped, the Cuban doctors took the time to attend to the immediate questions and concerns of their interlocutors and greet them with a handshake or a quick hug.

Touching and listening were more intense in patients’ homes than in the treatment rooms. Entering patients’ homes was a sensory way to learn about their physical and social worlds through smells, physical arrangements, and visual impressions, which in many cases indicated possible sources of health problems. At the same time, at-home medical encounters made patients feel more comfortable, affecting their interactions with the medical staff. The Cuban doctors sat close to their patients, often next to them on sofas or beds, inclining their bodies to their patients. In this intimate situation, small talk flowed more easily than in the clinic’s treatment room, and more personalized narratives of pain and suffering followed. Such a situation unfolded when I went that day with Dr. Emanuel’s team on home visits.

Dr. Emanuel sat close to Dona Terezinha on her shabby mattress, exerting himself to listen to her low, shaky voice while holding her hand. The rest of our team—CHW Rose, nurse auxiliary Katja, and me—tried to fit into the small, dark, and humid room that served as kitchen, living room, and bedroom all at once. Dona Terezinha told us that she had not eaten properly because her granddaughter had not come to bring her meals for several days: “I almost do not manage to get up from the mattress; I feel too weak.

And I am too lazy to even prepare some food.” After apologizing that she had not cleaned up for our visit, she instantly excused her granddaughter: “She is working so hard now in the city [in a middle-class neighborhood], I can’t blame her. She has to care for her family now and should not have troubles with an old lady like me.” She interrupted her speech constantly with heavy breathing, as if her emaciated body could not bear her narration. She told us that she understood why her granddaughter would try to avoid this hut: it was full of bad memories of violence, as her son did not treat his wife and children well. A rattling cough interrupted her once again.

In addition to his engaged listening, Dr. Emanuel encouragingly caressing Dona Terezinha’s arm from time to time, which she seemed to enjoy, indifferent to their divergent racial, gender, class, and national belongings—she, a poor white woman from Brazil’s northeast, and he, a Cuban *internacionalista* of mixed racial background. She continued describing her story, including her hardships while raising a son in the violent environment of the favela. Her story was accompanied by the sensory impressions of different smells—sweat, pus, and disinfectant. After a period of simply listening, Dr. Emanuel began to examine the state of her venous leg ulcer, her blood pressure (which continued to be too high, as she did not take her medication properly), and her upper body, where a protracted pneumonia was rendered audible in her breathing. Dr. Emanuel was visibly moved—as we all were—by her story, the circumstances of her life and living conditions, and her undertone of resignation. With a lump in his throat, he started to joke with her, using an exaggerated Cuban accent: “Dona Terezinha, your leg has improved a lot since the last time. In a couple of weeks, we will be dancing salsa together.” Dona Terezinha chuckled: “Ah, doctor, you are kidding me. But if I were a few years younger. . .” When we said goodbye, she almost did not release Dr. Emanuel’s hand. Deeply stirred, we went silently to the next patient, who was waiting for us with another, similarly haunting story.

This sensitive encounter with Dona Terezinha not only expanded the time dimension of our visit but also transcended the present with descriptions of the past: her personal story and the hardship of her surroundings. Along with her story, the intense bodily, sensory, and emotional *Erleben* of that moment impressed itself on the emergent sociality of intimate with-ness and uncoupled any awareness of structural constraints and politics of care, at least for a short while. This sensitive encounter claimed its very own affective relatedness and temporalizing practices. At the same time, it enabled a particular form of knowing as “situated in practices” of embodied and sensitive engagement with the other—as “a social, participatory and embodied process” (Pink 2009: 22)—that affected Dr. Emanuel’s medical performance. His patients became embodied and emplaced, making the home, neighborhood, and community part of his medical knowledge and embedding the patient in a social context and history. Far from being an isolated moment, this time-intensive affective caring relatedness beyond crisis emerged in innumerable occasions of physician-patient encounters within the PMM.

## Conclusion

Going beyond mere medical work turned out to be the most valued aspect of the Cubans’ commitments in their work settings, echoed not only in my ethnographic data but also in patients’ accounts registered in a variety of evaluation reports after the first three years of the PMM (Padilla 2017). The medical encounters between patients and physicians in the context of the PMM comprised but also transcended the affective moments and sensitive perceptions of the present. Patients’ past embodied experiences were marked by rather sporadic contact with physicians—often quick, routinized, and rationalized—wherein the patients’ bodies were left as strange and rarely touched, and their subjectivities were hardly recognized. These past experiences were not just individual but also

part of a collective history of exclusion. Cuban physicians inverted these experiences: they went to, listened to, touched, and physically inclined toward their patients, all in time-intensive ways.

Encounters were also sensitive, as patients and doctors knew that they were framed by a limited duration. Patients were aware that “their” Cuban doctors would only stay for a certain period, and they frequently expressed worry about “what will be next” as the Cubans’ assignment to the PMM came close to an end. One patient joked about this, saying that, when the Cubans left, Brazilians would go back to their “crisis as usual.” These words point to the local perceptions of the Brazilian health care crisis as something permanent that is lived as normality, while the Cuban mission would figure as a temporally limited, sudden, and unexpected—“emergent”—incident for them. At the same time, patients had quickly learned that they could rely on being cared for during the time of the Cubans’ assignment to the PMM. Three years may have been a short and determinate period, but it was nevertheless a period of reliable and intensive care. These years gave Brazilians a glimpse of the possibilities of a more dignified life under the chronicity of crisis.

This awareness of the temporal limitedness and exceptionalism of their mission also enabled the Cubans to apply their temporalizing practices with greater ease. Against the backdrop of the prejudices and mistrust they faced at the beginning of their mission, their method of attendance became the main tactic of creating trusting relationships with both their patients and their subordinate medical staff. Learning quickly about the challenges to Brazilian public health posed by the request for economic efficiency, the Cuban doctors knew that they could make a difference for their Brazilian colleagues and thereby challenge the resentments they faced with respect to their medical competence. Set against the standards of clinical routines, their temporalizing practices formed an implicit critique of the Brazilian care regime by introducing their interpretation of what a humaniz-

ing approach to medical care should look like in practice.

Cubans' temporalizing practices were therefore not random: they formed part of their medical training in Cuba and were incorporated into their treatment modalities. The Cuban physicians had learned how to build trust with strangers in the course of their former international missions. Comparable to the other contributions in this theme section, the emergent sociality enabled by these temporalizing practices was an embodied expression of rather abstract discursive figurations like "solidarity," "compassion," and "debt." This emergent sociality framed, at least for the moment of interaction, a more horizontal relationship with the suffering others, in contrast to the often-perceived hierarchical relationships between helpers from the North and their "distant others" in humanitarian settings or in the actual care-in-crisis case between the Brazilian physicians and their "close others."

The temporal dimension of care-related practices that move beyond crisis constituted an integral component of affective relatedness between patients and physicians alike. Caregiving as a relational practice lasted not only for a certain length of time measurable by abstract time reckoning. Its duration and timing endowed caregiving with meaning. Time thereby affected and even shaped the relations and affectivities among patients and physicians (cf. Das and Cavell 2007: 87). Time-taking practices expressed the mutual recognition and valuation of the other's subjectivity—patients as deserving care receivers and Cuban physicians as appropriate caregivers—thus actively constructing a sociality of an intentionally co-productive seeking of understanding. The situational and sensitive dimension of intersubjectivity even undermined, at least for a moment, the temporal politics and practices of the Brazilian and humanitarian care regimes.

The political dimension of time in care regimes became especially apparent in individual and collective experiences of the lack of care and time in medical encounters among favela

residents in Brazil's past. The colonial legacy of the Brazilian care regime of deservingness had not only shaped subjectivities on the care-receiving end in regard to race, class, and gender. Here, the temporal dimensions of long-term under-care manifest not just in a lack of care but also in sporadic, rationalized, and quick medical encounters, constituting an embodied experience of disregard and bolstered collective sentiments of anger, indignation, and resignation related to the Brazilian care regime. The colonial legacy also framed Brazilians' affective expectations on appropriate medical subjectivities, which further affirmed dominant humanitarian imaginaries of the appropriate medical professional, to which Cuban *internacionalistas* did not correspond. Through their time-taking practices, the Cuban doctors challenged the temporal horizons of the Brazilian care regime and its effect on favela residents in particular by showing that a humanizing approach to medical care was possible despite an ongoing crisis in public health and, thus, turning these temporalizing practices of care into a political act.

Finally, these temporalizing practices of medical care and its effects on affective relatedness in emerging socialities also called into question hierarchical relationships in humanitarian care that typically foster an ontology of inequality within the aid industry (Brun 2016: 405; Fassin 2007). The divergent temporality of medical practices and of political horizons in health care turned into a distinguished feature of and highly valued resource in this South-South partnership. First and foremost, the PMM had local situational effects; however, despite its challenges of dominant care regimes, the partnership could not undo the more general malfunctioning of public health care in Brazil over the long term and against the political turnovers at the local and national levels since 2016.

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## Notes

1. All names in this article are pseudonyms.
2. I use “Global South” in a metaphorical and political sense (Fiddian-Qasmiyeh 2015) that encompasses the complexity and diversity of, but also transcends, the postcolonial (Comaroff and Comaroff 2012: 45). Though the term is inclusive of a wide range of more or less powerful actors who position and organize themselves under that label (Six 2009), it still acknowledges their mostly “hard-edged political and economic realities” (Comaroff and Comaroff 2012: 45).
3. The Brazilian media and opposing politicians emphasized that Brazil paid adequately for the work completed through the PMM. For each Cuban physician, the Brazilian government paid a monthly salary of approximately 10,400 Brazilian reais (about 2,500 euros in 2015) to the Cuban government via the Pan-American Health Organization. About 30 percent of this amount went to the doctors (Portal Brasil 2014),

meaning that the Cuban doctors were paid approximately the same amount as the Brazilian auxiliary nursing staff. In comparison, Cuban physicians working in Cuba earned a maximum of 1,600 Cuban pesos (about 64 euros) per month (cf. Martínez Hernández and Puig Meneses 2014).

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