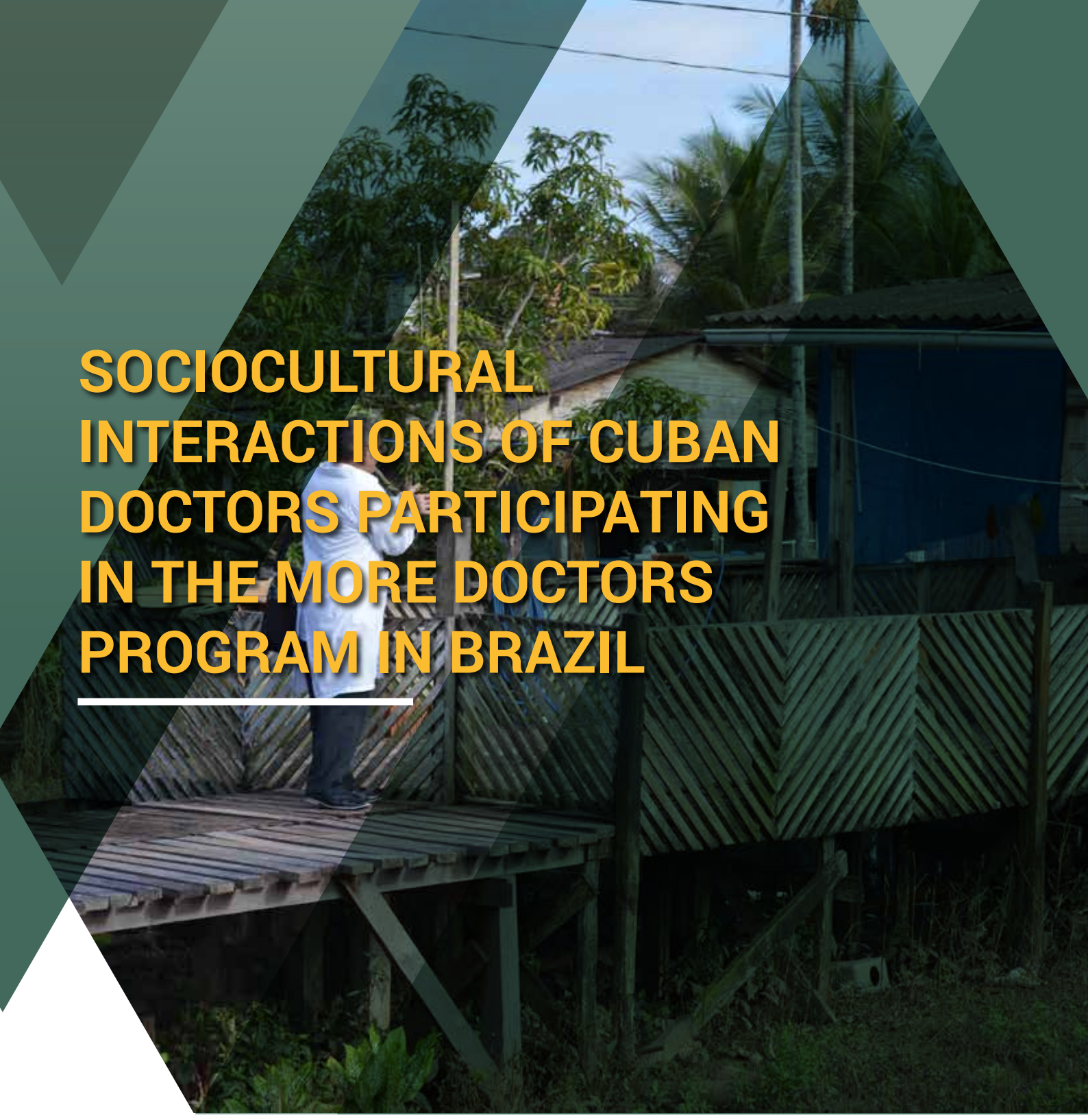

SOCIOCULTURAL INTERACTIONS OF CUBAN DOCTORS PARTICIPATING IN THE MORE DOCTORS PROGRAM IN BRAZIL

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

PAN AMERICAN HEALTH ORGANIZATION

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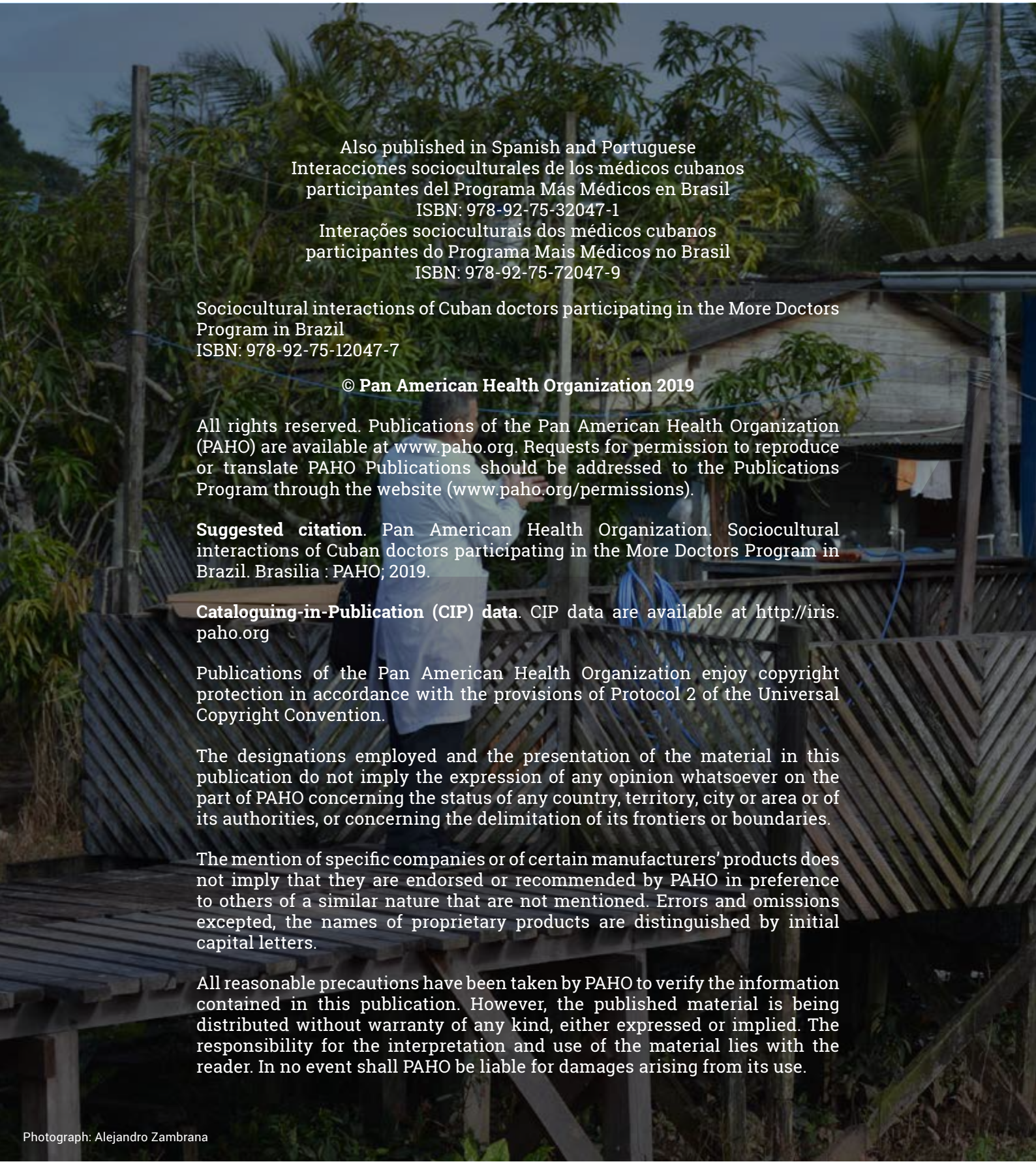
BRASÍLIA – DF

2018



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Photograph: Alejandro Zambrana

Summary

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

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FOREWORD

Countries in Latin American, together with the Pan American Health Organization (PAHO) and the World Health Organization (WHO), have come a long way in developing primary health care initiatives, which have been collectively approved and accepted in agreements such as the Alma Ata Declaration (1978)[1], the Renovation of Primary Health Care in the Americas (2005)[2], the Universal Health Care Access and Coverage Strategy (2015)[3] and the recent Human Resources Planning for Universal Health (2018)[4]. These documents certainly constitute a powerful landmark of policies, strategies and knowledge for the implementation of health systems in the region.

In Brazil, for instance, there has been an unprecedented development after the creation and evolution of the Unified Health System (known as SUS), with numerous accomplishments in its thirty years of existence. Founded in 1998, after the promulgation of the new Federal Constitution, SUS has shown the capability to overcome different obstacles to its development and expansion, keeping a public, universal and free health care model that singles Brazil out in the international scenario. However, the system's advocates have been facing criticism, especially because of its funding policies, which raise certain concerns about the system's sustainability over time. In late 2018, such contradictions were still there. On one hand, progress has allowed the materialization of a health system with which the population is satisfied; on the other, the old challenges that threaten the evolution and capacity of the system to fulfill its mission remain.

Created in 2013, the More Doctors Program in Brazil (MDPB) had the purpose of helping to expand and ensure coverage and access to primary health care, especially of those who are most vulnerable socially. Based on a holistic perspective, it was developed not only to solve the local shortage of doctors, but also to guarantee the development of primary care capabilities, investments in infrastructure, and the qualification of health care personnel, with a focus on both quantity and quality. Finally, the recruitment of doctors is an emergency action, as it aims to reduce the gaps in coverage of underserved communities. The MDPB has indeed shown actual impacts since its implementation and it has been positively perceived by its target population, a response to the strong criticism by certain groups, including health professionals.

1 http://www.alma-ata.es/declaraciondealmaata/declaraciondealmaata.html
2 https://www.paho.org/hq/dmdocuments/2010/Renovacion-Atencion-Primaria-Salud-Americas-OPS.pdf
3 https://www.paho.org/hq/dmdocuments/2014/CD53-5-s.pdf
4 https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=56=-directing-council-spanish9965-&alias-45773-cd56-10-s-pda-rh-773&Itemid=270&lang=en

The fact is that the program has become an authentic "brand" in public health, in terms of management, user satisfaction, and solutions to some of the health concerns of Brazilian citizens.

This book focuses on a different and underexplored attribute of the More Doctors Program by surveying doctors in the field with the purpose of identifying important answers regarding the sociocultural interactions of Cuban doctors recruited by the program and of producing knowledge, while also making improvements in the participation, still limited, of foreign doctors in the primary care services offered by SUS. It proposes to induce perceptions, memories, and possible explanations to anyone who is somehow associated with the Program's development, especially those committed to universal health care and primary assistance as the only paths to an effective health system.

For an organization such as PAHO/WHO, whose institutional mission is to articulate collaborative strategic efforts among Member States, one of our responsibilities is to mobilize Cuban doctors and create all the necessary conditions for their work in Brazil. In addition, we also need to attempt to understand the sociocultural interactions that have resulted from their professional practice. This, to all of us, constitutes a duty, as it consciously allows us to repay the trust of the Brazilian and Cuban governments.

To the approximately 18 thousand Cuban doctors who currently work or have worked in Brazil, the present publication could mean "...a new look at the Brazil we don't see in soap operas...." They will certainly understand what we mean by that. This expression was used in several interviews conducted throughout the present research.

We hope you enjoy the reading. We expect that this book can serve as a source of informed thinking about the themes discussed herein and inspire the pursuit of new knowledge as well.

Dr. Joaquín Molina
Representative of the Pan American Health Organization/
World Health Organization in Brazil

Photograph: Alejandro Zambrana

Photograph: Alejandro Zambrana

Chapter I

INTRODUCTION: SOCIOCULTURAL INTERACTIONS OF CUBAN DOCTORS IN BRAZIL

Joaquin Molina[1], Eduardo Siqueira[2], Leonardo Cavalcanti[3], and Tânia Tonhati[4]

This book discusses the process of sociocultural interaction of Cuban doctors in Brazil during their participation in the More Doctors Program, as part of a qualified and scheduled immigration process promoted by the Brazilian government in partnership with the Pan American Health Organization, the World Health Organization, and Cuba.

In the last few years, Brazil has experienced a combination of different migration scenarios by maintaining emigration flows simultaneously to the return of Brazilian people who had previously migrated to other countries. More recently, there has been new and diverse immigrant flows, especially from the Global South, such as the arrival of Haitians, Bengalis, Senegalese, among others (CAVALCANTI, 2015; ROSA, 2012; HANDERSON, 2015; SILVA, 2015). Furthermore, available data attest that Brazil has become an important destination for internal migration flows in Latin America, favoring the return to the country's "migratory tradition", which had been relatively stagnant during the post-World War II period (SOUCHAUD, 2010: 50). Among the different immigration groups moving to Brazil in recent years, skilled workers holding university degrees stand out.

In the context of this broad and complex migration phenomenon, one significant flow included skilled immigrants within the health sector, members of the cooperation agreement established by the MDP. This is where Cuban doctors are included, as participants of a temporary immigration model organized by Brazil and Cuba, with the support of PAHO/WHO. The presence of Cuban doctors in Brazil is not unprecedented. In the 1990s, the city of Niteroi signed a technical cooperation agreement with the Lawton Clinic, Havana, in the context of a project based on the Cuban model of family medicine. However, it was only after the MDP Program, in a scenario of shortage of doctors in Brazil, that Cuban doctors became relevant participants of the State's Unified Health System (SUS).

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3 Professor at the University of Brasília and active researcher sponsored by CNPq. Coordinator of the International Migration Observatory (OBMigra).
4 Researcher at the International Migration Observatory, OBMigra, University of Brasília (UnB). PhD in Sociology, Goldsmith College, London University.

The More Doctors Program illustrates a Brazilian public policy directed towards qualified migration. According to WHO, most countries face some level of difficulty to ensure the presence of doctors in rural areas, urban outskirts and remote locations. In this sense, many countries have adopted specific policies to expand medical training and to attract foreign doctors to work in underprivileged areas. This difficulty affects several developed and developing nations, and in Brazil, is an important contemporary issue. In other words, the MDP was the solution proposed by the Brazilian government to the current local shortage of health care professionals (MINISTRY OF HEALTH, 2015: 25,26; OLIVEIRA et al, 2015).

According to Oliveira (2015), before the MDP, several programs tried, with no significant success, to attract and retain health care professionals in remote regions of Brazil, such as the Health and Sanitation Expansion Program (PIASS - 1976), the Unified Health System Expansion Program (PISUS - 1993), the Health Care Expansion Program (PITS - 2001) and, most recently, the Primary Care Professionals Valorization Program (PROVAB). For Oliveira, despite some important victories and investments to supply health professionals, through programs and public policies promoted by the Brazilian State in the last few decades, no program or initiative had the extent, magnitude and celerity of the MDP. Thus, in various underserved regions of Brazil, where doctors were scarce or inexistent, the presence of healthcare professionals was only possible because of the MDP. The Program was able to reach small cities, rural communities, *quilombos*[5], indigenous areas and riverside communities, as well as peripheries, favelas and other marginalized urban communities.

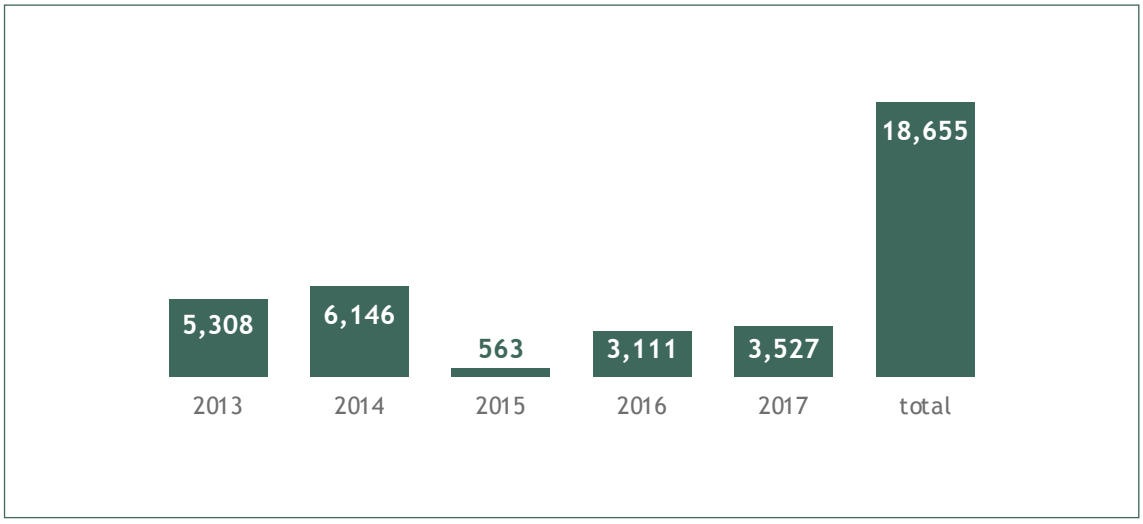
Nevertheless, unlike countries such as the United Kingdom, the United States and Australia – which attract doctors from less developed countries or with a lower doctor/inhabitant rate – a phenomenon known as "brain-drain" (CASTLES, MILLER, DEHAAS, 2014) –, Brazil tried to accomplish its goal by means of the South-South cooperation. The intention was to attract skilled labor while also avoiding possible negative effects to their country of origin. Therefore, the doctor/inhabitant rate of participating countries had to be higher than Brazil's rate (1.8 doctor/1,000 inhabitants).

The participation of Cuban doctors in the More Doctors Program, through the South-South technical cooperation resulting from the triangulation between Brazil, PAHO/WHO and Cuba, became a model procedure to attract skilled labor to the health sector, without the consequences of the so-called "brain-drain". Cuban doctors are called cooperative-exchange doctors and they are specialists in Comprehensive General Medicine with at least 10 years of professional experience, a minimum of two years of foreign experience, and basic knowledge of Portuguese (MOLINA, TASCA and SUAREZ, 2016: 2932). The 80th Cooperation Term signed between PAHO and Brazil, with the support of the Ministry of Health, enabled these doctors' participation in the Program (MINISTRY OF HEALTH, 2014).

An assessment by PAHO/WHO showed that, between 2013 and 2017, 18,655 Cuban doctors had arrived in Brazil by September 2017, as shown in Chart 1. The first two years of the Program registered the highest number of Cuban doctors arriving in Brazil. In 2015, there was a significant decrease, while in 2016 and 2017 the number of Cuban doctors arriving in Brazil remained stable, although below the numbers registered in those two initial years.

[5] Quilombo: a Brazilian hinterland settlement founded by people of African origin.

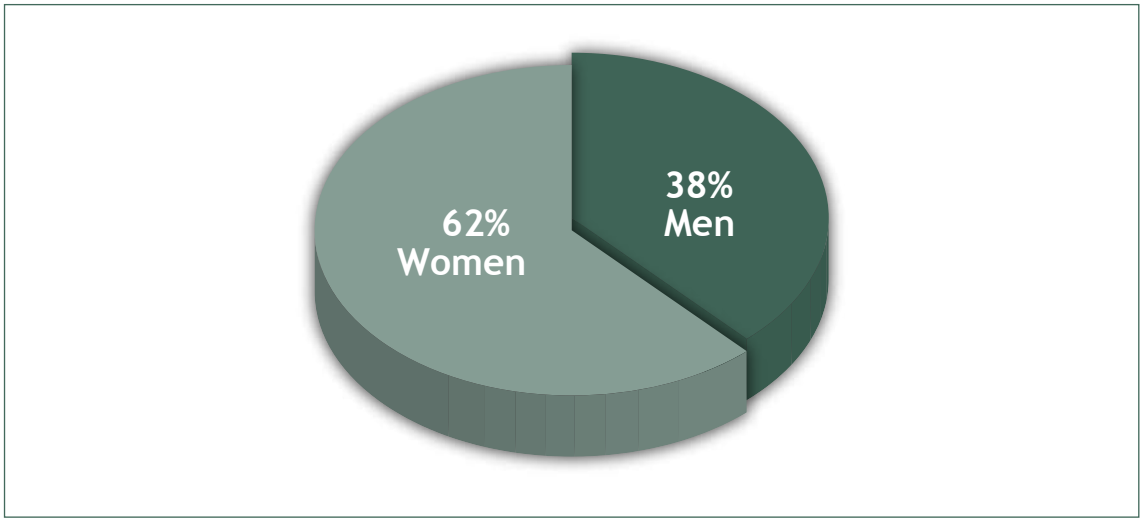
Chart 1. Number of Cuban doctors who arrived in Brazil, per year. Brazil 2013/2017



Source: Pan American Health Organization (PAHO), 2017.

In general, migration to Brazil has been characterized by a predominant flow of men (CAVALCANTI, et al. 2017). However, among Cuban doctors in the MDP, the number of women was almost twice the number of men (6,937 men and 11,283 women), as shown in Chart 2.

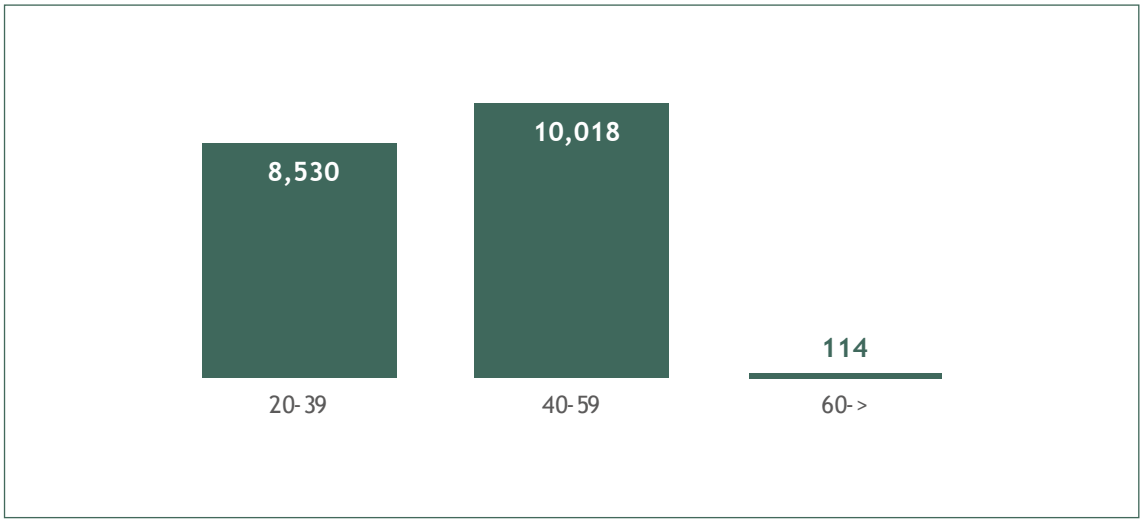
Chart 2. Number of Cuban doctors in Brazil, per gender. Brazil 2013/2017



Source: Pan American Health Organization (PAHO), 2017.

With regard to age distribution, most Cuban doctors ranged between 40 and 59 years of age (53%), and between 20 and 39 (45%). Therefore, it is an economically active population, with the perspective of a long-term professional career.

Chart 3. Age distribution of Cuban doctors. Brazil 2013/2017



Source: Pan American Health Organization (PAHO), 2017.

Cuban doctors have been allocated to all Brazilian regions. The Northeast received the highest number of doctors, 6,339; followed by the Southeast, with 5,502 doctors; the South, with 2,979; the North region, with 2,763; and the Center-West, which received 1,079 doctors. Of all states, São Paulo was the most benefitted by the program, followed by Bahia, Minas Gerais, Rio Grande do Sul, Paraná, Maranhão, Pará and Ceará.

Table 1. Geographical distribution of Cuban doctors per state. Brazil 2013/2017

GEOGRAPHIC AREA			
STATE	**TOTAL**	**STATE**	**TOTAL**
Rondônia	335	Sergipe	198
Acre	206	Bahia	1,802
Amazonas	631	Minas Gerais	1,531
Roraima	140	Espírito Santo	435
Pará	1,048	Rio de Janeiro	573
Amapá	194	São Paulo	2,963
Tocantins	209	Paraná	1,122
Maranhão	1,049	Santa Catarina	518
Piauí	455	Rio Grande do Sul	1,339
Ceará	1,048	Mato Grosso do Sul	250
Rio Grande do Norte	317	Mato Grosso	289
Paraíba	265	Goiás	466
Pernambuco	897	Distrito Federal	74
Alagoas	308		
BRAZIL			**18,220**

Source: Pan American Health Organization (PAHO), 2017.

Among all 5,570 Brazilian cities, 3,544 have welcomed Cuban doctors. The Northeast received the highest number of doctors. In the Southeast, the city of São Paulo welcomed 257 doctors and Rio de Janeiro, 182. These two states received the highest number of doctors per municipality in the country. Table 2 shows the distribution of exchange doctors in the five cities that received most doctors.

Table 2. Geographical distribution of Cuban doctors throughout the main cities, per region. Brazil 2013/2017

SOUTH	2,979	SOUTHEAST	5,502
Ponta Grossa	116	São Paulo	257
Porto Alegre	56	Rio de Janeiro	182
Novo Hamburgo	49	Campinas	108
Curitiba	39	Osasco	94
Gravataí	38	Limeira	81
NORTH	**2,763**	**NORTHEAST**	**6,339**
Macapá	63	Fortaleza	88
Santana	42	Morada Nova	39
Manaus	40	Iguatu	38
Rio Branco	40	Salvador	37
Porto Velho	35	Chapadinha	35
		Recife	35

Fuente: Organización Panamericana de la Salud (OPS), 2017.

519 Cuban doctors were allocated to indigenous areas. In the North Region, 313 doctors were distributed throughout 20 Special Indigenous Sanitary Districts (known as DSEI); in the Northeast, 102 doctors were allocated to seven DSEI; in the Center-West, 85 doctors were sent to six DSEI; in the South and Southeast Region, 21 and 10, respectively, to only one DSEI in each region. The information is listed in the following table.

Table 3. Geographical distribution of Cuban doctors among DSEI, Brazil 2013/2017

DSEI	STATE	TOTAL
DSEI Alto Rio Juruá and Alto Rio Purus	Acre	30
DSEI Alagoas and Sergipe	Alagoas	12
DSEI Amapá and Norte do Pará	Amapá	11
DSEI Manaus, Parintins, High Negro River, Alto Rio Solimões, Mid Purus River, Mid Solimões River and Affluents, and Vale do Javari	Amazonas	131
DSEI Bahia	Bahia	31
DSEI Ceará	Ceará	4
DSEI Maranhão	Maranhão	27
DSEI Cuiabá, Kayapó, Araguaia, Xingu and Xavante Indigenous Parks	Mato Grosso	60
DSEI Mato Grosso do Sul	Mato Grosso do Sul	25
DSEI Minas Gerais and Espírito Santo	Minas Gerais	10
DSEI Altamira, Guamá-Tocantins, Kayapó and Tapajós River	Pará	43

DSEI	STATE	TOTAL
DSEI Potiguara	Paraíba	2
DSEI South Coast	Paraná	2
DSEI Pernambuco	Pernambuco	24
DSEI Porto Velho e Vilhena	Rondônia	22
DSEI Leste de Roraima and Ianomâmi	Roraima	50
DSEI Southern Countryside	Santa Catarina	21
DSEI Tocantins	Tocantins	14

Source: Pan American Health Organization (PAHO), 2017.

Such data show the comprehensiveness, depth, and celerity of the Program's implementation in the Brazilian territory. As a result of this reality, PAHO/WHO sponsored several studies to evaluate the MDP's impact on the quality of SUS's primary care services. However, little has been published until now regarding the social interactions of Cuban doctors as temporary skilled immigrants.

In order to fill this gap, the next chapters analyze sociocultural interaction processes, relationship, and the knowledge exchange between Cuban doctors and the Brazilian people, as well as fellow nurses, community health agents, patients and the population of the various locations where they worked and lived.

The book consists of nine chapters, two of which complement the research that originated it. The first chapter presents a theoretical view of skilled migration and its analytical perspectives. The author shows that, for Cuba, the skilled migration of doctors today is a diplomatic, economic and geopolitical strategy and, therefore, goes far beyond the rationale of individual decisions. When we look at the specific case of Cuba, the skilled migration of doctors is not exclusively based on the economic dimension of seeking better salaries or jobs in other countries, nor the individual competition in the job market; on the contrary, it responds to a logic of South-South cooperation negotiated between States.

In chapter III, a group of invited authors propose a discussion on how the media approached the More Doctors Program. The authors were able to demonstrate how media discourses were created and how they have talked about the Program in a pejorative and prejudiced manner, particularly in its initial stage. The chapter also analyzes the news broadcast about the MDP throughout its implementation phase, from June to December 2013, by two printed newspapers from the state of Espírito Santo. In addition, the authors state that most media outlets treated the MDP under the perspective of symbolic conflicts and disputes over power, focusing on the obstacles faced by the Program and its need for reassurance and validation. They also claim that few media discourses explained how the Program worked, discussed the need for its implementation, or its possible positive impacts on the population's health.

The other chapters discuss the results of this research and were written by the active and persistent researchers who have worked in the field and also participated in the analyses of the collected information.

The next chapters analyze the interactions of Cuban doctors in three large ethnographic areas, with research focus on: 1) indigenous areas; 2) urban peripheries; and 3) *quilombo* communities. This regional division aimed at understanding the specificities of interactions in these different contexts, considering that social interactions depend on the social locus where they occur. Locations do not directly determine such

interactions; instead, they evidence varied and important dynamics, experiences, and perceptions of social relations, as they constitute, historically, spaces that are constantly and diversely built and recreated.

Chapter V deals specifically with the interactions of Cuban doctors in indigenous communities. Itpresents and discusses the results from interviews performed with Cuban doctors working at federal universities located in the area known as the "Legal Amazon". This region includes all seven states of the North region (Amazonas, Acre, Amapá, Pará, Roraima, Rondônia, and Tocantins), one from the Center-West (Mato Grosso), and one from the Northeast (Maranhão). Interviews were conducted in several Amazonian locations including the states of Acre, Amapá, Amazonas, Pará, Mato Grosso, Rondônia, Roraima, and Tocantins. The author describes and analyzes the specificities, and often the surprise, of these doctors' encounter with "the Brazil you don't see in soap operas", as they frequently mentioned. In other words, a place where rivers are the main or sole means of transportation, and where coexistence with animals and traditional beliefs amazes and sometimes disturbs, but also teaches a great deal. He demonstrates how, on the one hand, the combination of indigenous knowledge and practices on health and disease together with the doctors' scientific perception led to the valorization and recognition of traditional indigenous knowledge on herbs and healing rituals, while, on the other hand, these interactions also inspired doctors and promoted changes in indigenous practices regarding hygiene and body care.

Chapter VI analyzes the sociocultural interactions of Cuban doctors in urban peripheries. Forty-eight doctors were interviewed in 30 different municipalities located in 13 different states: Amapá, Rondônia, Bahia, Maranhão, Paraíba, Pernambuco, Goiás, Espírito Santo, Minas Gerais, São Paulo, Rio de Janeiro, Paraná, and Rio Grande do Sul. The authors highlight the fact that the interaction process in the peripheries of large urban areas was more limited than in smaller cities. In addition, they argue that urban violence was the most important factor inhibiting Cuban doctors' interactions with Brazilians in these areas. They also reveal that the sociocultural interaction processes were not only unexpected by Brazilian authorities during policy design, but were also absent from the list of concerns of local authorities and health teams who welcomed these doctors.

However, a significant social, professional and community interaction process occurred. As presented by the authors, the in-depth interaction of Cuban doctors with health teams and patients is a rule in Cuban medical practice. They demonstrate that interacting and becoming a part of their patients' and colleagues' lives were an essential component of their work. Thus, the authors suggest that Cuban doctors seem to believe in a mobility principle acquired with their experience abroad, which translates itself into their ability to understand, coexist, and respect social and individual differences, contributing to the construction of harmonious social relations and integrative processes.

Chapter VII analyzes Cuban doctors' interactions in *quilombo* areas. The author argues that Cuban doctors did not experience an interaction process typical of ordinary immigrant groups or individuals in terms of acculturation and integration because they were temporary residents in Brazil. Nevertheless, their performance and specialty led to broad, intense and deep interactions with Brazilian society and culture, reaching a far deeper level of insertion and participation than the one experienced by other immigrant groups.

We finish the book, but not the story of the Cuban doctors in Brazil, with two more chapters: one with suggestions on how to improve the MDP, in an attempt by the authors to allow doctors to voice their own

recommendations and suggestions to the Program. Clearly, the MDP was a successful experience, with positive impacts at different levels, including patients' health, medical and sanitary knowledge-building, and the construction of sociocultural bonds between doctors, patients, medical teams, and communities.

Finally, the final chapter synthesizes many of the issues discussed during the research as well as the suggestions presented in the previous chapters.

The stories reported imply that when a skilled migration policy is established in order to promote the recruitment of highly skilled professionals, as is the case of Cuban exchange doctors, it is important to admit that they are not coming exclusively as health professionals, but as people with different beliefs and customs who need social interactions, who need to learn the local language, and who dearly miss their family and friends. Some will get emotionally involved with the local population, and may fall in love and marry. A few may even pass away. In summary, when a skilled immigration process is organized, governments should not expect that their lives will be placed on hold during their stay in a specific location. Life will go on; consequently, these migration processes will be dynamic and life-changing as well. We invite all readers to attempt to more clearly understand the dynamics, surprises, and diversity of Cuban doctors' experiences in Brazil.

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Photograph: OPAS/OMS

Chapter II

THEORETICAL APPROACHES TO SOUTH-SOUTH MIGRATION FLOWS OF HIGHLY SKILLED PROFESSIONALS: THE ROLES OF CUBAN COOPERATION AND PAHO/WHO

Fanor Julián Solano Cárdenas[1]

Introduction

Since World War II, an intense and prominent debate has unfolded about the meaning and implications of the so-called "international skilled migration" (DAUGELINE & MARCINKEVICENE, 2009; GAILLARD & GAILLARD, 2009; KOSER & SALT, 1997; MIWAGIUA, 1991; STANTON, 1990). These profitable discussions have resulted in four perspectives, or approaches, for analysis: "brain drain," "brain gain," "brain circulation", and "brain networking", which attempt to understand the phenomenon of the international mobility of highly skilled people, in a debate about the profits and losses for the economies of the countries involved, particularly underdeveloped or developing nations (BEINE, ET, AL, 2008; FAN & STARK, 2007; SCHIFF, 2005; CARR et, Al, 2005; STARK, 2004; MEYER, 2001; MOUNTFORD, 1995; MIWAGIUA, 1991).

All of these perspectives are delineated according to pre-defined interests and theories, ranging from neoclassical economics to modernization or liberalism, which limit the temporal and spatial approach used for the interpretation of data, as well as the very objects of each research study. Taking these concepts into account, theories are usually developed with a focus on South-North and North-North migration flows, ignoring other relevant trends, such as South-South flows[2]. Also, they normally concentrate their analyses on individual migration processes decided upon by the individuals themselves, not as a collective phenomenon.

Thus, the usual scope limits the possibilities for the evaluation of other similar phenomena, among them the South-South migration flows of professionals, organized and managed by States, a s a result of international technical cooperation strategies. An example of this type of cooperation is the exchange program of Cuban health professionals who leave the island for pre-defined periods of time to work with international humanitarian aid.

By recognizing these limitations, this paper goes beyond the classical perspectives on international skilled migration, choosing an alternative strategy to analyze the sociocultural interactions of Cuban doctors who

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[2] The South-South flows correspond to the international movement of populations within one geopolitical unit. The geopolitical South tends to coincide with the geographic South of the globe; however, they overlap as a result of social zones of power relations and are not limited to a spatial or natural geographic zones.

have participated in the More Doctors Program in Brazil. As a result, we studied the notions, concepts and theories related to this study's findings on the one hand, and, on the other, the emerging categories revealed by the field work.

The present chapter comprises four sections. The first one describes the limitations of classical perspectives on international skilled migration used to interpret South-South mobility, especially the Cuban international technical cooperation program. The second section discusses the role of PAHO/WHO in guaranteeing appropriate work conditions to health professionals who circulate today around several countries in the world. The third section describes the social and historical background of the Cuban international medical cooperation, showing inflection points and trend shifts in the last few decades. The final section presents a reflection on the purposes of the current cooperation program, providing a proposal to support the development of sovereignty in health, foreign policy, fund raising, and geopolitical strategies.

Classical approaches and their theoretical and analytical limitations to the understanding of the international migration flow of Cuban health professionals

Despite their differences of opinion regarding the implications and effects of professional mobility, classical perspectives on the international migration of highly qualified people have various elements in common, which limit the analysis of different realities, while leading the study towards a pre-determined direction. First, these theoretical orientations place the debate in the context of economic rationale and monetary calculation, typical of the western spirit of modernity and utilitarian thinking (SIMMEL, 1986; SIMMEL, 1977), which understands migration flows within an excluding dichotomy, arbitrarily linked to macroeconomic interests.

Indeed, the response to issues regarding the effects of the exodus of professionals from their countries of origin are predominantly provided by economists who, by using different econometric models, attempt to measure the impact that the departure of professionals may have on a country's economy and its level of "development" (CARR et al, 2005; MOUNTFORD, 1995; MIWAGIUA, 1991).

There is currently an intense debate about what types of policies would be best suitable to promote or restrict the mobility of highly skilled professionals (LAVENEX DE 2007; MAHROUM, 2001; LOWELL & FINDLAY, 2001; IREDALE, 2001). Among the different theoretical perspectives regarding the study of this migration phenomenon, research efforts initially focused on the "brain drain" approach, which gradually developed into the "brain networking" approach in the beginning of this century. Between the "brain drain" and the "brain networking" approaches, other academic debates evolved in an attempt to understand the mobility of skilled professionals. Examples include the theoretic interpretations focusing on "brain gain", "brain exchange" and "brain circulation" (DAUGELINE & MARCINKEVICENE, 2009; KOSER & SALT, 1997).

Accordingly, Koser & Salt (1997) point out that research studies on the international migration of highly skilled people began in the 1960s, as a result of the preoccupation of some English economists with the "brain drain" process from developing to developed countries. In the 1970s, this concern spread out and economists began to question the effects that migration could have on developed countries.

According to Gaillard & Gaillard (2009), the "brain drain" perspective was a response not only to empirical facts related to the exodus, but also marked a shift in attitude towards the migration of qualified professionals,

which had occurred since the colonial and post-colonial period; therefore, it was not an exception, but the rule. At that time, economists greatly supported this debate, some to criticize the idea of brain drain, and others to corroborate it.

The main line of interpretation placed economic growth at the core of the debate, within a free-market economy with free circulation of currencies. The result was an evaluation of losses and gains measured in financial and commercial terms, reaffirming the neoclassical economics thinking, which often equates social welfare with the growth of a country's wealth (PIKETTY, 2014).

In the same context, other issues gained relevance, such as productivity, venture capital fundraising, business start-ups, consolidation of new niche markets, in addition to the establishment of transnational and transcontinental business networks (SAXENIAN, 2005).

Based on the same economic parameters, migrants were considered as rational subjects equipped with macroeconomic functions, embedded in and dependent on the conditions of a free market. This limited the debate around the structural and systemic losses and gains for countries, ignoring the subjectivity of the migrant, as well as the personal and family benefits that their international mobility could generate. People migrate because of unemployment in their countries of origin, in search of better opportunities to develop their professional careers, better pay, or professional recognition (GAILLARD & GAILLARD, 2009).

Discussions on the impacts of skilled migration in reducing poverty and inequality; the improvement of migrant living conditions; the modernization of health systems, or gains in the quality of education in their countries of origin have been limited by debates focused on economic growth or the transfer of knowledge and technology. The overvaluation of certain study themes and objects to the detriment of others reaffirms the liberal economic approach accepted by the dominant theories in this field.

Furthermore, in agreement with the neoclassical economics view, the main line of thinking on skilled international migration has posited the topic of development as one of the central concerns in the field, legitimizing it as a civilization process within a social paradigm (NISBET, 1981; ESCOBAR, 1998; SACHS, 1992; HETTNE, 1990). All perspectives were then influenced and inspired by this developmental project, with no questioning or criticisms against it. This bias becomes evident in the relevance that some phenomena gained in the various debates, such as scientific development, technological transformation, economic growth, and product diversification based on knowledge. The developmental project and its various components became more important after 1960, because it was the model of social change imposed by the United States after World War II, when the U.S. emerged as the world's hegemonic power and the great winner of the armed conflicts of the first half of the 20th century (BOESNER, 1977; SACHS, 1992; HETTNE, 1990).

The adoption of the developmental project as a social goal and theoretical reference resulted in embracing a teleological view of history and social change as a paradigm of society, a position that has been widely criticized by Latin American social theory (BAMBIRRA, 2013; DOMINGUES, 2012; MARTINS, 2011; SANTOS, 2004; CASANOVA, 2002; OSORIO,1994; CARDOSO E FALETTO, 1977; FRANK, 1975; SUNKEL, 1973; PREBISCH, 1962); by the anthropology of development theory (ESCOBAR, 1998); by the geopolitical theory (BORO, 2002; CECEÑA, 2005, CORONADO, 2014), and by the sociology of development (NISBET, 1981; SACHS, 1992; HETTNE, 1990; WALLERSTEIN, 1984).

Also, those perspectives view migrants as "human capital", that is, as permutable assets in a free market economy. As part of this connotation, people become production factors, a result of economic postulates which state that "the average level of human capital in a society has positive effects on productivity and growth" (LOWELL & FINDLAY de 2001: 11). From GAILLARD & GAILLARD's perspective (2009), this understanding about migrants relates to the historical and theoretical moment when the initial discussions on the international mobility of skilled workers took place, induced by a public debate called by the United Nations in 1963. This happened a few months after the scientific community was introduced to Gary Becker's human capital theory, which greatly influenced the understanding of professional migrants as economic agents, and their migration process as brain drain (MEYER, 2001, BIAO, 2005). On the other hand, this emphasis reveals the high level of influence of neoclassical economics theory – and its significant bias – on the analysis of migration flows.

Within the referential milestone of the discussions on the brain networking perspective, there is harsh criticism against the main research approach to international migration, and the way professional migrants have been perceived within its framework (MEYER, 2003). Based on the economic theories of endogenous growth and the principles of human capital theory, skilled professionals are viewed strictly as capital or individual factors; and their knowledge is seen as a personal characteristic, isolated from the social context in which it was built (MEYER, 2003). Therefore, from this point of view, keeping individuals in their countries of origin is a gain and their migration to another country is a loss, ignoring the time and place where these highly qualified individuals developed their skills. This "brain networking" approach analyzes these migrants within a collective dimension framework (MEYER & Brown, 1999), although it continues to see them as economic subjects whose interactions occur within the relations scope of a free market.

Based on the three elements previously described, classical perspectives of international skilled migration are greatly limited, and hinder the understanding of the mobility of Cuban health professionals within the scope of health cooperation programs. First, because they are constructed to explain a migration reality completely different from the Cuban professionals' reality, which follows a logic distinct from the South-North and North-North migration processes in the second half of the 20th century. Secondly, classical approaches are based on theoretical assumptions, concerns and dilemmas that do not fit the empirical reality underlying Cuban international medical cooperation programs.

The mobility of Cuban doctors is based on a State policy, with its pillars firmly grounded on principles such as South-South solidarity, exchange, and cooperation. In this sense, the migration of Cuban doctors cannot be understood exclusively by analyzing its contributions to the economic growth of nations or the increase in productivity, elements that constitute the focus of discussions and the base line of traditional perspectives in this theoretical field.

Programs such as the More Doctors Program, the *Barrio Adentro* Mission, the *Milagro operation*, the Integrated Health Program (PIS), or the International Contingent of Specialized Doctors (discussed in the next section), had the purpose of strengthening the health systems of receiving countries participating in the cooperation program, and providing support in situations of natural disasters, in a solidary manner (GARCÍA & ANAYA, 2009; MARIMÓN& MARTÍNEZ, 2010).

Cuban qualified migration has been regulated by a logic different from the economic rationale. Professionals are mobilized within the scope of bilateral and multilateral cooperation agreements, which have allowed Cuban doctors to connect directly and collectively to the institutional structure of the State, with the purpose of strengthening the host country's government health policies, programs, and strategies. Thus, the principle guiding the social interaction of Cuban doctors is cooperation, not competition. Based on this notion, the debate cannot take place in terms of macroeconomic gains and losses, but it should concentrate on the social benefits resulting from the migratory movement.

Cuban health professionals cannot be viewed as production factors or permutable assets, because their migration process does not correspond to an individual project motivated by economic profitability. The structure of this initiative represents an organized cooperation agreement between Cuba and other nations. Therefore, the mobility of Cuban healthcare professionals questions many of the classical analytical perspectives related to understanding the migration process of highly skilled people.

The role of PAHO/WHO in regulating the international migration of health workers

Market and capital globalization processes have hastened international migration flows in the last few decades (GAILLARD & GAILLARD, 2009, LAVENEX, 2007, SAXENIAN, 2005), and the international mobility of some professionals, including health workers, has gained recognition (LOWELL & FINDLAY, 2001, ILO, 2003). Migration has occurred predominantly from low-income countries to industrialized and high-income nations, consisting of the classical South-North flow, also taking into account migration between industrialized nations, which may be called North-North migration. A consequence of this phenomenon is the shortage of health professionals in low-income and developing countries, which has jeopardized the satisfactory fulfillment of the needs of their national health systems. Some countries, such as South Africa and the Philippines, are important examples of this trend, as more than half of their health workers have migrated to countries with better economic situations. The United Kingdom is one of the countries that receives this flow, and estimates suggest that more than half of doctors and nurses working in the UK are foreigners (ILO, 2003).

In the Americas, the migration of health professionals is also evident. WHO estimates that approximately 6,000 foreign doctors are registered every year in the United States. In the Caribbean, 35% of vacancies for nursing jobs remain open due to emigration, among other factors. A significant proportion of their human capital has migrated to Canada and the United States, countries that have received 83% of registered nurses from the region, despite reports on the shortage of approximately two hundred thousand health professionals (ILO, 2003).

Considering that several migrants work as outsourced or subcontracted employees, in regional contexts of deep deterioration of labor relations (ILO, 2018), PAHO/WHO have been acting arduously to ensure decent work conditions to migrant health professionals. One of the most important instruments to ensure regular and proper work, under the terms established by the International Labor Organization (ILO), is the Kampala Declaration, adopted by the First Global Forum of Human Resources for Health, which recommends that governments provide social protection and safe work environments to health professionals. At the same time, it defends an equitable distribution of doctors, nurses and other professionals among different countries, in order to avoid the shortage caused by migration processes (WHO, 2008).

Resolution WHA 63.16, promulgated at the 63th World Health Assembly (WHA) in 2010, has the same purpose as the Kampala Declaration, including a Code of Practices for the Recruitment of International Professionals. Similar propositions are included in Resolutions WHA 57.19 and 58.17, also approved at the WHA, with policy directives for the organization and regulation of the flows of health professionals around the world. These resolutions provide the legal basis for countries to monitor health workforce flows; support regional, bilateral and multilateral agreements on health-related migration; create mechanisms to improve the retention of health human resources in their countries of origin; and provide support to other countries for the development of public policies to deal with health workforce migration (WHO, 2010).

Taking into account the scarcity of health professionals in low-income countries, WHO has promoted and announced, since the early 21st century, principles and practices that may ensure the ethical hiring of this workforce, besides providing support to the formulation and implementation of bilateral agreements and facilitating cooperation in matters related to the recruitment of health personnel. By doing so, WHO has strived to serve as reference in the establishment of a legal structure that protects the rights of immigrant health workers (WHO, 2010).

The More Doctors Program is not an exception to such determinations. The intermediation and technical support of PAHO/WHO to the Program's implementation has sought to extend primary care coverage in Brazil, protecting and ensuring the rights and labor guarantees of Cuban immigrant doctors. Therefore, all Cuban doctors have been allowed to work under a legal employment contract and access all the benefits granted to non-precarious employment. Moreover, Cuban government policies are aligned with these objectives, as doctors are not only paid by the Brazilian government through a specialization scholarship, but also maintain their employment contract with Cuba. This articulation allows the protection of the doctors' rights in both the country of origin and destination.

Social-historical background of Cuban international medical cooperation

International medical cooperation has a long tradition in Cuba. It is one of the country's main mechanisms to propagate the Revolution to the world (MARTÍN, 2016; CABRERA, 2014). The origins of this important initiative date back to the colonial and republican period (GARCIA & ANAYA, 2009).

With the rise of the socialist government, such cooperation strategy became a foreign policy and evolved through various phases until reaching its current form. In the 1960s, the collaboration was initially of international nature, providing aid to a few countries in the region and Africa, in cases of natural disasters. The birth of this phenomenon may be more precisely located in 1960, when Cuba sent medical assistance to Chile after a devastating earthquake. The first international medical collaboration mission outside the Americas took place in Algeria, in 1963, with the participation of 55 collaborators (MARTÍN, 2016).

The same model persisted between 1970 and 1980, extending itself to several countries in Africa, Asia and America, with missions in Mali, Congo, Guinea and Vietnam (MARTÍN, 2016). Years later, different missions were organized to provide aid in natural disasters: in Peru, in 1970 (earthquake); Nicaragua, in 1971 (earthquake); Honduras, in 1974 (hurricane); Mexico, in 1985 (earthquake); Nicaragua, in 1988 (hurricane); Armenia, in 1988 (earthquake); Iran, in 1990 (earthquake); Honduras, Nicaragua and Guatemala, in 1998 (hurricane); Venezuela, in 1999 (flooding); El Salvador, Equator, Honduras and Nicaragua, between 2000 and 2003 (dengue epidemic);

Algeria, in 2003 (earthquake); Sri Lanka and Indonesia, in 2005 (tsunami); and Guiana, in 2005 (flooding) (GARCIA & ANAYA, 2009:33). There were also support missions to Pakistan (earthquake), Bolivia and Mexico (flooding), and the People's Republic of China (earthquake).

In 1990, following the collapse of the Union of Soviet Socialist Republics (USSR) and the global desintegration of the socialist bloc, Cuba altered its cooperation regime and founded the so-called "reimbursed technical cooperation" or "direct contract". With this change, the island began to solicit an economic compensation to the medical services rendered in order to finance the country's national health system and the cooperation itself (GARCÍA & ANAYA, 2009; MARIMÓN & MARTÍNEZ, 2010).

The Integrated Health Program (PIS) was created in the 90s to send general physicians to other countries for a two-year period. In 2007, PIS cooperated with 38 countries, in Latin America and the Caribbean, Africa, Asia, Oceania and Europe, comprehending 309 institutions and a population of more than 68.5 million people (GARCÍA & ANAYA, 2009:28).

Marimón and Martinez, in an official publication of Cuba's Public Ministry of Health, in 2000, explained the inauguration of this new phase as follows:

> *At the end of the 90s, natural events in Central America and the Caribbean (hurricanes George and MIT) changed everything that had been done. The model of international mission and the reimbursed technical cooperation have been gradually reduced. The Integrated Health Program (PIS) was inaugurated in November 1998, initially in Central America and the Caribbean, later reaching Africa and the Pacific. In addition, the Latin-American School of Medicine was created as a basic element for the continuity and sustainability of this program. (MARIMÓN & MARTÍNEZ, 2010:261)*

A new modality was inaugurated in early 2000: the Special Programs, as for example, the program Barrio Adentro, in Venezuela, within the scope of the Bolivarian Alliance for the Peoples of Our America (Alba). Barrio Adentro I and II were implemented in 2003, and, in 2006, it had approximately 30,000 doctors.

Within the scope of the program, primary medical care, dental and optometric care were provided to 17 million Venezuelans who had no access to health care services. The program also contemplated the creation of an Integrative Diagnostic Center (CDI), as well as high tech diagnostic centers, and rehabilitation and physical therapy centers, including training programs for Venezuelan doctors. (GARCÍA & ANAYA, 2009). The Barrio Adentro program was the result of a joint State initiative by Cuba and Venezuela, with a bi-national purpose of South-South cooperation and support, looking to improve the health of Venezuela's poorest citizens and, more specifically, promote comprehensive health care, family medicine and primary health care.

Other two important events impacted this new phase of cooperation: Operation Milagro and the formation of a group of doctors who specialized in disaster relief and severe international epidemics, known as Henry Reeve (GARCIA & ANAYA, 2009; MARIMÓN & MARTÍNEZ, 2010). Optometry centers were created throughout Latin America within the scope of Operation Milagro, in addition to diagnostic centers and integrative rehabilitation services. In 2007, almost half a million patients in Latin America, Caribbean and Africa have recovered or improved their vision through this program, by means of interventions performed in Cuba. By the end of 2008,

more than 1.3 million patients, in 33 countries, had benefitted from these actions (MARIMÓN & MARTÍNEZ, 2010:49). This operation has been developed since 2005 in 15 countries in Latin America and the Caribbean.

The implementation of these special programs reveals a significant change in Cuba's international medical cooperation strategy, which disconnects itself from the previous scheme and includes actions in training and funding in receiving countries, neglecting the medical assistance *per se*. Thus, the development of medical schools, the training of community leaders (formal and informal), the training of technicians, consulting initiatives with different Health Ministries and, above all, the application of a new medical training program through the successful Medical Brigades have all been added to the medical assistance work provided until then (MARIMÓN & MARTÍNEZ, 2010:263).

In 2005, Cuba began the training of Venezuelan doctors within the scope of the doctors' integrative training program. In 2007, over 13,500 young people, from 19 countries in Latin America, Caribbean and Asia attended this study program in Cuba (GARCÍA & ANAYA, 2009:31). However, the initiative of creating medical schools in other countries is not new. The inauguration of the first medical school took place in 1975, in Aden, in the Republic of Yemen. In recent years, other schools have been built in East Timor, Guinea-Bissau, Equatorial Guinea and Eritrea. These institutions rely on an integrated health approach, and, since the first year of study, students meet and interact with patients and deal with the different health problems of local communities, which is the strength of this teaching methodology. (GARCÍA & ANAYA, 2009:31-32).

In addition, from 1961 to 2008, more than 270,000 Cuban civilians provided technical assistance in more than 160 countries, comprising 113,500 health professionals and technicians, present in 103 countries. Besides the health field, other sectors have participated in the collaboration, such as construction, sports, agriculture, sugar industry, fishing and education, at different levels, in addition to other social and economic areas (GARCÍA & ANAYA, 2009:21).

On the other hand, Cuba has received, since the 1960, students from African, Asian and Latin-American countries to further their studies in different health specialties. The majority of students came from the Republic of Guinea, Congo, Vietnam, Chile, and Angola. Thus, by 2007, approximately 50,000 students from 129 countries, and 4 overseas territories, had graduated in Cuba. Among these, 26,500 graduate students from more than 30 countries, which represents almost 53% of the total number of students (GARCÍA & ANAYA, 2009:23).

Cuban international medical cooperation today: support to the development of health, diplomacy, the economy and geopolitics

Cuban international medical cooperation is based on the principles of South-South cooperation and it is postulated as an alternative to the weakening trend of international official development aid (MARIMÓN & MARTÍNEZ, 2011). In this sense, it opposes international North-South cooperation, historically linked to the developmental project of industrialized nations (CABRERA, 2014; MONJE, 2014; ALVES SMC et al. 2017; MARIMÓN & MARTÍNEZ, 2011). Thus, the South-South cooperation model is governed by principles such as alignment, horizontality and autonomy, implying in collaboration without political or economic subordination (ALVES et al. 2017; MARIMÓN & MARTÍNEZ, 2011).

The traditional sanitary model of international cooperation operates through hierarchical and vertical parameters that end up reproducing interstate dependency and subordination, representing a cooperation model whose main programmatic directives are based on the basic approaches of the States' foreign policies and not on the needs of the population who benefit from them (MONJE, 2014:40). By acting from a perspective of South-South cooperation, Cuba points to the direction of re-signifying the values and goals of international cooperation.

Contrary to North-South cooperation, Cuban international medical collaboration aims at strengthening national capabilities according to the priorities defined by beneficiary countries, based on the conjunction of capabilities. Sanitary actions developed by Cuban health professionals respect the sovereignty and autonomy of the Nations welcoming them, in a free exercise of political and economic conditions (MARIMÓN & MARTÍNEZ, 2011; ALVES et al. 2017).

Consequently, with this strategy, Cuba has sought to strengthen the unity and solidarity between all peoples from the Southern hemisphere in order to contribute to the social development of nations and real economic independency. (MARTÍNEZ REINOSA, 2008). From a geopolitical perspective, the Cuban government's initiatives have also been directed in support of the fight against the colonization process that many of these countries have endured or are still enduring, sometimes disguisedly (MONJE, 2014).

In order to reach this specific goal in terms of health, one of Cuba's objectives is to help countries build sustainable programs and initiatives, destined to sanitary sovereignty (MONJE, 2014). This view is based on what Feinsilver (2008) calls "long-term medical diplomacy", which includes increasing human capital, allocating medical personnel to hospitals and health centers, and developing and implementing integrative health programs. The geopolitics of Cuban medical cooperation should be perceived as an expression of its foreign policy, its social policy, and its fundraising mechanisms (MARTÍN, 2016; CABRERA, 2014).

The nature of the medical collaboration provided by Cuba around the world reflects the principles behind its national health system, which follow on a bio-psychosocial model that is preventive, and not only remedial, implying medical concepts, practices, doctor-patient relationships and public health initiatives different from those traditionally promoted by the pharmacological remedial model (MEJÍAS, DUANY & TOLEDO, 2010; MONJE, 2014).

Inspired by such principles, Cuban international medical cooperation aims at supporting the establishment of effective health systems in other countries, prioritizing, in particular, primary health care as the basis of this system (SANTANA & MARTÍNEZ, 2017; GARCÍA & ANAYA, 2009; MARIMÓN & MARTÍNEZ, 2011; MONJE, 2014; FEINSILVER, 2008). To do so, Cuban medical diplomacy has been developing actions at different levels and degrees that have impacted medical care, humanitarian aid, human resources training, and national health systems (FEINSILVER, 2008, 2010; MEJÍAS, DUANY & TOLEDO, 2010).

From Feinsilver's (2010) perspective, Cuban medical collaboration comprehends short-term and long-term initiatives. In the first group are included humanitarian aid during natural disasters; medical care; technology transfer; epidemiological monitoring; training of health professionals and technicians; consulting services to foreign Ministries of Health; provision of medicines, medical supplies and equipment; immunization campaigns; and sanitary education, as well as knowledge transfer. Long-term actions include training of secondary and

tertiary level hospital workers, support to the creation of health centers and broad health programs, as well as medical training in Cuba or in beneficiary countries. When all this information is considered, it becomes clear that Cuban internationalist collaboration in health has been indeed strategic. It has not only tried to improve the sanitary living conditions of millions of people in need, who are socially excluded, but it has also played a diplomatic role with strongly intertwined geopolitical and economic dimensions (FEINSILVER, 2008, 2010; MARTÍNEZ REINOSA, 2008; MEJÍAS, DUANY & TOLEDO, 2010; MARIMÓN & MARTÍNEZ, 2011; MONGE, 2014).

Cuban cooperation has been described as "medical diplomacy" and, in this sense, it is one of the island's most important strategies in foreign policy (FEINSILVER, 2008, 2010; MEJÍAS, DUANY & TOLEDO, 2010; MARIMÓN & MARTÍNEZ, 2011). The supply of health professionals has allowed Cuba to intensify relations not only with friends, but to establish relationships with governments that oppose its political regime. Feinsilver (2008, 2010) states that such diplomatic model has provided both symbolic and economic capital to the Cuban government, giving it the status of a developing nation with health indicators similar to or better than advanced capitalist and industrialized countries. Thus, this symbolic capital, turned into material or economic capital, has been useful to finance its own health system.

Additionally, this collaboration has played a geopolitical role as it has been formulated as a real anti-hegemonic alternative to the North-South model of international cooperation for development (MARTÍNEZ REINOSA, 2008; MONJE, 2014). Medical and humanitarian programs have dealt with very diverse issues in numerous countries including poor, oppressed and peripheral countries, often with a history of struggles against colonialism led by national liberation movements.

Finally, the economic structure imposed on Cuba due to the economic blockade established by the United States and, later, by the dismantlement of the USSR, led the Cuban government to search for alternative sources of income. In this scenario, the export of human capital, particularly medical personnel, has became the main source of foreign income to the island, establishing itself as a political economy based on knowledge (MONJE, 2014). The reimbursed technical assistance and specially the new generation of special programs, such as Barrio Adentro, in Venezuela, and More Doctors in Brazil means that Cuba has the opportunity to raise funds and access strategic goods, such as Venezuelan petroleum. This represents an important transversal economic function of the Cuban international medical cooperation, with a geopolitical and diplomatic role in the last 50 years.

Final Considerations

Classical theories on skilled international migration are inadequate to understand the mobility processes of health professionals within the scope of the cooperation programs organized and managed by countries, particularly those aligned with the principles of South-South cooperation, such as Cuba. Classical theories have been conceived after World War II in an attempt to understand the intense mobility of people from Southern countries to industrialized nations based on concepts taken from the Economic Sciences. They looked exclusively to migration flows that take place within the dynamics of capitalism and international trade.

Consequently, the limitation in the analysis of the sociocultural interactions of Cuban doctors, such as Brazil's MDP case, for example, was important to search for an alternative concept built according to the results of empirical research directly related to Cuba's international medical cooperation.

It is evident, therefore, that the temporary migration of health professionals promoted by the Cuban government, instead of the traditional South-North flows, has been founded on solidarity and cooperation, values deeply related to the Cuban sociopolitical model. Above all, it represents a migration process regulated by policies whose objective is to protect the safeguards and rights of health workers. Equally relevant has been the role of PAHO/WHO since early this century in defining important regulations to ensure dignified work in accordance with ILO's parameters.

Furthermore, international medical cooperation, the milestone guiding the migration flows of Cuban professionals, is characterized by its humanitarian purpose of helping populations in need and its diplomatic, geopolitical and economic nature, working simultaneously as a foreign policy and a defensive strategy against the economic blockade imposed on Cuba.

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Chapter III

HEALTH AND THE PRESS: MEDIA CONTENT ANALYSIS OF THE MORE DOCTORS PROGRAM'S IMPLEMENTATION PERIOD

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Introduction

The duality "public health" versus "health insurance assistance" has characterized the course of public health policies in Brazil, supporting the configuration of a private assistentialist model based on biomedical approaches (MACHADO, BAPTISTA & LIMA, 2012). Brazil's Unified Health System (SUS) was created as part of the Sanitary Reform (PAIM,2008), in the context of this fragmented and excluding health system, with a strong hospital-centric bias, at a time when the population had – and still experiences – unequal access to health care (PAIM et al., 2011).

SUS still suffers from sub-financing, concentration of healthcare services in the country's most developed regions, and pressures from the private sector (PAIM et al., 2011). Concurrently, there is a shortage of 50% in Family Health (ESF) coverage (PAIM et al., 2011), with considerable inequities among Brazilian regions (MIRANDA et al.,2017). One of the factors contributing to such reality is the historical deficit of doctors in the public health system (BAHIA, 2014; OLIVEIRA et al., 2015).

Nevertheless, the last edition of the study entitled "Medical Demographics in Brazil", published in 2015, indicates a relative improvement in the distribution of these professionals nationwide. In that same year, Brazil had 399,692 medical professionals for a population of more than 204 million people, corresponding to a ratio of 1.95 doctors per 1,000 inhabitants. During the same period, according to the Regional Council of Medicine, Brazil had 432,870 doctors, or a ratio of 2.11 doctors/1,000 inhabitants. These numbers place the country at the eighth position in a rank of 40 countries with the lowest doctor/inhabitant ratios (SCHEFFER et al., 2015, p. 12).

Despite advances towards the Ministry of Health's target of 2.5 doctors per 1,000 inhabitants, regional inequalities in the distribution of medical professionals within the national territory remain vast: "[...] both

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among federal states and among state capitals and rural areas, or when comparing groups of cities per population strata" (SCHEFFER et al., 2015, p. 47). The study demonstrates that, while the North and Northeast regions remain below the national ratio (1.09 and 1.30 doctor/1,000 inhabitants, respectively), the Southeast has the highest ratio (2.75), ahead of Brazil's Center-West (2.20) and South (2.18) regions.

When states are compared, the Federal District shows the highest ratio (4.28 doctors/1,000 inhabitants), followed by the states of Rio de Janeiro (3.75), São Paulo (2.70), and Espírito Santo (2.24). On the other extreme, in the seven states of the North region, the indicator varies from 0.91to1.51doctor per 1,000 inhabitants, while the Northeast has the state with the lowest ratio: Maranhão, with 0.79.

Besides the unequal distribution of doctors, the country is also affected by the concentration of these professionals in large urban areas and capital cities. To give an example, with 23.8% of the Brazilian population, the 27 capital cities account for 55.24% of doctors' registrations; on the other hand, the 5,543 Brazilian cities, where 76.2% of the country's population live, detain 44.76% of these professionals. This difference directly reflects the ratio of doctors per 1,000 inhabitants: while the capital cities reach ratios as high as 4.84, rural areas show ratios as low as 1.23.

The distribution of doctors in cities, grouped according to population strata, indicates another dimension of the same problem: the 39 cities with more than 500,000 inhabitants concentrate 30% of the population and 60% of all doctors in Brazil. The state of Espírito Santo reveals, emblematically, this inequality: despite having a ratio of 2.17 doctors/1,000 inhabitants, its capital, Vitoria, has 11.9, the highest national concentration of doctors per 1,000 inhabitants in all Brazilian cities. In the countryside, on the other hand, the ratio drastically drops to 1.27 (SCHEFFER et al., 2015).

In 2012, Scheffer and collaborators warned about the consequences of the imbalances caused by this scenario: "[...]imbalances in the geographical distribution of doctors, added to the concentration that favors the private health sector, will reveal a country that simultaneously experiences shortages and high densities of doctors" (BRASIL, 2013, p. 29).

Also relevant is the fact that the inequality in the distribution of medical professionals is a complex phenomenon that involves multiple employment relationships (almost half of all doctors hold three or more jobs), and work long hours (two thirds work more than 40 hours per week) as well as "on call" hours (45.0% are on call at least once a week), hoping for higher incomes. Medical practice within organizations and public and private institutions is also on the rise, with a progressive decrease of private offices (SCHEFFER et al., 2015). These authors believe that this movement, among other factors, may be related to the demands for specialization, and several specialties depend on high technology and the combination of knowledge and skills from different fields and practices, which are available only in hospitals, clinics and other more structured locations. Thus, the retention of doctors in a certain territory follows the concentration of other health professionals and institutions, contributing to increase social inequities.

On the other hand, three out of ten doctors work only in the private sector, while two out of ten work exclusively in the public health sector. Primary care units and the Family Health Strategy employs only 23% of those who work in the public sector, while 51% work in hospitals. Even more alarming is the situation of secondary and specialized care services at SUS, which employ less than 5% of the doctors. "[...] The strong presence of

specialists in private practices, in contrast with the shortage of outpatient services at SUS, is a great obstacle to scale up the offer of specialized medical care in the public sector" (SCHEFFER et al., 2015, p. 141).

The Brazilian government launched, in 2013, the More Doctors Program (MDP) (BRASIL, 2013) with the purpose of improving the recruitment and retention of doctors in public health services, especially in areas with low Human Development Indexes (HDI) and insufficient health coverage (located mostly in poor and remote regions), in Special Sanitary Indigenous Districts, and in the peripheries of large urban centers. The creation and implementation of the program was a response to popular demands that intensified in June 2013(DINIZ, 2013) as well as to the unequal distribution of doctors nationwide (PÓVOA& ANDRADE, 2006; BRASIL, 2013b; GARCIA, ROSA & TAVARES, 2014).

The Program was conceived in January 2013 also as a result of demands made by newly-elected mayors to President Dilma Rousseff (RBA, 2013). Thus, the program's formulation had the support of mayors and City Health Secretariats, and took into consideration the petition launched by the Mayors National Front entitled "Where is the Doctor?" (http://cadeomedico.blogspot.com/p/peticao.html), which, in July 2, 2013, publicly supported the strategies announced by the Ministry of Health to address the shortage of doctors in Brazilian underserved regions (BLOG DA SAÚDE, 2013; MACHADO, CAMPOS& LIMA, 2015).

Although the initial approach was an emergency response to solve the problem created by the lack of registered doctors in the regions prioritized by the MDP[6], the Program was the result of a political decision whose purpose was to promote structural changes in health care, based on three dimensions:

- **Emergency Care**, that is, the promotion of Primary Care in regions defined as priorities by SUS, with improvements in medical training through the integration of educational institutions and health services, with the purpose of ensuring the provision of primary care to the most vulnerable populations while simultaneously investing in training and professional qualification.
- **Investments in the infrastructure** of primary care networks, associated to a requalification program for respective units; creation of new BHUs in accordance with the new quality standards; and reformulation and expansion of services. This also includes information technology improvements in broadband, implementation of new information systems, and development of electronic medical records, among others.
- **Medical Training**, with a set of structuring initiatives, such as the development of public and private medicine courses, based on clear criteria of social needs; creation of new vacancies for medical residencies, following the same principle of a prior needs analysis; creation of a National Registry of Specialists, in addition to the qualification of medical training, both within the scope of graduate and residency programs (BRASIL, 2013).

Therefore, the Program began to authorize the creation of Medicine schools in private higher education institutions in compliance to defined criteria and pre-selection of municipalities, observing social needs and

[6] To provide a glimpse of the seriousness of the problem, a study entitled "Social Perception System of Indicator – Health" (SIPS), conducted and published by the Research Institute on Applied Economy (IPEA) in February 2011, showed that 58% of SUS users indicated that the main problem of the public health service was the lack of doctors. Through this one-to-one survey in households, SIPS aims to understand the perception of families regarding public policies implemented by the State, regardless of being or not users of the programs and actions. The study analyzes the following topics: "justice", "public safety", "education", "work and revenue", "workers' rights", "professional qualification"," urban mobility", "banks" (exclusion and services), "gender equality", and "health". Available at: <http://www.ipea.gov.br/portal/images/stories/PDFs/SIPS/110207_sipssaude.pdf>.

the existence of primary health services; actions and programs; emergency and urgency units; psychosocial care; outpatient and hospital specialized care; and health surveillance (BRASIL, 2013a).

In addition, the MDP regulates the curriculum guidelines of Medicine courses and medical residency programs, which must offer two types of residency: one in general community and family practice (with minimum duration of two years) and another providing direct access to the following tspecialties: genetic medicine, traffic medicine, sports medicine, physical and rehabilitation medicine, legal medicine, nuclear medicine, and pathology. Thus, the first year of the residency program in general community and family medicine becomes mandatory before attending medical residency programs in internal medicine (general practice), pediatrics, gynecology and obstetrics, general surgery, psychiatry, and preventive and social medicine. For all other residency programs, the applicant must have completed from one to two years in general family and community medicine, except for direct access programs (BRASIL, 2013a).

The most visible dimension is the actual work performed by doctors, submitted to professional qualification and ongoing permanent supervision, in addition to the support of an academic tutor (a medicine professor associated with an educational institution and responsible for academic advice). Doctors who apply to the program are distributed among three different modalities, prioritizing the first two, to the detriment of the third, which is only offered in case the first two do not have available openings. The first group comprises doctors who have been registered in Brazil and includes professionals from any nationality who have graduated in Brazil and abroad, with their diplomas revalidated in the national territory and registered with the Regional Council of Medicine (CRM). The second group is composed of Brazilian doctors who have graduated abroad but whose diplomas have not been revalidated in Brazil and, consequently, are not registered with the CRM, or foreign doctors who are licensed to practice medicine abroad, but hold a diploma that has not been revalidated and, as a result, have no CRM registration number, known as exchange doctors (BRASIL, 2015).

The Program was not able to fill the number of openings for the first two groups; thus, a third group was included: the exchange doctors, composed of Cuban doctors participating through a cooperation agreement between the Brazilian government and PAHO/WHO. These exchange doctors do not participate in the Program as professionals hired individually and they are allowed to work with a single registration valid for three years, renewable for another three (BRASIL, 2015).

Although these doctors had previous international experience, and despite the program's relevance to improve access to health care (OLIVEIRA et al., 2015), the initiative became the target of a fierce debate within Brazilian society: in the media (SCREMIN& JAVORSKI, 2013; SEGALIN, 2013; MORAIS et al., 2014), within the middle class (CARAMELLI, 2013; SCHANAIDER, 2014), and among collective health researchers (CAMPOS, 2013; RIBEIRO, 2015, BAHIA, 2014; EMERICH et al., 2015; NACIF, 2016).

From its early implementation, MDP has raised passionate discussions among the medical community and the politicians opposed to the federal government. In tune with this event, the corporatism of the former and the opportunism of the latter motivated an aggressive campaign to disqualify the Program, in an attempt to avoid its implementation, using the media as a tool to voice their perspectives.

This debate shows that mainstream media play a key role in the construction of reality in western contemporary societies. Indeed, it is possible to observe that the media have an enormous capacity to produce social facts

by using discourse practices that privilege repertoires and frameworks that promote themes of their own interest (MALINVERNI, 2017). From this perspective, mass communication grants visibility – or not – to health issues (CAVACA et al., 2016), creating different realities. In Brazil, the scenario is even more complex because of a national communications system that is predominantly private and oligopolistic (MALINVERNI, 2017), a profile that grants the news industry an almost unlimited power to control access to the production and circulation of discourses, according to the interests and sectors it represents, consequently defining daily perceptions.

Within the list of mass media products, printed newspapers, particularly those of national circulation, are still recognized for their role in shaping public opinion because of their power to influence other media (radio, television, internet and regional newspapers). However, regional publications that focus on local issues are also influential in the news industry, for their proximity to the public and the demands not met by high circulation media (CAMPONEZ, 2002).

In this context, this chapter analyzes and discusses the implementation of the MDP at SUS, based on discourse constructions used by the largest newspapers in the state of Espírito Santo, located in the Southeast region of Brazil.

Methodology

A quantitative and qualitative analysis of the media repercussion of MDP's implementation was performed, using a descriptive and exploratory approach and methodological triangulation[7]. The methodological triangulation is defined as the combination of different sources and methods of data collection, utilizing distinct methodological perspectives to analyze the same object (PATTON, 2002). It surpasses the limits of each method and looks for points of convergence between the quantitative and qualitative approaches, considering both equally relevant (MINAYO, ASSIS & SOUZA, 2005). We adopted the "*Quant* à *Qual"* sequencing model, beginning with the quantitative method and moving on to the qualitative method (DUARTE, 2009).

The newspapers studied are the two most important ones in Espírito Santo (Newspaper A and Newspaper B)[8], both strongly influenced by the national press's perspective. Up to the 1990s, the aesthetic forms used by these newspapers represented different positions that were coherent with their corresponding formal choices. Newspaper A had its front page perceived as "serious", "rational", while Newspaper B was seen as "sensationalist", "emotional". In general, the former had a more sophisticated audience, while the latter catered for a less educated population.

This popular perspective is reinforced by Newspaper B's association with *SBT* TV network (Brazilian Television System), considered one of the most sensationalist channels nationwide. Newspaper A, on the other hand, is associated with the Globo Network, with an audience comprised of wealthier and more educated viewers.

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7 The study was developed in partnership with the *Press Observatory on Health – Espírito Santo Regional Office* (OSM-ES), linked to the *Press Observatory on Health* of the Health Communication and Information Institute (ICICT) of the Osvaldo Cruz Foundation (FIOCRUZ), which monitors and critically analyzes news about SUS and specific health-related themes according to social and academic demand (Cavaca; Emerich; Lerner, 2016).

8 Newspaper A and Newspaper B are fictitious names used for the publications under study.

Both trends have been evident throughout the history of these newspapers (FERREIRA, 2000). Today, however, due to changes caused mainly by the expansion of digital communication and the gradual dismantlement of the printed publishing industry (CASTILHO, 2015), distinctions between audience profiles have diluted, resulting in an approach to health-related issues gradually more homogeneous in both media.

In this study, the keywords "More Doctors Program" and/or "More Doctors" were researched from June to December of 2013. June was the month when the MDP was announced as a government initiative and in October, most participating foreign doctors arrived in Brazil, which allowed the analysis of the reactions to the Program's initial implementation.

The elements considered for analysis include the distribution of news stories over the related period, which newspaper (A or B) broadcast the news, on which page, editorials, the space allocated to the story, the narrative framework regarding the Program, the presence of editing elements, citations of SUS, the advertisements (associated or not) appearing on that page, the front-page headlines, information sources mentioned in the article, and the legal dimension, approached as discourse events that are meaningful and participate in the process of qualitative data analysis.

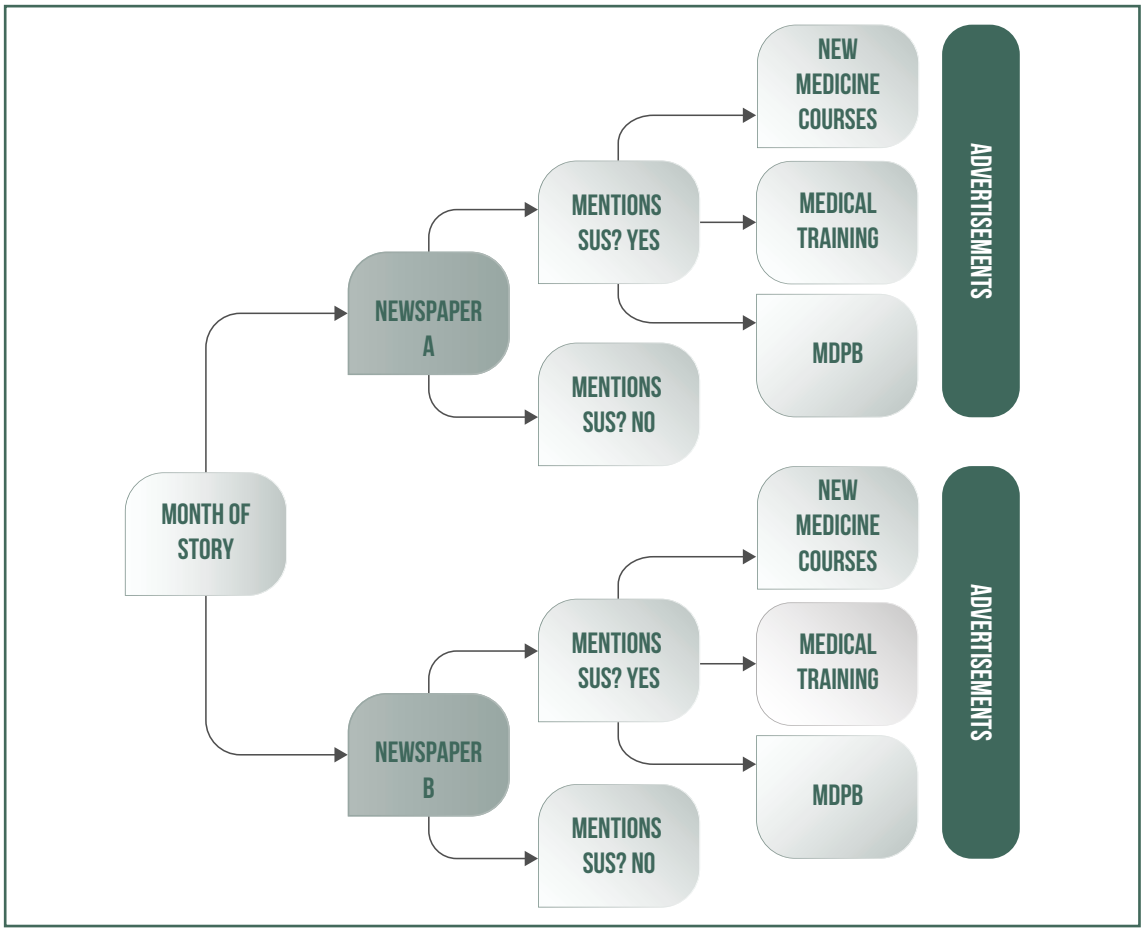
After locating all articles, each story was classified and organized by segment, according to the News Evaluation Protocol of the OSM-ES, adapted to the research and compiled in a Microsoft Office Excel, v. 2007 spreadsheet.

After the selection of the *corpus* articles, the qualitative analyses observed the following inclusion criteria, concomitantly:

- News articles from every month within the research period (June to December) were selected from both newspapers;
- The story must mention SUS;
- Stories that addressed distinct legal dimensions (new medicine courses, medical qualification, and the MDPB) to the detriment of those offering only one dimension; and
- Stories that had some associated advertisement published on the same page, since newspapers are for-profit cultural and mediatic industries that depend on the financial resources of advertisers, which, in turn, may filter and edit content (ADORNO, 2002).

Therefore, in accordance with the defined criteria and by choosing only the first news article from each newspaper for each month of the period of the study, nine stories were qualitatively analyzed. The qualitative criteria used are outlined in Figure 1.

Figure 1. Flowchart of the criteria established for the construction of the *corpus* of news articles submitted to qualitative analysis. Espírito Santo, 2016.



The chosen Discourse Analysis (DA) utilized the French-line qualitative technique, based mainly on the studies of Michel Pêucheux (2006) and Eni Orlandi (2009). Viewed as stemming from the classical streamline, it associates DA with the structuralist methodological plan and is grounded on the problematizing language as the material form of ideology (ORLANDI, 2009). DA presumes that there is always a plurality of meanings in the materiality of discourse (text, images, body language, dances), which changes over time, depending on power relations, context and ideology (PÊCHEUX, 2006; ORLANDI, 2009). Therefore, the study of discursive materiality must go beyond the evident meanings perceived in a text (PÊCHEAUX, 2013). Therefore, the text becomes discourse when analyzed as a social practice, which is both dynamic and alive. Thus, the purpose of DA is to understand what the text means or, in other words, how speech is organized (ORLANDI, 2009).

In order to analyze the discourse of the news articles and understand the predominant discursive constructions during the MDP's implementation, the methodological process followed three phases: 1) delimitation of the corpus of stories to be analyzed, according to the above mentioned criteria and their categorization according to variables, during the quantitative stage; 2) identification of the discursive constructions in the corpus under

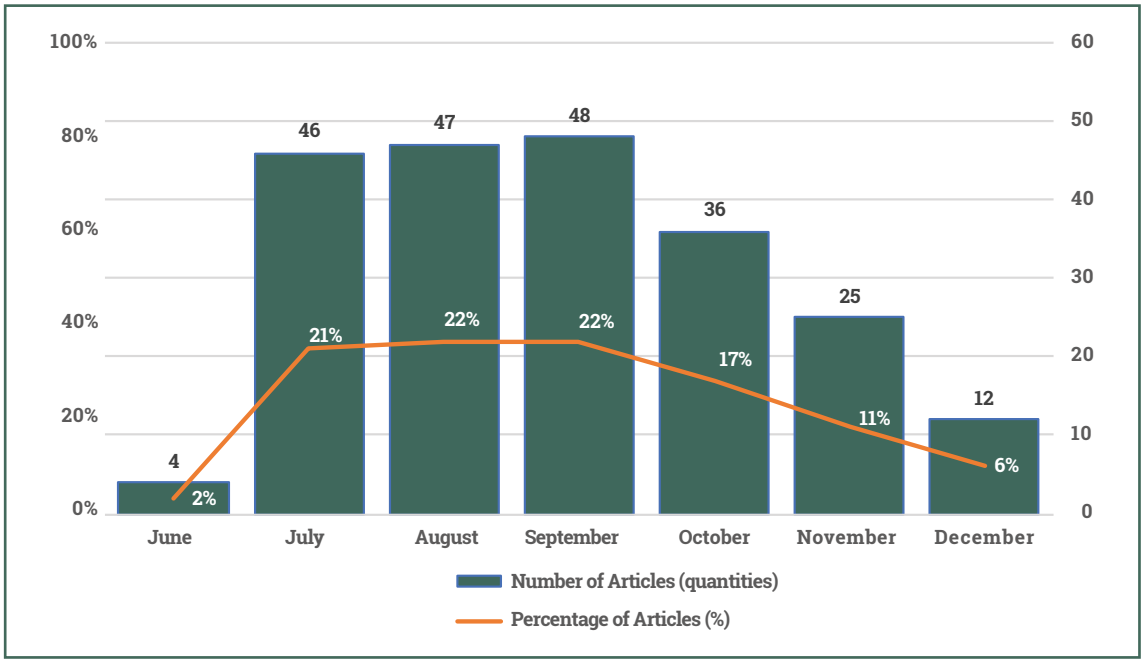
analysis, considering what was said and what was not said; and 3) comprehension of the discursive process, based on ideological and imaginary constructions that are implicit or explicit in the text (ORLANDI, 2009).

Results and Discussion

In this research study, 218 news articles were located. Considering that the study focused on the media discourse regarding MDP's implementation in newspapers, and the procedural nature of the implementation analysis, which is time-dependent, the stories were selected from a seven-month period.

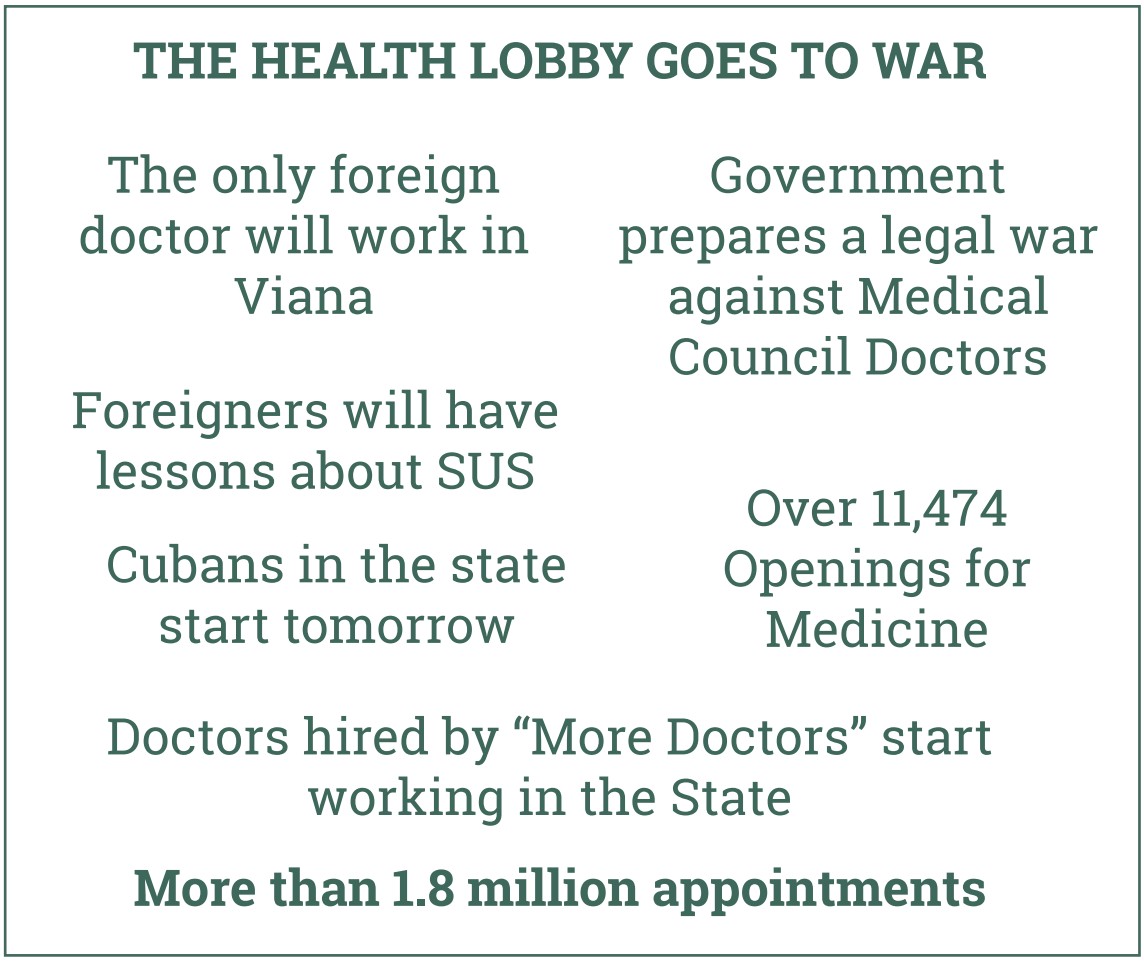
The distribution of news articles throughout the pre-defined period shows a predominance of articles in the months of July (21.1%), August (21.5%) and September (22.0%), with a decrease in the following months (Chart 1). This movement indicates that mass media addressed the program predominantly before the foreign doctors' arrival, particularly the Cuban doctors in October of 2013.

Chart 1. Distribution of the percentage of news articles about the More Doctors Program between June and December of 2013. Espírito Santo, 2013.



Two out of the nine stories submitted to qualitative analysis, as referred above (Table 1), used terms such as "war" in the titles, a strategy similar to the one observed in other studies about the media approach to health, in which there is a predominance of terms that refer to the need to fight a common enemy, such as the language used in news headlines about dengue (FERRAZ & GOMES, 2012).

Figure 2. MDP-related news headlines from the corpus used in the qualitative analysis. Espírito Santo, 2013.



After a more quantitative analysis, this strategy becomes more evident when we look at the total number of stories referring to the newspaper's position about the Program (Table 1). Despite the prevalence of the neutral stance (n=106, 42.6%), there was a significant amount of news items emphasizing criticism and opposing views to the Program's implementation (n=79, 36.2%), especially in the months of July (22.8%), September (24.1%) and October (22.8%). The number of articles classified as neutral include those where it was not possible to determine whether the newspaper had taken a positive or negative position about the program. These findings relate to the arrival of Cuban doctors, when medical authorities took an official and public stand against the program, basing their arguments on the theses, widely disseminated by the medical community, that it hurt the interests of Brazilian professionals (MACHADO, CAMPOS&LIMA, 2015).

Table 1. Analysis of the news articles about the More Doctors Program during its implementation period. EspíritoSanto, 2013.

		MES DE PUBLICACIÓN DE LA NOTICIA							
		JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
Newspaper	Newspaper A*	0	15 (16.7%)	25 (27.8%)	15 (16.7%)	18 (20%)	14 (15.6%)	3 (3.3%)	90 (100%)
	Newspaper B**	4 (3.1%)	31 (24.2%)	22 (17.2%)	33 (25.8%)	18 (14.1%)	11 (8.6%)	9 (7%)	128 (100%)
Page of publication	Odd	1 (1.2%)	19 (23.2%)	22 (26.8%)	15 (18.3%)	14 (17.1%)	7 (8.5%)	4 (4.9%)	82 (100%)
	Even	3 (2.2%)	27 (19.9%)	25 (18.4%)	33 (24.3%)	22 (16.2%)	18 (13.2%)	8 (5.9%)	136 (100%)
Section	Local	0	20 (20.6%)	18 (18.6%)	23 (23.7%)	17 (17.5%)	15 (15.5%)	4 (4.1%)	97 (100%)
	Opinion	0	4 (8.5%)	8 (17%)	13 (27.7%)	10 (21.3%)	8 (17%)	4 (8.5%)	47 (100%)
	Others	2 (28.6%)	0	2 (28.6%)	1 (14.3%)	1 (14.3%)	0	1 (14.3%)	7 (100%)
	Politics	2 (3%)	22 (32.8%)	19 (28.4%)	11 (16.4%)	8 (11.9%)	2 (3.0)	3 (4.5%)	67 (100%)
Space occupied	Informative	4 (3.1%)	33 (25.4%)	22 (16.9%)	31 (23.8%)	19 (14.6%)	15 (11.5%)	6 (4.6%)	130 (100%)
	Opinion	0	13 (14.8%)	25 (28.4%)	17 (19.3%)	17 (19.3%)	10 (11.4%)	6 (6.8%)	88 (100%)
Position of the article regarding MDP	Criticism	1 (1.3%)	18 (22.8%)	10 (12.7%)	19 (24.1%)	18 (22.8%)	9 (11.4%)	4 (5.1%)	79 (100%)
	Complement	1 (3%)	4 (12.1%)	7 (21.2%)	8 (24.2%)	4 (12.1%)	5 (15.2%)	4 (12.1%)	33 (100%)
	Neutral	2 (1.9%)	24 (22.6%)	30 (28.3%)	21 (19.8%)	14 (13.2%)	11 (10.4%)	4 (3.8%)	106 (100%)
Presence of editing elements in the article?	Yes	3 (4.0%)	14 (18.7%)	10 (13.3%)	20 (26.7%)	11 (14.7%)	10 (13.3%)	7 (9.3%)	75 (100%)
	No	1 (7.0%)	32 (22.4%)	37 (25.9%)	28 (19.6%)	25 (17.5%)	15 (10.5%)	5 (3.5%)	143 (100%)
Does the story mention SUS?	No	2 (1.2%)	34 (20.0%)	34 (20%)	40 (23.5%)	34 (20%)	17 (10%)	9 (5.3%)	170 (100%)
	Yes	2 (4.2%)	12 (25%)	13 (27.1%)	8 (16.7%)	2 (4.2%)	8 (16.7%)	3 (6.3%)	48 (100%)
Is there publicity associated on the same page?	No	2 (1%)	42 (20.7%)	44 (21.7%)	46 (22.7%)	34 (16.7%)	23 (11.3%)	12 (5.9%)	203 (100%)
	Yes	2 (13.3%)	4 (26.7%)	3 (20%)	2 (13.3%)	2 (13.3%)	2 (13.3%)	0	15 (100%)

In ES, Newspaper A has the largest number of subscribers, while **Newspaper B has the largest circulation.

According to Table 1, only 48 stories mentioned SUS, and they appeared mainly in the months of July (25.0%), August (27.1%), September (16.7%) and October (16.7%). This shows that the announcement of the MDP was disconnected from the very system in which it is inserted, weakening the program and contributing to SUS's invisibility.

This invisibility is constantly reinforced by the depreciation of the brand. Studies have demonstrated that SUS's logo (and name) is not visible in hospitals, health care units, medical coats, ambulances from the Mobile Emergency Service (SAMU), specialized care centers, and official vehicles serving health- monitoring teams, among others. When visible, the logo or the word SUS does not stand out. This invisibility also persists in media outlets, which usually associate SUS to the hardships and obstacles faced by the public system, particularly in relation to health care.

The MDP received more attention in the newspapers under study in July and August. Table 1 shows that, during this period, the stories about the Program were published on odd pages (23.2% and 26.8%, respectively), pages that are traditionally seen as privileged locations in printed media products. Table 1 also evidences the concentration of these articles in the "City News" section (44.4%).

Other studies on communication and health have already shown that this section concentrates the highest number of news about health on newspapers in general (MASCARELLO DA SILVA, 2017). In the case of the newspapers in this study, the local section deals primarily with state-related news, based on the coverage of local news by a local team of journalists. Consequently, the stories focused on the MDP's implementation, especially in Espírito Santo, based on the state's context and routine.

The politicization of the Program was also verified, given the theme's presence in the Politics section in July (32. 8%) and August (28.4%). These stories praise the More Doctors Program as a public policy viewed as strategic by President Dilma Roussef, although it involved a set of measures unanimously approved by the National Congress, constituting a State policy with the strong participation of state and local governments, whose representatives actively demanded the Program. This perspective was reinforced in 2015 when mayors from all political parties, including opposition parties, decided to support the program, a fact that was confirmed by Minister of Health, Arthur Chioro, when he announced in May of that year that all openings offered through the Public Notice had been filled by Brazilian doctors[9].

Fifteen stories had advertisements associated to the page (Table 1). By viewing newspapers as cultural and mass media industries, we reaffirm the relationship between media and economy (WASKO, 2006) and presume the influence of advertisers on how news agenda are constructed and how news articles are addressed. Newspaper companies are for-profit cultural businesses, with a strong advertising appeal that overlaps and interweaves with the stories they cover. Considering the health sector is one of the most important advertisers in the publicity market (IBOPE MEDIA, 2014), the presence of advertisements associated to the stories about the MDP need be taken into account. In the newspapers analyzed, the advertisements identified related to: radiological and diagnostic imaging clinic (only advertiser seen more than once); tourism company; automotive dealership; construction stores; civil construction businesses (three different construction

[9] PORTAL PLANALTO. Brazilians fill all vacancies of public notice for More Doctors. Brasília, May152015. Available at: <http:// www2.planalto.gov.br/noticias/2015/05/brasileiros-preenchem-todas-as-vagas-de-edital-do-mais-medicos>.

companies advertised in that period); early childhood education; Federation of Industries of Espírito Santo, and a real estate firm.

At the same time, opinion pieces were predominant, particularly in August (28.4%), September (19.3%) and October (19.3%) (Table 1). These stories may be related to the arrival of foreign doctors, most of them Cuban nationals. This aspect had great repercussion both in mass media and Brazilian medical corporations.

Editing elements were found in only 75 of the 218 stories that were quantitatively analyzed, with the highest concentration in September (26.7%). The absence of more editing elements may be explained, in general, by the "shrinking" of newspapers, a process that is gradually reducing editorial space, as well as by the fact that the newspapers under study follow the tabloid format and that there is growing precariousness of newsrooms, with smaller news teams. (MALINVERNI, 2016).

Given the MDP's characteristics, it is possible to consider that the presence of editing elements, such as infographics and images, may support the populations' understanding of the Program; however, they were not predominant in the articles analyzed. Indeed, as shown by Santos et al. (2016), users did not perceive the complexity of the Program, describing it only as a "program that brought foreign doctors".

Regarding the elements of the corpus of news articles submitted to DA, 8 out of 9 stories included photographs only. When analyzed qualitatively, these pictures show a strong politicization of the theme, highlighting congressmen/women (and their position about the program), or ethnic and racial features (foreign, black or biracial) of the doctors participating in the first Brazilian MDP's public notice.

In the first news item analyzed, a photograph shows a state representative – the leader of the so-called Health Lobby – who opposes the Program, with his arms slightly raised, his index finger pointing up, a serious expression, and the following caption: "Dilma removed the physicians' backbone" (Image 2). Editing elements were also used in this story: a picture of Congress and another of a different representative, a doctor opposed to the Program, speaking over the microphone with a furrowed brow.

Image 1. Images included in the stories about MDP that comprised the corpus of qualitative analysis. Espírito Santo, 2013

In the second one, there is a picture of a room filled with male and female doctors, all seated, wearing coats. The image shows the presence of black men and women, with the caption "FOREIGN DOCTORS receive training at the Federal University of Vitoria de Santo Antão, Pernambuco".

The third news item shows the picture of a white doctor at an airport, wearing jeans and a long-sleeve shirt, carrying a luggage cart and boxes, near a baby stroller with a baby, with the following caption: "Graduated in Spain, Brazilian doctor Thiago goes to Acre".

The fourth analyzed story, one of the most symbolic of the strong opposition of the middle class to the Program, includes a photograph of a black doctor trying to go through several people lined up in a "human corridor". On his left, an Army officer is visibly trying to allow his passage. On the right, there is a group of women in white coats, doctors or medical students, with their hands on their mouths, as if to yell at or boo the

black doctor. In the background, there is a reporter with a camera in his hands, taking pictures. The caption says, "Brazilian doctors call Cuban doctors 'slaves' and 'incompetent'".

In the fifth article, it is possible to see a white doctor, wearing a social shirt, open coat and a visible stethoscope, with the following caption: "SPANISH doctor Juan Luis works as a resident, in Vitoria."

The sixth story shows the picture of a female doctor, with the stethoscope in her ears, examining a black patient who is seated. The caption says "MEDICAL CARE: actions to train professionals to work in rural and peripheral areas". In this news item, other editing elements are visible: pictures of the mayor of Vitória, the President of the Doctors Union of the state of Espírito Santo, the Vice- President of the state's Regional Council of Medicine, and the Vice-President of the Medical Association of Espírito Santo.

The photograph that illustrates the seventh article shows a white doctor examining a baby who is on his mother's lap, with the following caption: "Marcel Siqueira started to work in Vila Velha and yesterday helped little Ana Carla, taken by her mom, Mikaelen".

The eighth news story does not show any editing elements, while the ninth includes a picture of the reception area of a health care unit where there are people seated, waiting for treatment. There are empty spaces, and the caption says, "FEU ROSA's UNIT was the second BHU to have the implementation of the "Acolher Mais" Program (Welcome More Program), which improves medical care".

On the other hand, media publications and appearances that emphasize SUS's programs, which may be considered successful in general, do not carry the logo or the name of the public health system (XAVIER&NARVAI, 2015). SUS's logo itself (blue plaster positioned as a cross) is unknown, underused and not regulated by any law, resolution or ordinance. Furthermore, restrictions by the Ministry of Health itself limit the logo's utilization considerably. For Xavier and Narvai (2015, p. 46) "[...] the analysis of the images of SUS's equipment and locations revealed that those who define SUS today are the enemies of SUS". Low percentages of references to SUS in the months under research demonstrate that its invisibility in the media is chronic, a fact that repeats itself with the MDP.

Other examples of this less known aspect of SUS are evidenced in the vaccination campaigns, high complexity procedures (organ transplants), internationally recognized prevention programs, such as HIV/Aids and the production of cutting-edge technology, as the ones developed by the Osvaldo Cruz Foundation or other public research institutions. This scenario has its roots on communication, since the media contributes to the invisibility of SUS's successes (DE LAVOUR, DOMINGUEZ& MACHADO, 2014).

As evidenced by the news stories about the MDP, positive aspects of the system do not seem to receive the same attention as the negative aspects, which are generally emphasized by journalists. In addition, the idea that public services and, consequently SUS, do not work well still prevails in the media discourse. What contributes to the publication of negative stories about SUS is the fact that few institutions consider the communication professionals who work for SUS, in the press offices of the Ministry of Health, and in the city and state Health Departments, as health professionals (DE LAVOUR, DOMINGUEZ& MACHADO, 2014).

This invisibility is also the result of fragile communication structures, lack of policies or even planning inside SUS itself, which "[...] operates as a 'counter', meeting timely demands" (ARAÚJO, CARDOSO, &MURTINHO, 2008). As a rule, according to these authors, communication actions at SUS within the three management areas, is predominantly directed towards managers' demands and, in less proportion, technicians. On the other hand, actions proposed by communications teams are rare, which indicates their low autonomy towards political-administrative determinations and, at the same time, the centralized decision-making process as the *modus operandi* of the communicative action. In this delicate scenario, there are clear actions by managers worried in publishing what they do personally, consciously or unconsciously forgetting to promote SUS as a federal State policy, not a governmental one. Finally, SUS (and its initiatives and programs) are often treated as the property of a party or government, similarly to what happened with the Program, since numerous stories have related the Program solely with its political dimension. The political appropriation of successful SUS initiatives is also frequent in the media (DE LAVOUR, DOMINGUEZ& MACHADO, 2014).

Table 2 shows that only one story, published in October, had a front-page reference, with the title "Cuban doctors take a tour on day off". The fact that the MDP had only one front-page reference indicates the low relevance of the subject to the newspaper, given that this space is one of the most important on printed media because of the limited number of topics it covers. From the discursive perspective, the use of a foreign expression at the front -page reference is worth mentioning, because it may have allowed numerous interpretations by the newspaper's audience, who probably did not know the word's translation. This expression may have also caused confusion, contributing to manipulate public opinion on the subject.

Official government sources were the most consulted (n=116, 53.2%), followed by doctors and/or health professionals (n=28, 12.8%); official sources and professional associations (n=26, 11.9%); unions and/or professional associations (n=25, 11.4%); and official sources and health professionals (n=13, 5.9%) (Table 2). On the other hand, citizens were included as sources in only eight stories (3.6%), showing that the population – the main interested party – was not heard, allowing the conclusion that there was a strong discursive polarization.

Despite being structured in three dimensions, as described in this chapter's introduction, the emphasis of news articles was placed on the emergency supply of doctor's dimension. This approach is also evidenced in Table 2, which indicates the prevalence of a discourse that privileges the foreign doctors' participating in the Program, since the legal dimension analysis showed that 205 stories prioritized the MDP, 21.4% in August. On the other hand, only 13articles approached the actions involving medical training and qualification, 76.9% in July. During the period under study, no story approached the Program's dimension related to the creation of new medicine courses (Table 2). Therefore, despite the fact that the MDP includes other dimensions, it was limited and reduced by the media to the emergency supply theme, as demonstrated later by KEMPER, MENDONÇA& SOUZA (2016).

The *corpus* analyzed allowed the identification of two predominant discursive constructions that permeated the meanings approached throughout the Program's implementation at SUS: 1) the confrontations faced by Program; and 2) the need for its reaffirmation and validation.

Table 2. Analysis of the presence of front page reference, sources and dimensions approached by the articles about the More Doctors Program during the months of its implementation in both newspapers analyzed (Newspaper A and Newspaper B). Espírito Santo, 2013.

		MONTH OF PUBLICATION							
		JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
Is there a front- page reference?	No	4 (1.8%)	46 (21.2%)	47 (21.7%)	48 (22.1%)	35 (16.1%)	25 (11.5%)	12 (5.5%)	217 (100%)
	Yes	0	0	0	0	1 (100%)	0	0	1 (100%)
Sources mentioned in the story ****	Professional associations and/or unions	1 (4%)	7 (28%)	2 (8.0%)	7 (28%)	5 (20%)	1 (4.0%)	2 (8%)	25 (100%)
	Doctors and/or health professionals	0	3 (10.7%)	2 (7.1%)	6 (21.4%)	6 (21.4%)	11 (39.3%)	0	28 (100%)
	Official sources (Government)	1 (9%)	22 (19%)	32 (27.6%)	26 (22.4%)	15 (12.9%)	12 (10.3%)	8 (6.9%)	116 (100%)
	Official sources (Government) + Professional associations	2 (7.7%)	8 (30.8%)	6 (23.1%)	3 (11.5%)	5 (19.2%)	0	2 (7.7%)	26 (100%)
	Official (Government) + Doctors and/or health professionals	0	3 (23.1%)	2 (15.4%)	6 (46.2%)	1 (7.7%)	1 (7.7%)	0	13 (100%)
	Citizens	0	1 (12.5%)	3 (37.5%)	0	4 (50.0%)	0	0	8 (100%)
Which dimension of the law is approached?	Medical training	0	10 (76.9%)	3 (23.1%)	0	0	0	0	13 (100%)
	MDPB	4 (1.9%)	36 (17.5%)	44 (21.4%)	48 (23.4%)	36 (17.5%)	25 (12.1%)	12 (5.8%)	205 (100%)

****In two of the stories, the sources were not mentioned.

1. Conflicts faced by the MDP

The title of the first story confirms the discursive construction that infers that MDP faced political and social conflicts during its implantation. The inclusion of terms such as "war" in the stories entitled "Health lobby goes to "war" and "Government prepares judicial war against RCMs" emphasizes the sense of dispute surrounding the Program, which, to be implemented, would need to "win the battle". In addition, in some parts of the stories, we can observe the use of words that reaffirm this struggle: "[...] the health lobby articulates for two important battles when returning from parliamentary recess" (NEWSPAPER B, 7/21/2013).

The use of war-related terms in stories on health has been reported in other studies in the health field, such as FERRAZ & GOMES's (2012). In the case of the MDP, this discursive repertoire induces the reader to associate such initiative with something to be confronted, demanding the adoption of real strategies to restrain it. Furthermore, news stories about the MDP were characterized by conditional conjunctions:

> *The president of the Regional Council of Medicine in Espírito Santo, Aloizio Farias de Souza, said that he is not against the work of doctors in the country, provided that they take the revalidation test (NEWSPAPER B, 27/08/2013).*

Negative conjunctions were also used:

> *Brazil does not need humanitarian action. We need effective health services, better work conditions for doctors and not war actions (NEWSPAPER B, 8/27/2013).*

It is still evident the stories' emphasis on the position of the Regional Councils of Medicine opposed to the MDP: "RCM-ES refuses to accept doctors with no diploma revalidation" and "The Regional Council of Medicine (RCM-ES) remains contrary to the More Doctors Program".

One of the stories was actually followed by a prejudiced comment published by a journalist on social media:

> *Forgive me if this seems like prejudice, but these Cuban doctors look like house cleaners. Are they real doctors, I wonder? "Oh, that's terrible. Doctors usually have the right posture, look like doctors; they assert themselves with their appearance [...]. I feel sorry for our population. I wonder if they know anything about yellow fever. May God protect our people! (NEWSPAPER A, 8/28/2013).*

Among the stories evaluated, the positions held by doctors and their professional associations against the MDP are clear:

Local doctors did not take well the proposal of President Dilma Roussef to increase openings in medical schools and medical residencies in Brazil, as well as the admission of foreign professionals (NEWSPAPER B, 6/25/2013).

Despite the restrictive position of Brazilian doctors about the Program, the problem of shortage of doctors is an unquestionable reality at SUS since inauguration. According to the Ministry of Health (Brasil, 2013c),

when the MDP was launched, in 2013, 700 cities (15% of the 5,570 municipalities) did not have a single health professional and other 1,900 cities had less than one doctor for approximately 3,000 inhabitants. The federal government calculated then, that at least 9,500 professionals would be needed to meet the demands of the country's poorest regions, a task that seemed impossible at the time. In a first attempt in January of that same year, for example, the Ministry of Health opened 13,000 vacancies for newly-graduated Brazilian doctors who would work in 2,900 municipalities. Notwithstanding the offer of a salary of $8,000 reals, the Ministry was able to fill only 3,000. This is the reason why a policy to supply physicians for SUS was, in fact, necessary in Brazil.

Therefore, despite being the first program to address this demand as an official resolution, it was the first governmental initiative to attract and retain health professionals in remote areas of the country (OLIVEIRA et al., 2015). Throughout the history of the Brazilian public health system, other initiatives dealt specifically with the supply of health professionals, particularly in rural areas, such as the Program for the Expansion of Health and Sanitary Actions (PIASS) of 1976; the Program for the Expansion of the Unified Health System (PISUS) of 1993; the Program for the Expansion of Health Care Service (PITS) in 2001; and the Program for the Valorization of Primary Care Professionals (PROVAB) (CARVALHO&SOUSA, 2013). None of them, though, had the same social and media repercussion of the MDP, which includes outbursts of intolerance and prejudice against the professionals who joined the Program:

> *While leaving the first class of the training program, Cuban professionals had to walk through a human corridor, where citizens from the state of Ceará yelled words like 'incompetent' and 'slaves' (NEWSPAPER A, 8/28/2013).*

This perspective is reaffirmed with the inclusion of three sources (doctors) who express opinions that confirm this position and occupy a large portion of the same news story (a special report). Furthermore, the initial opposition of the medical corporate field against the MDP is also manifested by the low participation of doctors in the first public notice, calling for applicants to the Program.

During the conflicts about the Program's implementation, social and alternative media had a major role, revealing diverse opinions and contributing to the mobilization and social participation in blogs, Facebook and Twitter. The positions expressed by these authors were more neutral and contributed to more in-depth debate on the subject, as opposed to what happened on mass media (MACEDO et al., 2016). These alternative media gave more visibility to peripheral issues and the players that were often invisible on traditional media. In addition, autonomous bodies allowed independent manifestations from communities and social movements. However, though relevant, the discourses mobilized by these means of communication are generally overshadowed by mainstream media (DOWNING et al., 2002).

2. The Program's need for reaffirmation and validation

Several parts of the news stories about the MDP manifested the Program's need for validation as a discursive construction:

> *After evaluation, these doctors will be able to show and prove their competency (NEWSPAPER B, 8/27/2013).*

The need to prove the competency of Cuban doctors coming from other countries is also evident. For example, one of the journalists highlights that the power of doctors would have to be confronted to reaffirm the MDP. One of the legislators cited as a source in the story, and who was favorable to the Program, named this power as "lobby or doctors' dictatorship":

> *It is a strong lobby, but not with me. Congress will prepare itself for the vetoes, but we have other categories that need to be considered. We cannot have a doctors' dictatorship (NEWSPAPER B, 7/21/2013).*

The discussion surrounding the *Revalida* (diploma revalidation test), which would work as a certification that foreign doctors are competent enough to work in the country, defended by the Councils of Medicine, was recurring on the news analyzed. Additional debate was raised by the issuance of professional licenses to foreign doctors, particularly Cuban, without the *Revalida*, which led to the dependency of the MDP on the RCMs themselves:

> *He [Spanish doctor participating in the Program] had already been working in the health unit for one month, but could not practice clinical care because he could not register with the RCM-ES (NEWSPAPER B, 11/10/2013).*

It is worth remembering that the arguments opposed to the MDP were not limited to the *Revalida* program (revalidation of the diploma in the country). Some studies published at the time questioned the communication challenges that a different language could cause on the population's healthcare (CARAMELLI, 2013); the recruitment process of participating doctors, given the temporary nature of contracts (CAMPOS, 2013); and the creation and increase in the number of medicine courses in private institutions, postulating that the best thing to do would be to invest in public universities (CAMPOS, 2013). Others remembered the fact that the MDP is a program for the poor, based on the principle of equity, not equality, pointing out that SUS was responsible for the shortage of doctors in the public system because of the precarious relationships and salaries (BAHIA, 2014). Nevertheless, these themes did not raise journalistic interests, which, as said before, were limited to arguments related to the *Revalida* test, based on the discourses of specialists (official sources, health professionals, and medical corporations), spokespersons, and sources preferred by the newspapers analyzed.

On the other hand, the polemic discussion about the Program's implementation did not reverberate among users who had, through the initiative, the possibility of accessing a doctor. To them, the scenario concerning the MDP was satisfying and the presence of doctors coming from other countries did not represent an obstacle to care (DOMINGUEZ, 2013). Later, different authors emphasized the MDP as retention models in countries like Australia and the United States, where similar strategies proved successful (OLIVEIRA et al., 2015). Other studies performed after the Program's implementation showed that it contributed to the reduction of inequities in health (SANTOS, COSTA& GIRARDI, 2015; GONÇALVES etal.,2016; MIRANDA et al., 2017), as well as to improved access to quality health care (GALAVOTE et al., 2016).

As later demonstrated, among the changes in users' perception after the implementation of the MDP are: the increased attendance of doctors at health units; the easier appointment procedures; the increased number of house calls; and improved standards of treatment, with more organized and applicable practices, and faster

services due to decreased waiting time for appointments; better monitoring of chronic diseases; and the development of prevention efforts in local communities (PEREIRA; SILVA; SANTOS, 2015).

The design of a Program does not always lead to a perfect and very coherent Project, as it involves numerous negotiations, and strength and power relations (ARRETCHE, 2001). Therefore, any program will be inevitably subject to discussions and debates, in an attempt to strengthen and improve its design. Obstacles to the retention of doctors in the Family Health Program (ESF) (NEY&RODRIGUES, 2012), driving force behind the MDP, were not the focus of the news stories, which limited themselves to the opinions, often superficial and polarized, of doctors who opposed the Program.

The MDP represents today a central strategy in the organization of SUS's primary care service. Concerning health training, the Program's doctors have been treated as sources of inspiration in the communities where they worked. The Ministry of Health, through the Secretariat of Labor and Education in Health (SGETES), has invested in training these professionals on urgent problems in public health, as, for example, the epidemics of zika, chikungunya, dengue and yellow fever. They understand that the capacitation of these players to control these illnesses may transform them into protagonists of clinical and educational initiatives contextualized for and multiplied in diverse local realities (MEIRELES, 2017). In spite of their potential, these arguments have not been mentioned by the news stories analyzed.

Final considerations

The methodological choice of triangulation allowed the analysis of the news broadcasted about the More Doctors Program during the months of its implementation, from June to December of 2013, in two printed newspapers of the state of Espírito Santo. The association of quantitative and qualitative data enabled a better understanding of the object of the study, since the approaches complement themselves, evidencing the way the theme was discussed throughout the months of its implementation.

The provision of doctors is a historical issue at SUS, placed categorically on the agenda by the MDP. However, despite evidences that indicated its social relevance, the Program was presented by the media mostly under the perspective of conflicts and symbolic power struggles, which was analyzed in this study based on the discursive constructions "conflicts faced by MDP" and the "need for its reaffirmation and validation".

In relation to editorial choices, both newspapers showed a prevalence of stories in less prominent pages (even pages). Besides the opposition to the Program, the stories evidenced a shortage of editing elements; modest references to SUS; only one front-page reference; poor participation of patients treated by the Program's doctors as information sources; and a predominant single dimension approach to the Program, covering the emergency supply of doctors.

Few were the media discourses that explained the work of the MDP as a whole, discussing the need for its implementation, or its potential positive impacts on people's health. Likewise, this study observed that the media discourse about the Program's implementation, according to both newspapers, did not contribute to advance its implementation.

Field studies in Health Communication have demonstrated the ability of the news media, particularly mass media, to generate social facts and establish realities, according to the repertoires and frameworks it decides to use. As one last observation that contributes to better understand this media capacity to establish social facts, it is worth mentioning that the news articles are not a "mirror" of reality, but the result of a simultaneous historical and contemporary interaction of facts that overflow every day, with the personal, social, ideological, cultural forces of physical and technical means of fixation and information dissemination, typical of the cultural and media industries. The conclusion reached while using this approach to look at the news production process is that the journalistic discourse that was developed and broadcasted during the MDP's implementation induced a negative representation of the Program that established itself as a reality. In spite of the biased coverage in mass media, some alternative media and social media players offered a counterpoint to such negative coverage and contributed to a more balanced debate about the MDP, although they were not able to counteract the lack of vital communication by the government nor the overreaction of Brazilian doctors.

In conclusion, the present investigation, despite having been conducted outside the largest Brazilian urban areas, is an example of the prevailing scenario in Brazil, particularly in times of great fragmentation and politicisation, as the ones transpiring in recent years.

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Photograph: Alejandro Zambrana

Chapter IV

KNOWLEDGE EXCHANGE BETWEEN CUBAN AND BRAZILIAN DOCTORS: METHODOLOGICAL NOTES

Eduardo Siqueira[1] and Leonardo Cavalcanti[2]

The present research analyzes the sociocultural interaction processes, the co-existence, and knowledge exchange between Cuban and Brazilian doctors, and between these doctors and nurses, health agents, patients and the population from the locations where they worked and lived. The initial hypothesis of the research is that the sociocultural interactions of Cuban doctors with Brazilians are and continue to be important for medical practice, for the social performance of the exchange doctors, and for the general health of the population served.

The study contemplated all five Brazilian regions (Center-West, North, Northeast, South, and Southeast), with intense fieldwork comprising ethnography, semi-structured interviews, and focal groups, performed between February and October of 2016. The collection and analysis of data were based on a typological model that divided the study into three distinct focus of attention: 1) indigenous areas; 2) *quilombos*[3]; and 3) urban peripheries.

There were three different phases of data collection. In the first one, after selecting the locations, the best way to approach and make contact with the doctors was defined in partnership with PAHO/WHO teams responsible for the supervision of Cuban doctors working in the More Doctors Program. Several meetings were held at PAHO/WHO's office in Brazil, located in Brasília, during which the authors decided that this contact would be made through the Cuban supervisors who were responsible for the exchange doctors in every state. Fieldwork was then initiated.

To conduct the interviews, researchers headed to urban peripheries, indigenous areas, and *quilombos* (former slave settlements). Some of interviews were organized with the help of PAHO/WHO supervisors; however, there were cases that interviews were conducted by means of snowball sampling[4]22, in which the Cuban doctors themselves suggested other doctors within the Program.

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1 Professor at the University of Massachusetts, Boston (UMass Boston).

2 Professor at University of Brasília and researcher with research productivity by the CNPq. Coordinator of the International Migration Observatory (OBMigra).

3 Quilombo: a hinterland settlement organized by fugitive slaves of African origin.

4 The data collection method known as snowball works as follows: in the initial movement, it uses documents and/or key informants, named as "seeds", in order to locate people with the right profile for the research among the population under study. The "seeds" then help the researcher with the first contacts and the selection of groups to be studied. Next, people who were previously referred to such process now indicate new contacts with the desired characteristics based on their own personal network, and so on. By doing so, the sample may grow at each interview, according to the researcher's needs (VINUTO, 2014).

The research was not limited to the supervisors' referrals, and the result was a diversified sample in terms of location, gender, and age.

Ninety-two semi-structured interviews were performed in nineteen states, with an average duration of ninety minutes each (Image 1). The script of the interviews was flexible and contemplated seven thematic blocs: 1 – Sociodemographic characteristics and migration precedents; 2–Social and family context and the role of family and personal life in the integration process; 3 –Decision to participate in the MDP, arrival in Brazil, interactions in neighborhood/city; 4 – Leisure spaces and social interaction in general; 5 – Social-professional interactions in Brazil; 6 – Relationship with patients and degree of proximity to the community; and 7 – Evaluation of life in Brazil and thoughts on the migration project.

The interviews were conducted at locations chosen by the subjects, generally near their workplace and/or their homes. In indigenous areas, they were generally conducted at the DSEI units and/or the participants' homes. The semi-structured format, with open questions allowed the collection of more detailed information, and allowed the inclusion of new themes to the study, as needed.

Besides the interviews, three focal groups were formed to provide further information about the exchange doctors' experiences that had not been directly discussed during interviews, such as suggestions for the Program's improvement.

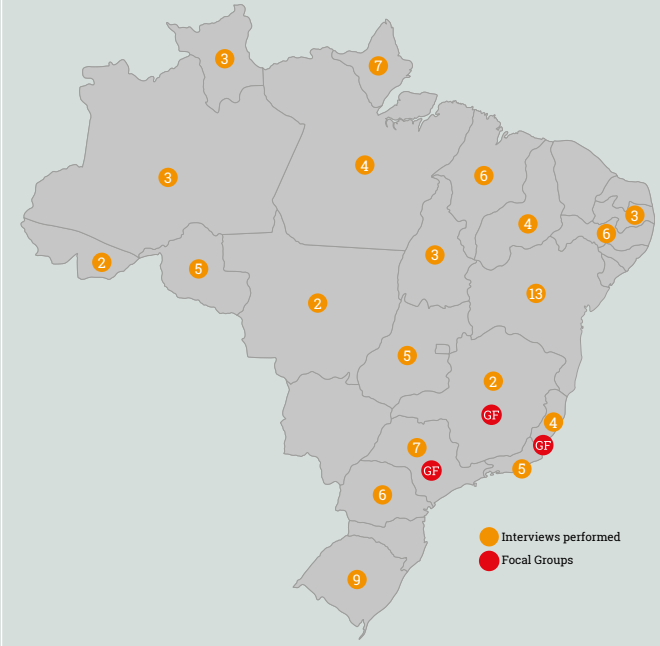
Focal groups were held in Rio de Janeiro, São Paulo and Belo Horizonte, capital cities of three states that concentrate a large number of exchange doctors from the MDP.

In Rio de Janeiro, four female and three male doctors participated, in addition to the local supervisor. The group met at one of the participant's home and lasted approximately one hour. In São Paulo, the group had eight members: six female and two male doctors. The meeting took place at the facilities of the Center for Migration Studies "Missão Paz" and lasted one hour and twenty minutes. In Belo Horizonte, the focal group met at the Federal University of Minas Gerais and gathered seven exchange doctors – five female and two male doctors – as well as PAHO/WHO's supervisor in Minas Gerais; it lasted two hours and forty minutes.

Figure 1. Map of interviews and focal groups, according to state and city.

- **Acre**: Santa Rosa do Purus
- **Amazonas**: Boca do Acre and Autazes
- **Roraima**: TI Yanomami/Ye'Kuana
- **Amapá**: Oiapoque, Macapá, Tartarugalzinho, Calçoene
- **Rondônia**: Guarajá-Mirim and Porto Velho
- **Tocantins**: Tocantins, São Felix do Tocantins and Palmas
- **Pará**: Itaituba
- **Maranhão**: São Luís, Alcantara and Itapecuru Mirim
- **Paraíba**: Cabedelo, Caaporã and Cruz do Espírito Santo
- **Pernambuco**: Recife, São João, Queimados, Passira, Venturosa, Jabitacá
- **Bahia**: Salvador, Jequié, Feira de Santana, Ipirá, Santo Antônio de Jesus, Ibotirama, Malhada, Santa Maria da Vitória, Vitória da Conquista
- **Rio de Janeiro**: Ilha do Governador, Complexo do Alemão, Queimados and Maricá
- **Espírito Santo**: Vitória, Serra, Domingos Martins, Iúna
- **São Paulo**: Campinas, Araçatuba, São Paulo and Penápolis
- **Minas Gerais**: Governador Valadares
- **Paraná**: Curitiba Ponta Grossa, Inajá
- **Rio Grande do Sul**: Porto Alegre, São Leopoldo, Novo Hamburgo and Guaíba
- **Goiás**: Goiânia, Britânia, Brazabantes, Cavalcante
- **Mato Grosso**: Barra do Graça and Juscineira

- Focal Group MG: Belo Horizonte
- Focal Group SP: São Paulo
- Focal Group RJ: Rio de Janeiro



In order to analyze the sociocultural interactions between Cuban doctors and the assisted population, the interviews were based on three major axes: a) social and professional interaction processes related to the workplace; b) community interaction processes, as for example, participation in the community and potential establishment of affective bonds; and, finally, c) sociocultural interaction processes involving the exchange of Brazilian and Cuban cultural values and practices.

The interviews were analyzed utilizing the qualitative thematic analysis of content and included the conceptual organization of data collected during fieldwork, based on significant categories, with priority to the content of these categories and their interpretation, rather than the frequency of codes. The procedure used to allow an integrated analysis based on the interviews was supported by text analysis software NVIVO®.

Photograph: Alejandro Zambrana

Chapter V

CUBAN DOCTORS IN INDIGENOUS AREAS: NATURE, DISEASE AND CURE IN A "BRAZIL NOT SEEN IN SOAP OPERAS"

Sandro Martins de Almeida Santos[1]

Introduction

The purpose of this chapter is to provide some reflections about the relationships established by Cuban doctors who worked in indigenous areas, within the scope of the national research on the "Sociocultural Interactions of Cuban Doctors in Brazil". It synthesizes the information gathered through the survey with the doctors involved in the More Doctors Program (MDP). It gathers happy and sad stories about their contact with indigenous cultural diversity, as well as the relationships developed with the forest, the rivers, and their human and non-human inhabitants. As one of the interviewees said, it was their first contact with "the Brazil you don't see in soap operas".

Considering the relationships between doctors and nature, very different from the one they knew in the Cuban island, and their contact with distinct perceptions of indigenous people about illness and cure, this text shows a theoretical reading of this reality, which attempts to combine the following aspects: a) the relationships with the social totality implied by the forest (socionature) and b) the agreements and disagreements related to differing medical practices (intermedicality).

Flora and fauna, rivers and spirits did not go unnoticed by our interviewees. On the one hand, the humanistic background of these professionals was tested by the need to live in close proximity to forest and rivers which, according to the natives' view, are endowed with personalities. On the other hand, conflicts and complementarities emerged from this diverse knowledge of disease and health. Cubans valued natives' traditional knowledge about medicinal herbs, but also tried to encourage their indigenous patients to adopt certain behaviors they considered to be healthy, aiming at the promotion of healthy habits based on a "positivistic" and "western" perspective.

The organization of this chapter encourages reflections about the context in which these doctors worked, through anthropological discussions regarding a "society of nature" and the challenges of "intermedicality". The next sections present the categories of analysis proposed by the researchers: a more general one

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that relates to sociocultural interactions, and two specific ones, derived from the first: socio-professional interactions and participation in the community.

In relation to sociocultural/socio-natural interactions, a broad category that guides the study, the relationship with nature and the mutual changes that occurred as a consequence of the interactions between indigenous people and exchange doctors are emphasized. Socio-professional interaction is approached from the perspective of the doctors' friendship and complicity with members from the Indigenous Health Multidisciplinary Teams (EMSI), which include nurses, boat drivers, and security officers, among others.

Relative to community interactions, the effects of this intercultural contact were observed in the potential valorization of the so-called "traditional indigenous knowledge". Finally, this chapter presents a brief digression about the interviewees' expectations before their arrival in Brazil and the reality encountered in the Amazon region and context, an aspect expressed repeatedly as the "Brazil you don't see in soap operas."

Society of nature and the challenge of intercultural health in the Amazon region

> *The "pajé" [spiritual leader and healer] has to spend seven days in the jungle with no food, eating only what he can find there. If, during these seven days, he survives, manages to live side by side with the jaguar and the snake, feeds himself, overcomes diseases and the rain, and returns to the village unharmed, he is then approved to be the village's "pajé" – Sancho Panza, two years in the Brazilian mission, South of the state of Amazonas.*[2]

The statement above, provided by a Cuban doctor, serves as an introduction to two other theoretical aspects that are crucial to understand the relationships between Cuban doctors and indigenous communities, as well as their relationship with the Amazon jungle environment. The explanation about the *pajé*'s preparation, learned by the doctor during his contacts with the Apurina people, raises reflections not only about the relationship the natives have with the forest, but also about the introduction to knowledge systems that are foreign to "western" scientific knowledge.

During the interviews with the doctors appointed to indigenous areas and, more broadly speaking, to the Amazon, it became progressively clear that the approach to analyze the relationship of Cuban doctors and indigenous peoples and cultures would have to transcend the theoretical urban and/or rural points of view. As outsiders, Cubans needed to learn about the indigenous jungle survival skills; also, the encounter of "western medicine" and "indigenous traditional medicine" produced a vibrant intercultural contact zone that cannot be ignored.

Thus, in order to enlighten the understanding of the relationships between Cubans and the forest peoples, two key theories from Social Anthropology were used. First, we provide a brief discussion regarding the Amerindian thinking and the symmetric relation between humans and non-humans that is established by these people. The forest, as argued by Bruce Albert (1995), based on his dialogues with Davi Kopenawa, is a social entity, a stage of relations that involves animals, plants, water, minerals, and spirits who display

[2] All names used in this chapter are fictitious.

different and varied moods. In this "society of nature", men, women, monkeys, jaguars, fishes, snakes, trees, spirits, all participate equally (ALBERT, 1995; DESCOLA, 2006; GASCHÉ, 2011).

Secondly, the fact that South American indigenous people consider plants, animals and spirits as social agents, with whom men, women and children routinely interact, directly impacts the way diseases and healing processes are interpreted. The contact between "western" medical knowledge and "indigenous" medical knowledge about diseases and cure, required Cuban doctors to experience the problem of a different assistance model – intermedicality – which is understood as the specific intercultural contact zone between different, and sometimes, contradictory medical knowledge (FOLLÉR, 2004; KELLY,2015).

According to French anthropologist Phillipe Descola (2006), knowledge systems are differentiated based on the definition of "who can do what" in a given relationship. Today, it is widely accepted that the indigenous peoples of South-American lowlands experience the world without philosophically separating culture and nature. This basic separation, established among Greeks during the Classical Period, supports the conceptual and practical framework of western science, in its attempt to separate itself from nature towards the superior stage of culture: overcoming our animal nature in order to establish human society. Among the populations that distinguish nature and culture/society, non-human agents are excluded from social relations[3]. However, South-American indigenous peoples perceive plants and animals are conscientious beings gifted with attributes for social life; therefore, they are considered intentional subjects capable of acting and interfering in the social world.

In the context where forest people live, the different bodies (animals, plants, minerals) share the same life source and, consequently, are involved in the same social fabric. According to Amerindian wisdom, women talk to the Mother Spirit of Herbs to ask for a good harvest; in this sense, they have to convince the protective "being" of manioc to grow their children's bodies. The manioc's spirit communicates with humans through their dreams, dictating the right time to plant. Similarly, men who enter the forest to hunt must make an agreement with the animals' protective being and respect the rules imposed by the spirit that protects the animal to be hunted. All relationships between indigenous people and the surrounding forest are, therefore, negotiated with other visible and invisible life forms. The whole forest (humans, animals, plants, rivers, etc.) is part of this society of nature (DESCOLA, 2006).

George Gasché, a Swiss anthropologist settled in Peru, and Peruvian agronomist, Napoleón Vela (GASCHÉ&VELA, 2011) created the notion of "socionature", trying to establish a synthetic concept to deal with the intercultural dynamics between "westerners" and "bush peoples", while inserted in this social totality that is the Amazon Forest. Gasché and Vela's concerns intend to adapt the scientific proposals for environmental conservation and management to the ancestral techniques successfully used by forest peoples (GASCHÉ&VELA, 2011).

This research study addresses the confluence of two models of health management. To do so, one must consider that neither natives nor Cuban doctors belong to impenetrable knowledge systems; therefore, it is important to know how these differences interact and lead to changes in people's lives, on both sides. Just as the indigenous people negotiate the cooperation of natural beings to execute their daily assignments

[3] Only in 2012, through the so-called "Cambridge Declaration of Consciousness", did a minority group of western neuroscientists began to fight for the recognition of the existence of conscience and, consequently, the possibility of "culture" among non-human animals.

(planting, hunting, curing, etc.), the exchange doctors were urged to get involved in this system of information-exchange and interaction. On the other hand, indigenous people were asked to learn from Cubans some notions of preventive medicine, such as, for example, washing their hand before handling food or boiling water before consumption.

Experiencing the forest and the social complexity that it produces was part of the adaptation to the workplace required of Cuban doctors. Just like the *pajé, who* needed to handle the presence of the jaguar and the snake, survive tropical diseases, and intimately know foods and poisons available in the forest, "western" doctors also had to adapt their knowledge and attitude towards nature and its social agents. It is a matter of survival to negotiate your space with snakes, mosquitoes and jaguars, as well as to know how to identify poisonous plants or learn to sail in rivers during the rainy season (when the water volume can overturn boats) and the dry season (when the sandbanks can ground them). Unlike the *pajé*, doctors did not need to deal with the spirits, but had to daily deal with poisonous snakes, for example (practically unheard of in Cuba) and with medicinal herbs with venom-neutralizing properties, something learned from the indigenous "doctors".

While living in the wilderness with forest peoples, the exchange doctors encountered different interpretation systems for disease and cure, as well as different forms of contact with Brazilian institutions. From this encounter, hierarchical relations emerged, derived from the contact between western and indigenous societies.

They do not relate to the simple imposition of one culture over the other, but above all, to the resistance and merging of knowledge that characterize the process of intercultural contact. This study attempts to reveal the contact zone created between biomedical tradition and some Amazonian traditions. The phenomenon of intermedicality deals with the construction of a "contextualized space of hybrid medicine" based on the interaction of "agents with socio-medical awareness" (FOLLÉR, 2004).

It is important to put into critical perspective the fact that biomedical knowledge is inserted within a Eurocentric cultural context, embedded in the fundamental concepts that feed the western Jewish-Christian tradition, in its capitalist or socialist variation. Historically, the medical knowledge of native peoples has been treated as non-medical knowledge. According to the Swedish anthropologist Maj-Lis Follér, "the practice and experience of survival, shamanism, the use of medicinal plants, and the insight of midwives have been depreciated in relation to biomedical knowledge" (FOLLÉR, 2004). Colonizers' powers have appropriated the referential right to decide which knowledge framework should or should not be valued.

In the context of Brazilian public health, biomedicine, as a knowledge system brought by the colonizer, plays the role of the dominating medical system, accompanied by a civilizing and salvationist discourse supported "not only by its healing efficiency, but also as the result of the expansion of the global market economy" (FOLLÉR, 2004). That is, through the depreciation of indigenous knowledge and the reproduction of behaviors similar to those of religious missionaries when presenting their faith, Brazilian health agents have introduced the consumption of allopathic medicines among indigenous people.

On the other hand, the Cuban doctors who participated in this study showed interest in the practical knowledge of native populations, despite having occasional negative judgements about their habits and way of living.

From one perspective, they had a multicultural discourse of respect and tolerance towards differences (SILVA, 2007); on the other hand, the socialist humanism view persisted as they displayed their solidarity with the material deprivation faced by these populations, believing in the possibility of an evolution of their habits and forms of production. While promoting actions to value indigenous knowledge about medicinal plants and the work of midwives, they also tried to influence the natives to take on more "progressive" and less "accommodated" roles.

Intermedicality emerges from the contact zone between different medical traditions and reveals the existence of an exchange between at least two knowledge systems about life and death, health and disease (FOLLÉR, 2004). The research allowed the perception, through the doctors' discourses, that an intense incorporation of biomedical elements occurred through medicines, either in the form of syrups, creams, or pills. South-American indigenous peoples are recognized in contemporary ethnology for their ability to incorporate "others" into their cosmological systems (VIVEIROS DE CASTRO, 2002). Consequently, it is a pragmatic epistemology, motivated by the search for the best therapy for each kind of illness. It does not represent the replacement of interpretation models of cure and disease, but the creation of a hybrid practice that combines features of biomedicine and traditional indigenous medicine. According to Follér,

> *Elements of biomedicine are included according to the sources, because they strengthen ethnomedicine, which constitutes a process of "indigenization". This middle-ground involves the acceptance of and resistance to the power and to the ideology of biomedicine (FOLLÉR, 2004).*

In regard to this hybrid medicine, it is worth mentioning the relevance of western methods to control diseases that were spread through the contact with the "white man's" world. The treatment of each disease depends on the identification of its origin. If this origin is the "white man", the treatment will be based on his medicine, and vice-versa; if the origin is recognized by the *pajé*, then the treatment is indigenous. The Yanomami people, located in the far Northern region of Brazil (north of the Amazon and west of Roraima), for example, offer the concept of *xawara* to designate those diseases that are unknown to *pajés* or shamans, introduced into indigenous communities by the presence of mine workers in the region, such as measles, malaria and mercury intoxication. In the words of the Yanomami leader, Davi Kopenawa:

> *These are illnesses that come from far away, that shamans do not know about. The spirits of our shamans can only destroy the diseases we know. When they try to fight Xawara alone, it may kill them too. In order to avoid these diseases now, we have to combine our medicine with white men's medicine (ALBERT & GOMEZ, 1997).*

Given the great geographical extension of the Northern states of Brazil, the coverage of health services and the presence of the State is, in general, precarious. The cases of Cuban doctors allocated to remote, difficult-to-access villages (some of them only accessible by plane or boat), whose populations have little or no contact with healthcare professionals, are compelling examples. To access some of these indigenous areas, doctors needed to travel for up to six days by river to reach the communities. The language barriers and some Amerindian practices were mentioned as factors that hindered the first contact between exchange doctors

and their indigenous patients. The lack of precise information about the specificities of each location, which should have been provided beforehand, was one recurring complaint. Also recurring were complaints about transportation, the difficulty to get to the Amazon region, and the isolation of workplaces:

> *The major difficulty doctors faced in the Yanomami reservation was the trip from the capital to the indigenous area. [...] you get there by plane, a small single-engine plane, and when you get a heavy rain on the way [...] We have doctors in Roraima who are living in cities in Amazonas because they are closer to their workplace. So, they go by boat. They prefer to take a 12-hour trip by boat than to spend one hour on a plane (Aureliano Buendía, Amapá and Roraima).*

> *By boat, after sixty days, I think you can get to Rio Branco. It's the same thing to go to Manaus. After forty-five, fifty days, you get to Manaus. Very difficult! Then, the only access you have is by plane (Sancho Panza, South of Amazonas).*

Aerial images of the city of Santa Rosa do Purus – AC, located at the border between Brazil and Peru. The city's headquarters is accessible only by air or water. Photograph provided by Mercedes.

The doctors who participated in the interviews are currently working in: Oiapoque (state of Amapá), at the French Guiana-Brazil border; Guajará-Mirim (Rondônia), at the Bolivian border; in Santa Rosa do Purus (Acre), at the Peruvian border; in Boca do Acre (Amazonas) by the Purus river; Itaituba (Pará), by the Tapajós river; São Felix do Tocantins, in the wilderness of the state of Tocantins. Also, there are the professionals who were hired to work at the Yanomami/Ye'kuana Special Sanitary Indigenous District (DSEI), at the Venezuelan border. All these regions are difficult to access. Consequently, these professionals ended up working as representatives of the State in those regions, in many cases considered "isolated" from the Brazilian indigenous policy.

> *Tocantínia has no doctor, there is no emergency care, and you have to cross a river to get to the hospital. I am always available for any emergency. It was beneficial to both the indigenous and the white communities to have a doctor living in the city, who could help these people. (Pantaleón Pantoja, Tocantins).*

> *First, our team was not used to having a doctor, you know? You have to get used to having doctors. (Manolo Ortiga, Pará).*

The vast distances within Brazil expose the limitations of a central plan that is not sensitive to the hardships of the North region, such as the long journeys by water and air; the difficult access to medication; the obstacles to patient removal; the linguistic misunderstandings with indigenous people, or even the difficulty in communicating with families in Cuba and with Brazilian academic supervisors because of no internet access. Cuban doctors who worked in the states of the Amazon region could even claim that they became familiar with a version of Brazil that most people who live in urban areas like São Paulo and Rio de Janeiro do not know, as "it is not shown in soap operas nor the media".

Despite the difficulties, and maybe because of them, the doctors reported situations of great learning and personal development. The statement below synthesizes other similar stories:

> *It was a good experience from the professional point of view because I treated diseases that I had never treated before, where I live. I shared [experiences] and worked in situations in which I had never worked before. I endured difficulties and dangers that I had never endured before. And at the end it worked out, it went well and I am happy (Diego Armando, Rondônia).*

Based on this context, researchers directed their attention to the processes of sociocultural and social-professional interactions, and the Cuban doctors' participation in the community. How did they react to life in the forest? How did they survive and have fun in the company of natives and other Amazonians? How did they behave when faced with the challenges of intermedicality? How did they approach traditional indigenous knowledge? How did they relate with the transformations within indigenous knowledge motivated by the contact with the Brazilian national government and western medicine? What is the relationship between the image of "the country of soap operas" and the shock with the reality of forest people?

Strangeness and Learning in Contexts of Intercultural Health

A visit to the Amazon may cause positive and negative reactions: the beauty that pleases the senses is the same that can threaten lives. In general, the Cuban doctors who participated in this study reported the need to learn how to deal with the reality of life in the forest, its enchantments and dangers. They needed to relate with an unexpected social totality: rivers with personalities[4], poisonous and constrictor snakes; mosquito vectors of infectious diseases; large felines; and medicinal plants. All this compounded by the cultural and linguistic diversity of indigenous peoples[5].

[4] "Angry river"; "nervous river"; "betrayer river", among other terms.

[5] The process of learning Portuguese and some lexicons of indigenous languages was mediated by the relationship with non - indigenous health professionals and, especially, the Indigenous Health Agents who did the translations. The tendency observed was that doctors learned Portuguese and mastered only a few indigenous expressions, such as the names of diseases, animals and plants.

...Getting to know the Amazon is a unique experience, a unique place in the world. It is a privilege to be here where Mother Nature is. It is pure nature, a unique experience. Only you Brazilians have this. (Manolo Ortiga, Pará).

Every trip that I take on the river, I take a picture and it has been two years and four months travelling by boat. I think some pictures may even look the same. [...] but at any given moment, I find something different. (Cayetano del Espíritu Santo, Amazonas).

On the other hand, they needed to learn by living inside this socionature:

You have to pull the boat, take off your belongings, remove the engine, take everything off, afraid of being punched by a stingray, beaten by a crocodile, everything... because the river has everything. A lot of jararacas [poisonous snake]! I lost count of the jararacas and snakes I've already killed! In schools, at the health care center, I would build my tent and when I woke up, my net or my tent would have a snake lying on it! (Diego Armando, Rondônia).

In a society of nature you have to live with the feared rattlesnakes and other poisonous snakes. Photograph Provided by Pantaleón Pantoja

In TI Xerente, Tocantins, a visitor interrupts the appointment. Photograph provided by Pantaleón Pantoja.

Rivers are the main transportation route in the Amazon and their waters are responsible for many accidents, as warned by Alonso Quijano, after spending two years in Pará: "The bass boat may overturn and if you can't swim, you drown!"

In the North region, Cubans discovered, as some have said, "a Brazil you don't see in soap operas". As important consumers of Brazilian television drama, they were disappointed with the actual living conditions of populations living far from main urban areas, which differ enormously from the lives portrayed in the soap operas seen worldwide. Brazil sells abroad an image of a "rich country" and, at the time of More Doctors' implementation, the country was ranked as one of the nine largest economies in the world. However, the reality witnessed by Cuban doctors working in the Amazon is not exactly that of a rich country. There were several complaints related to the unreliable infrastructure of public health services and intense criticisms

about the population's socioeconomic status, both indigenous and non-indigenous, which directly influenced the work conditions of health professionals.

> *There is no other way, my friend. On my first day: 'My God, what is this? Where is the health care center they told me about? Where are the safety conditions? Where is the comfortable chair? On several occasions we sat on the floor in the woods, or on a stone, while examining a patient on the floor..." (Diego Armando, Rondônia).*

Example of the precariousness of health care in villages. Photograph provided by Pantaleón Pantoja.

Even where the transportation is by land, the forest imposes difficulties. Everybody, including the doctor, needs to help. Photography provided by Pantaleón Pantoja.

This is how they described their reality shock in Brazil:

> *You watch Globo's soap operas and get an idea of a Brazil that is completely different from reality. I had this image of Brazil, the country of soap operas. When you arrive here in Amapá, Roraima, the rural areas, you see reality: that besides being a country with a large economy, the seventh in the world, there are many people in need, underprivileged people who have no knowledge of the outside world. (Aureliano Buendía, Amapá and Roraima).*

The issues of intermedicality and the existing tensions between "western" medicine and the so-called "traditional" medicine, especially "indigenous" medicine – defined as the knowledge derived from cosmology and bushmen lifestyles – are highlighted here. This is a very profitable frontier to emphasize certain dynamics related to the sociocultural interactions of doctors working in indigenous areas. On the one hand, there is biomedicine, supported by scientific-materialistic precepts and, on the other, disease interpretation systems and healing practices that incorporate spiritual agendas (for example, spirits that can take or save lives).

The coexistence of two medical systems does not imply in replacing one type of knowledge with another; what happens is a process of intercultural contact that creates hybrid medical practices that can actually collaborate to foster complicity between doctors and *pajés*:

Actually, I was seen by a "pajé". I suffer from strong headaches. I did not believe, but one day I went there with a strong headache and he asked me if I agreed to be treated by him. I said yes. And I spent a long time with no pain. He said some prayers and did some rituals... So, he accepted me much better after I accepted his treatment, because he is the chief of that village and, after that, he knew that I can *cure him as he can also cure me. He is diabetic (*Oriana Lisuarte, Mato Grosso*).*

As for spirituality, the doctors interviewed had a similar discourse of tolerance toward the practices viewed as "traditional". This discourse is in agreement with the alleged western multiculturalist thinking (SILVA, 2007), which considers that the cultural realm coexists with nature's realm and, consequently, there is no real conflict between biomedicine (nature) and indigenous medicine (culture), but a separation of purposes and ranges. As suggested by anthropologist José Antônio Kelly (2015), "white" health agents tend to see a certain "conceptual and practical complementarity" between biomedicine and traditional medicines. Distinct therapeutic systems are perceived as alternatives; therefore, access to a healing modality does not exclude or limit access to the other. Participating doctors recurrently stated that the healing procedures performed by the *pajés* occurred simultaneously to biomedical treatments:

> *I had a patient who was going through scientific treatment [with me] and at the same time he was doing his traditional treatment, with rituals and things like that! (Pedro Crespo, Rondônia).*
>
> *[The Munduruku] really care for the pajé, but they also like our western medicine... They always look for the pajé before the doctor; first, the pajé! (Alonso Quijano, Pará).*
>
> *The pajé prays while we give medicines and lecture about how to avoid these diseases. He starts and I finish, or he finishes what I've started. That way, no one else will die. (Alonso Quijano, Pará).*
>
> *We have to respect this, accept this and agree with it, because there is a balance between the biological and the spiritual. (Manolo Ortiga, Pará).*

Doctor and midwife trade their knowledge. Photograph provided by Amadís de Gaula.

Party day at TI Xerente.The doctor is dressed up accordingly. Photograph provided by Pantaleón Pantoja.

The perceived harmony between the medical treatment and shamanism, however, overshadows a clash between dissimilar concepts of health. From one perspective, the doctors providing primary care tried to change or transform those indigenous habits seen as "unhygienic". Their actions were supported by the narrative of improving these communities' primary health indicators. Indeed, they were successful in reducing symptoms, such as diarrhea, by encouraging the habit of hand washing among patients. On the other hand, some natives showed resistance to some of the prescriptions and kept on looking for doctors only to solicit medication or for secondary care.

> *It is difficult in reality because they [the Munduruku] are not used to prevention; they are more used to secondary care; they go to the doctor only to ask for medication and bandages; for me, it is the custom, they go to the health unit only when they are sick. (Manolo Ortiga, Pará).*

> *It was difficult in the beginning because everybody [Oro Wari] who came here had diarrhea or the flu, and asked for metronidazole or amoxicillin. I had to do an intense educational work. (Diego Armando, Rondônia).*

> *When I told them to undergo a natural treatment – for example, in the case of the flu, I would tell them to make a tea with a herb that I know of, for them to make the tea themselves [the Palikur] – the patient would stand up and leave! (Amadís de Gaula, Amapá).*

Such evidence leads to the following question: why did the natives not completely accept the primary care of educational nature provided by the doctors? One initial hypothesis raised by the Cuban doctors working in indigenous areas point to the habit of self-medication, motivated by the indiscriminate distribution of drugs in recent years. From the doctors' perspective, it was the collateral effect of State paternalism, expressed in

health campaigns based on the distribution of medicines, sometimes indiscriminately[6]. In the anthropological sense, it can be assumed that the doctors saw the indigenous cultures from the perspective of acculturation.[7] In cases where natives' interactions with Brazilian society was more intense (in Rondônia and Tocantins, for example), it was common to hear from doctors explanations about that how their indigenous patients had lost their ancient culture.

> *I think that since FUNAI took nurses to work in the indigenous villages, they [Oro Wari] have gradually adapted to modern medicine and many villages no longer want to use homemade medicines... this is so evident that in some villages there is no pajé anymore; these traditional customs are disappearing. Only the elderly knows about these practices now. (Diego Armando, Rondônia).*

This criticism to paternalism from an *acculturation* perspective, however, does not explain the entire problem. It reflects an idealized view of indigenous peoples, a concept that sees them as eternally primitive and victimized by civilization. Nonetheless, reality is more complex than that. The problem with this simple *acculturation* approach is that it assumes that nobody will remain without a culture. On the contrary, indigenous people incorporate new behaviors and treatments as they adjust the new information to their own cosmology (FOLLÉR, 2004). Thus, instead of talking about acculturation, it is better to discuss intercultural processes.

While reflecting about intercultural exchanges, the Cuban Exchange doctors also proposed changes that affected the lifestyle of indigenous people in various aspects. Hygiene habits were constantly mentioned and the following statements exemplify the concept of family doctors as agents of change:

> *This is the true family doctor. Interacting first and then working little by little with them, changing ways of life and lifestyles. Interacting first: learning, studying their culture to be able to analyze, see their problems and see how we can help them to overcome all the problems that may, somehow, cause a disease. (Pantaleón Pantoja, Tocantins).*

> *I really like to deal with children because I believe they hold the future, they hold the ability to change and they represent hope. You cannot change an old person because of what this person has already experienced; he will die with these customs, with his paradigms. However, children are growing and learning, and if you start interacting with them, you can have successful results that will benefit their health. (Pantaleón Pantoja, Tocantins).*

[6] For an in-depth analysis of the use of industrialized medications and the self-care or self-medication practices among indigenous people, see SCOPEL, 2007.

[7] Popular anthropological theory, popular in the period between 1930/50, which states that the continuous direct contact between groups of individuals from different cultures will result in changes and losses in one or both cultural models (HERSKOVITS, 1963).

Palikur children through the lenses of a Cuban doctor. Photograph provided by Amadís de Gaula.

From the exchange doctors' point of view, indigenous people lived under one of two conditions: they were either "assimilated" or "primitive", and needed to recover the culture that had been lost by years of contact, or they needed to evolve and change their modes of production, hygiene and health habits. The intention of this study is neither to detail the cultural transformations encouraged by Cuban doctors in the communities they assisted, nor present the cultural specificities of every ethnicity involved. The interviews revealed complex and varied conjunctures, whose understanding would require greater analysis of indigenous perceptions about the presence of foreigners in their territories.

Based on these perceptions of "acculturation" or "primitivism", doctors tried to act with the purpose of changing the hygiene habits or the modes of production of the population assisted. However, they had to deal with some opposition by the natives:

> *There are certain things that we have been talking about for three years now, telling them that they are wrong and they have to do it differently, but they keep doing the same thing, ever since the first day... It's complicated... (Manolo Ortiga, Pará).*

This opposition does not refer to the specific presence of Cuban professionals, or even to the doctors' humanistic background; rather, it relates to the broader context of western influence on indigenous people's culture and daily lives. These intercultural contact relations have historically contributed to the decimation of entire populations. As well described by Doctor Cayetano del Espíritu Santo, who worked with the Mura people in remote areas of Amazonas:

> *"I think they are still afraid, you know? Maybe they see us not really as foreigners, but as white people, so they get suspicious".*

It is worth noting that the doctor used the term "white people", incorporating into his own vocabulary a category invoked by the indigenous themselves to qualify their relations with the colonizers.

Moreover, Cayetano, when he heard the Mura people say that they felt undervalued in their own country, criticized the unequal relationship established between the natives and the "white man's world". He noticed a depreciation of indigenous people and culture by the surrounding society, a situation that affects the self-esteem of these populations and their future generations.

Within the context of intercultural contacts, the study also revealed a discrepancy between the views of Cuban doctors and Brazilian health professionals about the valorization and recognition of traditional indigenous knowledge on illness and health, life and death. While Brazilians tend to undervalue indigenous knowledge by considering it non-medical practices (LANGDON, 2004; FOLLÉR, 2004), Cubans were generally more open to the possibility of learning from them[8]. Such openness led to a friendlier attitude towards the exchange doctors, contributing to a closer relationship. There were doctors who tried to learn their patients' skills and those who were amazed by the expertise of indigenous midwives:

> *I have learned a lot about their practices... with the plants they know, they already taught me that... There are many medicinal plants with healing properties that we didn't know about... So, the indigenous know a lot about that. If we continue to study them, like I'm doing, we can get to know several plants that have not been discovered yet. (Amadís de Gaula, Amapá).*

> *I received a pregnant woman who came to give birth, but the baby was not in the right position, so I said, 'I have to refer you [to a hospital]'... Then, the midwife came, performed some maneuvers and put the baby in the right position, the cephalic position. They do these maneuvers and do that [get the baby in the right position]. In other words, we have to learn these things, right? [...] it's interesting... I was nervous the first time I saw this, a complicated delivery... If the child died... But they have a lot of experience and are very wise, the midwives. They are very good. (Alonso Quijano, Pará).*

Palikur midwife learning biomedical techniques. Photograph by Amadís de Gaula.

[8] This statement is a generalization and, as one, may impose on the reader a totalizing idea of people's behavior. It is important to keep in mind that there are Brazilian health professionals that are engaged in the appreciation of indigenous knowledge, at the same time that there are Cuban doctors who depreciate these practices.

Coworker turned relative: the social-professional interaction in the Amazon Region

One singularity that Cuban doctors experienced while placed in the Northern states was the fact that most social interactions took place between coworkers due to the relative distance from urban areas. The work in indigenous areas and locations categorized as "isolated" was performed through what doctors call "entries" – term that defines a separation between the workplace and resting place. During "entries", Cuban doctors worked and lived for days and weeks with the Indigenous Health Multidisciplinary Teams, comprised of nurses, nursing technicians, drivers, dentists, boat drivers and cooks. On their days off, in the city, doctors were welcomed by the families of these Brazilian coworkers and, with this continuous interaction with local kinship networks, they were invited for lunch, fishing, swimming, celebrations, etc. This "family relational" connection was evident in the relationship of doctors with their workers, as a mechanism that alleviated the distance from their families in Cuba[9]

> *The doctors who work in indigenous areas with Brazilians, with the health teams, have a much stronger relationship between them than the doctors who do not work with indigenous health... Because you have to live with them, sleep with them, spend the entire day, twenty-four hours with them... we have to share everything, because no one is going to eat cake in the forest while you are hungry there by the river. It's much stronger... The friendship bonds between doctors who work with indigenous health are stronger. (Sancho Panza, South of Amazonas).*

> *I would consider that driver who helped us as a family member... I didn't know anybody from his family and he said: 'No, you're wrong, you are my family, you will go there, and I said 'ok, I'll go'. 'And take your girlfriend', he said. Then it was great, I met his entire family, fun people, I really liked them! (Cayetano del Espíritu Santo, Amazonas).*

> *Actually, I am not lonely there, I am fine because since the first day I've made friends with all nurses of the unit, with the Director and I spend all day there. On weekends, they usually come to my house, we cook something, throw a little party, there are a lot of waterfalls, then they always call me. (*Dulcinea del Toboso, Amapá).

[9] About the theme of relationality as an essence of family, see CARSTEN, 2004 and SAHLINS, 2013.

EMSI from the Pantaleão Base (Autazes, Another day of work. Photograph provided by Cayetano del Espíritu Santo.

Lunchtime at EMSI of Tocantínia Base, with picnic inside TI Xerente. Photograph provided by Almeida Santos

The doctors also established close relationships with the indigenous health agents, and even kinship, in the indigenous sense of the term. Indeed, Brazilian natives are used to employing the kinship mechanism to express affinity, metaphorically cannibalizing those who are outside and transforming them into people inside (VIVEIROS DE CASTRO, 2002). Such thought process influenced the discourse of doctors in the South of Amazonas, who felt integrated in the life of a small isolated village:

> *I watch TV, go out, and walk around the square. I eat barbecue over there, have a beer and go to a relative's house… we call the natives, family. They are like relatives who live in the same city...I'll go there, we'll talk, I'll go to a coworker's home, that's the way it is. (Sancho Panza, South of Amazonas).*

After work, a doctor and the driver Xerente fish by the Tocantins River. Photograph taken by the author.

Medicine in Everyday Life and Community Gardening

One aspect of the Cuban doctors' training allowed them to weave personal relationships within indigenous communities: the cultivation and valorization of medicinal plants. At different locations, Cubans encouraged planting gardens to produce homemade medicines. Aside from providing an occupation for men and women, the activity in these gardens helped to decrease the consumption of synthetic drugs. Doctors supported this activity based on the knowledge of the communities themselves, particularly the elderly.

In Cuba, we are used to working with natural medicine as well. In the same pharmacy, there are cough syrups and several natural medications we use in Cuba. We are used to this, and so we also accept the treatments they use. (Oriana Lisuarte, Mato Grosso).

The interest of Cubans in medicinal plants has a historical explanation, based on the shortage of pharmaceutical products:

Our training in Cuba covers traditional medicine. It is the result of a period that Cuba experienced, a difficult period we call "the special period', with blockades and shortages of many things, right? Doctors in Cuba learned to work with natural medicines… plants, herbs. Things like that (Alonso Quijano, Pará).

Another factor is the shortage of medicines in indigenous areas. The work developed with community gardens implied in a change of habit for the indigenous, with a focus on health promotion and the exchange of knowledge about the medical properties of plants:

I really invested and encouraged the leading role of AIS and AISAN[10] *in the development of herb gardens, and they've worked a lot. They already know how to use the plants, what properties they have, what they can do... And so, we have this exchange of ideas, you know? We exchange ideas and knowledge (Amadís de Gaula, Amapá).*

Collective effort to build the community garden. Kumenê vilage, Palikur People, Oiapoque, Amapá. Photograph provided by Amadís de Gaula.

Community Garden at Kumenê village. Photograph provided by Amadís de Gaula.

The involvement of western doctors in the promotion of indigenous medicine point to the relevance of a dialogue between traditional medicine and biomedicine to promote the exchange of knowledge on the treatment of tropical diseases. The use of a hybrid medicine contributed to advance the cooperation between doctors and local communities.

[10] AIS: Indigenous Health Agents; AISAN: Indigenous Sanitary Agents.

Cuban Medicine in "A Brazil You Don't See in Soap Operas"

A review of the sociocultural interaction process of Cuban professionals in the Amazon shows that the immersion experience was definitely more positive than negative.

In fact, Cuban doctors developed relationships with their indigenous patients both as a result of the openness of these local populations and the different contexts of intercultural contact: whether Portuguese or native tongues were predominant; whether natives resisted or accepted biomedical treatments; whether doctors appreciated or ignored traditional knowledge, for example. From the doctors' perspectives, most locations assisted by the Program were open to the possibility of intense contact with their social surroundings, allowing a greater participation in community life. The socio-natural relations, on the other hand, also caused some strangeness and alerted them about the risks imposed by the forest: going up and down rivers, fighting mosquitoes, or encountering snakes and jaguars.

Thus, the hospitality of health agents, drivers, boat drivers and janitors, in addition to other team members, was critically relevant. Among the professionals who were interviewed, there were no complaints about solitude or feelings of isolation, even among those individuals who worked in extremely remote locations. Cubans were successful in building close relationship networks, especially with other health professionals, coworkers and their families, which represented the main reference of social interaction and hospitality in the Amazon region.

On the other hand, the administrative centralization of the More Doctors Program, with its headquarters located in Brasília, failed to consider the specificities of the Amazon Region, such as the distances between locations assisted, poor transportation systems, and communication infrastructure. This certainly contributed to the relative frustration of exchange doctors about the expectations they had before arriving in Brazil. The repeated reference to TV dramas showed that soap operas worked as showcases of fragments of a certain Brazilian culture, with its trends, music, stylish homes and lifestyles (MENDES,2012).

Through Brazilian TV soap operas, Cubans built a specific fantasy about Brazil which referred to its neighborhoods, parties, beaches, buildings, avenues and lifestyles of the country's large cities, especially Rio de Janeiro's. Such fantasy cannot be seen as a passive process, as it influenced their decision to participate in the Brazilian mission. The doctors frequently mentioned their criticism about their contact with a different Brazil, in addition to a certain disappointment with the image of Brazil advertised in Cuba. The sociocultural interaction with forest peoples was part of their broader interaction with the social totality of the forest; and life in the forest imposed risks that were not previously informed by the Brazilian media nor the authorities responsible for the Program.

Their contact with a reality different from that shown in soap operas has led to some situations of real cultural shock. A critical aspect is highlighted in their attitude of strangeness about indigenous practices related to life and death, particularly neonaticide practices among the Yanomami. As a MDP's assistant put it, "these are cultural habits that usually scare us". Although Cubans seemed to be more open to indigenous knowledge, in comparison with Brazilian health professionals, it does not mean that they approved or normalized all the practices they judged as "irrational" or "primitive."

Finally, the encounter with indigenous practices and knowledge about health and illness revealed a double link with the professional training provided to Cuban doctors, translated as the appreciation of traditional indigenous knowledge about medicinal plants and the work of midwives, as well as their commitment to the transformation of indigenous habits related to hygiene and body care.

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Chapter VI

CUBAN DOCTORS IN URBAN PERIPHERAL AREAS: AN ANALYSIS OF UNEXPECTED INTEGRATIVE PROCESSES

Márcio de Oliveira[1] and Gabriella Barreto Soares[2]

In the period between February and July 2016, 48 Cuban doctors from the "More Doctors Program" (MDP) were interviewed. They worked in the urban peripheries of 30 municipalities distributed around 13 states from all Brazilian regions. The table below shows their personal characteristics.

Table 1. Characteristics of the interviewed Cuban doctors

DOCTORS	AVERAGE AGE (YEARS)	AVERAGE TIME OF MEDICAL PRACTICE (YEARS)	AVERAGE NUMBER OF SPECIALITIES
16 Men	44	20	2
32 Women	43	19	2

Source: Field survey

The first approach analyzed these professionals' performance (who had been assigned to work in places with a significant shortage of doctors) in relation to their individual profiles, trajectories, work experience, participation in community life, and adaptation to the local socio- cultural reality. As shown in Table 2, the areas vary greatly in relation to size and to the number of doctors per 1,000 inhabitants; some of them have indicators above the recommendations of the World Health Organization (WHO s/d).

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Table 2. Number of doctors interviewed; population and number of doctors/1,000 inhabitants per region, state, and municipality.

REGION	STATE	MUNICIPALITY	POPULATION	DOCTORS/ 1.000 Inhabitants	# OF DOCTORS INTERVIEWED	HDI 2010	HDI QUARTILE
North	Amapá	Macapá	437,256	1.42[2]	03	0.733	High
	Rondônia	Guajará-Mirim	45,761	0.22[3]	01	0.657	Medium
Northeast	Bahia	Salvador	2,883,682	4.02[2]	02	0.759	High
		Feira de Santana	606,139	4.04[3]	01	0.712	High
		Santo Antônio de Jesus	99,407	0.46[3]	01	0.700	High
		Jequié	161,391	1.22[3]	01	0.665	Medium
	Maranhão	São Luís	1,053,922	3.16[2]	02	0.768	High
	Paraíba	Cabedelo	63,035	0.46[3]	01	0.748	High
		Caaporã	21,212	0.23[3]	01	0.602	Medium
	Pernambuco	São João	22,162	0.23[3]	01	0.570	Baixo
		Recife	1,599,513	6.48[2]	01	0.772	High
Center-West	Goiás	Goiânia	1,393,575	5.68[2]	01	0.799	High
		Brazabantes	3,444	0.3[3]	01	0.701	High
Southeast	Espírito Santo	Domingos Martins	34,059	1.08[3]	01	0.669	Medium
		Iúna	29,258	1.08[3]	01	0.666	Medium
		Serra	467,318	2.31[3]	01	0.739	High
		Vitória	348,268	11.90[2]	01	0.845	Very high
	Minas Gerais	Governador Valadares	275,568	2.31[3]	02	0.727	High
	Rio de Janeiro	Rio de Janeiro	6,429,923	6.28[2]	03	0.799	High
		Maricá	139,552	2.31[3]	01	0.765	High
	São Paulo	Campinas	1,144,862	4.35[3]	02	0.805	Very high
		Penápolis	61,371	1.77[3]	01	0.759	High
		São Paulo	11,821,873	4.65[2]	03	0.805	Very high
South	Paraná	Curitiba	1,848,946	5.81[2]	03	0.823	Very high
		Inajá	3,100	0.28[3]	01	0.705	High
		Ponta Grossa	331,084	2.33[3]	02	0.763	High
	Rio Grande do Sul	Guaíba	98,688	1.42[3]	01	0.730	High
		Novo Hamburgo	247,781	2.33[3]	01	0.747	High 0,799)
		Porto Alegre	1,467,816	8.9[2]	04	0.805	Very high
		São Leopoldo	225,520	2.33[3]	02	0.733	High

Sources: 1. Estimated population of Brazilian municipalities (IBGE, 2013); 2. Distribution of doctors, according to capital cities and regions – Brazil, 2014; Scheffer M. et al., Medical Demography in Brazil2015; 3. Distribution of doctors, according to municipalities, population groups, and regions – Brazil, 2014; Scheffer M. et al., MedicalDemographyinBrazil2015.

In relation to the numbers above, it should be pointed out that 26.9% of Brazilian doctors work in the private sector, while only 21.6% work in the public health network. Also, over half of the doctors in the public sector (51.5% of 21.6%) work only in public hospitals and do not provide services at the Basic Health Units (BHU). Consequently, when the total number of doctors from public and private networks are grouped, the indicator relative to the number of doctors/1,000 inhabitants does not reflect the precarious situation of available healthcare professionals in certain peripheral areas, where the population relies almost exclusively on the public network. Having said that, the analysis of the doctors' reports included in this paper refers exclusively to the reality of urban peripheries.

The reports in this study reveal that the Cuban doctors did not limit their practices to professional issues; there is evidence of social integration processes. Sociology defines integration as a process where an individual builds and keeps social bonds of inter-dependency, and actively participates in the social fabric[3]. This means that these individuals are not only integrated into society but that society itself is integrated (SCHNAPPER, 1996; KHELLIL, 2008; PIRES, 2012). However, integrative processes are uneven and greatly depend on each individual's economic and cultural capital, which immigrants may not have. (SIMON, 1999; SAYAD, 1999, 2006; WIEVIORKA, 2008). As a result, integration processes have been analyzed as a second generation phenomenon (PORTES & RUMBAUT, 2001; PORTES, 2008).

On the other hand, the integrative processes of immigrants in the host country are usually conceived and formulated in national terms. Governments and authorities establish integration policies for individuals or migrant groups with projects involving definitive settlement. (COHEN, 1999). In this study, although they arrived in Brazil with a reasonable knowledge of Portuguese and of Brazilian society, the Cuban doctors did not anticipate a lasting social integration[4].Their socio-professional insertion was governed by previously defined and well-known work contracts, and their average permanence time in the country was only 27 months[5]. Therefore, we are not (or should not be) discussing classic processes of social integration, nor the assimilation or acculturation of the dominant values of the destination societies, as analyzed in the works of Gordon (1964),Glazer&Moyniham(1970),Alba &Nee (1997) or Todd(1994).

Despite the factors that regulate their presence and professional practice in Brazil, the Cuban doctors' life experiences and reports show a variety of integration processes, from psychological adaptation (WARD, 2001) to cultural interactions (ALAMINOS & SANTACREU, 2011), which are not very usual among immigrant populations. The hypothesis is that Cuban doctors incorporated the *habitus* and accumulated *capital,* in the sense that Bourdieu (1972, 2015, 2016) attributed to these terms, specific for migratory processes, since during their qualification, they already expected to work in other countries. This *immigrant habitus*, would allow them, after their international experience, to gain a certain *mobility capital*, which would permit them to integrate better and faster into other societies or in situations similar to those demonstrated by Oliveira & Kulaitis (2017) in their analysis of Brazilian immigrants in Canada and Haitians in Brazil.

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3 It is worth mentioning, however, that the literature on the concept of integration in the field of Social Sciences is vast and not necessarily consensual (HAMMAR & LITHMAN, 1989).

4 This perspective implies establishing reception and integration contracts, such as the ones in France, for example. For further details, please see Aloui (2014).

5 The Cuban doctors started residing in Brazil in a temporal migration framework, qualified and organized by both countries. According to Law 12,871 (Oct 23, 2013), Cuban doctors are classified as "Exchange doctors", with the purpose of medical improvement, and hold a 3-year temporary visa, renewable for 3 more years. For further details, please see MORENO & VEDOVA- TO (2015).

In fact, the reports provided by the doctors make reference to a range of situations and general work conditions, from small discoveries, learnings, hardships and positive surprises, to the establishment of new modes of sociability that go beyond the formal doctor-patient professional relationship. Consequently, there were situations of socio-professional interactions, learning, and experience sharing (especially with nurses and community health agents), as well as the partaking of social values, cultural practices and socio-affective interactions[6] , including the establishment of romantic relationships and marriages, and the desire of both doctors and ordinary citizens to extend their time of permanence in Brazil[7] . The observed situation questions the current literature on migratory studies, especially because, as previously mentioned, this is not an immigrant population in the strict sense of the term; they are qualified migrants[8], with a temporary work contract.

In order to analyze the set of perceived integrative processes, the reports and situations described by the doctors were classified[9] into three axes: a) socio-professional integration processes specifically linked to the work place; b) community integration processes, with the participation in community life and eventual establishment of socio-affective bonds; and c) socio- cultural integration in situations where there is evidence of Cubans and Brazilians sharing values and cultural practices. In these axes, we attempt to highlight similarities and differences as a result of the size of urban areas, demographic diversity, economic and cultural issues, and municipal human development index (HDI-M). In brief, we attempt, as much as possible, to observe the impact of the previous migratory and professional experience on the integrative processes. The conclusion of this chapter lists the elements that were barriers to the integrative process (especially urban violence) as well as those that facilitated it, such as the linguistic and cultural proximity between Brazil and Cuba.

Integration Processes in the Peripheries

At the origin of socio-professional, socio-cultural, and community integration processes, we find the daily presence of Cuban doctors in the Basic Health Units; their qualification and medical practice; the 32-hour work week; the large number of patients assisted daily; and the need for team work. On the other hand, the negative images broadcast by the media regarding their reception in Brazil and urban violence hindered these processes.

Socio professional Integration

The Basic Health Unit (BHU) was the main space for these Cubans' interactions with part of the Brazilian society, formed by healthcare teams and patients. In this arena, the interaction process was strongly influenced by the types of bonds built with the local work team, usually formed by a doctor, a nurse, a nurse's aide, a dental surgeon, an oral health aide, and community health agents.

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6 According to Blumer(1937),social interactions are situations of contact where the acts are communicated almost instantaneously. These acts are mediated through gestures and words, whose meanings are interpreted by both parties at the very time of the social action. The term "symbolic interaction" is also used, that is, an interaction that is meaningful.

7 The country does not yet have an integration policy for immigrants and only recently did it approve the new Immigration Law (13.445, dated 27/05/2017). Actually, CNIg (National Immigration Council) has been in charge of managing the migratory issue.

8 They are not spontaneous or economic immigrants; rather, they are professionals who have been hired by the Brazilian State.

9 This classification results from the analysis of significant topics (captured in the form of "we" by software NVivo®) which rose from the interviews conducted during the field survey.

The professional activity in urban peripheries varied according to some learning factors, such as familiarity with the National Policy for Primary Care; reference and counter-reference systems; BHU's medical charts and protocols; the reception process and the professional environment (in relation to healthcare teams); and the daily medical practice. Other factors also impacted the process: BHU's infrastructure, size of municipality, and HDI- M.

Upon arrival at the work place, the Cuban doctors were, in general, very well received by local health secretaries and municipal managers, as well as by healthcare professionals. In small and medium- sized cities with a shortage of doctors in primary care, the reception was warmer, with managers often offering their own or a family member's house to accommodate them. Thus, social interactions started and, little by little, turned into real integrative processes, as shown in the reports below:

> *In those days, the first contact was the health secretary, a humble and very welcoming person, really nice! To me, it was wonderful! Then it felt like being home with the way he acted; so I felt calm, reception was amazing; there was no specific time to talk to him, any time I wanted, whenever I wanted, any problem I had, there he was, ready to receive me, and, in this manner, things evolved (A.G.D, Inajá-PR, 2 years and 8 months with the MDP).*

> *When I arrived in Brazil, I was sent to Brazabantes, and ever since I got here, I've had a great reception, attention, lots of care and solidarity. Initially, I lived with the health secretary's mother and, when they found a house where I could live on my own, I decided to continue residing with my health secretary's mother, who is elderly; and I lived with her all the time I was there (L.A.L, Brazabantes-GO, 2 years and 5 months with the MDP).*

The behavior of managers and healthcare teams correspond to the type of traditional, friendly and warm relationship that exists in Brazilian small cities. In larger cities, however, reception and professional co-existence depended more strongly on the local administrative structures. In fact, some of the main problems reported, suchas lack of information and poor management skills, as well as little interest in public issues, are more connected to the More Doctors Program management, as can be seen in the reports of the doctors who settled in Santo Antonio de Jesus (BA) and Governador Valadares (MG):

> *When I arrived, it was very late at night, and the first thing that drew my attention was the reception I got. A nurse from the secretariat came to fetch me in Salvador. The first impression was not good. When wear rived in Valência at around half past ten or eleven o´clock, they took us to a nice hotel, but when we got there, they said that was not the place. Then, we returned with our luggage and they took us to an inn at the entrance to a gas station. When morning broke, I saw where I was. It was shocked, not exactly by the accommodation, because I can sleep anywhere, but because the Health Secretary had given us a really bad reception. My co-worker talked to Luís, saying she wanted to go home. She had a nervous breakdown. Seven days after my co-worker left, the Ministry of Health came for us. They did not want Cuban doctors;*

they said that they had not asked for so many doctors. (L.C.K.A, Santo Antônio de Jesus-BA, 2 years and 6 months with the MDP).

Here in Governador Valadares the contact with the city hall was awful, awful. It is still bad. So, we [arrived], they took us to an inn. Very far. It was terrible, terrible. And they said, "you have a week to find a place to rent and leave the inn." It was really sad. The mayor, for example, we only saw her once. Never saw her again while I was there! We asked the Health Secretary for a written document. He stalled and it took a long time for him to receive us (L.T.A, Governador Valadares-MG, 2 years and 4 months with the MDP).

Some of these problems – reception and socio-professional co-existence – may have been due to the way some of the media (newspapers and television programs) presented the MDP, promoting preconceived and negative views. In some places, there were insults or reservations towards Cuban doctors, particularly regarding their professional skills. Reports of discrimination[10] from healthcare professionals and patients were also observed and broadcast in several cities, regardless of their size or regional location.

[...] what the media says about us, that we are not doctors. [...] that we don't have a graduate degree. Another day, a woman came here to insult me and she insulted me over and over because I had written a sick note for her and she works cleaning up for a couple of doctors. And she told me that when she got there with the sick note, they started saying that "how come you talk to someone who is not a doctor?" They began to say that we are not doctors, that we are not authorized to do this, and they didn't want to accept the sick note. The woman had suspected dengue. (F.A, Campinas-SP, 9 months with the MDP).

I'm going to tell you how a sad event happened. We have an opponent who is a doctor. As an opponent, he has forgotten that I am a human being. So, he posted on Facebook that we are fake doctors. He started bad-mouthing us, without knowing us. Then the population... That´s the first thing I heard from the population. So, it got very complicated for me (A.G.D, Inaja-PR, 2 years and 8 months with the MDP).

You refer a patient to the hospital, and the doctor who receives the patient at the hospital, when he sees it is a referral from the More Doctors Program, [referred] by a Cuban, he starts to say nonsense."Ah, Cubans know nothing. Nurses know more than him".You have to prove your worth. Let him talk. I did the right thing. (R.A. São Leopoldo-RS, 2 years and 7 months with the MDP).

More specifically, the professional activity depended on learning about SUS's protocols and reference and counter-reference systems, and on adapting to the routine of Brazilian Basic Care.

[10] See, for example, an article at https://massanews.com/noticias/plantao/policia-investiga-preconceito-contra-medicos-cuba- nos-em--pg- 1qOOX.html. Accessed on September 12, 2017.

> *It was really hard to start using a health system that is different from ours, and the language, which is difficult in the beginning; everything is documented here, lots of protocols, and it is complicated to do things you were not used to doing before, provide care you didn't use to, diseases, follow-up, certain things; because in Cuba we have the support of different specialists and these appointments with specialists happen very fast, and here, sometimes it takes a long time. So we have to do things that were done by specialists there* (O.L, *Porto Alegre-RS, 2 years and 8 months with the MDP).*

In larger cities, learning difficulties were partly compensated by greater access to the internet.

> *I access the internet and I study about some doubts I may have, about medicines that I don´t know or that I am unsure about (J.M.M.V, Rio de Janeiro-RJ, 2 years and 5 months with the MDP).*

Overcoming these initial barriers suggests the importance of professional experience: an average of around 20 years for the Cuban doctor. However, the factors that effectively favored the socio professional integration process were the reception they received and the relationship between Cuban doctors and healthcare teams. In all the cities of the study, professional relationship was facilitated by their daily presence atthe BHUs and by the need to work together with Community Health Agents (CHA).

> *Working is what makes me feel better in Brazil [..] we spend more hours at the health center than at home; this is our home. I get on well with everyone here. The best possible nurses and the healthcare workers, see, we all share everything! We almost always have lunch together. (F.A.R.T, Campinas-SP, 1 year and 7 months with the MDP).*

Collaboration with one or more members of the healthcare team, especially the nurses, was absolutely necessary for the smooth progress of the professional activities. Therefore, their relationship with nurses became the first indicator of socio-professional integration:

> *On the first workday, I often had to resort to the nurse, who really helped me. At first, because when I arrived she said that any doubt I had in relation to work or to procedures [I could call her]. She really helped me, because I asked about everything and she would help me fill out the chart, write everything correctly, showed where to inform data, where to checkmark. (A.V.C, Caapora-PB, 7 months with the MDP).*

Cuban doctor with the CHAs, member of the research team, and PAHO's supervisor em Paraíba.

When I arrived here, there was this other nurse who was pregnant. When I got back from vacation, she was on maternity leave and I felt a great affinity with this girl, and little by little, she has helped me because she is such a good person. I've met her mother, sister, children, husband, the whole [family] (L.C.K.A, Santo Antonio de Jesus-Ba, 2 years and 6 months with the MDP).

My introduction to Brazilian society occurred through this healthcare agent. She said I could go to her house on weekends to do my laundry. And that's how it all started. She makes Cuban food and teaches me some things. When I arrived, she introduced me to her family,and in the beginning, her family was my support group. Before I met other people and made friends (N.M.E.C, Vitoria-ES, 2 years and 5 months with the MDP).

Confirming the main theories on this topic, the core variable for Cuban integration was the work place (PORTES, 1981, 1995; PAUGAM, 1996, 2014; DEWITTE, 1999). On the other hand, and unexpectedly, the need to learn about Brazilian medical practice created mutual integrative processes, that is, it worked for the healthcare professionals of both countries. Specialized literature provides few instances of this type of reciprocity, which may be due to the specificity of the required teamwork as well as the very nature of the medical practice.

Our doctors have learned a lot here; we have brought nurses from Cuba to see these practices, such as basic nursing care. The work here is excellent. The experience with community health agents is really good because it is different in Cuba; there are other types of organized work there. It involves a little more work, but, basically, we have to recognize that the basic care activities and the healthcare team here in Brazil have really helped doctors to take this experience to Cuba (V.E.P, Curitiba-PR, 2 years and 4 months with the MDP).

Interactions with the health teams facilitated the acquisition of regional expressions[11],one of the most cited barriers for doctors in small cities with a population of low-income families.

[11] For an in-depth discussion about the learning of a language as a form of knowledge, please see ANÇA (2004), CABETE (2010) and BERNARDO (2016).

The worst thing was the language! Because you learn a language, but when you to talk to people, things change a little. You go to other cities and things continue to change. You hear a word and wonder.. what is this? I didn't understand a word! Some speak too fast, others too slow, others use dialects, and then you… go through everything again! That's why I asked the nurse to stay, because there are patients like that and you don´t understand anything! It is a dialect I know nothing about (T.U.S, Iuna-ES, 2 years with the MDP).

In Espírito Santo,I could understand everything, but here – and I am not referring to high-income populations, Iam talking about the community – there are many words that I don´t understand, that are unique to Bahia (L.C.K,Santo Antônio de Jesus- BA, 2 years and 6 months with the MDP).

After overcoming communication problems, gaining familiarity with assistance protocols, and beginning the interaction processes with health teams, the Cuban doctors stated that the quality of the HBU's infrastructure did not represent a barrier. On the contrary, in some cases, this shortcoming contributed positively to reinforce professional interactions.

My unit is not as new as Vera's, but it is in good condition. Teams have their own offices, my team is complete, very tight, very good. We work well together. The community health agents are really good. I have six micro areas under my responsibility, and well-prepared nurses. I like my job there, I have a good relationship with the Cuban doctor, the Brazilian doctors, the nurses, and the managers (J.M.M.V, Rio de Janeiro-RJ, 2 years and 5 months with the MDP).

Health Unit in Rio de Janeiro

I don't really like the structure of the place... it is a difficult neighborhood, Coronel Cláudio, one of the most difficult neighborhoods here in Ponta Grossa, with certain social characteristics, but we get on well with the work team (M.A.F, Ponta Grossa-PR, 2 years and 4 months with the MDP).

On the other hand, violence in some urban peripheries, especially situations of shootings or "war", curbed professional activities and inhibited more extensive integrative processes, as reported in the cities of Rio de Janeiro, Sao Luís do Maranhão, and Vitória.

> *Working here was a unique experience because it was the first time in my whole life that this happened to me! And it is still difficult. When I hear a shot, my legs shake, my hands start to sweat, and I can´t concentrate on what I am doing anymore. The clinic is located in this weird place on the top of a hill, and when it is time to catch the bus I find myself in the middle of a crossfire between criminals and the police (G.C.L,Rio deJaneiro- RJ (Complexo do Alemão), 4 months with the MDP)*

View of the Complexo do Alemão from the cable car – the Cuban doctor's daily trip to work.

> *Last year a fight broke out in a nearby region, exactly on the day the World Cup started and lasted until last year; it lasted one year. I never have seen anything, but I heard the shooting. Then, everybody started running to close the unit and, twice, we received people with bullet wounds. But I never witnessed anything myself (N.M.E.C, Vitoria-ES, 2 years and 5 months with the MDP).*

> *For example, in May last year, you couldn´t go out to visit patients, make house calls, because there was a conflict between the parties and they had sent [...] to expel [the people] from one neighborhood, one community. Then the police arrived and we couldn´t risk to get in the middle of the conflict; we could be in the crossfire. That month, production declined so much that I didn't see more than 120 patients. I usually see 300 (J.L.C, São Luis do Maranhão-MA, 2 years and 8 months with the MDP).*

In order to overcome some of these problems, the Cuban doctors proposed changes in the work processes of the BHU's healthcare teams, thus maximizing their socio-professional integration.

> *[...] I changed the team meeting because the team meeting was usually about administrative stuff (just for the record); I changed the concept of the team meeting*

into a scientific meeting: discuss a health case of a complex family. I always talk about some topic [...], or ask a health community agent [to present] some theme, or have a physical activity [for example]. We get to qualify the team. It is very good! Then, the pediatrician presents something (F.A.R.T,Campinas- SP, 1 year and 7 months with the MDP).

The system is to blame; it has always forced them to do it. Because they are used [...] 'I want a cervical examination, I want to see the gynecologist' [...] I can do it, prescribe a prevention method or make an intravaginal ultrasound or prescribe tests, evaluate whether there is some problem I cannot solve, and then refer [the patient] to a specialist. But they were not used to this. They were used to getting there and having an appointment [with the specialist]. Weare changing this(J.L.C, São Luis do Maranhão-MA, 2 years and 8 months with the MDP).

Two other situations should be highlighted. First, the migratory-professional experience of Cuban doctors who are trained to work in any country. In fact, many of them had been to Venezuela and Bolivia (GOMBATA, 2016). This may explain their rapid adaptation and socio-professional integration, confirming Oliveira & Kulaitis's analysis (2017).

Cuba prepares us to go to anywhere in the world that needs medical attention. Not only Brazil or any other specific country. Our training enables us to go to any country in the world.(L.B.B.P,Maricá-RJ,2years and 5 months with the MDP)

We need to say that we left Cuba first because of our convictions, because this is how we are, ever since we graduate. We have this belief in helping others, of leaving, learning, and taking healthcare to other places, knowing that they don´t have doctors. We are calm because when we left Cuba, we left with the idea that we had to work in remote places, that we might have to work in places full of silence, as you say, like the Amazon, and we prepared ourselves to work in these places. (R.A, São Leopoldo-RS, 2 years and 7 months with the MDP).

Secondly, Cuban doctors also counted with the presence and support of other Cuban doctors, especially in large urban centers.

We are five doctors, all Cuban. Two live in Itaquera and the other in Lapa. And on the weekends, the other two come here or we go there and we always go out together on weekends (M.S, Sao Paulo- SP, 2 years and 9 months with the MDP).

Here we are a little bit of the island (sic), there is the boys' house where Gabriel lives, there are four of them. In total, we are eight. We do things together, carnival together, New Year together, Christmas together, birthdays together (J.M.M.V, Rio de Janeiro-RJ, 2 years and 5 months with the MDP).

Cuban doctors working in Rio de Janeiro with a member of the project's team.

Bonding and co-existing, celebrating Cuban holidays, birthdays, and New Year together, for example, or doing errands, shopping or touring around the city in groups, these Cuban doctors found, in Brazil, some of their own personal and cultural references. Although it is hard to state with precision, we may be witnessing an embrionary process of the establishment of a network of immigrant Cuban doctors, which, in an inverse way, may also facilitate integration and lead to the development of the so-called multicultural citizenship (KLIMCKA, 2001; WEBER, 2004; DOYTCHEVA, 2011).

In conclusion, the fast professional integration processes of Cuban doctors with their Brazilian counterparts, regardless of the size of the city or of their Human Development Index, seemed to stem from social interactions that occurred as a result of three main factors: the specific Cuban medical practice, a full-time work week (32 hours weekly), and an intense relationship with the local healthcare team. This created an atmosphere and rapport favorable to the exchange of experiences and professional learning, to interactions with the community, and to the development of affective bonds (especially with the nurses and CHAs). The process was also facilitated by the socio cultural similarities between Brazil and Cuba, as we will see later in this article[12].

Community integration

The community integration analysis was based on the criteria of approximation to patients and Cuban doctors' participation in local activities, festivities and local gatherings, as well as social, festive and religious meetings, in general. Initially, this integration into the community's events seem to have been due to the type of medical practice (humanistic approach, ample time for appointments, health promotion activities, and house calls) and physical proximity. This would have promoted frequent contacts with the community's patients.

The relationship with the community varied according to the size of the cities. In large cities, where commuting to and from work is rougher and lifestyles are more individualized, the doctors' reports indicate less contact with the community. On the other hand, in small and medium-sized cities, the establishment of relationships

[12] See, for example the documentary: *FACCe CUFA. Vida sem Fronteiras2017.* Available at https://www.youtube.com/watch?v=zDMB- 8DA-A1zc Accessed on September 24, 2017

with neighbors or around the BHU's surroundings was more immediate, frequent and closer. In all the situations above, social co-existence depended, initially, on the type of reception and community solidarity and, later, on the friendship and affective bonds that were eventually built.

An example is what occurred in small towns when the Cuban doctors arrived. Many towns organized social events to receive them, including parades around town so that all inhabitants would kno w about their arrival and be able to recognize them in other daily activities unrelated to their work. In some places, ordinary citizens spontaneously offered to help with their daily chores. As a result, some of these doctors embraced the communities because of the warm reception and homages paid by local authorities (e.g. title of honorary citizen, as a recognition of the quality of the services rendered).

> *When we arrived here in Porto Alegre, at the airport ... a very warm reception with the flags of Cuba and Brazil, white and red roses, and people singing Guantanamera, a typical Cuban song. It was beautiful. (M.C.M.S, Guaíba-RS, 2 years and 7 months with the MDP).*

> *I became an honorary citizen of the municipality [...] everyone liked the way I worked. Actually, I am happy because, to tell you the truth, I didn't do anything extraordinary. I just did what I usually do. And will continue to do because it's my way of working. And then, I was actually surprised, my heart filled with joy and gave me more energy to continue working, because this recognition was the best thing that ever happened to me. There was no money, no salary raise, but the recognition of our work. (A.G.D, Inaja-PR, 2 years and 8 months with the MDP).*

> *They are really solidary with us; they want to help. Some of them with a profit, but they are very solidary, at least the ones I lived with here, even when I went shopping, I always had help. Very solidary and very kind. I remember we had a meeting in Cuba with this Brazilian guy, Marcelo, and he always said that we would see how Brazilians are. And that's how Brazilians are, and I'll always remember those words, because it was like this with me. I feel integrated, I haven't experienced any rejection. I am at home, watching TV and they invite me over for a meal (L.A, Brazabantes-GO, 2 years and 5 months with the MDP).*

After their reception (festive or not) and accommodation, the interviewed doctors got closer to patients and listened to them, a professional behavior that was initially seen with suspicion by patients.

Position of patient's chair next to the doctor. Fixed in this position.

At first they were terrified; they thought we got too close, because they were used to having a barrier between the doctor [and them]. Now, they arrive and come directly here and sit next to me (O.L, Porto Alegre-RS, 2 years and 10 months with the MDP).

In the past, the patient's chair would be positioned across from the doctor and, in my country, we place it next to us so that the patient gets closer. For them, this was good. They even told us about this difference when they compared us to Brazilian doctors (O.A.T, Porto Alegre-RS, 2 years and 7 months with the MDP).

In Cuba, according to their reports, this close relationship between Cuban doctors and patients is usual practice. Some doctors explain it:

A house call at the Complexo do Alemão Commun.

> *We are trained to help, [to provide] humanitarian assistance, since the beginning of our education, because the first studies were always [...] and now, those that are studying in Cuba have this mission (C.D.A, Jequié-BA, 2 years and 4 months with the MDP).*

> *Normally, we are here to alleviate pain, whether it is physical or spiritual. We are not God; we just need to be good people. If you don´t see the other like you see yourself, you are not good at what you are doing. So, if someone comes in pain and you don´t know what's causing it, you must try to find out! The solution is not to stop the pain now; it is to erase the origin of that pain. It is pointless to prescribe Buscopan now because the pain will return and I need to know why it hurts. (I.J.A, Feira de Santana-BA, 2 years and 8 months with the MDP).*

This kind of medical practice was also explained by the pillars of Cuban medicine.

> *You see, our appointments are a little different. We like to talk more with patients, to ask, to examine, to listen, and they like this. At first, they felt the difference because they were used to Brazilian doctors. When they come, we like to ask them how old they are, their names, where it hurts, does it hurt here and not there; to be close*

to them, listen, measure their heartbeats, their heart rate, and they begin to like it (L.C.K.A, Santo Antônio de Jesus-BA, 2 years and 6 months with the MDP).

Thus, little by little, this care (listening and touching, for example) and the close humanistic attention provided by Cuban doctors were evaluated very positively, mainly when compared to Brazilian doctors' practices.

As they say:" you treat us as people. Everyone has the right to that because we are all people and no one is better than the other". (I.J.A, Feira de Santana-BA, 2 years and 8 months with the MDP.)

House calls were also crucial to promote approximation to and interaction between Cuban doctors and community members. Some of the interviewees stated having heard from their patients that, for the first time, they had had a visit from a doctor, one who even shook their hands and stood close to them. This interaction, new to some Brazilian patients, was observed and explained as an example of current and usual practice of Cuban medicine. The example below illustrates this point well:

Cuban doctor and this health te arriving for a house call.

I make house calls. Sometimes the Secretariat helps with a car, once or twice a month. So, sometimes I walk and I like it because you interact with the community on the way, right? And you get to know community things which you wouldn´t know if you stayed in the unit: where a bar is located, where people gather to drink early in the morning, that person who comes to the unit and says that he doesn't drink, but you see him every day there at the bar. And you get to know the culture... interacting is really good. And visiting a patient at his own house… when the patient is sick, there is nothing better for a bedridden patient, one with some kind of disability, who is sick, at home; there is nothing better for that patient or his family (R.A. São Leopoldo-RS, 2 years and 7 months with the MDP).

This professional behavior approximated doctors and communities, even when conditions were adverse. This willingness on the part of the doctors was recognized by the communities.

I remember that last year, at the end of last year, there was a heavy rainfall and everything got flooded […] then I went there and made a house call and left with my shoes covered with mud. When I got there they even said, "Doctor are you going through that?" and I told them "Yes, I'm going to walk through that. How could I not?" And you see the people that live there, who walk through those places. Do I have something they don't or do they have something I don't? "No, sir, I am a person, a human being like everyone here. If you can walk through this, I can as well. And if needed, I will find another way, I will walk there." And everyone was […] and I got my shoes covered with mud, but it was okay (O.L, Porto Alegre-RS, 2 years and 8 months with the MDP).

From this moment on, the approximation produced unusual integration processes.

Patients will tell us things they had never talked about to anyone, intimate stuff, about their sex life, if they were satisfied or not. You can talk about these things, not before. Previously, I would arrive unexpectedly, you say 'papapapapa'. Now, they come here just to sit and talk (J.L.C, São Luís-MA, 2 years and 8 months with the MDP).

Patient receiving a Cuban doctor for a house call.

Coherently with their professional mission and supported by the legislation, the Cuban doctors also developed other activities such as health promotion and education, activities for groups of teenagers, pregnant women, smokers, hypertensive people, people with diabetes, and the elderly, among others. These activities also contributed to their integration into the communities.

Our team works together according to protocol. We have appointments and follow-ups for chronic diseases, pre-natal, child care, free demands, house calls, seminars at schools… according to the program. For example, men's health, women's health. We give speeches outside our work hours. And then, for example, the blue August for men, and the pink September for women (A.G.D, Inajá-PR, 2 years and 8 months with the MDP).

Basically it is healthcare, but we try to make speeches, have team meetings, use the waiting room to talk about a health education issue. But it is a process that needs to be cyclic, constant. It is useless to do it today and not tomorrow (I.J.A, Feira de Santana-BA, 2 years and 8 months with the MDP).

It is important to insist that the trigger for community integration was the Cuban doctors' medical practice of proximity and their physical presence in the region. As analyzed in relation to socio- professional integrative processes, the Cuban typical medical practice causes, sustains, and explains the success of these disseminated integrative processes.

We chat with everyone who is there. There are people of all ages: my age, younger, older. The doctors, dentists, those who work for the city hall or work in a bar (sic). Everyone there, together. Then we go [...] to the gym. And we stay there for 2 or 2 and half hours (A.G.D, Inajá- PR, 2 years and 8 months with the MDP)

In situations where this did not occur – when the Cuban doctor was not very social or professionally recognized, becoming just one more resident in the neighborhood –, community integration processes simply did not happen.

I've never felt so miserable in the world as in this country, which is supposed to be the happiest in the world, this one. The relationship among people. You live in a condominium; nobody talks to you. Nobody says anything. In Cuba, if you are 3 blocks away from my house and you ask for me, everyone knows who I am, you see? So, it was a shock. You spend three years living someplace and your next door neighbor doesn't know you.(J.R .,São Luís do Maranhão-MA, 2 years and 10 months with the MDP).

I can only talk about here. No one knows me, people don't talk to each other, you come into your house through a gate and a wall and your life is inside them and nobody knows one another. This is really shocking because Cuban people are very receptive, they know everyone in the neighborhood. They come to my mother's house and have coffee with the neighbor across the street. [Here] neighbors don't know me because I leave early for work, work all day and on the weekend, I go to a farm ranch (Y.A, Penápolis-SP, 2 years with the MDP).

This type of integration would have been more intense if the doctors had had a smaller number of appointments, less strict protocols and a lighter workload.

I don´t know why, but it is very bureaucratic here. Family health has several follow-ups and here at the Health Unit, you can´t have health promotion and prevention activities. You don't have time! I see twenty patients in the morning and twenty in the afternoon (Y.A, Penápolis-SP,2 years with the MDP).

Despite all this, house calls and health promotion activities produced new developments such as, for example, improvements in healthcare. In other words, the personal relationships that arose from the Cuban medical practices, promoted more interactions and led to better healthcare.

> *The attention we give them, when we listen to them. Patients need to be heard and we listen. It is not just prescribing; we listen to their problems because, sometimes, a social problem with their families may be affecting the disease. This is one of our principles: listening to the patient (Y.M.F, Goiânia-GO, 2 years and 1 month with the MDP).*

It is hard to say whether the professional behavior of the Cuban doctors and the reported integrative processes were sufficient to erase the negative images broadcast by the media. It is certain, however, that the daily contact with the community produced surprising situations of help and friendship, including the patients' desire for doctors to reside permanently, especially in small cities.

> *I'm supposed to go to Cuba in October and, as I've told you, there are patients who say they "are praying to Saint Anthony for you to stay!". Sometimes they come to my house, if they need something, even on weekends, and it is going to take a long time… then they come with this possibility, they call us and we find a solution. There are no barriers (D.C.O, Macapá-AP, 2 years and 11 months with the MDP).*

> *Yes, they bring chickens because they know we have lunch there. They give us pumpkins, fruit, stuff. They make lunch or take lunch to the Unit for us(I.J.A,Feira de Santana-BA,2 years and 8 months with the MDP).*

The variety of co-existence and friendship relations may be at the origin of the deepest form of integration: the establishment of lasting affective bonds.

> *They really like me. They say I am well liked and "Oh, Doctor. I talked with my niece, my neighbor." "Oh, my wife really likes you. I am also here for an appointment with you." And they are getting sadder and sadder because they know I am leaving (M.C.M.S, Guaíba-RS, 2 years and 7 months with the MDP).*

This type of close bond, built in such a short period was, in fact, the main surprise and the greatest novelty in the community co-existence process. Indeed, romantic relationships and marriages are evidence of the extent of these interactions (BOZON & HÉRAN, 2006). The study found at least five cases of Cuban doctors who married Brazilian citizens.

> *My friend introduced me to Tinder [application]. She met her current boyfriend through Tinder. Then she started, and I got interested. This is good, we are going tomeetsomeone. Makea friend and,whok nows, start dating? Okay. Ilearned about the app, she told me how it worked, and within a few days, I met Maurício. (N.M.E.C, Vitória-ES, 2 years and 5 months with the MDP).*

And from then on we started a relationship which got stronger and stronger. She traveled [to Cuba] with me on my first vacation. I didn't have an immigration permit, but she went there, liked it, and my family got on very well with her. She can understand [the language] now and keeps in touch with my family and my daughter through the internet, e-mail or Facebook. She has learned Spanish (R.A,São Leopoldo-RS, 2 years and 7 months with the MDP).

We got married here, but I wanted my mom and dad to be with us for the photos, but my mom and dad were not here. So, I told my husband, "Look, we have to get married here and legalize it in Cuba as well, but I want our wedding party to be there", and he said "That's okay, you're the one who will decide: if you want the party there, it will be there." So, we got married, but the big wedding reception was there (A.V.I, Novo Hamburgo-RS, 2 years and 7 months with the MDP)

In short, it is possible to state that the inter-relationship between a humanistic and close medical practice, along with health promotion activities and house calls, are at the basis of community integration. However, these factors, which explain the deep relationship bonds achieved, may also have a socio-cultural component, as we will see next.

Social-Cultural Integration

The Cuban doctors' professional activities in Brazilian municipalities were intense, with a variety of demands, such as learning the protocols and reference systems, working long hours, seeing a large number of patients, developing health promotion activities, and visiting families.

The combination of all these chores explains the great proximity of Cuban doctors with the health teams, patients and communities. Supported by this routine and the nature of medical practice, social interactions ranged from professional exchange of experiences to personal invitations to various meetings and festivities. The negative images of the MDP and the situations of violence in some of the larger cities hindered the integration of these doctors into Brazilian society. However, the intensity of professional and community relationships, and the development of affective bonds and romantic relationships were unexpectedly surprising, especially when you take into consideration the time of permanence in the various places. How to explain the variety of integration processes?

Caribbean sociability has been mentioned in this paper as a socio-cultural integration factor. Thus, would the Cuban doctors' openness and sociability be able to partially explain the integration process? The reports below point to that direction.

Cubans are more sociable; not that Brazilians are unfriendly, but Cubans are more open (M.B.T, Cabedelo-PB, 1 year and 5 months with the MDP).

We, Cubans, are friendlier, we visit more, we interact more with one another. A Cuban's problem is everyone's problem. Not here (Y.M.F, Goiânia-GO, 2 years and 1 month with the MDP).

If I am invited to go to a waterfall, to a restaurant for lunch or dinner, I will go and take my co-workers. I have so many friends that sometimes I don´t know how to divide myself. I accept all invitations: to tea, to a wedding, and to Church. (T.U.S, Iuna-ES, 2 years with the MDP).

Two other previously mentioned factors were involved in this sociability: The Latin -American feeling of proximity between Cuba and Brazil and the recognition that Cuban doctors and Brazilians share some cultural aspects, mainly in the field of music.

I believe the only thing that changes is the language. But the origin is the same: Portuguese and Spanish colonies, both European countries. Then, we blended, in Cuba there were no indigenous populations, but they brought Africans like here. Your religion is a mixture, like ours. It is catholic [mixed] with African religions. The spiritualists, the candomblé, we have that too. At least in Bahia, it is like that. Bahian people are great; they are very outgoing. It is different. (I.J.A, Feira de Santana-BA, 2 years and 8 months with the MDP).

Some of Brazilian popular singers that are still very well liked, very famous in Cuba are Roberto Carlos and Nelson Ned. But others have visited Cuba: Caetano Veloso, Chico Buarque. In Cuba, Michel Teló and his song "Ai, se eu te pego" are also very popular. Alexandre Pires too; they like him a lot. Alexandre Pires sells many CDs and DVDs in Spanish (R.A,SãoLeopoldo-RS,2years and 7 months with the MDP).

It should also be pointed out how the time dedicated to watching TV and soap operas (leisure activities), was also fundamental for Cuban doctors to acquire knowledge about Brazilian culture and promote sociocultural adaptation.

I like to stay home and I love watching TV, I love soap operas, like "Regras do Jogo". "Império" was also spectacular. Ireally enjoy Brazilian soapoperas and watch them every day (L.B.B.P, Maricá-RJ, 2 years and 5 months with the MDP)

Given the diverse history and culture around Brazil, the proximity was greater in certain regions, such as Bahia, and the differences were highlighted in others, as in Paraná.

Bahian and Cuban people are very similar. The only difference is the language. In Cuba, I live in the eastern side of the country. The eastern region is very similar to Bahia, because that is where the slaves were brought in. So, the population is more mixed, a blend of whites and blacks. It looks a lot like Bahia. The only difference is the language; but eastern Cubans and Bahians are the same, happy, festive, and maybe it is easier to adapt here than in the South. It is different there; there are other mixtures. (L.C.K.A, Santo Antônio de Jesus-BA, 2 years and 6 months with the MDP).

The culture here is different [...], for example how people party. The culture is different. Here, for example, there are horseback riding groups [...] church celebrations. It is a

very religious city. There are many churches. So, the way people party is different, in this sense. Because, according to the regional traditions,this is how you party. This cultural diversity is new tous, because there, in Cuba,every where is pretty much the same. People enjoy the same parties, the same religion. Almost. We don't have this diversity you see here. But we adapt quite fast, because they are the same patients, the same community. There are no problems. And you get to know another culture. For me, it was wonderful. Like the soap operas. The soap operas talk about everything(A.G.D, Inajá-PR, 2 years and 8 months with the MDP).

The doctors' reports showed that the cultural similarities between Brazil and Cuba go beyond the differences, and that socio-cultural integration did not vary much from one region to another.

Cuban food adapted to the Brazilian way of cooking, prepared by A Cuban doctor in Cabedelo (PB).

And the food... Except for the barbecue, the spices here are very similar to Cuban spices. Some recipes are different, but how you make fish is the same. Cuba is an island, so we have a lot of seafood. The regional spices here are very similar do Cuba's. So, when we had meals here, they were very similar to our meals there. Some of the recipes, like Japanese food, Minas Gerais cuisine (like the "tutu de feijão", is excellent. I love "feijoada", "caipirinha", beer (O.R.M, Serra-ES,2 years and 11 months with the MDP).

The way you make [barbecue] on skewers. Also, I was once taken to a steak house during the Gaucho Party, during the Farroupilha Week. There the barbecue was made in the ground and the meat was different, the way gauchos prepare it. And we liked it. I also loved the desserts, the cakes. Very good (M.C.M.S, Guaíba-RS, 2 years and 7 months with the MDP).

The integrative processes became evident and tended to consolidate when migrants experienced and adopted the cultural practices of the host society.

I already want to make "acarajé[13]" in Cuba. I have a co-worker who likes, loves cooking. We call her Dona Benta and she wants me to take all the Bahian dishes and set up a 'Bahianês' restaurant there [...] But I try to control myself. I spent some time addicted to 'farofa'! I would get hungry and leave the room and make an egg "farofa". An egg "farofa" just as an appetizer before lunch (I.J.A, Feira de Santana-BA, 2 years and 8 months with the MDP).

The socio-cultural processes may also explain the appreciation that Cuban doctors showed for the routine activities of the communities in which there were living. Many of these doctors participated in popular festivities such as Saint John's Festival, the June Festivities, Carnival, Gaucho's parties, as well as barbecues, bars and popular spaces in the urban periphery, in large or small cities all over the country.

I participated in the "corrado de corradinho" (sic) that they organize during Christmas. I went to Saint John's party twice, last year and this year. And Carnival. Carnival and Saint John's festivities. (J.L.C, São Luís do Maranhão-MA, 2 years and 8 months with the MDP).

There are also dances here at the park. German folk dances. I participated in these folk festivities. I took pictures in all of them, dressed in dancing outfits. There are many parties here. The Flower Festival, the Winter Festival, several German parties [...]. They go to the streets with trucks, with their culture, their way of dressing, with a stick being dragged in the middle of the streets, with people who work at farmlands. It is very funny (D.O.B, Domingos Martins- ES, 2 years and 1 month with the MDP).

The interviewees' insertion in urban spaces, their participation and involvement in social and cultural activities were not as intense in some larger cities, due to urban violence.

Not me. I am afraid of going out because Feira de Santana is a very violent city. Chiquaro is a calm place, but here I stay home or come here [to the Unit] (I.J.A, Feira de Santana-BA, 2 years and 8 months with the MDP).

I'm afraid of going out, I think that Rio is too dangerous! Knowing the local reality, that at any moment a shooting may break out with stray bullets..., I prefer to avoid crowds. I stayed in Bonsucesso. On the sixth day, there was a Carnival parade and I calmly watched it. (G.C.L, Rio de Janeiro-RJ, 4 months with the MDP).

I don't have a good impression of Rio's Carnival because of the violence.. I don't go out at night. There is a Carnival party every day [...] (R.B.A, Salvador-BA, 2 years and 8 months with the MDP).

On the other hand, in places where this violence was not so evident, some of the doctors even reported that they felt like they were 'Brazilian'.

[13] 'Acarajé': made from peeled beans and deep-fried in palm oil; 'farofa': toasted manioc flour.

Then when we went to the party, other singers passed by. Bahia has the best music in Brazil. It was good when Canário (sic) started; they said it was a joke: he asked for everyone who came from the periphery to take off their shirts. I took off my shirt and I looked Brazilian. They told me I didn't have to do that, it was a Brazilian thing and we went down the hill to go home. Have you ever imagined yourself surrounded by almost a million people? More than a million people! But it was prohibited by the city hall because it instigated violence (R.B.A, Salvador-BA, 2 years and 8 months with the MDP).

Ordinary leisure activities, shared with friends from the community, were also important examples of socio-cultural integration. There were doctors who participated in sports training centers and other outdoor activities.

I walk along the beach. There is a girl from basic healthcare who lives near my house and who invites me to walk. I get lazy if I have to go alone, but we get together and go(M.B.T,Cabedelo-PB,1year and 5 months with the MDP).

Part of my free time I spend playing basketball during the week. We have an arranged schedule (O.R.M, Serra-ES, 2 years and 11 months with the MDP)

Sometimes I would go to the gym, do something, but in my life before [I came here] I used to do sports. (O.L.D, Porto Alegre-RS, 2 years and 8 months with the MDP).

During these leisure activities, it was also possible to observe the use of regional expressions, such as 'guria' (girl) and which also revealed the strength of the integration process.

In my free time, I visit co-workers in Porto Alegre or go to the mall with some of the 'gurias' here. Or we go shopping, or to the cinema (M.C.M.S, Guaiba-RS, 2 years and 7 months with the MDP)

Other practices indicated a strong socio-cultural integration in more reserved Brazilian spaces, such as religious cults.

I usually go to church on Sundays. I like the people at the church, but I am very curious and have already visited several churches. Dr. Carlos's wife invited me to visit the World Church. I liked Pastor Pedro, but they now they have a new pastor and this one only asks for money (laughter) (T.U.S, Iuna-ES, 2 years with the MDP).

I like going to church. I am catholic. So I go to the catholic church, too. But, sometimes I also go to other churches to visit (A.G.D, Inaja-PR, 2 years and 8 months with the MDP).

All of these practices fit the definition of integration in migratory contexts, that is, a process through which migrants become part of the social, cultural, and institutional fabric of the host society, in a mutual and multidimensional manner (SCHOORl, 2005; IBÁÑEZ, 2009).

In conclusion, the interviewees' reports indicated that socio-professional and community relations were supported by a set of common Cuban and Brazilian cultural references, from music to cooking habits. These similarities minimized daily problems (among them, violence) and reinforced social and affective bonds, creating a favorable environment to the socio-cultural integrative processes, such as making friends, going out with them, participating in social and religious activities, and sports and festivity events, with small differences in relation to the various regions studied throughout the country.

Facilitators and barriers towards Cuban doctors' performance

Several elements fostered or hindered Cuban doctors' performance and integrative processes. It was possible to observe that the warmer the reception and the greater the number of social interactions spaces, the more these doctors achieved integration, developing the desire to stay in Brazil. Findings show that unexpected integrative processes may be explained by several factors, from the doctors' medical education and practices to the contacts and cultural similarities between Brazil and Cuba.

3. Facilitators

The combination of Cuban doctors' medical training and practices with the level of cooperation achieved within the health teams was, undoubtedly, the main element enabling professional performance. This space, where trust seemed to play a crucial role, the success of the MDP was evidenced in the socio-professional, socio-cultural, and community integrative processes, as previously mentioned.

Initially, we need to recall that the shortage of doctors and their arrival in places where they were needed and expected, partially explains the warm reception they received. After that, the intense and grinding work routine, along with the need to learn with the health team, also influenced these processes positively. "On the first day at work, I had to ask the nurse for help all the time, and that really helped", said a doctor designated to Caapora (PB). It should be pointed out that learning was mutual and that the Primary Care activities in Brazil received high praises, a fact that helped to reinforce the professional bonds. "Our doctor has learned a lot here. We brought nurses from Cuba to see the experience, such as basic nursing care. It is excellent here", a doctor in Curitiba stated.

In the above reports, Cuban's self-image and willingness to come closer to their patients was palpable, an attitude that stems from their humanistic and non-profit-seeking training, as well as from their eagerness to act as missionaries for the public health cause and for social medicine. "In capitalist countries, medical practice is different from the way we work with the community; that's why Cuban doctors have such a close relationship with the patient, with the population", said a doctor designated to Marica (RJ). Finally, house calls, as the one where the doctor did not mind dirtying his shoes to get to the patient's house, and health promotion activities were also facilitating elements.

It is in this context that invitations, and social and festivity meetings arose, promoting integration into the community activities, supported by the socio-cultural proximity (cuisine and music, especially) between Cuba and Brazil. Although some may have felt closer to the Bahian population than to the communities in the interior of Paraná, for example, the "gaucho" barbecue and the Espirito Santos's fish dish were equally appreciated. All these small elements provided support to the desire to stay in Brazil, to affective relationships, and to the expressive number of five marriages.

Finally, in large centers, where violence and anonymity are greater, the previous migratory experience – passages in Venezuela and African countries – as well as the embrionary networks created by Cuban doctors may have had a socializing and welcoming role. As a Cuban doctor in Paraná have said, "Yes, we celebrate birthdays and Cuban special holidays."

Barriers

Cases of precarious housing, BHU's poor infrastructure, and the lack of interest in the MDP shown by some municipal authorities, were the main elements hindering the performance of Cuban doctors working with the MDP. The negative images about the MDP or some of the discrimination experienced are probably underestimated – for reasons that are easy to understand – in the interviewees' reports. On the other hand, learning the language, the protocols and the reference and counter-reference systems were obstacles overcome over time.

Specifically, the strict protocols of our medical practice and the lack of time to conduct health promotion and prevention activities as well as house calls, inhibited a better performance by Cuban doctors, especially because they restricted interaction and the resulting integrative processes. The Cuban doctors, used to listening and coming close to patients in order to treat them, were deprived of the basic tools of their practice.

Anonymity and the violence of some of the larger cities (especially Rio de Janeiro and Vitoria) also caused perplexity and difficulties. "I had never heard a shot" or "they stole my cellphone" were some of the reports of scared doctors. Urban violence did not necessarily curb the medical activities themselves, but negatively affected the integrative processes to which Cuban doctors seemed to be used.

In summary, the expected barriers, such as communication difficulties, the need to learn the protocols, or how to refer patients, were not the only ones. What was not expected was the difficulties to conduct house calls or health promotion activities due to the excessive workload or urban violence.

Final Considerations

The multiple and varied integrative processes in such a short period constitute the most surprising finding in this survey. Cuban doctors interacted with the health teams and did not limit themselves to treating patients; they also created personal and affective bonds with them and the community and, often, built intense and lasting relationships. In one word, we were able to observe almost complete integration into their community's life. How to explain it? The current literature sways between two types of answers. On the one hand, they refer to segmented assimilation, when the integration into a host society is successful, but incomplete. In other words, they adopt some of the behaviors and participate in chosen social spaces, but not in all of them

(PORTES, 2001, 2008). On the other hand, they define successful integration when, alongside work, other social spaces for insertion arise, such as educational and cultural spaces (TUCCI, 2014; ALOUIS, 2014).

In this study, the employment relationship was not the result of a migratory process, but its cause. Moreover, the job was conceived as temporary. Thus, integration was not a factor to be considered, only the Cuban doctors' good professional performance. It is surprising, therefore, that integrative situations were actually found, not only because they were not expected to happen, but mostly because their presence maximized professional performance.

The integrative processes were not expected in the design of the Brazilian policy, or maybe they were not among the concerns of the municipal and health teams who received the doctors. Nevertheless, integration did occur. In a way, we may say that socio-professional and community integration was a core element of their medical practice[14]. Furthermore, Cuban doctors seemed to actually have a certain *mobility capital* (acquired from their experiences abroad) which translated into their ability to listen to, live with, and respect social and personal differences, thus explaining the speed and intensity of the integrative processes.

Parallel to this *habitus* and to this *capital*, the importance of cultural similarities between Cubans and Brazilians cannot be ignored. What seemed obvious became decisive. Music, spices, dances: many elements approximated Cubans and Brazilians. This historical-social mix sustained, at various levels, the mutual appreciation established by the citizens of these two countries, or, simply, between individuals who were culturally close and who developed affective bonds and set up mature and lasting relationships. At the origin of everything were the shortage of doctors and Cuba's humanistic approach to medical practices. Over time, integrative processes were based on lasting and intense affectionate relationships.

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[14] It should be pointed out, though, that a professional behavior is also expected in the National Policy for Primary Care.

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Chapter VII

SOCIAL INTERACTION, COMMUNITY INSERTION AND SOCIAL CULTURAL INTERACTION OF CUBAN DOCTORS IN RURAL AREAS AND QUILOMBOS OF BRAZIL

Fanor Julian Solano Cardenas[1]

Introduction

This chapter describes and analyzes different forms of community insertion and sociocultural interaction of Cuban doctors participating in the More Doctors Program in Brazil. With special attention to the professionals who worked in small rural communities and locations known as "quilombos"[2], this section's goal is to understand how this social-cultural interaction process unfolded. The intention is to describe, based on the narratives of doctors and patients themselves, the experience of these doctors, and the dynamics behind their insertion, participation, adaptation and adjustment to their new social reality. The sociocultural interaction process is analyzed based on three social-symbolic spaces: the professional space, the cultural space and the socio-community space.

In migration studies, interaction has been a traditional theme, in the sense that every human displacement forces people to confront other social, cultural and institutional universes, in which, somehow, they have to participate and be a part of. According to Pires (1999), the concept of interaction has been used in sociological literature, in the micro sphere, to understand "how players are incorporated in a common social space", and, in the macro, "the way different social subsystems become compatible" (PIRES, 1999: 9). From Herrera's (1994) perspective, this concept was also used to explore "the interaction of the subject's individual practices and the measures taken simultaneously by receiving countries and countries of origin" (p. 75).

In the context of migration, the concept of interaction refers to the process through which immigrants become part of the social, cultural and institutional fabric of the receiving society (SCHOORL, 2005). In this

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[2] In Brazil, the term "quilombola" refers to the residents of Quilombos, a typical phenomenon of the Americas. During slavery, this term referred to African slaves and African descendants who escaped from sugar plantations, farms and small properties to build small villages called quilombos, a term derived from an African word, *quimbundo*, which means "society created by young warriors who belonged to uprooted ethnic groups and their communities". Today, the term refers to the descendants of these slaves who still live in rural, peripheral or urban areas characterized by subsistence farming and cultural manifestations that are strongly related to their African roots. There are more than 2,000 of these communities in Brazil that are still alive and vibrant, fighting for their property rights guaranteed by the Federal Constitution since 1988. They are mostly present in Alagoas, Pernambuco, Paraíba, Pará, Bahia, Maranhão, Amapá, Mato Grosso do Sul, Goiás, Rio de Janeiro, Mato Grosso, Minas Gerais, São Paulo, Paraná, Espírito Santo, Santa Catarina, and Rio Grande do Sul.

sense, it is a reciprocal, multidimensional and two-way process, in which immigrants and different players and institutions from the receiving society participate (IBÁÑEZ, 2009).

Classical studies normally analyze the process of social interaction, based on the second or third generation of immigrants, with the purpose of establishing how social interaction occurred in the receiving societies (HAMMAR & LITHMAN, 1989; PORTES & RUMBAUT, 2001; FELDMAN, 2009; FREEMAN, 1986;

BOSSWICK & HECKMANN, 2006). The experience described by Cuban doctors revealed, however, that this would not be a typical case of long term social interaction, in which individuals experience or are submitted to assimilation/acculturation processes or binational interaction after living several decades in the countries of destination (HOFSTEDE, 2003; ZARZA & SOBRINO, 2007; ALAMINOS & SANTACREU, 2011; Berry, 2003).

Cuban doctors do not comprise an immigrant population in the classical sense of the term, being classified as exchange doctors, residing in Brazil in the context of a temporary migration process guided by previously established employment contracts. This requires this group to live and participate as part of a different scheme, which takes into consideration that, because of the nature of their work and their medical training, such professionals should insert themselves rapidly, comprehensively and intensely into social life, especially in regard to community relations and sociocultural contexts. As mentioned earlier, the insertion of Cuban doctors in the Brazilian society transcended the professional doctor-patient relationship and other work--related activities, because they were able to establish new forms of sociability and social ties, inside a dynamic and intense process of interaction within community life.

This chapter describes the results of this process of social interaction of Cuban doctors in rural communities and quilombo areas in the interior of Brazil, from the perspective of three related dimensions. The first section describes the social-professional interactions established between Cuban doctors and the members of the health teams comprised of nurses, technicians and Brazilian doctors.

The second part of the chapter centers in a more symbolic dimension of the social interaction, related to the appropriation of cultural expressions, the participation in traditional Brazilian celebrations and the dialogue with the medical practices of black and urban peripheral communities. The last section analyzes the socio-community interaction, with emphasis on the construction of friendships and affective relationships, neighbor relations, use of free time, and the feeling of interaction per se.

Seventeen doctors were interviewed, eight men and nine women who worked in four Brazilian states where there are quilombo communities: Maranhão, Bahia, Goiás and Mato Grosso. Their ages varied from 34 to 52, with graduation in integral internal medicine and other specialties. They also had previous experience in international medical cooperation in countries of South America, Central America and Africa.

The interviews were conducted in 13 locations: two state capitals (São Luís and Goiânia) and 11 cities in the countryside (Brazabantes, Cavalcante and Britânia – Goiás; Juscimeira – Mato Grosso; Vitória da Conquista, Malhada, Santa Maria da Vitória, Ibotirama and Jequié – Bahia; Alcântara and Itapecuru Mirim – Maranhão).

The doctors interviewed were initially selected based on a typological matrix with a focus on region and state of work. Later, two additional variables of social differentiation were considered as possible keys to

understand their actual diverse experiences: gender and marital status. Lastly, the availability of professionals was taken into account, and communication was mediated by the state's assistants. Most interviews were conducted at the workplaces by the end of the work day.

Social-professional relations: fraternity, welcoming, matches and mismatches in the professional space

One of the main scenarios of interaction and participation of Cuban doctors in Brazilian society was the work place. Unlike other groups, the doctors arrived in Brazil within the context of temporary migration, with an employment relationship of three years, extendable for the same period. This situation allowed their rapid integration into the job market with very favorable conditions, reaching, therefore, one of the main goals of every immigrant: to guarantee material living conditions. In addition, the doctors were effectively awaited by the primary care health units, where they were trained. In this process, the doctors also started to improve their knowledge of formal Portuguese, learning about the differences in relation to the language used by the local population in their daily lives.

In the work space, the doctors made friends and were able to integrate themselves with the Brazilian culture, which, for many immigrants, was enigmatic, only witnessed through the soap operas broadcasted in their homeland, and their knowledge of Brazilian soccer. Thus, it is evident that the processes of insertion and social immersion of Cuban professionals into Brazilian society were strongly marked by the social interactions and ties built through their participation in the work environment.

The work space, however, constituted a specific social microcosm, where situations of fraternity, welcoming and professional partnership unfolded, as well as situations of rejection, prejudice and rivalry based on national and professional identity, within the scope of what Bourdieu (1979) called *class habitus*. Consequently, matches and mismatches, within the labor and personal contexts, marked the passage of Cuban doctors through the health care units where they worked. The differences did not rise from the that fact they were "new people"; rather, they resulted from their being seen as inconvenient by some professionals who were asked to interact with a different system of ideas, another vision of society, another notion of medicine, a different model of health care and the threat they potentially posed to the "Brazilian doctors' jobs", as it was commonly stated by some Brazilian doctors and politicians, as well as common people and the media. The rejection of Cuban doctors was related to a power game in the field of health care between public and private agents who operate the Unified Health System (SUS).

As a reference point, it is important to remember that Cuban doctors began working in places with a hostile and unfavorable environment as a result of the rejection they felt from Brazilian medical corporations when informed that Cuban doctors would be incorporated into the Unified Health System, even with their concentration in indigenous areas, *quilombo* communities and urban peripheral areas (BEZERRA, 2016).

Tensions certainly derived from the challenges that the More Doctors Program presented in relation to the liberal and privatist model of health care (CEBES, 1984; CAMPOS, 2007; PAIM, 2013), which has been implemented in Brazil along several decades. This aspect was aggravated by the fact that different countries in the region went through a series of structural reforms by the end of the 20th century that led to considerable

cuts in public expenses, including in health care (SANTOS, 2002; DIAS DO SANTOS, 2014; PRECIADO, 2014; AHUMADA, 1995; SARMIENTO,1998).

As stated by CAMPOS (2007) and PAIM(2013), SUS services are performed in the midst of contradictions and limitations involved in articulating the principles of the Welfare State with the basis of the liberal State, characterized by large private investments in and state funding to health insurance companies. Although the Brazilian State recognizes health as a citizen's right to be guaranteed to all Brazilians within the national territory, SUS does not oppose the hybrid public-private structure because the State has become a buyer or provider of funds to health care services, constituting an assistance model that points to privatization (PAIM, 2008).

The MDP was created as part of a strategy to strengthen public health care and guarantee the social rights of the most vulnerable populations of Brazil that have traditionally experienced difficult access to SUS. Some areas of Brazil did not even have one doctor per 1,000 inhabitants and, in some locations, communities never had the assistance of a SUS doctor. To some of these people, the contact they had with the Cuban doctor was their first encounter with a physician in their entire lives, which represented the possibility of becoming aware of numerous personal health issues.

Because they were inserted into this reality, Cuban doctors ended up becoming the targets of internal conflicts between State agents and medical corporations, each one trying to impose their own interests, advocating for certain medical practices in the health field and in media discourses. It was this social scenario – full of tension and contradictions, of matches and mismatches between public and private forces – that MDP's doctors found when they arrived at their respective workplaces. Thus, this situation allowed us to verify, not only in *quilombo* communities but in other locations as well, whether these Cuban professionals had established close, fraternal and partnering relationships with other medical professionals and the community.

> *Yes, all monthly meetings were held [...] Always by the end of the month. [in order to see the] productivity, the monthly statistics [We always have] lunch when we are not at the unit, in the home of a community agent or someone from the team. And they have collective birthdays; they are posted on a message board, [the birthday announcements] (Federico, two years with the MDP, Maranhão).*

> *I have good relationships with all of my work colleagues. Fortunately, since I got here, it has been good. With the group, I also showed they could trust me, if they had any problems they could approach me; not only health-related problems, any problem. I try to participate in the activities we organize. Sometimes, we hold activities among ourselves, for example, we celebrate everyone's birthdays. We all participate and I was open to it (Eduardo, two years with the MDP, Mato Grosso)*

In some cases, not representative of all, the relationship between the Cuban doctor and the health team, as opposed to the friendly scenario generally identified, was characterized by conflicts deriving from the disarticulation and misunderstanding about how the work should be done in primary care, especially in regard to planning house calls:

> *Look, as I have said to the health agent, she is used to something different[...] she has always agreed, but finally she wanted to impose her way. Yes, she wanted to impose how the house calls should take place, for example ... and I said "by logic, if I visited the home four weeks ago, if they have current prescriptions and medication, have no complaints, no emergency took place, why would I need to go back within such a short period?" And she didn't understand, they made house calls just because they had to... [And I said] "Look, I am here to make house calls, tell me about other cases and let's go visit them" (Sonia, two years with the MDP, Bahia).*

It is evident that Cuban doctors have significantly different concepts about doctor-patient relationships, medical practice and public health, when compared to the one in force in the privatist-liberal or pharmaceutical-healing model of countries where health is not a right guaranteed to all (MEJÍAS, DUANY &TOLEDO, 2010; MONJE, 2014). This may constitute a problem to Cuban medical intervention in countries where medical corporations and even individual health agents are not open to new practices and ideas (FEINSILVER, 2008).

The case analyzed here showed that work relations were sustained by the groundwork of informal agreements and rules established between Cuban doctors and their Brazilian health teams, based on respecting the system of ideas that guides each health system, and having cooperation as their basic principle. The work of Cuban professionals in Brazil is consonant to the principles that guide the international medical cooperation from Cuba, which is founded on the purpose of strengthening national capabilities by aggregating the specific strengths of both countries involved in the partnership (GARCÍA & ANAYA, 2009; MARIMÓN & MARTÍNEZ, 2011; MARTÍNEZ REINOSA, 2008).

> *The work environment here is very cordial, very good from the beginning. I never had any problem. [...] since the beginning we sat, talked about the Cuban health system, which is different from the Brazilian system [...] And we are used to doing this everywhere we go; we didn't come here to change anything, but to provide help.You do things a certain way, we adapt to what you do. We won't change the work system (Pedro, two years with the MDP, Bahia).*

The construction of this sort of rules was paramount in the sense that it dealt not only with the interaction of professionals from different nationalities but the interaction of very different work modes and concepts about health and disease. The Cuban National Health System, just as its international medical cooperation programs, is grounded on the promotion of health and disease prevention; in other words, it is a preventive and curative system that tries to improve primary care as the basis of the whole structure of public health (SANTANA & MARTÍNEZ, 2017; GARCÍA & ANAYA, 2009; MARIMÓN & MARTÍNEZ, 2011; MONJE, 2014; FEINSILVER, 2008).

Unlike what occurred within the health teams, the relationship between Cuban doctors and Brazilian doctors were more distant, conflicting and competitive, in general. Some Cuban professionals stated that the relationship with their Brazilian colleagues was bureaucratic and even apathetic, with no great exchange of knowledge. Therefore, one of the goals of Law no. 12,871 was not reached: the promotion of knowledge exchange between Brazilian professionals and foreign doctors.

I worked with four doctors on different occasions. [..] Only with the last one [of them] I developed a relationship. And it was a relationship like "hey, how are you, everything's fine..." (Federico, two years with the MDP, Maranhão).

The social-professional relationships between doctors were, therefore, fragmented due to the conflicts induced by the medical corporations and other reasons related to the social representation that Brazilian doctors developed regarding Cuban doctors. In some cases, the distance could be explained by the fact that the Cuban doctor sometimes would be the only doctor stationed at the health unit, while Brazilian doctors worked shorter turns. This may have hindered the establishment of strong, consistent and long-term bonds.

Besides circumstantial and localized situations, this difference may also have stemmed from a possible hierarchy established and constructed by the Brazilian doctors themselves that led them to see their status as higher when compared to Cuban doctors, due to their concepts of social class and their lifestyles. This, from the perspective of Basabe, Z1obina & Paez (2004), seems to indicate that relationships among doctors and health professionals were measured by the status assigned to the foreign groups by the national group. This was certainly influenced by other factors, such as the stigma, prejudice and representations that Brazilian doctors developed towards Cuban doctors. As mentioned by some of the Cuban doctors interviewed, however, they have established good relationships and have shared scientific knowledge with their Brazilian colleagues:

> *At the primary care unit, we do share knowledge. And every month we hold a meeting where everybody talks about medical issues. With three Brazilian doctors who work here[...]every month, with a Brazilian supervisor. We all meet, four Cubans and three Brazilians, in addition to the Brazilian supervisor, and we talk about health issues, we raise topics for further discussion and resolution, we talk about medicine [...] we share the experiences that each one of us had during that month. And ideas too. We even had a group on WhatsApp[...] (Federico, two years with the MDP, Maranhão).*

As a result of this situation, in some cases Cuban doctors were disqualified by Brazilian doctors who questioned their specific knowledge. This was expressed through suspicions and invalidation of diagnosis and treatments proposed by the foreign professionals, and the denial of referrals for complementary and specialized exams. One critical example of this situation was particularly observed at more specialized levels within the health system, which led to relationships marked by tension, conflict and disqualification, a fact that could have caused misfortunes such as the death of a patient. Such difficulties, however, may not result directly from the arrival of Cuban doctors, and may not be typical of the interactions between national and foreign doctors. On the contrary, they reflect a tendency to a previous disarticulation between different levels of SUS in Brazil, which seriously affects patient safety.

> *We exchange [actions]. When she [a colleague] sees a patient that has already been treated by me, she asks me [about the situation]. So, as she does with me, I do it with her as well. Here I didn't feel any resistance from any of the doctors. The greatest resistance came from the hospital doctors. [...] And it was not because of what they told me directly, but because of what patients told me. But I don't even pay attention, it does not concern me because I am aware of my knowledge. My years of study [...] to become a doctor were real. In Venezuela they said we were like gardeners, drivers, all of these things. Cuba does not do that. Cuba only sends qualified people abroad. We are all doctors, we have professional qualification (Miguel, two years with the MDP, Maranhão).*

> *There are still difficulties regarding operational procedures. [...] I diagnosed a brain cancer on a 16-year old girl and made all the referrals to another doctor who should see her in three months; the mother came here and I asked her [about the girl] and she said: "she died". But what do you mean – I said – how did she die if I asked for a magnetic resonance imaging and told you to see a neurologist to find out if there was any chance for surgery? "I wasn´t able to make an appointment...". This would never happen in Cuba, because if the case is mine, I'll accompany the patient to the hospital until I see the imaging done and talk to the doctor about the treatment (Darío, two years with the MDP, Maranhão).*

Taking into consideration the main trends on social-professional relationships, it is reasonable to assume that the prejudice and stigma of Brazilian doctors against Cuban colleagues were mitigated, but did not disappear. This scenario led to a certain social and professional detachment that resulted in tension and conflict instead of scientific enrichment. From the perspective of Cuban doctors, their Brazilian colleagues saw themselves as having a higher professional status because of their better salaries, purchasing power, adaptation to the political and economic systems, and their medical training. The establishment of a certain social-professional hierarchy, dependent on nationality, was also evident, simultaneously to the traditional hierarchies that exist among different medical specialties, which commonly attribute lower status and less recognition to general practice in relation to other medical specialties.

Social interaction and appropriation of cultural expressions: "living at a soap opera city" – forms of socialization with Brazilian culture

Classical theories on assimilation and multiculturalism (GODENAU ET, AL, 2014; RETORTILLO, et al. 2006) as well as more recent critical theories that discuss segmented assimilation (PORTES, 1989), disaggregated insertion (FREEMAN, 1986) and multicultural interaction (BOSSWICK & HECKMANN, 2006) (which generally analyze long-term interaction processes), have tried to establish whether migrants lose, maintain or enrich their cultural/ethnic identity from living permanently in other countries. From Berry's (2003) perspective, the contact established between the migrant and the receiving society's culture result in four different forms of interaction: assimilation, interaction, segregation, and marginalization:

> *Assimilation is the case where there is a negative response to the desire of maintaining the cultural identity, and a positive one regarding intercultural contact.*

> *Interaction is when there is a positive response both to the desire to preserve the cultural identity and to intercultural contact. This strategy is associated with a bi-cultural identity. Segregation occurs when the maintenance of one's cultural identity is positive, but there is a negative attitude towards intercultural contact. The last strategy is marginalization, which results in rejection of the original cultural identity and also of the contact with the host society (Basabe, Zlobina & Paez).*

The transformation or assertion of cultural identity happens as an adaptive response from the migrant, both at the psychological and social levels, to the processes of insertion and participation in the new society (ALAMINOS & SANTACREU, 2011). Assuming bi-cultural attitudes is a strategy that generates a higher degree of adaptation, from the psychological perspective, although it is not always chosen by individuals (BASABE, ZLOBINA & PAEZ, 2004). The theories previously mentioned, however, serve to analyze the interaction process throughout several decades, according to the experiences of the second or third generation of migrants. On the other hand, but they may not be the most adequate to interpret the situation of people who participate in a temporary or short-term migration process, such as the case of Cuban exchange doctors. The institutional, social and psychological situation in which these professionals find themselves does not impose a choice between their culture of origin and the culture of the place of destination, as is the case of migrants who live indefinitely in the receiving societies.

Thus, temporary migrants, such as the Cuban doctors, cannot be placed within the dichotomy acculturation/interaction processes, although they are induced to participate more intensely in the societies of destination, as opposed to other groups. As an alternative, some suggest that the contact of Cuban professionals with the Brazilian culture may not be exclusively interpreted from the perspective of interaction, in the classical sense of the term, but based on the levels of interaction and socialization that they develop with the symbols, signals, customs, practices, norms and values of Brazil, a continent-country whose culture is not homogeneous, given the notorious diversity among different regions.

In order to complete this task, the present research analyzed the interaction of Cuban professionals allocated to *quilombo* communities with the Brazilian culture, based on three important dimensions: 1) cultural consumption; 2) direct participation in Brazilian festivities and traditional celebrations; and 3) the dialogue that these doctors established with the traditional medicine practiced by the black population and the healing practices of mixed peripheral urban communities. Based on the assumptions presented herein, it was possible to realize that Cuban doctors interacted in a comprehensive and intense manner with Brazilian culture. There were different degrees of interaction, due to the symbolic expression in question, and the doctor's place of residence, which relates to the social bonds and the existing community relations in those areas. The forms of interaction were also mediated by the degree of contact that the Cuban nationals had with the Brazilian culture; in other words, with the cultural distance or proximity between their country of origin and the country of destination (SMITH & BOND, 1999; WARD, BOCHNER & FURNHAM, 2001; MOGHADDAM, TAYLOR & WRIGTH, 1993). The specific characteristics of Cuban culture and its historical variations also played an important role.

In regard to the first dimension, knowledge of and interaction with some cultural expressions were observed, especially in relation to music, soccer, TV shows, printed and audio-visual news and gastronomy. However, their contact with written literary and academic culture, unrelated to the medical field, was limited. The

consumption of such cultural expressions showed certain variations related to the specificities of the Cuban culture. For example, soccer is not popular on the island, as it has not been incorporated into the local recreational customs, which elected baseball as the most popular sport. Consequently, many Cuban doctors did not watch soccer games, and the ones who did, were not as enthusiastic. Some didn't even know the teams of the Brazilian League, but only international teams, such as Real Madrid, Barcelona, Manchester United, among others, all recognized for their international prestige.

> *Sometimes I watch some soccer matches. I am not fond of watching local championships in Cuba, only if my province is playing. The same here in Brazil, when we have the national league, you have to cheer for specific teams [...]. I prefer to watch international soccer, when Brazil is playing against another country (Eduardo, two years with the MDP, Mato Grosso).*

Other types of consumption, such as soap operas, have also showed variations that relate to the degree of familiarity with Brazilian culture in Cuba. For several decades, Brazilian soap operas have been broadcasted in Cuba, thus most doctors stated they kept watching these TV series here in Brazil, as part of an already embodied practice. In some cases, the doctor was actually living in one of these "soap opera locations"; in other words, one of the cities that have served as a scenery for these Brazilian fictional novels; this increased the level of empathy towards this product of Brazil's cultural expression. This fact is significant for contemporary discussions on cultural interaction because it shows that cultures are not isolated, and migrants do not arrive at their destination as a *tabula rasa*. It is not an issue of cultural distance or proximity, as discussed by Smith &Bond (1999) and Ward, Bochner & Furnham (2001), but an issue of previous intercultural knowledge and contact, within a transnational and globalized context, as established by contemporaneity. The cultural universes that get in contact may be different, but are close, due to the fact that the international circulation of symbols and contents is motivated by the transnational comprehensiveness of businesses in the audiovisual market.

> *For many years, Brazilian soap operas have had an important space on Cuban television. People watch them a lot over there, for a long time [...] Sometimes, I watch the news or one or another soap opera because the training we are going through demands time. So, when I'm doing something for the course [at home], I turn on the TV and watch a soap opera. I started watching "Império", which was on for some time and, when I went on vacation to Cuba, it ended here. When I came back, another soap opera had started. So, when I returned to Cuba, they were watching it there, but I didn't watch it because I wouldn't be able to see it all. Now I watch more movies and Cuban shows (Eduardo, two years with the MDP, Mato Grosso).*

In the case of music, we witnessed a similar situation, because some singers, especially the ones from the Bossa Nova era and others, like Roberto Carlos, have been known in Cuba for quite a while. Thus, it was not difficult for Cubans to open themselves to this type of music.

Other genres, such as "*forró*" or "*sertanejo*", were not previously known by Cuban doctors, but this was not an obstacle for their contact with this cultural expression. "*Samba*" and "*pagode*" were also enjoyed by Cubans doctors for their notoriety among other countries in South-America, including other continents, as they are

considered emblematic symbols of Brazilian culture. This is interesting, in the sense that, due to idiomatic differences, songs in Portuguese do not circulate widely in the Spanish- speaking world, and vice-versa. Also notable is the fact that the Brazilian music best known by Cubans are artistic expressions generally associated with a higher social status, with stronger international appeal.

The differences between the music played abroad and the diversity of music styles played in the interior of Brazil reveals, as signaled by Portes (1989), that societies into which people insert themselves are not homogeneous, but segmented and diversified. To ignore this reality is a typical bias of assimilationist models and policies, based on the assumption that host societies are culturally homogeneous and, therefore, the migrant's task is to adopt the way of life and the customs of the prevailing culture (GODENAU et al, 2014; RETORTILLO, et al. 2006). Considering that the Cuban migrants arrived in a society that differ from their own, they showed a particular openness, something that certainly favored their interaction with the multiplicity of Brazilian music, especially the genres enjoyed by the less privileged classes that are not popular in other countries. This attitude was necessary for their participation in local celebrations and festivities, as will be discussed later in this chapter.

> *I listened to a lot of old songs, Reginaldo Rossi, Roberta Miranda, Aguinaldo Timóteo, but I also like Alexandre Pires, Roberto Carlos, José Augusto. And other people don't. And all of these new artists: Luan Santana [...] Luciano Camargo. "Forró" I don't like that much [but] I listen to "Aviões do Forró" sometimes. Here, I see a lot of TV shows. The interactive ones, such as Caldeirão do Huck, Faustão, Silvio Santos, Eliana, Roberto Caprini [...] (Darío, two years with the MDP, Maranhão).*

As for the gastronomic experience, most doctors who worked in *quilombo* communities stated that there are little differences between Brazilian and Cuban cuisines, which made it easy for them to maintain their eating habits. Only a few interviewees pointed to some discomfort towards certain foods, such as the "*piqui*" (a strong-flavored fruit), not known in Cuba, or manioc flour, which is known but not frequently consumed in the Caribbean. Those who did not appreciate Brazilian foods, chose to cook at home, as a strategy to save money as well. Such practice was particularly observed among those who decided to share housing with other people, as it helped in the organization of household chores and domestic economy. The shorter cultural distance, identified as a facilitating factor of social interaction (SMITH & BOND, 1999; WARD, BOCHNER & FURNHAM, 2001) evidenced by the food consumption habits in Brazil and Cuba, contributed to the doctor's adaptation to the local cuisine. Interviewees attributed the similarity between products and preparations to the influence of African food and culture in both countries.

> *I didn't like manioc flour, but everything [else]I liked. The taste is very similar to Cuban food. The only difference is manioc flour, the 'farofa', these things. In Cuba, you don't eat that, but you eat rice, beans, meat and its variations. The same thing. And the same taste. (Enrique, two years with the MDP, Maranhão).*

The participation in the host country's culture is a complex issue in the sense that it does not deal only with engaging in some sort of practice, but with getting in touch with and accepting a new symbolic and cultural universe with its meanings, symbols, idiosyncrasies, social imageries and representations. To be open to a new culture implies playing with one's own cultural identity, because the individual who migrates must adapt

his or her lifestyle to the new customs, values, rules and traditions of the culture at destination (ALAMINOS & SANTACREU, 2011; BASABE, ZLOBINA & PAEZ, 2004). Although many doctors watched Brazilian TV and the national soccer league known as "Brasileirão," listened to typical local songs, or read national newspapers, they kept reproducing the preferences and practices of Cuban culture. Consequently, the insertion of Cubans in Brazilian culture did not jeopardize their ethnic identity, nor did it require an acculturation/assimilation process in the classical sense of the term (HOFSTEDE, 2003; BERRY, 2003; GODENAU et al, 2014; RETORTILLO, et al. 2006).

The doctors who worked in rural areas and small urban centers knew and participated in traditional Brazilian festivities, which contributed to their socialization with the national culture and the interaction with the communities they assisted, sometimes becoming the main guests in such celebrations. Some doctors considered the participation in typical Brazilian festivities as part of their customs and planned their activities during the year accordingly, with the possibility of participating in all of them. Such participation was more evident in the cases where Cuban professionals spent Christmas and New Year's Eve in Brazil and in those cases where they established affective relationships with Brazilian citizens. Some of these doctors got to know in detail the rituals and meanings of traditional parties not only because they routinely participated, but also because they ended up playing a protagonist role in some of these events.

It was the community itself that attributed this leading role to the doctors, as a potential form of recognition for the work they did. Surely, the participation in traditional parties led the doctors to interact more deeply and intensely with the Brazilian culture. Through this cultural interaction, Cuban professionals were integrated into the social fabric of the communities where they worked, penetrating the finest fibers of culture. In contrast, the professionals who assisted the population of urban peripheral areas of great cities did not get so involved in Brazilian traditional celebrations. The social distance observed in this case was due, on one hand, to the lower value attributed to these festivities in large urban areas and, on the other, because it was more complicated for those doctors to participate in such events, either for logistical or financial reasons. Thus, the physical, social and cultural characteristics of the place of residence influenced their chances of participation and their proximity to such expressions of national culture. This particular issue fostered or hindered the density of relationships and interactions of Cuban doctors with the communities they assisted.

> *The festivities of "The Divino" just happened. [...] They last from Friday to Monday. And they wait for these parties because they take place once a year and it's really fun. They truly wait for us with open hearts.*
>
> *Everyone prepares for these parties. I have a video [showing this]. [...] I already participated last year, but only a little; this year I had more time to see what happens. It was the best thing. We tried the food, wonderful! So, while this is happening here, people walk around [...] and try some food (Rosário, two years with the MDP, Bahia).*
>
> *Well, here they have several parties every year. Let's start with the New Year's celebrations [where] there is always a concert [...] carnival, party, concerts, electronic music. Then, the "Holy Week" follows, which is more or less the same thing, the same party, with concerts, many tourists. Then it's the farmer's party, with typical religious procession, cavalcades. A real celebration [...], people come from all farms*

in the region; there is a cattle exhibit. Then, there is the whole vacation season, in July, which generally has music concerts. Then, the season is over and it's time for the "Festa do Peão" (rodeo party), the most important in the region. I participate in everything, absolutely everything. First with my friends, and sometimes I'm invited by the Mayor. As the city is small, we are invited and, as they say, our presence in these festivals is an honor for them (Mable, two years with the MDP, Goiás).

Finally, the Cuban doctors had the opportunity to interact with traditional medical practices and knowledge from the Afro-Brazilian population and the mixed communities, very common in Brazil. It was not an unexpected and unpleasant encounter, because Cuban medicine has long considered the use of traditional and natural medicine in its treatments as a way to recognize ancestral wisdom. In Cuba, the intercultural approach is widely used in the promotion of integral health care with the adoption of a medical practice model that combines conventional allopathic medical knowledge with the island's African heritage and Chinese acupuncture (MONJE, 2014). The use of non-conventional medicines has been regulated in Cuba since 1995 when the National Natural and Traditional Medicine Commission (MNT) was created, promoting a countrywide network of services and MNT centers. In 1997, the Cuban State also created a national program to develop and generalize MNTs, including the training and capacitation of human resources (MONJE, 2014: 22).

Such holistic perspective allowed Cuban professionals to establish a horizontal dialogue, free from prejudice against traditional healing practices and medicine experiences from local communities, belonging to diverse levels of approaches, maintaining a strong relationship with diverse elements of Brazilian culture.

First, traditional medicine is commonly associated with indigenous practices and knowledge, and the use of herbs and plants as an instrument to balance people's health. Here, although Cuban doctors did not know some of the plants commonly used by indigenous people in Brazil, they were already sensitive to their application as part of medical treatments. Furthermore, some of these doctors stated that they had received specialized training in homeopathic medicine in Cuba and frequently prepared natural medications for their patients because plants can be perfectly adjusted to a model based on disease prevention, among other reasons.

Secondly, there are the practices of black communities, especially the knowledge associated with African worship. Although they are still used, in this case, plants are less relevant than prayers and image worship, which are the basic elements of the healing processes.

Spirits and all of these things [...] are also part of the culture. With prayer, they may decrease blood pressure, or something like that. In this community we have a "candomblé medium", an elderly lady, who prays, cleans bad energies, these types of things... They pray, use leaves and such [...] but I don't know her name. She refers patients to the health care unit herself (Rosário, two years with the MDP, Bahia).

Over there, as I assist four different areas that are close, but different, there was more than one [traditional healer] in each area. There is always a person who is dedicated to this type of praying and healing. And also in my community there is a lot of trust

in the Church, many patients treat their diseases praying and going to Church. [The healers] say they are Catholic, but there is "candomblé" as well. But all of them go to Church according to their personal beliefs (Stella, two years with the MDP, Bahia).

Social interaction and cultural appropriations (bonding of social ties, loneliness and functional interaction)

Classical studies of interaction in the context of migration have considered the establishment of ties and friendship networks along the migratory experience as one of the most relevant factors that lead to social interaction itself. It allows the participation and knowledge of national culture and the development of linguistic and intercultural competence (PADILLA, 1980; ALAMINOS E SANTACREU, 2011).

When migrants are isolated in the receiving society, it is harder for them to expand their circle of social relations and participate in different spaces. Solitude also increases the feeling of nostalgia or longing for their country of origin, which affects the processes of psychological and social adaptation (BASABE, ZLOBINA & PAEZ, 2004; WARD, 1996). In the case of Cuban doctors, it was easy to build friendships because, as opposed to other migrant groups, their job consisted in constant interactions with people in an intimate and profound manner.

Therefore, as general integral medicine in Cuba adopts a biological and psycho-social approach, Cuban doctors ended up building a close relationship with their patients and the communities where they lived.

The friendship ties built by Cuban professionals who worked in *quilombo* areas were significantly diverse. Foremost, Cuban doctors improved and expanded their ties with their colleagues from Cuba. Secondly, they created relatively strong friendships with technicians, nurses and other employees of the BHUs (primary care units).

On the other hand, the relationships developed with Brazilian doctors at those same BHUs were generally superficial. They were able to establish relationships and strong friendship ties with members of the community they assisted, bonds that evidenced the intensity of the interaction between Cuban doctors and the communities, leading occasionally to romantic and close relationships with Brazilians. The diversity of ties and social networks has contributed both to the insertion into and participation in Brazilian society, and to the job they performed in the locations they assisted.

The first space with which these doctors interacted, and where they developed friendships, was the Portuguese classes and the training and lectures about SUS that they attended. These lectures were organized by PAHO/WHO in Brazil, in partnership with the Ministry of Health, as a strategy for the socialization of exchange doctors with the country, the language, and the reality of the national system and the epidemiological profile of Brazil.

There, they met other Cuban doctors, with whom they had the first social contact. This initial contact, added to the fact that most doctors were sent to their locations as part of a team, allowed them to build new social networks with their fellow countrymen and women. These networks certainly provided them with some emotional support.

Thus, the establishment of these ties was easier when the doctors shared their housing with other doctors to reduce expenses, to have emotional support and benefit from mutual empathy, or still, to strengthen their networks, by celebrating birthdays, promoting Cuban national parties, shopping, or sightseeing together.

The niches of sociability they built helped them to enjoy themselves and reproduce their lifestyle and customs. They served as a mechanism to reduce or alleviate feelings of nostalgia. The interactions among Cuban doctors strengthened their ethnic/cultural identity and their feeling of national belonging.

> *There is no problem, neither here nor out of town, because we are brothers. Everything is fine [...] we get along very well. Someone's pain is everybody's pain; when we have a birthday, we get together and celebrate it together. And the Cuban special holidays, especially the Cuban holidays, we don't forget; for example, the 14th of February, Valentine's Day. July 26, Rebellion Day, a very important date in Cuba, we celebrate it here. Mother's Day, International Women's Day, we always celebrate them (Rosário, two years with the MDP, Bahia).*

> *We visit each other, the Cuban doctors. There are 16 Cuban doctors here in Goiânia, [whom] we visit; we go to the market, go shopping, to the movies (Núbia, two years with the MDP, Goiás).*

When the Cuban exchange doctors arrived at the SUS units where they were stationed, they found a second space of sociability, comprised of two types of social players. On one hand, the doctors, clearly at the top of the pyramid, and, on the other, technicians, nurses, community agents and cleaning personnel, placed at a lower level of the social-professional stratification scheme. Brazilian doctors, as mentioned earlier, did not see Cuban doctors as equals, because they regarded them as a sort of second class professional due to the characteristics of their medical training. As a result, hierarchical levels were further magnified, leading to unbalanced relationships because of the relative position of Brazilian and Cuban doctors in the social pyramid.

The social differentiation structure that was built led to weak bonds and tense interactions between Cuban doctors and their Brazilian colleagues. In certain locations, Cuban doctors said they had cordial relationships with Brazilian colleagues or even built friendship ties. With the reservation that this was mediated by common interests, these interactions were mostly superficial and merely instrumental, basically limited to the workplace. Nevertheless, there were cases where Cuban doctors were invited by Brazilian doctors to participate in family events, weddings, and recreational trips.

On the other hand, solid ties were established with the members of their work teams that were similar to the ones built with members of the communities assisted. This form of relationship is closely related to the self-perception of the exchange doctors, that is, having the same social status as nurses, janitors or security guards. The fact that they were doctors did not mean they had a higher status than other members of the team or the community. Such perception derives from the principles and values that regulate relationships and social interactions in the society where they live (CAÑIZARES, 2016; SANTANA & MARTÍNEZ, 2017; MEJÍAS, DUANY & TOLEDO, 2010), as well as the nature of Cuban international medical cooperation (CABRERA, 2014; MONJE, 2014; ALVES SMC et al. 2017).

When we arrived here, our supervisor was a doctor, a very nice guy. But we did not have the opportunity to participate in family gatherings and such, but the relationship is still good today. And Severino is also another very nice doctor, and I have nothing to say against him. Nothing negative (Stella, two years with the MDP, Bahia).

Well, with our colleagues, we were all single in the beginning, we had just arrived, all basically at the same time and, so, we would get together every week at a colleague's house, all of us single, doctors, nurses, technicians, everyone. Only two of them got together [romantically] and the rest looked for relationships elsewhere. It was funny, because many were married or had relationships and separated after getting here. So, every week or every two weeks we had these gatherings, even if we ended up discussing work-related issues (Mabel, two years with the MDP, Goiás).

Of all social ties, maybe the most solid and profound ones were the relationships established between Cuban doctors and the members of the communities they assisted. The development of close friendships between Cuban doctors and people was evident and enabled by the house calls, as well as the participation in family events and leisure activities. The friendship networks built by the doctors served as emotional and social support. Especially in those areas where they did not have the support of a fellow Cuban professional.

They invited me to a lunch here and there, and, of course, we went. There are many weddings and they invite me almost every time. Not all of them I can attend. But if they invite me... I go to weddings, children's birthdays. I really do, why wouldn't I? (Carmen, two years with the MDP, Bahia).

The same thing did not happen in the immediate circle of interaction, that is, with people from the neighborhood around the health care unit, which would have probably favored the process of integration into the society in general. At least, the relationship with neighbors and members of the neighborhood was not highlighted by the Cuban professionals working in *quilombo* communities. In the cases where these relationships were mentioned, interviewees stated that the contact was superficial and distant, in comparison with their previous experiences in other countries, and in Cuba. The doctors attributed the lack of contact to the values and the idiosyncrasy of Brazilian people, which, according to them, means keeping diplomatic and friendly but superficial relationships with foreigners.

For example, I've lived in a condo for two years and I don't know anybody there. It is not like that in Cuba. There, you live in a building and you know everybody there, everybody interacts and talks. Not here. Sometimes they greet you when they pass by, sometimes they don't. Each one in their own little space, locked. This shocks me. I have never felt as sad as here, in the country that is supposed to be the happiest in the world. [...] In Cuba, you can be three blocks away from my house and ask for me, people know who I am, you know? They might even tell you what I had for breakfast, because everybody knows each other. So, it was terrible. You end up finding a person here, you end up building a life with someone, but [that doesn't mean] that you fell in love for the country or the culture, for the company. [...] because Brazilian culture is very beautiful, but I am talking about the people. You spend three years living

somewhere without knowing your next-door neighbor. I've been here for three years and I can count in one hand the houses I've visited (Miguel, two years with the MDP, Maranhão).

This situation was different in small locations and rural areas, where neighbors and members of the neighborhood were also patients, which facilitated the construction of social ties and friendships. However, the professionals who worked in rural areas, but lived in the nearest urban center, did not develop the same relationships with neighbors because they were away during the weekends. Thus, the fragmentation of interaction spaces impacted the consolidation of strong social ties in the doctors' immediate surroundings.

Some doctors went beyond the establishment of friendships and social ties and networks, and developed romantic and affective relationships with native Brazilians. This was the case of two of the 17 professionals who were interviewed in *quilombo* communities. Undoubtedly, this was an important form of social interaction, because through the establishment of a romantic bond, the doctor was able to get closer to the local culture, expand his or her social networks and friendships, and become integrated with Brazilian culture. Interesting is the fact that the love bond was not necessarily established with a person from the same professional level or social status, confirming the concept of a horizontal social identity shared by Cubans, a world view that considers that everyone is equal regardless of profession or income. This way of thinking is at the core of a society that, at least from the point of view of its ideological proposition, promotes the idea of social equality and tries to limit the formation of social hierarchies.

I met my husband on a trip I took as a tourist to Barra do Garças, Mato Grosso. I met him there and soon we exchanged phone numbers and the relationship started to flow. He works as a taxi driver and he spent the whole trip with me. It has now been a year since we met and we moved together four months ago (Mabel, two years with the MDP, Goiás).

In relation to the participation of doctors in other groups and civil society organizations, the testimonies indicated a low level of insertion in these spaces. Almost the totality of Cubans refused to join religious cults and they were forbidden to participate in political organizations. Some enrolled in sports centers and others got involved in the organization of cultural activities related to Brazilian traditional festivities. Some stated that they did not participate in any physical or cultural activity for reasons such as limited free time, fear of violence, sedentary lifestyle and health issues. In regard to the participation in religious cults, most did not get involved because of the secular nature of Cuban mentality, the social system they share, and their educational level.

We were taking a walk. We walk every day for one hour, at 6 p.m. [...] after that, I started feeling pain on my leg, I had to see an orthopedist, and I was a little scared. He kept on exercising, but I became a little lazier [...] we are on a diet now. Actually, when we come back from work, life is a little more sedentary (Rosário, two years with the MDP, Bahia).

I never participated in a religious cult or something similar. I've been to a wedding at a church, mas it was just once (Carmen, two years with the MDP, Bahia).

I go to the gym, I train every day after we moved together [...] it depends on my day at work [...] I get home, rest a little, relax, organize some things, start cooking. I don´t often go to the Catholic [Church] (Mabel, two years with the MDP, Goiás).

As for these ties and sociocultural interactions, Cuban doctors have identified similarities between Brazilian and Cuban cultures, which contributed to intercultural contact and social relations. These common points derive from the African heritage and a certain "Latin feel" shared by both cultures and influenced by their inter-ethnic formation.

As described by Smith and Bond (1999) and Ward, Bochner & Furnham (2001), the cultural distance between both cultures was not a great one. However, the doctors also perceived that the interactions between Brazilians and Cubans had no depth, despite being cordial and friendly. They did not feel excluded, but they did feel frequently lonely due to the superficiality of these social interactions. In order to soften such feeling, some decided to live with Brazilians so they would have emotional and affective support. Others looked for support in other Cuban doctors, with whom they built a friendship and solidarity network. The superficiality of social relations may have influenced their psychological adaptation (ALAMINOS & SANTACREU, 2011; MOGHADDAM, TAYLOR & WRIGTH, 1993) and the degree of satisfaction (WARD, 1996) that Cubans felt about their lives in Brazil as well.

Yes, really lonely. I asked myself on several occasions what I was doing here (Mabel, two years with the MDP, Goiás).

Yes, several times. I felt lonely on several occasions during this time, and I thought about going back to Cuba (Enrique, two years with the MDP, Maranhão).

No. I didn't feel lonely because here we have nine Cubans in town. Whenever someone needs us, we are there to help. Besides, there are Brazilians who offer unconditional help, who have given us their phone numbers and said that we could call in case of any difficulty, at any time [...] one of them was the driver who worked with me. And some other people offered their unconditional support, like my landlady, who is always aware of what is going on with me, if I left, if I closed the door, if there is any problem (Darío, two years with the MDP, Maranhão).

Although they were participating in a temporary migration process, the doctors felt integrated despite associating their adaptation to Brazilian society to specific interests, both instrumental and work- related. In other words, it was a *functional interaction*. They felt integrated while they participated as health professionals and paid taxes over consumption, but not because their culture was accepted and recreated in Brazil. It is fair to say that the cultural orientation of the Cuban people was bi-cultural in the terms defined by Alaminos & Santacreu (2011), but their acculturation strategy in Brazil was the one defined by Berry (2003) as an affirmative response to the desire to keep their cultural identity and maintain the intercultural contact.

However, given the context presented herein, it was a limited interaction that did not affect the Cuban doctors' ethnic identity. Variations in interactions were closely related to the geographical place of residence. In small urban areas, doctors participated in traditional parties, were invited to family gatherings and recreational

events, and were known by the entire population, who admired them and recognized their contribution to society.

In large cities, on the other hand, the impersonality of contacts prevailed and ties were established as a result of specific interests, which caused them to feel virtually excluded, even with no explicit expressions of despise from Brazilians. In these metropolitan areas, Cuban professionals were socially invisible and their work was not visible to a population that didn't find anything new in medical care. In addition, there were some reports of racial discrimination, at least in the Northeast region.

> *I do think so, I feel integrated as a professional because of my participation here, with my work, but no more than that, I think. People contribute to Brazilian society by paying their taxes [...] we are and we aren't, we are here physically, but virtually we are nothing, we have only one goal here: to improve Brazilians' health and try to offer them good health care (Stella, two years with the MDP, Bahia).*

> *Well, I can say yes, although I cannot state that the interaction is deep, because of our different customs. I don't feel excluded. I participate in several social activities that I'm invited to by some friends and families [...] public events, for example, the open markets. But I cannot say I am one hundred percent integrated in the community, I cannot say I am a Brazilian (Eduardo, two years with the MDP, Mato Grosso).*

> *Look, I haven't been discriminated. But I felt the weight of my skin color. I did. I went to a store and the security guard started paying attention to me immediately, to my movements [...] you realize it is racism, it is nothing else. I felt it... no one told me [directly], but I have noticed that (Enrique, two years with the MDP, Maranhão).*

Final Considerations

The collective case of Cuban exchange doctors who came to Brazil to support the expansion of SUS in specific regions in need of physicians is a particular case within the context of migration studies. The situation of Cuban health professionals, who have more than 50 years of experience in international cooperation all over the world, cannot be interpreted through the lenses of classical theories of international skilled migration because they are limited and insufficient to explain the South-South migration flows within the scope of anti-hegemonic and supportive cooperation programs.

Also, this movement does not fit perfectly into the classical studies in the field of migrants' long-term social interaction because this model of Cuban migration to Brazil is temporary and the process has been organized by the State. The singularity of this migration flow leads us to think about the Cuban experience from a theoretical perspective that takes these specificities into account.

A feasible proposal is trying to understand the participation and insertion of Cuban doctors in Brazilian society outside the assimilation-acculturation/binational interaction dichotomy, where people are forced to choose between confirming or rejecting their own ethnic identity. In contrast, the migration process of Cuban doctors may be sorted out based on the degree and levels of interaction and socialization with the culture of the host

country. Despite being in a short-term migration context, they were induced to engage in intense interactions with Brazilian society and its culture, and especially with marginalized populations, which led to higher levels of social interaction and community participation when compared to the interaction experienced by other groups of migrants involved in temporary international assignments. The greater intensity of the doctors' interactions with these populations resulted from the specificity of the medical activity, the clinical expertise of professionals, and the Cuban model of health care.

Cuban doctors have established close social ties and bonds with the communities they assisted and with the technical teams working at the BHUs. However, these ties with fellow Brazilian doctors and neighbors were often more distant and fragile. The depth and the type of interaction were influenced by macro-structural factors, such as the conflicts between public and private agents at SUS; the transformations in their lifestyles and the consequent subjectivities associated with modern life; the differences in social values and principles, based on different economic and political systems; and the tensions and contradictions that are embedded in every intercultural contact, despite Brazil's long history of migration.

The ethnic identity of Cubans was not reaffirmed in Brazil, nor was it pressured by a society that is apparently cordial and welcoming. In general, the doctors made friends and shared experiences; some engaged in romantic relationships and socialized with several expressions of Brazilian culture from small rural communities, including *quilombos*; and many participated in Brazilian traditional parties and celebrations. Their presence also brought multiple benefits to hundreds of communities that had never had the opportunity to access a doctor.

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Chapter VIII

EXCHANGE DOCTORS' SUGGESTIONS AND CRITICISMS TO THE MORE DOCTORS PROGRAM

Carlos Eduardo Gomes Siqueira[1] and Gabriella Barreto Soares[2]

Introduction

Three focal groups of Cuban doctors were interviewed and several conversations with PAHO/WHO state supervisors were conducted, as described in Chapter IV, raising a series of issues related to improvements of the More Doctors Program (MDP). Overall, Cuban doctors appreciated their participation in the MDP, from the selection process and the Portuguese lessons to the continuous training and their work in Brazil. They stated that, of the international Missions in which they had already participated, Brazil's was the best paid and the most structure done. However, they offered criticisms and suggestions to improve exchange doctors' participation in the MDP.

This article presents a synthesis of statements collected in the three major areas in which they participated, comprising the diversity of their experiences in each one of them. Some of these opinions regarding the MDP, however, are not specific to an area; rather they concern the general features of the program.

Indigenous areas

Cuban doctors admire SUS's design and proposal, although they have criticized its poor effectiveness. According to them, the reason lies in the distance between the reality of the national planning defined in the Ministry of Health's central offices and the reality of Amazonian riversides and bushes.

> *Brother, sometimes we have to go down to where they are; have to leave the cool office, great, with a good chair, with air-conditioning, and have to go to the field. It is very simple to design a program for us to conduct, but you do not know the structure of your own country (Cayetano del Espíritu Santo, Amazonas).*

Cuban doctors interviewed in Amazonia repeatedly mentioned the lack of previous and more precise information about the work conditions in the region. According to them, quality information is needed, mainly

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anthropological data about indigenous people and their ecological life in different places. They suggested offering courses on those topics upon their arrival in Brazil or even before leaving Cuba:

> *I didn't think that I was going to sleep in the village; I don't even know how to swim! I stayed the whole time by the river. I think that people have to ask, explain the conditions that we are going to face (Alonso Quijano, Pará).*

> *...But I believe that when they talk about working in an indigenous area, they think that it is a fantasy, a movie. Some want to know this life [...]. However, these are different things: one thing is visiting an indigenous area; living and working there for three years is something else altogether (Aureliano Buendía, Amapá and Roraima).*

Preparation of bilingual materials (Portuguese and indigenous languages) would truly facilitate communication between doctors and patients.

> *"Yes, Yes, something like general symptoms, how to ask questions. This would be good (Alonso Quijano, Pará).*

Others complained about the absence of previously defined functions and responsibilities for each national, state or municipal agency receiving the doctors, making it clear that there is a need to establish more precise norms for the roles of public health management institutions, particularly regarding indigenous health. In some cases, they also complained about the lack of official support from Special Indigenous Health Districts (DSEI) in facilitating housing or accommodation in cities. To illustrate this issue, the following statements reveal the poor articulation among the national, state, and municipal levels regarding the MDP management.

> *[In Roraima] some of the municipalities had problems with our reception. When a doctor arrived in the municipality, there was nobody waiting for him. He did not have where to stay. No! It was very difficult...it was a problem for the doctors (Aureliano Buendía, Amapá and Roraima).*

> *When we arrived here, leaving the airplane, the first thing we asked the employee [from DSEI] who came to welcome us was: "In which hotel are we going to stay?" She said: "No, I am taking you to a hotel, but you have to pay the hotel." We asked: "But how come are we paying if Brasilia told us that all this would be covered by the Indigenous Health District and that we did not have to pay for anything?". And she replied: "No, no, no, here you have to pay for everything!" Then, I told her: "but we have not received our first payment yet, the first salary, how are we going to pay? (Amadís de Gaula, Amapá).*

> *They knew that two doctors were arriving and neither the leadership nor the health team, nobody [came to welcome] them, I tell you, the global [group] was good, the regional was even better, but the local [group] was bad! (Cayetano Del Espíritu Santo, Amazonas).*

This mismatch between national guidelines and what the municipalities were able to provide hindered the exchange doctors' work. As a result, doctors who worked in remote places received less attention from Cuban and Brazilian managers.

> *See, to travel to Roraima, I had to catch four planes: Macapá-Belém, Belém-Brasília, Brasília-Manaus, Manaus-Roraima. We spent twenty- seven hours travelling...And the states are very close to each other, but they do not communicate with each other... (Aureliano Buendía, Amapá and Roraima).*

> *In the municipality of Bonfim [border between Roraima and Guiana], for example, six months went by without receiving expense aid because the Municipality had financial problems [...] So, health assistance remained in the same condition: without providing support for the doctors or the population...Then, it generates a... – how can I say it? – a barrier between what the More Doctors Program intends to do and what the Municipality is able to do (Aureliano Buendía, Amapá and Roraima).*

A solution for this problem would be to give managers greater autonomy and to facilitate funds transfers in order to meet the needs of doctors in remote areas, since distance imposed serious challenges. Perhaps, this explains why the Cuban doctors praised and were grateful to units' staff who, going beyond their duties, made great efforts to receive them well.

> *This girl had to pay for the first three nights at the hotel. She helped us very much. Really, a lot; but it was personal because she did not have to do this. Her mission was to take us to the hotel and we had to find our way out, do you understand? (Amadís de Gaula, Amapá).*

It is worth mentioning that professional work in remote areas requires greater assistance in many aspects, such as transportation, supplies, safety, support in situations of conflict, and communication with local authorities, among others. One exchange doctor in Acre recommended a rotation among doctors allocated to remote areas and those in more comfortable urban centers .Another doctor in Rondonia, raised the possibility of offering life insurance to the MDPdoctors.

> *We are working without life insurance and in such conditions that you do not know if you will wake up the next morning, if you will return to your family (Diego Armando, Rondônia).*

One of the exchange doctors in Amazonas referred to the high cost of transportation to the regional urban centers on his days off.

> *I had to pay five hundred and fifty Brazilian Reals to travel from Pauini to here [Rio Branco] [...]. Very expensive, very difficult, and only by plane. You cannot use other means of transportation (Sancho Panza, south of Amazonas).*

In addition to the afore mentioned issues,there were risks not computed in the medical service rendered in indigenous areas. Several doctors faced challenges to give continuation to social projects initiated with the communities. One of the exchange doctors in Amapá suggested signing institutional partnerships with research agencies, non-governmental organizations, and public foundations, among others, to maintain cooperation, even if at a distance. Besides, he emphasized the need to establish long-term relations, so that research studies already initiated would not be interrupted.

> *Working across Oiapoque, visiting all villages, carrying out this Project, they did not allow me. I wanted to do it, to get permission. I was ready to use my days off, but I wanted permission and support. What could I do if they did not allow me? Then, how are you going to present the project there? [...] We could get to know many plants that haven't been discovered yet, that are still unknown to the white man, not discovered by the white man, that have not been studied yet.... Then, it is not just leaving behind a souvenir. It is also having the possibility of finding new medicines that could be the cure for many diseases still incurable (Amadís de Gaula, Amapa).*

The underutilization of the Cuban doctors in the MDP must also be pointed out. Despite their specializations in ophthalmology and orthopedics, for example, these services could not be offered as secondary care; Cuban professionals were not allowed to offer specialized services in Brazil, leaving the population without due care. Furthermore, many doctors felt undervalued for being treated as students in specialization courses. In the interior of Para, a doctor reported his desire to resume discussions on the revalidation process in order to facilitate incorporating their specializations in the provision of health care to indigenous populations.

> *There are Cuban doctors with specialization in ultrasonography and there are patients who need an ultrasound; but it cannot be done because he cannot do it, do you understand? There are two doctors who are ophthalmologists and you have to wait for months to make an appointment with the ophthalmologist. And there's an ophthalmologist in the district. They are working in the field of indigenous health, but they can only offer preventive health care... The revalidation test is not an exam to approve or fail anyone. There are other countries that also have this kind of exam, but they help, do you understand? They help people take it. I don't know...Like us, who are taking the course. The course could very well allow you to later take the revalidation test... It is difficult for Brazil to give me such a course, you know, on family health, because, with all due respect, there is no family health here, there is none (Manolo Ortiga, Para).*

Other criticisms about the MDP regard the design of basic care services in Brazil, because the health system does not value information on healthy people; it focuses more on disease treatment, and less on prevention. The lack of equipment at health units was another problem pointed out in primary health care. As an alternative, especially for indigenous healthcare, they state that it is necessary to better train Indigenous Health Agents (AIS),so they can inform their relatives about disease prevention. In addition, they suggest investing more in primary care units to reduce the flow of patients who look for hospitals:

Why do we have a system, information, requirements, data that you have to feed the system, almost everything is secondary, do you understand? Hypertensive care... It is not about assisting a healthy individual [...]. [You need] to work with people at risk of hypertension. People with a hypertensive mother or father, who are obese, who are sedentary. Then, you work with the risk. You cannot wait for him to become hypertensive in order to act. ... (Manolo Ortiga, Para).

For the MDP, I think that the Basic Health Units still lack some equipment. It would make things easier. In order to work more [...] Here there are children with asthma, adults as well. I may have saline solutions, but I do not have oxygen or the appropriate equipment. It is all there on the wall, but nothing works. If I had, [the patient] would not stay in a hospital occupying a bed (Cayetano del Espíritu Santo, Amazonas).

Finaly, the interviewees stressed the wire transfers to Cuba, calculated in U$ dollar, and how they were impacted by the devaluation of the Brazilian Real in relation to the U$ dollar. In November 2013, BRL $1,000.00 bought US$ 450.00, while in September 2015, they were worth only US$240.Therefore, it is clear that contracts in dollars, and not in the domestic currency, would protect the financial planning of doctors and their families.

Quilombola areas

One of the recommendations was the improvement of communication between PAHO/WHO and doctors'in the *quilombola* areas, especially because of the feeling of uncertainty as to the continuity of the MDP. For example, once the Brazilian government opened the possibility of continuing the MDP, doctors did not know whether their contracts would be renewed. Additionally, the contract's termination date as well as the date of their return trip were unclear. These and other uncertainties limited their capacity to plan short-term activities.

Here, in general [...] we have no information about most things, we are not informed. Then, there's this thing, things that come through social media that we don't know whether they are true. In the end, PAHO tells us "just ignore what they say"; but it is an uncertainty that does not clear anything up, because of the situation they create on social media. Then, this is where we are. We are leaving in August, but the Mission renewed the contract. What is going to happen to those who wanted to renew the contract for another 3 years, or one year, or those who will actually stay [until the end of the Mission]? (F. Rodríguez, Maranhão).

The importance of establishing mechanisms to facilitate wire transfers from Brazil to Cuba was addressed by the doctors, who complained of the high fees charged. According to some of the interviewees, the Cuban government could have signed an agreement with *Banco do Brasil* in such way that transfers would have a lower fee. The interviewees also reported the importance of setting up the salaries in such a way as to protect them from variations in the U$ dollar to Brazilian real exchange rate.

We are losing because we signed a contract of one thousand dollars per month and we were told that the dollar would be at around 2.20, but this value has only increased. As a result, right now, they are paying us a little over 600 dollars; nothing

> *near the 1,000 dollars because the problem is that the dollar is now around 3.80. It went up to over 4. So, it did not reach the amount that was established. Then Cuba made a contract that was set at 1,245 (dollars) monthly. It there was any variation, if it went up or down, we would receive 2,976 BRL and 26 cents every month. Now, if you exchange this value into dollars every month, we are getting 600, almost 700 dollars (Rosa León, Goiás)*

On the other hand, the exchange doctors suggested that the Cuban government could send part of them one directly to Cuba and deliver the other part here, decreasing the tax fees they had to pay for the transfers.

> *The problem is that the idea was not to transfer the money to Cuba. The idea was that we would sign a contract, that is, our country made a contract with PAHO of 10,000 Brazilian Reals. Out of these ten thousand Brazilian Reals, we would receive one thousand dollars: 600 would stay in Cuba and we would get 400 here to cover our personal expenses. In addition, the municipality would give us money for other things, and this was another problem. The problem is that [...] the bank charges a fee for any operation we make, no matter how low, it is still a fee. And in Cuba you have to pay another fee when you make a transfer. And we also lose money when we exchange to Cuban currency. We are losing (F. Espinosa, Maranhão).*

In more remote areas, funds management policy for accommodation, food, and transportation was particularly erroneous. Some of the doctors mentioned the need for national guidelines, because the management of the funds varied according to the preferences and interests of each municipality. They felt they were wronged in many cases: when the salary was delayed, or insufficient,or not delivered to the doctors, or the amounts limited by the municipalities. In several places, the rented houses were far from the Health Units, lacked minimum household conditions, or were too expensive.

> *In the beginning we received 670, which was for food. This was what we received here in the municipality all the time. Then, they became responsible for paying the rent, electricity, and other services. However, they paid a very high price because they did not want to give the money for us to manage. Because if you manage, there is no need to pay an exaggerated price for the rent, since I do not want a 1,000-real rent; I want a 200-real rent, for example. I do not want to live in a house …in a big house when I only need a kitchen, a room, and a bathroom. I do not have family here (F. Espinosa, Maranhão).*

Doctors also discussed healthcare monitoring and efficacy. In each location, activities were supposed to be conducted longitudinally and transversally, thus allowing for an evaluation of the evolution of incidence rates, prevalence, and other epidemiological changes. Many doctors never received any feedback or statistic data related to their work; therefore, they could not plan strategies focused on improving health promotion and prevention programs.

> *They never gave us feedback. Look, ever since we arrived here, we are adapted, because in Cuba we have a lot of information on the results of our work. You gather*

every three or four months and they tell us "we have this percentage of child mortality." We know all the statistics. Here, ever since we arrived, we have had monthly statistics and we have asked them to meet with us every two or three months to inform the DSEI whether the municipality had decreased child mortality rate. We wanted to know all these things, but this information never reached us. Now, in the specialization course, we had to do a research study, and I went directly [to the sources] and it was a chaos, because this is a very bureaucratic country. I started requesting data for the previous year and they did not have anything, since they don´t have backups, and they don´t keep the information that they send to Brasília (Luisa, Mato Grosso).

Peripheral urban areas

The statements regarding the Cuban doctors' criticisms and suggestions were divided into three groups: preparation before immigrating from Cuba; arrival and permanence in the MDP; and return to Cuba.

In relation to the preparation period, exchange doctors attended preparatory courses, which lasted,in general, 15 days in Cuba and 30 days in Brazil,a time that was viewed as insufficient to learn and achieve proficiency in Portuguese and to prepare them to feel ready to carryout their activities which, besides providing basic medical care, include other activities such as health prevention and promotion programs, lectures, group talks, and interviews with community members, among others. Therefore, it was clear the need to increase the Portuguese preparatory course duration, both in Cuba and in Brazil.

It is complicated because we have promotion and prevention activities, treatments, and rehabilitation in another language, and this means, for example, creating groups, giving lectures, making interviews with the community, attending diagnostic meetings with the community that is Brazilian and you are alone, as a foreigner, a Cuban speaking in another language [...] speaking in Portuguese to all these people; this would be much better if there was more time to learn a bit more of Portuguese (Aline, Rio de Janeiro).

In addition to extending the time to learn Portuguese while stil in Cuba,they also stated that it was essential to include Brazilian History in the preparatory courses and expand the content on Brazilian regional cultures, especially local music and cuisine. Participants stressed the relevance of an intensive course on regional culture, after defining which doctors would go to which Brazilian states:

I also think that lessons on Brazilian History and Culture should be given. It would be phenomenal, because what happens is, for example, that Rio Grande do Sul, which we already know, is amazing and has enchanted us. It is also another culture with a fantastic history; almost another country that I knew nothing about and which I only got to know when I arrived here with the MDP. Well, I only got to know it when I arrived here with the MDP. I had no information about it in Cuba (Aline, Rio de Janeiro).

In fact, as a constructive criticism, it would be better to talk more about Brazilian culture, about the regions, and to talk about the food, and the specificities of the

culture. It is true that it should be done later, when the groups of doctors are already defined for each state, before arriving in the state; an intensive course (Marcel, Rio de Janeiro).

In addition to a more intensive Portuguese course and learning more about the historical and cultural features of Brazil, several doctors mentioned that the Mission experience would have been more profitable if they knew where they would work in Brazil before they left Cuba.

Maybe knowing where you are going. Because you leave Cuba and go to Brazil and you don´t know where you're going. Brazil is not just a country; it is a continent. There are places where it is never cold and there are places where it snows. So, we should know there [in Cuba] where you are going and the ethnic features of the place: it is this way here and different there. (Ingrid, Sao Paulo).

It would help a lot to personalize your preparation, to know, while still in Cuba, at least the state that you are going to. Because, I will tell you, it changes preparation. I would not say that you are listening, that you will miss the bow and arrow if you are going to Amazonas, that you do not need to have them if you are going to Sao Paulo; that is, it helps [to prepare] to move. Preparation should not be so general. Perhaps the language, yes, but from the professional point of view, I think that all of us here have seen illnesses that, thank God, we are not used to seeing in our daily routine in Cuba. Tuberculosis or leprosy. In primary care, we practically never see someone with tuberculosis, for example (José António, São Paulo).

Regarding their arrival and permanence in Brazil, several doctors reported difficulties in relation to accommodation and transportation. According to them, in many cities, they stayed in hotels while looking for a place to rent. However, in some cases, they had to look for a place to rent on their own, a fact that caused some discomfort, because they frequently had no confidence in their Portuguese skills, or with the contracts, to feel able to negotiate. Since they were not familiar with the city's districts, they often rented places far from their health centers or in dangerous neighborhoods. They suggested the presence of a mediator to help them find accommodation upon their arrival in Brazil.

The specialization course attended by the MDP's doctors was also questioned. First, because it started as soon as they arrived in the country. According to the doctors, they should have initially been allowed to learn about the population to which they would provide healthcare, in order to make a health diagnosis of the community. After that, they would be able to propose an intervention project which they would later present as their final paper. Many questioned the course content because most of the doctors had specialization, post-graduate courses, and some were even college professors in Cuba, with a vast experience in Family Health Medicine. Therefore, are-evaluation of the specialization course organization and are vision of the course content should be conducted. The intervention project proposal would be presented only at the end of the Mission:

During the first year, the More Doctors Program training should focus on learning the protocols, the healthcare system. Here, it was the other way around: you arrived and

did the specialization course which, actually, made no sense because you didn't know the population. The level of population that you have, it is very hard for you to make an overall diagnosis of the community. First, you have to know how you will make the intervention using the protocols, get to know the population, the work system, get integrated and later take another [course] (Juan, Minas Gerais).

For the next groups, it would be nice to arrive knowing the population, knowing the assistance protocols, because each municipality has its own. The Ministry has one, fine. Then, you are able to do something in accordance with the established protocol. Then, you add more, to the study, to the intervention project that you will present later, in your final paper. And the course's final paper should be delivered at the end [of the Mission] when you are more proficient in the language… Concerning the specialization course, I would also like to register here what I believe that the majority, if not all of us, agrees with: we did a specialization course, alright. But we all have post-graduate experience, all of us…no doubt. We took a specialization course with imposed Brazilian norms (Amanda, Minas Gerais)

The work at SUS was considered very intense, due to the large number of patients assisted daily at the BHUs; consequently, the time allotted to each patient was very short. The doctors regretted not being able to practice Integral Medicine, which includes health promotion and prevention activities, because the number of doctors was insufficient to assist the large number of individuals registered in the Family Health Program. They suggested an evaluation of the number of users assigned to each one of these doctor's health team as well as of the protocols proposed by the municipalities:

My health team is responsible for almost six thousand people; then, when you start working, you want to have prevention and promotion activities, and you need time for that. It is very difficult because when you look at the mobility of a population of six thousand people, it is difficult for you to follow-up all those patients. There are eight hundred patients with arterial hypertension, there are five hundred patients with diabetes, and many with asthma. Thus, establishing a control system is desirable (Bianca, Minas Gerais).

Each area has its own characteristic. In my area, the time for each appointment [prevails]. I think that this is a difficulty in the Program and it should be analyzed by other management levels. I am in São Paulo where the population is very large. The district has many shortages; in order to assist patients as a family doctor should assist, using a psychosocial approach, it is impossible to do it in 15 minutes, with all those documents that you must fill in. I think that this is stated somewhere, it should be taken to the people who decide this. Please, they should come and sit in an office with a doctor to see if it's possible to examine a human being in 15 minutes (Glaucia, São Paulo).

Still in relation to the work in the MDP, some doctors argued that they had to face many challenges to have their suggestions accepted. According to them, it would have been more profitable if the MDP managers

had listened to them during the project's development or had invited their collaboration during its design, and not only during execution. They said that the structure of the Brazilian health system is very good, but that, according to the experience they had, there were several aspects that could be more thoroughly contemplated, resulting in improvements for SUS. Among them, they pointed out the discontinuity between primary and secondary care.

> *We arrived here with the MDP, and the program was a novelty, but not health, not SUS, right? SUS had already been implemented. We came to add; we did not come to change anything (Amanda, Minas Gerais).*

> *We got into a program that had already been implemented. There's an office in the health unit and we adapt ourselves to their protocols, to their work characteristics. The intention is to help. To assist the patient who needs a doctor… (Marcel, Rio de Janeiro).*

> *I think that it is one of the best-designed health systems in the world. Because, they exist in other places: in Canada, the United States, Europe, Cuba, also in England… But […] the agendas are not built as they should be. And something else that impedes solving patients' health problems is the relationship with secondary care, that is, the continuity of solutions for patients' health problems is very hard (Monica, Minas Gerais).*

In past experiences, particularly in Venezuela, doctors lived in the community where they rendered medical assistance, and this facilitated their interaction with society and the provision of healthcare to the assisted population. Taking into account this previous experience, they suggested evaluating the possibility of exchange doctors living in the community where they would provide assistance. On the other hand, many others pointed to the difficulties of living close to work, because of violence or the precariousness of these places:

> *…but, in the specific case of the Program, I think that if the health professional lived where he worked, I am talking about the doctors, they would have more social relations (José Antonio, Sao Paulo).*

> *There [in Venezuela] we lived inside the office; we had equipment to assist a patient. Not here; here, the office closes at 5 p.m. and everybody has to go home (Hugo, Rio de Janeiro).*

> *For example, in Cuba we have the house office, but the doctor lives in the community. What happens in the face of violence, I think that it is going to prevent [the work], the work is going to be…, it is going to be negative for the doctor because he will not be able to work in this community (…). We all work in dangerous neighborhoods and I think [that the problem] is not that you get up at 3 a.m. to assist a patient. We are used to this because we are a guardian body. The problem is that the patient is going*

> *to call at 3 a.m. and, for example, if they point a gun at your head, and [they will point a gun at you] every day at 3 a.m. (Aline, Rio de Janeiro).*

In relation to their return to Cuba, the interviewed exchange doctors showed concerns with what would happen with the population that they had assisted: whether they would continue to have a doctor available, or who would substitute them. They reported that there was a long waiting list of patients and that the doctors' agenda was full until the end of the year. This uncertainty about the immediate availability of new doctors to meet the demand remained a great concern for the exchange doctors.

> *We are leaving; maybe a new doctor will take our place. And my patients... Now I am already worried about what will happen to them, who will stay with them when we leave. And which doctor will stay with my team (Aline, Minas Gerais).*

The emphasis that the doctors gave to their capacity to adapt to different societies also stands out. They believe that it results both from cultural aspects and from the medical training they received in Cuba.

This also depends on our medical training. We, Cubans, by habit or because of the training that we have, we believe that we adapt; we are already trained to adapt to any environment; it is part of the training that we already receive during the career (Ilza, Rio de Janeiro).

When we get married, we become one. So, I think of returning here. So, if God gives me the opportunity to continue in the More Doctors Program, it would be very good. If not, I will have to study and take the revalidation test to continue working as a doctor. And I will study until I reach my objective (Arlenys, Rio Grande do Sul).

Final Considerations

The voices of the Cuban doctors, presented in this chapter, summarize the major features of their critical evaluation of the MDP, SUS, and the experiences they had in the diverse regions of Brazil.

The majority of interviewed doctors evaluated their participation in the MDP as very profitable, professionally and personally; however, according to them, there were several problems. If, on the one hand, they derived great satisfaction from their work, the warm reception by the population, and their contributions to improve the health conditions of Brazilians in need of medical care, on the other hand, they made several criticisms and offered suggestions to improve the MDP and SUS. When their broad international experience is taken into account, there is no reason to question their credibility and expertise when they compare SUS's Primary Care Services with those of other countries where they have worked, particularly Cuba. Even if some of the reports are not explicitly comparative in nature, it may be surmised that the main reference source for their opinions is the Cuban health system. Nevertheless, most of what they observed and understood as fragilities in the SUS system merely confirms the analyses and studies on Brazilian health policies made by researchers, such as the lack of financial resources, the significant administrative and management difficulties, the poor interaction between primary care and secondary care, and the lack of qualified human resources.

In summary, there is a gap between what SUS proposes in its design and what it actually offered to underserved communities, as stressed by Brazilian authors such as Paim (2011) and Santos (2009,02013).

It makes sense to analyze the identified proposals and alternatives to the MDP, such as: (a) expand and specify the cultural and historical content about Brazil during the training course in Cuba; (b) improve the logistics relative to reception and permanence in the different regions of the country; (c) facilitate wire transfers to Cuba; and (d) take better advantage of Cuban doctors' previous qualifications in order to allow them to achieve their full potential, by adapting the training program and the original supervision.

Finally, continuous improvement in the design and management of the More Doctors Program as well as an analysis of the participation of the Cuban doctors in the project are crucial to implement the desired and needed changes in Brazilian Primary Care, similarly to what should occur in all large-scale government programs.

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Photograph: Ana Lucia Kist

Photograph: Alejandro Zambrana

Chapter IX

EPILOGUE

Joaquín Molina[1] and Carlos Rosales[2]

The Brazilian sanitary reform was a landmark in the evolution of the approach to health and public health development in the Americas. Its origins go back to the Federal Constitution of 1988, which established the universal right to health, determining also that each state is responsible for guaranteeing the necessary conditions for the full exercise of this right by the population.

The 30th anniversary of Brazil's Unified Health System (SUS) unfolded within various political, economic and social contexts that did not represent insurmountable barriers to important advances in access, coverage, integral care and social participation in public health management. At the same time, many other challenges persisted in collective health and the administration of health care service networks which, added to the new health challenges and the financial restrictions imposed on public administration, must be resolved to achieve the most relevant goals regarding access to quality health care and universal coverage.

One important progress has been the improvement of primary health care in Brazil. After SUS's implementation, primary health care began a decentralization process in 1990, and is now available in more than 5,500 cities, with approximately 38,0000 basic health care units (BHUs) installed.

In the late 1990s, the Ministry of Health created the Family Health Program as a strategy to develop new guidelines for basic care in the entire country, strengthening the concept and practice of primary health care by defining it as the first point of contact between the Brazilian population and the health system. This strategy is organized around a multidisciplinary team comprised of doctors, nurses and community health agents (CHAs), with the opportunity to interact with other professionals such as dentists, psychologists and specialists, with actions directed towards the provision of healthcare and sanitary monitoring of the population living in geographically delimited areas, with approximately 3,000 inhabitants.

In a country with the territorial dimension and the population of Brazil, the family health model is being progressively implemented and, today, data show that approximately 70% of the population is already covered, according to official statistics of the Ministry of Health. However, a noticeable

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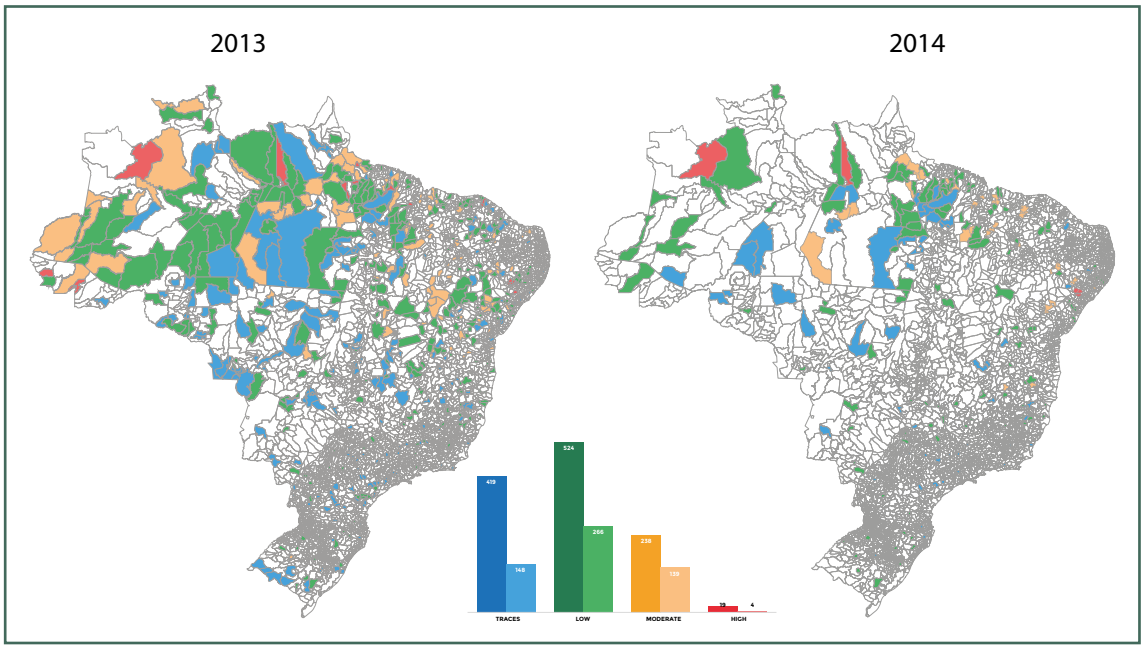
[2] International Advisor of PAHO/WHO in Brazil.

limitation evidenced in recent years has been the shortage of doctors working in primary care. This deficit affects the national distribution and adequate training of professionals at this level of care.

Chart 2. Cities with shortage of doctors in primary care – levels of shortage in 2013 and 2014



Source: EPSM/UFMG

This scarcity of doctors was exposed both by social movements and city administrations, at the Mayors National Front(FNP), which demanded support to recruit physicians using the motto "where is the doctor[3]". This movement fostered the organization of a public petition on the issue and strengthened the lobby in the National Congress to approve the legislation that allowed the creation of the More Doctors Program.

At that time, the cmayors assured their support to rigorous criteria for the selection of these doctors as, for example, previous experience in primary care and willingness to relocate to underserved areas. According to a research study by the Research Institute for Applied Economics (IPEA), the main problem faced by 58.1% of SUS's users is the scarcity of physicians. Official data indicate the existence of 1.8 doctors per 1,000 inhabitants in Brazil, while in other countries, like Argentina and Uruguay, this proportion exceeds 3 doctors per 1,000 inhabitants.

As a result of these movements and the effective action of the federal government, the More Doctors Program was created through Interim Order No. 621, published on July 8th, 2013, and made official in October of that same year, by Law No.12,871, after intense public debate within society and the National Congress. It was an initiative that, at first, faced tremendous opposition from political and corporate institutions within the health sector.

[3] http://cadeomedico.blogspot.com/p/peticao.html.

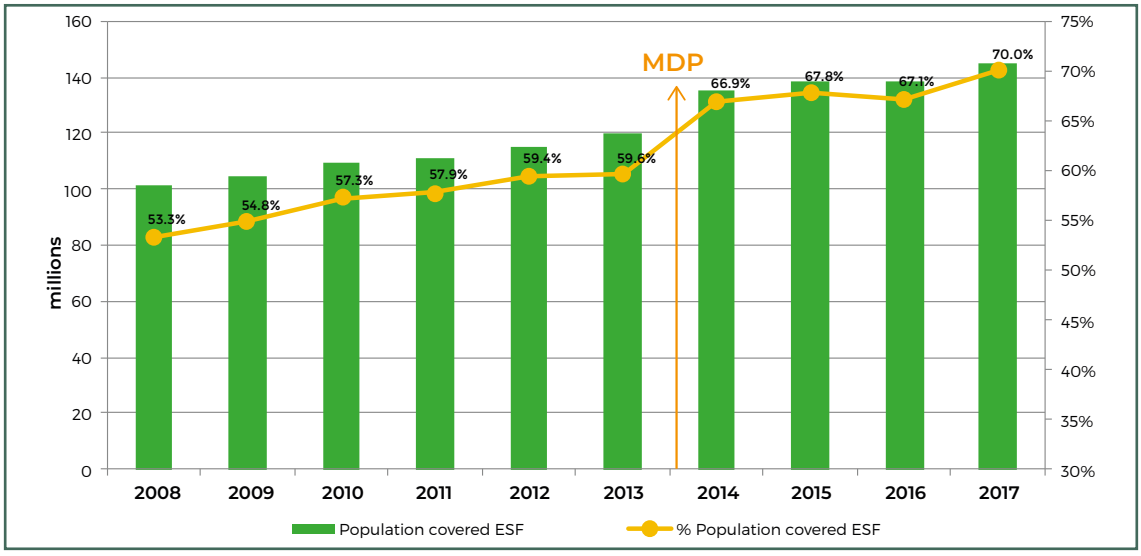
The premise behind the creation of the More Doctors Program was the lack of access to health care services affecting the less privileged population in Brazil, from the perspective of integrality in health care. Thus, the Program was structured based on three action plans: (1) qualification of doctors; (2) investment in infrastructure for the first level of care; (3) contingency recruitment of doctors for primary care positions, with the employment of Brazilian and foreign doctors from countries with higher doctor/inhabitant ratios than Brazil.

The organization and execution of the Program, particularly in regard to the contingent supply of doctors, relied on the participation of foreign doctors, most of them Cuban. Some conflicts emerged as a result of prejudice about the technical qualification of the exchange doctors. Political opposition also questioned the need of their presence, their skills, and the relationship established with the Cuban government.

The Pan-American Health Organization/World Health Organization (PAHO/WHO) played a vital role in the articulation of agreements between the two countries, and the mobilization and supervision of Cuban health professionals in Brazil, a process that is still in progress.

After five years of the Program's implementation, there have been changes, numerous investigations, case studies, theses and analyses, demonstrating the positive impact of the Program, both in terms of scaled-up coverage and access to health care, and improved quality of primary care. This information is evidenced by the evolution of health indicators on the effectiveness of primary care (i). There is evidence of an important increase in the national coverage of the Family Health Strategy, as shown in the following chart.

Chart 3. Population covered by the Family Health Strategy, Brazil, from 2008 to 2017.



Source: Chart created by PAHO/WHO Brazil with data on the coverage of the Family Health Strategy of the Ministry of Health.

In addition to this research on the sociocultural interactions of doctors with the population assisted by SUS, there were numerous other studies, which assessed the relevance, accessibility, efficiency, efficacy, and impact of the MDP throughout its five years of existence. The information gathered allows us to look at the impact of the mobilization of Cuban doctors under a different light, as described next.

As in a photograph, a synchronous perspective that shows the views and perceptions of male and female Cuban doctors mobilized for a period of three years; what they have learned from their interactions with specific population groups from Brazil, such as the indigenous people and *quilombolas*; the interlacement of knowledge with traditional indigenous medicine; and the practice of primary care in diverse locations. This perspective analyzes, therefore, the social- professional and sociocultural interactions, and leads us to infer that the impact of the Program goes far beyond the results described by common indicators of public health.

A historical and relational perspective, based on the various narratives of participating doctors about their experience in developing relationships with a new culture, in the heart of a community that, at first, was suspicious but later welcomed the visitors. They combine their stories and emotions in Brazil with their life stories in their country, where they have their loved ones, their families, and their life references.

The different chapters in this book indicate that the More Doctors Program and the participation of Cuban doctors have inaugurated a new sanitary landmark and new sociocultural relations at three different levels, at least: in the relationship between doctor and community, towards equilibrium and harmony; in the community's perceptions on health and how to improve and preserve it; and in the population's empowerment regarding their right to health care, including the immediate availability of doctors and health care teams.

This publication also confirms the need to approach the international migration of health professionals from a holistic perspective. It is important to identify and understand how these professionals are prepared to better address the sociocultural challenges of the migration process and recognize the human and professional gain from these experiences, for all those involved, including the population assisted, local government agencies, professionals and technical cooperation agencies, such as the PAHO/WHO, an active participant in the development of the MDP.

A few points below are listed for consideration which will serve as guidelines for other studies that may further the understanding of these processes and provide useful information for similar exchange programs.

This has been a singular experience given the limited duration of the migration (three years) which included the assurance of employment provided to Cuban doctors in terms of salary and welfare benefits in their countries of origin.

The mobilization of health professionals between countries to address medical deficits in health care – in this case, managed by PAHO/WHO – is effective in extending coverage. However, it must be pointed out that it cannot solve the structural problems that lead to the shortage of health care professionals. Thus, this mobilization of professionals needs to be accompanied by policies and strategies regarding the training and employment of medical personnel, in terms of quantity, locations of employment, as well as the necessary preparation, as a tool to promote the sustainability of universal access to health and coverage.

It is also evident the need to continuously monitor the prevailing social discourses during the implementation processes of strategies such as the MDP, not only with the purpose of becoming aware of public opinion movements, but to generate favorable opinions and actions, and counteract negative assumptions, considering the influential power that some of the players involved may have. Therefore, the role of social communication, conveying correct information from health authorities and their partners, is extremely

important. In particular, the population benefitted by the program needs to be heard to allow an opposing view when most media contents are unfavorable.

The relationship between traditional indigenous medicine and western medicine has always been the object of analysis about how they may establish a mutual dialogue within a respectful and knowledge-based framework. This perspective allows the possibility of complementary work and acceptance by indigenous communities. The stories and findings presented in this study emphasize the respect of Cuban professionals for native traditions and knowledge, recognizing their implications in the relationship with the Program's beneficiaries. Exchange doctors were unanimous about the need to systematize best practices, promote an interchange with other experiences developed in similar contexts, and include this knowledge in the qualification programs directed to foreign doctors allocated to work with native populations.

One of the themes exhaustively analyzed throughout this publication is the understanding that the provision of healthcare is not limited to promoting doctor's appointments, which implies in two major conclusions : (a) the bonds between professionals and the population, and the establishment of respectful relationships between doctors and other health professionals advanced the higher goal of public integrated care with the quality standards defined by SUS's model of care; (b) The interaction between two cultures – with different views and practices in their respective societies, but having several elements in common, determined by similar ethnic and cultural origins – influenced the remarkable acceptance of cooperating doctors, providing them with spaces of influence to transform practices and conditions for the improvement of health care.

Although Cuban migration is temporary, the Cuban doctors' concerns with the population's health, going beyond their stay in Brazil, was demonstrated by their strong, morally- and ethically-based commitment, within a process of integration and spontaneous engagement with no hierarchies and barriers, except in the initial contact, due to the limitations imposed by language differences which were eventually resolved.

In conclusion, the processes included in the definition of public health policies involving the mobilization of human resources between nations, with the purpose of obtaining positive results in improving general health, may be limited if success is measured only through traditional indicators such as mortality and morbidity rates, access, and coverage. On the contrary, it is imperative to expand the analytical horizon, incorporating the international health perspective, reviewing and documenting the changes in people, processes and institutions involved in such international migration processes, both permanent and temporary, such as the MDP.

Finally, it should be pointed out that the More Doctors Program is already in its 6th year. According to authorities, there are over 18,000 doctors financed by the program in all Brazilian states. The number of participating Cuban doctors was 11,400 in the first three years; since 2016, this quantity has progressively decreased, reaching approximately 8,500, while the number of Brazilian doctors has increased, particularly doctors who have graduated in other countries and, like the Cubans, worked exclusively in primary care health centers. Until 2013, the 27 Brazilian capital cities together accounted for 8,858 opening in medicine courses, while the more than 5,000 municipalities offered 8,612. Today, the number of openings in capital cities has increased to10,637 and, in the countryside, 14,522.

Due to the demand of municipalities, and taking into account the number of family health teams with no doctors available full time, particularly in regions less developed socially, the number of doctors to be recruited by the MDP may be even higher than the current 18,000. This suggests that the presence of doctors with foreign diplomas will still be needed for many years to come.

Consequently, the reflections, considerations, and recommendations exposed in the various chapters of this book become especially relevant and need be taken into account by all those involved in the development and supervision of the More Doctors Program in Brazil.

This book was organized by Joaquín Molina, Eduardo Siqueira, and Leonardo Cavalcanti, based on the results obtained from the study entitled "Sociocultural interactions of Cuban doctors participating in the More Doctors Program in Brazil".

This publication has been revised and approved by PAHO/WHO's Editorial Committee, whose attributions include quality assurance and strategic alignment of all published documents. The names of the authors are exhibited in every chapter. Final revision was made by Flávio Goulart, Janine Giuberti Coutinho, and Lucimar Rodrigues Coser Cannon.

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