

Moving medicine inside the neighborhood

Health care and sociospatial transformation
in Caracas, Venezuela

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Abstract

This article focuses on the spatial significance of health care access, analyzing how state health programs effected sociospatial transformations in poor urban neighborhoods in Caracas, Venezuela. Starting in 2003, the leftist state constructed a parallel public health system to shift biomedical care from hospital emergency rooms to small clinics in neighborhood settings, arguing that it would improve the quality and accessibility of medical care for the poor. The new national health program, Barrio Adentro (Inside the Neighborhood), explicitly reorganized public medicine according to the pragmatic and symbolic significance of place.¹ This article, based on fifteen months of ethnographic research in central Caracas, focuses on the meanings of these new health spaces for patients. Patients viewed the placement of clinics – and doctors – in barrios and working-class

¹ In this article I use the most popular English translation of Barrio Adentro: ‘Inside the Neighborhood’. I do this for simplicity’s sake and because no satisfactory term exists in English to communicate the meaning of ‘*barrio*’ in the Venezuelan context. However, ‘*barrio*’ does not mean ‘neighborhood’ in general; rather, it refers to a poor urban neighborhood characterized by informal settlements (journalists often describe *barrios* as ‘slums’).

neighborhoods not only as logistically necessary but also as a moral and political commitment on the part of doctors and on the part of the state that employed them. In a context of marked spatial segregation along class lines, the placement of doctors ‘inside the neighborhood’ was symbolically significant because it marked such communities as deserving of services and challenged longstanding divisions between marginalized and privileged social groups in Caracas.

Keywords

space, medicine, public health, socialized medicine

Therapeutic landscapes and spatializing culture

This article integrates the concept of therapeutic landscapes from the field of health geography with an anthropological analysis of the social construction of space to show how Chavez-era health projects changed marginalized urban spaces in order to render them more therapeutic. Integrating different disciplinary approaches to space, I argue that this development in Venezuelan state health care is an example of sociospatial change.

Over the past twenty years, health geographers have developed the concept of therapeutic landscapes to explain how certain social and natural environments promote healing (Conradson 2005; Gesler 1992; Kearns and Gesler 1998; Tonnellier and Curtis 2005; Wakefield and McMillan 2005). Focusing attention on the notion of health in place and emphasizing the social construction of space, the concept of therapeutic landscapes encourages us to consider how shared cultural expectations of a place’s healing potential may affect the outcome of medical encounters (Gesler 1992, 1993, 1996). First applied to the study of famous healing sites, such as Lourdes or Bath (Gesler 1993, 1996, 1998), the concept has expanded to include ‘natural and built, social, and symbolic environments as they contribute to health and well-being in places – broadly termed landscapes’ (Williams 2007, 1–2). Scholars have applied the concept of therapeutic landscapes to analyses of roadside art (Einwalter 2007), fictional accounts of healing (Tonnellier and Curtis 2005), and even nonphysical healing environments such as telephone- and internet-based anxiety therapy (Davidson and Parr 2007). In my analysis, I focus on understanding how spaces with a longstanding reputation for endangering health may be intentionally transformed into therapeutic spaces (see also Frazier and Scarpaci 1998; Wakefield and McMillan 2005). In doing so, this article builds on the work of Gesler (1993) and others who claim that therapeutic landscapes may emerge organically over time or they may result from intentional planning and construction. I examine how the deliberate placement of clinics, medical professionals, and community health programs in socioeconomically marginalized areas did

not merely promote healing for individual bodies but resignified these areas as social spaces that could heal the body politic (Scheper-Hughes and Lock 1987). Programs like Barrio Adentro signified more than the physical reparation of disease for local residents. State health programs were intentionally spatialized to transform the experience and the imaginary of the barrio from a marginal 'red zone' to a life-affirming part of the formal city. State-endorsed associations between health and space promised social reintegration via the provision of health care, which was compelling for residents of poor neighborhoods who already understand health to be tied to space and place.

I integrate the concept of therapeutic landscapes with an anthropological approach to the study of space that posits that space and place are not neutral sites upon which social life independently plays out. Instead, spatial processes are implicated in everyday meaning making, in the institution and maintenance of social and political order, and in the perpetration of and challenges to social exclusion and inequalities (Low 2011). Low (1996, 861) proposes an analytic approach, which she calls 'spatializing culture', 'to locate . . . social relations and social practice in social space'. She identifies four types of social practices for anthropologists to study: the production of material space, people's uses and experiences of space, discursive practices that make meaning of space, and embodied practices in which people's bodily presence produces a sense of place (Low 2011, 392). By paying attention to spatial processes and spatial meanings, we can better understand how governments construct populations and social hierarchies, and how people contest and attempt to reformulate unequal power relations.

Anthropological research on space and place often examines the state-directed spatial entrenchment of inequalities and the responses such policies engender (Rabinow 1989; Holston 1989; Caldeira 2000; Garcia 2010). My research provides a different perspective on state-directed processes of urban planning, by examining health programs that aim to reform spatialized inequality. Integrating a theoretical understanding of how place constitutes health with an analytic approach to spatializing culture that emphasizes power relations, I show how patients understood state health programs as transforming their neighborhoods into spaces that were healthier and less marginalized. This analysis demonstrates that spatialized inequalities may be challenged by state health programs, given sufficient resources and political will. More broadly, this work also directs theoretical attention to landscapes as constructed and thus transformable environments.

Spatial inequality in urban Venezuela

Anthropologists of Latin America have already shown how social inequalities become ingrained in the urban landscape via formal and informal processes of city development

(Caldeira 2000; Holston 1989; Low 1996). Their work highlights how urban spaces in Latin America are spatially segregated along racial and class lines. For example, Caldeira's work on suburban enclaves of Sao Paulo reveals how wealthy families literally walled themselves into their residences out of fear of crime, making longstanding spatial divisions between social classes in Brazil more visible, tangible, and impenetrable (Caldeira 2000). In Latin American cities, the development of informal settlements beyond the remit of city infrastructure and services (such as barrios and favelas) has resulted in landscapes of inequality. Often, fear of crime, popularly instantiated in the figure of the barrio or favela dweller, legitimizes new forms of spatial and social exclusion that further marginalize residents of these zones.

Spatial segregation along class and racial lines in Caracas was acute and immediately palpable, even to foreign visitors. Here, as in popular imaginaries elsewhere in Latin America, the association between informal settlements and criminality was strong. *Caraqueños* in particular were extremely concerned about violent crime, as the city's homicide rates were some of the worst in the world (Romero 2010; King 2014; Rebotier 2011). It would be difficult to overstate the extent to which the fear of crime and violence, glossed as 'insecurity' (*inseguridad*), dominated daily life, although the risk of crime was unequally distributed across urban spaces, leaving barrio residents far more vulnerable to crime than residents of wealthier neighborhoods (Zubillaga 2015; Rebotier 2011). For example, as of 2015 approximately 85 percent of homicide victims in Caracas resided in poor barrios (Zubillaga 2015).

Barrios and colonial-era neighborhoods in central Caracas (known as *el centro*) like Santa Teresa, where I conducted much of my fieldwork, were figured in popular imaginaries as *zonas rojas*, literally 'red zones', spaces of heightened insecurity that wealthy residents avoided unless absolutely necessary. While barrio residents would spend time in urban centers and wealthier neighborhoods for work, recreation, and shopping, members of the city's middle and upper classes rarely entered barrio spaces. As sociologist David Smilde (2008, 42) writes, 'many of the middle and upper classes have never in their lives set foot in a popular barrio'.

Caracas residents described barrios in terms that underscored the centrality of space and place in making sense of social inequalities in Venezuela. Even though not all barrios are located on the peripheries of the formal city or on hillsides, people described barrios as 'far', 'outside', and 'up'. Similarly, people often alluded to barrio residents with spatialized metaphors like 'socially excluded' or simply 'the excluded'. Policy discussions about how to deal with poverty often employed euphemistic spatial terms like 're-inclusion' or 're-integration' when referring to the goals of social welfare programs.

It is impossible to understand health care and health outcomes in Caracas without understanding spatialized forms of social inequality and exclusion. Like much of urban Latin America, life chances and social relations in Venezuela's capital city are shaped by systematic spatialized inequalities. In Caracas, *barrios* were the poorest urban spaces, the most socially marginalized, and the most deprived of services. *Cerros* were particularly problematic; these *barrios* were built into the valley's steep hillsides and were subject to unexpected mudslides in heavy rains. Other neighborhoods, while often not as economically or sociopolitically marginalized as *barrios*, also contended with poverty, crime, and intermittent or inadequate public services. For example, in Santa Teresa residents worried about the appearance of streets, sidewalks, and public spaces; violent crime, drug and alcohol use, and prostitution; and people living on the streets, squatting in abandoned buildings, or staying in cut-rate *pensiones* scattered throughout the neighborhood. All of these conditions posed a challenge to the health of residents. These areas were far from what health geographers might call a therapeutic landscape.

Until the mid-2000s, the physical landscape of poor neighborhoods in Caracas was often devoid of public health clinics or programs, a legacy of a historical failure to invest in *barrio*-based social services combined with the disinvestment that accompanied neoliberal reforms in the 1980s and 1990s. But the historical inequalities of Venezuela's health care system are not unique when considered cross-culturally. Systemic inequalities in health care access are all too common across societies in the global North and global South (Castro and Singer 2004; Farmer 1999; Pfeiffer and Chapman 2010). Anthropologists and others have demonstrated that the unequal distribution of health services not only leads to poor health outcomes, but also maps on to other social inequalities based on class, race, gender, citizenship status, etc. In recent years, few countries have attempted to expand or overhaul national health services to the degree that Venezuela has. As a result, the case of Venezuela's Barrio Adentro offers a unique opportunity to consider the material and symbolic effects of widespread improvements in health care access for poor and working-class people.

Moving medicine 'inside the neighborhood'

My research focuses on people's experiences of recently founded health programs, based on fifteen months of ethnographic fieldwork in Caracas between 2006 and 2009. I conducted the majority of my research in the working-class neighborhood of Santa Teresa, located in the middle of the historic city center, and in the *barrios* of Catia and 23 de Enero, both located west of the historic city center.² I conducted participant observation in health care

² These neighborhoods all lie within the densely populated Libertador municipality of Caracas.

sites (Barrio Adentro clinics, health promotion programs, and hospitals) and more than fifty in-depth interviews with patients, health professionals, and health activists. Most research participants were patients of Barrio Adentro and residents of the neighborhoods named above.

In 1999, the leftist political leader Hugo Chávez was elected to the presidency and soon after the people ratified a progressive new constitution that guaranteed access to health care. Four years later, the government began to institute the Barrio Adentro program of universal primary care as a cornerstone of its broad efforts to promote social justice and popular participation in government via innovative social welfare programs. The oil-rich state invested in expanding no-cost health care offerings in the public system by creating a new network of community-based clinics. Each clinic was designed for one doctor and nurse to provide free basic health services and pharmaceuticals. The government built thousands of clinics across the country in a unique architectural style, a red brick octagonal structure with blue trim, that made them easily recognizable symbols of the new health program's reach (see Figure 1). Filling approximately 80 percent of their physicians' posts with doctors from Cuba and modeling the system on Cuba's family doctor program, the Venezuelan government transformed access to medical services in a short period of time (Westhoff et al. 2010). Tens of thousands of doctors began working in new clinics, the country's rate of per capita pharmaceutical use rose to one of the highest in Latin America (E.M.S. 2008), and the government reported that infant mortality rates fell by more than 30 percent between 1998 and 2007 (Alvarado et al. 2008; Weisbrot et al. 2009). In the Libertador municipality of Caracas where I conducted my fieldwork (with a population of two million), more than five hundred Barrio Adentro primary health clinics were established between 2003 and 2008, most in neighborhoods that had had no public health services before (Mara Gomez, director of public health for Libertador municipality, personal communication, 2008). As a result, many people could walk from their home to a free clinic, which transformed many residents' perspectives of their neighborhoods. The public health system expanded to include other specialized programs, such as neighborhood-based health promotion programs for the elderly, called 'Grandparents' Clubs'. At the same time, the Venezuelan government rolled out many other social development projects to empower the poor and working classes. People's responses to Barrio Adentro were thus intertwined with their overall response to a deeply changed government that promised radical improvements in their quality of life.



Figure 1. Unmistakable architecture of a Barrio Adentro community clinic. The second story was designed to house the clinic's doctor who lived there full time. Catia, Caracas, Venezuela, 2008. Photo by the author.

For poor and working-class residents, the changes to health care could be quite profound. In the 1990s, people who needed biomedical care but could not afford private clinics sought treatment from hospitals. Patients commonly lined up outside hospitals at dawn and often waited until after nightfall to see a professional, or else were sent to another hospital across the city because workers were overburdened. One public health official critiqued this system as *la ruleta* or 'the roulette wheel' because patients were like the roulette ball, being bounced around from one overcrowded hospital to another before being admitted for care (Cancel 2007). According to Westhoff and colleagues (2010), since the introduction of Barrio Adentro the number of medical consultations with a physician has increased from 3.5 million per year to 17 million per year and emergency room consultations in Caracas hospitals decreased an estimated 30 percent. During my fieldwork I observed that in neighborhood clinics, individuals sought most services on a walk-in basis, without referrals or appointments. While some continued to seek care in the public hospitals and at older, pre-existing walk-in clinics, a many people seemed to prefer the Barrio Adentro community clinics.

Nearly every Barrio Adentro user I spoke to during my fieldwork claimed that the program provided them with much-needed access to biomedical care. Patients commented not only on the sheer fact of access but also on the significance of the local placement of clinics inside communities. For example, in December 2008 I met with medical professionals and

community health workers in a *barrio* in Catia, a sprawling region in western Caracas where families built their homes, sidewalks, and staircases into steep hillsides (see Figure 2). Residents relied on special four-wheel-drive trucks or *camionetas* to travel between their homes and the main streets below, from which they could connect to the city center using public transportation. In 2003, the government established a Barrio Adentro clinic in a living room of a resident's home, with a Cuban doctor and Venezuelan nurse overseeing the medical needs of residents. High in those hills, sitting in the makeshift clinic, the nurse and community health workers who worked there and resided in the area explained that the home in which the clinic was located was over sixty years old. They emphasized that this long-established *barrio* was not one of 'extreme poverty' (*pobreza extrema*) like some others, as many residents attended college and worked in the formal economy. In spite of this, they explained, there had been no health programs or clinics in the area prior to the current administration, and that many had suffered as a result.

The doctor and nurse explained that they staffed the clinic in the morning and made house calls in the afternoon, which was the expected practice for Barrio Adentro community clinics. The bulk of their work was in identifying and monitoring the chronic health problems of the community. Hypertension, asthma, and diabetes were their patients' most common diagnoses. The Barrio Adentro workers helped keep these illnesses in check with monthly clinic visits, medications, and lifestyle recommendations. The doctor explained that many of his patients had these diseases before Barrio Adentro, but they had gone undiagnosed due to lack of access to medical care. This narrative was characteristic of many I heard from Barrio Adentro workers and patients in other areas of the city.

In impassioned tones, volunteer community health workers (who also used the clinic as patients), explained what the clinics meant to their community. Luis,³ one of the community health workers, said:

Here, [in the past], many people died. They died because – first, just to get down to the, the transportation, you know? – at any time of day, whether daytime or in the morning, there just wasn't transportation, and then, who would take care of these people? When they would arrive at the hospitals, they were totally, totally congested [*colapsado*], it was hellish. Then, well, the Barrio Adentro network was born. . . . Truly, from our point of view, health has advanced considerably; these primary care [clinics] are here so the hospitals don't come to a standstill, so the hospitals don't continue to become even more congested.

³ This and all other names of research participants are pseudonyms.

During this conversation, health volunteers and the clinic's nurse narrated examples of patients they had seen who benefited from having the clinic in the steep hillside neighborhood. For example, wheelchair-bound patients who could only access roads via steep, uneven staircases now had doctors and health volunteers visiting them at home for routine care. The broader point they sought to make was that before Barrio Adentro, residents who sought biomedical care not only had to travel distances but also arrived in already overextended hospital emergency rooms; now, many of these cases could be treated (often long before they reached a critical stage) inside the neighborhood. As one Barrio Adentro nurse said matter-of-factly, when I asked how Barrio Adentro was different from other public health systems: 'It's different because people can get health care at any hour of the day and they don't have to travel all over the place just to be seen. Instead, we care for you right inside the community'.

Luis described the improvements brought about by various state projects, but noted that more needed to be done. During my visit, a community health worker named Mireya served chamomile tea and *ballacas*, homemade Christmas tamales wrapped in banana leaves and filled with meat, olives, and raisins. Everyone enjoyed them except for Wilmer, a local community organizer, who had to rush to a meeting to discuss the problem of uncollected trash that was creating a burden for the neighborhood. Luis offered concrete suggestions for improving the community's health care and revitalizing the barrio. These included adding a fleet of vehicles that could transport patients from their homes to specialized medical facilities (Barrio Adentro community clinics offer primary care only), and 'rescuing' nearby abandoned buildings to offer more social services. The group radiated excitement over the improvements brought about by state social projects, which was tempered by an impatience and frustration in their desire to further and deepen these transformations.



Figure 2. Barrio of Catia. Caracas, Venezuela, 2008. Photo by the author.

In order to understand how Barrio Adentro represents not just improved access to biomedical care but also a reordering of spatial politics and political belonging, we must take account of the spatial politics of Venezuela's capital city more generally. It is in this context that the new primary care program takes on added political meaning. From the beginning in 2003, the health program was conceptualized – in explicitly spatial terms – as a project of promoting equal access to care. The spatial emphasis is evident in the program's name itself, which focuses attention on the placement of clinics. In a country beset by striking social inequalities, instituting a universal health program called 'Inside the Barrio' makes a political statement about which communities merit attention and resources. Government officials advertised Barrio Adentro as a righting of past political wrongs (such as the failures of neoliberalism), as a means to equalize access to health care, and as a way to promote 'social re-integration' (Gobierno Bolivariano de Venezuela 2006; Coordinación Nacional de Barrio Adentro 2008).

The following excerpt from an interview I conducted with Viki and Katerina, two young women from Santa Teresa, illustrates how Barrio Adentro promoted a spatial politics of inclusion and recognition. Both women were college students; Viki was a nursing student at a prestigious national university and Katerina was a Barrio Adentro patient.

AC: What is the difference between Barrio Adentro and other systems of public health?

Viki: Well, look, there's a big difference because Barrio Adentro has integrated itself in a very special way that is aimed at the patient. In other words, Barrio Adentro is a very profound public health system because it is in the barrios, whereas doctors,

previously, did not go to the barrios. Now, Barrio Adentro is indeed including all these areas, you see?

Katerina: In other words, it is including the excluded [or marginalized people, lit., los excluidos].

Viki: Yes, exactly. Including the excluded, I mean, the excluded don't have to come down here. Right up there we have Barrio Adentro and with specialist doctors, those with medical specialties.

A woman from the same neighborhood named María vividly described the transformation of health care access in spatial terms. As she speaks, one can imagine an animated map of the country with doctors and medical services flowing from economic and political centers to the peripheral zones of cities and states:

In Venezuela what is happening is – well, I'll speak first about what's happening at the national level – and that is that the Venezuelan doctors, I don't know why, but they haven't wanted to integrate themselves, but you'll see that the Cuban doctors are spread out across the entire country. There isn't the smallest corner of Alto Apure or Amazonas [in Venezuela] where they are not offering their solidarity, their medicine, all the way to the indigenous communities of the Wayúu, the Piaroa – all the way to the very top of the *cerro* Petare [in eastern Caracas]! The people [I've met in Petare] have told me: 'look, *señora*, here if we don't have a car and we have to get a patient to medical care at 11 or 12 at night, they die on us', and more than one has died because the transports only run until a certain hour. So the miracle that here you have right beside your house a doctor, this is a blessing of God, and this is thanks to the Cuban-Venezuelan agreement, you know?

The fact that most Barrio Adentro doctors came all the way from Cuba to work in poor Venezuelan communities was one of the most unique features of the health program, and one that carried deep political significance for its patients. Most patients I knew characterized Venezuelan doctors as elites who were unwilling to step foot in a barrio, much less work there. In comparison, many patients thought that Cuban doctors communicated solidarity with the poor by living in the neighborhoods where they worked. This made accessing health care convenient, as after-hours emergencies could often be addressed in one's neighborhood, and it distinguished the doctors in Barrio Adentro from other doctors in Venezuela. In order to staff the clinics in the future, the government has been offering free medical training for thousands of Venezuelans, many of them from the same communities that Barrio Adentro services target. This also effects a spatial reorganization of health care, since in the past, most Venezuelans doctors hailed from wealthier neighborhoods.

Therapeutic landscapes for aging Venezuelans

Placing clinics, doctors, and medications in poor neighborhoods was the most obvious way that the state sought to transform barrios from places that endangered health into places that promoted health, transforming them into new sorts of therapeutic landscapes. But the development of related health programs, like the Grandparents' Clubs, also transformed the meaning of neighborhood spaces. More than five thousand of these community-based exercise clubs have been established with state support since 2003. The clubs recruit aging neighborhood residents into daily exercise and other recreational activities in public space, and, as I show, change the experiences of health and place for their participants. Technically, each is sponsored by a Barrio Adentro clinic, though I did not observe any practical ramifications of this beyond advertising the club to patients when they visited clinics for medical services. I began conducting sustained participant observation with Grandparents' Clubs after a serendipitous encounter on one of my first days of fieldwork when a contact of mine brought me to observe a club's lively dancing and socializing in an otherwise sleepy courtyard.

In the club that I observed regularly, between twenty and forty aging adults – over 90 percent of them women – met weekdays as the sun was setting, spending up to two hours stretching, dancing to blaring pop and salsa music, and gossiping under the tutelage of a local volunteer teacher.⁴ The club meant different things to its members, who ranged in age from fifty to more than ninety years old. Some used it as an informal physical therapy, supporting themselves with canes or walkers while attempting pared-down versions of the challenging moves the teacher performed. Other more sprightly members wore vibrant spandex outfits and enhanced their workouts with homemade weights of water bottles filled with sand. Still others made little pretense of attending *bailoterapia* (dance therapy) for the exercise; they wore street clothes or housedresses and perched on concrete benches at the periphery of the action, talking amongst themselves. In spite of these differences, I documented among members a shared conviction that participating in the club made them healthier. Also, meeting in public spaces was seen to be meaningful for their health regardless of the specific activities each person performed.

⁴ Near the end of my fieldwork, after the club had been operational for approximately one year, a Cuban sports trainer was assigned to lead the group's activities.



Figure 3. Bailoterapia (dance therapy) with a Grandparents' Club in a public school courtyard, Santa Teresa, Caracas, Venezuela 2006. Photo by the author.

Members associated the physicality and sociality of bailoterapia with the activation of mind and brain, and with generating positive emotional and psychological effects. More specifically, people reported that socializing and exercising in public space were essential for good health. Some even claimed that staying indoors, in private spaces like the home, could lead to illness and death. As Lourdes, a club member, told me:

On various occasions, I've told my family that I am truly very content [with the Grandparents' Club], because this is what people like us have been missing, people of the third age. Because if we don't have a job we should [still] go outside every day, right? Join in many activities. I believe that one just starts rusting inside the house, staying inside, staying inside, getting sick, getting fat, and worst of all, the brain is closing in on itself. Because being inside the house is just – every day you're dying a little more: not talking to anyone, not learning about anything, so the brain just goes to sleep, the mind closes.

Although others shared the belief that staying indoors threatened physical and psychological health, they told me they found it challenging to take advantage of being in public space, given especially their fear of crime. The Grandparents' Clubs provided opportunities to publicly socialize with other residents, and thereby counter the sense of *inseguridad* that prompts many to *encerrarse en la casa* or 'lock themselves in' by 6 or 7 pm every evening. The idea of having, as one woman called it, 'a place to come to', where older adults can socialize and relax in public space, was important to these people, as evidenced by the frequent comments that no such spaces were previously available to older people like themselves, with their limited financial resources.

As I got to know club members, I learned they shared a narrative of having become more contented and healthy from participating in the clubs. Estrella was a quiet, mild-mannered, seventy-eight-year-old resident of Santa Teresa who attended *bailoterapia* regularly, nearly on a daily basis, and became one of my favorite people to talk to when I attended. She seemed well-liked by the other members, too: most people made a point to seek her out, give her a hug, and ask how she was feeling. Estrella shuffled about in a well-worn dress and thick-soled orthopedic shoes. Some days she walked with visible difficulty, which she attributed to an illness or some worry she was having. This made her seem older than other club members of the same age who dressed in more youthful, athletic clothing and who exerted more energy in their movements. However, Estrella's slow movements and quiet speech belied a charming mischievousness that she displayed in conversations when she took breaks from exercising. For example, when a Cuban sports trainer was assigned to live in Santa Teresa and work with their club in December of 2008, Estrella made sly jokes with other women about which of them should let the handsome young trainer sleep in their home.

Estrella learned about the club from the club's founder, an elected neighborhood council member, because she lived next door to their offices. The nurse in her local Barrio Adentro clinic also encouraged Estrella to join. By her own account, Estrella had been living an isolated, sedentary life before joining the club at the beginning of 2008. She had lived in an apartment in the center of Santa Teresa for thirty-five years, and was now a widow living with her only surviving child, an unmarried son. When we first met and I asked her what she thought of the Grandparents' Club, she told me that she liked attending *bailoterapia* because 'it's good to get out of the house'. I did not think much of this claim until I learned that Estrella would often spend the entire weekend inside her apartment, not leaving until Monday when she would attend *bailoterapia*. Estrella also joined in most of the club's outings that year, which included trips to thermal baths, the beach, meet-ups with other clubs in public parks, and theater performances.

In an interview, Estrella described her experience of the Grandparents' Club:

AC: Has the Grandparents' Club helped you?

Estrella: Yes, because if I don't go for a while I lie around in bed, and then at night I'm tossing and turning, but here I distract myself, you see? And when I go to sleep at night, before it was very difficult for me, but now I wake up feeling lighter on my feet, even though I don't do that much exercise here [in *bailoterapia*].

AC: . . . Do you think the lives of older adults are improving now or is it similar to the way it has been before?

Estrella: No, now there are more clubs.

AC: More clubs?

Estrella: Yes, more clubs. I see people of the third age as more optimistic now, because of these clubs and things.

AC: So who organizes and who funds these clubs?

Estrella: Well, this all started after Chávez. Before, people would have to pay to go to some therapy like this.

AC: So, why did they fund these clubs for grandparents?

Estrella: Oh, I don't know, for our well-being, and because he [Chávez] is such a caring person and he loves the grandparents – you know that!

Eugenia was another woman involved in the club, but unlike Estrella she was involved in many organizations and courses. Each time we met, Eugenia told me a story about something interesting she had done recently. The seventy-eight-year-old grandmother traveled across town to a government day center for older adults, belonged to a dance group that performed choreographed dances, and took free computer literacy classes taught by youth social workers. In an interview she described her experience with the new health projects as a significant improvement in her quality of life:

AC: Do you feel as if your health has improved?

Eugenia: Yes, yes, yes. Very much so, but more than anything, psychologically and emotionally. Because before I used to feel – left out, that I was nothing more than a slave in the home: cooking, washing, ironing, with no incentive, without that something special that one needs, you know?

AC: And how have you changed?

Eugenia: I've changed a lot, because today I feel like a different person. For example, with [the Grandparents' Club] we go to the beach. Different people go and we hang out like family. If we have to make a *sancocho* [traditional stew], each person helps to peel the potato, the yuca, the plantain, and cook it and serve it and, well, it's a beautiful brotherhood. Really great. You know, we didn't have these before, these clubs for older adults.

Eugenia emphasized the sociality she enjoyed through her participation in the new health and social programs like the Grandparents' Club. Her personal transformation had spatial aspects, as she associated her interior home life with misery and isolation, and her outdoor activities with happiness and kinship/social relations.

In January 2009, Eugenia competed in – and won – a beauty pageant for older adults that the club's founder had organized to coincide with the city's Carnival celebrations. Many neighborhoods chose a 'King and Queen of the Third Age' to compete in a citywide pageant during the week of Carnival. The club's founder, who was also an elected neighborhood councilperson, set up a large stage and sound system in the largest plaza in the

neighborhood, Plaza la Concordia, and encouraged many of the club members to participate; as a result, the majority of contestants were club members. Each person dressed up in their best dress and wore heels and makeup. A few women who had participated in the recent pageants had special costumes made to look like showgirl outfits. Balloons decorated the stage and red chairs were set up in orderly rows for the audience, made up of contestants' families and neighbors.

Contestants took turns standing in front of the microphone and giving 'advice for the younger generation'. All seemed to enjoy this opportunity to publicly address their neighbors, share their worldviews, and bask in the attention. Eugenia beamed throughout, standing up proudly with one leg positioned in front of the other like a beauty pageant participant. The event offered a counter-narrative to accepted ideas about the elderly, as the men and women on stage presented themselves and were celebrated as socially and politically engaged with active, vital bodies.



Figure 4. Contestants in the 'Queen of the Third Age' Carnival pageant in Plaza la Concordia, Santa Teresa, Caracas, Venezuela, 2008. Photo by the author.

The pageant also resignified the space of the plaza. During fieldwork in the neighborhood, I heard two stories of people being murdered in the plaza, and some residents reported that they avoided walking through it out of fear. The plaza was flanked by narrow colonial-era streets, and as we walked down these corridors, informants had chided me for not holding my shoulder bag properly to avoid having it stolen. Holding this event in Plaza la Concordia was a political statement that temporarily reconfigured the dilapidated concrete plaza as a

safe, viable site for health-promotion activities, public entertainment, and sociality (notwithstanding the fact that some visibly inebriated men on the margins of the event heckled the speakers from time to time). Similar events included a day-long Olympics of the Third Age held in a large centrally located park, with neighborhood teams of elderly residents competing in athletic events (topped off by a huge *bailoterapia* session), and an event honoring The Day of the Older Adult (Día del Adulto Mayor) in the symbolic Plaza Bolívar, adjacent to the National Assembly.



Figure 5. Plaza la Concordia during the day. Caracas, Venezuela, 2006. Photo by the author.

Transforming social space through health projects

Since 2003, changes to Venezuela's public health system have not only transformed access to medical care, they have also transformed understandings of communities as life-affirming spaces. This is important in a city like Caracas, where so many communities are stigmatized as places that endanger health. My research reveals some of the conditions that enable institutions and individuals to resignify even life-threatening places as therapeutic landscapes.

Applying Low's concept of spatializing culture, and its rubric for analyzing the constructed nature of social spaces, can help us understand the process of change I describe. She discusses four processes that anthropologists should analyze: (1) the 'social production of space' (actions to physically create spaces, such as constructing buildings, transport systems, or cities); (2) the 'social construction of space' (people's experiences of and in physical spaces that give meaning to those spaces); (3) discursive practices, including everyday conversations, media reports, and official pronouncements, that make meaning of space; and (4) embodied

practices that change the meaning of places, in which the person is ‘a mobile spatial field’ who, through everyday actions, ‘produces place and landscape’ (Low 2011, 392).

I found that Barrio Adentro and other new health programs transformed poor neighborhoods into therapeutic landscapes in at least three ways. The first way of effecting change was discursive: through the use of language and other symbols, government officials and institutions reframed existing understandings of space and health. The creative naming of the nationwide program that promised to bring medicine ‘inside the barrio’ was an important semiotic move that drew attention to the place-making qualities of this community-based health program. Speeches and pronouncements emphasized concepts of social exclusion (*exclusión social*), social inclusion (*inclusión social*), and social reintegration (*reintegración social*), highlighting the fact that health programs were not only seeking to improve health outcomes like life expectancy, infant mortality, or vaccination rates but also were explicitly interested in effecting sociospatial transformations as well. Symbolic features of Barrio Adentro, such as the iconic architecture of the eight-sided red brick clinics, were unlike any other aspects of the built environment in the city. They were unmistakable symbols of social and spatial change that visually popped out of the landscape, marking poor neighborhoods as capable of attending to the population’s health in new ways. These aspects of space making clearly map onto Low’s category of ‘discursive practices’.

The second way such programs effected sociospatial change was through physically changing neighborhoods and how people used them by building clinics and providing health services. Offering free access to biomedical care within the neighborhood changed people’s experiences of personal health, encouraging them to view their neighborhood as a place that can treat diseases and promote health. Barrios and other poor neighborhoods became, quite literally, more therapeutic spaces after the institution of Barrio Adentro clinics. In some areas, this change has been very dramatic, as in Santa Teresa, which had no public health presence prior to the first Barrio Adentro doctor arriving in 2004. Providing new clinics and free medical services, pharmaceuticals, and health promotion activities on a massive scale not only improved health outcomes, but these activities also resignified the poor as deserving of state services, as full citizens. Government construction of new clinics and programs were top-down (state-led) practices in the social production of space (Low 2011). Sometimes, these were also bottom-up (community- or activist-led) practices in the social production of space, because the state relied on local community activists to identify disused spaces for clinics and to oversee the work of construction teams building new clinics (Cooper 2015a). The construction of new clinics remade poor and working-class spaces not just through the physical construction of clinics (what Low (2011) calls ‘the social production of space’), but also through the way people responded to and used the clinics (what she calls ‘the social construction of space’).

The third way that health programs effected sociospatial change was by claiming space, particularly public space, for new, pro-social purposes. These different forms of claiming space often entailed aspects of the social construction of space and embodied space making (Low 2011). Often, local residents occupied and enacted changes to public spaces in response to calls for them to participate in state health-promotion programs. In densely populated urban areas, community health activists commonly established new clinics by repurposing local government offices, using the front rooms of a willing resident's home, or taking over an abandoned building while plans developed for a more permanent, purpose-built structure. Participants in Grandparents' Clubs used public school courtyards and neighborhood plazas to perform their daily exercises, and in the process reclaimed these spaces for leisurely socializing and community well-being. Claiming public spaces for health also occurred when government leaders worked with activists and health professionals to host *jornadas de salud* (health fairs) in neighborhood plazas. These were usually held on weekends and offered a range of services. One that I attended focused on healthy eating and provided body mass index measurements and dietary recommendations for attendees. Another fair, pictured in Figure 6, offered a range of medical services as well as educational seminars for residents and community health workers. The celebration for the Day of the Older Adult included a separate tent where medical professionals provided flu shots and basic health checks for attendees. Such public spaces were generally not considered healthful or even safe spaces in these neighborhoods, so offering health-promotion activities there was not a neutral act, but rather a deliberate resignification and reclamation of parks and plazas as healthful, public places. Drawing people into public spaces to dance or receive medical care produced embodied spaces (Low 2011) that remade the meaning of these places. Groups like the Grandparents' Clubs encouraged residents to literally move their bodies in public spaces for the purposes of promoting health and sociality, and in so doing, sought to transform the meaning of those spaces.



Figure 6. Waiting for free optometry exams at a health fair in Plaza O'Leary in central Caracas, 2008. Photo by the author.



Figure 7. Members of Grandparents' Clubs and Cuban sports trainers pose for photos at a meeting in Parque del Oeste, Caracas, Venezuela, 2008. Photo by the author.

Public health programs entailed the social production and social construction of space as well as embodied and discursive practices of remaking space, resulting in a multifaceted process that promoted barrios and other poor neighborhoods as therapeutic landscapes. Of course, this sociospatial resignification was always partial and fragmented. State-sponsored health projects have faced a number of financial and political challenges. The Chávez-era health programs, which continue apace today, promised more than they could deliver, though it must be noted that they promised quite a lot: universal medical coverage, the vitalization of deeply marginalized communities, and empowerment for historically disenfranchised Venezuelans, all in the name of a new brand of socialism. Thinking in terms of therapeutic landscapes, it would be unreasonable to suggest that these programs transformed poor neighborhoods into therapeutic landscapes in any totalizing or wholesale way. Barrios and other poor communities continue to be perceived and experienced as threatening to health and well-being, due to continued problems of *inseguridad* and poverty. This manifested in an ironic turn of events near the end my fieldwork in Santa Teresa in 2008, when a Barrio Adentro clinic started locking their exterior door during business hours because the doctor was afraid of crime and wanted to control who entered. The exterior door was made of iron bars, giving the clinic a prison-like appearance even when it was open to the public. Visitors had to stand at the door and call out for a community health worker to let them in, a process that community health workers complained about because it symbolically undercut the program's promise to make medical care accessible and integrated in the community. Efforts to transform poor urban areas into therapeutic landscapes were hampered by the lack of more broad-based social and economic changes that could lead to a decrease in violent crime. At the same time, for many people these neighborhood spaces have nevertheless changed for the better, becoming more life affirming in both a pragmatic and symbolic sense.

Conclusion

This article expands the concept of therapeutic landscapes by presenting a detailed analysis of a government effort to transform neighborhood spaces into therapeutic landscapes. Using Low's analytic rubric of spatializing cultures, we can see that sociospatial change was not solely the result of a top-down government intervention but was also produced by a variety of community actors using, engaging with, and changing spaces in tandem with state efforts to institute health services.

Elsewhere, I argue that health and public health care have become the grounds upon which new forms of citizenship are negotiated in Venezuela (Cooper 2015b). When for decades a doctor's visit was something that only the elite could be assured of, going to the doctor, especially one that now lived and worked in one's own neighborhood, signified much more

than the services themselves. The program was in this way also an act to de-marginalize people who previously lacked easy access to public health care. By going to a doctor in Barrio Adentro, patients were enacting their right to access free medical care provided by the state, a fact that many patients made explicit in conversations with me. Taking advantage of new health services could be as easy as walking to the neighborhood clinic a few blocks from one's house, or it could involve a much more complicated 'therapeutic itinerary' (Brotherton 2008) that combined biomedical, herbal, and spiritual healing.

The social and political significance of Barrio Adentro transcended the sheer fact of improved access to doctors and medications. Here, I show how the spatiality of that health care access – such as the decision to locate clinics inside poor neighborhoods – was of utmost importance to many who use the clinics. I suggest that the spatial logic of the Barrio Adentro project both indexed and enacted changes for residents of historically marginalized zones of the city, improving their quality of life and drawing them into relations of belonging with the oil-rich state from which they had long felt excluded. Focusing on space and place in this analysis allows us to see how health programs effect changes that act on the social body as well as on individual bodies.

About the author

Amy Cooper is a cultural and medical anthropologist whose research examines the sociopolitical effects of people's engagements with health care. As the first in-depth analysis of health reform in Chávez's Venezuela, her book project, *In Excess of Medicine: Pleasure and Politics in Venezuelan Health Care*, offers a personalized account of people's struggles for social justice via health care. A new research project tracks the deauthorization of biomedicine in North America via the off-label use of psychopharmaceuticals. Amy earned her PhD from the Department of Comparative Human Development at the University of Chicago and is currently an assistant professor of anthropology at Saint Louis University.

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