FROM COOPERATION TO CAPACITATION: CUBAN MEDICAL INTERNATIONALISM IN THE SOUTH PACIFIC

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Abstract

This article analyses Cuba’s medical missions in the South Pacific and specifically in Timor-Leste (East Timor), the largest outside of Latin America. Here, the adaptation of Cuba’s low-technology and low-resourced preventive-focused medical model (based on the development of human capital) is used to highlight lessons regarding effective medical cooperation. This article finds that these lessons should be drawn from the dynamic and creative adaptations of the Cuban medical model, which are assisting South Pacific medical systems by scaling up primary care workforces to target previously underserved areas. Thus, the contribution of Cuban medical personnel, bolstered by the education of indigenous South Pacific students (trained by Cuban professors, both in Havana and locally) has developed into unique medical models for South Pacific nations. Such models of cooperation are also clearly adaptable elsewhere.

Keywords: Cuba, developing countries, South–South cooperation, medical internationalism, capacity building, Cuban medical model, scaling-up of health workforce, South Pacific, Timor-Leste, human capital, ELAM, medical education, Pacific Island countries (PICs)

Introduction

Since its first comprehensive mission in Algeria in 1963 Cuba has continued to develop its medical internationalism assistance, and Cuban programmes are now operating in 68 countries of the developing world. This article analyses Cuba’s medical missions in the South Pacific and specifically in Timor-Leste (East Timor), the largest outside of Latin America. It is here that Cuban medical international-
ism has continued to spread and train students from Timor-Leste and its South Pacific neighbours. Cuba’s low-technology and low-resourced medical model, focused on the development of human capital, is dynamic, creative, efficient and effective. Most important of all, it is independent and sustainable, rejecting traditional ‘aid’ models championed by G8 nations, and providing them with an alternative system of cooperation.

Cuba’s medical collaboration programme in Timor-Leste is the first of its kind in the South Pacific, as has been pointed out in some excellent research by Tim Anderson (Anderson 2010a: 81). This article starts with some general thoughts on the nature of Cuba’s approach to public health and its approach to medical education, since this constitutes the basis for the model exported elsewhere. The implementation of the Cuban medical model and medical education system in Timor-Leste will then be analysed to highlight some of the unique characteristics of this approach, its successes, and its challenges. Finally, the spread of Cuban medical internationalism from Timor-Leste to other South Pacific nations will be noted to show how these bilateral medical agreements could become a lesson in capacity-building and foreign aid for developed nations to employ in their own programmes.

This article illustrates the evolution and success of a radically different form of medical cooperation in this region, often ignored by academics. Clearly, traditional medical models have failed to become sustainable in the South Pacific – which is why Cuba was invited to cooperate in the realisation of a radical, extremely pragmatic medical system that can truly address the pressing health needs of the region. Our central argument is that the Cuban model is indeed different from forms of traditional aid, and instead is a programme of cooperation that, over time, begins the process of capacitating the host country’s public health process to become independent and sustainable. It addresses the fundamental research question as to whether such a radically different model can be adapted to capacitate struggling medical systems in such diverse contexts. In sum, the paper is largely a descriptive analysis of the impact of Cuba’s approach to developing a sustainable public healthcare system in the South Pacific, using Timor-Leste as its focal point.

One of the most significant aspects of Cuban medical internationalism is that Cuba has more medical personnel serving in developing countries than those of the G8 countries combined (through official missions), and more than those employed by Doctors without Borders and the World Health Organization (Kirk and Erisman 2009). This occurs despite the fact that Cuba, considered a ‘developing nation’, is only a small island of approximately 11 million people. With over 38,000 medical personnel serving abroad,1 Cuban healthcare workers are having a greater global medical impact than any other country.
While it is outside the focus of this article, a common question asked has to do with Cuba’s moral rationale for this enormously important role in the developing world. This has been analysed in Kirk (2009a and 2009b) and the reader is encouraged to consult these sources.

**General Philosophy**

The national health profile of Cuba provides an excellent basis for considering Cuba’s international cooperation programme. Recent World Health Organization (WHO) data put Cuba’s health indicators such as life expectancy and infant mortality in line with the US and Canada (WHOSIS 2008). Cuba’s health indicators, which are comparable to those of developed nations, occur despite Cuba’s Gross National Income (GNI) per capita (at $3,000) being among some of the lowest in developing nations (WHOSIS 2008). This unique situation has become known as the ‘Cuban Paradox’ (Pérez 2008), and the Cuban example challenges the belief that economic development is always needed before meaningful social improvement can occur. Another facet of this feature is that, despite limited funding for Cuba’s 24 medical faculties, many countries including the US recognise the high quality of the Cuban medical schools as being of a similar standard to their US counterparts (Anderson 2010c: 185).

One of the main reasons for the success of Cuba’s medical accomplishments at home and abroad is the leadership of the country, which has traditionally seen access to healthcare and education as being of paramount importance. This is significant given its experience as a developing nation with limited access to resources and technology. Having survived the Special Period (starting in 1990 following the implosion of the Soviet Union, when 85 per cent of Cuba’s trade disappeared, and GDP dropped 35 per cent in five years), the country has had to strengthen an established and resilient preventive medical model that utilises human capital in place of resources and technology. By contrast, most western models of healthcare are curative-focused and often utilise large quantities of resources and technology. As a developing country, this approach was far too expensive for Cuba, which preferred to resolve potential medical conditions before they needed intervention.

Preventive health access measures involve greater attention to social and economic conditions of development than say curative measures, which focus more on clinical treatment. Prevention goes beyond the assessment of the individual patient’s health, and instead examines the healthcare needs of the community as a whole in an effort to put in place public health policies to create a healthier environment. Pérez (2008) notes that in the Cuban medical model, the patient is then seen as a ‘bio-psycho-social’ person, influenced by his/her environment.
Thus, Cuba’s proactive medical care is directed at the prevention of ill health through immunisations, popular education, and the adoption of healthy lifestyles, all of which entail much more contact with health personnel. Furthermore, Cuba employs a medical focus on health promotion, involving many different sectors of government and society.

Cuba’s preventive primary care focused on health promotion is worth emphasising, since by focusing on health promotion, Cuba’s medical system and internationalism programme actively seek to change the institutions, cultures and structures that constitute human health (Anderson 2010c). What also makes the Cuban medical model unique is that it targets the most vulnerable populations. Focusing on rural and marginalised populations is one of the ways that sets the Cuban medical education model apart from the many other medical education models (Brouwer 2011). In essence, Cuba has adapted a medical model fitted for low-resource settings instead of following the path of its ‘developed’ northern neighbours, which increasingly depend on costly technology and overly reactionary care.

Though there are different forms of social medicine, the Cuban model is distinctive in its resiliency and its ability to adapt over time to different health challenges and availability of resources. This dynamic, participatory model is manifest in Cuba’s revolutionary history of solidarity and internationalism. Having been formed from these ideological roots, Cuban medical aid (or the less paternalistic term ‘cooperation’ as Cubans prefer) is unique in that it ‘regards cooperation as a matter of solidarity between peoples, not of financial flows or financial leverage’ (Anderson 2008: 55) – a significant difference from the approach used by most developed nations.

A Distinctive Approach to Medical Training

Key to understanding why this medical model has been effective in its adaption by many developing nations around the world is Cuba’s medical education system. Both the 24 medical faculties (a large increase from the single faculty in 1959) as well as the Cuban medical school for foreign students, Latin American School of Medicine or Escuela Latinoamericana de Medicina (ELAM), are highly regarded in international circles. (ELAM has an annual intake of some 1,500 students and is the largest medical faculty in the world.) Their development of medical talent is exceptional. Julie Feinsilver notes that during the 2009–2010 year alone, Cuba was training 51,648 medical students either in Cuba or in their own countries under the tutelage of Cuban professors. Of that number, 8,170 are enrolled in ELAM, 12,017 in the new program to train doctors (polyclinic-based), 29,171 are being trained by Cuban
medical brigades abroad, 1,118 are matriculated under other projects, and 1,172 are studying medical technician careers... Also in 2009, more than three hundred nursing students from the English-speaking Caribbean, and two from China, participated in the Cuba–Caribbean Community (CARICOM) training program for the provision of services to HIV/AIDS patients. (2010: 94)

In the case of South Pacific nations, Cuban scholarships at ELAM have been utilised in order to prepare and train personnel to transform the national health systems, initially in Timor-Leste but ultimately in the entire region. This will occur when the local medical graduates (trained by Cuban medical personnel) become established, and a medical education system, instituted by Cuban professors, can be implemented in the host country. This is seen in Timor-Leste, where 700 Timorese accepted a Cuban government scholarship to study medicine. Following their training in Cuba and locally, within a decade the host countries’ medical personnel will eventually take the place of their Cuban counterparts, including Cuban medical professors (Anderson 2010a). This process is already occurring, with hundreds of Timorese already graduating as doctors and returning to work, as the article notes:

A significant part of the medical capacitation process starts with the recruitment of students. It is important to bear in mind that initial cooperation agreements (by which local students are trained by Cuban medical professors and doctors while Cuban medical personnel address pressing health issues in the host country) eventually lead to capacitation as the local medical workforce is scaled up to address health issues through the development of human capital, and gradually take over the roles of Cuban medical personnel. Huish and Kirk note that by choosing students from impoverished backgrounds with limited opportunities to obtain a medical education this selection process helps the students ‘buy in’ to the Cuban medical system of returning to serve their marginalized communities instead of merely pursuing a career for profit (2007). In Timor-Leste, former health minister, de Araújo, notes that the students were being trained ‘to serve the public and not trade their services’. (Anderson 2010a: 79)

Thus, a sensitivity to support the most vulnerable populations is found in the education practices at ELAM where the goal is to ‘educate physicians primarily for public service’ in an attempt to develop ‘competencies in comprehensive primary care, from health promotion to treatment and rehabilitation. In exchange for a non-binding pledge to practice in underserved areas, students receive a full scholarship with a small monthly stipend, graduating debt-free’ (Bull World Health Organ 2010: 325).

In particular, Huish has identified the core sense of duty ingrained in students as one of the reasons for the success of ELAM. It is emphasised that ‘the importance of [the ELAM] project is the development of an institutional ethic that values success
as a graduate’s ability to serve the indigent’ (Huish 2008: 552–3). Also important is the healthcare team’s duty in service towards the communal good, since they are expected to participate actively in community education about general health issues and environmental health (Spiegel and Yassi 2004; Pérez 2008).

Rather than compartmentalise each health aspect, as is done in most medical education systems, the Cuban medical education system ensures that the diverse aspects of health are seen as interrelated and taught in a participatory manner. Brouwer highlights one of the main courses of the Cuban medical education system, called ‘Morphophysiology’, which is an ‘interdisciplinary combination of all basic sciences that are taught separately in the traditional...medical school’ (2011: 121). In addition to this comprehensive course, the first year medical education system also adds a ‘Community Health and Medicine component (social-medical sciences and social science) that includes introduction to social sciences, introduction to primary health care, social communication, and civics’ (ibid.).

The second year expands through the study of basic sciences in ‘Human Morphophysiopathology’, where the Medicine and Community Health aspect covers ‘public health, history of health, epidemiology and hygiene, medical research, community intervention and health analysis’ (ibid.). This model situates the patient as part of the wider and interlinked bio-psycho-social spheres of health, and away from the narrow view of the patient as suffering from a singular ailment resulting from a singular diagnosis and treatable by a simple prescription (Pérez 2008).

Most Cuban medical cooperation follows a fairly standard path. The bilateral agreement between Cuba and the host country establishes the appropriate numbers of scholarships to be awarded to local students to study at ELAM. This is an effort to train the host countries’ medical personnel in hopes that they will be able to develop their own sustainable system by taking over from the Cuban medical personnel. In addition, Cuba deploys an agreed-upon number of medical personnel to marginalised areas so that the most pressing health issues within the country can be addressed as soon as possible. Based upon the Cuban view of ‘health as a right rather than a commodity’ (Asante et al. 2012: 8), these doctors are sometimes placed in the local medical system but are most often directed to vulnerable and underserved populations where the local medical system and private practice are unable or unwilling to serve. Thus, most of the Cuban medical teams begin their work in rural and marginalised areas (Anderson 2010a) – some 200 Cuban doctors in the case of Timor-Leste.

Cuban Medical Cooperation in the South Pacific

The focus of Cuba’s medical cooperation in the region is Timor-Leste. At the time of independence in 2002, the country had just 47 physicians (Kirk 2012) serving
a population of almost 1,150,000. This poor doctor-to-patient ratio was relieved somewhat by the arrival of the first 16 Cuban doctors in February 2004, at the request of the country’s leader (de Araújo 2009). Their impact was immediate, and by 2008, with the arrival of more Cuban medical personnel, ‘more than 2.7 million consultations had taken place, and an estimated 11,400 lives had been saved because of their medical interventions’ (Anderson 2010a: 82). This number has grown since 2010, when ‘two out of every three doctors in the country (162 out of 243) [were] from Cuba’ (Hawkins 2010: 12).

Fortunately these doctors have already begun to be reinforced by Timor-Leste medical graduates from ELAM and the new faculty of medicine at the National University of Timor Lorosa’e (NUTL), that Cuba helped establish in 2004. The graduates emerge from a curriculum that emphasises ‘responsibility to society, critical thinking, flexibility and openness to knowledge exchange, quality with equity, long life education’. Thus the teaching and learning processes are based on the approach of “learning how to learn”, creativity, innovation and solidarity with the changes and transformations in scientific knowledge, research, social insertion, inter and trans-discipline thinking, inter-relation and inter-dependence with other professions, and education on good and productive citizenship’ (de Araújo 2009: 4).

The Cuban doctors have been continually reinforced each academic year with Timorese medical graduates trained by Cuban professors: 64 in 2010–2011, 501 in 2011–2012, 245 in 2012–2013, ‘and 17 in 2013–2014, with an average of 50 students being admitted in each subsequent year’ (Kirk 2012: 83). Essentially, Timor-Leste will soon have 17 times the number of doctors it had in 2002 – a truly remarkable achievement in such a relatively short time.3

Graduates of the NUTL Medical School receive the title of Médico Geral Básico-MGB / Basic General Doctors. These new medical professionals are expected to have:

- skills in diagnostics and therapeutics, able to provide comprehensive medical services through promotional, preventive, curative and rehabilitative interventions on individuals, families, communities and their living environment, by applying clinical and epidemiologic methods, with a profound social focus, embedded in ethical and humanistic values, solidarity and good citizenship, called upon to transform the health situation in accordance with the expectations of the society. (de Araújo 2009: 2)

The NUTL medical school that these doctors have graduated from is on its way to becoming a regional version of ELAM in the South Pacific. By 2009, there were 845 undergraduate medical students registered, with 186 located at the ‘Medical School of NUTL (from year 1 to year 6), and 658 at various medical schools in Cuba (from year 1 to year 5)’ (de Araújo 2009: 1). In all cases the role of Cuban
medical personnel is worth noting. The goal of the education process created at Timor-Leste has been summarised concisely:

Timorese students have either been trained in Cuba or in small groups by Cuban physicians working at local hospitals and district health centres. Increasingly students from the region will be trained locally, instead of travelling to Cuba. Cuban medical personnel will also gradually withdraw, as the need for their cooperation decreases and their role as physicians and educators is filled by Timorese – who in turn will be able to use their Faculty of Medicine to train medical students from several South Pacific islands. The multiplier effect of medical personnel is thus the goal, with the intention of gradually reducing the number of Cubans as local practitioners fill the vacuum. (Kirk 2012: 82–3)

It is also important to highlight the decentralised version of the Timorese medical education system since all 13 districts of Timor-Leste have District Team Lecturers with training locations onsite. The Coordinator, who oversees the 13 districts, reports directly to the Dean of the NUTL medical school. In 2009 there were ‘78 certified lecturers distributed throughout the 13 teams, and 146 medical doctors, nurses and health technicians holding a certificate in pedagogy, who are also part of the district teams’ (de Araújo 2009: 1). Thus, medical coverage for previously underserviced areas is implemented throughout the country instead of reinforcing structures that foster the emigration of physicians, or cost substantial amount of resources, and use technology which is often rendered ineffective in areas with limited access to reliable electricity.

Part of the challenge facing medical authorities in Timor-Leste is resolving the differences between the public sector Cuban-trained doctors and those from earlier medical training programmes that emphasise private practice. Besides working at hospitals performing functions at outpatient and inpatient settings, the Basic General Doctors are ‘prepared to work at the facilities of the national health system and, particularly those of primary care such as health posts and villages, health centers at sub-districts and districts, which are the main venues to provide comprehensive health services’ (de Araújo 2009: 2). Their counterparts (a minority) trained in traditional capitalist models, find these challenges hard to bear, and prefer working in more lucrative urban locations.

The Cuban presence in the region is growing quickly. In 2006, for example, the Cuban medical response to a devastating earthquake in Java resulted in requests for Cuban doctors to remain. The medical team of 135 Cubans saw up to 1,000 patients a day at two field hospitals during the first two months after the earthquake. Within this crucial period the Cuban medical team treated 47,000 patients, immunised 2,000 people against tetanus, and performed 900 operations (Fawthrop 2006). Tables 1 and 2 provide some basic data on the medical profile of the region.
Between 2006 and 2008, ties with Kiribati, Nauru, Vanuatu, Tuvalu and the Solomon Islands followed the initial contact in 2003 with Timor-Leste. Asante et al. noted that by 2010, ‘33 Cuban health personnel work in Pacific Island Countries and 177 Pacific Island students are studying medicine in Cuba in 2010 with the most extensive engagement in Kiribati, the Solomon Islands, Tuvalu and Vanuatu’ (2012: 1). In their findings, Asante et al. track the evolution of Cuban

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Table 1 Health-related indicators, selected Pacific Island countries and Australia

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Fiji</th>
<th>Kiribati</th>
<th>Nauru</th>
<th>Papua New Guinea</th>
<th>Solomon Islands</th>
<th>Tuvalu</th>
<th>Vanuatu</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions 2008)</td>
<td>0.8</td>
<td>0.1</td>
<td>0.01</td>
<td>6.6</td>
<td>0.5</td>
<td>0.01</td>
<td>0.2</td>
<td>21</td>
</tr>
<tr>
<td>GNI per capita (ppp US$ 2008)</td>
<td>4,270</td>
<td>3,660</td>
<td>3,433</td>
<td>2,000</td>
<td>2,580</td>
<td>3,213</td>
<td>3,940</td>
<td>34,040</td>
</tr>
<tr>
<td>Life expectancy at birth (2008)</td>
<td>70</td>
<td>67</td>
<td>60</td>
<td>62</td>
<td>70</td>
<td>64</td>
<td>69</td>
<td>82</td>
</tr>
<tr>
<td>Infant mortality per 1,000 live births (2008)</td>
<td>16</td>
<td>38</td>
<td>36</td>
<td>53</td>
<td>29</td>
<td>30</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>Under-5 mortality per 1,000 live births (2008)</td>
<td>18</td>
<td>48</td>
<td>45</td>
<td>69</td>
<td>36</td>
<td>36</td>
<td>33</td>
<td>5</td>
</tr>
<tr>
<td>Maternal mortality per 100,000 live births (2005)</td>
<td>210</td>
<td>56</td>
<td>–</td>
<td>470</td>
<td>220</td>
<td>–</td>
<td>150d</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes mellitus prevalence estimate (%)</td>
<td>9.1</td>
<td>6.6</td>
<td>30.9</td>
<td>2.1</td>
<td>23</td>
<td>13.9</td>
<td>2.4</td>
<td>7.2</td>
</tr>
<tr>
<td>Total health expenditure per capita (ppp US$ 2007)d</td>
<td>169</td>
<td>358</td>
<td>812</td>
<td>65</td>
<td>123</td>
<td>150</td>
<td>145</td>
<td>3,357</td>
</tr>
<tr>
<td>Government health expenditure per capita (ppp US$ 2007)d</td>
<td>118</td>
<td>301</td>
<td>575</td>
<td>53</td>
<td>113</td>
<td>149</td>
<td>111</td>
<td>2,266</td>
</tr>
</tbody>
</table>

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\(^{a}\)WHO World Health Statistics 2010.
\(^{d}\)Figures from UNICEF (www.unicef.org/infobycountry) and represent country reported deaths for 2003–2008.

Diplomatic relationships between Cuba and the countries in the Pacific were largely initiated in the early 2000s, except for Vanuatu, where such relations began in the early 1980s. In 2004 cooperation between Nauru and Cuba led to the arrival of 11 Cuban doctors. However, their contracts were terminated ahead of schedule due to language difficulties. Over the next few years, bilateral agreements between Cuba and a few PICs were signed and some Cuban doctors arrived in the region. However, these relationships were made more concrete in September 2008 when the first Cuba–Pacific Islands ministerial meeting was held in Havana and representatives from ten Pacific countries – Fiji, the Federated States of Micronesia, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu – attended. (2012: 4)

Essentially, what looks at first sight like a small number of Cuban doctors is actually providing a very significant amount of service to the low-populated, small PICs. The 33 Cuban medical personnel found on the Solomon Islands (10), Kiribati (16), Tuvalu (5) and Vanuatu (2) account for a quarter of the 120 combined medical workers found there (Asante et al. 2012: 6). Perhaps more important is the potential role of local medical graduates, since as of 2009, in terms of students on full Cuban government scholarships there were: ‘50 from the Solomon Islands, 20 from Kiribati, 10 from Tuvalu, 7 from Nauru, and 17 from Vanuatu’ (Feinsilver 2010: 94). A more recent article notes that by 2010 there

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**Table 2** Health workforce numbers and density by selected Pacific Island countries, 2000–2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Doctors</th>
<th>Density (per 10,000 population)</th>
<th>Nurses and Midwives</th>
<th>Density (per 10,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia*</td>
<td>68,689</td>
<td>33</td>
<td>272,741</td>
<td>130</td>
</tr>
<tr>
<td>Fiji</td>
<td>380</td>
<td>5</td>
<td>1,660</td>
<td>20</td>
</tr>
<tr>
<td>Kiribati</td>
<td>20</td>
<td>2</td>
<td>260</td>
<td>30</td>
</tr>
<tr>
<td>Nauru</td>
<td>10</td>
<td>8</td>
<td>63</td>
<td>48</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>275</td>
<td>1</td>
<td>2,841</td>
<td>5</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>60</td>
<td>1</td>
<td>630</td>
<td>13</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>10</td>
<td>9</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>30</td>
<td>1</td>
<td>360</td>
<td>17</td>
</tr>
</tbody>
</table>

* Australia Institute of Health and Welfare 2010. (Note: figures are for 2008. The density per 10,000 was obtained by dividing the figures by total population of 21 million.)

were 177 Pacific Island students studying medicine in 2012 (Asante et al. 2012). This will undoubtedly translate into a significant improvement in their medical capacity when they begin to take over from the Cuban doctors.

As Julie Feinsilver has noted, even though the numbers of Cuban doctors working in PICs is relatively small,

their impact is great. For example, when Cuba sent eleven doctors to the island of Nauru in September 2004, it provided 78 percent of all doctors in Nauru, an increase of 367 percent.

Two Cuban doctors were working in the Solomon Islands in 2008, and the remaining seven arrived in early 2009.... Vanuatu and Cuba signed an agreement in 2008 for six Cuban doctors to work in provincial hospitals. (Feinsilver 2010: 92–3)

In Tuvalu the original three doctors who arrived in October 2008 ‘attended 3,496 patients as well as saved fifty-three lives’ by the following February. In addition they delivered 76 babies – including the first 11 caesarean sections – and undertook 47 major surgical operations (the first ever to take place on small South Pacific islands). Doctors have also opened up abortion services, and provided specialised consultation services for patients with diabetes, chronic paediatric diseases and hypertension. They also instituted a family medical model to train local staff (Cuban Daily News 2009).

The impact of the work of Cuban personnel has been noted throughout the region. In 2007, for example, Radio New Zealand highlighted how in Kiribati the arrival of ten Cuban doctors had reduced the child mortality rate by 80 per cent – from 50 in every 1,000 to 9.9. Six more doctors were to arrive at the request of the Cuba–Kiribati cooperation committee’s request. Dr Airam Meetal comments on the impact of the Cuban doctors:

It’s a wonder. The reality is the home visits and they study every person in the home and they collect data on each of the people staying in each of the households and then they work like that, checking all pregnant mothers, following them up, check them and then referred them to the specialist. (Radio New Zealand 2007)

Again one can see how the earlier Timor-Leste–Cuban medical cooperation programme has spread in the region, and been replicated.

Prior to 2007, the Solomon Islands had approximately 10,000 patients for every doctor (Wasuka 2007). With 80 per cent of the population in rural areas amongst its 350 islands, medical accessibility has clearly been a challenge for this nation of 500,000 (Asante, Roberts and Hall 2012: 167). As part of the Solomon Islands bilateral agreement with Cuba, ten Cuban doctors arrived in May 2007, improving the doctor–patient ratio to 1 to 3,300 (Asante, Roberts and Hall 2012). The Cuban government initially provided medical scholarships (Wasuka 2007) to locals in order to help with the poor patient-to-doctor ratio. The first cohort
of 25 departed for Cuba in February 2008, with the remainder (25 each year) following in July 2008 and December 2009 (Asante et al. 2012: 4). Following their graduation they will undoubtedly make a significant difference in the health profile of their country.

Until that time the Solomon Islands public healthcare system depends on the services of Cuban physicians. The Health Minister of the Solomon Islands, Clay Forau, noted that the cost of employing Cuban doctors was much less then recruiting doctors on the international market. The local government pays approximately $300 a month as an allowance to the Cuban doctors, as well as their return airfare. (An undisclosed retainer is also paid to the Cuban government.) This has turned out to be a much cheaper alternative to the reliance on other doctors who were currently earning $170,000 per year. What was even more unaffordable was to bring in doctors from the international market, a process which, according to the Ministry of Health, used to cost taxpayers approximately $400,000 each per year. Another aspect worth noting is that the Cuban doctors have substantial experience in dealing with certain diseases such as malaria which are very problematic for many South Pacific nations (Wasuka 2007).

In the Health Ministry’s 2007 budget documents, it was noted that there were 196 vacancies in the country. Clearly, considering the cost of doctors on the international market as well as those from the traditional medical system, there was not the funding to fill all these vacancies. At the Solomon Islands’ largest hospital in Honiara, for example, there were 11 such vacancies for doctors and an additional 20 more vacancies in other provinces. The situation was much worse in rural areas, one example being the Malatya region’s hospital – which was supposed to serve 122,620 people – but which had only three doctors prior to the Cuban medical agreement (Wasuka 2007).

The Cuban Cooperation agreement shows no signs of letting up in the face of the health challenges faced by Solomon Islanders, and recently a request was made for a further 40 Cuban specialists (Asante, Roberts and Hall 2012: 171). With the return to the country of 75 Cuban-trained doctors in 2013 (ibid.: 166), and the medical agreement in place, hopefully the Solomon Islands will finally be able to provide medical accessibility for its rural population. A similar arrangement has been put in place with other nations in the region. In 2008, the Vanuatu government finalised an agreement with Cuba to receive six Cuban doctors. In addition to this, the bilateral agreement between Cuba and Vanuatu also included 17 scholarships for local students to begin their education at the ELAM (Radio New Zealand 2008).

Once again the basic Cuban model of working within and with the local community, of developing a preventive healthcare model, and of grassroots campaigns in public healthcare have proved successful – particularly for the
traditionally underserviced sectors of the population. The combination of providing immediate medical care, a strategy supplemented by the training of local students from limited financial means, is proving to be an extremely useful, and sustainable model in the region.

**Concluding Thoughts**

It is clear that developing countries can ill afford to adopt a Western healthcare system while providing medical accessibility to their rural and vulnerable populations. A focus on curative healthcare, with accompanying higher wages, utilising large amounts of resources, and needing advanced technology, is not only unsustainable for developing nations, but is also becoming increasingly unaffordable for even developed countries to sustain. Indeed rural and marginalised populations are often overlooked and underserved in developed and developing nations.

The Cuban approach to healthcare is radically different, as noted in the first part of this article, as it facilitates capacity building and operations in low-resource settings. The case history presented here – of the Cuban medical cooperation in the South Pacific – reveals that the fundamentals of the model can be successfully applied elsewhere, and not just in Latin America and the Caribbean (where their efforts are concentrated). The contribution of Cuban medical personnel, bolstered by the education of indigenous students (trained by Cuban professors, both in Havana and locally) has developed a unique model, but one that is clearly adaptable elsewhere.

It is significant that other developed countries are also beginning to understand some of the core lessons found in the Cuban internationalist programme. Anderson noted that the Australian government has traditionally chosen to ignore the regional Cuban role, despite it being the most significant medical cooperation to ever happen in the South Pacific. The government had somehow overlooked Cuba’s significant medical cooperation with Australia’s South Pacific neighbours (Anderson 2010b). However, more recently, the Australian government has taken notice that Cuban internationalism may actually constitute a major contribution to solving complex medical issues, and medical personnel shortages within the region.

In 2011 Australia’s Parliamentary Secretary for Pacific Island Affairs, Richard Marles, said in a radio interview with ABC Radio Australia that Australia was engaged in a ‘scoping study of Cuban experts and Australian experts’. This is because he believes that Cuba’s effort at improving healthcare is of crucial importance since a healthy population is ‘probably the key social indicator’. As a response to Cuban success, Marles said the Australian government wants to look at ways in which they can ‘leverage the Cuban [medical] expertise against our presence in the South Pacific to do something really important’ since ‘they...
are engaged in developing assistance for the same reasons we are...[to help] the developing world’ (Marles 2011). This is quite a difference from the position just a few years earlier.

Perhaps the most interesting acknowledgement of Cuban medical internationalism, however, comes from President Barack Obama. During the 2009 summit of hemisphere leaders in Trinidad and Tobago, he noted that the ‘United States could learn a lesson from Cuba, which for decades has sent doctors to other countries throughout Latin America to care for the poor [and] won Cuban leaders Fidel and Raul Castro deep goodwill in the region’ (Welling et al. 2010: 469). He was right, since there is indeed much to be learned from the Cuban medical cooperation to developing nations – as the South Pacific Islands have learned in the last decade.

Notes

1. In a statement on 11 June 2012 by Ambassador Oscar León González during the United Nations Plenary Meeting on the Implementation of the Declaration of Commitment on HIV/AIDS in New York, he highlighted that there are ‘currently 38,868 healthcare professionals, including 15,407 medical doctors, who are rendering their services in 66 nations. Over 14,000 students from 122 countries have graduated from the Latin American School of Medicine (ELAM)’ (León González 2012).

2. For Haiti, where Havana has a large medical programme, this meant that 75 per cent of the students trained in Cuba were drawn from communities and areas previously underserved by medical personnel ‘including a broad representation of ethnic minorities and indigenous peoples’ (Bull World Health Organ 2010: 325).

3. More details, including videoed interviews of Timorese medical students, can be found at http://www.youtube.com/watch?v=OLmUIGdYjE&feature=plcp, as well as other students from the South Pacific at ELAM (http://www.youtube.com/watch?v=AhMANNnEDQQ&feature=plcp) can be found at Tim Anderson’s YouTube channel (http://www.youtube.com/user/timand2037/videos?sort=dd&flow=grid&view=0&page=2).

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