

# Cuba & Global Health

## Cuba & the Global Health Workforce: Health Professionals Abroad

Cuba's contribution to the developing world's health workforce has been essentially a practical one, focusing on **health care delivery and medical education**: since 1960, over 100,000 Cuban health professionals have served in 101 countries, staffing public health infrastructures; and over 21,000 students from Africa, Latin America, Asia and the Caribbean are currently enrolled in Cuban medical schools, not counting those in nursing and allied health professions (1)(2).

This collaboration has evolved over time. The first Cuban medical team was sent to earthquake-devastated Chile in 1960, when the two governments had no formal relations. Such disaster relief missions were dispatched to another 16 countries over the next decades, but were soon overtaken by a more long-term modality: by virtue of government-to-government agreements, Cuban health professionals (the vast majority physicians) began providing health care to underserved populations and regions in Africa, Latin America, the Caribbean and Asia (3). Since the 1963 request from the Algerian government of Prime Minister Ahmed Ben Bella (bereft of physicians at the end of French occupation) another 100 governments have initiated pacts with Cuba for a sustained presence of Cuban health professionals in their countries' health care delivery programs: six in the 1960s; 22 in the 70s; 11 in the 80s; 47 in the 90s; and 15 since 2000 (1)(4)(5).

The fact that half this cooperation began in the nineties speaks to developments during that time in Cuba's own health system, which made larger numbers of physicians available for international service and also reinforced Cuban health authorities' **commitment to primary care** as key to improving health status. In particular, by mid-decade, the neighborhood-based family doctor-and-nurse program was in place across the country, by 1999 covering 98.3% of Cuba's 11 million people (6). The program culminated a process of embedding health services deeper into communities, aimed at more effective health promotion and disease prevention efforts. As a result, curricula in Cuba's 21 medical schools were revamped, and a residency created in family medicine, ratcheting up the number of graduates annually to cover needs at home and growing interest from other countries. By the end of the decade, Cuba had nearly 30,000 family physicians, and a total of some 60,000 doctors, more than Sub-Saharan Africa. By 2005, the island's physician population had reached over 70,000. (6)(7)(8).

The other factor explaining the jump in cooperation during the nineties was external: in 1998, Hurricanes Georges and Mitch swept Central America and the Caribbean, leaving 2.4 million homeless. Cuban medical teams, at first deployed on an emergency basis, stayed on at the request of several governments under **Cuba's Comprehensive Health Program (CHP)**, created in response to the region's crisis and later expanded to include a total of 27 countries in Latin America, the Caribbean, Africa and Asia. By way of example, in May, 2006, there were 448 Cuban health professionals in Guatemala, 426 in Haiti, 113 in Belize, 347 in Honduras, 93 in Botswana, 188 in Ghana, 109 in Mali, 134 in the Gambia, 143 in Namibia and 278 in East Timor. (9)

Under these agreements, the host country provides accommodations and food, domestic transportation, a locale for work, and a monthly stipend (usually US\$150-\$200), while Cuban personnel receive their regular salaries, airfare and other logistical support from the Cuban health ministry. In arrangements outside the CHP with wealthier countries such as South Africa, the host government pays additional hard currency salary, part of which is kept by the professionals and part of which is remitted to the Cuban health ministry. (9)(10)

In July, 2006, 28,664 Cuban health professionals were serving abroad in 68 countries. (5). In each country, the thrust of Cuban assistance has been to **bolster public health infrastructures**, providing

the often desperately needed staff in remote areas - some in hospitals, but mainly in primary care clinics and medical posts - regions where local governments have been unsuccessful in attracting local physicians to the public sector. In several countries, such as Honduras, Haiti, Guatemala, Mali, South Africa and the Gambia, there are whole regions where the Cubans have been the first bearers of local physician services to rural, indigenous and other marginalized communities. They also bear the Cuban philosophy of **combining population-based public health principles and prevention with clinical medicine**.

On other levels, Cuban medical scientists and advisors have participated in design of public health departments and systems, and in **epidemiological research and campaigns** tackling specific health problems (malaria in several African countries, dengue in El Salvador and Honduras, cholera in South Africa, etc.). They have also worked with health ministries to devise **more reliable statistical record-keeping and information systems** in many countries, especially in those with the heretofore weakest infrastructures (11).

Health professionals on the ground participate and often lead local courses for **midwives and other community-based health personnel** and participate in more formal **training for paramedical and allied health professionals**. Most recently, Cuban **biomedical engineers** and technical support have been increasingly in demand, repairing nearly 55,000 pieces of medical equipment since 1999. (5)

Cuban coverage has resulted in an increase in patient care levels in poor communities, according to statistics kept by the medical teams. For the 22 countries in the CHP by 2004, from November, 1999 through February, 2004, this translated into: 36.7 million doctor's visits, 917,381 surgeries, 397,636 deliveries, 11.9 million health promotion activities, and medical education courses for 910,120 local health personnel, including midwives (12). **Health status** has also improved in areas where Cuban doctors serve: in Guatemala, the infant mortality rate in these regions dropped from 45 to 16.8 deaths per 1,000 live births; in the Gambia, from 121 to 61; and in Haiti from 59.4 to 33, from 1999 through May, 2003 (13).

Recently, Cuba has taken a more pro-active role in initiating **trilateral collaboration**, in which a third country or agency donates resources for health programs developed between Cuba and another nation. This was the case of the 2001-2002 vaccination drive in Haiti, when Cuban epidemiologists and family doctors teamed up with Haitian health authorities to immunize 800,000 children against five childhood diseases. Funds from the French government and 2 million doses of vaccines from the Japanese government completed the triangle. The German government contributed to Cuban projects with Niger and Honduras; the South African government donated US\$1 million for Cuban medical cooperation with Mali; and the WHO has supported Cuban collaboration in the Gambia and elsewhere (14). According to the Cuban government, 95 non-governmental organizations worldwide contributed to CHP projects between 1999 and 2004. (13)

Since 2000, Cuba has launched **four special cooperation initiatives**: one **focuses on HIV-AIDS in 19 countries**, through joint projects in prevention and treatment (Botswana, Honduras, Mali, and Haiti among them); and in 2001, Cuban officials offered African countries 4,000 doctors and other health professionals, medical school professors, a stock of anti-retroviral drugs and diagnostic equipment to help combat the epidemic (15).

The second, begun in 2003, makes a major **commitment to Venezuela**, a country with one of the greatest discrepancies between rich and poor in South America.(16) The Venezuelan government's "Barrio Adentro" program relies on some 20,000 Cuban family doctors to provide health services and health education in medically underserved communities ranging from the shantytowns of Caracas to the jungle riverbanks of Amazonas State. The agreement falls under the ALBA accords (Bolivarian Alternative for the Americas), offered as a South-South alternative to the FTAA, in which several Latin American and Caribbean countries now participate—the principle being that each brings to the table the

resources at its disposal to be used for social programs bilaterally and throughout the region. Thus, in Cuba and Venezuela's case, the arrangement is often boiled down in the international press to "oil for doctors".

The third initiative is a **vision restoration program**, begun in mid-2004, which addresses the condition of the estimated six million persons in Latin America and the Caribbean who have reversible blindness or vision loss due to cataracts and other conditions—but who are too poor to pay for the surgeries in their own countries. Since the program began through July, 2006, 317,489 patients had been treated from 27 countries (including 69,000 Cubans). Ophthalmology centers have also been opened in Ecuador, Bolivia and Mali under this program, which receives support from local governments as well as the ALBA. (17)(18)

The **fourth new initiative** is the Henry Reeve Disaster Response Contingent, originally some 1500 physicians offered to the USA in the wake of Hurricane Katrina. When the Bush administration turned down the offer, the contingent was established as a permanent volunteer corps and given special training, ready to be dispatched to disaster areas within 24 hours. Their first mission came in October 2005, when 2500 traveled with 32 field hospitals to earthquake-stricken Pakistan, where they remained for five months. Since then, the contingent has also been dispatched to Guatemala, Indonesia and Bolivia. The Contingent builds upon earlier Cuban cooperation in disaster relief since the 1960 earthquake in Chile, which took Cuban health professionals to Nicaragua, Honduras, and several other countries thereafter. The treatment in Cuba of over 17,000 children of the Chernobyl nuclear disaster is also part of this history. (5)(19)

Over time, Cuba's South-South cooperation has faced endless challenges: the political and social instability besetting many developing countries; the sheer size of the effort and resources needed to make a dent in the poorest countries' health status, sometimes straining domestic health facilities; barriers to access and treatment found in the various health systems staffed by Cubans; initial concerns from in-country medical associations fearful of job displacement; the need to expand the skill set of Cuban physicians serving abroad, who confront circumstances and infectious diseases long absent from the Cuban health picture; and unabating effects of the US embargo which continue to generate barriers for Cuban health care at home and abroad.

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