STUDIES OF THE AMERICAS

CUBAN MEDICAL INTERNATIONALISM

Origins, Evolution, and Goals

John M. Kirk and H. Michael Erisman

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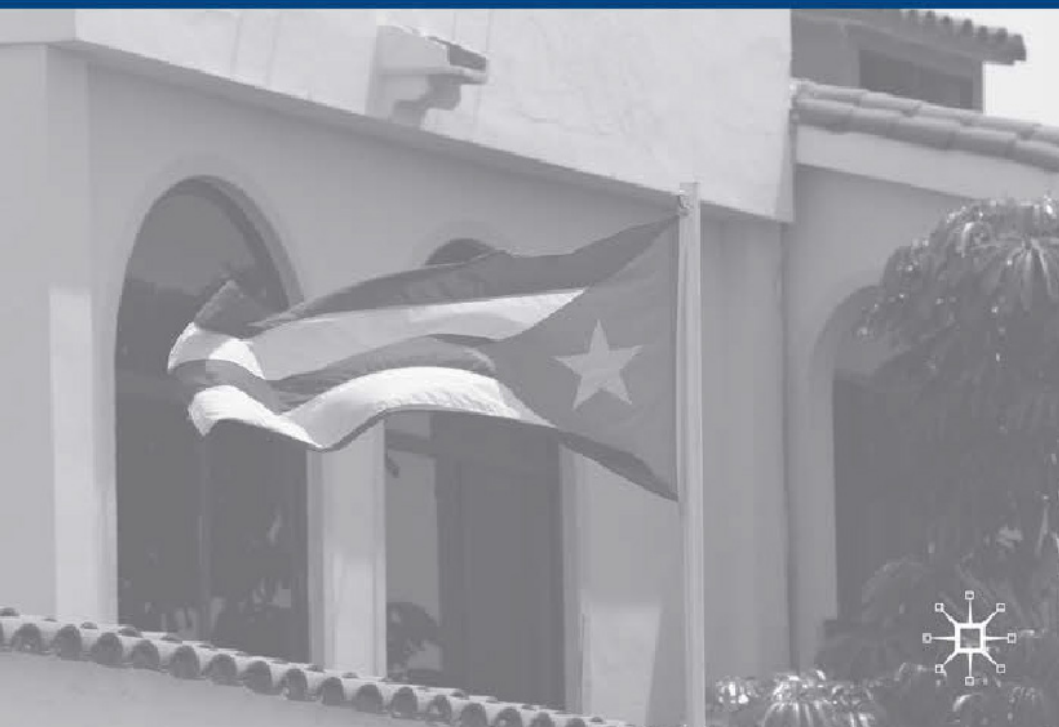

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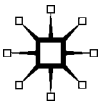

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Preface

One of the most famous observations about Cuba's international personality was made in 1978 by Jorge Domínguez, who stressed that Havana was behaving like a major actor on the world stage despite its small size and lack of any significant economic/natural resources.[1] These comments were made essentially in response to the Revolution's demonstrated ability to project *military* power thousands of miles from it shores (i.e., in Africa beginning in the 1970s and continuing into the 1980s). While this characterization was widely accepted and frequently quoted in subsequent years, few, if any, expected it to have continued validity as the international community made the transition (which was especially difficult for Cuba) into the post-Cold War era. But conceptualizations of power (and hence a "major power's foreign policy") can extend beyond the conventional paradigms of military and/or economic strength. Joseph Nye has adopted this broader view by promoting the idea of "soft power,"[2] arguing that such considerations as the diffusion of a national culture, legitimization by religious authorities, or humanitarian initiatives can translate into influence (i.e., soft power) on the global scene.

Keeping the above material in mind, we have tried in this exploration of Cuba's medical aid activities to achieve the following two very general goals:

> To provide a chronicle of these programs as a remarkable case study of state humanitarianism which has, quite frankly, been largely ignored by both the mass media and the academic world in the more developed countries.
>
> To probe the interplay between these programs and Havana's larger foreign policy interests and concerns, suggesting in the process that they have always been and continue today to be a significant factor in defining the Cuban Revolution's role as an actor on the global stage.

> Indeed, with respect to post-Cold War international affairs, a strong case can be made that the nature and impact of Havana's medical aid programs (in both humanitarian and political terms) function to support the conclusion that Cuba continues in the Domínguez tradition to pursue, admittedly in a more low-profile fashion, a great power's foreign policy.

Telling this remarkable story has been, to say the least, both fascinating and rewarding for both of us. But the reader should understand that likewise it has sometimes been a bit difficult trying to do so as *accurately* as possible, especially when dealing with very recent developments. One major problem that we confronted was the harsh reality that there are no sources providing comprehensive or even reasonably broad summary data on Cuban medical aid programs. Consequently we had to adopt the proverbial jigsaw puzzle approach, gathering small and often disparate pieces of information that we then combined into both narrative and graphical presentations.

Further complicating the situation is the fact that Cuba's contemporary aid efforts are very much a "moving target," by which we mean that they are constantly changing with respect to both the types of programs being offered and the number of people being served. As such, we cannot and do not claim that what has emerged from this dimension of our research is a completely up-to-date portrait. Instead, perhaps a better analogy of the picture being portrayed is that of a dynamic kaleidoscope where the action involved can sometimes be several steps ahead of its observers.

Nevertheless, utilizing a broad array of sources that included several trips to Cuba to conduct interviews and gather primary data, we feel that these problems have for the most part been surmounted and that what is presented here is indeed the most accurate and most comprehensive overview of Havana's medical diplomacy available at this time. But overriding all of these technical research issues is the most important consideration about Cuba's aid programs for those in developing countries who are desperately in need of such services—that is, the Revolution remains firmly committed to the principle of medical diplomacy and consequently this drama will continue to unfold, the result being a better life and indeed even life itself for dispossessed people all over the world.

As is invariably the case with such book projects, there are numerous people who have provided invaluable assistance to the cause. In

Michael Erisman's case, special recognition and thanks go to: the University Research Committee of Indiana State University, which provided funding for field research in Cuba; Dagoberto Rodríguez of the Cuba Interests Section in Washington, who assisted in procuring academic visas and arranging logistical support in Havana; Priya Ramachandran and Ying Chen, graduate research assistants at Indiana State who helped with bibliographical searches as well as the construction of various charts and tables; Carlos Alzugaray, Soraya Castro, and Milagros Martínez, good friends at the University of Havana who have always helped to make my visits to Cuba most enjoyable; and, certainly most important, John Kirk, who was kind enough to invite me to join this project and who has been an outstanding colleague over many years.

For his part, John Kirk also would like to extend special recognition and thanks to members of Cuba's Ministry of Foreign Relations (MINREX) who helped to facilitate visas and to make contacts for our research in Cuba. Ernesto Sentí, Cuban ambassador in Ottawa, was extremely helpful in this process, as were colleagues in Havana: Josefina de la C. Vidal, Raúl Delgado Concepción, and especially the deputy minister for cooperation, Dr. Yiliam Jiménez Expósito. Drs. Danay Saavedra and Pura Avilés of Servicios Médicos Cubanos were also crucial in understanding the importance of medical internationalism, as was Dr. Arturo Menéndez, president of the Consejo Científico de Salud in Camaguey. Hal Klepak and Juanita Montalvo, Canadian colleagues with extensive experience in Cuba, have always proved to be superb sounding-boards (and wonderful friends), while Robert Huish (author of an excellent doctoral dissertation on Havana's Escuela Latinoamericana de Medicina) at the Université de Montréal also helped in the formulation of ideas for this project. My daughter Emily Kirk, who has developed her own respect for the topic after studying at the excellent FLACSO-program at the Universidad de La Habana and participating in several vigorous discussions, did much of the early research for the project. Friends from a variety of walks of life in Cuba also helped to formulate ideas for the book–Rafael Hernández, Jesús Benjamín Piloto, Aurelio Alonso, Leonardo Padura, Esteban Morales, Enrique Beldarraín, Magda González-Mora, Jorge Mario Sánchez-Egozcue, and the colleagues at FLACSO-Cuba. Finally, my gratitude to the many Cuban doctors, nurses, and medical technicians who gave freely of their time,

explaining their invaluable experiences as *internacionalistas* around the world. They are a model for us all and demonstrate in their daily work the concept of José Martí that "patria es humanidad" (All of humanity is our homeland).

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Chapter 1

Introduction: Cuba as a World Medical Power

The life of a single human being is worth a million times more than all the property of the richest man on earth… Far more important than a good remuneration is the pride of serving one's neighbor. Much more definitive and much more lasting than all the gold that one can accumulate is the gratitude of a people.

Che Guevara, 1960, *On Revolutionary Medicine*

It is time to overcome the ridiculous myth of the invincible Cubans. Who ever heard of Cubans conducting a global foreign policy?

Henry Kissinger, U.S. secretary of state, 1978

Clearly and certainly not surprisingly, the above quotations demonstrate that Che Guevara and Henry Kissinger had very different ideas about the nature of the Cuban Revolution's potential role on the world stage. Guevara, who had been trained as a physician in Argentina before becoming radicalized and joining Fidel Castro's guerrillas on an odyssey that would eventually lead him into the realm of legend, is thinking in terms of self-sacrifice and service in the pursuit of basic human needs (e.g., health care) that will earn the Revolution the gratitude and respect of not only the Cuban people but also those in other countries (i.e., "one's neighbors") who are fortunate enough to become the beneficiaries of Cuban aid initiatives. Kissinger, on the other hand, reacts with both incredulity and contempt to the notion that Cuba could or should be seen as a major player in international affairs. Admittedly, Kissinger's outburst was not prompted by Cuba's commitment to the kind of health care and related aid programs to which Guevara was referring, but instead it was in reaction to the Revolution's extensive

(and successful) military initiatives in Africa in the 1970s (e.g., in Ethiopia and especially Angola). In reality, however, the "global foreign policy" that was creating so much consternation on Kissinger's part involved more than just the military activities that tended to attract the most attention, especially from Washington and the U.S. mass media. Indeed, there was another key element to these internationalist initiatives that, although more low-profile than Havana's military campaigns, proved to be much more significant in the long run. This often overlooked dimension entailed Cuba's extensive developmental aid efforts, at the center of which were its health care programs. Various sources indicate that the number of Cuban developmental aid personnel (mostly medical professionals) working overseas in the late 1970s totaled approximately 14,000 (mostly in sub-Saharan Africa), with the figures rising as high as 46,000 in the late 1980s.[1]

What was unfolding, then, was indeed a unique phenomenon on the modern international scene—a less developed country with no special natural resource base to draw upon (e.g., such as oil reserves) was, like the great powers, not only conducting major military operations thousands of miles from its home territory but was also implementing ambitious foreign aid programs all over the globe. To a hard-bitten realist such as Henry Kissinger who looked upon small countries like Cuba as nothing more than pawns on the global chessboard where the superpowers were the only players of any consequence, Havana's audacity was simply inconceivable—the great powers do not share the spotlight on the international stage with such upstarts.

Ultimately, however, it has been Che Guevara rather than Henry Kissinger who has proven to be the better visionary with respect to the global potential of the Cuban Revolution's contemporary foreign policies. Granted, the overseas military operations that so concerned Kissinger are no longer an element of Havana's international affairs menu. On the other hand, Cuba's medical aid programs have, after a brief hiatus at the height of the country's traumatic Special Period, [2] reemerged stronger and more ambitious than ever in recent years. And, like Henry Kissinger, his heirs in Washington are equally appalled that Cuba is once again demonstrating ability via its (medical) aid programs to play a major role in LDC (Less Developed Countries, sometimes also referred to as the Third World) affairs and thereby enhance its potential to influence significantly the dynamics of contemporary international relations.

The first significant Cuban foray into medical aid activities occurred in 1960 when Havana dispatched medical teams to Chile (with which it did not have diplomatic relations at the time) to provide short-term assistance in the wake of a major earthquake there. While Cuba would over the years continue to engage in such ad hoc disaster relief operations, they were soon overshadowed by the more comprehensive, long-term projects based on formal pacts/contracts that would become the hallmark of the Revolution's medical aid programs. The first such initiative occurred in 1963 when Havana entered into an arrangement with Algeria's newly independent government, resulting in the dispatch of the Revolution's first international medical brigade composed of 58 doctors and other health workers. Since then approximately 100 other governments (mostly in sub-Saharan Africa and Latin America) have concluded agreements resulting in a sustained presence of Cuban aid delegations involving a grand total of more than 100,000 health professionals. The impressive scope and energy of Havana's efforts can be illustrated by the fact that the number of Cuban medical aid personnel working overseas in 2009 (38,000, of which 17,000 were doctors) exceeded those deployed by the World Health Organization and indeed the G-8 nations of the industrialized world.

Currently the terms of these government-to-government agreements, which operate under the umbrella of Havana's Comprehensive Healthcare Delivery Program (CHDP; another designation applied to such programs is Programa Integral de Salud–PIS), usually commit the host country to provide the Cuban medical brigades with lodging, food, domestic transportation, and a modest monthly stipend (usually 100 to 150 dollars). However, Havana can and often does waive some or all of these provisions—especially the stipends—in cases where they would constitute an extreme hardship for the recipient nation. On the other side of the equation, the Cuban Health Ministry assures that its emissaries receive their regular salaries, round-trip transportation to and from their assigned country, and various kinds of miscellaneous logistical support.[3] The Cuban Foreign Ministry summarized the CHDP's general (operating) principles as follows:

- The cooperation offered by the Cuban Government is based on the free of charge delivery of health specialists and technicians, particularly Family Doctors, for a two-year term at most.

- . . . the brigades render their services in rural areas where they do not interfere with the local physicians' work.[4]

The "rural areas" proviso should not be taken literally, for Cuban personnel also operate in urban barrios (i.e., slums) that are sorely lacking in government and/or private medical services. So, in a more general sense, Havana is committing its personnel to poverty-stricken areas into which local healthcare providers have not, for whatever reasons, ventured.

Although traditionally these CHDP agreements have been bilateral in nature, Cuba has recently begun to experiment with trilateral configurations wherein a third party will provide various kinds of support to a basic CHDP program. A 2007 MEDICC (Medical Education Cooperation with Cuba) report, for example, notes that "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."[5]

Cuba's medical aid efforts have involved various facets, the main (but not only) dimensions of which are:

- The CHDP agreements whereby Cuban medical brigades are dispatched to provide direct medical care in the recipient countries. These initiatives are the most ambitious and most extensive of Cuba's overseas medical aid efforts.
- In-country medical training programs. Sometimes these operations are undertaken within the framework of CHDP programs while in other instances Cuba may make separate arrangements to assist governments in their efforts to create medical schools (see table 1.1).
- Bringing foreign patients to Cuba for (free) surgery and other medical procedures, two well-known examples being the radiation/cancer treatments for Chernobyl victims and the Latin American vision restoration program that provides operations for those who have reversible blindness or vision loss due to cataracts and other conditions.
- Awarding scholarships to foreign students for full-time medical studies in Cuba, the flagship institution in this endeavor being the Latin American Medical School in Havana.
- Extending short-term disaster relief, including a proposition (which was spurned) to Washington offering assistance to deal with medical problems in the aftermath of Hurricane Katrina.[6]

Table 1.1 Countries with Medical Schools Established by Cuban Cooperation

Country	Year Established
Yemen	1976
Guyana	1984
Ethiopia	1984
Uganda	1986
Ghana	1991
The Gambia	2000
Equatorial Guinea	2000
Haiti	2001
Guinea Bissau	2004

Source: Vice Ministry for Education & Research, Cuban Ministry of Public Health (MINSAP), 2005. See also C. Caminos Gorry, "Healing Globally, Empowering Locally: Cuban Medical Cooperation in Africa," available on the Internet at <www.saludthefilmnet/ns/Cuban%20Cooperation%20in%20Africa.pdf>.

Basically, then, just as Che Guevara had hoped, the Cuban Revolution has, during both the Cold War and post-Cold War eras, assumed the mantle of a major player in international medical diplomacy.

The Evolution of Cuba's Medical Aid Programs: A Brief Comparative Survey

In a very general sense, the evolution of Cuba's medical aid programs can, just like the overall dynamics of its international relations, be viewed in terms of two broad time frames—the Cold War and post-Cold War eras. Initially most of Havana's foreign policy energy was devoted to dealing with the Cold War's two superpowers as it tried to counter Washington's growing hostility toward the Revolution and to establish a mutually satisfactory relationship with the USSR. As these issues were increasingly brought under control, Havana began in the early 1970s to expand its foreign policy perspectives beyond these narrow Cold War parameters by interjecting a stronger South/South dimension into its international agenda. Probing these new horizons, the Cubans began to devote increased attention to launching initiatives designed to redefine and widen their contacts with other developing countries. In Latin America, these efforts initially generated fairly modest results, since the outcomes usually did not involve anything more than the establishment or normalization

of formal diplomatic relations. Africa, however, was a radically different story, for a major Cuban presence began to develop there as Havana launched various developmental as well as security assistance programs.

Cuba, like many other Caribbean islands, has a large black-based population[7] descended from slaves who were imported to work its colonial sugar plantations. The impact of this African community has been especially dramatic in the cultural realm; Cuban music, for example, draws heavily on the country's black roots and its most popular religion is Santería, a syncretic mixture that is essentially an African creed that slaves "Europeanized" somewhat with cosmetic overlays of Catholicism. But these historical/cultural links to Africa had never translated into a significant foreign policy interest on pre-revolutionary Havana's part.

Shortly after Castro's triumph, however, the Cubans began developing a presence on the continent. This saga started in 1963 when Havana sent advisors and a small contingent of combat troops to Algeria to help Ahmed Ben Bella's radical socialist government in its border dispute with Morocco. A cease-fire was signed before these forces became involved in any fighting and they were withdrawn shortly thereafter, but the very fact that they were dispatched in the first place suggested that revolutionary Cuba was beginning to flirt with a fairly ambitious conceptualization of its international role. At this time, Havana also became involved in supporting various African national liberation movements, especially those struggling against Portuguese colonialism in Angola and Mozambique.[8] Later it would take the unusual step for a small developing country of setting up formal government-to-government military aid missions in Congo-Brazzaville (1965), Guinea (1966), Sierra Leone (1972), Equatorial Guinea (1973), and Somalia (1974).

Although Cuba's security activities attracted the most attention and sometimes concern (especially on Washington's part), these initiatives were usually part of a larger package that included developmental cooperation programs within which medical assistance played a prominent role. Thus, just as the United States and other great powers had long used their economic muscle as a tool of foreign policy, so too was Cuba incorporating developmental/health care aid into its international relations repertoire, with sub-Saharan Africa initially serving as the main venue for such medical diplomacy.

Surveying the situation in the late 1970s, Paul Grundy and Peter Budetti noted that

> Our figures for 1978 (see table 1.2), obtained directly from the Ministry of Health sources, reveal that the total number of Cuban medical personnel overseas is over 2,300. This is probably an underestimate, since our data on Iraq, Angola, Ethiopia, Jamaica, and Laos include only physicians. The number of medical doctors totals approximately 1,500, meaning that nearly 13 per cent of Cuba's 12,000 national health service physicians are now overseas.[9]

While sub-Saharan Africa would remain the main focus for Cuba's Cold War medical and other aid programs, Latin America (especially the Caribbean Basin) began in the late 1970s to receive increased attention, the key factor behind this development being the emergence of the New Jewel and Sandinista governments in 1979.

Several Caribbean nations, including Guyana under Forbes Burnham and Jamaica under Michael Manley, were among the first countries in the Western Hemisphere to break ranks with Washington's anti-Castro policies, normalizing their relations with Havana in 1972.[10] Subsequently, given the growing ideological affinity with them, Havana dispatched fairly modest delegations of medical and other aid personnel to the two countries. It was, however, in the small eastern Caribbean island of Grenada, where a group of young radicals calling themselves the New Jewel Movement (NJM) seized power in March 1979, that Cuba made its first major hemispheric commitment to developmental aid programs. Many in the NJM, including its leader Maurice Bishop, had long been sympathetic toward the Cuban Revolution and had developed various kinds of fraternal ties with it. Consequently, when the NJM government made clear its need/desire for assistance in implementing its plan for socialist transformation, Havana moved swiftly. It soon was involved in such diverse operations as a literacy campaign, various medical aid programs, road construction projects, and the construction of a new airport to facilitate tourism.[11]

Grenada's radicalization was, however, soon overshadowed by events in Nicaragua where insurgents whose main leadership came from the leftist core of the Sandinista Movement (Frente Sandinista de Liberación Nacional, FSLN) finally won their long struggle against the Somoza dynasty on July 19, 1979. As was the case with the NJM

Table 1.2 Distribution of Cuban Health Personnel Working Abroad, 1978

Third World Country	Number of Cuban Health Care Porsonnal*	Number of Cuban Physicians*	Total Number of Physicians** (1977)	Percentage of Cuban to Total Physicians	Population in Millions***	Population per Physician
Iraq	378	208	4500	4.6	12.5	2,778
South Yemen	94	56	98	57.0	1.8	18,367
Algeria	17	11	1698	.6	17.6	10,365
Benin	9	†	95	†	3.3	34,737
Cape Verde	81	44	62	71.0	.32	5,161
Angola	286	286	383	75.0	6.4	16,710
Congo	31	17	213	8.0	1.5	7,042
Equatorial Guinea	48	26	31	84.0	.33	10,645
Guinea	73	41	188	22.0	5.1	27,127
Guinea-Bissau	55	30	55	55.0	.62	11,273
Libya	650	357	2588	14.0	2.8	1,083
Mozambique	120	67	510	13.0	9.9	19,412
Elhiopla	†	300	674	45.0	31.9	47,329
Sao Tome	86	47	69	80.0	.084	1,424
Tanzania	15	8	797	1.0	16.8	21,079
Zambia	18	11	472	2.3	5.4	11,441
Guyana	18	18	120	15.0	.81	6,750
Jamaica	17	17	570	3.0	2.2	3,860
Laos	12	12	46	26.0	3.5	76,087
Vietnam	†	†	†	†	51.1	†

† Number Unknown

Source: *See text.

**World Health Statistics Annual 1977, Volume 3, Health Personnel and Hospital Establishments (Geneva: World Health Organization, 1978).

***W. Prichett, World Population Estimates 1978 (Washington: The Environmental Fund, 1978).

government, Havana warmly embraced the new regime in Managua and began to provide it with both developmental and security assistance. By year's end, approximately 50 Cuban military advisors and 2,000 civilian workers (mostly teachers and doctors) had arrived to help the Sandinistas consolidate their revolution and to rebuild a country shattered by the decades of abuse inflicted upon it by the Somozas. Ultimately Sandinista Nicaragua would come to represent Havana's most extensive commitment to radical solidarity politics in the Western Hemisphere, as illustrated by the large number of support personnel that it dispatched. The developmental aid contingent peaked at about 5,300 in 1984, with a roughly equal contingent of 5,000 Nicaraguans undergoing professional/technical training in Cuba. An additional 2,500–3,500 Cubans were also serving as security advisors (early 1986).[12]

At this point, then, Cuba had, despite its small population and its lack of any significant natural resource base, created a remarkable package of socioeconomic programs for Third World nations—an achievement that in some respects equaled and even surpassed the efforts of highly developed countries. Indeed, by the mid-1980s, Havana was sending one civilian aid worker abroad for every 625 of the island's inhabitants, the comparable U.S. figure being approximately one Peace Corps volunteer or AID (Agency for International Development) employee per 34,700 U.S. citizens. Moreover, during the 1984–1985 academic year, 22,000 scholarship students from 82 LDCs were attending high schools and universities in Cuba. In the United States, on the other hand, the federal government in 1985 provided only 7,000 university scholarships for students from the Third World. A similar pattern emerges with respect to the USSR and its Warsaw Pact allies—in 1979, Cubans represented 19.4 percent of all Soviet bloc economic technicians working in the Third World even though the island's population constituted only 2.5 percent of the combined USSR/Eastern Europe/Cuban total.[13] Proportionately, then, it would appear that Cuba's Cold War developmental aid efforts compared very favorably with those of the two superpowers.

But as the 1990s dawned, the proverbial "all hell broke loose" phrase became a painfully accurate description of Havana's situation as the USSR and the Soviet bloc disintegrated and the world moved into what has become known as the post-Cold War era.

This transition, known in Cuba as the Special Period, was especially difficult for Havana, for in the process its extensive network of highly lucrative trade and other economic relationships with Moscow and Eastern Europe simply disappeared. Indeed, as a consequence, the Revolution was confronted with what some might characterize as an economic holocaust, as illustrated by such facts as the following: economic productivity as a whole plunged by approximately 40–45 percent; a reduction of vital oil imports resulted in the elimination or reduction of over 50 percent of all industrial activity and 70 percent of public transportation services, as well as widespread electrical disruptions; perhaps most important in terms of the impact on the quality of people's lives, shortages developed in food and medicines.

Addressing these economic problems required, as might be expected, a drastic reprioritization of Cuba's domestic and international policy agendas. Included among the many sacrifices that had to be made was the downsizing of its developmental aid efforts, including medical assistance programs. As the decade progressed, however, the economy began to rebound as Havana's remedial responses began to take effect (see figure 1.1, which utilizes GDP growth rates to

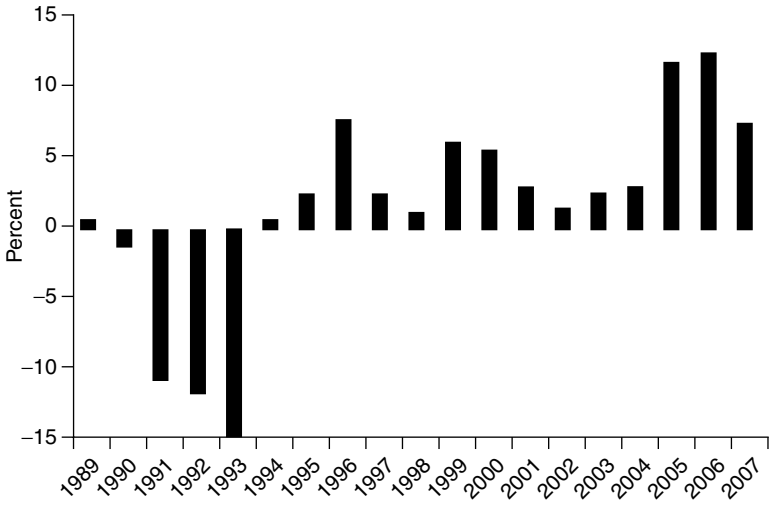

Figure 1.1 Cuban GDP Growth Rates, 1989–2007

Source: Figure created by the authors using data gleaned from various governmental and media sources.

illustrate the economy's general performance). This improving situation led not simply to a revitalization, but rather to a veritable explosion of Cuban medical aid activity.

The post-Cold War period has witnessed a significant decline in the commitment to foreign aid on the part of the major powers of the world (see figure 1.2).[14] This reticence cannot really be attributed to an *inability* (i.e., lack of resources and/or personnel) to underwrite such programs, as has been the case with many of the former Soviet bloc countries that have confronted serious problems as they have attempted to shift from command to free market economies. Instead the explanation has usually been rooted in more crass political considerations—specifically, the end of the competition with

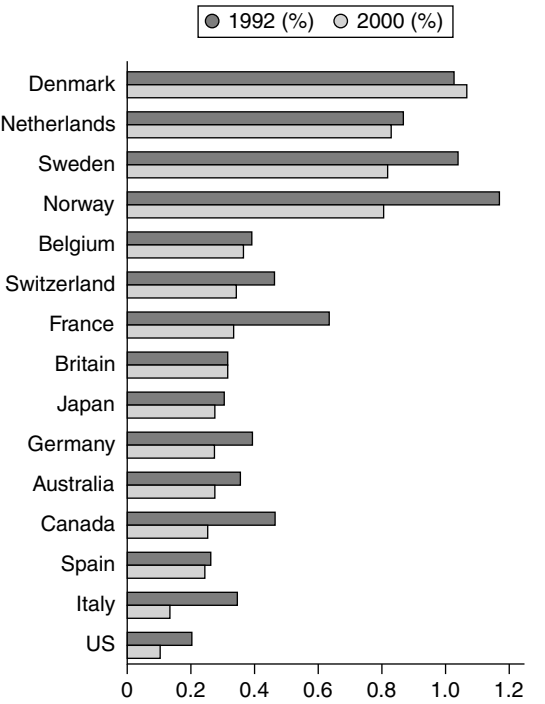

Figure 1.2 Share of GNP Allocated to Foreign Aid

Sources: Organization for Economic Co-operation and Development (OECD), "OECD Study in 2000; Other Flows Decline," December 12, 2001; OECD Development Assistance Committee, Committee Outline, updated January 30, 2002; and OECD Development Assistance Committee, Development Co-operation 1993 (Paris: 1994), 168–69.

the Soviet bloc for international influence and prestige has meant that foreign aid, which was often employed as a Cold War policy tool, has lost much of its strategic rationale. The most dramatic and indeed remarkable exception to this litany of growing neglect has been Cuba.

Beginning in the late 1990s, as the island began to emerge from the travails of the Special Period and especially as it increasingly consolidated the benefits that flowed from the restructuring of its international economic relations,[15] Havana launched an upgrade of its medical aid efforts (see figure 1.3) that ultimately would establish them as the flagship of the Revolution's foreign assistance programs. However, contrary to the situation in the 1970s and 1980s when sub-Saharan Africa was the main theater for Havana's activities, the new millennium has seen the Latin American/Caribbean region moving (slightly) to the forefront. Specifically, in 2007, the number of hemispheric recipient nations was 28 (which represented 41.2 percent of the overall 68 countries involved) while sub-Saharan Africa's total was 24 (or 35.3 percent).[16] The overall (February) 2007 aid profile

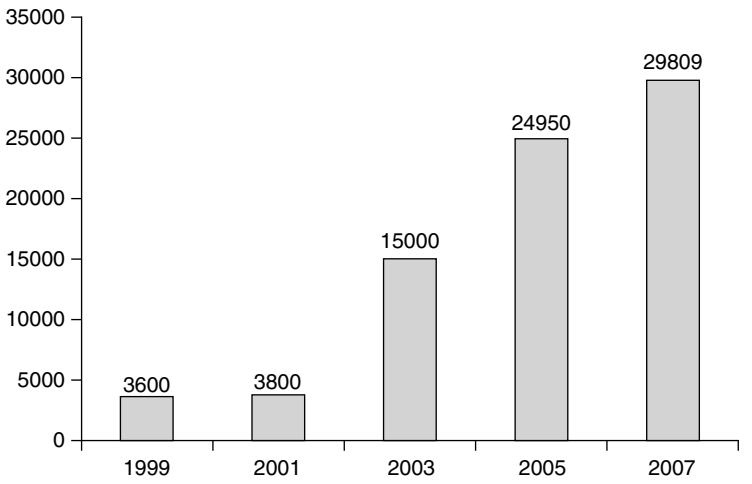

Figure 1.3 Cuban Medical Personnel Overseas

Sources: Figure created by the authors using data gleaned from various IGO and media sources. An especially useful source of data and information about Cuban medical aid activities are the various issues of MEDICC Review available at <www.medicc.org/index.php>.

was as follows:[17]

Number of Cuban health professionals working internationally	29,809
Percent of those who are physicians	70 percent
Countries with the most Cuban personnel by region:	
South America	Venezuela
Caribbean	Haiti
Central America	Honduras
Africa	Ghana
Asia	East Timor

Within this remarkable global reach, it has been Venezuela where Cuba's involvement has been the most extensive. Hugo Chávez won Venezuela's presidency (via democratic elections) in 1999. As might be expected given Chávez's flamboyant charismatic style and his penchant for radical left-wing populism, Havana quickly embraced the new regime in Caracas, with Fidel making the first of what would become a series of state visits in October 2000. Ultimately what would emerge was a de facto and multifaceted alliance between the two countries, with the 2004 ALBA (Alternativa Bolivariana para las Américas—Bolivarian Alternative for the Americas) pact constituting its most visible and most ambitious manifestation.[18] Essentially ALBA serves two basic functions: (1) to provide the framework for a broad range of bilateral trade/developmental cooperation programs (with Havana focusing heavily on medical aid projects); and (2) to serve as a vehicle for socioeconomic integration inspired by Simón Bolívar's vision of a politically unified Latin America that would be staunchly independent of Washington, the ultimate goal being to put the hemispheric community (defined as South America and the Caribbean Basin countries) in a position where its pooled economic power would to a great extent be sufficient to counterbalance that of the United States.

Certainly one of the most dramatic manifestations of this growing Cuban/Venezuelan collaboration is the vision restoration program known as Operation Milagro (Miracle). Its bilateral dimension allows Venezuelans who are suffering from cataracts and glaucoma to come, at no cost to the patients, to Cuba for operations. Also, consistent with ALBA's hemispheric perspective, the project offers help to anyone in Latin America or the Caribbean affected by blindness or other eye problems. Caracas provides the funding while Havana supplies the

specialists, the surgical equipment, and the infrastructure to care for patients during their treatment in Cuba. Approximately 1.5 million people (including Cubans) had been treated by March 2009, the long-term goal being a million patients annually.

Another factor that needs to be taken into consideration beyond the remarkable *scope* of Havana's contemporary medical aid programs is their effectiveness—that is, their *impact* upon the countries and the people that they serve. The Cuban brigades almost invariably operate where even the most rudimentary medical services are and have long been essentially nonexistent. In other words, they are dispatched to urban slums (often termed "barrios" in Spanish) and to isolated rural areas that the local medical establishment has avoided, often because there is little available to them there in terms of substantial monetary rewards. Consequently the Cuban presence in such deprived environments often produces immediate and dramatic results, as illustrated by the mortality rate data in figure 1.4.

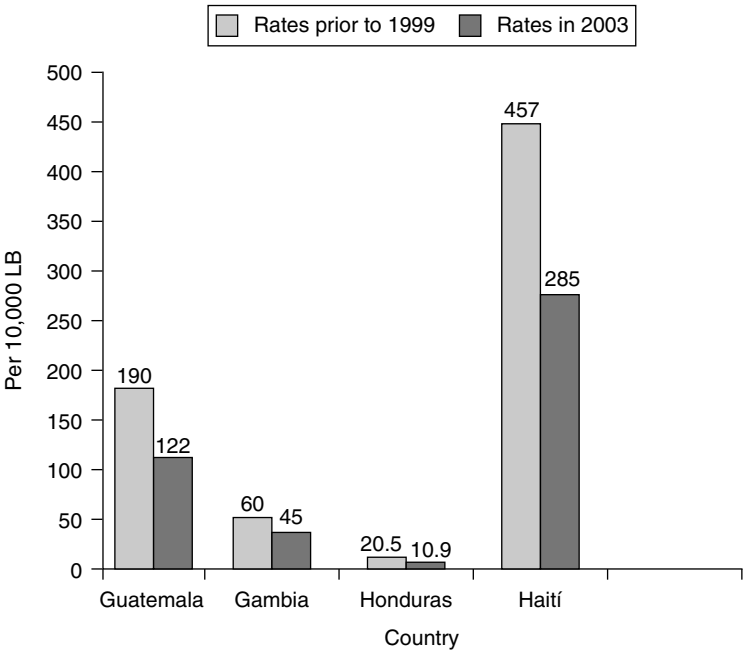

Figure 1.4 Maternal Mortality Rates in Zones Served by Cuban Medical Teams, 1999–2003

Source: Gail Reed, "Making South-South Collaboration Count," MEDICC Review, Vol. 6, No. 1 (2004), <www.medicc.org/publications/medicc_review/1004/pages/international_cooperation_report.html>. Original data from Country Reports from Cuban medical teams, Unidad de Colaboración Médica, Ministry of Public Health, Havana, 2003.

Table 1.3 Per Capita Aid Personnel, 2007

	Population	Aid Personnel Overseas*	Per Capita Aid Personnel Overseas
Cuba	11,416,987	29,809	1 for every 374 citizens
United States	301,962,442	7,180	1 for every 42,056 citizens

* Medical aid personnel in Cuba's case and USAID personnel in the U.S. case.

Source: Table created by the authors based on calculation of data gleaned from various governmental sources.

Basically, then, Cuba has now resumed and even expanded the role that it played during the Cold War as a major world medical power/provider. Indeed, as was previously the case, Havana's medical assistance programs are once again outshining and in many respects embarrassing the foreign aid performance of some great powers (e.g., the United States), as illustrated in table 1.3.

Obviously these efforts on Havana's part, which are very much a "work in progress" that can be expected to continue and expand, are interesting and important in their own right. But to be fully understood and appreciated, they need to be viewed in terms of their status within and relationship to the larger overall context of Cuba's foreign policy.

Medical Aid and the Broad Contours of Cuban Foreign Policy

The essential dynamics of any nation's foreign policy, including that of revolutionary Cuba, involves an often subtle interplay between elements of continuity and change. In general, the tendency among observers is to focus on the latter consideration (i.e., innovation and change), for that which is novel is almost always perceived as much more interesting than business as usual. The frequent result is analyses that attempt to delineate various phases, stages, eras, etc. in a country's international relations, with the benchmarks utilized often involving shifts in issue emphases, regional concerns, power capabilities, ideological orientations, and the like. Indeed, this chapter's previous section has displayed such an affinity, categorizing Cuba's medical aid activities in terms of Cold War and post-Cold War time frames.

Yet the inescapable fact is that elements of continuity will remain part of the overall policy landscape that cannot be overlooked in any comprehensive analysis. Or, to put it in historians' terms, one must take into consideration that the present is always to some degree a product

of the past. This cautionary note holds true with respect to revolutionary Cuba, where certain basic elements of its foreign relations equation have indeed persisted over time. As such, specific initiatives can often be more effectively analyzed and understood by viewing them in a broader perspective that explores their dynamic interplay with the continuities that characterize Havana's larger policy agenda. This fundamental principle will be applied here with respect to Cuba's medical aid programs, seeking in the process to ascertain their role in promoting and/or protecting the three following (and sometimes interconnected) attributes that have constituted vital national interests from the very inception of the Cuban Revolution.

Effective Sovereignty

Many observers, particularly those like Henry Kissinger who are devotees of the Realist school of international relations, are not very optimistic about the prospects for small countries to be able to control their destinies. Instead, the tendency is to see such states as victims of global power differentials whose weaknesses often result in their incorporation into someone's sphere of influence.

William Demas, president of the Caribbean Development Bank, eloquently summarized such sentiments when he noted that

> Many people in the [Caribbean] region . . . hold pessimistic and deterministic positions regarding our prospects for any degree of effective independence vis-à-vis the outside world. They believe that we are doomed to abject subordination because of our small and in some cases minuscule size, and because of our long colonial history as mere political, economic, military, and cultural appendages of the metropolitan countries. They consider that we . . . [are] impotent, unable to control our destiny, . . . and inevitably subject to the decisions, and indeed the whims, of outside countries.[19]

What Demas is suggesting here is the very important need to distinguish clearly between formal and effective sovereignty. The former is in many respects symbolic, involving such things as admission to the United Nations and other similar badges of acceptance into the international community. Effective sovereignty, on the other hand, refers to circumstances where a country and its people truly control their own destinies; they are, in other words, exercising their right of national self-determination to the greatest extent possible.

The architects of the Cuban Revolution, acutely aware of the island's tragic history of encounters with imperial Spain and a hegemonically inclined United States, have enthusiastically embraced the proposition that their highest priority must be to maximize their country's effective sovereignty. Indeed, this pursuit represents the leitmotif underlying much of Havana's foreign policy.

Economic Security

Economic security, like many other general concepts, can and has been defined in various ways. One common approach is to conceive it in terms of the progress that occurs within a society toward higher levels of industrialization and modernization.

But for smaller, lesser developed countries, defending against potential external economic threats is often the most important dimension of this issue. Applied to Cuba's foreign policies, such concerns have translated into efforts to configure the island's relations in such a manner that its vulnerability to hostile economic penetration or economic sanctions will be minimized. In particular, Havana has sought to use its international ties as a buffer against the economic warfare that Washington, using such tools as the trade embargo and the Helms-Burton law, has long waged against the Revolution.

International Stature/Influence

Like many other societies, especially those born of revolutionary upheavals, Cubans on the island have tended to see some of their experiences as having relevance that goes beyond their own national borders. In this respect, then, Cuba has not been markedly different from other nations that seek to exert an impact on the international scene. Such aspirations can, says Joseph Nye, be best understood in terms of the acquisition and exercise of "soft power."

Soft power, a concept first popularized by Nye, can be summarized as follows:

> Power is the ability to alter the behavior of others to get what you want. There are basically three ways to do that: coercion (sticks), payments (carrots), and attraction (soft power). . . . A country's soft power can come from three resources: its culture (in places where it is attractive to others), its political values (when it lives up to them at home and

> abroad), and its foreign policies (when they are seen as legitimate and having moral authority).[20]

As is the case with "hard power" (i.e., coercion and payments), soft power can be and often is seen essentially as a prerogative/resource of the world's larger, more industrially/technologically developed nations. Yet from its very inception, the Cuban Revolution has in various ways served as a beacon and an inspiration to Third World governments and political movements, thereby suggesting that soft power is not necessarily synonymous with the traditional great powers. Within this context, Havana's medical assistance programs can be seen as an intriguing effort to exercise the LDC soft power proposition. The Cubans, however, are more inclined to conceptualize their aid efforts in terms of "revolutionary internationalism."

Cuba and Revolutionary Internationalism

Roughly the first decade of the Cuban Revolution, sometimes referred to as the "heroic period," was characterized by exceptionally intense idealism, of revolutionary romanticism with lofty goals to assist other nations also suffering under tyranny. The declaration of the socialist nature of the revolution in 1961, the massive social polarization, sweeping nationalization of the economy, and unbridled nationalism against U.S. hostility all helped to forge the essence of the Cuban revolutionary cultural identity. Humanitarian ties with the peoples of other exploited nations—from Vietnam to Nicaragua, from the Congo to the Dominican Republic—were the order of the day, these sentiments and actions being conceptualized in terms of the Revolution's commitment to the principle of proletarian internationalism.

The idea of proletarian (or revolutionary) internationalism can trace its ideological roots, at least within the leftist tradition, to Karl Marx's famous call for unity among the workers of the world in the inevitable class warfare that he foresaw. His logic here was fairly straightforward—he viewed existing political boundaries as artifices that functioned to weaken the dispossessed masses by separating them into more manageable smaller units (i.e., the classic divide and conquer tactic) and, therefore, concluded that victory in the struggle to achieve egalitarian social justice throughout the world demanded solidarity among all those truly committed to the

cause. In other words, genuine revolutionaries had to be willing to join the fray whenever, wherever, and however their assistance was needed. Perhaps the most melodramatic example of attempts to put this maxim into practice can be found in the experiences of the international brigades that fought in the Spanish Civil War during the 1930s.[21]

One early example of incorporating this principle into the Revolution's foreign policy was the Second Declaration of Havana (February 4, 1962). Drawing on the tradition of the anticolonial wars of liberation waged by Simón Bolívar and José Martí, Fidel Castro eloquently argued that it was once again necessary for the Latin American masses, who had been betrayed by governments that were little more than Yankee puppets, to join together in armed struggle—this time to free themselves from U.S. hegemony and exploitation. No hemispheric people, he said,

> is weak—because each forms a part of a family of 200 million brothers, who suffer the same miseries, who harbor the same sentiments, who have the same enemy, who dream about the same better future and who count on the solidarity of all honest men and women throughout the world.
>
> Great as was the epic of Latin American Independence, heroic as was the struggle, today's generation of Latin Americans is called upon to engage in an epic which is even greater and more decisive for humanity. For that struggle was for the liberation from Spanish colonial power, from a decadent Spain invaded by the armies of Napoleon. Today the call for struggle is for liberation from the most powerful world imperialist center, from the strongest force of world imperialism and to render humanity a greater service than that rendered by our predecessors.[22]

Cubans, Castro indicated, would provide whatever support they could to this crusade, proclaiming that it was their obligation to do so because, in his famous phase, "the duty of every revolutionary is to make the revolution."

This commitment initially manifested itself primarily in terms of Cuban support for armed struggles being waged by anticolonial movements (e.g., in Africa) and left-wing guerrillas (e.g., in Latin America). Later, however, this position became more flexible. Rather than applying strict ideological criteria that functioned to limit its political horizons to like-minded radicals, Havana proclaimed its

willingness to cooperate with any regime that was "progressive," which it defined in a very broad sense as being committed domestically to reforms that would enhance social justice while internationally pursuing an independent foreign policy rather than operating as a U.S. client-state. This more ecumenical approach was reaffirmed in the Preamble to the (1976) Cuban Constitution, where it is stated that the country's national identity is based in part upon "proletarian internationalism, on the fraternal friendship, aid, cooperation and solidarity of the peoples of the world, especially those of Latin America and the Caribbean."[23]

The tendency, particularly in Washington and in the U.S. media, has been to portray Havana's (proletarian) internationalist policies almost exclusively in military terms. In other words, the public dialogue in the United States (which has sometimes verged on near-hysteria) has revolved essentially around instances where: (a) Cuban armed forces have been dispatched overseas on combat or advisory/training missions; or (b) Havana has allegedly extended moral or especially material support to the efforts of armed subversives to seize power. In reality, however, Cuba has devoted most of its energy and resources to *developmental assistance*, with health care at the forefront of such efforts. Indeed, the provision of medical aid has been a fundamental principle of the Cuban Revolution from the very beginning, a principle that has flowed from the conviction that medicine should not be perceived as a business, but rather as a right of the citizens and a duty for physicians, regardless of the ability of the patient to pay. Clearly such sentiments have contributed significantly to the emergence, particularly in the post-Cold War period, of medical assistance as the most prominent manifestation of (proletarian) internationalism in Havana's foreign policies.

Clearly, the international health care dimension of the Cuban Revolution and its relationship(s) to Havana's overall foreign affairs agenda is a fascinating topic that unfortunately has not received the attention that it deserves. Hopefully the pursuit of this book's basic goals will represent a major advance in remedying that situation.

Key Questions and Issues

Any attempt at this point to provide a definitive portrait of Cuba's medical assistance programs is in many respects a very daunting task,

for, although Havana's aid efforts have been and continue to be not only ambitious but indeed breathtaking in scope, there has been very little in terms of serious scholarly or policy analysis studies of the subject. Julie Feinsilver's excellent 1993 book entitled *Healing the Masses* is the only published academic work[24] wherein there is extensive description and analysis of Cuba's (Cold War) initiatives. The only contemporary entity that regularly publishes news and research articles covering the international as well as the domestic aspects of Havana's health care activities is MEDICC, a nonprofit NGO founded in 1997 that produces first-rate analysis.[25] Otherwise, the cupboard is pretty bare with regard to broad, systematic studies. Indeed, even Cuban academics and government officials who were contacted for information in the course of this inquiry sometimes indicated that they were not aware of the full scope and details of the overall policy.

To help flesh out the rather barren landscape sketched above, this study seeks to provide a comprehensive, in-depth examination of the nature, evolution, and dynamics of Cuba's medical aid programs, with special emphasis on developments during the contemporary post-Cold War period. In a purely narrative sense, the two primary goals here are:

- To establish the background for Cuba's contemporary medical aid programs by looking at the genesis and development of such activities during the Cold War.
- To explore in detail the recent development (i.e., post-Cold War) and current status of such initiatives, with special emphasis on the role of health care in the evolving relationship between Havana and Hugo Chávez's government in Venezuela.

Having supplied the descriptive material necessary to appreciate the nature and the extent of Cuba's medical aid programs (in both the Cold War and post-Cold war eras), the spotlight will then shift to examining the interface between Havana's international health care activities and its larger foreign policy concerns. This process will address in particular such crucial analytical questions as:

- What is the relationship of Cuba's medical aid programs to the Revolution's ideological foundations?
- What is the relationship of Cuba's medical aid programs to Havana's larger foreign policy goals and strategies?

- What are (in both the Cold War and post-Cold War eras) the primary considerations that have engendered and/or facilitated Cuba's medical aid programs?
- What are (in both the Cold War and post-Cold War eras) the major constraints or obstacles that have confronted Cuba's medical aid programs?
- Based on performance thus far, what is the potential of Cuba's medical aid programs to make a significant contribution to the achievement of its larger foreign policy goals? Or, to state the issue in more systemic terms, what impact might Cuba's medical aid programs have on its evolving role on the international stage in the foreseeable future, with special emphasis on its prospects for reinvigorating its leadership role in Third World affairs?

The above concerns are, of course, rather unique to Cuba since it is the only developing country in the modern (i.e., post-World War II) era that has established any kind of significant track record in the field of international medical aid. One might, therefore, be tempted to think that there is limited scholarly utility in pursuing an investigation of the topic, the basic contention being that a singular experience contributes little to understanding the larger dynamics and especially the prevailing patterns of international relations. Such a conclusion would, however, be not just inaccurate but even irresponsibly myopic, for there also are larger conceptual/theoretical dimensions to Havana's medical aid policies that can provide a compelling rationale for an in-depth analysis. For example, such an inquiry can serve as

- a case study in an attempt by a smaller developing country to acquire and wield "soft power" on the world stage.

In the field of international studies, power is often defined and measured in terms of a nation's material resources and capabilities. While criticism can, should be, and has been leveled against this tendency, it nevertheless continues to be a common practice. One consequence thereof is a propensity to view the world's most highly developed countries as the only international actors of any real significance, the essential point being that a strong positive correlation exists between a country's level of material (e.g., economic/technological) achievement, its power (both the hard and soft variety), and hence its ability to influence (or in some cases even control) the behavior of other international actors. As such, there is within this mind set a bias that

relegates less developed countries to the periphery of interest and concern, for it is assumed that they do not possess the wherewithal (i.e., the power) to exert a significant impact on the dynamics of international affairs.

Havana's medical aid programs and the potential soft power flowing from them would appear to raise questions, both conceptual and practical, about this paradigm and the status of less developed countries therein that merit consideration not only by Cuban specialists, but also by the larger international studies community.

- a case study of an effort to interject reprioritization into the process of energizing and promoting greater South/South cooperation.

Greater South/South cooperation has long been an LDC goal, with a broad range of mechanisms (e.g., the Group of 77, various economic integration experiments, special United Nations and other multilateral commissions, and the Nonaligned Movement) having been created in whole or in part to achieve it.

Two key traits that have traditionally characterized the dynamics of South/South cooperation are: (1) a tendency to give macroeconomic cooperation (e.g., regarding trade, finance, marketing) priority over more civic-oriented collaboration in such fields as health, education, community development, etc.; and (2) a penchant for reaching broad agreement in principle on issues of mutual concern followed by limited to no progress in translating such consensus into concrete comprehensive programs due to a failure to create the grassroots infrastructures necessary for effective implementation.

Since Havana has been critical of these tendencies, its extensive experience in operating medical aid projects may very well serve to provide crucial insights into the challenges involved in trying to redress them.

No matter whether one is engaged in specific policy analysis or is dealing with broader conceptual/theoretical concerns, it is widely accepted that foreign affairs are often *intermestic* in nature. What this suggests, quite simply, is that there are both *inter*national and do*mestic* elements that must be considered when dealing with the dramas that are played out in the global arena. Certainly this perspective applies to Cuba's medical aid programs, for the Revolution's commitment to and success in building a world-class health care system on the island represents the foundation upon which Havana's medical diplomacy rests.

Chapter 2

The Cuban Health Care System

As documentary-maker Michael Moore explains, "Cuba is a very poor country, our embargo has made it very difficult for them, and yet in spite of that they are able to put together a health care system that guarantees they have a better life span than we do, a better infant mortality rate and more doctors per capita."[1] A very different picture is offered by Jorge Salazar-Carrillo, a professor of economics at Florida International University: "After many years of disrepair, the Cuban health system is now in crisis."[2] Similarly, Dr. Julio César Alfonso describes the Cuban medical system as "a disaster"—where doctors reuse needles to draw blood from patients, have a sharpening stone for the needles and use X-ray machines that haven't been replaced since 1959.[3] Empirical evidence gathered by the World Health Organization (WHO), UNICEF and the Pan American Health Organization (PAHO) reveals a radically different picture. For instance, statistics show that the HIV prevalence for adults in Cuba is one-tenth the corresponding figure for the United States, a life expectancy that is comparable to U.S. rates, and better infant mortality rates, illustrating successful Cuban approaches to public health in at least some areas.

Clearly there are radically different opinions about the Cuban health care system, and both criticism and praise fly in all directions (at times confusingly) when public health in Cuba is analyzed. The main focus of this chapter is to shed some light on this debate. It explores the principles of Cuba's health care system, as well as its evolution, in order to understand its extraordinary importance in revolutionary Cuba. Our thesis is that it is imperative to understand the basis of these philosophical underpinnings of public health in general

if we are to understand how they are applied in a foreign context. The second part of the chapter expands this focus, showing how Cuba has sought to "internationalize" its health care system in a domestic environment by bringing patients and students from a number of nations to Cuba for medical services. Specifically there is an analysis of two case histories—the treatment given to more than 20,000 survivors of the Chernobyl nuclear meltdown since 1986, and the evolution of the Latin American Medical School (ELAM in its Spanish acronym) founded in the wake of the devastation caused by Hurricane Mitch in Central America in 1998. Armed with an understanding of the philosophical base for public health in Cuba, and an analysis of how it has been applied in terms of what could be called "domestic internationalism," the reader will be better able to appreciate the broad sweep of Cuban medical cooperation and aid in dozens of developing and underdeveloped countries.

The complex reality of the Cuban approach to public health (vastly different from the U.S. system) and the interweaving of its basic principles into the provision of medical aid to developing countries are at first difficult to grasp. When one factors in the size and scope of Cuban medical internationalism, and the many different projects pursued simultaneously in dozens of countries, it is an even more challenging concept to understand. What is Cuba trying to do with this delivery of free or heavily subsidized public health? What fundamental principles is this approach based upon? What does it gain from these projects? Moreover, in light of the differing interpretations noted earlier, just how good *is* the Cuban health system? Does it really have valuable medical experience and "know how" to export? Finally, a question that needs to be considered is the relationship between these principles, and the delivery of public health care for almost five decades to developing and underdeveloped nations: why *does* Cuba provide such an extensive medical cooperation program to so many countries? During the course of these chapters, some thoughts will be provided to answer these and other related questions.

Prerevolutionary Conditions

In order to understand the principles and the nature of the Cuban health care system, it is first important to achieve an appreciation of prerevolutionary Cuba, and the level of health care available to the

population at the time.[4] From the outset, however, one needs to state that the level of medical care available in Havana to those who had access to it was among the best in the Americas. Too often the image is given that the quality of medical care available in prerevolutionary Cuba was substandard, and that the situation improved only after the revolutionary victory over Batista was consolidated in 1959. This is false. That said, prerevolutionary Cuba was largely characterized by widespread inequality and underdevelopment on several levels—between the developed and underdeveloped areas, the rich and the poor, and in particular the rural and urban sectors. This manifest lack of equitable development was present in many aspects of Cuban life and clearly affected the health of the Cuban people as a whole. Some basic data on living conditions and dietary deficiencies of the time help to better appreciate the vast gulfs that existed in Cuban society. Before the revolution in 1959, for instance, 75 percent of rural housing consisted of one-room dwellings, with no power or water. In addition, only 4 percent of rural people regularly ate meat, 1 percent ate fish, 3 percent ate bread, 11 percent had milk, and less then 2 percent ate eggs.[5] For these impoverished rural sectors, access to health care was extremely difficult, and, of course, their poor diet predisposed them to many long-lasting medical conditions.

At the same time, the urban bourgeoisie could obtain first-rate medical care, in many ways comparable to the best available in the United States. Indeed, the Faculty of Medicine at the University of Havana had a justifiably superb reputation, followed closely the syllabi of U.S. medical schools, and had its students take U.S. professional board exams. As a result, when the exodus of doctors started, following the revolutionary victory in January 1959, they readily found employment in the United States. The wealthy urban sector, however, formed a distinct minority of the Cuban population. They might as well have been living on a different planet, if one compares their socioeconomic profile with the miserable conditions of the rural poor. As Fidel Castro explained at his trial in 1953 following the attack on the Moncada Barracks: "There are two hundred thousand huts and hovels in Cuba; four hundred thousand families in the countryside and in the cities live cramped in huts and tenements without even the minimum sanitary requirements; two million two hundred thousand of our urban population pay rents which absorb between one-fifth and one-third of their incomes; and two million

eight hundred thousand of our rural and suburban population lack electricity."[6]

There were truly vast differences between people living in the two sectors. For instance, 54.1 percent of rural dwellings were without a toilet or privy, while only 5.0 percent of urban dwellings lacked them.[7] This rural/urban divide—complete with vastly differing housing and sanitary conditions and access to safe drinking water and a proper diet—understandably influenced the level of health care provided to the many people in rural areas. As Castro stated, "ninety per cent of the children in the countryside are consumed by parasites which filter through their bare feet from the ground they walk on."[8] The differences in the quality of education in the two sectors are also illustrative of massive differences between the two sectors. For example, 43.09 percent of people living in rural areas were illiterate in 1957, while only 11.8 percent were illiterate in urban areas in 1953.[9] The lack of education in rural areas also brought into focus the lack of medical professionals working for the government. In 1958, for instance, there were only 2,404 medical personnel working in the offices of the Ministry of Public Health (including 1,125 physicians, 250 dentists, and 46 pharmacists).

The private medical sector was lucrative indeed, particularly in the two main urban centers (and fully 65 percent of doctors worked solely in Havana or Santiago), while other areas were poorly serviced by health care professionals. There was only one blood bank for the entire country, located in Havana, again underlining the centralization of medical services in the capital, a fact that the government remedied by opening a further 21 by 1974. In 1958, out of the 339 hospitals and clinics in the country, 214 hospitals had less than 50 beds.[10] Furthermore, infant mortality was 60 per 1000 live births, and life expectancy was only 55 years[11] (see appendix A for further details of the health profile). A recent article on postsecondary education in the Isle of Youth illustrates the poor prerevolutionary conditions in rural Cuba (and the emphasis placed by the government on providing medical care in underserved areas). In the past two years, some 650 doctors, dentists, and nurses have graduated there. This compares favorably with the situation in January 1959, when the island (at that time called the Isle of Pines) had just three doctors, three dentists, four nurses, and a 25-bed hospital.[12]

In sum, those analysts who claim that prerevolutionary public health care in Cuba was the best in Latin America are indeed correct.

But they fail to see the contrast between the presence of good quality medical care and facilities in the cities (where 64 percent of available beds were located to serve 20 percent of the population) and the glaring lack thereof in rural areas. In 1961, the revolutionary government began construction on 156 rural hospitals to remedy this situation. Clearly, while the largely white and privileged minority in urban areas had access to excellent health care services, the majority lived poorly. As noted earlier, in his defense speech of 1953, Fidel Castro provided a broad summary of the wide-ranging problems affecting the Cuban population and made a commitment to resolve those major deficiencies. These sweeping improvements for the majority of the population would come at the expense of the traditionally privileged elite, leading to their steady disillusionment, and eventual exodus.

Principles of the Cuban Health Care System

To appreciate how drastic the change in equitable access to health care has been since the revolutionary victory in 1959, it is essential to understand the core values on which the Cuban health care system is based. Indeed, these beliefs have been and remain today the very foundation of Cuba's medical system. By extension, they can also be understood as the basis on which medical internationalism is structured, as can be seen from an analysis of key speeches and documents from the revolutionary leadership, and indeed from the manner in which medical cooperation has been applied throughout the globe. The revolutionary government has thus included the same approach and bases utilized in the domestic approach to public health in the strategy for the export of medical goods and services. From the outset, it must be remembered that the most important principle existing in Cuba's health care system is Cuba's belief that health care is an inalienable human right. It is to be enjoyed by all, regardless of race, social class, sex, geographical origin—or indeed, as this study shows, regardless too of nationality or country of origin.

This health care was, of necessity, to be provided by a new breed of professionals, one for whom the profit motive should never enter into the analysis—and whose essential duty was to serve those in need of medical support. This was a dramatically different sea change in the approach and philosophy of the mission of physicians, long accustomed to working in the private sector, and for whom medicine

was both a profession and a business. As is the case in most capitalist medical systems today, Cuban doctors used to work on a fee-for-service basis, receiving payment depending on the number of clients they had, services they performed, and ability to pay. Since 1959, the government has instilled the belief in medical students that being a doctor is an important privilege, with enormous responsibilities—physicians exist for the good of the people and need to pursue their vocation selflessly. They are not allowed by law to receive payment from patients for medical services performed. Doctors who sought to see medicine as a money-making career were no longer welcome in Cuba, where the new approach was on forming a broad humanitarian awareness among medical staff. Doctors trained within the revolutionary process were to serve all Cubans, regardless of their class or geographical location. Significantly, they were to be paid a salary deemed appropriate by the government and were no longer able to charge patients what the market would bear. In addition, private clinics were no longer morally acceptable, since they implied privileged treatment for those with resources to pay for such specialized care—unacceptable in a revolutionary socialist system. The doctors would now be trained for free but had to work for a two-year period wherever they were needed in the country, and not where they would necessarily prefer to live or could pursue a lucrative career. Fully one-half of Cuban doctors at the time found these restrictions to be unacceptable and left within a year.[13]

The principle that health care is an essential human right in revolutionary Cuba is thus based upon three significant and equally important philosophical pillars. First, health care is free; no Cuban will ever pay for medical attention. From the outset, Fidel Castro had made it clear that the revolutionary process would benefit those who traditionally had been the least favored. This essential equality of opportunities was necessary, and it encompassed the right for all Cubans, regardless of their social station, to have access to free public health. The importance of the government's obligation to provide this fundamental human right can be seen from the fact that it was even written into the socialist constitution of the Republic of Cuba. As Article 49 of the Constitution states, "Everyone has the right to the care and protection of their health. The State guarantees this right: By offering free hospital and medical services . . . By offering free dental treatment; By developing plans for sanitary efforts, health education,

periodic medical exams, general vaccinations, and other preventive medical means."[14]

The second of these philosophical "pillars" is the government's insistence that health care be provided regardless of geographic location. As has been noted, prerevolutionary Cuba was divided not only between the wealthy and the poor, and between black and white, but also between rural and urban areas, with most of the wealthy and the middle class living in the cities, particularly Havana. For this reason, the vast majority of medical personnel resided in the urban areas, close to those who were able to pay for medical attention. Many doctors and nurses (with roots in the urban middle class) preferred not to live in rural areas, as they were comparatively underdeveloped; in addition, the population was widely dispersed, and, of course, most peasants were poor. In 1953, for example, fully 1,779,236 Cubans were unemployed. Of the 1,972,266 people who were employed, the vast majority lived in urban areas: 607,487 worked in Havana, 519,289 in Santiago, and only 125,895 in Matanzas and 150,684 in Pinar del Río.[15] Many doctors trained in the prerevolutionary system were thus opposed to leaving the comforts of Havana (where they could charge their patients for medical services provided) and moving to rural areas, where they feared that their earning potential would be far less.

As noted earlier, one of the major challenges for the government in the early, heady years of the revolutionary process was the need to change radically the traditional attitudes held by doctors. The severity of this challenge cannot be underestimated. A new breed of doctors and, before that, of medical students, was called for—not an easy task, given the break with decades of traditional values that this implied. Throughout the world, the medical profession receives extremely high levels of income, far greater than the median salaries of society. This is no longer the case in Cuba, due to the government's insistence that they earn similar salaries to those of other Cubans. (Indeed, since the onset of the Special Period following the demise of the Soviet Union, and the emergence of the resultant inverse social pyramid that now exists, physicians earn significantly less than most menial workers in the tourist industry). Perhaps more important, however, is the way in which doctors are socialized and are taught to see themselves as revolutionaries, with a duty to contribute actively to their (socialist) society.

Indeed, the entire ethos surrounding Cuban medical schools is that of equality and humanitarianism. Ernesto "Che" Guevara explained the essence of forming this new breed of physicians, each of whom was of necessity to be "a revolutionary doctor, that is, a person who puts the technical knowledge of his profession at the service of the revolution and of the people."[16] In other words, revolutionary doctors, created by the revolution, are expected to use their abilities for the complete benefit of their patients, and their society. Related to this concept is the need for doctors to view their patients in a holistic fashion—as human beings with different bio-psycho-social needs. An integrated, overall view of patients, one that understands their background in all of these facets, is thus required in order to better serve their public health needs. Che Guevara had called for a "new man" (and woman) to be forged in revolutionary Cuba, with medical cadres exemplifying more than anybody else the selfless, humanitarian interests of a society born out of a capitalist system.

The revolutionary government, in an effort to provide adequate numbers of medical personnel for the entire island so that every Cuban had access to a doctor, began a series of far-reaching medical reforms, the essential objective of which was to provide coverage to as many Cubans as possible, particularly in traditionally neglected areas: after all, this *was* a socialist revolution. There was an urgent need to provide medical care, mainly because about one-half of the island's 6,000 doctors had fled the revolutionary process, along with all but a handful of the professors of the only medical school at the University of Havana. Just as important, however, was the need to distribute the newly trained doctors throughout the island. In fact, Act 723 of the Revolutionary Government (January 23, 1960)—which created the rural medical services—stipulated that, upon graduation, doctors were to serve in rural communities for a year (a period that was later increased to two years).[17] The system continues to this day, and as a result all Cuban medical graduates have first-hand knowledge of practicing medicine where they are needed, and not where they would necessarily choose to go.

The early years of the revolutionary process were characterized by a whirlwind of social polarization, nationalization of key industries and foreign investment, the exodus of the bourgeoisie, and increasing tension with the United States, all accompanied by a fair amount of chaos and even violence. With the departure of so many specialists,

the quality of medical care understandably decreased dramatically. Indeed, the idealism of the government during those early years must have rung hollow for many, particularly middle-class Cubans who were long accustomed to an excellent quality of medical coverage. With so many doctors leaving for lucrative opportunities abroad (and yet with the pressing political demand to deliver improved public health as tangible proof of the successes of the revolutionary process), accelerated medical training was required.

In terms of the delivery of medical care, the first decade under the revolutionary process had mixed results indeed. The quality of specialized care suffered greatly (largely the result of the exodus of specialists), while the traditionally underserved population (the urban poor and in particular the rural sector) saw their medical service improve dramatically. A sweeping reform of medical practice began. The old North American-centered curriculum of the Medical Faculty was soon replaced by an approach more in keeping with Cuban reality. The study of medicine was also opened to those who in earlier times would not have been able to study at the University of Havana because of a lack of funds. It was a time to make the most of what was available, and the approach to medicine—with a skeleton academic staff in the Medical Faculty—was now very much a pared down version of the traditional teaching model. There were limited physical resources, few medical professors, a large reduction in the number of physicians, and yet increasing social needs. Clearly a pragmatic, hands-on, no-frills approach was called for: "What Cuba needed were people with a good grounding in emergency medical techniques, who could relate to those Cubans who were not known for their polish and sophistication and who could improvise with inadequate equipment stocks."[18] That first decade was extremely difficult in terms of the delivery of public health, for obvious reasons. By the end of it, however, stability had been imposed, social equity had been established as one of the essential norms of the process, and doctors (imbued with a different understanding of their medical vocation) were graduating in ever-increasing numbers. The noticeable increase in the number of medical schools and hospitals was impressive. The number of large hospitals, for example, increased from 97 in 1958, to 163 in 1984 and 310 in 1994. Rural hospitals also increased from 1 in 1958, to 54 in 1984, and 65 in 1994[19] (see appendix B for further information).

The sector that gained most from this steady increase was clearly the peasantry, who a decade after the revolutionary victory saw a noticeable redistribution of medical staff to serve their previously isolated communities. By the mid-1980s, for example, the patient-doctor ratio had dropped from approximately 900:1 in prerevolutionary times (largely residing in urban areas) to 700:1. The major difference, however, was that medical staff was now equally distributed throughout Cuba. Today the patient-doctor ratio continues to drop, including in rural areas, and there is now one doctor for approximately every 170 Cubans, although numbers from other sources vary slightly.[20] It is estimated that about 24 percent of the nation's 70,000 doctors are currently working abroad on internationalist missions, and as a result many Cubans are disgruntled that their doctors are abroad for an average period of two years. As a result, family doctors' responsibilities have been reorganized, and medical clinics have been centralized, in order to better utilize the human resources of the medical staff in the country. It is significant, however, that even with those doctors abroad, the doctors to patients ratio is better than that of most industrialized countries. Even more relevant is the fact that they are distributed equitably throughout the country, and that all Cubans can (and do) take advantage of those medical services.

The third and final "pillar" of health care as a human right is that it should be provided to all. The question of race needs to be considered here. Following a line similar to the rural/urban geographic divide, there was also significant racial segregation in prerevolutionary Cuba. Typically, the peasants who lived in the rural areas were mulatto or black, while those living in urban areas were from wealthier backgrounds, and often were more light-skinned. This racial division was prevalent in prerevolutionary Cuba. Indeed, doctors (usually coming from very wealthy urban families, with a preponderance of white male physicians) participated—often unconsciously—in maintaining this racism simply because they chose not to work in rural areas where the people were viewed as inferior to them in many ways, and where they would earn significantly smaller salaries. With the Cuban revolution, however, this attitude was significantly altered, and graduating doctors were sent where they were needed.

In the Cuban context, a corollary to the principle that health care is a human right is the belief that health care must be government-controlled in order to ensure that it meets the goals outlined by the

government. In a recent article criticizing the Cuban public health model, Katherine Hirschfeld condemns "centralized planning, which inevitably leads to chronic material shortages and inefficiency," as well as the "disempowerment of individual patients that results from the devaluation of individuality and autonomy."[21] These comments are based largely upon an ideological rejection of state involvement in public health and reveal a profound ignorance of the role of medicine in Cuba. The underlying objective of the "centralized" system is to provide health care at no cost to the patient, regardless of his/her ability to pay and definitely not to make a profit. Accordingly the government maintains a monopoly of all medical goods and services. This approach also ensures the rational distribution of these services throughout the island, an important consideration as we have seen. In addition, the government assumed control of all medical schools as well as all medical institutions and allowed qualified students to train to become physicians regardless of their ability to pay university tuition. The government was clearly able to mold Cuba's medical system to their exact specifications (and the country's needs), thus ensuring that their model of medical care delivery would be available to all Cubans. By contrast, one can see how poorly a free market system delivers public health in the developing world—and to the 47 million U.S. citizens without medical insurance.

Another essential component of the Cuban approach is the need for health care to be participatory, with the patient acting as an important protagonist in the discussion of his/her health needs. While in capitalist societies competition is an important facet of a successful economy, in socialist countries citizens are socialized from birth to believe in cooperation. This belief in cooperation over competition—which is taught throughout school—creates a humanitarian attitude and promotes communal participation. It contributes to the national awareness about the need for social equity and for a fair distribution of available resources—including medical services. From the time that children enter a day care center, early childhood education is imbued with values of cooperative play. This communal ethic is also incorporated into Cuban society throughout their education, and Cubans are socialized to believe in working collectively for the better of society. The collectivist, organized Cuban response to hurricanes, for example, stands in stark contrast to the approach in Southern Florida, where individuals take the leading role in protecting themselves from natural disasters.

One of the underlying reasons in Cuba for incorporating community participation in health care models is the need to bring to people's consciousness an awareness of their power to change their lives, and to engage their creativity and ultimately their contribution to the process. This harnessing of the community potential is also found in the use of mass organizations. Indeed, Cuba has used these widely to develop participatory health care—largely through already existing neighborhood block groups, or Committees to Defend the Revolution (CDRs), and through local trade unions and the Federation of Cuban Women (FMC in the Spanish acronym) to which most women belong. Since the 1959 revolution, Cuba has actively promoted community organization throughout its society. This process both reduces the cost of providing many services and, more importantly, makes the participants stakeholders in the process, hopefully more committed to its success because of their contribution. The Cuban government has also used these groups to carry out health promotion activities—such as vaccinations—as well as to survey the public health needs of the general populace, thus enabling the physician to provide medical help if needed. These community groups have also been called upon to lobby neighbors to follow the doctor's orders, thus supporting at the grassroots level the delivery of health care. Indeed, in many ways family doctors depend on the CDRs to support their medical role in the community.

Participatory health care is also promoted in the relationship between the family doctor and the community. Indeed, the doctor usually lives in the community where s/he serves (working half a day in the clinic and spending the other half visiting the patients in the neighborhood; moreover, they are also on call on a 24-hours basis). As the doctor and patient see one another almost daily in the communities, they become very close, and the doctor is able to keep a ready eye on them. Similarly, community members are observant of one another and their health concerns and will often alert the doctor if a neighbor needs medical attention. This communal participation is extremely important as the doctor and the community thus form a cooperative team that works together to ensure enhanced communal health and the betterment of society.

This approach to health care is also present in the actions of the community itself. In addition to inoculating children, local organizations work with the family doctor in public health campaigns,

addressing issues ranging from alcohol consumption to smoking and other health hazards in the local community. These hazards could range from the need to pick up garbage and store it properly to the need to reduce stagnant water (in which mosquitoes breed).[22] Community participation is thus a major component of the hands-on approach employed at the grassroots level, with the physicians working closely with local organizations and individuals in order to better serve the medical needs of their patients.

An Emphasis on Preventive Medicine

Since the government is in control of all aspects of public health, it has been able to tailor the approach to medicine in keeping with its revolutionary socialist ideology. Of particular importance was the emphasis placed on preventive medicine, an area incorporated into all medical school curricula. In 1975 and 1976, for example, compulsory modules dealing with this topic were instituted in each medical school and nurse training schools. A new compulsory examination entitled "Community Health, Family and Preventive Medicine" was also created for students in their final year of medical school.[23] As revolutionary Cuba evolved, so too did the curriculum in Cuba's medical schools, but always maintaining the emphasis on preventive (as opposed to curative) approaches. Despite that health profile, however, it was discovered by the government in 1960 that the Department of Pediatrics at the University of Havana had never researched the three causes of high child mortality: "parasitic infestation, usually intestinal; gross malnutrition [mainly starvation] and enteric infections in the first two years of life which lead to uncontrolled diarrhea and hence to death by dehydration."[24] Thus, the government insisted that Parasitology and Internal Medicine become mandatory classes for students wishing to graduate from medical school. MacDonald analyzed the medical prospectuses and lecture programs at the medical school in prerevolutionary Havana and discovered that the curriculum was geared toward health problems found in North America: "The three lectures that dealt specifically with childhood malnutrition were derived from standard American nutrition textbooks and dealt with vitamin and mineral deficiencies attendant upon excess intake of 'junk foods'—hardly a major problem for Cuba's destitute."[25] Faced with this prerevolutionary model that was completely out of touch

with Cuba's reality, a total restructuring of medical education was implemented, with enormous stress being put on the need to practice preventive medicine. The medical school system thus evolved to cater to the real health needs of the public, a process that was accompanied by educational campaigns at the grassroots level in basic hygiene.

This emphasis on preventive medicine has also resulted in significant changes in the importance placed on maternity homes for high-risk pregnancies. Before 1959, maternity homes were seen as a novelty and as only for the very wealthy—and the end result was an infant mortality rate of 60 per 1,000 live births. By 1974, however, 47 maternity homes had been built, and as early as 1976, 97 percent of all births occurred in hospitals—with each expectant mother receiving an average of 8.5 antenatal checkups.[26] Some 30 years later, just over 99 percent of births now take place in hospitals, and the infant mortality rate is one-tenth of what it was in 1958. Indeed, Cuba's infant mortality rate is lower than that of the United States, and comparable to other "developed" countries.[27] There is a particular emphasis placed on preventive medicine in maternal health. For example, family doctors are expected to give a thorough exam before the ninth week of pregnancy, and at least 12 prenatal visits, as well as a battery of regular lab tests and screenings, are the norm. In addition, high-risk pregnancies get extra attention, including special tests, "community-based maternity homes with both day and overnight facilities, supplementary nutrition programs, and inter-consultation with other specialists (pediatric cardiologists, obstetricians, pediatricians, etc.)."[28] Mothers also receive payment for time off work for prenatal visits as well as their standard annual pay for an extensive maternity leave—up to one full year.

In addition to maternal health, child health care has also become imbued with the preventive health mantra. Immediately after birth, family doctors frequently visit their patients and their newborns in the hospital and do their first full medical examination within 72 hours of birth. Moreover, beginning in their first year, Cuban children are also immunized against 13 childhood diseases. In addition, new and specialized screening—such as early detection of hearing loss in infants—has also made it possible to implement a policy of intervention in the hearing impaired as young as three months old. Commenting upon this focused attention to preventive care for children, one writer observed, "Cuba's statistical time series

for infant mortality documents one of the most rapid declines ever recorded."[29]

The importance of preventive medicine as the keystone to the Cuban approach to public health cannot be overemphasized. Quite simply, it permeates the entire philosophy employed by MINSAP (Ministry of Public Health) and has done so from the outset of the revolutionary process. As Ernesto "Che" Guevara said, "One day medicine will have to become a science that serves to *prevent* diseases, to orient the entire public toward their medical obligations, and that only has to intervene in cases of extreme urgency to perform some surgical operation or to deal with something uncharacteristic of that new society we are creating."[30] Guevara's sentiment did indeed take hold, as this preventive medicine approach has become a fundamental element of Cuba's medical strategy. As McDonald notes, "A peso's worth of preventive medicine equals 10 pesos worth of interventionist medicine. Keeping people from falling sick should cost only a tenth of treating them once they have become sick."[31]

But this preventive medicine is found not only in medical school curricula, since all other educational facilities (from preschool onward) also preach this message. Indeed, the education system has regular classes to teach students how to maintain a healthy lifestyle, and the mass organizations (such as the FMC and the CDRs and local trade unions) also engage in health promotion and education campaigns, supporting the family doctor. Perhaps the fundamental reason for the impressive health track record is the close relationship that family doctors have with their patients. It is an ideal setting for practicing preventive medicine, as they are able to meet and live alongside their neighbors/patients and as a result can detect illness and treat it immediately—before it becomes a significant problem. It is a lesson that makes sound financial sense as well as good medicine.

The health care system has also taken an unexpected turn toward developing biotechnology and pharmaceuticals, largely because of U.S. government pressure on multinational pharmaceutical companies not to sell their products to Cuba. Despite the emphasis on simple techniques of observation and early intervention, it is also clear that medication will be required in the treatment of patients. Because of the U.S. embargo and an end to decades of dependency upon the Soviet Union, in the last two decades Cuba has embarked upon a policy of "establishing a biotechnology industry that has effectively introduced

drugs and vaccines of its own, along with a nascent pharmaceutical industry that has achieved considerable success in exports."[32] Largely due to Cuba's heavy investment in education at all levels, they have impressively developed their technology and practices.[33]

Guided largely by Fidel Castro, the Cuban biological program was created in 1981, with several research/production centers founded in the late 1980s. To the west of Havana, several research centers have been established in what is now know as the "Scientific Zone." Here there is "a complex of more than 40 institutions, employing over 12,000 workers and more than 7,000 scientists and engineers."[34] The research here is generally seen as being of high quality. For example, during the 1990s, Cuba became the first country to develop and market a vaccine for meningitis B.[35] This biotechnology industry was created by the state to work in tandem with the government-controlled public health system. Common to both is the objective of protection and development of people's health, and not the maximization of profits. (It is ironic that the export of pharmaceutical/biotechnological products and medical services in general has now overtaken the tourist industry as the leading generator of hard currency in the country). Unlike private corporations, however, the profits generated by the sale of these products revert back to state coffers to be spent on the needs of the Cuban people—and they are used to purchase everything from penicillin to school books.

The Evolution of the Cuban Public Health System

The Cuban models of health care delivery have undergone significant development over the past five decades, creating and developing different forms of institutions as the revolutionary process itself evolved. The principles outlined earlier have remained the same, but the method of providing the resulting medical care has changed with time and experience, much as the revolutionary process has. These different stages in the Cuban approach to public health have also been mirrored in the international health cooperation that Cuba has provided—for instance, the development assistance given to Algeria in the early 1960s is nothing like that provided to sub-Saharan Africa or Bolivia today. An understanding of the evolution of Cuban public health strategies thus provides an insight into the application of that approach abroad. After putting the greatest emphasis on satisfying

the immediate public health needs of the population (particularly of those sectors that had traditionally been marginalized), the government then sought a means of maximizing the medical service in order to provide medical care to the greatest number of patients. After "thought, experimentation and grass-roots consultation,"[36] they came up with the idea of providing polyclinics for the community, starting in 1962. They used "multi-specialty clinics as the basic building block for ambulatory care."[37] Polyclinics were originally created as a means to provide health care for workplaces, childcare centers, homes, and neighborhoods and still do. For a North American visitor they would appear to be small-sized local hospitals, where one would go for immediate treatment in an emergency or for more specialized care with a doctor's referral. The polyclinics offered general medicine, pediatrics, gynecology, obstetrics, dental care, control of communicable diseases, hygiene, and health education.

Polyclinics were a very important part of Cuban medical history as they were used to take care of all of the primary health care needs such as immunizations, antenatal and neonatal care, school health, and the like, again highlighting Cuba's emphasis on disease control and prevention.[38] They represented the next logical step for medical care after visiting the family doctor, and often patients went directly to the polyclinic instead of visiting the local physician. In fact, it was largely due to polyclinics that many diseases were either successfully eradicated or notably reduced. There were problems, though, with the structure of these facilities; by the 1970s, assessments showed that the polyclinic setting was not helping to integrate at the local level the different medical specializations working there—a concept that had been an original and important goal. Other problems hindering their overall effectiveness included the physicians' tendency to apply curative, rather than preventive, medicine and the generally distant relationship between the doctors, dentists, and their patients in the community.

The government later tried to improve the polyclinics by bringing in additional nurses, incorporating more preventive medicine into the model, and trying to create a greater level of communication between the employees and the people. The government's attempts to improve the polyclinics were only partially successful, and the centers were later altered to conduct research and to facilitate interdisciplinary consultations between different specialists. Another major innovation was the

use of the polyclinics to train medical personnel—largely family doctors. Although the polyclinics are still of tremendous importance in Cuban communities, government emphasis since the early 1990s has increasingly been placed on the role of the family doctors—who cover almost the entire Cuban population.

With the belief that, although specialists are very important, family doctors are able to help more people with a larger spectrum of problems, Cuba has thus developed a new health care model based largely on the importance of family doctors in medicine. They now are the basis of the Cuban public health system. Indeed, Cuba has a vision of a "new" family doctor to keep communities both mentally and physically healthy as well as to inspire cohesion in communities. As the MINSAP explains, "the chief objective of the Family Doctor Program is to improve the state of health of the Cuban population in its entirety through the implementation of integral, broadly based health programs aimed at serving the needs of families, communities, and the physical environment in a dynamically and interrelated fashion."[39]

Cuba had first started a five-year plan to explore how to train large numbers of family doctors in 1976. The program stemmed from a noticeable decrease in previously common diseases, which had largely been eradicated throughout the 1970s. The mortality rate from infectious and parasitic diseases, for example, had decreased from 13.3 percent in 1962 to 2.8 percent in 1976, and that of death from acute diarrheal disease had decreased from 8.2 percent in 1962 to 1.0 percent in 1976. The Ministry of Public Health thus decided that having resolved the most pressing medical problems, it was now time to face new challenges, with a major emphasis on working more closely with the community through a family doctor program. In this plan, the government wished to increase the doctor-patient ratio and thus improve the prevalence of preventive medicine as well as create a stronger doctor-patient relationship. The philosophy was simple: the more the family doctors became incorporated into the community, the more impact they would have on those communities. The mission of family doctors in Cuba is thus remarkably different from that of their North American counterparts. Indeed, the government believed that—and insisted that—"the 'new' family doctor sees him/herself as a social worker as much as a medical/technical expert."[40]

In September 1984, after several years of encouraging medical students to specialize in family medicine, Cuba officially introduced the actual family doctor model.[41] It sought to practice preventive medicine, to understand the value of social factors contributing to health, to promote actively healthy living practices, to put into practice a holistic approach to public health (seeing the patient as a product of a number of biological, psychological, social, and environmental factors), and to place far greater emphasis on the importance of the doctor-patient relationship in the community. A doctor and a nurse were stationed in every community, in which they were to live alongside the people they treated. The doctor's home was typically part of the building that housed the clinic. "Having medical practitioners live in the communities where they practiced was an innovation designed to reduce isolation, increase access, improve communication, and enhance equity."[42] Thus the doctor and nurse saw their patients/neighbors on a daily basis and soon became familiar with their medical history and problems, both through visiting them at their homes and meeting then on the street—as well as through patients' trips to the medical clinic.

MINSAP began this process by giving general practitioners specialized training in family medicine. Each worked three days a week as a family doctor in training and devoted the rest of the week to studying. By 1986, each Cuban medical school was offering a three-year postgraduate degree to qualify as a family doctor.[43] Before a GP could enter the program, however, they needed sufficient hospital experience. In 1991, they again altered the course to a two-year postgraduate program. Indeed, "by the 1990s, the strategic goal was reached whereby a team of a family physician and nurse lived on every block and provided care for 120–160 families."[44] This is the model that is in place today throughout Cuba.

It is important to note that the doctor-nurse team did not just live in the community but also took an active role supporting and leading it in health matters, using different means to promote preventive medicine. They organized and participated in various educational projects and presentations and promoted better dietary habits in order to modify poor behavior patterns. Moreover, the family doctor was supposed to be proactive and involve him/herself in a variety of community decisions, working with the local CDRs, schools, and unions. Even their workload was geared toward preventive care.

Family doctors spend the morning taking appointments with patients, and the afternoon visiting the neighborhood homes to check up on the sanitary habits of their patients.[45]

The importance of this extensive family doctor program cannot be understated, since it touches virtually all families on the island. Indeed, as Presno and Soberat note, "experts even credit the continued government priority afforded to health care during the worst years of the economic crisis—occurring after the collapse of the Soviet Union—and the presence of family doctors and nurses in Cuban communities, as fundamental reasons why the majority of basic health indicators did not take the plunge with the economy."[46] Today there are 32,000 family physicians in Cuba—a number that will likely continue to grow.[47] The impact of family doctors is also clear in the revision of statistics: infant mortality was as low as 5 per 1000 live births in 2006, and the under-5 mortality rate has dropped to 7 per 1000 live births.[48] As a further indicator of the value (in both public health and economic terms) of this harnessing of preventive medicine, hospital outpatient visits have also decreased (from 21.7 percent in 1980, to 13.2 percent in 2000). To promote the well-being of older Cubans, there has also been notable growth in the creation of "seniors' clubs," some 14,000 of which now exist. Another important statistic is the level of immunization of children—which now surpasses 95 percent.[49]

It is clear that family doctors have had an enormous impact on the health profile of Cuba. Today they are very important in communities, not just for the direct medical aid they provide, but also for their promotion of continuing preventive measures as well as for being both communal leaders and advisors. Indeed, as MINSAP itself states, "The Family Doctor, then, is the cornerstone of Cuba's primary health care system."[50] They have deliberately shunned overspecialization, preferring to develop a holistic view of their patients in their home environment and in their community. They are in effect specialized generalists, since that is what is most beneficial to the community. After all, what good are you as a dedicated specialist in the inner left ear, if a child has a ruptured appendix or a fever?

Health Care in Cuba Today

Thus far the chapter has covered the principles on which Cuba's health care system is built, as well as its evolution. It is equally important,

however, to have an understanding of what it means for Cuba today and what priority is placed on public health. Today, Cuba allocates 23 percent of its central government expenditure to health and 10 percent to education, while the United States allocates 22 percent to health and 2 percent to education. It is worth noting, though, that Cuba spends only $251 annually per person on health care, while the United States spends $5,711 annually per person.[51] The fact that Cuba's health profile compares very favorably to that of the United States illustrates how wisely that money is spent. Perhaps more telling is the fact that it is distributed equitably among all. Today, 99 percent of Cubans have access to health care professionals.[52] According to the World Health Organization, Cuba's doctor-patient ratio is 1 to 170—ahead of the United States at 1 to 188.[53] Moreover, while doctors in the United States are concentrated largely in urban areas—leaving those in the countryside far from medical personnel—Cuban doctors are evenly distributed across the island so that every Cuban has access to a medical professional. The number of nurses has also increased. As nurses, not doctors, are more likely to be immediately instrumental in reducing infant mortality rates, Cuba had made a significant effort to increase the number of nurses. From 1975 onward, 2,000 assistant nurses were also being trained annually.[54] It is useful to put this in contrast with prerevolutionary times: in 1959, for example, there were only 800 nurses who worked exclusively in hospitals, usually private ones, while today that number has grown to over 50,000.[55] Additionally, the number of medical facilities has greatly increased. Between 1958 and 1994, for example, the number of polyclinics grew from 0 to 400. During the same time period, the number of hospitals increased from 97 to 310 (with rural hospitals increasing from 1 to 65, and children's hospitals from 3 to 28). Again, from 1958 to 1994, the number of medical schools grew from 1 to 28, dental schools from 1 to 8, nursing schools from 4 to 76, and blood banks from 1 to 24.[56] With their innovative family doctor program, there are now 31,857 family doctors distributed equitably throughout the island.[57] Also notable, life expectancy is now approximately 78[58] (the same as in the United States[59]) and the infant mortality was a low 6 per 1000 in 2003[60]—lower than the United States' 7 per 1000.[61] As noted earlier, these figures have continued to drop—and are still better than the figures for the United States. These figures speak volumes about Cuba's successful approach to public health. Clearly,

James Wolfsensohn—the president of the World Bank—had it correct when he stated, "Cuba has done a great job on education and health care…They have done a good job, and it does not embarrass me to admit it."[62]

The Impact of the Special Period on Public Health in Cuba

The previous section ended on a positive note. If Wolfensohn had made his comments eight years earlier, however, a different picture would have emerged. The collapse of the Berlin Wall in late 1989 was an enormously potent symbol of the decline of socialism in Eastern Europe—a trend that became even clearer with the dominos of Czechoslovakia and Romania falling in quick succession. Soviet subsidies began to dry up, and oil supplies fell from 13 million tons in 1989 to just over a third of that by 1993. Sadly for Cuba, erstwhile socialist allies turned on Cuba, demanding payment in hard currency for supplies that for decades had been provided in a COMECON (socialist Common Market) barter arrangement. Imports of food from the Soviet Union were halved between 1989 and 1993, and nothing would ever be the same again. The trouble for Cuba was that about 86 percent of its trade had been with the socialist bloc and so, after the demise of the Soviet Union, the revolution was faced with a loss of everything—fuel, food, spare parts, and a market for Cuba's sugar and nickel. Even though the economy started to grow steadily after touching bottom in 1994, by 2000 imports were still 40 percent lower than they had been in 1989. This era in the Cuban revolutionary process is known as the Special Period, and the remnants of it continue even today.

This obviously had a major impact on all forms of social and economic development on the island. Import of foodstuffs tumbled, Cuban adults lost an average of 20 pounds in weight, and caloric intake dropped dramatically. An epidemic of optical neuropathy affected some 60,000 people between 1992 and 2001, largely due to a vitamin deficiency. The rate of low birth-weight babies increased from 7.6 percent in 1990 to 9 percent in 1993.[63] During the 1990s, the shelves in Cuban pharmacies were often bare, and patients in hospitals often had to bring in their own sheets and food. The health care system was stripped bare of all but essentials. Visitors to

hospitals at the time would see "disposable" supplies—everything from syringes to gloves—being washed and reused several times over. Electricity blackouts affected all sectors, even hospitals. Spare parts for machinery—everything from incubators to x-ray machines—were desperately needed. In addition, many medical professionals were demoralized. Often there were not the medicines necessary to treat their patients, an enormously frustrating experience for medical professionals who could diagnose the medical condition but were powerless in the face of little or no supply of appropriate medicines. Many doctors left the profession, seeking to join the burgeoning private sector, selling food on the streets, driving taxis, or working in the tourism market. This moral crisis was far more difficult to resolve than a material one, for it caused many physicians (and indeed many, many Cubans) to question the "Special Period," during which social values decreased. The very nature of medicine as a vocation was challenged as medical professionals, who had always been held in high esteem by the public, now questioned why their salaries were a fraction of less educated Cubans selling handicrafts or driving taxis.

Despite these major challenges, the government response was instructive, again protecting the principles of public health for all that are referred to earlier in the chapter. No hospital was closed, for example, despite this enormous crisis. Universal accessibility, even in remote areas, was maintained—even with ever-dwindling medical supplies. The priority of health care for the Cuban government can be seen in the social expenditures, which actually increased (in terms of actual funds disbursed and as a percentage of GDP) between 1990 and 2000.[64] "Doing more with less" became the official mantra, as closer collaboration, an even greater emphasis on preventive medicine, and a focus on the most vulnerable groups were employed.

As the economy plummeted following the demise of the Soviet Union, the Cuban government introduced a series of reform measures to stimulate the Cuban economy. The first of these in 1993 was the legalization of the use of hard currency (previously illegal), and this resulted in about $1 billion in remittances arriving annually from family and friends abroad. Other measures quickly followed, as the government sought innovative measures to keep the sickly economy afloat. Foreign investment, which had been ignored during the decades of Soviet subsidies, was now courted. Tourism was chosen as the most likely source of hard currency generation, and the fact that it

has increased eightfold in the last 12 years illustrates its importance in the current economy. Cubans were also encouraged to pursue various forms of self-employment, and almost 200,000 did.

At a time of desperation, the government pulled out all the economic stops to generate much-needed revenue. One of the sources was in the field of medical tourism. While hard data is hard to come by, anecdotal evidence from a variety of sources would suggest that around 2–4 thousand foreigners underwent surgery each year during the worst years of the economic crisis. An undated article suggests that in 1996 "more than 7,000 'health tourists' paid Cuba $25 million for medical services."[65] In a 2003 BBC report, Tom Fawthrop estimated that the previous year "more than 5,000 foreign patients traveled to Cuba for a wide range of treatments including eye surgery, neurological disorders such as multiple sclerosis and Parkinson's disease, and orthopaedics."[66] He claims that health tourism generated about $40 million a year.

Critics of this service have emphasized the "medical apartheid" aspect of the specialized treatment given to foreigners, while Cubans received second-rate service. There is no doubt that there was a major difference, particularly in the worst years of the "Special Period," in the quality of treatment received by the two groups. The Cuban rationale in many ways springs from Fidel Castro's reference ("a pact with the devil") to the liberalizing economic reforms he reluctantly introduced as the Soviet Union imploded. Tourism in Cuba, just as anywhere else, is a double-edged sword, bringing in hard currency and exposing 2 million tourists annually to Cuba, while at the same time encouraging the development of a reverse societal pyramid (with workers in the tourism industry earning many times more than professionals in the state education and public health sectors). When the medical element is introduced, it raises other ethical issues, since health care and education had been the twin jewels in the crown of social reform.

But desperate times require desperate measures. And the money obtained from medical services was plowed back into the state budget to cover essential expenses. It would appear that in recent years this supply of medical services to tourists has been reduced for several reasons. An analysis of Cuba's leading hospital in this servicing of foreigners, the Clínica General Cira García in Havana, is instructive. The hospital is accredited to serve the diplomatic corps in Havana,

the foreign business sector, as well as visitors to Cuba in general. Its website (www.cirag.cu/clinica.htm) lists detailed medical treatment, and prices for these services. A thorough checkup for men costs $240, for which the patient receives two consultations with a specialist, a variety of laboratory tests (from uric acid to creatinin), X-rays, electrocardiograms, and ultrasound of the prostate. Cosmetic surgery is more expensive, with liposuction of the thighs, waist, and abdomen costing $2,295.

The surgery carried out in the "medical tourism" genre appears to be of excellent quality and is certainly far less than a patient would pay in a private clinic in the industrialized world. The fact remains, though, that specialized and superior care *was* provided (and still is) to foreigners.[67] What needs to be understood, however, is that the funds generated in this way were and are diverted to the central medical budget—to be used to provide treatment for Cubans. The money is indeed profit—but it is profit for the Cuban people, and not for a drug manufacturer or a private health care facility.

A recent article on the delivery of health care at this outstanding hospital is instructive. During 2006, "more than 1,000 patients from 86 countries, mainly Barbados, Spain, Canada, United States, Italy, Haiti, Mexico, Grand Cayman, and England, were admitted at Cira García Hospital."[68] Clearly the number of private patients from industrialized countries has reduced in recent years. The same article also hints at why this has happened—some 10,000 Venezuelan patients have been treated (significantly at no cost) in this same hospital since 2001. In other words, as the economy has improved, the priority to provide foreign patients with high quality private care has decreased—basically because the economic need has decreased. Instead, because of a series of mutually advantageous arrangements between Venezuela and Cuba (to be discussed in a later chapter), Cuba has reverted to its traditional emphasis on socialized medicine.

A further illustration is germane. At the Cira García hospital, cornea transplants are offered at $3,788, glaucoma treatment at $2,103, and cataract surgery at $2,473 (per eye). At the same time, through a medical program called "Operation Miracle," more than a million citizens of Latin America and the Caribbean have had surgery on their eyes performed by Cuban doctors at no charge in the last three years. Understanding the big picture is clearly essential here, and criticisms of "medical apartheid" need to be taken accordingly.

What is clear from a study of the delivery of health care on the island is that it is generally of a high standard. It is also clear that, while "medical tourism" delivered to private patients did at one point contribute modestly to the state coffers, far more important has been the delivery of health care to Third World citizens—tens of thousands of whom have had their lives saved by Cuban medical intervention.

Medical Internationalism in a Domestic Setting: The Chernobyl Case

Despite the horrendous challenges facing Cuba during the "Special Period," the government continued its policy of medical aid to groups abroad considered to be living in even more dire straits than those in Cuba. Such was the case of the medical support offered to the children from Chernobyl. In April 1986, the reactor at the Ukrainian nuclear plant exploded. A massive exodus of some 150,000 people over a 30-kilometer radius occurred, but soon it became clear that the toxic fallout was responsible for the death of an estimated 125,000 people. The enduring effect of this industrial tragedy can be seen in the region today, where the thyroid cancer rate is 100 times the norm. A further estimated 9 million people have been affected by the resulting radiation. Several countries rushed to help, in particular offering to transport children away from the affected region. Cuba sent a team of specialists to evaluate the major medical problems facing the local inhabitants and then drew up a plan of assistance.

In March 1990 some 139 severely ill children arrived in Cuba, where they were cared for in Tarará, a small recreation area to the east of Havana. Since that time, some 23,000 people have been treated (about 80 percent of whom are children), at no charge to the patients or to the government of the Ukraine. Each year, between 700 and 800 children from the affected area arrive, both for medical treatment and to recuperate. The children receive free medical treatment, as well as room and board, and on average stay between two and three months. This has cost the Cuban government an estimated $300 million since the program was first implemented. The first generation of victims (suffering from the immediate effects of the nuclear accident, and from leukemia and other forms of cancer) has now been replaced by those affected by long-term medical conditions associated with radioactive exposure, including genetic malformations and skin

disorders that respond well to Cuban medical treatment, aided by the Cuban climate.

It is important to remember the context in which this medical cooperation has occurred. The Ukraine had, prior to the implosion of the Soviet Union, been one of Cuba's leading trading partners (accounting for almost one-third of the USSR's exports to Cuba). By 1990, the Cuban economy was reeling, with no end in sight to the resulting food scarcities, shortages of everything from spare parts to school supplies, a massive drop in imports, a major decrease in public transportation, and blackouts. The estimated $5 billion in subsidies from the Soviet Union had long evaporated, and Cuba was on its own—with mountains of sugar (and no buyers), inefficient Soviet equipment (without spare parts), and scarcely a trickle of fuel. Given that disastrous economic situation, the logical action for the government would have been to reduce all unnecessary expenditures and to cut back on all but the essentials for their own population. The Chernobyl support clearly fell into that category, particularly because many Cubans felt betrayed by their erstwhile Soviet allies. Yet the government refrained from such a step and instead supported the common Cuban refrain that "Children are born to be happy," regardless of where they come from and despite the policies employed by their leaders.[69] As a humanitarian gesture, it is remarkable indeed.

The Role of the Latin American Medical School (ELAM)

A similar comment could be made about the Latin American Medical School (ELAM in the Spanish acronym). There is a popular saying in Cuba that Cubans either don't reach their goals—or else they go way past them. A case in point is the Latin American Medical School. Anybody who has been to the ELAM facility in the former naval academy west of Havana cannot help but be amazed by the grandeur of the original concept. Like many great initiatives, its basic goal was very simple—to train (at no cost) doctors from poor backgrounds in regions affected by natural disasters to treat their fellow citizens who would otherwise have difficulty in accessing medical care. It was born out of the ashes of Hurricane Mitch in 1998, when over 30,000 Central Americans lost their lives. Cuba responded by sending over 1,000 doctors to the region to provide immediate disaster relief. Later, the revolutionary government came up with a far-reaching

suggestion: rather than provide emergency medical support, why not train Central Americans in Cuba to become doctors, so that they could look after themselves? In this way the necessary radical surgery would be provided, instead of "band-aids" (no pun intended), allowing the countries in the region to develop a sustainable public health system. Out of this basic idea ELAM was born. (There is another institution at the Medical Sciences Institute in Santiago, where some 500 French-speaking students from Haiti, Mali, and Djibuti are also studying medicine, again at no charge).

The original intake of students was only from the area affected by Hurricane Mitch—Honduras, Nicaragua, and Guatemala—but was later extended to the entire hemisphere, and indeed to some African countries. The initial name of the institute (the Latin American School of Medical Sciences) was subsequently changed to "the Latin American School of Medicine," signaling its intent to qualify students as doctors, and not just as apprentices working with scholars of medical sciences. In 1999, the Cuban government initiated medical studies at ELAM. In his address at the inauguration of the medical school in November 1999, Fidel Castro recited the numbers of students—1,929 from 18 countries. The majority were from poor backgrounds (several were the children of victims of torture and of the "disappeared" in Latin America), whose financial limitations would have remarkably limited opportunities to study medicine in their home countries. They represented different religions and diverse political ideologies and were from dozens of indigenous groups. They were expected to study hard and return to their underserved medical communities (or to others where they were needed) when they graduated. They would pay no tuition, and their food, accommodation, and books would be provided for free. First- and second-year students would study at ELAM (in all, about 3,500), after which they would spend four years furthering their studies in some 20 Cuban hospitals throughout the country, working alongside Cuban doctors who would tutor them. This may well be the largest medical school in the world, with almost 10,000 students attending—and again at no charge.

The philosophy of the ELAM is a unique model of medical training and counters two major trends in the international health care sector. First, it rejects the concept of privatization in both capacity building and health accessibility. Second, its success is based upon the central control of medical services, and the rational distribution

of these based upon human need. This is particularly important because throughout Latin America (and indeed across most of the world), there has been a concentration of services in urban areas, responding to market forces. Many medical graduates focus their attention on the same urban areas, in an effort to repay the debt of their education. By contrast, ELAM graduates represent a totally new (and thus challenging) model for the associations of medical professionals: they have no debt upon graduation, they have extensive experience in rural and underserved communities, they are willing to work in outlying areas, and they have been schooled in a different approach to public health, seeing their patients (and not their clients) in a holistic fashion, having lived with them, visited their homes, and engaged with them on a frequent basis. Moreover the new breed of physicians graduating from ELAM has contributed to the empowerment of the community, working alongside them to improve living conditions in the neighborhood, reduce health risks found in the environment, and participate in educational campaigns promoting a healthy lifestyle. The training, development, and empowerment of ELAM students are unique. The essential principle behind the Cuban training model is in essence to empower locals to take on community responsibility, to become active stakeholders at the local level—in short, to act as protagonists instead of passive recipients. And in this process the role of the ELAM graduate in the community is crucially important.

Fidel Castro has waxed eloquent about the mission of the students at the medical school. They were expected to follow in the true tradition of the vocation of medicine with "absolute devotion to the most noble and human endeavor, that of saving lives and preserving health. More than physicians they shall be zealous guardians of what human beings appreciate above all else. They shall be apostles and builders of a more humane world."[70] The first graduating class in many ways was typically like the students who entered each year: the average age was 26, 45.9 percent were women, there were students from fully 33 indigenous groups, 71.9 percent were from working class or rural backgrounds, and 84.6 percent of the students who were enrolled six years earlier graduated.[71] The Cuban leader had left no doubts as to the high expectations he had for them—it was now their turn to pay back to humanity the debt incurred as a result of their studies: "They will be doctors ready to work wherever they are needed, in the

remotest corners of the world where others are not willing to go. Such are the doctors who will graduate from this School."

In many ways, the ideas expressed by the Cuban president represent an excellent synthesis of the principles of the medical system in Cuba. Physicians were to be selfless "apostles" and, like their Cuban counterparts, were to go and serve where they were needed. Like their Cuban colleagues, they were also to sacrifice personal aspirations in favor of the collective, offering safe health care to all who need it, regardless of social station, geographical location, or race. Significantly, all of their professors at ELAM have spent several years on internationalist medical missions and thus constitute living examples of doctors who practice what they preach.

Another reflection of the values contained in the Cuban medical system can be seen in the curriculum followed by the students. Even more important is the four-year practicum spent working in the Cuban community alongside Cuban doctors while furthering their studies on the island. Clinical medicine—alongside a strong emphasis on preventive medicine, perhaps one of the most deeply rooted principles of the Cuban system—is taught at ELAM; its application is seen when the students work in the community. This integral approach to medicine (looking at patients in terms of their bio-psycho-social background) is followed at all times, both at ELAM and in the practicum. This "hands-on" approach can be seen in the fieldwork that some 300 students in the first graduating class did in 2005 during the last six months of their medical program working abroad in Guatemala, Honduras, and Haiti. The students provided medical care during that fieldwork experience to over 773,000 patients. In 2007, this was expanded to other countries.

At the graduation ceremony of the first cohort of physicians trained at ELAM (some 1,610 students from 28 countries), Castro spoke about the cost of training a doctor in the United States (approximately $300,000) and then put this in context by showing that Cuba could contribute to world health by training 100,000 doctors in the coming years. Unlike First World nations that increasingly contributed to the "brain drain" by attracting doctors from developing nations, Cuba was helping the "brain gain" by training these physicians, turning each of them into a "true guardian of health and life, who is ready to go to any country where its services are required, convinced that a better world is possible!"[72] The mission of ELAM

is to train a new breed of doctors, one with a true sense of solidarity with their patients, a profound ethical sense, and a streak of pragmatism. Havana, in short, has offered a radically new approach to medical training to the poor of the south on a scale never before seen.[73] It is worth noting that at the graduation ceremony of the first cohort of ELAM graduates, Venezuelan president Hugo Chávez announced that his country would establish a second ELAM—so that, together with Cuba, some 100,000 more physicians could be trained over the next decade. That process was initiated in 2006, and at present 50,000 medical students are being trained in Cuba, with a similar number in Venezuela—using an approach known as the "new paradigm." According to this, students are placed with a doctor—usually in the countryside—and after a basic science course begin to accompany the mentor-doctors in their treatment of patients. It is very much a "hands-on" approach, supplemented by web-based research and video-taped lectures from ELAM.

The return of the ELAM medical graduates to their home countries has not been without significant challenges, however. While it is clear that their services are desperately needed (particularly in underserved communities, where many are too poor to pay for a visit to a doctor), at times hostile (and jealous) associations of medical professionals have placed obstacles to their attempts to establish themselves as doctors. The ideology behind practicing medicine in Cuba—where a philosophy of human solidarity, a determination to share all resources equitably (and without charging for medical services), and the goal of a just sustainable public health system are supported by the government—is clearly very different from the approach used elsewhere in Latin America.

Concluding Thoughts

The Cuban approach to public health is unique. It flies in the face of conventional wisdom about a variety of traditional strategies and beliefs and does so in an unapologetic fashion. In essence it provides a Cuban antidote to the time-honored paradigm of the (privatized) centralization of medical services, dependence upon costly technology, and a fee-for-payment approach. In its place it offers a system that emphasizes a preventive rather than a curative approach, a strategy based upon a low patient-doctor ratio and an active grassroots

involvement of the physician in the community. Moreover, it has done this despite almost five decades of hostility from the world's only superpower, located just 90 miles away. The irony of the fact that this small country, which invests just a fraction of the amount spent per capita in the United States, has health outcomes comparable (and in some cases superior) to those of its powerful neighbor should not be lost on anyone.

Perhaps most important of all, it has resolutely promoted public health as a fundamental human right for all, regardless of wealth, socioeconomic status, race, or geographical origin. The basic principles of the Cuban public health system have been outlined in this chapter and are in themselves extraordinary. Even more so, however, is the deliberate extension of these principles since 1960 to other countries in worse condition than Cuba. This level of humanitarian solidarity is unprecedented, with Cuba doing more to assist underdeveloped and developing nations than any other country in the world.

This chapter has also studied two diverse case histories, both of which show an important facet of the Cuban campaign to use domestic facilities to improve public health abroad. This internationalist solidarity in terms of promoting a sustainable system of public health, as will be shown throughout this book, is deeply rooted in revolutionary Cuba. The first of these, the treatment of the victims of the Chernobyl nuclear reactor tragedy, is important because it illustrates Cuban altruism at a time when the domestic economy was in freefall, with Cubans in dire economic straits. Despite the massive cutbacks, the fact that Cuba continued to treat thousands of Ukrainians at no cost shows clearly the government's commitment to humanitarian solidarity. The case of ELAM illustrates the same tenet of Cuban medical internationalism and yet goes beyond medical treatment by promoting a sustainable public health model. For the revolutionary government, the emphasis placed upon the vocation of medicine has been consistently upheld. As the Cuban president himself remarked in 2005, "Graduating as a doctor is like opening a door to a long road leading to the noblest action that a human being can do for others."[74] At present there are tens of thousands of foreign students studying medicine (at no cost) in Cuba, and they are being trained with the same principles encountered in the approach to domestic public health. Their contribution (and by extension that of Cuba) in the future to the so-called Third World will be great indeed.

Speaking in 2005, Fidel Castro summed up well the goal of this humanitarian internationalist education at ELAM, one that parallels clearly the principles of the very public health philosophy of Cuba: "What is the secret? It lies in the solid fact that the human capital is worth far more than the financial capital. Human capital involves not only knowledge, but also—and this is essential—conscience, ethics, solidarity, truly humane feelings, spirit of sacrifice, heroism, and the ability to make a little go a long way."[75]

Appendix A: Latin American Medical School

Fact Sheet	
Year founded	1999
Number of students currently enrolled (all campuses)	8,705 (additional 1,300 expected to enroll in March 2007)
Number of countries represented in student body	29
Number of U.S. students	85
Number of ethnic groups represented	101
Percentage of women in student body	51%
Graduates to date	2,888 (1,498 in 2005; 1,390 in 2006)
Expected graduates, class of 2007	1438
Percentage of students on full scholarship	100%
Attrition rate	20%
Average class size	20–30 students (practical courses and seminars)
Length of MD program	6 years (includes one-year Internship)

Source: MEDICC, 2007. Found at <www.saludthefilm.net/ns/elam-fact-sheet.html>.

Appendix B: Cuban Health Data, 1958–2007

	1958	1975	2007
National Health Budget	$22,000,000	$400,000,000	X
Hospital Beds	28,536	46,402	54,857
Physicians	6000	10,000	70,594
Infant Mortality	60 per 1000 live births	28.9	5.3
Life Expectancy	55 years	70	77.6

Source: Calculations made from MacDonald, MEDICC, UNICEF, WHO.

Chapter 3

Cuba's Cold War Medical Aid Programs

Cuba's Cold War Foreign Relations: A Brief Overview

Cuba is certainly unusual and some might even say unique among less developed countries in terms of the fascinating odyssey that it pursued through the tangled web of Cold War and post-Cold War politics. Indeed, one of the very few things that both the proponents and the detractors of the Revolution can agree upon is that Havana has consistently cast a much longer shadow over the international stage than one might have expected given its small size (approximately 11 million inhabitants) and relatively meager natural resources. This was true even in pre-Castro days, for a special aura always seemed to have surrounded Cuba. The Spanish, for instance, called the island the Pearl of the Antilles in recognition of its status as the crown jewel of their Caribbean empire. Later it would gain added notoriety when various writers, Ernest Hemingway being perhaps the best example, and even Academy Award-winning filmmakers such as Francis Ford Coppola (in *Godfather II*) would use it as the backdrop for some of their most popular works. Undoubtedly, however, it has been Fidel Castro and the Revolution that he unleashed that have thrust the country most prominently (and most controversially) into the public limelight.

It could be said in a very general sense that during the Cold War there were two key aspects of Havana's international personality, the first being its triangular relationship with the era's two great superpowers (the United States and the USSR) and the other its linkages with the rest of the world. These two dimensions did not, of course,

exist in total isolation but instead often interacted. It was, for example, quite common for the dynamics of Cuba's dealings with the superpowers to generate a ripple effect that had significant implications for its ties with other nations. In other words, once it was swept into the often turbulent waters of the Cold War, Havana often found it necessary to trim its foreign policy sails to adjust to changes in the prevailing geopolitical winds. Normally this process did not involve adopting an entirely new set of goals and strategies, but rather the re-ranking of existing concerns while perhaps also gradually incorporating a few new elements into the overall equation. In particular, such incremental change often involved shifts in emphasis between the superpower dimension of Havana's international agenda and its relations with other parts of the globe. Although admittedly a somewhat arbitrary enterprise given the multidimensional complexity of the Revolution's foreign policy agenda,[1] these fluctuations can for our purposes here be utilized to break the evolution of Havana's Cold War international relations into the following three basic stages:

- U.S. Hostility and the Cuban Response, 1959–1968
- Consolidating Havana's Soviet Connection, 1968–1972
- Cuba's Emergence as a Global Activist, 1972–mid-1980s

During the first two periods listed above, the essential dynamics of Cuban foreign affairs tended to function primarily as a reflection of the island's shifting and often contentious ties to the Cold War's two superpowers. Specifically, much of Havana's attention was focused on performing a delicate and often tumultuous balancing act that involved managing its exploding confrontation with Washington while simultaneously trying to work out a relationship with Moscow that contributed to the Revolution's security without sacrificing its independence. In short, Cuba's international agenda was at this point very much "reactive" in nature, with Havana adjusting its policies to developments in its relations with the United States and/or the USSR. Subsequently (i.e., in the third period listed above), the Revolution's international style would become much more "proactive" as Havana assumed the initiative on a number of policy fronts. In the process, developmental aid efforts in general and medical assistance programs in particular would move to center stage as major items on the its foreign affairs menu.

U.S. Hostility and the Cuban Response, 1959–1968

During this initial period, the Revolution's attention was focused primarily on its deteriorating relations with the United States. Washington, accustomed to looking at the Caribbean Basin as its special sphere of influence where docile client states were routinely maintained, soon lost patience with the rambunctious Fidelistas who had seized power in Havana and insisted upon pursuing such heresies as attempting to establish control over their country's economic destiny by nationalizing foreign (mostly U.S.) companies operating on the island and embracing the kind of radical left-wing ideology that Washington has long been committed to excluding from "its backyard." Indeed, the United States had already vividly demonstrated by its 1954 overthrow of the Arbenz regime in Guatemala that it would not hesitate to take strong measures against Latin American governments that challenged its traditional hegemony, especially if they could be delegitimized on the basis of alleged pro-Soviet sympathies. Consequently the United States promptly launched an anti-Cuban crusade that included severing all diplomatic ties with Castro's government, organizing the Bay of Pigs invasion, instituting an economic blockade of the island (which has continued to the present time), and making numerous attempts to assassinate Fidel Castro. Understandably, such behavior aroused obsessive security fears in Havana, whose main response was to begin to turn to the Soviet bloc for economic and security assistance.

This Moscow connection developed rather gingerly, however, since both parties had some qualms about the whole process. Initially the Soviets displayed rather mixed feelings about the Cuban Revolution, their main misgivings centering on what they felt to be a lack of commitment to orthodox Soviet-style Marxism on Havana's part, combined with a tendency to take unnecessary foreign policy risks (especially when dealing with Washington). The Cubans were likewise quite cautious in moving toward the USSR, restrained by their fears of simply trading Yankee for Soviet dependency and uncertain as to the depth of the Kremlin's commitment to defend the Cuban Revolution. This latter concern became increasingly salient in Havana's foreign policy calculations as a result of the 1962 Missile Crisis, where Havana felt that its interests had been ignored and even betrayed by the Kremlin. In a nutshell, the Cubans saw the Soviet missiles as a crucial

resource that would serve to demonstrate the USSR's commitment to defending the Revolution's security and thereby deter any inclination on Washington's part to launch a direct attack on the island. As such, Havana's confidence in Moscow's reliability and trustworthiness was severely undermined when the Soviets reached an agreement with the Kennedy administration to resolve the crisis without including the Cubans in or even informing them about the negotiations.[2]

Subsequent to the Missile Crisis, Havana's complicated and often testy relations with both the Cold War superpowers produced an increasing emphasis in its foreign policy on radical activism in Third World affairs. A stimulus for this development emanating from Washington came in the form of the limited successes that the United States had achieved in its efforts to isolate the island (economically as well as diplomatically) in the hope that such external pressure would ultimately destroy the Castro government and its Revolution. Although this campaign did not receive a very favorable reception in most Western European capitals, Washington was able to persuade/browbeat the bulk of the hemispheric community (Canada and Mexico being the sole exceptions) as well as some other LDCs (Less Developed Countries) into severing practically all of their ties with the island.

Havana's response to this U.S. challenge was to go on the offensive, its basic strategy being to implement a policy of support for the armed struggles of ideologically like-minded left-wing insurgents (which it characterized as "proletarian internationalism") in an attempt to build an independent power base rooted in radical Third World circles. Ironically the Cubans' willingness to confront Washington during this period sparked an outburst of ideological bickering with Moscow that produced serious strains in the Cuban/Soviet relationship, the basic problem being that the more staid, conservative leadership in the Kremlin did not share and refused to support Havana's enthusiasm for armed struggle as the primary, if not sole, strategy for undermining U.S. power and interests in the less developed regions of the world.

The Cubans' greatest hopes were focused on Latin America, where they felt that conditions were especially ripe for Fidelista-style revolutions. The basic idea here was that a rash of insurgencies on Washington's southern flank would inevitably trigger its Cold War obsession with containing the spread of leftist ideologies and

movements. Consequently, if it rose to the bait and tried to respond to multiple challenges, the United States would no longer be able to focus all or even most of its counterrevolutionary attention on Cuba. This strategy was encapsulated in Che Guevara's exhortation to create "two, three, many Vietnams" throughout the Western Hemisphere. Indeed, the most ambitious/optimistic version of this scenario foresaw rebel victories in Latin America and elsewhere (e.g., Africa and southeast Asia) producing a bloc of radical Third World governments that would ally with and rally behind Havana in playing a significant (and superpower-independent) role on the international stage. Ultimately, however, this vision would fade as the hemispheric guerrilla offensives of the 1960s were smashed.

Although hemispheric affairs dominated Havana's international agenda between 1962 and 1968, Cuba unobtrusively began developing a presence in Africa that would later become one of the centerpieces of its foreign policy. This saga started in 1963 when Havana sent advisors and a small contingent of combat troops to Algeria to help Ahmed Ben Bella's radical socialist government in its border dispute with Morocco. A cease-fire was signed before these forces became involved in any fighting and they were withdrawn shortly thereafter, but the very fact that they were dispatched in the first place indicated that Cuba was indeed beginning to implement a much more ambitious conceptualization of its international role.[3] At this time, Havana also became involved in supporting various African national liberation movements, especially those struggling against Portuguese colonialism in Angola and Mozambique. Later it would take the unusual step for a small developing country of setting up formal government-to-government military aid missions in Congo-Brazzaville (1965) and Guinea (1966). Thus the seeds of what would become a major Cuban presence in African affairs in the mid-1970s and would lead observers such as Jorge Domínguez to characterize Cuba as a "small country [with] a big country's foreign policy"[4] were quietly planted during the 1960s.

Consolidating Havana's Soviet Connection, 1968–1972

Several factors converged in the late 1960s and early 1970s to produce a reconsideration of Havana's foreign policy priorities. The most salient among these were (a) increased pessimism about the prospects,

especially in Latin America, for successful Cuban-style guerrilla warfare; (b) the need for the Revolution's leadership to devote more attention to questions of domestic development due to the economy's poor performance in 1968–1969 and the severe dislocations caused by the unsuccessful 10 million-ton sugar campaign of 1970; and (c) ongoing strains in the Cuban/Soviet relationship that tended to generate a sense of growing political isolation and economic vulnerability on Havana's part, which in turn translated into intensified security concerns. Consequently Cuba made some major changes in the configuration of its international agenda.

Rapprochement with the USSR represented the Cubans' most dramatic initiative. Although Havana still refused to embrace the Kremlin's position on some issues, this reconciliation proceeded swiftly following Fidel Castro's endorsement of the 1968 Soviet intervention in Czechoslovakia and the subsequent Brezhnev Doctrine, with cooperation in the economic field (where relations had always been fairly normal) leading the way. This process culminated in 1972 when Cuba became the first non-European nation to be granted full membership in the Council for Mutual Economic Assistance (CMEA, which was the Soviet bloc's rough equivalent of the European Economic Community). This affiliation provided Havana assured access to a broad menu of socioeconomic aid programs that would be instrumental in helping it to achieve levels of development comparable in some respects to those of the most modernized nations.

The other major change that Havana made was in its approach to Third World affairs. Although not abandoning its long-standing dedication to the principle of supporting the armed struggles of revolutionary movements, Cuba began to devote more attention to normalizing and expanding its conventional state-to-state relations. Specifically, it began to emphasize the idea of cooperating with any regime that was "progressive," which it defined in a very broad sense as being committed to liberal social justice programs at home and especially to pursuing an independent foreign policy. This more ecumenical approach to its foreign relations allowed Havana to look upon the governments of most developing nations as potential allies and thereby opened the way for it to begin to play a much more active role in Third World affairs.

The combination of the two initiatives noted above—that is, establishing a highly lucrative economic connection (which also included

large infusions of military aid) to the socialist bloc and expanding dramatically its relations with developing nations—would become a defining hallmark of Havana's foreign policy for the remainder of the Cold War and would allow it to pursue a remarkably ambitious agenda on the international stage. This complex exercise will, for the purpose of simplicity, be characterized here as "dual-tracking."

The CMEA/Soviet link was pivotal to the Cubans' dual-track scenario, the key by-products of this special relationship being: (a) it provided the Revolution with a sense of military security that had been sorely lacking in the 1960s, thereby allowing it to move beyond its earlier trepidation about the possibility of a U.S. attack and to turn its foreign policy attention to other concerns; (b) it significantly reduced Cuba's exposure to the economic warfare that the United States was trying to wage against the Revolution; and (c) it enhanced the resources, both human and material, upon which rested Havana's capability to pursue an extremely audacious global agenda, particularly in the realm of Third World affairs. Essentially, then, what Cold War dual-tracking entailed was Cuba's tapping into Soviet/Eastern European resources to bolster its security, stabilize its economy, and thereby put itself in a better position to explore new frontiers in its foreign relations. The result was an explosion of activity on the international scene that would solidify Havana as a major player in Cold War affairs.

Cuba's Emergence as a Global Activist, 1972–mid-1980s

Beginning in the early 1970s, Havana's foreign policy shifted away from being essentially reactive to moves made by Washington or Moscow and instead became more proactive as the Cubans began to devote increased attention to launching their own initiatives designed to redefine and widen their role in international and especially Third World affairs. In the Caribbean Basin, for example, diplomatic ties were reestablished with the following nations in the early 1970s: Barbados, Guyana, Jamaica, and Trinidad/Tobago in 1972; Venezuela in 1974; and Colombia in 1975. The Caribbean nation with which Cuba had the most cordial dealings throughout most of the 1970s was Jamaica following Michael Manley's election as prime minister in 1972. Although a democratic socialist rather than a full-fledged Marxist, Manley nevertheless displayed (particularly

following his 1976 reelection landslide) growing admiration for the Cuban socioeconomic model as well as interjecting an increasingly militant nonaligned coloration into his foreign policy. Havana responded enthusiastically, extending substantial moral and material support to what it perceived to be Kingston's progressive proclivities. Similarly close relations blossomed with Grenada after Maurice Bishop's New Jewel Movement seized power in March 1979 and with Nicaragua following the successful culmination in July 1979 of the Sandinistas' long, brutal war against the Somoza dictatorship. It was, however, in Africa where Havana emerged most dramatically onto the international stage, establishing a major presence there by instituting numerous developmental as well as security assistance programs and by deploying thousands of combat troops that were decisive in winning two wars (in Angola, 1975–1976, and, cooperating closely with the USSR, in Ethiopia, 1977–1978).

The military/security aspects of a country's foreign affairs almost always receive the greatest attention, for it is these policy areas that produce the great political melodramas of nations locked in mortal combat that so captivate the media and the general public. Often overlooked in the excitement of the moment are such admittedly more mundane, yet extremely important, dimensions of the overall picture as economic relations and related developmental assistance programs. Certainly such myopia existed with respect to Cuba during the 1970s, especially in the realm of African affairs where (U.S.) news accounts were dominated by sometimes fanciful stories of shadowy Fidelistas fanning out to promote guerrilla uprisings and particularly by reports about Havana's involvement in the Angolan/Ethiopian conflicts.[5] As such, what was for the most part overlooked was the fact that Havana was increasingly and astutely employing developmental aid (especially medical assistance) as a sophisticated tool in its foreign policy repertoire.

Cuba, unlike the highly industrialized nations, simply did not (and still does not) have the funds to underwrite the costs of major modernization projects in LDCs. Consequently, its developmental assistance efforts have always been labor- rather than capital-intensive, Havana's basic strategy being to commit whatever human resources are necessary to get its initiatives off to a strong start and especially to conduct training so that local cadres will be able to take charge as quickly as possible. While Cuba has tended to concentrate on construction, education, and health care since it has large pools of highly

trained professionals in those fields upon which it can draw, it has also provided help in such diverse undertakings as community development, agronomy and animal husbandry, communications, transportation, cultural affairs, applied marine biology and fishing, tourism, trade union organization, and sports.

Normally Havana's developmental aid was supplied on a completely gratuitous basis, although the host government was often expected to assume responsibility for the Cubans' minimal living expenses and for furnishing the logistical support necessary for the projects. Even these limited obligations could, of course, be waived if Havana decided that they created undue hardship for the recipients or if there were good diplomatic/ideological reasons for an exemption. Beginning in 1978, however, Cuba began to charge some countries—particularly oil-producers and other whose financial status warranted it—for services rendered. For example, a contract worth US$150 million was signed in September 1979 whereby Havana would provide construction workers and technical assistants to help Libya build houses and highways. Similarly, the Cuban Construction Enterprise concluded a US$50 million deal with Angola in November 1979 involving 50 apartment complexes and three bridges. But despite the introduction of this compensation factor, Cuban spokesmen stressed that in the final analysis,

> the essential internationalist principles on which such aid had been based from the beginning remained unchanged. Those . . . countries suffering under economic difficulties continued to receive assistance free, and others were subsequently exempted from having to pay when faced with adverse economic conditions.[6]

In any case, even when remuneration was involved, Cuban personnel represented a significant bargain for their Third World employers in comparison to the comparable technicians dispatched by the Western developed countries or most international organizations.

The scope of Cuba's overall developmental aid programs at the height of its Cold War global activism (i.e., mid-1970s to mid-1980s) is summarized in table 3.1. Clearly, in terms of both the number of nations served and the total personnel involved, sub-Saharan Africa constituted Havana's main theater of operations, with Latin America firmly ensconced in second place (the sole exception being 1981 when a flurry of activity in Libya gave the Mideast/North Africa region a brief edge over the western hemisphere in the total number of Cubans deployed there).

The post-1981 reduction in the number of Cubans posted overseas indicated in table 3.1 should not be taken as symptomatic of any major reassessment or downgrading of Havana's commitment to developmental internationalism. Instead, it can be explained primarily in terms of economic considerations or political exigencies. The cutback of the Middle Eastern contingent in 1984 and 1986 can, for example, probably be attributed at least in part to the completion of contracts arranged when petrodollars were flowing into Arab coffers and to the relative scarcity of such funds to underwrite new projects as the bottom fell out of the oil boom in the early to mid-1980s. In the Nicaraguan case, which represents Havana's other main demobilization in 1986, a large Cuban presence constituted a potential political liability in the sense that it could be used to generate support for Washington's anti-Sandinista crusade and also could have unduly complicated efforts to promote a negotiated settlement of the confrontation that both Havana and Managua were undertaking at that time. Thus it served the larger diplomatic interests of both the Sandinistas and the Cubans for Havana to assume a lower profile by reducing both its security and developmental aid contingents in Nicaragua.

Table 3.1 Cuban Developmental Aid Personnel Abroad*

	1977	1978	1979	1981	1984	1986
Mideast/N. Africa						
Algeria	25	50	100	250	275	100
Iran				3,500		
Iraq	375	415	1,350		400	100
Libya		400	1,000	5,000		100
Mauritania				50		15
Morocco					15	
S. Yemen	100	500	300	150	200	
Syria						100
W. Sahara						75
Other					3,575	
(Total)	(500)	(1,365)	(2,750)	(8,900)	(4,465)	(490)
Africa						
Angola	4,500	8,500	6,500	6,500	6,000	6,000
Benin						35
Burkina						15
Burundi						15
Cameroon						10
Cape Verde			13			15
Congo	20				140	85

Table 3.1 Continued

	1977	1978	1979	1981	1984	1986
Equatorial Guinea	150					10
Ethiopia	150	500	450	1,000	1,000	1,100
Ghana					40	35
Guinea		35	200	125	240	25
Guinea Bissau	45	85	40		75	85
Madagascar			25	50	35	5
Mali					10	15
Mozambique	100	400	600	1,000	900	900
Nigeria					5	5
Sao Tome Y Principe		140	200			60
Seychelles					20	20
Tanzania	425	200	80		150	25
Uganda						10
Zambia		20				15
Zimbabwe						55
Other		1,090	290	760	345	
(Total)	(5,403)	(10,970)	(8,385)	(9,435)	(9,060)	(8,540)
Latin America						
Bolivia					5	5
Colombia						5
Grenada			350			
Guyana			65		60	50
Jamaica		100	525			
Mexico						15
Nicaragua			1,800	4,000	5,300	2,500
Panama						30
Peru		10				
St. Lucia			12			
Other		80		640	55	
(Total)		(190)	(2,752)	(4,646)	(5,420)	(2,605)
Asia						
Afghanistan				100		10
Laos			250			
Sri Lanka						5
Vietnam			75			
Other					100	
(Total)			(325)	(100)	(100)	(15)
Grand Total	5,903	12,525	14,212	23,075	19,045	11,650

*When a range of figures is given in the sources, which is common when estimates are being presented, or when two sources give different figures this table uses the average of the highest and lowest figures available.

Sources: The 1977–1979 figures come from H. Michael Erisman, *Cuba's International Relations: The Anatomy of a Nationalistic Foreign Policy* (Boulder, CO: Westview Press, 1985), 78–79. The 1981 figures come from U.S. Department of State, *Soviet and East European Aid to the Third World, 1981* (Washington: Department of State, 1983), 20–21. The 1984 figures come from U.S. Department of State, *Warsaw Pact Economic Aid to Non-Communist LDCs, 1984* (Washington: Department of State, 1986), 16. The 1986 figures come from U.S. Department of State, *Warsaw Pact Economic Aid Programs in Non-Communist LDCs: Holding Their Own in 1986* (Washington: Department of State, 1981), 12.

At the epicenter of these foreign aid initiatives were Cuba's health care programs. Consequently such assistance would increasingly come to symbolize Havana's overall commitment to improving the quality of life throughout the developing world, with its doctors, nurses, and related personnel representing the front-line contingents in this remarkable exercise of medical diplomacy.

Africa as the Main Incubator for Cuba's Medical Aid Programs

As previously noted, the Revolution's first foray into conventional medical diplomacy occurred in May 1963 when Havana dispatched a medical mission of 35 doctors/dentists and 23 nurses/technicians to Algeria, which in July 1962 had finally won its independence from France following a brutal anticolonial struggle led by Ahmed Ben Bella during which more than a million Algerians were killed. Cuba, consistent with its emphasis at that time on supporting radical left-wing wars of national liberation, had provided some clandestine military aid to Ben Bella's guerrilla forces and had also brought wounded fighters and civilians (especially children) to Havana for free medical care. As such, the foundation was laid for the "official" aid that was subsequently provided to Ben Bella's government.

The May 1963 medical assistance initiative was undertaken in conjunction with Cuba's efforts to help Algeria in a border conflict with Morocco by supplying tanks and other modern arms to Ben Bella's government. It soon became clear, however, that Algeria lacked the trained personnel to use such equipment with maximum efficiency and so ultimately Havana decided to become directly involved by deploying combat units from its regular forces, including an armored battalion that arrived on October 28, 1963. But because a cease-fire was signed on October 30, these troops never entered the fighting and most were withdrawn shortly thereafter. The Cuban medical brigades, on the other hand, remained on the scene until Ben Bella's government was overthrown in June 1965, at which point Havana's first major foray into medical diplomacy came to an end. Summarizing this extraordinary episode, Piero Gleijeses wrote in 2002 that

> The story of Cuba and Algeria is now almost forgotten, and yet it was not only Cuba's first major contact with Africa, but also a foretaste of

> Cuban policy toward the continent. The military aid to a national liberation movement—the Algerian FLN—was repeated, on a larger scale, with aid to liberation movements of the Portuguese colonies. The military aid to an independent African government (Algeria, in October 1963) was repeated with aid to other governments, beginning with the Congo in 1965. And it was in Algeria that the saga of Cuban civilian internationalism began. The doctors who went to Algeria in 1963 were followed by others who went to independent countries in Africa and by the *médicos guerrilleros*—those doctors who went to Zaire with Che [Guevara] and to the guerrilla-held areas of Guinea-Bissau.[7]

Che Guevara's African sojourn, to which Gleijeses refers above, merits some additional attention. In April 1965, along with approximately 200 Cuban volunteers, Guevara arrived in Africa to join insurgents who were trying to throw Moise Tsombe out of power in Zaire (previously known as the Belgian Congo). Included in this group was a small medical contingent that not only served the guerrillas but also the larger civilian population. In particular, having noted that polio was rampant within the country, the Cuban *médicos guerrilleros* arranged to have Havana and Moscow provide 61,000 doses of vaccine, which were then administered to children in June 1965 and which represented the first mass vaccination program ever undertaken in Africa. In late 1965, having participated in the fighting for several months, Che's forces were withdrawn at the request of their Congolese allies. Although Guevara was ostensibly operating as a private citizen since he had given up his Cuban citizenship as well as all of his posts in Castro's government, his presence strongly suggested that Africa's status was rising on Havana's international agenda.

In the mid-1960s, as Gleijeses indicates, Havana not only became involved in supporting various African national liberation movements, especially those struggling against Portuguese colonialism in Angola and Mozambique, but also took a step unusual for a small developing country—of beginning to establish formal government-to-government military aid missions in Congo-Brazzaville (1965), Guinea (1966), Sierra Leone (1972), Equatorial Guinea (1973), and Somalia (1974). In many cases these training/advisory groups were accompanied by medical delegations that launched health care programs that often proved to be ultimately more extensive and more long-term than the security assistance efforts (see table 3.2 for a

Table 3.2 Cuban Cold War Medical Aid Programs in Africa: Starting Dates

Algeria	1963	Mozambique	1977
Mali	1965	Benin	1977
Congo	1966	Ethiopia	1977
Tanzania	1966	Saharan Arab Republic (Polisario guerrillas)	1977
Guinea-Conakry	1967	Uganda	1979
Equatorial Guinea	1973	Burundi	1980
Guinea-Bissau	1975	Ghana	1983
São Tomé and Príncipe	1976	Burkina Faso	1985
Angola	1976	Zimbabwe	1986
Cape Verde Islands	1976	Botswana	1988

Source: Julie Feinsilver, *Healing the Masses: Cuban Health Politics at Home and Abroad* (Berkeley: University of California Press, 1993), 160–161.

comprehensive list, with starting dates, of Cuba's Cold War medical aid programs in Africa).

It was, however, in Angola during the 1970s and the 1980s where Cuba's Cold War internationalist policies—both military and medical—would burst into full bloom. The first act in what would eventually become an extremely complicated drama[8] involved a struggle that began in earnest in the Spring of 1975 between three Angolan factions—Agostinho Neto's Popular Movement for the Liberation of Angola (MPLA), Holden Roberto's National Front for the Liberation of Angola (FNLA), and Jonas Savimbi's National Union for the Total Independence of Angola (UNITA)—for control of the government following a long anticolonial struggle that finally forced Portugal to grant the colony independence. The United States and South Africa had for some time been providing covert aid to Neto's rivals and in October 1975 they dramatically upped the ante when South Africa sent its armed forces into Angola to fight beside the MPLA's opponents, thereby transforming what had been a civil war into an international conflict.

Confronted with a potentially fatal crisis, Neto drew upon his well-established ties to Havana and asked for assistance. In an unprecedented move, the Cubans responded and in November 1975 they began to dispatch large contingents of their own combat troops to Angola where they soon had a major impact in turning the tides of war in the MPLA's favor. Indeed, it appeared that Neto's control of the country was secure once the last South African units withdrew in late March 1976. Certainly Havana seemed to think so, for in mid-1976 it began

to reduce its forces in Angola (which were estimated to have peaked at approximately 36,000); almost 12,000 returned to the island by March 1977. But this move, based on the assumption that the situation had stabilized, proved to be premature. Instead, tensions once again rose in mid-1978 when South Africa once again sent troops into southern Angola as part of its campaign against rebels who were fighting to free nearby Namibia from South African control and also to bolster UNITA's ongoing guerrilla campaign against Neto's government.

This reescalation was seen by Havana as a second wave of foreign aggression against Angola's sovereignty and thus, at Neto's request, more Cuban forces (which ultimately numbered about 50,000) began to pour into the country to confront and deter the South Africans. Havana maintained this protective shield throughout much of the 1980s. Finally, however, after protracted negotiations mediated by the United States involving Cuba, Angola, and South Africa, an agreement resolving the conflict was reached in December 1988 that provided, among other things, for Namibian independence in 1989, the cessation of all South African aid to UNITA, and the subsequent total withdrawal of Cuban combat forces from Angola—a process that was completed on schedule in 1991.

Not surprisingly, it was Havana's military involvement in Angola that dominated the reporting of the Western media as well as the cacophony of alarm and protest by Western governments, particularly Washington. What was generally overlooked in all of this uproar was the major investment that Havana was making in Angola (and elsewhere in Africa) with respect to developmental aid in general (see table 3.1) and health care assistance in particular. Indeed, the lead elements of what would become Havana's largest Cold War foray into medical diplomacy arrived hard on the heels of the first troops in late November 1975.

Although precise figures are not available, it would appear that there were approximately 700 and perhaps as many as 800 Cuban health professionals in Angola at the height of the program. Certainly thousands rotated through the country during the 1970s and the 1980s. Julie Feinsilver provided a snapshot of the extent of their activities in Angola when she reported, based on Cuban sources, that

> during 1986 they [Cuban medical teams] saw 1,280,787 medical and surgical cases and 17,160 dental cases. In 1987 Cuban doctors treated 1,051,982 cases, including surgical cases, and dentists attended 13,104 patients.[9]

Beyond being a trendsetter in terms of the scope of Havana's medical assistance programs, the Angolan case can also be used to provide some insights into the financial arrangements involved. Initially Cuba did not ask for or receive any payment for its medical (and other developmental) services; instead Havana covered the participants' salaries and some other program expenses. However, as the efforts expanded dramatically, and given the fact that Angola was an oil-exporting nation that benefitted from the OPEC-driven rise in petroleum prices that began in the early 1970s, Angola began in January 1978 to pay some compensation that in any case still represented a "bargain." For example, Cuba received a monthly payment of $815 per doctor, with one-half being hard currency (which Havana needed to help finance its imports from Western developed countries) while the remainder was in soft Angolan funds that were nonconvertible and thus not very useful outside of Angola. In late 1983, however, growing weaknesses in the Angolan economy prompted Cuba to return to its previous non-compensation policy.[10]

Ethiopia represented Havana's second major African initiative in the 1970s and in many respects mirrored its Angolan experience, especially in the sense that it began primarily as a military operation that later assumed major developmental/medical aid dimensions. Initially Cuba had aligned itself with the enemies of Emperor Haile Selassi's pro-American regime in Addis Ababa, especially the neighboring Somalis and the national liberation forces in Ethiopia's Eritrean region that were fighting for independence. However, a dramatic realignment of Cold War allegiances within the region was set into motion when Haile Selassi was driven out of power by a military coup in September 1974. On the one hand, as the Ethiopian government drifted steadily leftward under a radical army faction headed by Haile Mariam, Havana as well as Moscow cooled their previously close relations with the Somalis and concentrated instead on solidifying their ties to Addis Ababa. The Somalis, feeling betrayed, responded by mending their fences with various Western powers, including the United States.

The growing tensions in the region exploded into open conflict over the long-simmering Ethiopian/Somali border dispute involving the Ogaden Desert region (which was claimed by both countries but was under Ethiopian control). Somalia, its confidence bolstered by its newfound Western support, decided to force the issue by invading

the Ogaden with 40,000 troops in July 1977 and initially its forces gained the clear upper hand. But then the tide turned as Havana and Moscow, fearing that the very survival of Haile Mariam's government might be at stake, responded to Addis Ababa's cries for help by launching a closely coordinated counteroffensive against the Somalis is late 1977. Basically the Cubans supplied the combat forces, which peaked at approximately 15,000, while the Kremlin provided logistical support and Soviet officers commanded the overall joint operation. The struggle was for all practical purposes over by March 18, 1978 when the Somali army, which had taken a terrible beating from Cuban artillery and air attacks, began a final retreat back to its own borders.[11]

As had likewise occurred in Angola, the Cuban military forces that were deployed to Ethiopia were joined by large contingents of health care workers and other developmental aid personnel. Indeed, as indicated in table 3.1, Ethiopia emerged as the second largest recipient of Cuban developmental aid professionals in the late 1970s through the mid-1980s (followed closely by Mozambique). In terms of medical assistance, Sergio Roca reported that sources in Havana indicated that there were 139 Cuban doctors involved in Ethiopian aid programs in 1979 (compared to 323 in Angola). Moreover, according to Roca, in 1978 about one out of every four physicians in Ethiopia was Cuban and these aid brigadistas treated more than a million patients over an 18-month period.[12]

There is one cautionary note that needs to be interjected into any attempt to paint a broad portrait of Havana's aid programs based on data concerning the number of Cubans assigned to operate overseas. The caveat here is that in some instances these individuals were functioning more as contract workers than as pure aid personnel. This was especially true in the Middle East, with Iran and Iraq providing examples where such discretion may be necessary. The figures in table 3.1 indicating 1,350 Cuban developmental specialists in Iran (1979) and 5,000 in Iraq (1981) could create the impression that these countries were major beneficiaries of Havana's aid programs (medical and otherwise). In fact, these governments were in almost every instance paying for these services, often in hard currency that they had earned through their substantial oil exports. In short, the Cubans dispatched to Iran and Iraq were overwhelmingly there due to "labor contracts" arranged by the three governments—they were

not deployed within the context of conventional aid programs. The commercial nature of these arrangements is illustrated by the dramatic reduction of Havana's contingents noted in table 3.1—by 1986, only 100 Cubans remained in each country. Quite simply, what was happening was that the Cubans were returning home because their contracts had been fulfilled. As such, unlike Algeria, Angola, Ethiopia, Mozambique, and others, these (contracting) countries cannot be seen as major venues for Cuban developmental assistance or medical aid diplomacy.

Caribbean/Central American Activism

During the early 1970s, Cuba began to interject a new geographical dimension into its assistance programs—the Western Hemisphere. Focusing initially on Peru, Havana furnished disaster relief in 1970 to help the country recover from an earthquake (even though there were no formal diplomatic ties between the two nations at the time). Later, in May 1971, Cuba sent a construction brigade to Peru to help build six hospitals in the country's mountainous northern region. Ultimately, however, it was in the Caribbean Basin region where Havana became most heavily involved in Cold War health care (and other) aid initiatives. The recipient governments fell into two broad categories: those that Havana considered to be "progressive," which were the most numerous, and those that were clearly controlled by radical elements, that tended to receive extremely generous treatment.

Medical Aid and Progressive Politics

The early 1970s saw Havana launch an effort to normalize its relations across a broad spectrum of countries. In the CARICOM region, this initiative led to diplomatic ties with Barbados, Guyana, Jamaica, and Trinidad/Tobago in 1972. The most cordial links, however, were forged with Jamaica following Michael Manley's election as prime minister in 1972. As noted previously, Manley displayed a strong affinity for the Cuban Revolution—especially some aspects of its socioeconomic model—particularly after his 1976 landslide reelection. Havana responded in kind, extending substantial moral and material support to encourage Kingston's increasingly progressive

tendencies in both domestic and foreign policies. Fidel, for example, repeatedly stressed during a highly successful October 1977 state visit his eagerness to provide developmental aid, as illustrated by his comments during a mass meeting at Montego Bay:

> We are willing to bring to Jamaica all our experience in agriculture, cattle-raising, public health, education, economic development, fishing, sports—in everything we can. Our universities are open to you, our research centers, hospitals, technological institutes—we shall never keep a secret from you. Anything that might be useful to us, we are willing to offer to you.[13]

The concrete manifestations of such enthusiasm included a medical brigade of approximately 50 doctors that was dispatched to Jamaica during the first Manley administration. Indeed, by 1979, Jamaica was hosting the second largest Cuban aid contingent—a total of 525 people from all fields—in the entire Western Hemisphere (see table 3.1).

The attention lavished on Jamaica was not idiosyncratic but instead can be seen as symptomatic of Havana's desire to play an increasingly assertive role in the Anglophone Caribbean. Accordingly, developmental assistance personnel (including health care specialists) were also dispatched to other countries such as Guyana, Suriname, and St. Lucia. While the numbers involved in these cases were not dramatic, their impact often was due to the relatively small size of the countries in which they were working.

Eventually, however, the shifting political tides in the Eastern Caribbean undermined Havana's aid efforts as moderates and indeed often strongly anti-communist conservatives scored a series of electoral victories over progressive left-wing parties. The most important race occurred in Jamaica (October 1980) where Harvard-educated Edward Seaga won convincingly with 57.6 percent of the vote over incumbent Michael Manley.[14] Shortly thereafter, following the lead of the new Reagan administration in Washington, Kingston adopted a hard-line anti-Cuban stance; diplomatic relations were severed in October 1981 and practically all Cubans were expelled from the island. Similar reversals of fortune would occur also with respect to the medical and other aid programs that Havana undertook on behalf of the more radical governments that emerged in the region in the late 1970s.

Medical Aid and Revolutionary Politics

A major breakthrough (at least from Havana's perspective) occurred in the radicalization of the Caribbean Basin's politics when a group of young leftists led by Maurice Bishop staged the Anglophone region's first successful armed insurrection in Grenada in March 1979 and proceeded to begin to implement their brand of radical socialism on the small island. Although the Cubans had played no direct role in Bishop's coup, they had maintained strong fraternal relations with his New Jewel Movement over the years and hence moved quickly to demonstrate their ongoing solidarity with his new government. Indeed, once Bishop made clear his need and desire for assistance in implementing his plan for radical socialist transformation, Cuba responded with such initiatives as a literacy campaign, assistance in building a new airport to help the Grenadians expand their share of the lucrative Caribbean mass tourism market, and of course, various medical aid programs (which were increasingly becoming Havana's signature item in its foreign aid repertoire).

The first Cuban medical team arrived in Grenada in June 1979 and was soon joined by additional colleagues as well as public health advisers who were dispatched to help the New Jewel government formulate plans for implementing a comprehensive national health care system on the island. By December 1982, there were approximately 20 Cuban health professionals working in the field delivering a broad range of services. When in-country treatment could not, for whatever reason, be provided, Grenadian patients were often flown to Cuba where their needs could be addressed. All of this assistance, whether provided in Grenada or in Havana, came at no cost to either the individual patients or the New Jewel administration (known as the PRG—People's Revolutionary Government). John Cotman summarized the impact that this Cuban aid had in Grenada:

> What gains did Cuba bring to health care? First, its doctors and dentists were central to a 42 percent net increase in these personnel from 1978 to 1982.... The PRG period saw a 25 percent drop in infant mortality from 24 deaths per 1000 live births to 18.... Cuban aid was crucial to PRG primary, preventive medicine.... Havana gave the lion's share of training for a new generation of health providers. In the 1982–83 academic year Cuba accounted for 84 percent of those training in health.... Cuban experience with mass participation in health services was invaluable.[15]

But ultimately these efforts and these achievements would fall victim to the unraveling political situation on the Spice Island. In October 1983, a dissident faction within the New Jewel Movement ousted Bishop and placed him under house arrest. Although freed one week later by his supporters, he was soon recaptured and then summarily executed along with several of his closest associates. The Reagan administration—which had been hostile toward the New Jewel Movement from the very beginning and which was looking for an opportunity to demonstrate Washington's willingness (after the Vietnam debacle) to use military force against governments that it perceived as being too radical and perhaps too closely aligned to its old nemesis Cuba—capitalized on this instability to invade the island on October 25, 1983. Much to Havana's dismay, a considerable number of neighboring Anglophone Caribbean states not only approved of the U.S. intervention, but a few also participated in it. Despite fierce opposition from some of the Cuban military advisors and construction workers who had been posted to island, the remnants of the PRG quickly succumbed to superior U.S. firepower and numbers. Thus the Grenadian Revolution came to an end, with Havana's security and developmental aid personnel being promptly expelled.

The U.S. attack had a sobering effect in many Caribbean quarters, causing some who otherwise may have been inclined toward cordial relations to begin to put some distance between themselves and Havana. Such tendencies were reinforced by the fact that Cuba did not always assign the Caribbean countries, aside from Grenada, a very prominent place on its international agenda during the 1980s. This tendency was confirmed by Cuban deputy foreign minister for American affairs Ramón Sánchez-Parodi when he stated in a December 1989 interview that

> Washington's hostile policy against the Cuban government has been a very important factor in the links with countries that are economically dependent on the United States. But we must also acknowledge that there was a lack of diplomatic work [on our part] and our foreign policy didn't give the [Caribbean] area adequate priority.[16]

Certainly one factor reinforcing this propensity was the increasingly heavy investment, in both political and material terms, that Havana was at this time making in Central America, particularly Sandinista Nicaragua.

During the 1970s, Cuba for the most part moved away from its prior practice of extending material aid (e.g., arms, personnel, etc.) to Latin American radicals who were waging armed struggles and instead shifted its emphasis to functioning as a political broker whose top priority was to unify a country's various revolutionary factions into a comprehensive, flexible "popular front" organization. In so doing, Havana was attempting to address the problem of extreme fragmentation that had long plagued the hemispheric left and rendered it vulnerable to divide-and-conquer tactics that Washington and others had used with devastating results in the 1960s. These Cuban-brokered agreements, whose main concern was to establish mechanisms for coordinating the political/military activities of radical leftists, generally succeeded in making the Central American revolutionaries (e.g., in El Salvador and Guatemala) much more formidable. This was especially true with respect to Nicaragua, where in 1977 and early 1978, Armando Ulises Estrada, one of Havana's top Central American specialists, played a pivotal role in helping to bring together the three major wings of the country's Sandinista movement. These efforts, along with those of others in the international community who were trying to aid the insurgents in their struggle against the brutal Somoza dictatorship that had long plagued Nicaragua,[17] were finally rewarded when the Sandinistas marched triumphantly into Managua in July 1979.

As was also the case in Grenada, Cuba promptly launched a wide variety of programs designed to help the new Sandinista government, led by Daniel Ortega, in its efforts to rebuild a country devastated by decades of abuse at the hands of the Somoza dynasty and to institute its programs for revolutionary change. By late 1979, Havana had already dispatched approximately 2,000 civilian workers (mostly doctors and teachers) to begin the process. It has been estimated that at the zenith of these efforts there were approximately 5,300 Cubans involved in developmental projects (1984—see table 3.1) and 2,500–3,500 serving as security advisors (early 1986).[18] As always, health care was a key component of Havana's aid equation. Indeed, over the approximately 10 years that Ortega was in power, the country became the epicenter for Cuba's Cold War developmental aid activities in the Western Hemisphere—no other Latin American or Caribbean nation received more in terms of Cuban medical and related assistance than did Sandinista Nicaragua. Julie Feinsilver, for example, illustrated the

extent of Havana's health care programs (in a country of approximately 3 million people) when she reported that "In 1987 the Cuban medical brigade in Nicaragua attended 856,000 patients, performed 7,163 major operations and delivered 1,704 babies."[19]

But just as the United States sought to destabilize and overthrow the New Jewel government in Grenada, so also was the case in Nicaragua. In this instance, Washington organized, financed, armed, and directed a guerrilla war conducted by an anti-Sandinista group known as the Contras. The Contras were never able to win their armed struggle, but they created so much misery and unhappiness that the Sandinistas' conservative opponents, running on a platform which contended that they were the only party that could bring about peace, were able to take control of the country in the 1990 presidential elections. In contrast to Grenada, however, this political reversal did not signal the end of Cuban health care in Nicaragua. Havana did, once again according to Feinsilver, withdraw

> most of its civilian aid workers at the request of the new government, but a medical brigade of 167 workers remained. In [late] 1990 there were 150 Cuban doctors working in various Nicaraguan provinces. . . . In October alone they attended over 30,000 outpatients and expected to treat up to half a million people by the end of 1990. Under specific agreements with the [new] government, some new medical brigades [were] sent. In mid 1992, over one hundred Cuban doctors were providing medical care to Nicaraguans, many in areas where other doctors would not work.[20]

This ongoing medical assistance, undertaken despite the fact that the host government was now one with which Havana had deep ideological differences, was a harbinger of the massive as well as politically far-reaching programs that Cuba would undertake in the post-Cold War era.

The Cold War Balance Sheet

Although Africa and the Caribbean Basin were the primary theaters of operation for Cuba's medical assistance personnel during the Cold War, there are some other venues and activities that can be added to the overall policy equation. For example, in the late 1970s and continuing into the 1980s, Havana dispatched aid contingents to both Laos and Vietnam to help them to recover from the immense

damage inflicted upon them by the United States during its wars in Southeast Asia. Admittedly the scope of these programs (e.g., in terms of the number of people involved) was rather modest compared to similar efforts in sub-Saharan Africa and Central America. But particularly in Vietnam's case, there had long been close ideological ties between the two countries and it is clear that the Cubans felt a special bond to the North Vietnamese, seeing them as fellow combatants struggling in the front-line trenches against U.S. imperialism. Consequently, Havana was anxious to demonstrate its solidarity with North Vietnam by sending medical and other aid workers to help alleviate the postwar problems that the Vietnamese were confronting. Similar ideological/Cold War considerations were almost certainly a factor in the aid relationship that developed between Cuba and South Yemen.[21]

In addition to providing health care services within host countries, Cuba sometimes brought other patients to the island for free treatment. For example, in the late 1980s, several hundred children from various Latin American countries received free heart operations at a world-class pediatric hospital that opened in Havana in 1986 while adults also received treatment at other facilities in the capital.[22] Probably Cuba's most highly publicized project in this area occurred following the 1986 meltdown of the Chernobyl nuclear power plant in the Ukraine that exposed thousands of nearby residents to high levels of radioactive contamination. In response, Cuba offered free medical treatment to those suffering from such exposure (especially children). Finally, Havana was extremely generous in terms of offering scholarships for free medical study in Cuba to thousands of students from developing countries. In 1984, for example, 1,800 awards were made to people from 75 nations while in 1990 there were approximately 3,600 such graduates.[23] These efforts were precursors to the much more extensive efforts that would be launched in the post-Cold War period, especially with the opening of the Latin American Medical School (ELAM) in late 1999.

Given the breathtaking scope and, in some instances, the remarkably deep commitment of the Cubans' Cold War medical aid programs, some basic analytical issues inevitably arise, the principal ones being: (1) Why did they pursue such policies?; and (2) How successful were they in doing so? The answers, of course, are unlikely to be as straightforward as the questions, for the Cuban Revolution has long

had an uncanny ability to generate dissension and controversy among its observers. The Surrogate Thesis, which was advanced as an explanation of Havana's Cold War foreign policy in general and its medical aid activities in particular, provides a classic example of this phenomenon.

Advocates of this proposition contended that the very survival of Fidel Castro's government had become dependent on the massive injections of economic/military aid that it constantly received from the Soviet bloc. This severe dependency, the theory continued, gave the Russians so much leverage over the Cubans that Moscow was in a position to dictate the island's domestic and international agendas. As such, according to this scenario, the Kremlin could and regularly did use the Cubans to spearhead its attempts to subvert and eventually dominate vulnerable Third World countries. The surrogate concept first began to acquire widespread publicity (especially in the United States) during the mid-1970s as a result of Havana's growing military involvement in Africa. Soon it became standard practice, particularly for opponents of the Revolution, to portray practically all Cuban initiatives on the international stage, including its medical aid programs, in surrogate terms.

If such was the case, it would mean that Havana had in effect abandoned two of its three core foreign policy principles/vital interests mentioned in chapter 1—that is, the promotion of the Revolution's effective sovereignty and the acquisition of international stature based on the exercise of (independent) soft power. However, despite the popularity of the Surrogate Thesis in the hotbeds of Cold War orthodoxy (e.g., Washington, Miami, and much of the U.S. mass media), most dispassionate Cuba specialists rejected it as an overly simplistic and ultimately untenable explanation of Havana's international behavior. Even Edward González, often a critic of the Castro government, conceded, especially with respect to the Cuban presence in Africa, that

> the surrogate thesis fails to account for Cuba's own domestic and foreign interests as an autonomous . . . actor in world affairs.[24]

Anthony Payne reached a similar conclusion with regard specifically to Havana's activities in the island Caribbean (and by inference in the rest of Basin):

> Whatever may be the case in respect to Cuba's African adventures, in the context of the Caribbean Cuba has to be seen as an autonomous

> actor in its own right rather than as a pliable agent of the Soviet Union.[25]

Finally, with respect to Havana's developmental aid programs, Susan Eckstein's research revealed that

> there is little evidence that Cuba coordinates its education, construction, medicine and technical assistance programs with the Soviet Union. Since the Cuban government contracts civilian programs at its own initiative, the military and civilian components of Cuba's foreign aid program have different roots, or Cuba normally does not extend aid at the behest of the superpower.[26]

In short, the consensus among such observers was that the epicenter for Cuba's foreign policies was Havana, not Moscow. Indeed, the scenario that was often being played out saw Cuba utilizing its dual-track strategy to generate Soviet support for its overseas initiatives (including its medical aid programs), thereby allowing Havana to take on more ambitious tasks and to carry them out more effectively than might otherwise have been the case.

Economic gain is another disputed consideration that has sometimes been presented as a primary motivation behind Cuba's overseas medical and other developmental aid policies. One of the best representatives of this viewpoint was Sergio Roca, who argued in 1981 that

> Cuba's civilian aid programs to African countries are commonly characterized by service charges levied for the use of technical personnel and the rendering of professional advice. The development of this new field of economic activity augers well for the perennial Cuban need for convertible foreign exchange. . . . The contracting of medical personnel and public health expertise are particularly attractive because of relatively abundant Cuban supply and strong foreign demand.[27]

Certainly no one would quarrel with Roca's contention concerning Havana's need for hard currency. Despite the large amounts of Cold War economic aid and preferential trade flowing from Cuba's Soviet bloc connections, Havana nevertheless continued to purchase goods and services from Western free market countries (mainly in Europe) that required payment in convertible funds. The problem, of course, was that currencies of its main economic partners—the

socialist nations—were of no help here; they were considered "soft," nonconvertible currencies and hence were not readily acceptable in international financial transactions. Consequently Cuba was always looking for alternative sources of hard currency to fund its trade with and to repay its debts owed to various Western states.

It likewise is true that in the 1970s Havana became increasingly inclined to levy hard currency charges on wealthier countries—especially oil exporters—for various developmental services rendered. In 1977 and 1979, for example, such arrangements generated an estimated $50 million and $140 million respectively, which was equivalent to approximately 9 percent (1977) and 18 percent (1979) of Cuba's hard currency trade in those years.[28] Included in this broad service panorama was, of course, health care, as illustrated by the fact that Cuba's 1981–1985 economic plan included provisions for training 10,000 new doctors and related personnel specifically for overseas assignments involving assistance provided out of solidarity to poor nations or to work in fulfillment of commercial contracts. In the latter case, Havana was unique among all other countries in the sense that it was deliberately producing health care specialists as an export commodity.

There is, however, a fundamental conceptual flaw in analyses that point to these facts to conclude that economic gain was a key motivating factor behind Cuba's overseas medical assistance initiatives. The basic problem lies in the failure to make a clear distinction between aid programs and contract service programs. It is simply not accurate (as indicated previously in this chapter) to characterize activities based on agreements entailing payment for services rendered (even at rates lower than those offered by other countries) as medical "aid"—they are commercial *contract worker* projects wherein profit (i.e., earning hard currency) is obviously a primary consideration behind their establishment. Aid programs, on the other hand, are by definition undertaken in cases where, for whatever reason(s), commercial arrangements are not considered appropriate and hence the profit motive does not enter the picture to any significant degree (if at all). Thus it in no way follows that Cuba's Cold War medical aid programs were motivated by profit (i.e., currency-generating) considerations just because such was the case with its contract service deals. Indeed, quite the opposite was true—Havana did not wish or expect to reap any significant monetary gains, in hard or even soft currencies, from

its overseas medical aid programs (a conclusion that likewise holds true today).

The other major current in the "economic gain school" focused on Cuba's Cold War aid programs as a mechanism to open new markets and expand the country's foreign trade. Susan Eckstein, for example, suggested that

> Castro expanded the civilian assistance program in the late 1970s for economic and not merely ideological reasons, the official policy rationale notwithstanding. While overseas activities did not immediately generate significant trade, by the 1980s aid seems to have opened new markets. . . . Cuba's medical and educational assistance programs seem . . . to have opened markets. In the mid-1980s Cuba exported some 12 percent of its total pharmaceutical production, and later in the decade the island produced electronic medical equipment that the government sought to market abroad as well.[29]

Under closer scrutiny, however, this explanation of the motives behind Havana's medical and other developmental aid projects does not appear to be very persuasive. Indeed, even economist Sergio Roca rejects it, contending among other things that Cuba's vast and highly lucrative ties to the Soviet Bloc eliminated any economic incentives to do so and that especially in the case of African countries the high degree of similarity in "output structures" (potential export products and commodities) between them and Cuba functioned to hinder any significant expansion of trade.[30] Certainly the data found in table 3.3 supports Roca's position. The island's trade with sub-Saharan Africa, where most of its developmental and especially medical aid programs were located, was minuscule throughout the entire Cold War period. In particular, there was no significant increase after 1975, the point at which Cuba became heavily involved in providing medical aid to the region. Instead it was in North Africa, where contract service (rather than conventional aid) programs prevailed, that Cuba experienced some substantial trade expansion. Indeed, the figures for Africa as a whole, which are not terribly impressive, are driven almost entirely by North African (contract services) rather than sub-Saharan (aid programs) countries.

In the final analysis, then, there is little to suggest that Havana's larger foreign policy concern with questions of economic security—whether defined in terms of minimizing its vulnerability to hostile

Table 3.3 Cuban Trade with Africa, 1965–1990

	1960	1965	1970	1975	1980	1985	1990
North Africa, Total	21.4	34	11.2	84.2	172.5	56.3	181
North Africa, Percentage of Total	3.5	5	1.1	2.3	3.8	0.9	13.8
Sub-Saharan Africa, Total	0	0	0	18.2	0	0	1
Sub-Saharan Africa, Percentage of Total	0	0	0	0.5	0	0	0.08
Africa, Total	21.4	34	11.2	102.4	175.2	56.3	182
Africa, Percentage of Total	3.5	5	1.1	2.9	3.8	0.9	13.9
Total Cuban Foreign Trade	617.2	683.6	990.4	3590.4	4966.8	6182	1304.8

Source: Table created from data sets available at <www.fbc.keio.ac.jp/~endoh/downloade.htm>.

economic pressure by diversifying its network of trade and related linkages or of realizing substantial financial gains—were connected in any significant way to its Cold War medical aid efforts. In short, enhancing its economic security was not a major factor motivating Cuba to initiate such activities and the successful implementation of these programs did not contribute markedly to advancing such vital national interests. Such is not the case, however, with regard to ideological considerations and the soft power option.

As noted previously in both chapters 1 and 2, the concept of proletarian internationalism as well as other philosophical/idealistic principles were important elements in the policy equations that have produced Havana's medical aid programs (in both the Cold War and subsequent eras). Wolf Grabendorff presented a concise summary of this viewpoint when, on the basis of a wide-ranging and thorough examination of Havana's involvement in African affairs, he reached the conclusion that

> the strongest element of Cuba's perception of its role in Africa is the emphasis it places on proletarian internationalism. Here the revolutionary ideology is clearly foremost, with Cuba's own experience again becoming the yardstick for its external conduct. The Cubans are well aware that without the Soviet Union or the socialist camp their revolution would not have had the slightest chance of survival in a generally hostile environment. This is a central argument for Cuba in turn would like to give other Third World countries a similar chance at

> survival in such an environment. Since such support surely cannot be given in the form of material aid, proletarian internationalism, as Cuba sees it, can best be expressed in the form of development aid and temporary military aid.[31]

Cynics might, of course, contend that Havana could easily afford to behave in such a manner during the Cold War because there were no significant costs or risks involved, perhaps even employing the dual-track idea mentioned here to bolster their case (i.e., Soviet bloc aid provided the wherewithal for Cuba to pursue these policies). But the fact that Havana's East European connections helped to lay the (technological) foundation for its aid initiatives did not by any stretch of the imagination eliminate or even drastically reduce the cost/risk factor.

Consider, for example, the fact that Cuban aid to Algeria (both pre- and post-independence) had the potential to do serious damage to its relations with deGaulle's government in Paris. Viewed from the pragmatic perspective of the Realist School of international affairs, which places top priority on the promotion of one's narrow national interests, the most prudent course of action for Havana would have been to forego giving assistance to Algeria and thereby avoid problems with deGaulle, whose inclination toward irritating Washington led him to be willing to establish normal relations with the Cuban Revolution. Consequently France represented Havana's second most important trading partner in Western Europe in the early 1960s. There was, however, a 20.8 percent decline in the overall volume of this commerce from 1960 to 1965, the period during which Cuba was, much to France's chagrin, heavily involved in various aid programs to Algeria.[32] This suggests, then, that Havana paid both a political and an economic price on its French front for its willingness to help Ben Bella and his government.

A very similar scenario unfolded in the 1970s, this time involving both the Ford and Carter administrations in Washington. Cuban/U.S. relations, which had for years been frozen into a pattern of mutual loathing and confrontation, began to thaw somewhat in late 1974 when secret negotiations aimed at lessening tensions were undertaken. These initiatives led President Ford's secretary of state, Henry Kissinger, to declare on March 1, 1975 that

> the U.S. government saw "no virtue in perpetual antagonism" with Cuba, while Fidel later responded by describing Kissinger's statement as "positive."[33]

But this civility proved to be short-lived, for Havana's involvement in Angola elicited fury on Washington's part. Illustrative of this reaction was a February 1976 speech in Miami where Ford portrayed Castro as an "international outlaw" with whom no more diplomatic dealings were possible. Reconciliation, however, seemed to be possible once Jimmy Carter entered the White House in January 1977 indicating a desire to improve and even normalize the two countries' relations. Havana's reaction was prompt and conciliatory, with Fidel Castro publicly characterizing Carter as a man of morals who would abide by a policy of principles. Concrete progress followed shortly thereafter as a number of cooperative steps were taken, perhaps the most symbolically important occurring in September 1977 when permanent U.S. and Cuban "interest sections" staffed by diplomatic and consular personnel were opened in the two capitals. But then, as had happened previously with the Ford administration, the pendulum swung sharply in the other direction, the catalyst this time being Havana's involvement in Ethiopia. The White House demonstrated its displeasure with an exceptionally virulent propaganda campaign that portrayed the Cuban government as totally untrustworthy, irresponsible, and a threat to international peace. Typical of these sentiments were the bare-knuckle comments by one high-ranking Carter administration official, who said that

> this administration has gone damn far to be friendly to Cuba, and we've gotten 12,000 Cubans in the Horn of Africa for it. We're all very disillusioned about Cuba.[34]

In each case here, Havana was willing to incur considerable, if not immense, political as well as potential economic costs in pursuit of its assistance programs (both civilian and military). As such, based on these French and U.S. examples, it appears inaccurate at best and ingenuous at worst to suggest that significant costs and risks did not enter into the Cuban Cold War (medical) aid picture.

The closest linkage that emerges between Cuba's medical assistance initiatives and its larger foreign policy concerns appears in connection with its desire to enhance its international status and prestige, which Joseph Nye has conceptualized (see chapter 1) as the acquisition and utilization of *soft power*. Stated in its simplest terms, soft power can be seen as the ability to persuade (as opposed to the capacity to command

or coerce).[35] The sources of such power can vary widely depending on the situation and the actors involved. In the case of governments, it often rests on moral principles and the willingness to put them into practice in an unselfish manner that addresses the needs of other states and/or peoples. With respect to the Cuban Revolution, proletarian internationalism has represented the moral tenet while medical (and related developmental) aid programs have served as policy vehicles though which it has been concretely operationalized.

Like any other endeavor, Havana's Cold War health care initiatives did not always elicit a favorable response within the regions involved and sometimes even in the recipient countries. In Africa, for example, there were qualms in some quarters that Cuban influence (i.e., soft power) could lead some states to attempt, at Havana's behest, to destabilize neighboring governments. The Surrogate Thesis, of course, served to fuel such fears, the idea being that lying behind the Cuban threat was the even greater Soviet danger. A variation on this theme raised the specter of a possible "contagion effect" associated with Havana's aid programs. This theory proposed that people might be so impressed with the Cuban model of development being showcased through its aid programs in other countries that they would be susceptible to being persuaded to turn against their governments if similar social benefits (e.g., free high-quality health care) were not available to them. In other cases, the concerns were more individually self-centered, the major dissidents being doctors and other health professionals in recipient nations who feared the Cuban aid workers as competitors. As such, specific charges as well as vague innuendos were often spread about the allegedly inferior caliber of the services that Havana was providing, one common tactic being to question the training expertise of Cuban medical schools and the rigor of the professional standards used by Havana to accredit its physicians.

Overall, however, it seems safe to say that the goodwill generated by Cuba's medical aid programs far outweighed any such negativity and thereby helped to supply Havana with the soft power from which flowed influence on the Cold War international stage. It would, of course, be irresponsibly simplistic to suggest that the Revolution's health care initiatives were the sole or the only significant variable contributing to its acquisition of soft power. One could, for instance, also point to such considerations as: (a) other dimensions of Havana's overall developmental assistance menu, education being one area

where Cuba was recognized as LDC trendsetter; (b) Fidel Castro's personal prestige and especially his immense charisma that conferred upon the Revolution a legendary status in many quarters of the global community; and (c) the Cubans' success in defying the United States and frustrating all of Washington's many attempts to throw them out of power, this audacity often being celebrated in Third World circles due to the existence therein of large reservoirs of anti-Western suspicion rooted in colonial experiences. Nevertheless, given the sweeping scope of its programs, the gratitude that they elicited on the part of recipient governments as well as the millions of patients whose lives were dramatically improved, and the reputation that they generated for Havana within LDC ranks as a bastion of selfless solidarity, Cuba's medical aid activities must be seen as a major contributory factor to its stature and influence (i.e., its soft power) on the Cold War's international stage.

One obvious problem that arises with a somewhat ambiguous concept such as soft power is that of measurement or operationalization. In other words, how can an observer determine with some certainty that a government possesses and/or is effectively wielding soft power? There are no easy answers to such questions nor does broad consensus exist on how to address them. One way to proceed is to look for a pattern of non-coerced behavior which indicates that states are acting in a deliberate, reciprocal manner that serves to benefit the international interests of another country. In Cuba's case, there are various instances during the Cold War to which one can point that suggest that such soft power dynamics were at work, a few major examples being:

- *Cuba's rise to leadership of the Non-aligned Movement*

Havana's Cold War commitment to proletarian internationalism, especially as manifested in its medical and related developmental aid programs, firmly established Cuba as a major player in LDC affairs and thereby reinforced the Revolution's image of itself as primarily a Third World country rather than a member of the Soviet camp. This particular perception of its political personality led Havana to place increased emphasis during the 1970s on its role in the Movement of Nonaligned Nations (commonly referred to as the NAM). The NAM, which Cuba had joined as the Western Hemisphere's only charter member in 1961, was established as an organization independent of (i.e., not aligned with) the two Cold War superpower blocs that would

serve as the main institutional vehicle for promoting cooperation between the world's developing states and representing their interests on the international scene.

Cuba's involvement in the movement eventually expanded beyond mere participation to include leadership ambitions. These aspirations were finally realized in 1976 when the NAM *unanimously* selected Havana as the site for its next summit meeting in 1979, which meant that Cuba would at that point become the movement's chief international representative and Castro would serve as the organization's chairman until the next scheduled convocation in 1983. In a larger sense, what these developments signified was Havana's acceptance into the innermost circles of Third World leadership.[36]

- *Cuba's membership in various organizations promoting LDC interests and cooperation*

As noted previously in this chapter, lying at the very core of Washington's Cold War policies toward Havana were its ongoing efforts to portray revolutionary Cuba as a pariah (or rogue nation) and to isolate it from the international community, the hope being that Castro's government would ultimately disintegrate in the process. One aspect of this larger campaign involved attempts on Washington's part to pressure international associations, especially those that could be characterized as Third World groups, to exclude or expel Cuba from membership. Probably the best-known case where the U.S. achieved some success in trying to delegitimate the Cuban Revolution occurred in 1962 when the OAS (Organization of American States) barred Havana from further participation on the grounds that its Marxist ideology was incompatible with the principles of the inter-American system.

The OAS scenario, however, represented the exception rather than the rule, for in most instances the developing nations refused to support Washington's anti-Cuban crusade and instead welcomed Havana into their consortiums with wide-open arms. These friendly venues included large groups such as the NAM and the G-77 (Group of 77)[37] whose membership rosters ranged across the entire spectrum of the Third World community. Indeed, Havana was admitted even into various regional organizations in Latin America, where the United States had historically been able to function as the hegemonic power

and where Washington had in the early 1960s succeeded in persuading or bullying all hemispheric governments except Mexico and Canada to sever all bilateral ties with the Revolution. But such compliance proved to be somewhat elusive, as illustrated by the fact that during the 1970s, when its medical/developmental aid activities were shifting into high gear, some hemispheric nations began to normalize their relations with Havana while in other cases Cuba became a founding charter member of such regional associations as the Latin American Energy Organization (OLADE, 1973), the Latin American and Caribbean Sugar Exporting Group (GEPLACEA, 1974), the Caribbean Multinational Shipping Company (NAMACUR), the Caribbean Committee of Development and Cooperation (CCDC), and the Latin American Economic System (SELA), all in 1975.[38]

- *Cuba's election to the UN Security Council*

Although circumstances surrounding the Soviet invasion of Afghanistan had compelled Havana to abandon its prior attempt to secure a seat on the UN Security Council (see note 38), this proved to be only a temporary setback. Approximately a decade later, bolstered by the soft power flowing from its (medical) aid programs, Cuba was ready to try again. In October 1989, riding a groundswell of support from the developing nations and despite the fact that Washington once again mounted a major counteroffensive, Havana prevailed with surprising ease. In fact, it received the largest number of votes—146 out of a possible 156—ever cast in such an election. Even the Latin Americans, who in the past had often been prone to succumb to U.S. pressure in such situations, were solidly behind Havana, as evidenced by the fact that in May 1989 the Latin American/Caribbean caucus in the UN chose Cuba as its *consensus nominee* to fill the hemispheric slot in the Security Council being vacated by Brazil.

Reinforcing the observations noted above regarding the linkage between medical aid programs and soft power benefits is Julie Feinsilver's conclusion that "Cuba's medical diplomacy contributes to the positive views held by other governments as translated into voting results at the United Nations on issues of particular importance to Cuba, such as an end to the U.S. embargo of Cuba and the stressing of human rights issues."[39]

The relevance of Havana's Cold War medical diplomacy to its larger foreign policy concerns can be seen as extending beyond the soft power to the effective sovereignty dimension. This proposition can be graphically summarized as follows:

Medical Aid---generates→*Soft Power*---which contributes to→*Effective Sovereignty*

A key consideration for a small country such as Cuba with respect to maximizing its effective sovereignty (i.e., its ability to control its destiny) involves the *means* that are available to achieve that end. This issue becomes especially salient when dealing with large countries that have superior economic and military resources at their disposal, for in these instances the hard power option is unlikely to be terribly viable. As such, the prospects for controlling one's destiny tend to become heavily dependent on the acquisition and successful use of (soft) bargaining power in negotiating the terms of the relationship. In this respect, Havana's Cold War medical (and related developmental) aid programs appear to have served it well. Wolf Grabendorff reflected this sentiment when, referring specifically to the Revolution's activities in Africa, he concluded that

> Cuba's greatest expectation [was] the possibility of gaining a two-folded bargaining power from its African involvement. On the one hand, it could enhance its position visa-à-visa the hegemonic USSR, since the Soviet Union [was] probably well aware of the fact that the military, organizational, and developmental achievements of Cuba could serve antithetical interests in the Third World. On the other hand, Cuba could also gain bargaining power vis-à-vis the United States. Its African card could become a useful trump in overcoming problems and resuming diplomatic relations with the United States.[40]

In hindsight, it appears that Grabendorff was perhaps somewhat overly optimistic with regard to Havana's potential bargaining power on its U.S. front, for there is little evidence of any significant *negotiated* concessions obtained from Washington during the most intense period of Cuba's Cold War aid efforts (i.e., the late 1970s and into the 1980s). On the other hand, it is indisputable that Havana's developmental internationalism greatly enhanced its status among the LDCs and thereby markedly increased the political costs that Washington would have incurred in terms of an adverse Third World reaction had it resorted to strong-arm tactics against the island. In other words,

just as the Soviet Union found its influence among the developing nations badly damaged by its invasion of Afghanistan, so also would the United States have found itself in a similar situation had it decided to flout Third World sensitivities by threatening the Revolution's security in any major fashion. In effect, then, medical/developmental aid programs, by consolidating Havana's South/South axis, helped to engender a climate wherein Third World deterrents existed which helped to protect and promote the Revolution's (effective) sovereignty.

The bargaining power scenario does, however, resonate strongly when the spotlight shifts to Cuban/Soviet relations, where the strengthening of Havana's Third World ties implicit in its medical/developmental aid programs clearly functioned to enhance its maneuverability and its negotiating position as it sought to maximize its control over the general nature and specific details of its Moscow connection. The interface between this South/South dimension of Cuba's foreign policy and its dealings with the Kremlin was essentially based on Havana's ability to function as a broker between the Soviet bloc and the developing nations. The three-step chain of logic involved here is as follows: (1) anything—including medical internationalism—that contributed to Cuba's influence in Third World affairs and its prospects for playing a prominent role therein represented political capital upon which Havana could draw to enhance its linkage capabilities; (2) any increase in Cuba's linkage capabilities served to make it a more valuable ally in Moscow's eyes; and (3) improving its stature as a Soviet ally translated into a stronger negotiating position for Havana when working out the terms of its relationship with the USSR. Moreover, there was an additional bonus involved in the sense that any concessions that Havana procured from the Kremlin as a result of its successes in Third World politics gave it an even greater ability to operate effectively on a South/South axis and thereby derive even more bargaining power relative to the Soviet Union. To clarify this idea, consider the aid that the Russians provided to subsidize the island's economy. Without such help, it is likely that Havana would not have been able to sustain its own foreign assistance programs at their usual high-powered levels. However, contended Sergio Roca, not only did Moscow generally maintain its commitment to Cuba's economic well-being, but there is evidence that Havana was able

to up the ante of Soviet support by playing its Third World cards. Specifically, he said,

> Cuba's increased leverage and strengthened bargaining position with the USSR [due to Havana's internationalist initiatives in Africa] have been . . . useful in the resolution of key economic issues involving trade and aid agreements, oil supplies, and debt repayment.[41]

But the true holy grail in terms of an effective sovereignty payoff for Cuba was the potential for a feedback loop that would function to make the whole process self-sustaining. The basic dynamic being projected here saw the Cubans using their strengthened position in the Third World (based on their medical diplomacy) as well as in the socialist camp (based on the aid-generated soft power that enhanced their bargaining position) as leverage to assure that their evolving relationship with the Kremlin would become increasingly beneficial to them, thereby allowing the three-phase phenomenon detailed above to recycle itself. There never really was, however, an adequate opportunity to test the long-term viability of this proposition, for the disintegration of the USSR in 1991 plunged Cuba and the rest of the international community into the uncharted waters of the post-Cold War era.

Chapter 4

Contemporary Cuban Medical Aid Programs: The General Third World Arena

A Cataclysmic Change of Context

Although international affairs often appear to be a quite chaotic enterprise entailing widespread instability, those who track the long-term dynamics of the overall context (or system) within which governments and other players interact note that fundamental structural change therein is actually quite rare. But such reconfigurations do occasionally occur, a few major examples in the Western tradition are as follows: the fall of the Roman Empire and the subsequent development of the medieval feudal system; the consolidation of the modern European nation-states and their colonial empires; and, flowing from World War II, the relatively short-lived Cold War era that included, as mentioned in chapter 3, the emergence of medical diplomacy as a major dimension of Havana's foreign policy. Then, as the twentieth century drew to a close, the global landscape would once again be radically altered. In the process, the Cuban Revolution (including its medical aid programs) would confront the daunting challenge of surviving the cataclysm and successfully navigating the stormy passage to a post-Cold War order.

The disintegration of the old bipolar system was greeted enthusiastically in some quarters, especially by Western Cold War warriors who were loudly (and inaccurately) proclaiming the eradication of radical socialism from the global body politic as well as by other less partisan elements who were nevertheless relieved to see what they perceived to

be the fading of the specter of superpower nuclear war that had long plagued the global community. For Havana, however, the negatives involved were devastating, the most dramatic being the triggering of a catastrophic free-fall of the Cuban economy[1] (with 1989 being used here as the base comparative year). Among the litany of dreary statistics that have been presented to document the crisis, the following are illustrative (see also table 4.1). The island's overall economy shrunk by at least 40–45 percent. Trade flows, which are almost inevitably crucial in the economies of island nations such as Cuba, slowed to a trickle. Imports, for example, dropped from $8.12 billion in 1989 to a low of $1.99 billion in 1993. More specifically, economist Andrew Zimbalist reported that such crucial imports as oil from Russia

> decreased from 13.3 million tons in 1989 to 1.8 million tons in 1992; fertilizer imports plunged from 1.3 million tons to .25 million tons; and animal feed imports fell like a stone from 1.6 million tons to .45 million tons.[2]

By 1992, the ripple effect of the petroleum drought noted above had led to the suspension or curtailment of over 50 percent of all industrial activity, to a 70 percent reduction in public transportation, and to extensive electricity blackouts (especially in Havana and other major cities). On the export side of the equation, overall earnings fell

Table 4.1 Basic Cuban Economic Indicators, 1989 and 1993 (in billions of pesos, unless otherwise indicated)

	1989	1993	Percentage Change
National Product (GSP)	27.2	15.95*	–41.4
Gross Domestic Product (GDP)	19.6	12.8	–34.7
GDP Per Capita (in pesos)	1,865	1,177	–36.9
Soviet/CMEA Aid	6.0	0	–100.0
State Budget Deficit	1.4	4.8	+243.0
Foreign Trade Transactions (total exports and imports)	13.5	3.4	–75.0

* The estimated GSP ranged from 12.5 billion to 19.4 billion. The average of those two figures is used here.

Sources: Based on official Cuban sources presented in Carmelo Mesa-Lago, "Prospective Dollar Remittances and the Cuban Economy," in Archibald R. Ritter and John M. Kirk (eds.), *Cuba in the International System: Normalization and Integration* (New York: St. Martin's Press, 1995), 59; and on Jorge F. Pérez-López, "The Cuban Economy in Mid-1997" (Paper presented at the 1997 conference of the Association for the Study of the Cuban Economy; available on the Internet at www.lanic.utexas.edu/la/cb/cuba/asce/cuba7), 3.

from $5.39 billion in 1989 to $1.28 billion in 1993 (a 76.3 percent drop). The bottom line, then, was that by 1993 the cumulative impact of such hammer blows had driven the Cuban economy deep into depression.

Compounding this crisis was the Fidelistas' old nemesis—Washington—which had never abandoned its objective of destroying the Revolution that had been so successful in defying and frustrating its hegemonic pretensions not only in what it had long considered to be its Caribbean backyard, but also on the larger global stage. During the Cold War, Havana's Moscow connection had provided it with a considerable degree of protection against U.S. hostility, especially with respect to thwarting Washington's efforts to achieve its goals by waging economic war against the island. Now, however, Havana seemed to be more vulnerable than it had been in many years and consequently the United States hoped that it could finally move in for the kill. Two of the major weapons that it deployed were the 1992 Torricelli law and the 1996 Helms-Burton law, both of which were designed to intensify the Revolution's economic suffering to the point where it would either capitulate to U.S. demands or simply disintegrate under the increased pressure.[3]

However, despite Washington's intrigues as well as an economic holocaust that saw its standard of living plummet under shocks that in any other society would have produced at least blood in the streets and probably the total collapse of the government, the Revolution amazed many observers by its ability to meet and ultimately overcome these challenges.[4] In particular, Havana was able to protect and even enhance its remarkable gains in the two areas considered to be the crown jewels in the Revolution's pantheon of social achievements—education and medical care. With respect to the latter, the public health system admittedly experienced serious strains during the darkest days of the Special Period; there were shortages of medicines (even as basic as aspirin) and replacements often could not be procured for equipment that was used or worn out. But in the end, ingenuity combined with sacrifice and hard work prevailed. Indeed, the island's medical system not only weathered the storm but has continued to project a health care profile that far exceeds LDC norms and is in many respects equal to that of the most economically developed nations of the world (see table 4.2 for some comparative data).

Table 4.2 Cuba and the Region, Selected Indicators

Region	Infant mortality per 1,000 live births	Under 5 mortality per 1,000 live births	Life Expectancy Male	Life Expectancy Female	Life Expectancy Both Sexes
Caribbean	22	33.4	66.9	71.7	69.3
Latin America	22	27.7	70.3	76.4	73.3
United States	7	8	75	80.4	77.7
Cuba	5.3	8	75.8	79.5	77.6

Source: UNFPA, *State of World Population, 2006* (except for Cuba); UNDP, *Human Development Index 2006*; and MINSAP, *Annual Health Statistics* (2005 and 2006).

Perhaps the most dramatic illustration of the Cuban medical profession's ability to perform at an extremely high level of technological sophistication can be found in the development of the island's biotechnology industry. The flagship institution in Cuba's large biotechnology R&D (research and development) community is the Center for Genetic Engineering and Biotechnology (CIGB) in Havana, which opened in 1986. The government's commitment to biotechnological excellence was vividly demonstrated by the fact that during the extremely lean years from 1990 to 1996 it annually allocated approximately $50 million to support and expand R&D activities. Eventually such investments paid off handsomely, for today it is widely recognized that Cuba's biological research industry is one of the most technologically advanced in the world and is able to compete favorably with its counterparts in many industrialized nations.[5] Basically, then, such dedication on Havana's part to the health care dimension of the Revolution meant that the foundation of its medical aid programs did not disintegrate under the pressures involved in making the transition to a post-bipolar international order and hence they would ultimately emerge stronger and more vigorous than ever.

Cuba's Post-Cold War Foreign Relations: General Trends

Attempting to delineate clear stages (marked by watershed events) in Cuba's post-Cold War foreign relations is a more problematical venture than has been the case with respect to the Revolution's earlier years, the basic difficulty being that Havana's adjustments to the new international order have to this point been a rather complicated and

in some respects an unsettled process that does not yet lend itself to neat, tidy segmentation by observers trying to chronicle its progress. Nevertheless, for our purposes here the evolving configuration of Havana's post-Cold War foreign relations will be viewed in terms of the following two admittedly somewhat imprecise time frames: (1) the "Damage Control" period, spanning roughly the decade of the 1990s; and (2) the "Millennial Renaissance" era, beginning shortly after the turn of the twenty-first century.

As likewise had been the case during the first approximately 10–12 years of the Revolution, Cuba's approach to international affairs was at this juncture essentially *reactive* in nature, its main threat being the previously mentioned economic crisis combined with and intensified by the escalating U.S. hostility. Reflecting the *intermestic* character (see chapter 1) of the challenge that it was confronting, Havana's response entailed both internal and external dimensions.[6]

Domestically attention was focused on implementing various reforms designed to "jump-start" the economy by (a) incorporating into it some elements (which remained under close government scrutiny) that would move it more toward a mixed rather than a pure command model; and (b) creating conditions whereby Cuba's system would be able to interact more easily and more profitably with the larger global economy where free market competition generally prevails. Among the more high-profile actions taken in pursuit of these goals were[7] the following:

- Legalization of associations with foreign investors (1992)
- Legalizing the U.S. dollar as an acceptable currency for everyday domestic financial transactions (1993)
- Authorizing self-employment (1993), which in effect represented official acceptance of the development of a private (although admittedly fairly modest and highly regulated) sector of the national economy
- Reopening farmers' markets (1994), where certain products could be sold outside the system of state-set prices
- Expanding self-employment, including legalizing small, privately operated restaurants called "paladares" (1995)
- Approving a new law that significantly reduced the restrictions on foreign private investment (1995) and thereby served to encourage

it, including in the package the previously heretical and totally unacceptable notion that in some cases there could be 100 percent foreign ownership of domestic enterprises (although in reality joint ventures with the Cuban government and/or state-owned companies have usually been the norm).

One of the most dramatic developments flowing from such initiatives was the emergence of the tourist industry as the most dynamic sector of the Revolution's economy.

The young insurgents who came to power in 1959 shared a widespread (and in many respects accurate) perception of tourism's impact on the island—in a nutshell, it was seen as a U.S.-controlled cesspool of vice, corruption, and exploitation that fundamentally maimed both Cuban society and Cuban culture.[8] Consequently steps were taken that markedly reduced the country's profile in the international tourism industry, the consequences of these moves being reinforced and indeed intensified by Washington's ban on travel to the island that applied to practically all U.S. citizens (who had constituted the overwhelming bulk of the country's prerevolutionary tourists). The Special Period, however, engendered a radical change of heart on Havana's part, for tourism was now seen as generating such benefits as new jobs, increased demands for local products and services, and, perhaps most important, large reserves of hard currency that were desperately needed to finance imports and to help defray the substantial debts that Cuba owed to various Western European countries. As such, the Revolution now embraced mass tourism with a vengeance.

This courtship soon produced impressive results (although there were also some negative side effects such as the reemergence of prostitution). For example, the tourist industry's share in the total national foreign revenue grew from 4 percent in 1990 to 41 percent in 2001, with this figure rising to 50 percent by 2005. In hard balance sheet terms, gross tourism revenues increased from $243 million in 1990 to $2 billion in 2002 based on an increase in visitors from 340,000 in 1990 to 1.9 million in 2003. (See table 4.3 where Cuba's popularity as a tourist destination is compared to that of other Caribbean hosts). In the process, the industry has provided direct or indirect employment for about 300,000 Cuban citizens.[9]

Table 4.3 CARICOM and Cuba Visitor Arrivals, 2000

CARICOM and Cuba Stopover Tourists 2000	
Antigua & Barbuda	206,871
The Bahamas	1,596,160
Barbados	544,696
Belize	195,596
Dominica	69,578
Grenada	128,864
Guyana	84,879
Haiti	140,492
Jamaica	1,322,690
St. Kitts & Nevis	73,149
St. Lucia	285,422
St. Vincent & the Grenadines	72,894
Suriname	57,700
Trinidad & Tobago	299,957
TOTAL CARICOM	5,078,948
Cuba	1,773,986
Cuba as % Total CARICOM = 34.9%	

Cuba ranks first-data do not include cruise ship visitors whose stay is limited to a few hours ashore.

Source: *Association of Caribbean States, Tourism Statistics, 1995–2002*. Updated June 2003, http://www.acs-aec.org/tourism/stat/tourism_stats0603.pdf>.

Shifting to the foreign policy side of the damage control equation, Havana now found itself in a situation where the international arena had been transformed in ways that reenergized the Revolution's deeply rooted fears of being forced to operate within narrow and potentially very threatening policy parameters. Within this context its most immediate concerns were to resuscitate its foreign trade and especially to develop a more diversified network of economic partners. For Havana, these questions had serious security connotations since, as indicated previously, Cuba no longer had its Soviet/Eastern European linkages to function as a counterweight against attempts on Washington's part to isolate the island and thereby force it into a highly vulnerable position. Indeed, Havana periodically expressed fears that Washington might be tempted to launch a military strike against the island now that Soviet power no longer loomed as a viable deterrent, although realistically such a high-risk move was never really very likely. Such a conclusion

did not, however, apply on the economic front, where the island's post-Cold War problems represented potential levers that could be used by the U.S. government and its allies among the vehemently anti-Castro elements of the Cuban exile community to try to destabilize Cuban society (as had occurred in the early 1970s in the anti-Allende campaign in Chile) to the point where the Revolution would be completely crushed. It was such considerations that conferred an aura of special urgency on Havana's efforts to expand and strengthen its post-bipolar network of international economic relations.

By the turn of the twenty-first century, the difficult process of restructuring and diversifying Cuba's foreign economic relations was for the most part complete, as can be seen in the island's changing export and import profiles that are illustrated in figures 4.1 and 4.2. Note in particular how Havana's almost total Cold War dependence on the Soviet bloc had by the turn of the century been replaced by a much more eclectic network of trading partners, with Western European and hemispheric nations playing an especially crucial role in supplying goods and services as Eastern European sources essentially dried up. This restructuring on the international side of the economic ledger combined with domestic reforms and gut-wrenching sacrifices on the part of the Cuban people eventually began to have

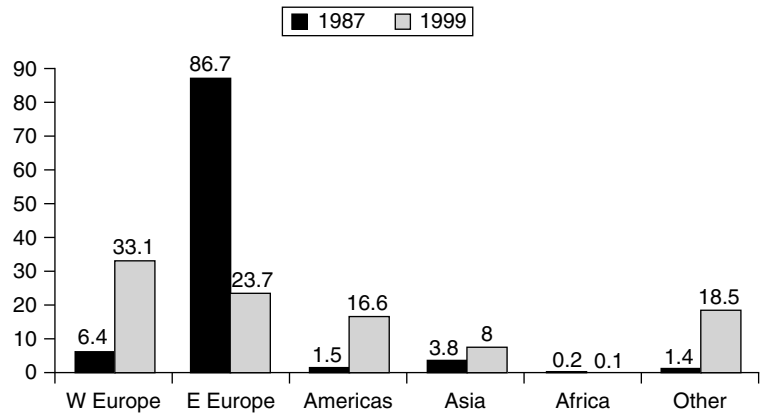

Figure 4.1 Cuban Export Profile, 1987 and 1999 (percentages)

Source: The graph was created by the authors using data gleaned from various editions of U.S. Central Intelligence Agency, *Cuba: Handbook of Trade Statistics* (Springfield, VA: National Technical Information Service).

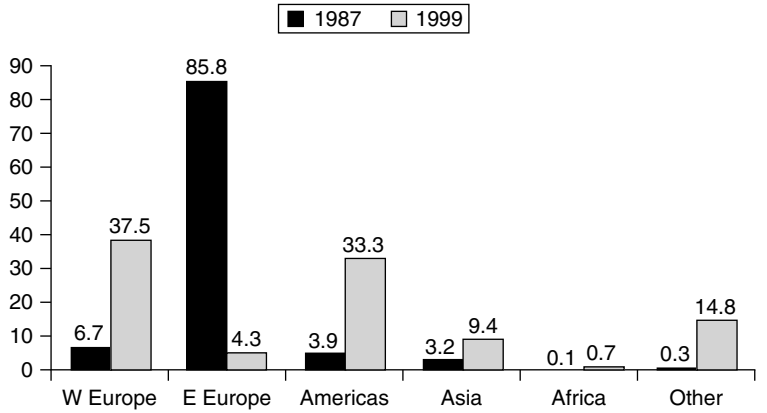

Figure 4.2 Cuban Import Profile, 1987 and 1999 (percentages)

Source: The graph was created by the authors using data gleaned from various editions of U.S. Central Intelligence Agency, *Cuba: Handbook of Trade Statistics* (Springfield, VA: National Technical Information Service).

an impact. Slowly, but surely, the Revolution began to recover from the catastrophe that had engulfed Cuba as it approached the dawn of a new century.

Recognizing that there are various indicators that could be used to track and measure Cuba's efforts to deal with the challenges posed by the Special Period, table 4.4 utilizes a per capita GDP (Gross Domestic Product) index to provide some insights into the economy's overall long-term performance (i.e., the GDP component) and its evolving potential to enhance the population's standard of living (i.e., the per capita component). Using 1989 as its base year, this survey indicates that the unraveling of the island's economy bottomed out in the 1993–1995 period; at this point, the suffering and the hardships, in both macroeconomic and individual terms, had become a tragic and inescapable aspect of Cuban life. But the consistent upward trend that subsequently emerges clearly demonstrates that Havana had weathered the deadly survival challenges posed by the Special Period and was making a successful transition into the post-bipolar economic world, thereby once again frustrating Washington's hopes of somehow triggering an apocalyptic implosion of the Revolution. As such, conditions were ripe for Havana to shift its foreign policy into a much more proactive mold.

Table 4.4 Cuba's GDP per Capita Index (1989 = 100.0)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
96.0	86.1	77.1	66.1	66.4	67.9	72.8	74.3	75.0	79.3	83.3	85.6

Source: Archibald R. M. Ritter, "Cuba's Economic Performance and the Challenges Ahead," which can be found on the internet at <www.cubasource.org/pdf/aritter.pdf>.

Millennial Renaissance

The twenty-first century has seen Cuba once again interjecting into its international agenda a vigorous South/South dimension that goes beyond trade diversification concerns. The Revolution's foreign relations have, as emphasized in the previous chapters, always had such a focus rooted in both empathetic and strategic factors. It should hardly be surprising that Havana—as a small, developing island country whose present has in many respects been conditioned by a tumultuous past entailing tragic encounters with colonialism and foreign domination—has displayed a natural affinity for what was known during the Cold War as the "Third World", that is, former colonial nations struggling to meet the challenges of modernization and economic development. But beyond such ties based on common histories and problems, the exigencies of hard-nosed power politics have suggested to Havana that close cooperation with the LDCs (Less Developed Countries) could be a significant asset when dealing with the major actors on the global stage. However, as is inevitably the case in the tumultuous and uncertain world of international diplomacy, Havana has occasionally had to revise the priority it assigned to Third World affairs. Certainly its attention tended to be directed elsewhere (e.g., on expanding its trade relations with Western Europe) during the depths of the Special Period. But one bonus for a government that has finally weathered the worst of such a calamity is that it usually finds itself in a position where it can finally devote some serious attention to matters that heretofore had to be sacrificed to the demands of crisis management. In Havana's case, such a policy revitalization with respect to its South/South relations has occurred because the island's economic health and security have improved since the dark days of the mid-1990s. Certainly two dramatic illustrations of this renewed emphasis have been (1) Cuba's remarkable alliance with Venezuela to promote Latin American integration; and (2) its resumption of a leadership role in the Nonaligned Movement.

Havana's desire to inject a strong South-South dimension into its foreign policies as well as its penchant for playing the Latin American David to the U.S. Goliath have been neatly combined in its strong support for what has come to be known as Neo-Bolívarianism—a concept that is relevant in general to the dynamics of Latin American integration politics and in particular to the efforts of the region's countries to develop an effective collective response to Washington's campaign to implement its neoliberal agenda for the hemisphere. The essentials of this idea are as follows:

> Neo-Bolívarianism represents the Hispanic (and Anglophone Caribbean) alternative to a neoliberal landscape dominated by the United States. The key idea here is that any contemporary developmental cooperation schemes launched by hemispheric states should be modeled along the lines of Simón Bolívar's vision of a politically unified Latin America that would be clearly separate from and independent of the Colossus to its north. As such, this approach rejects, at least for the time being, any significant involvement in the process on Washington's part. Instead it sees the whole enterprise unfolding under Latin American (rather than U.S.) leadership, the ultimate goal being to achieve a level of integration that would put the hemispheric community (defined as South America and the Caribbean Basin countries) in a position where its pooled economic power would to a great extent be sufficient to counterbalance that of the United States. Only at this point, when the hemispheric nations could bargain effectively from a position of collective strength, would NAFTA/FTAA affiliation be seriously considered.

Havana has long been an advocate of this vision in one form or another. What has, of course, changed this policy equation rather dramatically in recent years has been the emergence of Hugo Chávez's government in Caracas not only as an increasingly important economic partner of the Cuban Revolution, but also as its key associate in Neo-Bolívarian politics.[10]

The watershed event in the development of this alliance occurred on December 14, 2004, in Havana when Cuba and Venezuela signed the ALBA (Bolívarian Alternative for Latin America) Pact, thereby transforming Neo-Bolívarianism from what had heretofore been a broad (philosophical) concept into a formal international treaty. Although Latin America has a long history of such economic cooperation/integration projects never really moving much beyond often grandiose paper proclamations of commitment and intent, such has

not been the case with ALBA. Instead, Havana and Caracas soon moved decisively to transform its principles into substantive policy. The first of these initiatives occurred on April 28, 2005, when the two governments agreed on specific, detailed plans for programs designed to begin (or in some cases to expand) the institutionalization of the goals set in the initial December 2004 accord. Some key examples of these initiatives are as follows:[11]

- Cuba would provide full scholarships for the training of 10,000 Venezuelan doctors and nurses. During their studies, the students would live with Cuban families.
- Cuba would dispatch up to 30,000 doctors and other medical personnel to offer services throughout Venezuela by the second half of 2005. Another 100,000 Venezuelans were to undergo free eye surgery in Cuba.
- Venezuela would grant preferential tariffs for 104 new export lines from Cuba, plus a progressive tariff exemption schedule that would benefit current and new exports.
- Havana would exempt Venezuelan exports to Cuba from paying customs tariffs.
- Cuba would acquire $412 million in Venezuelan industrial goods and manufactured products for direct public consumption, which was expected to contribute to the creation of some 100,000 jobs in Venezuela.

It did not take long for such moves by Havana and Caracas in pursuit of their Neo-Bolívarian vision to begin to attract attention in various hemispheric quarters, the result being that ALBA's membership began to grow. Bolivia joined in April 2006 followed by Nicaragua in January 2007, Dominica in January 2008, and Honduras in August 2008.[12]

Beyond such expansion, perhaps the best (or at least a certainly dramatic) indication that the Neo-Bolívarian alliance has "arrived" as a major factor on the Latin American scene is the alarm that Washington has raised about it. Indeed, some comments by U.S. officials suggest that the ALBA project has aroused fears that strike at the very heart of cherished beliefs that Washington has long held about its hemispheric prerogatives as the Colossus of the North. Such sentiment (or, if one prefers a more clinical term, this psychology) is illustrated by

the position taken by Daniel Fisk, the Bush administration's national security adviser for the Western Hemisphere, when he

> clearly articulated the nature of the perceived [Neo-Bolívarian] threat at a congressional hearing in October 2005. Identifying the "strategically located Caribbean basin" as a "high priority for this Administration," he warned of the growing influence of Cuba and Venezuela in the region:
>
> Ultimately the threat is political, Fisk explains, because of "Cuban and Venezuelan attempts to drive a wedge between the U.S. and its Caribbean partners." In effect, he is saying, both endanger traditional U.S. dominance in the Western Hemisphere and are viewed as acting in tandem.[13]

There is considerable irony here for anyone familiar with the shifts in nuance that have occasionally occurred in U.S./Cuban relations. Specifically, having spent several decades and considerable resources in trying to eradicate what was often characterized as the Fidelista virus in the hemisphere's body politic, Washington and others (e.g., in the media and in Miami) were in the 1990s denigrating the Cuban Revolution as an irrelevant anachronism that was on its last legs. Yet now Havana (along with its Neo-Bolívarian ally Chávez) was once again being demonized as a major obstacle to U.S. aspirations and even U.S. vital interests in the region.

Moving beyond a hemispheric view to a macroperspective on South/South cooperation and LDC affairs, in 2003, Cuba had bestowed upon it the honor of being the only current member of the Movement of Non-aligned Nations (NAM) who until that point had twice been selected to serve as the organization's leader.[14] Havana's first term as the NAM chairman covered the period September 1979 to March 1983. Then, during the NAM summit meeting held at Kuala Lumpur, Malaysia, in February 2003, Cuba was once again elected to head the Movement when it was decided that the next summit conference (2006) would be held in Havana, after which the host nation automatically assumes the chairmanship of the NAM for the next 3–4 years (i.e., until the next summit meeting is convened). The Latin American/Caribbean caucus within the NAM had, without any dissenting voices, nominated Havana as its candidate to head the group and this recommendation was subsequently ratified by the rest of the 114 members, thus once

again conferring upon Cuba the mantle of leadership that it had previously exercised.

Prior to the 2006 summit in Havana, the most comprehensive summary of Cuba's vision of the NAM's role and goals in the new, post-bipolar international order appeared in a major Foreign Ministry position paper prepared for the 2003 summit. The document begins with an analysis of the contemporary international situation and then proceeds to discuss in considerable detail an extensive list of issues that Havana feels the Movement must address; one of the most prominent is the following:[15]

> Promoting greater economic and social development in the context of the international cooperation. The search of effective cooperation mechanisms to achieve concrete results on this issue should equally be a priority for the Movement, both reinforcing the idea of South-South cooperation, and preparing more solid conditions for negotiation and exchange with industrialized countries, especially with G-8.

Finally, in an annex to the main text, Havana suggests health and education (two fields in which the Cuban Revolution is especially strong) as two top-priority areas for greater South/South cooperation.

Havana's emphasis on the need for greater South/South developmental cooperation was strongly reasserted as the Cubans prepared once again to assume leadership of the NAM. Fidel Castro, for example, announced at a June 2006 literacy conference in Havana that Cuba would place heavy emphasis at the movement's upcoming summit on establishing NAM-sponsored initiatives for the implementation of literacy programs in every country, the training of doctors, and the carrying out of an energy revolution aimed at saving billions of dollars worldwide.[16] Speaking in a similar vein in an interview shortly before the Havana Summit, Abelardo Moreno, Cuban vice minister of foreign affairs, indicated that one of the NAM's main problems has been the limited number of major autonomous cooperative projects that it has undertaken. "We believe," he said, "the Movement must be more proactive in the future, rather than reactive; rich in initiatives, ideas and projects of its own." Consequently, in an attempt to launch some bold experiments in this area, Cuba prepared a set of ambitious proposals for the Havana Summit involving action plans to combat illiteracy, train health personnel, and increase the efficient use of energy—plans that also stressed the need to create a

cooperation agency within the NAM that would be responsible for transforming ideas into concrete projects and finding the funding to put them into practice.[17] Although details of the Cuban proposals were not made public, it appears that what Havana may have had in mind was a dramatic expansion via the NAM of similar and very successful programs that Cuba and Venezuela were implementing in the Western Hemisphere under the aegis of their 2004 ALBA agreement. Ultimately and rather surprisingly, Havana decided not to present its proposals at the Havana summit for official approval. In what many felt was at best a vague explanation of this decision, Abelardo Moreno stated during a September 13, 2006 press conference that[18]

> the presentation or not of the cooperation document about which we have spoken with you on many occasions, was the object of serious analysis and reflection. It seems to us that the process of concrete cooperation in the Movement requires just a little bit more development. Therefore, we preferred that the plans for cooperation in those spheres of which you spoke and others which it might be possible to add in the future, the Movement will deal with them after the Summit.

In any event, whether via the NAM or some other mechanism, what is clear is that Havana remains strongly committed to expanding the concept of South/South cooperation to include a vigorous social as well as the more traditional economic dimension of development.

In both the ALBA and NAM leadership cases, which as indicated above represent key examples of the proactivism that has characterized the Millennial Renaissance phase of Cuba's post-bipolar foreign relations, Havana's medical assistance programs have played a pivotal role. Indeed, in many respects, they stand as the epitome of Cuba's reemergence as a major actor in international affairs. As such we turn now to a general survey of Havana's Third World initiatives, with the Latin American/Caribbean components of this complex, ambitious aid equation being detailed later in chapter 5.

Contemporary Cuban Medical Diplomacy: The General Third World Arena

The Revolution's ability to meet the challenges posed by the Special Period has infuriated those who hoped and indeed expected that

it would sink inextricably into the abyss. Among the most notable of the hallmarks that went through the ordeal have been Havana's medical assistance programs; they have not merely survived but indeed have become more vigorous and more ambitious as Cuba made the transition from its Damage Control period to its Millennial Renaissance phase. Table 4.5 provides an illustrative snapshot of the overall geographical scope of Havana's medical diplomacy around 2004–2006. What is particularly interesting in this listing is the inclusion of several European EDCs (Economically Developed Nations). The Ukranian link has a well-established pedigree going back to the Chernobyl nuclear disaster of April 1986. The Swiss-Italian connections, on the other hand, have emerged more recently and are indicative of the increasingly high international prestige that the Cuban health care profession has acquired. It is, however, in table 4.6 where the massive *human impact* of Havana's efforts really strikes home. Note especially the last entry—almost 2 million people throughout the world, many of whom were probably children when they received help, owe their very lives to the availability of Cuban medical services. Surely, then, it must be conceded (whatever may be one's attitude regarding the Revolution) that it is truly remarkable as well as admirable that such a small country has been able to accomplish so much.

Traditionally it has almost always been the case that it has been the Cubans working alone who have been responsible for producing this impressive track record. Havana has, in other words, normally functioned as the sole provider of medical services within the framework of its aid programs. In the Millennial Renaissance era, however, a "joint venture" (sometimes also termed "trilateral") approach has occasionally been utilized whereby other parties can contribute to the endeavor. It is, for example, noted in chapter 1 that a Cuban/French/Japanese consortium was established in 2001 to assist Haiti. In other instances, MEDICC has reported that

> 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 [World Health Organization] has supported Cuban collaboration in the Gambia and elsewhere. According to the Cuban government, 95 non-governmental organizations worldwide contributed to [Cuban medical aid] projects between 1999 and 2004.[19]

Table 4.5 Countries with Cuban Health Cooperation

Americas	**Africa**
Antigua & Barbuda	Algeria
Argentina	Angola
Aruba	Botswana
Bahamas	Burkina Faso
Belize	Burundi
Bolivia	Cape Verde
Brazil	Chad
Colombia	Congo
Costa Rica	Djibouti
Dominica	Equatorial Guinea
Dominican Republic	Eritrea
Ecuador	Ethiopia
Grenada	Gabon
Guatemala	Gambia
Guyana	Ghana
Haiti	Guinea-Bissau
Honduras	Guinea Conakry
Jamaica	Lesotho
Mexico	Mali
Panama	Mozambique
Paraguay	Namibia
Peru	Niger
St Kitts & Nevis	Nigeria
St Vincent & the Grenadines	Sahrawi Arab Democratic Republic
St Lucia	Rwanda
Suriname	Säo Tomé & Principe
Trinidad & Tobago	Seychelles
United States	Sierra Leone
Venezuela	South Africa
	Swaziland
	Tanzania
	Uganda
	Zimbabwe
Middle East	**Asia**
Qatar	East Timor
Yemen	Laos
Europe	
Italy	
Switzerland	
Ukraine	

Note: Two countries have recently signed bilateral health accords with Cuba, which will dispatch health professionals presently: Kiribati and the Solomon Islands.

Source: Registros estadísticos de la Unidad Central de Cooperación Médica, 2006.

Table 4.6 Summary of Cuban Medical Aid Activities (through approximately 2007)

Visits to doctor	House calls	Childbirths	Surgical activities	Dose of vaccines	Lives saved
96,454,586	22,401,258	834,634	2,407,647	9,424,262	1,720,301

Note: The above webpage does not specify the exact dates covered by its statistics, although it appears that the information is updated periodically.

Source: Data made available by the Cuban Foreign Ministry on its website at <www.cubacoop.com/CubaCoop/Cooperacion_ProgramaIntegralSalud.html>.

But whatever the format might be in individual instances, the vanguard in the overall LDC struggle has more often than not been composed of Cubans.

The magnitude of the challenges confronting Havana's medical workers has frequently been daunting, to say the least, for the health care situation is indeed precarious in many Third World quarters. Consider, for example, the case of sub-Saharan Africa. Although a 10 percent share of the global population can be found here, the comparable figure for medical schools is 4 percent and only 1 percent for doctors. Moreover, the distribution of health personnel within the region is skewed very unevenly along several axes. First, there is a phenomenon common to many developing nations where the concentration of doctors is heaviest in the prosperous urban areas while the city slums and the countryside go wanting. Finally, there is the problem of extensive income-induced migration (or "brain drain") both within the subcontinent and internationally. Physicians in Sierra Leone, for instance, may be sorely tempted to relocate to South Africa where their earning potential will be 20 times greater than in their home country. The lure of the developed world can be even greater, as illustrated by the estimate that more than 60 percent of the doctors produced in Ghana during the 1980s had gone abroad by the end of the century. Zambia's losses have been even more dramatic, where it is believed that only 50 of the 600 doctors trained there since independence were still practicing in the country in 2008.[20] It, therefore, should not be surprising that Africa generates some of the most depressing health statistics in the world. For example, a pregnant woman there has a 1 in 16 chance of dying in childbirth and 3,000 children die *every day* of malaria. In short, then, the need for medical aid in the post-bipolar developing world, whether in sub-Saharan Africa or elsewhere, has

been and continues to be tremendous. And so also has been the Cuban response.

Havana's health care diplomacy is, as indicated previously, labor- rather than capital-intensive. In other words, its basic approach to resolving LDC problems relies primarily on people (i.e., dispatching medical brigades) rather than money (i.e., financing host country programs). Its ability to implement this strategy rests upon the large reservoir of human resources that the Revolution has so assiduously developed over the years. Table 4.7 illustrates this point with respect to doctors, who obviously are the key actors upon which Cuba's aid efforts rely.[21] Similar trends were operative in the areas of such support personnel as nurses and lab technicians.

Sub-Saharan Africa, as was the case during the Cold War, has been one of the major venues to which these health care professionals have been dispatched in the post-bipolar era. Indeed, it is not an exaggeration to say that Havana's medical diplomacy had practically engulfed the subcontinent by the year 2007, with the number of nations receiving some form of assistance numbering 33 in 2006. Within this broad panorama, the AIDS epidemic that has been sweeping through Africa has received special attention. The scope and severity of the crisis, which has intensified in succeeding years, was illustrated by a 2004 report which estimated that 29 million people in sub-Saharan Africa were infected with HIV/AIDS.[22] Consequently, one of the four special cooperation initiatives that Havana has launched since 2000 has focused on the treatment and especially the prevention of HIV/AIDS. In 2001, for example, Cuba offered African countries 4,000 doctors and other health professionals, a stock of antiretroviral drugs, and diagnostic equipment to help combat the AIDS plague.

Table 4.7 Cuban Medical School Graduates, 1960–2004

1960–1969	1970–1979	1980–1989	1990–1999	2000–2004	Grand Total
4,907	9,410	22,490	37,841	9,334	83,982*

* 1,612 of these graduates were from other countries

Source: Cuban News Agency (AIN) report, "Cuban President Fidel Castro Said That Freedom Can Only Be Won Through Solidarity" (August 21, 2005). Available on the Internet at <groups.yahoo.com/group/CubaNews/message/41405>.

Supplementing these front-line efforts have been Havana's programs to enhance medical education in Africa and thereby help to foster the development of self-sustaining indigenous public health capabilities. Whether these initiatives have involved building brand-new medical schools (see table 1.1) or providing assistance to existing institutions in restructuring their curriculums,

> training students to collaborate with the communities they serve, known as Community-Based Education, is the backbone of the Cuban medical education philosophy both at home and abroad and has been put widely to the test in Africa. The pedagogy of the approach is based on the public health concept of community diagnosis, whereby health indicators for a given community are collected in a systematic way over a period of time to characterize the overall health picture of the population. By better understanding the health status of the community and the prevalence of pathologies affecting it, health professionals can tailor services and provide more effective treatment. Furthermore, this type of training inserts soon-to-be doctors squarely in the community, so they are engaged directly with patients, and sensitized to their living conditions and daily reality.[23]

The basic idea here is, of course, not merely to provide students with the technical skills that they will need in order to function as health care professionals, but to also instill in them a deep commitment to service at the grassroots level that will result in bonds between them and the (common) people at large that are more than strong enough to resist the lure of the brain drain option.

But whatever form Cuba's medical aid might take in specific cases, the overall scope and impact of Havana's sub-Saharan African programs have quite frankly been astonishing, especially when one takes into consideration the fact that the country orchestrating this scenario is a small developing island nation, thousands of miles away from the African mainland, that has been in the process of recovering from an extraordinary economic crisis. Table 4.8 provides some insights as to just how audacious Cuba's efforts have been. But ambition, no matter how praiseworthy, does not necessarily translate into impressive results. In Havana's case, however, the correlation has indeed been present. Consider, for instance, the following official statistics: infant mortality in areas where Cuban medical professionals have provided assistance has plunged from 59 to 7.8 per 1,000 live births in Ghana, from 48 to 10.6 in Eritrea, and from 131 to 35.5 in Equatorial Guinea.[24]

The 7.8 and 10.6 figures for Gambia and Eritrea put their rates on a par with those of many developed nations. In another example, Havana launched an aggressive antimalaria campaign in Gambia

> in which the Cuban team, in cooperation with local authorities and international partners, implemented epidemiological mapping to identify the most vulnerable populations, determined insecticide susceptibility, applied biolarvacides at breeding sites, introduced clinical and laboratory quality control measures, carried out local health promotion and education and provided specialized training to local personnel.

The results of these efforts were dramatic, with reported cases dropping from 600,000—nearly half of the entire Gambian population—in 2002 to 200,000 in 2004.[25]

Moving eastward from Africa, Cuba has in recent years been expanding its presence and activities in the Asian/Pacific area. Havana had, of course, previously established links with various countries in

Table 4.8 Results of Cuba's Comprehensive Health Care Program, November 1998–June 2004

Country	Doctor's Visits	Pediatric Visits	House Calls	Deliveries	Surgeries	Vaccine Doses
Botswana	98.275		583	560	2.831	1.648
Burundi	29.564	6.507	250	1.380	682	939
Burkina Faso	146.073	39.059	10.851	4.312	5.984	283.303
Chad	41.368	4.245			558	
Eritrea	305.575	67.702	3.261	935	3.707	
Gambia	3.757.036	1.235.492	221.851	220.794	40.074	328.812
Ghana	5.990.431	1.748.815	1.860.019	70.566	68.637	203.619
Equatorial Guinea	1.197.793		239.527	17.891	28.867	18.863
Lesotho	459.867			1.110	2.831	
Mali	748.911		42.240	33.090	6.449	98.125
Namibia	2.863.313	333.600	94.444	14.119	5.257	3.887.129
Niger	748.911	77.929	5.186	17.981	17.977	220.803
Sahrawi Arab PDR	12.573				317	
Tanzania	6.324				50	
Zimbabwe	3.115.085	808.080		21.169	58.315	
Total	19.521.099	4.321.429	2.478.212	403.907	242.536	5.043.241

Notes: "Doctor's Visits" are patients' visits to the doctors' offices; house calls are home visits. "Surgeries" include both major and minor surgeries.

Source: *Comprehensive Health Care Program*, MINREX (Havana, September 2004).

the region. Its relations with China and Vietnam can, for example, be traced back to the early days of the Revolution, while in other cases, such as increased trade with Japan, its strengthened ties are of a more recent (i.e., post-Cold War) vintage. In the Millennial Renaissance period, Havana's medical diplomacy has often played an integral role in this process. Indeed, says British reporter Tom Fawthrop,

> Cuba has been flooding some poorer parts of the region with doctors and humanitarian workers since the tsunami tragedy in Indonesia on Boxing Day, 2004. Swathes of the Pacific, from Kiribati to East Timor, are becoming dependent on Cuban medical aid, and the Cubans appear to be winning hearts and minds.[26]

The most prominent of these initiatives have involved several disaster relief undertakings. As Fawthrop indicates above, the expansion of contemporary (i.e., Millennial Renaissance) Cuban medical diplomacy into Asia was triggered by the massive tsunami of December 2004 that devastated large stretches of land bordering the Indian Ocean. Havana quickly deployed two medical teams to help the survivors—one being dispatched to Sri Lanka and the other to Aceh in Indonesia, which was at the very epicenter of the destruction. Unfortunately, however, this tragedy was just a forerunner of other natural disasters in the area over the next few years that would pose even greater challenges to the rapid response capabilities of Cuba's medical establishment.

Less than a year later, one of Havana's most ambitious undertakings was set into motion when the Kashmir region of Pakistan experienced one of the worst earthquakes in its history on October 8, 2005, with approximately 75,000 being killed while 100,000 were injured and more than 3 million were left homeless. Shortly thereafter Havana dispatched 200 doctors along with several tons of supplies that were used to build and equip 30 field hospitals in mountainous areas. The number of Cuban aid personnel would soon grow to more than 2,000. A summary of their initial activities is follows:

> Statistics for Cuba's Relief Effort in Pakistan (October 2005–January 24, 2006)
> - Number of medical personnel: 2,378 (including doctors, nurses, and other paramedical staff)
> - Locations in which they served: 44
> - Number of field hospitals: 30

- Number of lives saved: 1,315
- Number of consultations: 601,369 (276,491 women)
- Number of surgeries: 5,925 (2,819 major)
- Births attended: 125
- Caesarean sections: 24

By the time the Cubans finally departed in late April/early May of 2006, they had treated 1.5 million patients and had performed 13,000 surgical operations, which according to official Pakistani data constituted 73 percent of all disaster relief patients treated. As such, when officially thanking Havana for its help, Pakistan's President Pervez Musharraf emphasized that the Cubans had provided more aid than any other participating country.[27]

There was, however, little respite for Havana's aid cadres, for on May 27, 2006, Indonesia was rocked by an earthquake that killed over 6,000 people in Java while leaving approximately 650,000 displaced and homeless. Once again Cuba responded without hesitation, setting up two fully equipped field hospitals manned by 135 doctors, nurses, and technicians (many of whom were veterans of the preceding tsunami and Pakistan operations). Tom Fawthrop, who has written extensively on Havana's medical aid programs, reported in August 2006 that

> since the two hospitals opened in early June, 47,000 patients have visited. Nine hundred operations have been performed, 350 of them involving major surgery. The doctors have performed thousands of lab tests, x-rays and ultrasound scans, and nearly 2,000 people have been immunized against tetanus.[28]

Although various governments contributed money, supplies, and/or personnel to the overall aid effort, Indonesian officials publicly stated that the Cuban contingent's efforts had a greater impact than those of any other country in addressing the crisis. Indeed, the Cubans became so popular with the local people that they were asked to remain for another six months after most of the other international missions had been withdrawn.

Disaster relief campaigns such as those summarized above tend to receive a great deal of attention from the mass media and the general public due to the dramatic nature of the crises being tackled. Yet, no matter how necessary and effective they are in relieving human suffering, they are generally rather transitory; in other words, they cease

once the immediate problem at hand has been resolved or at least brought under control to the point where national authorities can assume full responsibility for them. But recognizing that the Asia/Pacific region has long-term health needs that demand more comprehensive efforts, Havana has established a more permanent presence there by instituting some extended in-country programs similar to those operating in Africa and Latin America.

Table 4.9 (which is similar to table 4.8) provides a rough profile of Cuba's "conventional" public health activities in the Far East. Admittedly, these initiatives are more modest than many of Havana's programs in other parts of the world, but the impact thereof nevertheless can be considerable since the recipient nations are often relatively small-sized. Cuba has entered into bilateral medical aid agreements with (in addition to the countries listed in table 4.9) Laos, Kiribati, and the Solomon Islands, with Papua New Guinea also expressing interest in establishing a formal cooperative relationship.

When the remaining LDC components (see chapter 5) are added to the landscape surveyed here, what emerges is a pattern of medical diplomacy with few, if any, parallels in the post-Cold War world. Quite simply, Cuba's aid network reaches into literally every corner of the modern developing world (sometimes called the "global South") and unquestionably has been a massive boon to its recipients. There remains, however, one additional issue to be explored—the relationship of Havana's medical assistance programs to other major dimensions of its foreign policy equation. This analysis (see chapter 6) must, however, wait until we complete a survey of what has become the most vigorous and fascinating center of contemporary Cuban medical aid activity—Latin America and the Caribbean.

Table 4.9 Results of Cuba's Comprehensive Health Care Program, November 1998–June 2004: Asia and Oceania

Country	Doctor's Visits
Cambodia	3.417
Nauru	1.482
East Timor	12.923
Total	17.822

Source: *Comprehensive Health Care Program*, MINREX (Havana, September 2004)

Chapter 5

Contemporary Cuban Medical Aid Programs: Latin America and the Caribbean

The implosion of the Soviet Union led to a series of major reforms in Cuba starting in the early 1990s. Policies that would have been inconceivable just a few years before were now reluctantly accepted by the revolutionary leadership as being essential for the survival of the Cuban revolution. As a result, starting with the legalization of hard currency in 1993, a number of economic innovations were introduced—some 200,000 Cubans became self-employed, foreign investment was successfully courted and hundreds of joint ventures were soon in place, state farms were reorganized as collectives with greater autonomy, tourism (which for decades had been studiously neglected) became the locomotive dragging the economy in its wake—and the numbers of tourists increased eightfold between the early 1990s and 2007. Cubans living abroad who returned after an absence of several years hardly recognized the country.

A massive shift also took place in the foreign relations of Cuba. Previously Havana had placed most of its economic eggs in the nest of the Soviet Union and the socialist countries of Eastern Europe—with whom some 85 percent of its trade had been carried out. Western Europe, and particularly the Americas, were widely ignored. But by 1990 the situation was desperate—trade with the erstwhile allies was rapidly disappearing (largely because they demanded payment in hard currency, which was in alarmingly short supply in Cuba), and the generous subsidies from the Soviet Union (generally estimated to have been about $4 billion annually) vanished. The situation was

grim. Indeed, between 1989 and 1992, Cuba's purchasing power had dropped 75 percent, GDP had fallen an estimated 35 percent, and export earnings had fallen by 76 percent. The future looked exceedingly bleak. Desperate times called for desperate measures, and soon Cuba was keenly pursuing a development plan of concessions that Fidel Castro bitterly referred to as a pact with the devil.

It was also a time to rethink and redirect foreign policy in a radically different direction. With the diplomatic cold shoulder being given by what had been referred to by political scientists as the "socialist bloc," Cuba was now on its own, an ideological orphan in a cruel capitalist world. It badly needed foreign investment to revive the moribund economy, financial stimuli to pay for the continuation of the social benefits—literally from cradle to grave—that people had come to expect, and new trading partners. It was not going to be easy.

One of the key challenges facing Cuba was the need to redirect its foreign trade, which was far easier said than done. For decades, Cuba had depended upon the Soviet Union and the socialist bloc, with the rest of the world largely ignored, as table 5.1 illustrates.

The precipitous drop in exports to Eastern Europe (seen most dramatically between 1989 and 1991—just as the Soviet Union was disintegrating) had a disastrous impact on the Cuban economy, which was left with mountains of sugar and nickel ore that had traditionally been destined to this market, and little else. Reading the writing on the wall, the Cuban government quickly had to find alternative trading partners, no easy task after almost three decades of subsidized commerce (and a deliberately planned monoculture economy) with the socialist bloc. Suddenly, Western Europe, Asia, and in particular the Americas all appeared very attractive markets for Cuban

Table 5.1 Cuban Export Profile, 1985–1992 (millions of US$)

	1985 (%)	1987 (%)	1989 (%)	1991 (%)	1992 (%)
Total	6,531.0	5,402.0	5,392.0	3,550.0	2,030.0
W. Europe	426.0 (6.5)	343.2 (6.4)	361.5 (6.7)	353.1 (9.9)	316.9 (15.6)
E. Europe	5,617.2 (86.1)	4,683.2 (86.7)	4,064.8 (75.3)	9.2 (0.3)	651.8 (32.2)
Americas	79.5 (1.2)	81.6 (1.5)	157.9 (3.0)	235.3 (6.6)	269.3 (13.2)
Asia	290.3 (4.4)	207.4 (3.8)	379 (7.0)	349.4 (9.8)	303.4 (14.9)
Africa	28.5 (0.4)	12.5 (0.2)	111.4 (2.1)	99.9 (2.8)	85.9 (4.2)
Other	88.9 (1.4)	74.2 (1.4)	317.4 (5.9)	2,503.1 (70.6)	402.7 (19.9)

Source: H. Michael Erisman, *Cuba's Foreign Relations in a Post-Soviet World* (Gainesville, FL: University Press of Florida, 2000), 118.

products. As can be seen here, there was an extraordinary shift in trade patterns pursued by Cuba. Trade with the socialist countries soon dropped drastically (in 1992, it was one-eighth of what it had been in 1985, while that with the Americas tripled, and in percentage terms increased elevenfold). Clearly, this represented a major sea change in Cuban foreign policy.

Diplomatic Relations with the Americas in Pre-Special Period Times

Too often when discussing the "Cuban Revolution" writ large, we tend to think of a particular period, or even a point of time, that summarizes "the revolution." This is particularly true of media coverage, with journalists becoming instant specialists and commenting with new-found, and apparently profound understanding of events—before they move on to another area. Contextualization is often sadly missing. In fact, we are analyzing a revolutionary process that has been evolving for 50 years, with many significant changes, successes, and failures and influences along the way, all of which need to be seen and understood in a broad historical context. The question of Cuba's hemispheric relations since 1959 needs to be seen in that light.

An important point of departure in understanding this complex, multifaceted relationship is 1962, the year when Cuba was officially suspended from the Organization of American States. In essence, this was because its form of government was termed "incompatible" with the rest of the hemisphere. To this day it remains officially suspended but, in fact, has excellent diplomatic relations with all but a couple of its members. A useful barometer of how far the relationship has evolved since the early 1960s is Cuba's remarkably close relations with the Anglophone members of the Caribbean, many of whom had earlier shunned Cuba deliberately—and which now are the grateful recipients of significant amounts of Cuban development assistance. The July 2007 meeting of Canadian prime minister Stephen Harper and his Barbadian counterpart Owen Arthur is instructive in this regard. For, while Harper expressed "concern about certain aspects of governance and human rights in Cuba," his host—who chairs the 15-member Caribbean Community economic union—took him to task: "We have a relationship with Cuba that's over 30 years old," he stated, adding that the world's approach to

Cuba should be guided by principles of "respect for people's sovereignty, and non-interference, and the right of people to pursue alternative paths to their development."[1] This sort of observation would have been unthinkable 15 years later.

A path of diplomatic rapprochement can clearly be seen in Cuba's relationship with Latin America and the Caribbean during the 30 years prior to the Special Period in Cuba.[2] But it has not always been so rosy a process, and there have, in fact, been periods of great hostility during these five decades. In essence, we can see several phases in this relationship between Havana and the region:

- 1959–1962, a period of increasing tension and hostility ending in the suspension from the OAS
- 1962–1970, a period of the rupture of relations with virtually all of Latin America and the Caribbean—Mexico and Jamaica being notable exceptions
- 1970–1979, from the election of the socialist Allende government in Chile to the Sandinista revolutionary victory
- 1980–1990, with a constant and gradual warming of diplomatic relations between Cuba and the rest of the hemisphere
- The years of the Special Period, when trade has developed, civilian internationalist programs have increased enormously, and Cuba's relations with the hemisphere have normalized almost completely

Some observers in Washington remain fixed on the idea of Cuba as the region's trouble-making nation—an "outpost of tyranny," according to the U.S. State Department—determined to overthrow governments through the "exportation of revolution." It is true that in the 1960s Cuba had supported liberation movements and guerrilla struggles in many countries. The capture and assassination of Che Guevara in October 1967 brought to an end that chapter in Cuba's support for other revolutionary movements in the spirit of what is usually referred to as proletarian internationalism and anti-imperialism. During these years, Cuba remained isolated—an international pariah in the region. The socialist bloc provided substantial financial aid, economic security, and military aid, badly needed by the revolutionary leadership in Havana, which was widely shunned by its neighbors in Latin America and the Caribbean.

Cuban military support was restarted in the late 1970s in Central America, following the overthrow of the Somoza dictatorship in

Nicaragua in 1979, and the guerrilla struggles that had exploded in the region, particularly in El Salvador and Guatemala. This decreased drastically in the early 1980s, in no small degree because of U.S. opposition, and because of an apparent interest in dialogue during the Carter presidency. At this time, the focus shifted from military support to civil assistance in Nicaragua, as Havana sought to shore up the government headed until 1990 by Daniel Ortega. A successful Cuban-based literacy program was implemented in Nicaragua, hundreds of Cuban doctors and medical technicians came, and construction brigades, agronomists, and economic advisors were soon working throughout the country to help stabilize the Sandinista government.

It is important to put in clear context the value of Cuban international civilian solidarity at this time, since it is sometimes assumed that Cuban medical internationalism is a recent phenomenon. In fact, it is not, since (as noted earlier) Cuba had dispatched its first emergency medical mission to Chile in May 1960 following a devastating earthquake there, while its first internationalist medical contingent was dispatched to Algeria in 1963. This emphasis on a twin-track approach to Cuban medical missions (both in response to medical emergencies and to providing ongoing, sustainable medical support) has continued to this day.

The electoral defeat of the Ortega government in 1990 (in no small part because of the ongoing U.S.-supported war of attrition using the "contras") resulted in a gradual Cuban withdrawal from the country. This development, it should be noted, was gratefully viewed in Moscow, long displeased with the Cuban role in Central America. Respectability and normalcy in international relations then followed gradually as Cuba sought to mend diplomatic fences—a process that developed with far greater urgency as the Soviet Union imploded in 1989–1990.

Yet the goals of Cuba's international strategy during all these 50 years have remained constant: "Havana has called for unity, integration, and collaboration in Latin America and the Caribbean (*latinoamericanismo*), which implies the necessity to confront the problem of U.S. hegemony over the continent and has as its ultimate goal the construction of a community of nations united in the common commitment to obtain the independent development of the region."[3] The strategy and tactics have changed dramatically, as this book seeks to show, but the ultimate goal of Cuba remains the same. To a large

extent the isolation of Cuba is a thing of the past as a result of this decades-long approach; the annual repudiation of the U.S. embargo at the United Nations General Assembly illustrates this well (185 countries supported Cuba in October 2008, with only the United States, Israel, and Palau voting against). Likewise Cuba's election to the UN Human Rights Council with the support of 135 countries (the United States did not stand as a candidate, while Canada received five votes less than Cuba) and its election to lead the 118-nation Non-aligned Movement for three years in 2006 illustrate its successful international reintegration, particularly among the developing and underdeveloped nations. Cuba now enjoys excellent diplomatic relations with the Caribbean community and has been joined by a number of social democratic and socialist governments in the region (sometimes referred to as the "pink tide") since 2005. As this book seeks to illustrate, the medical and civilian assistance programs provided by tens of thousands of Cuban cooperants in recent years has solidified enormously this level of widespread regional support. It has also been pursued with tremendous success in Africa and, in more recent times, in Asia.

The Impact of Hurricane Mitch

If the electoral defeat of the Sandinistas in 1990 signified the end of a successful period of South-South cooperation, the devastation of Hurricane Mitch in Central America represented the beginning of the most recent (and most successful) phase of Cuban medical internationalism. On October 27, 1998, Hurricane Mitch hit the region, ravaging Central America. The immediate impact was devastating: 75 inches of rainfall and waves reaching 44 feet in height, massive floods and mudslides ensued, virtually destroying the entire infrastructure of Honduras and wreaking havoc in parts of Nicaragua, Guatemala, Belize, and El Salvador. Indeed, whole villages were swept away. With approximately 30,000 dead, more than 3 million people—10 percent of Central America—either homeless or severely affected by the hurricane, and upward of $5 billion worth of damage, Mitch was by far one of the worst hurricanes to have ever hit Central America.

Out of all the areas affected, Honduras was hit the hardest and suffered the greatest loss of lives—18,000 dead. Due to the massive flooding, 70–80 percent of transportation infrastructure was

destroyed. Roads were completely washed away, and even airports were submerged. A total of 25 villages were simply swept away and disappeared.[4] Honduras also suffered $3 billion in losses—due largely to the destruction of 80 percent of their banana crops.[5] As Tipper Gore stated, "the world must know the tragedy in Honduras is of biblical proportions."[6] Both Nicaragua and Guatemala also greatly suffered. In Nicaragua, for example, the damage was estimated at $1.6 billion, four villages were completely buried in mud, and 750,000 people lost their homes and possessions.[7]

Cuba reacted immediately to the crisis in Central America. As Fidel Castro explained it, he wanted to help Central America take "revenge" on Hurricane Mitch, by punishing it for the horrible human price exacted by nature. Directly following the hurricane, Cuba sent 200 doctors to Honduras and Guatemala. Furthermore, on November 21 of that year, he offered an additional 2,000 doctors to the areas affected—free of cost—explaining that the doctors there would help save many more lives each year than the number of people killed by the floods and other causes associated with Mitch.[8] Significantly, most U.S. and European media outlets ignored the Cuban contribution, despite it being the largest commitment from any single country. Sadly, this has been the case on most of the occasions when Cuba has sent medical aid, either to provide support after a natural catastrophe or to help build a sustainable public health system. The mass media instead prefer to concentrate on the "feel good" stories about their own countries' contribution and sadly miss the "big picture." As table 5.2 shows, Cuba has continued to provide significant relief efforts since 2005 and the devastation of Hurricane Stan and has a record that puts the industrialized nations to shame.

Table 5.2 Cuban Response to Post-2005 Natural Emergencies

Country Affected	Number in Response Team	Number of Doctors	Percentage of Doctors in Response Team
Guatemala (Hurricane Stan)	688	600	87.2
Pakistan (Earthquake)	2564	1463	57.1
Bolivia (Flooding)	602	601	99.8
Indonesia (Earthquake)	135	78	57.8
Total	3989	2742	68.7

Source: Ministry of Foreign Relations, Cuba, August 2007.

Later, an even more significant step was taken as the Cuban government sought to develop a sustainable medical response to assist the affected countries of the region. Hundreds of Cuban doctors would stay in Central America to provide badly needed medical support. But now there was a significant paradigm shift as President Castro announced that he would be offering medical scholarships to students from Central America for the next 10 years. He offered 1,000 spaces for the first academic year, and 500 for each subsequent year—50 percent of which would be reserved for students from indigenous communities, who otherwise would be unable to afford medical school education. The basic concept was simple: these students would return to provide long-term care for the affected areas, assisting their disadvantaged community to emerge from the ruins of Mitch. In this way the Latin American Medical School (ELAM in its Spanish acronym) was born, with hundreds of medical students from Central America already having graduated and working in their homelands. A study of the number of students from Central America registered at ELAM (see table 5.3) reveals the extent of Cuba's contribution.

Although 2,000 Cuban medical workers were posted in the areas affected, it is important to understand the significance of their work in comparison to similar work by other countries and organizations. In 1998, the European Union, for example, offered $8 million worth of aid.[9] Additionally, by 2000, according to USAID, the United States had given a total of $121 million dollars to the countries affected by the hurricane.[10] The kind of aid provided by other countries in contrast to that given by Cuba is instructive as it illustrates the different attitudes toward aid; in essence, it offers dollars instead of human capital. Cuba lacked the financial means to support the region but

Table 5.3 ELAM: Enrollment by Students' Country of Origin, 2004–2005

Country	Pre-med	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year	Total
El Salvador	79	77	61	81	111	86	119	614
Guatemala	93	46	58	64	91	158	187	697
Honduras	84	54	46	66	96	150	215	711
Nicaragua	50	52	46	61	73	99	178	559

Source: Michele Frank and Gail A. Reed, "Doctors for the Developing World," *Medicc Review*, vol. VII, no. 8 (Aug./Sept. 2005). Available at <www.medicc.org>.

was rich in human capital and so decided to employ that natural advantage. A dispassionate analysis could well argue that the saving of tens of thousands of Central American lives by the training at no cost of hundreds of doctors was significantly more important than the transfer of funds.

Each country affected by Mitch received significant Cuban support. For example, Honduras, which suffered the brunt of the hurricane, was the recipient of the greatest amount of concentrated Cuban medical attention. By November 23, for example, five Cuban medical brigades[11] had already flown to Honduras to join the international relief efforts, while two additional brigades were preparing to leave for the same destination. Moreover, the medical brigades worked exceptionally hard, seeing 400 patients a day in Guatemala, for example.[12]

Cuba's medical aid following Hurricane Mitch was also remarkably different from that of other countries, as the Cuban medical staff stayed, providing continual support to the Honduran and indeed Central American people. (It is often forgotten that several hundred Cuban medical personnel remain to this day in the region, although their numbers are gradually being reduced as students from the region who have been educated at the ELAM come home to take up their medical duties). By contrast, most of the other international medical teams stayed for just a few weeks. The Cuban record in Honduras is noteworthy indeed in terms of tending to the needs of the population—between 1998 and 2003, for example, Cuba had provided approximately 3.7 million consultations (including 31,627 major operations and 28,346 minor surgeries) and repaired 6,510 pieces of medical equipment.[13] Two years later, with 300 Cuban medical staff still working in the country, some 7 million consultations had been provided.[14] Significantly, Cuba was not just attending to the immediate medical needs of the population but was also making a significant difference in the lives of Hondurans. For example, in the first 18 months of Cuba's work in Honduras, there was a significant drop in infant mortality, which fell from 80.3 per 1000 live births to 30.9. This trend, as noted in the next section, has continued, as we seek to update Cuba's role in the region. In addition, the free medical training given to hundreds of Hondurans also ensures the eventual development of a sustainable model of public health. The popular reaction to this act of solidarity is noteworthy, since it is people in the underserved regions who have most benefitted, and indeed

the Cuban physicians are often the first doctors they have seen in their lives. Indeed, in 2005, when, Merlin Fernández, the Honduran health minister, stated that Cuba's medical brigades would soon be returning to Cuba due to Honduras' diminishing need for medical assistance, there was such a massive public outcry that the government was forced to overturn its initial decision and allow them to stay an additional year.[15] They remain today, again because of popular pressure. It is also important to bear in mind that, when the Cuban emergency medical support began, there was an extremely cold diplomatic relationship between the two countries. Fortunately humanitarianism trumped political tensions, thereby contributing to the re-establishment of diplomatic relations—suspended since 1961—in January 2002.

Also impressive is the medical support Cuba provided to neighboring Nicaragua. Initially, the conservative Nicaraguan government (which again had a strained relationship with Havana) refused Cuba's offer to send medical personnel in the wake of Mitch, instead accepting only the 30,000 pounds of medical supplies offered. However, as a result of the Nicaraguan people's outrage at the government for turning away much needed aid, the government backed down and accepted Cuba's offer. In fact, on November 21—just two days after Nicaragua revised its decision—a group of 18 Cuban medical volunteers arrived. The following day, six three-person medical brigades were already busy working in some of Nicaragua's most remote areas. In the first two days of working, the Cuban medical volunteers treated 300 people.[16] In addition, Cuba stated that, in light of the devastation caused by Mitch, it would write off Nicaragua's $50 million debt. Cuba's medical assistance was so good that President Arnoldo Alemán and Vice President Enrique Bola (ideological foes who had originally rejected Cuban medical aid) both expressed their gratitude to Cuba.[17] Significantly, the election of Daniel Ortega in 2006—16 years after his electoral defeat—marked the beginning of a new chapter of Cuban support for Nicaragua.

Sadly, 1998 also witnessed the havoc caused by Hurricane George in Haiti. Just a month before Mitch it had devastated the Caribbean, and in particular Haiti. Hurricane George hit on September 20 and 21, 1998, causing damage in 17 islands in the northeast Caribbean. At least 500 people were killed, hundreds of thousands were left homeless, and the damage was estimated at $5 billion.[18] Just as it had

rushed to serve the people affected by Mitch, in the aftermath of George, Cuba also sent medical brigades to Haiti. It is worth noting in passing that the strained relations that Cuba had experienced with Honduras, Guatemala, and El Salvador were mirrored in those with Haiti, whose government had, in fact, ended diplomatic relations with Cuba in 1995. However, it soon welcomed Cuban aid in 1998, after the massive destruction by Hurricane George.[19] It is no coincidence that diplomatic relations with all of these countries have improved significantly since the arrival of Cuban medical aid, particularly in the case of Guatemala and Honduras—which reopened diplomatic ties after a hiatus of some 40 years. (It would appear that "soft power" can sometimes succeed where bluster and threats do not). This is not completely surprising, since it is almost impossible to maintain frigid relations with a country that is saving thousands of your compatriots' lives.

Doctors without Borders and other aid groups stopped providing services to Haiti, claiming that the conditions were too dangerous there.[20] While others left or would not even consider sending medical missions to help after George, the Cuban government immediately sent 200 doctors to support the population. Previously, Haiti had only 2,000 doctors, of whom 90 percent were working in Port-au-Prince.[21] The Cuban medical brigades, however, arrived and spread across the country and were soon working in 95 percent of Haiti's 133 municipalities. By 2004, they were providing health care to 75 percent of the country's 8.3 million inhabitants.[22] Cuba's aid continued, with a shipment of 12.2 tons of medicine in 2004, while the number of Cubans working in Haiti also grew. The initial contingent of 200 Cuban doctors in 1998 had grown to a medical brigade of 525 participants by 2004—332 of whom were doctors.[23] Between 1998 and 2004, Cuban doctors had tended to the needs of the Haitian population with approximately 5 million consultations, assisted in almost 45,000 deliveries, and performed 59,000 surgical operations. In the areas in which the Cuban doctors worked, the infant mortality rate of children under 1 year of age has dropped from 80 per 1000 live births to 28. Similarly, the mortality rate of children under 5 years of age has dropped from 159 to 39 per 1000 live births. As can be seen in table 5.4, the impact of Cuban medical cooperation has been enormous.

As in the case of Central America, the Cuban government also adopted the proactive approach of developing a sustainable public

Table 5.4 Impact of the Cuban Medical Team in Haiti, 1998–May 2007

Statistic	Total
Visits to the doctor	10,682,124
Doctor visit to the patient	4,150,631
Attended births	86,633
Major and minor surgeries	160,283
Vaccinations	899,829
Lives saved (emergency)	210,852

Source: Anna Kovac, "Cuba Trains Hundreds of Haitian Doctors to Make a Difference," *MEDICC Review* (August 6, 2007). Available on the Internet at <www.medicc.org/publications/cuba_health_reports/018.php>.

health policy for Haiti. And again the concept was simple: instead of having hundreds of Cuban medical staff working there indefinitely, it made more practical sense to train Haitian doctors in Cuba, so that eventually they could return home to ultimately replace the Cuban medical staff and provide the badly needed medical care. Cuba has thus been educating (at no charge to the students) large numbers of Haitian medical students since the onset of Hurricane George, with the Cuban government offering scholarships for students wishing to attend medical school in Cuba. By 2004, for example, there were 247 Haitian students studying in the medical school in Haiti that was founded by Cuban professors, with a further 372 attending medical schools in Cuba on scholarships.[24] By 2005, there were 600 Haitian students studying at the medical school in Santiago de Cuba and the first group of Haitian doctors studying in Cuba had graduated and returned to Haiti to practice medicine.[25]

In addition to the amount of medical aid provided by Cuba, also equally important is the quality of the care that was provided. As noted earlier, the data on the decrease in mortality rates are impressive. Largely, what differentiates Cuba from other countries is that, as opposed to simply sending soldiers or money,[26] Cuba has engaged in a two-stage strategy: first dispatching large numbers of doctors to deal with the immediate emergency and subsequently working to train doctors (mainly from underserved areas), so that eventually they can return and work in their home communities. In the case of Haiti, specialists in a variety of other fields—education,

aquaculture, construction, the sugar industry, communications, the fishery, environment, and veterinary medicine—were also sent to help the country, the poorest in the Western Hemisphere. Accounts of the pragmatic, selfless attitudes of Cuban medical staff abound, both in Haiti and in the various Central American countries where they have worked. In order not to compete with doctors in affluent urban communities, they usually go to work in poor rural areas, often without the most basic amenities. As one Cuban doctor explained, "we're trained to serve and help save lives; wherever that is necessary, I'm willing to go."[27] In all our interviews with scores of medical personnel from Cuba who have served on internationalist missions, this approach was seen to be commonly held. German Padgett, the Honduran minister of culture, explained well in 2002 the vital role of Cuban doctors, comparing their attitude with that of their Honduran counterparts: "the Cubans are excellent professionals who provide loving care to their patients and their professional ethics come first, before anything else, unlike their Honduran colleagues who put money first."[28]

Cuban medical students have continued the tradition of medical cooperation with countries that badly need it, a process that—it should be emphasized—started in 1960. In fact, when Hurricane Mitch initially hit in 1998, 14,800 of the 21,000 Cuban medical students in the country at the time volunteered to go to Central America or Haiti to help, if called.[29] In a further example of "thinking on its feet" and applying a pragmatic approach to the medical education offered, the Cuban government saw the advantage of both assisting the devastated communities and providing invaluable medical training to advanced students at the same time. Accordingly, beginning in 2000, the "Outstanding Graduates" program was developed. This is intended for medical students with excellent grades, and the goal is for them to carry out their residency in the most needy regions of Cuba, as well as in Haiti, Guatemala, and Honduras. The program was established to train new doctors to be able to work in difficult conditions so that they can better serve in other challenging international areas, thus pursuing the original goals of Cuban medical internationalism.[30] So far, several hundred residents have trained in these countries in order to have practical "hands on" experience, and countless lives have been saved as a result of this farsighted approach to medical education.

Update of Cuban Cooperation with Central America and Haiti

Keeping track of the Cuban medical cooperation in 72 countries and territories is no easy matter. The number of Cuban medical personnel in any given country is constantly changing, depending on the needs of the country and the availability of Cuban personnel. Emergencies such as earthquakes or floods occur that cause officials in the Ministries of Foreign Affairs and Public Health consider an immediate response. Different strategies and emphases are added as the medical training evolves. And, of course, the number of students in the 20 medical faculties in Cuba where foreign students train after their time at ELAM rises and falls as students join programs or graduate. Countries from around the world appeal to Cuba also for a variety of regular (i.e., non-emergency) forms of medical cooperation, ranging from humanitarian relief (as seen in the cases studied thus far in the chapter) to paid medical support where physicians, nurses, and technicians are in short supply (as in the case of Venezuela).

There are two distinctive models that are followed by Cuban officials. One deals with those countries receiving support under the Programa Integral de Salud (PIS), or Comprehensive Medical Program, which is set up by Cuban officials at the request of home countries. The recipient country provides housing, covers local living expenses, and pays a modest honorarium to the Cuban medical staff. In Latin America and the Caribbean, the most recent data (January 2009) provided by the Cuban Ministry of Foreign Relations showed that there were 3,089 medical personnel working in 12 countries in the region, of whom 2,040 were doctors. In addition Cuban medical staff was working in PIS missions in 22 countries, as well as in 3 countries of Asia and Oceania.[31] The other model, encompassing some 36 countries, is a patchwork of arrangements all worked out in a bilateral framework with each country. The example of Venezuela, studied later in the chapter, is a good illustration of this approach.

In terms of the countries of Central America and in the case of Haiti, it is clear that these—among the poorest in the Western Hemisphere—have received special treatment from Cuba. The first stage of the most recent phase in Cuban medical cooperation in all cases was the emergency response to a disaster. This was followed by the maintenance of Cuban medical staff in these countries (which

continues to this day), accompanied by a strategy of training indigenous medical staff to develop a sustainable public health system in their home countries. This latter approach makes perfect sense but has come up against severe challenges in some countries—such as Honduras—where the local College of Physicians has resented the presence of the Cuban-trained doctors, most of whom are from lower social classes, emphasize preventive medicine and local involvement in public health matters, do not apply a fee-for-service approach to their patients, and are debt-free. Despite claims made by the hundreds of physicians trained in Cuba that they do not constitute a threat to their private sector colleagues (since they will work in the underserved sectors, many of whose members simply cannot afford private medical care), tensions have resulted. Demonstrations and counterdemonstrations have taken place, and the local College of Physicians has criticized the doctors trained in Cuba.

Despite these background tensions, it is clear that in Central America Cuba continues to make an important contribution to the social development of its peoples. In the case of Guatemala, for instance, Cuban doctors have been working for nine years and are now in 17 of the nation's 22 provinces and in all there are almost 400 Cuban physicians at present in Guatemala. Data found at the Cuban government website http://www.cubacoop.com/cubacoop/Inicio.html reveal the extent of Cuban involvement. Altogether, some 3,500 Cuban doctors have served there. In total, they have saved an estimated 270,000 lives, carried out 26 million consultations, and performed 144,000 surgical operations—including 40,000 eye operations through Operation Miracle. In addition they have assisted at 70,712 births and have reduced by more than half both infant and maternal mortality rates in the locations where they are working. Current rates are 6.8 and 61.1 per thousand, respectively. What is particularly pleasing is to see the contribution in Guatemala of the 470 graduates of ELAM, back home and working in their native land.[32] A further 600 Guatemalan medical students are studying in Cuba and will return to their homeland after graduation.

A similar picture is encountered in Honduras where, a decade after Hurricane Mitch, there is still a noticeable Cuban medical presence—some 300 personnel found in all 18 departments of the country. In all, over 1,550 Cuban doctors have served there. Since arriving in the impoverished Central American country, Cuban

medical staff has conducted more than 16 million medical consultations. In addition, they have performed (at no charge) some 455,000 operations and saved the lives of 236,000 people. Three centers for eye surgery have been set up and staffed by Cuban doctors, with 6,500 operations performed by October 2007, part of the Operation Miracle process. As a means of ensuring a sustainable public health process, 461 Honduran medical students have already graduated from ELAM. A further 1,200 are still studying there. Most striking of all, however, is the drop in the infant mortality rate in those regions where the Cuban medical staff is working. Cuban medical personnel have assisted at the birth of over 85,000 babies, and this has made a major difference. Indeed, while the national infant mortality rate is 37 per 1,000 live births, the comparable rate where the Cuban medical staff is working (usually in inaccessible and underserved regions) has fallen to just over 10.[33] Honduran president José Manuel Zelaya spoke with the 353 students from his country during his visit to ELAM in October 2007 and, in thanking Cuba "for its great example of dignity, independence and human solidarity" with his country, summarized well the improved state of relations between Cuba and Honduras: "With a program like ELAM's, we are creating the beginning of a new society, in which relations between countries are not only based upon commercial exchange and on putting a price on items exchanged, but, and more importantly, based on the expression of solidarity without asking in return, a principle of which the Cuban people are exponents."[34]

The ELAM was instituted as a direct result of the Cuban government's desire for a long-term, sustainable approach to the training of physicians for Central America and Haiti following the ravages of two massive hurricanes. It is no surprise that in the 2004–2005 enrollment figures, students from the Central American countries should be among the largest contingents—610 from Guatemala, 650 from Honduras, and 500 from Nicaragua. There were also some 187 Guatemalans among the first graduating class in the summer of 2005, mainly from indigenous communities, and most have returned to work in their homeland. As is the norm at ELAM, their first two years were spent at ELAM, followed by almost four years at teaching hospitals and polytechnics affiliated with some 20 medical faculties in Cuba.

As is the case with students at ELAM, they read about medical problems and diseases prevalent in their own countries (often

different from the Cuban situation, where many of the illnesses found in Central America and Haiti have already been eradicated). They also studied extra course material dealing with disaster management, reflecting the major challenges such as earthquakes and hurricanes faced in their home countries. During the last semester of their program in 2005, many of the graduating students also returned to Guatemala for a pilot internship back home in communities where the students would soon be working. The idea—soon implemented for students from other countries represented at ELAM—was to provide clinical experience in a practical, grounded atmosphere.

Of particular note is the success of Cuban doctors in implementing "Operación Milagro" (Operation Miracle) to deal with vision problems in Central America. The program began on July 10, 2004, at the Ramón Pando Ferrer hospital in Havana, where the first Venezuelan patients were treated. This free eye surgery program, an important project of ALBA (Bolivarian Alternative for the Americas), had treated some 1.5 million patients from 33 countries, mainly Latin America and the Caribbean, by March 2009. The objective is ultimately to treat some 6 million people in 10 years, and in order to achieve this Cuba has set up some 40 ophthalmology hospitals in Venezuela, Bolivia, Guatemala, Honduras, Ecuador, Panama, Nicaragua, Mali, and Haiti. Since three ophthalmology hospitals were inaugurated in Guatemala in 2007, more than 36,000 patients had been operated on.[35] A similar number of Nicaraguan patients (mainly of limited economic resources) were treated in the same year, while 20,000 eye operations were carried out on Panamanian patients by the spring of 2008. The basic concept is to provide eye surgery regardless of the patient's ability to pay. This surgery has taken place at 37 ophthalmology centers set up by Cuban specialists in eight countries in the region. All of the laboratory testing, medical assistance, accommodation, and travel are provided to the patients at no charge, with the costs being underwritten by Venezuela as part of the ALBA development program.[36]

In Nicaragua, the election of Daniel Ortega in 2006, some 16 years after his loss to Violeta Chamorro, has led to a clearly invigorated relationship with Cuba. This has taken several forms, ranging from construction and energy support to medical and education cooperation. One of the most successful facets has been the introduction of a far-reaching literacy program, "Yo, sí puedo" (Yes, I can…),

which by January 2009 had reduced illiteracy rates from 22% to 6.8% in two years. The Cuban literacy model is taught in a "multiplier" fashion by Cuban specialists, some 80 of whom are leading the campaign to Nicaraguan teachers, who then teach illiterate adults in more than 3,700 locations. The approach has also been used successfully in Panama, where an ambitious plan to eradicate illiteracy by 2009 has been introduced.

In the case of Nicaragua, a desperately poor country where 80 percent of the population lives on less than $2 per day, the reforms have been particularly welcome. One of Daniel Ortega's first official duties after his inauguration was to sign on to the Bolivarian Alternative for the Americas, an agreement founded on cooperation, mutual assistance, and solidarity. Both countries are firm believers in the central concept of ALBA, in essence a Latin American alternative to the U.S. proposal of a Free Trade Area of the Americas (FTAA, or ALCA in its Spanish acronym). The basic idea of ALBA is to develop a network of support for the nations of Latin America, sharing resources on a people-to-people basis, rejecting the dominant neoliberal dogma and the extremes of globalization, in order to come up with a "made in Latin America" approach to developmental challenges. The prime architect (and principal source of funding) is Venezuela's Hugo Chávez.

Supported by his country's vast store of petrodollars, Chávez has embarked upon an ambitious program, seeking cooperation with recently elected leftist governments in the region. It is often (mistakenly) thought that ALBA is a program of regional commercial integration. That is one of its objectives—but, as noted in an earlier chapter, it goes far beyond that. Former Cuban foreign relations minister Felipe Pérez Roque has explained well the essence of its philosophy: "The ALBA is a new formula for integration, and views trade and investment not just as ends in themselves, but as instruments to reach a sustainable development of the people."[37] It also takes in matters of health, culture, education, and South-South cooperation. Nicaragua, in the wake of the electoral victory of Ortega, was a logical—and willing—partner in ALBA, as was Evo Morales in Bolivia. Other countries in the region (Ecuador and Haiti, for example) are now considering participating, while Honduras is the latest country to join.

Cuba has clearly decided to provide substantial medical assistance to Nicaragua, especially with the costs now being underwritten by

Venezuela. It is important to note, however, that this humanitarian support had already been implemented decades before ALBA had been considered, and not just since the Sandinista electoral victory of November 2006, or indeed that of Chávez. That said, it is clear that both Cuba and Venezuela are keen to both promote ALBA and support the Ortega government, which clearly shares an ideological affinity for and a deep friendship with the Cuban leadership. Mention has been made of the medical support provided to date by Cuba, most clearly seen in the training of Nicaraguan students at the ELAM, a process that is already a decade old. Already approximately 100 Nicaraguan students have graduated, with a further 1,200 in various stages of their medical training in Cuba. In addition, three ophthalmologic centers have recently been built, with the one in Ciudad Sandino (13 km. west of Managua) performing 60 surgeries daily. By June 2008, already some 25,000 Nicaraguans had been operated on to correct vision problems, and 13,000 treated. By December of that year, this had increased to 40,000, illustrating the extent and speed of Cuban medical support. In part this was due to the completion of the third ophthalmological hospital. In addition, an ambitious vaccination campaign had been started, with the goal of giving 1,400,000 shots against the most common pediatric diseases. In addition, Cuban medical personnel had carried out 1.2 million consultations, almost 2,500 surgical operations had been conducted, and 1,934 births had been attended to by mid-2008. These are all examples of the potential and the successes of ALBA.

The Atlantic Coast of Nicaragua is among the poorest and the most neglected areas of the country and has been the target of concentrated Cuban medical cooperation. Two field hospitals have been established in the area (and these are to be converted into permanent structures). The 40 Cuban medical staffers working in them since May 2007 and some 56 fifth-year Nicaraguan medical students at the ELAM serving a practicum there were strengthened by the arrival of a further 85 Cuban medical professionals in August of that year. The idea is to build upon this relationship between the ELAM and the Nicaraguan government and to have 210 students (both interns and others in their last year of medical training) return to Nicaragua to work alongside the Cuban doctors, who would act as their supervisors. In all, 378 Cuban medical professionals were expected to be working in the country by late 2007.

The Cuban medical staff was called into action in September 2007 when Hurricane Félix roared through the region with 260-kmph winds, leaving 65 dead and 134 others unaccounted for. Hundreds of buildings were destroyed (including the accommodation for the Cuban doctors in Puerto Cabeza). The 61 Cuban doctors in the Puerto Cabeza and Waspam regions of the Atlantic Coast assisted 5,400 patients. Tent hospitals in the disaster areas were set up, and after the worst of the storm was over, the medical staff concentrated on education campaigns to prevent disease in the stricken area. They were assisted by fifth-year Nicaraguan students from the Latin American Medical School who were working on their community internship in remote areas of their country, under the supervision of Cuban doctors.

Despite speaking a different language, Haitian students are taught in much the same way as their Spanish-American counterparts. They make up the largest student body at the Santiago de Cuba campus of the ELAM (about 650 were enrolled in 2007). In the 2004–2005 academic year, they were distributed in the following way: 67 in first year, 55 in second, 249 in third, 111 in fourth, 116 in fifth, and 128 in the sixth year, thus forming a total of 726. The essence of the Cuban approach to teaching medicine is its pragmatic, hands-on approach. One fifth-year student from Haiti summarized it well: "From the first year, we have a class on community medicine to help us get to know the population, where we learn alongside family doctors. In the second year we work with doctors in polyclinics and from the third year on, in hospitals. Before we get our diplomas, we've already learned from experience."[38] The approach employed by Cuban medical professionals is exemplary, appropriate for the pressing needs of Haiti, where there is an enormous need for medical staff, since fewer than 2,000 doctors treat 8 million people.

One of the characteristics of the approach used by the Cuban medical professors in teaching since the founding of the ELAM is to improvise and to innovate as experience is gained. The needs have been so pressing in Haiti that one particularly important amendment to the teaching schedule has been the decision to send students back home for their final term, as has been the case for the Central American students. This started in 2005, when 80 students were selected to return to Haiti under Cuban medical supervision. They were followed in the subsequent year by another 80, and in July 2007

all 63 Haitians (the third graduating class since the medical school accepted them) returned to their homeland to complete their training with practical experience, working under Cuban supervision with patients. They joined the 226 Cuban-trained doctors already there (128 from the class of 2005 and 98 from the following year), as well as the more than 500 Cuban medical professionals currently working in Haiti. It is worth noting that by December 2008 some 490 Haitians had graduated from their medical training in Cuba and had returned home to deal with the pressing need for medical care.

A final comment is worth making, since the Haitian graduates from ELAM will soon have new (badly needed) facilities to practice in, as a result of a March 2007 agreement between Venezuela, Cuba, and Haiti. Supported by Venezuelan financing, some 12 Comprehensive Diagnostic Centers (one for each of the country's provinces) will be established, with three more in the capital, Port-au-Prince. All will have state-of-the art equipment and will also be used as teaching facilities where Cuban medical professors will provide further training to the Haitian students. This will hopefully signal a new chapter in providing sustainable health practices for Haiti. Until the return of Haitian graduates from ELAM, Cuba had been providing support for the majority of the population. The figures illustrate clearly the dependence upon Cuban medical personnel. In the last decade, Cuban medical personnel have given over 13.5 million consultations, assisted at 105,000 births, and performed 213,000 surgical operations (apart from the 27,000 through Operation Miracle)—in all saving an estimated 229,000 lives. One shudders to think what would have happened without that medical assistance.

ALBA in Practice: The Cuban Medical Presence in Bolivia

Just as Nicaragua has benefitted significantly from Cuban cooperation since the electoral victory of Daniel Ortega, so too has Bolivia gained since Evo Morales was elected in December 2005. Directly after the results were known, and even before his inauguration, the indigenous leader visited Havana and met with Fidel Castro. The two leaders subsequently announced a 30-month plan to end illiteracy in Bolivia through the Cuban literacy program "Yo, sí puedo." But it is in the field of public health where Cuba has made the greatest contribution. There are some 1,852 Cuban medical workers stationed there,

of whom 1,226 are doctors. The members of the Cuban medical brigade are working in 174 of the country's 327 municipalities with support to a further 41 and have provided almost 15 million medical consultations since arriving in Bolivia. In terms of Operation Miracle, there are 18 specialized medical stations there, and by May 2008, Cuban eye specialists had operated on 200,000 Bolivians and 45,000 patients from Peru, Argentina, Paraguay, and Brazil. Moreover, there are 5,291 Bolivians studying medicine in Cuba, including 621 at ELAM.[39] The most recent figures indicate that Cuban medical staff had attended over 9,000 births and saved 14,000 lives.[40]

Morales had clearly rejected Washington's overtures to Bolivia, nationalizing energy resources (many owned by U.S.-based multinationals) and rejecting U.S. plans for a coca eradication program. In a symbolic flourish, he announced prior to taking office that he, together with members of his cabinet, would halve their salaries and donate the monies toward the nation's pressing education and public health needs. Taking advantage of the successful experience of cooperation between Cuba and Venezuela, Bolivia has seen dramatic tangible benefits result in a short time from this closer relationship with Cuba. In many ways, through their association in the Bolivarian ALBA model, Evo Morales, together with Fidel Castro, Hugo Chávez, and Daniel Ortega, have become the symbolic opposition leadership of Latin America, an alternative to the Washington Consensus.

The extent of Cuban cooperation since Morales took power in early 2006 is far-reaching indeed. As is the case with most countries in Latin America, however, Cuba had already been training at no charge medical students from Bolivia at the ELAM and had in addition provided medical assistance in that country. Indeed, in 2004, prior to the electoral victory of Morales, there were already 563 Bolivian medical students in Cuba. Once again, Cuba cannot be accused of short-term political gain, since its long-term humanitarian goals (and strategic sense) are clearly far more significant. Since Morales became president, however, Venezuelan and Cuban support has increased dramatically to that country. Between 2003 and February 2007, for instance, Cuban records show that their medical staff had provided 3,370,000 medical consultations, delivered 3,730 babies, carried out 4,600 operations, and saved the lives of 4,300 Bolivians.[41] The speed with which Cuban medical assistance had grown can be judged from

the official figures from July 2008, just 17 months later. Since the Cubans had arrived, they had carried out over 15 million consultations, delivered 9,269 babies, operated on 22,243 patients, and saved 14,284 lives. Clearly, medical conditions had improved dramatically since the Cuban medical presence had continued to grow, with over 1,800 medical professionals working in Bolivia by then.

The bilateral relationship of Bolivia and Cuba has expanded rapidly with Morales in power, much like that between Cuba and Venezuela. Indeed, all countries involved in the ALBA realize the need to show dramatic results from their joint ideological venture as quickly as possible, in order to illustrate a successful alternative to the traditional U.S. hegemony in Latin America. (There is justifiable concern that Washington, fearful of the threat of the ALBA example, might seek to destabilize the leftist governments in Venezuela and Bolivia). In May 2007, a formal agreement was signed by both countries to establish and promote commercial opportunities for interregional trade. The objective was to analyze ways in which all ALBA nations can support each other with the sale of local products and the development of national industries as an alternative to the Free Trade Area of the Americas proposed by the United States. One avenue currently being explored by Cuban medical researchers, specialists in the production of inexpensive generic medicines, is the possible commercialization of the coca leaf in various pharmaceutical products. For its part, Venezuela loaned money to the Morales government to build factories in order to produce coca tea.

The most significant tangible benefits of this alliance, however, are clearly those registered in the fields of education and public health. In terms of education, Cuba's emphasis has been on reducing illiteracy through its internationally regarded "Yo, sí puedo" program. (By September 2007, over 2.1 million people in 20 countries had graduated from it). It has been a success, and by December 2008 some 880,000 Bolivians had learned the rudiments of reading and writing. The ambitious goal for the literacy campaign was to eradicate illiteracy by 2010 (not surprisingly, 68 percent of the illiterates in Bolivia lived in rural zones, and 80 percent were women). At present, there are 331,763 students taking lessons in Spanish, Quechua, and Aymara at 19,500 centers, an astonishing number; although the level of education accomplished is not particularly sophisticated, it is still an extraordinary improvement on the situation two years ago.[42]

To help students with vision difficulties, the Bolivian government has also distributed over 51,000 pairs of glasses. This concentrated 65-day literacy program based upon audio-visual methods started in recent years, and some 2.1 million people have already been made literate. In addition to Bolivia, 15 other countries, mainly in Latin America and Africa, are using this program.

The gains in terms of an improvement in public health are even more noticeable, and the numbers stunning. By August 2007, for instance, Cuba had already set up 20 field hospitals and 11 ophthalmology centers and was to establish a further 20 fully equipped clinics in 2008. In addition, 632 tons of medicine and medical equipment had been donated. By February 2007, some 3,717,434 patients had been seen by Cuban medical staff, and 4,642 lives saved.[43] Within the first year of their arrival, Cuban medical staff had delivered 3,730 babies, reduced the infant mortality indicators, performed 4,600 surgical operations, and carried out 197,000 medical examinations.[44]

The ambitious medical program of Cuba is based upon the need for primary health care coverage for 4 million Bolivians. Sadly, as was the case in Honduras, the Bolivian Medical Association has opposed the presence of the Cuban medical staff, claiming that there were 10,000 unemployed physicians in the Andean country. Cuba has responded that their doctors are situated in the most distant and underserved areas of Bolivia, where their patients—mainly poor indigenous—cannot afford medical services, and as a result they do not offer competition to the established medical profession. It is significant that most of the hospitals set up by Cuban medical staff are mainly in rural areas.

One of the most successful aspects of the ALBA in a continent-wide show of human solidarity is Operation Miracle, referred to earlier. This project was in many ways an accidental by-product of Cuba's massive literacy program. Many Cuban teachers engaged in the program in various Latin American countries realized that a fundamental problem for those wanting to read and write was poor vision. As a result the mission to provide free ophthalmology services (the most common of which is cataract surgery) was born. In important symbolic terms, it is noteworthy that by August 2007, after just 18 months of its inauguration in Bolivia, more than 115,000 people (mainly poor) had recovered their sight.

Between 2005 and 2008, Cuba set up ophthalmology clinics in several countries, including Venezuela, Guatemala, and Bolivia, after deciding that this approach was more cost-effective than the original strategy of transporting patients to Cuba for surgery. In total, Cuba has established 12 centers in Bolivia, including some in border regions to facilitate transportation of patients from neighboring countries, to perform the operations. Speaking in April 2007, President Evo Morales thanked Cuba for its cooperation in the project, noting that in the 14 months since it began, Operation Miracle had delivered medical services to patients to the value of $80 million.[45] Of those operated on in Bolivia in the first 18 months, 92,611 were Bolivians. Of the others treated in Bolivia, there were 13,031 Argentines, 5,772 Peruvians, 819 Brazilians, and 167 Paraguayans, a fitting symbol of inter-American human solidarity.[46] (As of August 2007, the total number of patients operated on throughout Latin America and the Caribbean was over 760,000, an astonishing number, particularly if one bears in mind that patients paid nothing toward the cost of this medical service).

In addition to launching the successful medical and educational campaigns, Cuba also assisted relief operations to combat massive flood problems in Bolivia in early 2007. Once again the nature of the Cuban response was instructive, particularly in comparison to aid received from other countries. This was the worst flooding in 40 years, with eight of the nine provinces in the country severely affected. A national emergency was declared on January 18, 2007, and on February 7 support from the international community was officially requested. Crops were destroyed, thousands of head of cattle were killed, dozens of people were swept away, 260 schools were flooded, and 350,000 people were displaced. Outbreaks of various diseases occurred, such as dengue, malaria, and leptospirosis, as the crisis intensified; particularly severe problems were water- and sanitation-related diseases. A lack of sanitation and hygiene became a major threat as drinking water became contaminated by the flooding. Immediately some 100 Cuban doctors were reassigned from their general medicine responsibilities in Bolivia to work with persons affected in 29 evacuation camps. Within four weeks of the emergency being announced, they had provided medical attention to 50,000 people.

Looking at official government and media reports on this massive crisis, it is worth noting the amount and the type of support

provided by various governments and NGOs. The UN Office for the Coordination of Humanitarian Affairs produced a detailed four-page list of all of the pledges of support from around the world—more or less $10 million. Goods and funding poured in, ranging from $19,023 in food aid from tiny Andorra to approximately $1 million from the United States. Significantly there was little media coverage of Cuba's role and no entry in the official UN list. Yet there were 601 Cuban doctors involved in the rescue mission, working in camps for the evacuees, treating infectious diseases and trauma, and organizing preventive health campaigns.

In addition, Havana offered the services of 1,700 members of the Henry Reeve Emergency Brigade, should Bolivia require their services. (This was the same emergency response medical brigade offered to the United States when Hurricane Katrina devastated New Orleans in 2005. Sadly, President George W. Bush put politics before lives and rejected the Cuban offer of 1,200 Cuban medical staff and 30 tons of medical supplies). By mid-February Cuban doctors had treated over 60,000 patients. Two points should be emphasized. First, the deliberate ignoring of Cuba's contribution (arguably more significant than many of the other donations) was disturbing, and second, the consistent nature of Cuban disaster relief in the shape of person-to-person support—in essence, the same type of assistance provided to the victims of Chile's earthquake in 1960—was particularly helpful in saving lives.

Cuba's Role in the Anglophone Caribbean

The Anglophone Caribbean is another region where Cuba has provided extensive humanitarian assistance but is often forgotten. Yet in the Anglophone Caribbean it is worth noting that Cuba's support dwarfs that given by the United States and other industrialized nations. Cuba's warming up to the region started in earnest in the late 1980s, as the impending demise of the Soviet Union became clearer. Prior to that time, the relationship had been sporadically developed, most notably by the decision of four nations—Barbados, Guyana, Jamaica, and Trinidad and Tobago—to establish diplomatic relations with Cuba in 1972. The language barrier had been one obstacle to closer ties, since the Cubans at times found little in common in cultural terms with their Caribbean neighbors. Another serious obstacle

was the ideological hurdle, because apart from the close ties during the years when Jamaica was led by Michael Manley, and later when Maurice Bishop led Grenada, there was not that much in common between revolutionary Cuba with its Marxist-Leninist ideology and the rest of the British-influenced Caribbean and its British parliamentary traditions. The years of the Reagan administrations (1981–1989) were marked by manifest muscle-flexing in the region—especially in Central America, where Washington provided large amounts of military aid to U.S. allies, while supporting Nicaraguan counterrevolutionaries to overthrow the Sandinista government. Likewise, in 1983, a U.S. military force of 7,000 invaded tiny Grenada to bring about "stability." In the wake of such a massive military presence, the Reagan Doctrine was understandably taken seriously in the Caribbean, a situation that made it extremely difficult for Cuba to cultivate allies. And finally the Cubans had never viewed the small islands of the Caribbean as having much strategic or commercial value. That would change after the implosion of the Soviet Union, as Cuba struggled to find trading partners and allies anywhere. In May 1992, full normalization of relations arrived, when members of CARICOM and Cuba announced formally that they were re-establishing normal diplomatic ties. The degree of change in the relationship between Cuba and the Caribbean can be seen in the fact that in July 2006, when the Bahamas opened its embassy in Cuba, it became the ninth CARICOM member to set up an embassy there.[47]

Some 15 years later, those ties have evolved into a solid and most cordial trading and strategic partnership. Mention was made earlier in this chapter of Barbados prime minister Owen taking Canadian leader Stephen Harper to task for his criticisms of the Cuban political model. There was good reason for him to do so, because in terms of Cuban cooperation, the Caribbean has gained substantially. It was also true that for years there has been substantial discontent with U.S. attempts to impose various trading and tax regimens (particularly on sugar and banana exports), an approach that had been largely counterproductive since several of the (conservative) island governments could see an increasing North-South gap and were, therefore, disillusioned with U.S. policy. During this time, Washington has focused more heavily on the Middle East and on Mexico, with the Caribbean often ignored. Moreover, U.S. aid to the region has also fallen by a third since the 1990s.

Cuba has provided substantial medical and educational support to the region; at the Second Cuba-CARICOM summit held in Barbados in December 2005, Fidel Castro reminded the leaders of the Caribbean of this human capital provided to their peoples. The list was impressive: at that time 1,142 Cubans were working in the CARICOM countries, almost 1,000 of whom were in the health sector; 1,957 students from 14 Caribbean countries had already graduated from Cuban schools, while a further 3,118 were training in 33 university and technical specialties; and 11 Caribbean countries were participating in Operation Miracle, and in the 4.5 months that the program had been in place, over 33,000 citizens had received surgery in Cuba at no charge. Castro concluded by encouraging even closer ties with Cuba: "We support the efforts of our Caribbean brothers to consolidate their regional integration and, as always, Cuba is willing to offer its modest contribution in those areas where that may be possible. The peoples of the Caribbean community can always count on Cuba's respect and friendship."[48] It is important to update these data, since in just two years there was a notable increase in the amount of development assistance provided by Cuba. By December 2008, the number of graduates from Caribbean countries had increased to 2,800 (including 815 in medicine), with a further 3,140 students from CARICOM countries attending Cuban universities (including 1,600 receiving medical training). In addition, "over 4 million Caribbean patients have been treated by Cuban doctors since 1996. Since mid-July 2004, 40,500 patients from the Caribbean community have recovered their sight thanks to 'Operación Milagro' (Operation Miracle)."[49] At the third CARICOM summit held in Santiago in December 2008, an updated version of Cuban medical cooperation with its Caribbean neighbors was given. Some 280,000 surgical procedures had been carried out by Cuban physicians on CARICOM citizens, 118,000 births attended by Cuban medical personnel, 17 million medical consultations had been given, and the number of patients treated under Operation Miracle had increased to 48,000 patients (see table 5.5). As is the case with Central America, Haiti, and Bolivia, Cuban medical cooperation had grown rapidly and had reached large numbers of the population through the Caribbean community.

The list of current Cuban cooperation efforts is certainly significant. In the case of Jamaica, for example, in 2005, there were dozens of Cuban nurses on the island, as well as a small team of Cuban doctors

Table 5.5 Operation Miracle: Areas of Origin of Patients, and Total Number of Operations

Geographical Areas	Total Number of Patients Operated on from 2004 to August 8, 2007
Caribbean (14 countries)	33,306
Latin America (14 countries)	187,467
Venezuela	380,939
Mali	3,101
Cuba	145,822

Source: Ministry of Foreign Relations, Cuba, 2007

and 67 Cuban teachers. Cubans also worked as engineers and surveyors with the Ministry of Water and Housing, as civil engineers with the National Works Agency, and as sports trainers. It was announced in May 2008 that additional 91 Cuban health care workers were also to arrive soon in Jamaica. More important, over 500 Jamaican students have graduated from Cuban universities, while there are presently 290 studying in Cuba—including 124 in Medicine.[50]

But it is the field of public health where, as in Central America, Cuba has been most successful in winning converts. In addition to the many eye clinics in Latin America, there were 14 in Cuba, where citizens from the Caribbean were transported, housed, and operated on at no charge. At the peak of this process, over two dozen flights from across the Caribbean arrived weekly from all corners of the Caribbean. Fidel Castro had also claimed that the (already staggering) number of patients would be increased—to as many as 25,000 people from the Caribbean each year, as well as 100,000 from Cuba (about the same from Venezuela), and 120,000 from the rest of the Americas. In September 2006, the government of Saint Lucia announced a new phase in Operation Miracle, since a state-of-the-art ophthalmology center was planned to be opened there to provide service in the Eastern Caribbean for people from the neighboring islands of Antigua and Barbuda, Dominica, Grenada, Carricou and Petite Martinique, as well as Saint Vincent and the Grenadines.

Jamaica in particular has benefitted from Operation Miracle: some 20,000 people have been screened since it started, and 4,000 operations have occurred, including 1,000 patients who traveled to Cuba. Understandably the people operated on and their governments were grateful for this act of human solidarity, as Elinor Sherlock, Jamaica's

ambassador to Cuba, noted: "This is an example of integration and south-south co-operation. . . . You see them, especially poor people who cannot afford care, staring in awe for hours out the window after their operations. It really is miraculous."[51]

It appears that no island, no matter how small, has been overlooked by Cuba's medical missions. Even tiny Montserrat (population 4,500) has sent citizens to Cuba for eye surgery, following consultations with Cuban ophthalmologists resident on nearby Antigua. And, as is the case for all patients of Operation Miracle, there is no charge for the patients. By April 2006, some 300 Bahamians had received treatment in Havana, and by June 2007 some 1,488 Grenadians got similar help. Antigua and Barbuda report a similar experience, with over 1200 of their citizens receiving surgery through Operation Miracle by June 2008. By October 2007, some 1,585 citizens from Belize had benefitted from Operation Miracle, while the 112-member Cuban medical team had provided 1,825,000 medical consultations until that time. Havana had also provided scholarships to 132 students, including 80 at ELAM. Meanwhile some 37 Cuban doctors and technicians work in Antigua, providing basic health care. Indeed, in this small Caribbean island some 50 Cuban medical staff had been working since 2000. Between 2003 and 2008, they had attended some 101,000 patients, carried out 2,116 surgical interventions, and provided eye surgery to 1,180 patients through Operation Miracle.

One of the major problems facing the development of public health in the Caribbean is the lack of skilled nursing staff. The temptation of far greater salaries in the United States, Canada, and Britain is great indeed for nursing graduates. To combat this nursing brain drain, Cuba has instituted several nurse-training programs. For example, in Dominica, some 89 nursing students started their studies under Cuban supervision in January 2006. Following a visit by Prime Minister Kenny Anthony to Havana in May 2006, it was announced that nursing students from Saint Lucia would be trained in Cuba, starting in October 2006, and that a further 25 Cuban nurses would work on the island. (The students from Saint Lucia, together with those from Saint Vincent and the Grenadines, Jamaica, and Saint Kitts and Nevis, are studying at the Jaguey Grande nursing school in Matanzas, all told, some 351 students from the Caribbean). As in the case of the Dominican students, the Cuban government pays all training costs. Seeking the services of Cuban nurses was also at the top of the list of

requests from Jamaican health minister Horace Dalley when he met with his Cuban counterpart in Havana in June 2006.

Roosevelt Skerrit, Prime Minister of Dominica, has traveled to Cuba on four occasions seeking Cuban support, most recently in February 2006, to request help in health and construction. In many ways Cuban ties with Dominica are a microcosm of Havana's relations with the Caribbean. They had been particularly strained at the time of the U.S. invasion of Grenada, when Dominica had been a staunch ally of Washington and indeed condemned the presence of Cuban construction brigades on the island. Times changed significantly, however, and Dominica established relations with Cuba in 1996, since which time 238 young people from the island have graduated from educational programs in Cuba, while 15 Cubans worked on the island. In September 2006, a medical center on the island, financed by Cuba and staffed by Cuban medical personnel, opened its doors, to the relief of the population that previously had to travel abroad for medical care. This facility serves to support the diagnostic center established by Cuba at Portsmouth Hospital on the island. Finally, in May 2007, potentially the most important development was announced by Dominican prime minister Skerrit—Cuba's offer to establish a medical training facility for Eastern Caribbean, capable of teaching 400 students.

Education is clearly a major focus of Cuban cooperation in the Caribbean. As is the case with Havana's support of public health initiatives throughout the region, Cuba's support for educational initiatives in the region has deep roots. Caribbean students have been educated at no charge on the island for decades, and there are approximately 1,300 students from the Caribbean studying in Cuba at present. One of the largest groups comes from Jamaica—in all some 400. In the 2005–2006 academic year, 30 Jamaican students graduated in various technical and engineering fields, with a further 40 graduating in medicine and other public health professions.[52]

Since the ties with the Anglophone Caribbean were renewed (and in some cases established) in the 1990s, Cuban cooperation has become far more significant for the Caribbean nations. In many ways typical is the case of St. Vincent and the Grenadines, which established diplomatic relations with Cuba in 1992. Prime Minister Ralph Gonsalves visited Fidel Castro in Cuba in February 2006 to meet patients from his country being treated under the Operation

Miracle program. In all, between mid-2005 and February 2006, just over 1000 citizens had been treated, with a further 670 on a waiting list. He also met with students from St. Vincent who were attending university in Cuba (approximately 140, of whom 99 are studying at ELAM). Discussions were also held on the planned construction of an airport, to be built with support from Cuba and Venezuela by 2011. As in the case of so many of the islands, clear and tangible development assistance from Cuba has overridden any earlier ideological concerns that Caribbean neighbors might have had.

The case of St. Lucia mirrors this experience. Prime Minister Kenny Anthony was awarded the highly regarded José Martí Order by Fidel Castro in 1999 as a sign of respect for his efforts to strengthen bilateral ties. Education and health care have been the two areas in which Cuban support has been greatest—in all, some 235 students from the island have studied at Cuban institutions, 214 of them at the university level. At present, a further contingent of 162 students is enrolled in programs in Cuba. In addition, Cuba has also provided substantial relief through Operation Miracle, and by the time of Prime Minister Anthony's visit in May 2006, more than 1,700 patients from Saint Lucia had been treated in Cuba, with a further 14,000 treated back in St. Lucia itself.[53] At a press conference in Havana, the prime minister criticized countries that claimed to be friendly but had done little to help. By contrast, he praised Cuba lavishly: "Only a people, a government or an extraordinary leader like you have in Cuba could do what you do for us." He concluded by noting that, if Saint Lucia had been obliged to pay for the medical costs incurred from the thousands of eye operations for its citizens, it would have cost many millions of dollars. Cuba's role and compassion were exemplary, he added: "Through these actions, Cuba reveals to the whole world its legacy of humanism."[54]

Havana has also helped in a number of other ways, all contributing to the strengthening of relations with the Caribbean. In the case of Antigua and Barbuda, for example, Cuban tourism officials are helping in the restoration of historical buildings, providing instruction in tourism, and offering sports training. In Saint Kitts and Nevis, Cuba has provided assistance in a number of agricultural matters, including urban agriculture, biological pest control, organic fertilization, and the diversification of agriculture. Cuba's domestic program of energy conservation has also been exported to several islands in

the Caribbean. It has, for example, provided at no cost energy-saving fluorescent light bulbs to replace the traditional incandescent ones to St. Kitts and Nevis. In addition, a large delegation of Cuban social workers was sent to explain the importance of promoting energy-saving strategies.

Jamaica has been the largest recipient of Cuban assistance in this initiative. In July 2006, for example, some 250,000 fluorescent bulbs were received at no cost from Cuba—the first part of a shipment of 4 million—and 200 Cuban social workers and technicians came to install them and to explain strategies of reducing energy costs. The objective is to reduce Jamaica's oil import bill of $1.31 billion in 2006, a 46 percent increase from the previous year. In Saint Lucia, a similar strategy was adopted, and 700,000 bulbs were donated. By August 2007, more than 4 million bulbs had been exchanged in 10 Caribbean countries, resulting in a fuel saving of $40 million to the region.

In sum, Cuba's experience in the Caribbean has been extremely successful since the demise of the Soviet Union, particularly if one bears in mind how enormously strained the relationship was just a few years earlier. To a certain extent, the flourishing of relations is due to the studied neglect shown to the region by Washington. In June 2007, Guyanese president Bharrat Jagdeo, addressing his U.S. counterpart on behalf of the CARICOM nations, lectured George W. Bush on the importance of ties with Cuba: "We, too, have national interest considerations. . . . But our national interest considerations are a little bit different from those of the United States, and they relate more to educating our people, getting them out of poverty and providing decent health care for them."[55] Implied was a criticism of the U.S. approach to development and aid in the region, as well as a vote of confidence for Cuba's pragmatic support.

The proactive stance of Cuba, particularly in the delivery of development assistance, is thus crucially important in strengthening ties with the Caribbean community. This is not a new strategy, but it has become particularly successful in recent years, mainly through the delivery at no cost of high-quality medical care, both in Cuba and on the various islands of the Caribbean. (It is no accident, therefore, that Trinidad prime minister Patrick Manning had a heart valve replacement in 1998 and a pacemaker implanted in 2004 and had a tumor on his kidney removed in 2008, or that Haitian prime minister

René Preval had prostate surgery there. Dominican prime minister Roosevelt Skerrit had a leg operation in 2006 to remove a metal pin in his leg, while his counterpart in St. Vincent, Ralph Gonsalves, spent two weeks of convalescence in April 2007 after a car accident). There is a strong belief in and respect for Cuban approaches to public health in the region—and the Cuban medical assistance program has been enormously successful in winning support among the Caribbean community. The fact that several leaders from countries in the region have traveled to Cuba for surgery illustrates well the respect for Cuban medical professionalism.

Education and health care are the two principal areas in which Cuban influence is most appreciated, as Timothy Harris, foreign minister of St. Kitts and Nevis noted in December 2006. At the time, there were some 3,000 students from the Caribbean taking classes in Cuba (including 1,145 Caribbean nationals who were studying medicine), while a further 1,000 Cubans (doctors, nurses, technicians, engineers, and teachers) were working on the islands. In addition, 365 Caribbean students were participating in a two-year nursing program. Historically, Caribbean students have taken advantage of educational opportunities in Cuba—with 2,688 graduating since 1961 and 3,380 studying on the island at the time. No wonder he ended his presentation expressing gratitude to Cuba, in particular to Fidel Castro, "whose contribution to humanity and to South-South cooperation is inestimable and unequalled by any other contemporary leader."[56] Relations have never been warmer, as can be seen in the unanimous vote that the entire Caribbean cast against the U.S. embargo of Cuba at the UN General Assembly in October 2008.

Cuba-Venezuela Relations

The single most important bilateral relationship enjoyed by Cuba today is that with Venezuela. In terms of economic support, trade, and investment, this is particularly clear. But there are several myths that need to be dealt with in examining the complex, and often misunderstood, relationship between Cuba and Venezuela. And, because this is the most important international relationship for both countries, we dedicate a substantial section of the chapter to this analysis. Undoubtedly both countries represent the most outspokenly critical opponents of U.S. policy in the region, and their leaders have been

scathing in their denunciations of the Bush foreign policy. For its part, the U.S. government has lost little opportunity to criticize both revolutionary governments and in November 2006 appointed Norman A. Bailey as a special security adviser to study intelligence on the two countries as "mission manager." (To judge the priority of this concern, it is worth noting that the Bush administration established just five other similar positions—for Iran, North Korea, counterterrorism, counterproliferation, and counterintelligence). Moreover, there is ample evidence to suggest Washington's hand in a number of plots to bring about what is now known as "regime change," particularly in the Cuban case. The relationship has clearly stirred concern among U.S. policymakers that Chávez "might meddle in the post-Castro transition,"[57] clearly viewed as a threat in Washington.

The most common example of media oversimplification is the "Cuban doctors for Venezuelan oil" thesis, according to which Venezuela has purchased the services of doctors in return for oil. There *is* some fundamental truth in this, in that Cuba has sent some 30,000 medical staff to Venezuela and is indeed importing at preferential rates some 96,000 barrels of oil each day, resulting in a major saving for the national economy. (It was estimated in November 2005 that this represented a savings of $1.8 billion for 2005 alone).[58] But the reality of the multifaceted relationship goes beyond this oversimplified thesis. Bilateral ties have also come under close scrutiny, as has the personal relationship between Fidel Castro and Hugo Chávez, and again there has been a simplistic treatment of the two issues, largely the result of lazy journalism. The same can be said for the coverage of their extremely proactive foreign policies, and for their promotion of the ALBA agreement in Latin America. The reality is, in fact, more complicated than is widely presented.

The current proactive stage of Cuba-Venezuela relations dates back to the election of Hugo Chávez in December 1998. Fidel Castro attended his inauguration ceremonies in 1999, and the relationship (on both bilateral and personal levels) has been getting visibly stronger since then. Later that year, both countries announced several initiatives illustrating their interest in improving bilateral trade relations, with Venezuela guaranteeing oil supplies to Cuba and offering to support the fast-developing Cuban oil industry. In 2000, an agreement was signed, according to which Venezuela would provide 53,000 barrels of oil a day at preferential rates, in return for the services of

20,000 Cuban professionals (mainly medical staff and teachers). Four years later, this agreement was expanded, with 90,000 barrels of oil being offered, and Cuba in return sending 40,000 professionals.[59]

Relations between the two countries have developed apace since October 2000 when both presidents signed a major cooperation agreement. Joint commissions were set up with the specific mandate to develop cooperation between Cuba and Venezuela. There have been several key dates in the fast-paced development of bilateral relations since the election of Hugo Chávez. In December 2004, a joint declaration on the application of ALBA was signed, laying out the framework for a mutually beneficial agreement of solidarity that sought to take advantage of the natural assets enjoyed by both countries, provide access to each other's markets, save costs, and promote employment.

Of key importance was the October 2005 Sixth Meeting of the Joint Commission, which outlined the economic and social goals and projects for 2006 to be carried out by both countries. Bilateral agreements were authorized for a multitude of projects (199 in all, for a total value of $834 million) in many diverse fields: communications, computer technology, science, technology and environment, sugar, housing, tourism, energy, transportation, construction, hydraulic resources, agriculture, fishery, light industry, food, basic industry, and steel. Preferential customs duties between both countries were agreed to, and generous credit terms were also extended.

In January 2007, another set of key trade and investment pacts was concluded in Venezuela. This is an extremely useful synthesis of the gains made in bilateral cooperation. The figures are quite astonishing. At the first ALBA meeting on October 30, 2000, Fidel Castro and Hugo Chávez presided over 10 working groups to explore avenues of collaboration. At the seventh meeting held in Havana (February 28, 2007) and based on the preceding January accords, there were 26. The number of projects approved in 2000 was 31; seven years later, this had increased to 355. The budget for the first agreement was $28.5 million, while in 2007 this had risen to a staggering $1.5 billion. In December 2008, agreements were signed for new projects worth $2 billion, as relations strengthened. Bilateral trade was $460 million in 2001, but by the end of 2006 this had increased sixfold, to $2.6 billion.[60] Speaking in December 2007, Vice President Carlos Lage noted that by the end of that year "new accords totaling more than

$7 billion in investments were penned by the two countries"—an extraordinary increase.[61]

Discussions ranged over a number of topics, with further bilateral agreements being signed on agriculture, finance, telecommunications, energy, tourism, transportation, and steel. Of particular interest was the agreement for Venezuela to build a 1,522 km fiber optic connection between the two countries to improve secure telecommunications. Also unusual was an agreement to loan money to some 100,000 Venezuelans so that they could travel to Cuba on package vacations. Agreements were also signed to create a joint venture in the exploration, development, and processing of nickel resources and to form another joint venture that would build three hotels in Cuba, and one in Venezuela. An agreement was also reached for Cuba to have access to South America's first satellite (named the Simón Bolívar). Cuban television programming is now shown in Venezuela, and vice versa. Another joint venture company is to modernize, build, and refurbish ports in Cuba and Venezuela. Altogether the value of the agreements was $1.2 billion, which resulted in the formation of 21 joint venture projects.

Bilateral trade has understandably grown rapidly between the two countries as their political ties strengthened. Cuba has clearly decided to use an import substitution approach from abroad, purchasing Venezuelan products through the generous credits extended. Significantly the vast majority of the Venezuelan exporters are small and medium-sized companies with little export experience; they are gaining valuable experience through these sales. In November 2006, there were some 200 companies from Venezuela represented at the 29th Havana International Trade Fair. Joint development projects that had been funded to the tune of $36 million in 2001 had increased even more rapidly to $840 million.

To illustrate this enormous growth more clearly in human terms, one can also cite the Cuban presence in Venezuela: in 2001, there was no Cuban medical cooperation in Venezuela, yet by 2005 there were 23,501 medical staff. In 2006, this had increased to 26,600.[62] By the end of 2007, the number had reached 31,000—with an additional 8,000 Cubans working in other development projects. Although much has been written about the many thousands of Venezuelan patients who have received extensive medical treatment from Cuban medical staff, it is important to remember that it was

only on November 30, 2000, that the first group arrived in Cuba. On that occasion, 46 patients, accompanied by 45 family members or friends, arrived. In 2006, the corresponding figures would be 3,077 and 2,553, for a total since the first flight of 14,539 and 11,675, respectively.[63] As can be seen, both countries had merged development plans significantly since 2000, Cuba providing human capital and Venezuela giving substantial financial support.

A significant part of the cooperation agreement was the participation of Cuban medical staff in Venezuela through the program known as "Misión Barrio Adentro," whose role was to work in the neglected and dangerous barrios of Caracas, as well as in marginalized rural areas, where Venezuelan medical services had traditionally not reached, and where doctors preferred not to go—both because of reasons of safety and because of the limited commercial possibilities. In April 2003, the first Cuban doctors arrived. Speaking in April 2006, Cuban minister of foreign investment and economic collaboration Marta Lomas provided data on both Cuban participation and the results of the massive medical campaign.

In the first stage (Barrio Adentro I), which started in early April 2003, 23,601 Cuban medical personnel participated, providing medical coverage to some 17 million people. By December 2008, there were an estimated 30,000 Cuban medical personnel involved in this process, including 13,000 doctors, 3,000 dentists, 4,100 nurses, and some 10,000 health technicians, working out of 6,500 clinics across the country. Annually, 50 million medical consultations are carried out in Venezuela by Cuban doctors, and over 40,000 lives have been saved.[64] By August 2008, some 308 million consultations had been carried out, including 136,000 home visits by Cuban medical personnel. In Barrio Adentro II, the results of the massive provision of hospital infrastructure were similarly dramatic: 133 Comprehensive Diagnostic Centers (CDC) had been built, as had 171 Comprehensive Rehabilitation Wards (CRW) and 5 High-technology Diagnostic Centers (HDC), distributed throughout Venezuela, while another 300 centers were near completion, together forming a total of 1,235 new medical centers—all built and equipped within a three-year period.[65] To appreciate just how quickly Cuban influence has increased, it is worth noting that 11 months later there were 307 CDC, 406 CRW, and 11 HDC completed.

Cuba has also been providing medical training for Venezuelan students, with over 3,300 being educated in Cuba in May 2006 (over

4,000 in August 2007), and a further 12,940 Venezuelan medical students being supervised in their homeland by 6,525 Cubans through the Barrio Adentro program. By March 2007—again to show how the Cuban presence was expanding—this too had increased. Almost 20,000 students were being trained in Venezuela by Cuban professors working in the Barrio Adentro program, while a further 2,400 Venezuelan medical students were being trained in Cuba.[66] The success of Barrio Adentro was recognized by the Pan American Health Organization in a special report called "Barrio Adentro: A Right to Public Health and Inclusion in Venezuela." It has been presented as an example for other nations, and the report has been translated into several languages. Cuba's successful Operation Miracle ophthalmology program had been employed in Venezuela too, with over 315,000 operations performed by March 2007. (A further 11,950 Venezuelan patients had been operated on in Cuba).[67] Speaking on September 30, 2007, on his weekly radio address, "Aló, Presidente," Chávez took on critics who accused him of giving away Venezuelan oil to Cuba. He noted that the debt incurred by Venezuela as a result of massive Cuban medical cooperation was far more significant: "Those who accuse me of giving away our petroleum to Cuba are fools. If somebody were to count up bolívar by bolívar, cent by cent [the cost of five years of medical service from 30,000 Cubans, they would see that] it is priceless." He concluded: "What in real value is worth more—barrels of oil, or this medical contribution?"[68]

A related program is Barrio Adentro Deportivo, which has seen hundreds of Cuban sports and recreation advisors working in Venezuela. (It is interesting to see that Cuban government media insists upon including them with medical staff, thereby emphasizing their supportive role in promoting health matters and illustrating their integrated approach to public health in general.) An August 2007 report, for example, notes that "Cuba has 6,000 sports trainers and specialists working in Venezuela including sports doctors, paramedics and former top athletes."[69] The objective is to encourage a massive participation of communities throughout the country to engage systematically in physical activity. The program has two goals—to increase physical activity as a means of promoting sports and to support public health initiatives of Cuban medical staff. Indeed, advisors work closely with medical colleagues, seeking to improve the health of communities. Drawing upon their rich experience in Cuba, in terms

of both supporting highly successful athletic skills and promoting well-being through recreational exercise, Cuban sports and recreation specialists have implemented a series of competitive initiatives and health programs with a variety of Venezuelan organizations such as seniors' social clubs, trade unions, and schools. They also work alongside medical colleagues promoting rehabilitation programs for people recovering from injury, and in dance therapy.

Another key component of the Cuban contribution to social development in Venezuela was the literacy program "Yo, sí puedo," which began on July 1, 2003. The objective was to eradicate illiteracy. In October 2005, UNESCO declared Venezuela "Territorio Libre de Analfabetismo" [Illiteracy-Free Territory] after 1,482,543 Venezuelans learned to read and write. Making an important symbolic move, in the following March, Bolivian president Evo Morales, accompanied by the education ministers of Cuba and Venezuela, announced the launching of his own country's literacy campaign, initiated by 20 Venezuelan and 48 Cuban advisors. Meanwhile in Venezuela, Cuban advisors have been busy developing a follow-up program (Misión Robinson II), which started in October 2003, to encourage the newly literate to continue their education until grade 6. In all, some 400 Cubans have been supporting various education-related initiatives in Venezuela.[70]

There are many other ways in which Cuban and Venezuelan government initiatives have been dovetailed, seeking to provide substantial mutual benefits. Security and intelligence services have worked together, with Cuba's formidable service both protecting Chávez and training their Venezuelan counterparts. The large (2 million) reservist force, built to counter a perceived U.S. threat, has also been heavily influenced by Cuba, which for decades has resisted U.S. efforts at "regime change." Several large military delegations from Venezuela have visited the island to learn from their Cuban counterparts. Dozens of joint ventures have been formed by both countries, typical of which is FERROLASA (Empresa para la Infraestructura Ferroviaria S.A.), founded in June 2006 with the objective of building railway equipment for use in Cuba and Venezuela, and also for export throughout Latin America. There are plans afoot to use Cuban expertise to produce ethanol in Venezuela based on sugarcane (this would involve using bagasse, the crushed cane left after the sugar has been extracted).

Of particular importance was the role of Cuban assessors in developing improved agricultural strategies in Venezuela. Indeed, by November 2006, there were 26 joint projects, all involving Cuban technicians and advisors. The assistance was concentrated in small and medium-sized enterprises in areas of water engineering, fishing, and sugar. It had also resulted in the creation of a Center for Technical Assistance to Producers in Venezuela. Of particular importance were courses given by Cuban specialists to some 5,000 Venezuelan farmers.[71]

One of the most unusual examples of Cuban influence over Venezuela has to do with energy conservation, which is quite ironic, since Venezuela sits atop the largest proven oil reserves in the Western Hemisphere and is the world's fifth largest oil exporter. So how can Cuba influence Venezuela in energy use? By taking its energy-saving light bulb campaign to Venezuela, just as it did in the Caribbean. Chávez has apparently been convinced by Castro's arguments that, despite its massive oil reserves, Venezuela needs to conserve more of its energy. The plan, in fact, is to save 12 percent of the domestic energy use by distributing 52 million energy-saving light bulbs. In addition, in another similar approach in the second stage of this environmentally friendly program, Cuba is to construct a series of small electric plants that will provide energy during emergencies.

An area that has only recently been explored is the possibility of closer cultural cooperation. In 2007, a series of 21 Cuban films (including documentaries and cartoons as well as full-length movies) were screened at the Cinemateca Nacional de Venezuela. In April 2007, the prestigious Casa de las Américas cultural institution in Havana (whose annual literary awards are among the most coveted in the Spanish-speaking world) and the Centro de Estudios Latinoamericanos Rómulo Gallegos of Caracas also announced that they would engage in a number of combined cultural projects. Both centers are involved in theater, visual arts, music, literature, and cultural research and also expect to be involved in various literary projects. In a fitting symbolic gesture of shared potential interests, plans were also announced in July 2007 to open a Center for Latin American Political Studies at the former leper colony where Che Guevara served as a doctor during his motorcycle tour of Latin America.

Mention is made throughout the book of the shared vision held by both leaders of a just socioeconomic development model, with the

benefits accrued remaining in "Nuestra América." There is clearly a shared ideological vision of the need for a united action by traditionally ignored countries of the Third World. And both are also bitter critics of the Bush policy around the globe—from Iraq to Mexico. In terms of human rights—areas where Washington usually attacks them—both countries have also criticized U.S. hypocrisy, as seen in the abuse of prisoners at the U.S. Guantánamo detention facility, and in the release of Luis Posada Carriles, a Cuban American who is an admitted terrorist and who escaped from prison in Venezuela in 1985. All attempts to extradite him to Venezuela have been rebuffed by U.S. authorities.

And finally there is the close personal bond between Fidel Castro and Hugo Chávez, one that has grown rapidly in the decade that Chávez has been seeking (and listening to) the counsel of his mentor, described by Chávez as his "reference point in terms of morality, politics, and ideology—in essence a Caesar of both socialism and dignity."[72] It is Chávez who visited Fidel Castro more than any other foreign leader after Castro became ill in the summer of 2007, and he also maintained contact through frequent phone calls. In the personalistic world of Latin American politics, this connection is enormously important. Chávez and Castro probably see the Venezuelan as the heir apparent to the mantle of regional anti-imperialism, and it is clear that they share remarkably similar views. Ian James has summarized this well: "Castro and Chávez are united by what they call a crusade against U.S. dominance of Latin America and unbridled capitalism that is driving the world to ruin. A personal connection feeds their ideological closeness."[73]

Chávez visited Castro in 1994 after being released from a Venezuelan prison following his failed coup attempt. After winning the Venezuelan presidency in 1998, he sought the advice of his mentor. At Castro's bedside in Cuba later, Chávez lovingly grasped the hand of the man he says he sees as a father. "He's like the father of all the revolutionaries of our America. He's the lighthouse that lights the paths.' "[74] It is significant that Chávez has been a frequent visitor to the ailing Cuban president and that he speaks fondly of Castro as a father figure, a mentor, an inspiration. While the relationship with Raúl Castro, who took over as president in February 2008, does not exhibit the same "chemistry," it is abundantly clear that there is tremendous mutual respect between the leadership of both countries.

No change in the extremely close ties between the two countries is expected.

Venezuela-Cuba: A Cost-Benefit Analysis

How has Venezuela benefitted from its increasingly close ties with Cuba? In socioeconomic terms, the relationship has contributed to the realization of the benefits flowing from a massive redistribution of oil wealth, admittedly inflated by windfall profits. But it is significant to note that for decades Venezuela has also been awash in petrodollars—and yet most Venezuelans have received few benefits from that natural wealth. By contrast Chávez has sought to use those funds to buy services designed to benefit his society as a whole and not just the elite. He had been elected promising sweeping social reforms and offered a series of innovative social reform programs (known as "missions"), but he lacked the professional staff to deliver these ambitious strategies. The cheapest way to obtain better health care and education for the masses who elected him is with Cuban human capital—hence the large presence of Cuban professionals. In the short term, this has resulted in some 40,000 Cubans working in Venezuela (almost one-quarter of Cuba's sizeable medical force), with over 35,000 Venezuelans in Cuban universities and colleges, including 4,000 who are studying medicine. In subsequent years, if the political system and the bilateral relationship remain intact, this will result in a new generation of professionals in Venezuela trained in Cuba and capable of providing substantial socioeconomic benefits to their people.

In terms of immediate improvements, more than a million Venezuelans have learned to read and write, with tens of thousands of lives saved, as this section has illustrated—not a bad list of gains. The value of this Cuban contribution to the development and well-being of Venezuela should not be underestimated, as one observer has noted with insight.[75] Writing for the *Financial Times*, Marc Frank has clearly outlined the benefits received by Venezuela: "Venezuela received an instant free healthcare system from Cuba that would have taken tens of billions of dollars to build, and educational resources to help Mr. Chávez keep his promise to teach every citizen to read and write."[76] In addition, the Venezuelan government claims that the massive medical reform programs introduced with Cuba have resulted

in 86,000 lives being saved. Certainly there is no doubt that access to public health for the population—especially for the urban poor and rural communities—has improved enormously.

Cuba, too, receives tremendous benefits—not the least of which is the stable supply of oil, at heavily subsidized prices. The guarantee of almost 100,000 barrels daily of petroleum to Cuba is extremely important for the island. There are preferential terms for the sale to Cuba and deferred payment options (similar to those for other countries in the region, according to the generous PetroCaribe accords).[77] In addition, Venezuela has purchased a 49 percent interest in updating the oil refinery in Cienfuegos (which came on stream in December 2007 with an initial output of 65,000 barrels per day) and is also working with the Cuban petroleum agency (CUPET) in the active exploration of oil. The heavily subsidized oil results in an estimated saving of $2 billion, according to the *Miami Herald*.[78] Over the last seven years, oil prices have increased from $20 to over $120 a barrel, with Cuba being sheltered from the shock of this increase by preferential pricing. It is estimated that Cuba pays $27 per barrel, which results in a significant saving. In the same newspaper report, U.S. academic Susan Kaufman Purcell is quoted as saying, "It looks like Chávez has a stranglehold on what's going to happen in Cuba [...] Cuba is dependent on him." This is too simplistic.[79]

In actual fact, both countries receive substantial benefits from the current arrangement, as we have tried to show. Clearly the most important aspect is the delivery of medical care to the Venezuelan population—particularly to those sectors that in the past were marginalized, and generally ignored. The national medical association of Venezuela has criticized the role of Cuban medical staff, claiming that the Cubans are taking their jobs. This misses the point, however, about the contribution of the Cuban medical staff, who receive salaries that are far lower than those of their Venezuelan counterparts and work in areas where most Venezuelan doctors prefer not to. Moreover, it is important to remember that the Cubans generally work in the slums, marginalized areas, and neglected rural zones—places where Venezuelan doctors generally prefer not to work).[80]

There are two schools of thought about the costs and benefits of the strategic alliance between Cuba and Venezuela. A commonly held view is that expressed succinctly by a Venezuelan political analyst

that "It's a replay of what the Soviet Union was doing," while Hans de Salas-del Valle, a colleague at the University of Miami's Cuba Transition Project, maintains that "Raúl will run the country . . . but Chávez holds enormous leverage."[81] Writing in the *Los Angeles Times*, Daniel Erikson emphasized how Chávez is indeed a hero in Cuba. Over the last seven years he has become Castro's key economic benefactor and political partner. As a result, goes one perspective, Caracas pays the bills and sets the policy—much like Moscow did. Indeed, back in Venezuela, some opponents have painted their president as a man who has given away untold wealth to Cuba, a claim rejected outright by Chávez: "Cuba pays us for the oil in different ways, and I can assure you of something. If anyone calculated to the last cent what Cuba spends and invests in helping Venezuela, I am sure that, cent to cent, this has cost a value much greater than the oil we send."[82]

In essence, Chávez is correct and the reality is somewhat different from the views expressed in the Cuba Transition Project report, whose basic thesis is mistaken. In the first place, while Cuba did receive generous subsidies from the Soviet Union for almost 30 years, a study of its foreign policy shows an extremely independent approach to international relations—as can be seen from its role in Angola and Nicaragua, for example. Moreover, both observers vastly underestimate Cuban political culture. For, although appreciation for Venezuelan solidarity is clear and although the economic advantages are manifest, Havana sees the current relationship as one of equals.[83] The medical services provided by Cuba—serving 17 million Venezuelans—alone represent an enormous gain by Venezuela. In terms of political and ideological interests, it is also abundantly clear that there is much affinity between the two governments. This was never the case with the Soviet Union, where relations were often extremely strained.

In addition, both see the commercial relationship as one to be taken advantage of jointly—without winners and losers. Moreover the revolutionary government maintains that the bilateral relationship is based upon converging interests. Indeed, Felipe Pérez Roque, the former minister of foreign relations, has categorically denied the thesis that Cuba would collapse without Venezuelan oil. The Cuban revolution had survived for a whole decade before the first agreement with Venezuela was signed and it was already making economic

headway. In addition, Cuba's cooperation has also been decisive for Venezuela's own development:

> Cuba has sent 30,000 health care workers and doctors, as well as teachers to eradicate illiteracy—all for free. We share with Chávez a very close alliance, based on common values, objectives that we both aspire to, and similar visions of foreign policy. This relationship, however, is not based upon the influence or power of Chávez. He respects us, and vice versa.[84]

Behind the commercial arrangements, the large Cuban presence in Venezuela, and the extensive financial support for Cuba, lies an ideological affinity of Chávez and both Castro brothers, who see the shared destiny of their countries united in their struggle to provide a Latin American alternative to U.S. hegemony. Chávez alluded to this in an emotional speech in January 2007, following the signing of a number of joint venture agreements. He expressed his joy at the success of the bilateral negotiations:

> In the name of both our peoples, which in essence is one and the same, and in the name of both our governments—which is basically the same one too—I wish to congratulate the ministers and comrades for this intensive, productive mission to which you have contributed. We have made major advances in our efforts, which go far beyond any form of integration, union or strategic alliance between Cuba and Venezuela.[85]

Between the two countries, there is clearly a profoundly held, shared political view on the future of Latin America, something that cannot be quantified or in any way likened simplistically to Cuban and Soviet strategic interests.[86] This can be seen in speeches of both leaders, typical of which was the conclusion of the final speech of Chávez (in November 27, 2006) before his reelection as president. He claimed that he would win the election and dedicated it both to the Venezuelan people and "to Cuba, some 50 years after the landing of the Granma on the Cuban coast on December 2 of 1956, on a mission led by Fidel Castro."[87] Both seek to break U.S. hegemony, showing that it is possible for Latin America to manage its own destiny and to develop foreign relations without fear of punitive action.[88]

This campaign had been led for four decades by Fidel Castro, who has defied the odds and survived despite constant pressure from

Washington. Hugo Chávez's election and subsequent reelections have strengthened the alliance, allowing both leaders to cast their gaze further afield to Latin America. The election of several left-of-center presidents (in particular Evo Morales and Daniel Ortega) has allowed them to dream of developing an "axis of good" (as opposed to the term "axis of evil" used by George W. Bush), supporting substantial development projects in Bolivia and Nicaragua, with other smaller projects funded in several other countries in the Caribbean and South America.

The birth of ALBA in 2004 has been particularly helpful, providing a viable alternative to the Free Trade Area of the Americas promoted by Washington; the "Bolivarian" alternative has clearly made headway in the region. Speaking in the fall of 2005, the then Cuban vice president Carlos Lage summarized this partnership of equals in a speech in Caracas in which he stated bluntly: "We have two presidents: Fidel and Chávez."[89] For his part, in June 2006 the Venezuelan president made clear his own view of the unity between the two countries: "We are totally committed to this process. Our two peoples are in fact the same one. We stand together, embracing each other before the gaze of history, each respecting the other's sovereignty. And this is true to such an extent that, as we have said before, if it should ever occur to anybody to invade Cuba, Venezuelan blood will also flow"[90]

Concluding Remarks

There are tens of thousands of Cuban medical workers around the globe—literally from A to Z, from Antigua to Zimbabwe—making an enormous difference for humanity. In all, they are working in some six dozen countries, an extraordinary contribution. A story from Zimbabwe in April 2008 makes the point that a provincial hospital "has received a major boost after getting three medical doctors from Cuba."[91] At first glance this appears of limited relevance: after all, what importance is such a small number of doctors? The hospital, it turns out, has only four doctors instead of the required complement of 25, so the Cubans (who replace three Cuban doctors returning to Havana) make a major difference in these circumstances. Yet whether it be three doctors in provincial Zimbabwe or 30,000 medical personnel in Venezuela, the Cuban medical staff has made an exceptional difference around the globe. The emergency response brigade of

Cuban medics to Chile in 1960, a spontaneous reaction in the face of a burgeoning disaster, has, in fact, set the tone for almost five decades of cooperation, human solidarity, and extraordinary diplomatic success. And it is in the Americas that Cuba has focused its energy. Rare indeed is the country in this hemisphere that has not benefitted from the Cuban experience, as this chapter has sought to show.

In fact, from 1960 to the present, Havana has shamed the industrialized world through the extent of its humanitarianism. Put simply, no country or organization, no matter how wealthy or powerful, can match Cuba's record in this regard. The results are stunning—with literally millions of lives saved in the hemisphere. In countries such as Venezuela, Bolivia, and Nicaragua that have leftist governments, it is understandable that socialist Cuba would assist political allies. But that argument cannot be made for many, many others—such as Somoza's Nicaragua, or indeed modern-day Peru. The Cuban medical contribution has had a major impact in winning over former opponents. The cases of Guatemala and Honduras illustrate this well. Indeed, speaking during his first visit to Havana in October 2007 (significantly at ELAM), Honduran president Zelaya summarized the importance of the normalization of relations between his country and Cuba: "This visit to Cuba breaks a 40-year period during which we had become distant from the apostle, José Martí." For his part, Haitian president René Préval agreed that the Cuban medical assistance has also proved exemplary: the 400 doctors who had been there for the past five years had seen 8 million patients and had performed 100,000 operations. They had also trained at no cost some 600 Haitian medical students, reduced infant mortality from 80 to 28 per 1,000 live births, and had saved an estimated 100,000 lives. His moving summary of their contribution can be taken to reflect their work throughout the hemisphere: "After God come the Cuban doctors."[92] Many countries in the hemisphere would agree.

Chapter 6

Toward an Understanding of Cuban Medical Internationalism

Of all the so-called developing nations, Cuba has by far the best health system. And their outreach program to other countries is unequaled anywhere.

President Jimmy Carter, interviewed in "Salud"

The facts are clear and speak for themselves. Indeed, any one of the following highlights of Cuban medical internationalism could be seen as being a truly exceptional example of international solidarity: 23,000 children, victims of the Chernobyl nuclear meltdown, have been and continue to be treated in the Tarará beach resort outside Havana; 1.5 million people in Latin America, Africa, and the Caribbean have had their eyesight restored through Operation Miracle; tens of thousands of victims of natural disasters have been treated by extensive emergency medical missions—from Pakistan to Peru; some 9,000 students from the developing world are studying (at no cost) to become doctors at the Escuela Latinoamericana de Medicina, and 50,000 other medical students are currently being trained in Cuba through an alternative medical curriculum; medical schools with Cuban cooperation have been established in Yemen (1976), Guyana (1984), Ethiopia (1984), Uganda (1986), Ghana (1991), Gambia (2000), Equatorial Guinea (2000), Haiti (2001) Guinea Bissau (2004), and East Timor (2005); and finally tens of thousands of Cuban doctors have saved countless lives in dozens of countries since 1960. Indeed, by 2008, Cuban medical staff were caring for over 70 million people in the world and in some countries—such as in Haiti—practically the entire population. This multifaceted

contribution undoubtedly reaches more people than the work of all of the G-8 countries together, as well as that of the World Health Organization (WHO) and Nobel Peace Prize recipient Médecins sans Frontieres (MSF). Each one of these Cuban initiatives puts the industrialized world to shame and, sadly, the extraordinary value of this Cuban contribution to humanity has been badly ignored by Western media. The obvious question to be asked about this five-decade long approach to medical internationalism is: why does Cuba pursue this approach?

Rationale for Cuban Medical Internationalism: Misreading the Tea Leaves

It would be easy to discount Cuba's approach as being selfish and claim that the revolutionary government was pursuing this mission as a means of selling its pharmaceutical products abroad (the island produces approximately 83 percent of the medications used domestically). Anybody who has seen the controversial Michael Moore documentary *Sicko* will understand that medicine in Cuba is extremely cheap, particularly if compared with similar products in North America. (Cubans would argue that this is a fair price and that consumers in the "developed" world are being exploited by powerful multinational pharmaceutical companies). It could be argued, therefore, that Cuba was seeking to develop a market for its products abroad through the good services of its medical staff. This argument is strengthened by the fact that since 2005 the export of medical goods and services has brought in more money to the national coffers than the two major industries of tourism or nickel. Indeed it was recently estimated that the sale of medical services brings in between $5 and 6 billion annually.[1] What is missed in the analysis, however, is that medical services (money paid for the work of doctors, nurses, and related professions) by far make up the major component of this income—particularly the compensation paid by Venezuela for Cuban medical services there. The sale of actual medicines generated $162 million in 2006, compared with the $237 million for sugar and sugar by-products, $257 million for tobacco products, and $1.4 billion for nickel.[2] There is no doubt that Cuba has exceptional potential to export its pharmaceutical products, and the sophisticated technical level of work being carried out at a dozen research institutes (all with state-of-the-art

equipment mainly imported from Japan and Europe) in Havana's "polo científico" (science research area) illustrates this well. That said, it is significant that the countries where Cuban medical staff work are usually obliged by their contracts to provide the medicines used—which mainly means buying U.S. or European products on the international market. There may well be large sales of pharmaceutical products abroad when a normalization of relations with Washington occurs, but until then Cuba's international market share, although growing, is still relatively small.

There are other bizarre suggestions to explain Cuban medical internationalism. Linda Robinson, for example, offers the suggestion that medical internationalism is merely an expression of the messianic personality of Fidel Castro. She even likens him to the mad scientist Dr. Moreau, invented by H.G. Wells, and notes: "Cuba's attempt to leapfrog the natural chain of technological advancement reflects both its long isolation from outside investment and Castro's ego. His avid interest in medicine—and his belief that Cuba can play in the big leagues of science—has led him to personally direct many of the ventures."[3] Writing in the *Miami Herald*, Christopher Marquis also provides a simplistic suggestion, seeing medical internationalism as a blatant attempt to co-opt neighbors to accept Marxism: "After relying for decades on guerrillas and guns to export his Marxist model, Cuban president Fidel Castro has found another tool: 'doctor diplomacy.' "[4] He adds that this is all a part of a deliberate tactical ploy on the part of the Cuban leader "to inoculate himself from further regional attacks and play the humanitarian in a part of the world where Washington has slashed economic aid in recent years." While recipients of Cuban medical support will undoubtedly be appreciative of Havana's cooperation, there is no evidence to suggest that spreading the revolutionary Gospel is an objective.

Julie Feinsilver, who has studied the issue in depth, has noted accurately the "symbolic capital" that has resulted from Havana's medical diplomacy: "because good health is necessary for personal well-being as well as societal development, the positive impact of Cuba's medical aid to other countries has greatly improved both its bilateral relations with those countries as well as its standing and support in a number of multilateral forums."[5] Where we disagree with her analysis is the importance that she attributes to the by-products of this Cuban approach—the conversion of symbolic capital into material

credit. While this may be true in some cases, we believe that in fact the explanation for Cuba's extraordinary medical internationalism is rather more complex, with a variety of important factors at play.

Diplomacy (and Humanitarian Internationalism) at Work

There is no doubt that Cuba's policy of medical internationalism has brought tremendous diplomatic benefits for the island. The cases of Guatemala and Honduras illustrate well the argument. In the wake of the devastation of Hurricane Mitch in 1998, Cuba sent hundreds of medical staff to the region. Guatemala normalized diplomatic relations with Cuba that same year, while Honduran president Carlos Flores did so shortly before leaving office in 2002, and bilateral relations have expanded with both countries. Since that time the presidents of both countries have visited Cuba and expressed their appreciation for extensive Cuban support—support that continues to this day. It is greatly appreciated in revolutionary Cuba, which has sought to reengage in the Western Hemisphere, particularly since the collapse of the Soviet Union. Indeed in Havana, the importance of the direct relationship between medical cooperation and diplomacy for the government can be clearly seen in the official media. Often, for example, on the occasion of a dignitary from a developing country visiting Cuba, the local press provides a rather simplistic juxtaposition of the state of bilateral relations, annual trade figures, the number of Cuban cooperants in the country, number of students from that country who are studying (usually medicine) in Cuba, and the level of diplomatic support provided to Cuba by the recipient nation in international fora.[6] Clearly, then, from Havana's perspective, medical cooperation on the part of Cuba *is* indeed a significant aspect of Cuban diplomacy.

Toward the end of chapter 1, there is a series of questions on which we have based the structure of this book. In essence, they boil down to an analysis of the interplay between the ideological basis of the revolutionary process on the one hand and the Cuban foreign policy (with medical internationalism as a key element of that process) on the other. These two themes are in many ways complementary. The case of Bolivia, examined in some detail in chapter 5, illustrates this phenomenon well, since we see the concept of international proletarianism (support for the socialist government of Evo Morales,

clearly under attack by Washington) combined with Havana's continued interest in uniting the countries of what José Martí termed "Nuestra América," or "our (Latin) America." The case of oil-rich Venezuela is an extension of this relationship, since again we see a socialist and nationalistic government—the object of tremendous opposition from the U.S. government—badly in need of improved social services in order to prove to the population that the Chávez government cares for them. It goes without saying that the oil wealth of the Caracas government has been an enormous boon for domestic and international policy in Havana, as the section on Cuba-Venezuela ties in chapter 5 illustrates. Without it, the extent of Cuba's medical internationalism would undoubtedly have been far less—particularly in Venezuela where the greatest number of Cuban medical workers abroad are stationed. At the same time, there was already a large medical internationalism program started decades before the election of Hugo Chávez—even during the worst days of the "Special Period"—and so it seems logical that, with or without Venezuelan support, this would have continued.

But in many cases, it is not that simple. In some instances, Cuba provides medical assistance to wealthier countries (such as Qatar), where these factors are clearly not pertinent. It is a wholly different form of internationalist cooperation—but it is still cooperation (since the cost of medical services is significantly less than it would be if medical staff were contracted from other countries), although, of course, international politics are still a key factor. In late April 2008, for instance, the Emir of Qatar was in Havana, where he met with President Raúl Castro. Cuban media outlined the usual details of the ties: bilateral relations ("based on the strictest respect for sovereignty and independence") were established in 1989; Qatar maintained a progressive political stance, with both countries agreeing on the role of the UN, particularly in matters pertaining to Arab countries; the Qatar government had consistently supported Cuba in UN resolutions; both were members of the Non-aligned Movement; and there were 22 Cuban medical professionals working in the emirate.[7] It is worth noting that the Emir was met at the airport by Marta Lomas, minister for foreign investment and economic cooperation, her presence highlighting the principal goals of the mission—investment and cooperation. Two agreements were signed during the state visit—one that called for a new hospital in the town of Dukhan to be entirely

staffed by Cuban doctors, while the other detailed a joint venture between a Qatari group and its Cuban counterpart to build hotels in Cuba. In this case, proletarian internationalism clearly does not factor into the analysis; rather, a combination of medical internationalism, mutually beneficial economic benefits, and enhanced diplomatic relations were the result.

The example of Qatar (and a handful of other, generally wealthier countries) is the exception, however, and is included mainly to illustrate the wide variety of forms that medical cooperation can take. Far more common is the heavily subsidized medical internationalism that Cuba provides to the developing and underdeveloped world, and where the key factor for Havana's involvement is a pressing need for humanitarian help in a poor country—not proletarian solidarity, much less honest lucre. Indeed there are many more countries where neither financial gain nor shared revolutionary ideals can explain Cuban involvement. This can be seen, for example, in many of the African countries referred to in chapter 4, particularly those in sub-Saharan Africa, the poorest area in the world. South Africa, for example, began importing Cuban doctors in 1996, and within two years there were 400 in the townships and rural areas. By 2004, there were over 1,200 Cuban doctors in Africa.[8] In Mozambique, fully 40 percent of doctors are Cuban.[9] In a January 2008 lecture at London Metropolitan University, Margaret Blunden outlined the significant challenge to neoliberalism presented by the Cuban public health model.[10] This is seen clearly in sub-Saharan Africa, an area that has 10 percent of the world's population, but only 1 percent of its doctors (usually concentrated in larger cities), and only 4 percent of its medical schools (which, with the exception of the Cuban cooperative schools, follow traditional Western approaches). There is a large salary gap between those doctors working in private practice and those working for the state (even in post-apartheid South Africa, 60 percent of doctors work in private practice). There is also massive migration of doctors—a physician in South Africa can earn up to 20 times his/her salary in Sierra Leone, while doctors in the U.K. earn 10 times the salary of their Malawi counterparts. This "brain drain" is extremely noticeable in sub-Saharan Africa—more than 60 percent of doctors trained there have fled, the worst example being Zambia, where only 50 of the 600 doctors trained since independence remain.

The case of Gambia is interesting, since in terms of the "typical" countries in which Cuban medical assistance is found, this is a good example of the approach employed. It is a small African country of 1.4 million inhabitants, a British colony until its independence in 1987. In the 2004 Human Development Index, it ranked 155 of 177 countries. Seven years after independence, the capital city had only four doctors per 100,000 people, with an infant mortality rate of 100 per 1,000 live births. Life expectancy was just 49, with malaria being the major killer.[11] Following a request for support from the Gambian government, in May 1996 a Cuban medical team of 22 arrived there and were assigned to several hospitals. Three years later the Gambian president requested greater medical cooperation from Cuba, and plans were drawn up to build a medical school in order to train doctors locally. That year nine teachers from Cuban medical institutes arrived to set up a six-year program based upon the Cuban pedagogical model and local conditions. At present, there are 20 Cuban medical professors in Gambia.[12] A study of the curriculum shows the Cuban insistence on primary health care and community health, which are taught throughout the academic program, while both community work and disaster preparedness are also obligatory.[13] In 2005, the first Gambian doctors—12 in all—graduated. That same year, there were 20 students in premedicine, 34 in first year, 18 in second year, 6 in third year, 16 in fifth year, and 15 in the final year, in all 109 future doctors for Gambia. So, in addition to the Cuban doctors who are serving in the Comprehensive Medical Program, the Cubans are also focused on teaching the Gambians to help themselves. This is seen most clearly in the new model of medical training, soon to start. In all, 43 Gambian students have been selected to work with Cuban doctors (on a 3 to 1 basis), to train as community doctors in a "hands-on" approach. This follows a Cuban proposal that will see four teaching units established in different areas of Gambia. They will be assisted by 20 young Gambians who are currently in Cuba studying Health Technology.[14] The objective is to establish a sustainable health system, with the supervision and initial influence coming from Cuba in response to a request from the Gambian government. Ultimately, however, it is expected that the Gambians will take over the direction of the system, allowing Cuban medical staff to be redeployed where they are needed more urgently.

One of the keystones of the public health system in Cuba is the preventive approach of health care—and this is seen in the Cuban strategy of eradicating the principal killer in Gambia: malaria (traditionally responsible for 40 percent of hospital deaths of children and pregnant women). Cuba has not had a major malaria outbreak since 1967 but does have extensive experience with dengue and uses similar strategies to eradicate the mosquitoes that cause both forms of epidemics. In 2000, a team of Cuban specialists was invited by Gambia's president to visit the country and provide advice. Working with others, they participated in reinforcing the National Malaria Control Program in several key initiatives. For example, a Cuban biolarvicide is widely used, Cubans set up a National Reference Library for clinical and laboratory research and provided extensive training (including a semester of medical entomology for nursing, public health, and medical students). Finally, the 145 Cuban doctors serving there (mainly as family doctors) play an important role, given their distribution in a primary care role throughout the country—since previously most deaths had occurred at home or on the way to the (few) hospitals in rural areas. It is worth noting that, as a result of these concerted efforts, the number of malaria cases dropped from almost 600,000 in 2002 to 200,000 in 2004.[15] At present, the 145 Cuban doctors in Gambia are working in 4 hospitals, and 7 health centers in as many villages. In addition to the 20 professors at the Medical School, there are others who are advisors in the national programs to combat malaria, TB, and HIV/AIDS, and also in the Ministry of Health. The essence of the Cuban presence in this small, poor country is a combination of pragmatism and a determination to ensure a sustainable healthcare model—the hallmark of Havana's medical internationalism strategy. Enhanced diplomacy is, of course, a welcome by-product of the Cuban involvement—but it is not the primary goal in the case of Gambia.

Several thousands of miles away is the case of another small country, East Timor (Pop. 1.2 million), which mirrors many aspects of the approach used in Gambia and, in particular, reveals Cuba's ongoing interest in public health sustainability. One of Asia's poorest countries, it finally became fully independent in 2002 after some 450 years of occupation by, for most of that time, Portugal and subsequently by Indonesia. In 1999, only 35 physicians remained after violence displaced most of the population. Cuba has provided medical cooperation

since 2002, initially sending medical staff and subsequently educating young students from that country. At present, there are 269 Cubans working in East Timor—some 234 of whom are providing medical assistance, while 35 are involved in the Cuban literacy program "Yo, sí puedo." Perhaps most useful, however, is the fact that Cuban medical professors are, as in Gambia, teaching students from East Timor to take over from them in delivering public health services. In May 2008, for example, there were an astonishing 689 students in Cuba and a further 148 training at the Faculty of Medicine in East Timor—all, of course, at no cost to the students.[16] The Cuban medical staff, since beginning work in the country, has reduced infant mortality rates by 50 percent, and has provided more than 2 million consultations. It is an enviable record.

Common to the cases in both Gambia and East Timor is the need for a sustainable public health system. Doctors had not been trained in these countries before: instead they were largely educated in the West, where—as in the case of Africa—they tended to stay, drawn by substantially higher salaries. Yet under the Cuban plan, instead of a "brain drain" there is now a "brain gain." Two different approaches have been used by Cuba in the training of medical personnel. After first sending local students to Cuba to train medical staff, the focus has now switched to using Cuban medical professors and doctors to train medical students at home. Small medical faculties have been organized and designed to produce sufficient numbers of doctors, nurses, and medical technicians in East Timor. Significantly those chosen to study these careers are from poor backgrounds and underserved areas—students who all their lives have witnessed shortages of medical services and are fully aware of living in difficult economic conditions. They understand fully well the challenges facing "their" people who previously were ignored. As a result, they are much more likely to remain in their country and to contribute to the well-being of their fellow citizens. The essence of this practical, hands-on Cuban approach being employed throughout the country has been summarized well: "We are returning to the tutorial system [. . .] supplemented by information technologies and other teaching aids, so that students from low-income families can go be educated in classrooms and clinics in their own communities, where their services are so sorely needed."[17] How can such a massive outlay of Cuban medical expertise and human capital be explained by claiming that Cuba is merely

playing politics, seeking East Timor's vote at the U.N? Surely this could be obtained—if this were the primary goal—in a much more economical fashion. It is abundantly clear that in many cases diplomatic concerns are not the major reason behind such extensive medical cooperation—with a combination of basic humanitarianism and international solidarity appearing an extremely important element in the explanation of this extraordinary medical cooperation program.

An area that also needs to be considered in assessing Cuba's medical internationalism is its response to natural catastrophes and emergencies. We have mentioned Cuba's offer of some 1,500 medical personnel in the aftermath of Hurricane Katrina in New Orleans. But there are several other disasters where the Henry Reeve Emergency Brigade (named after a U.S. volunteer in the Cuban war of independence in 1898) has responded. Cuba is probably the only country in the world with such a large medical emergency response corps on standby. The largest deployment came in Pakistan, following a massive earthquake in October 2005 that killed 75,000, injured 120,000, and left 3.3 million homeless. Cuban medical staff arrived six days later and stayed for six months, working in 44 locations. During that time, they cared for over a million people and performed 12,400 operations. Again they were determined to ensure that a sustainable model was kept, and so they donated the fully equipped field hospitals that they had set up (32) and offered 1,000 medical scholarships to children of the region to study medicine in Cuba.[18] In addition, in August 2008, when a major earthquake occurred in China's Sichuan province, Cuban medical staff, together with 4.5 tons of medical equipment, was among the first batch of international doctors and paramedics to be deployed there.

As can be observed, seeking a simple and straightforward rationale for Cuba's medical internationalism is no easy matter. It *is,* of course, clear that the furthering of Cuba's diplomatic goals—particularly in the developing and underdeveloped world—is of paramount importance. Both the revolutionary government and the administrations in the countries where Cuban *internacionalistas* work are fully aware of this connection. Indeed, as the foreign minister of East Timor, Zacarías Albano de Costa, noted in Cuba in May 2008: "We are a small nation. But our vote [at the UN] is worth the same as that of a large country. We shall continue supporting Cuba in international fora."[19] Understandably this is music to the ears of government

ministers in Havana. In an interview with the authors in May 2007, we bluntly asked Deputy Minister Jiménez whether it was true that medical internationalism was carried out solely to garner international diplomatic support. Her response was provocative indeed: "Even taking the most cynical view, namely that Cuba is sending doctors abroad to poor countries in order to win votes at the UN, why doesn't the industrialized world do something similar? Surely the most important thing is to save lives. That is precisely what our policy is doing."[20] Her challenge, sadly, is yet to be taken up by the First World.

Clearly Cuba has benefitted substantially from the successful medical internationalism program in terms of developing its foreign policy, its main contribution being to enhance the Revolution's international stature and thereby its potential soft power (see chapter 1 on international stature as a key Cuban national interest). It is important to bear in mind that the massive medical cooperation program is housed in the Ministry of Foreign Affairs and is headed significantly by a deputy minister (and medical doctor), Dr. Yiliam Jiménez. She is extremely clear about the role of the program, which she describes as "an integral part of Cuban politics [...] Our goal is to develop solidarity bridges with African, Caribbean and Latin American countries," concluding, "We believe this is the best diplomacy we can develop."[21] The fundamental goal could not be explained any more clearly—and it has been remarkably successful. Indeed, even the most skeptical critic cannot help but be impressed by Cuban development assistance (significantly termed "cooperation" and not the more paternalistic "aid" to which the West refers) and the strategic alliances that it has created. The exceptionally high diplomatic profile of Cuba in the Third World and the support for Havana in international fora constitute eloquent testimony of the success of this approach. In terms of Central America, the 180 degree change in positions of the governments of Guatemala and Honduras (and indeed most of the Caribbean nations) is extraordinary. And, while it is difficult to see this normalization of relations in the last five years as solely the result of Cuban medical internationalism, there is no doubt that it has indeed been the principal factor in this development. Speaking in November 2006, Prime Minister Perry Christie of the Bahamas revealed how he had been influenced by Cuba's medical assistance, even to the extent of criticizing U.S. leaders: "I sat with the president of the United States of America [George W. Bush] and I bared my soul to him honestly and frankly [...] I sat

with [U.S. secretary of state] Condoleezza Rice and before officials of my country and I bared my soul to her. They all understood that I represent people, 1500 of whom without my intervention go every year looking for medical care in Cuba."[22] The open and frank criticism of Canadian prime minister Stephen Harper by his Barbadian counterpart when he criticized Cuba (unthinkable a decade ago) also illustrates the degree of support for Havana.[23] In sum, a solid case can be made that "soft power" a la cubana has been extremely successful in winning support for Havana.

As an extension of this respect for Cuba's humanitarian zeal and successful social programs in the Caribbean and Latin America, it is also interesting to see many countries resisting pressure from Washington to criticize Cuba. In the past, smaller countries could be encouraged, co-opted, or bullied into accepting Washington's pressure at the United Nations—either in the General Assembly or in the Human Rights Commission. For many countries of the region, those days are past—as can be seen in the evolution of the annual UN General Assembly vote on the U.S. embargo on Cuba. Put simply, many nations of Latin America and the Caribbean were disturbed by the Bush administration's studied neglect and widespread ignorance of the region as well as its emphasis on selective military support. More importantly perhaps, many have lost their fear of criticizing Washington. It, of course, remains to be seen which new directions in regional foreign policy will be pursued by the Obama administration.

In sum, it is clear that Cuba's medical internationalism throughout the world has been extremely successful on many levels. It has won the support of many erstwhile critics and in doing so has significantly reduced U.S. influence. The offer of some 1,200 Cuban doctors to assist the United States after Hurricane Katrina in 2005 (and, sadly, the rejection of medical assistance by the Bush White House) speaks volumes for the international stature achieved by this approach. Assisted by the converging interests of Hugo Chávez in Venezuela, and the rise of almost a dozen leftist governments in the region, Cuba's profile has risen as a sense of regional identity and the need for an alternative development model have fortuitously coincided at an intriguing conjuncture. In all of this process, the stated goals of Deputy Minister Jiménez would appear to have been remarkably successful.

At the same time, it is important to emphasize again the fact that Cuban medical internationalism is *not used solely to score political points abroad*. In other words, while its employment is crucially important, there are several other reasons to explain its success. The medical assistance provided to Chile and Algeria nearly five decades ago, as well as that given to Somoza's Nicaragua a decade later and that offered to Washington following Hurricane Katrina's destruction in New Orleans—as well as a dozen other such cases—all definitely include political interests, but they also reflect genuine humanitarian goals. South-South cooperation thus cannot be discounted as a major goal of the medical cooperation. What we see, therefore, is a case of converging interests rather than any simplistic political tactic—with the fundamental goal of providing humanitarian support where needed. Be it sending over 2,500 medical staff to Pakistan after a massive earthquake or a smaller contingent to Veracruz after the Mexican state was flooded in 2007, the goals are the same. On the one hand, the missions reflect Cuba's standing as a major international power (and, of course, win the respect of the country in need), while on the other, they employ in a selfless way their imposing human capital. Cuba is in the fortuitous situation of having an excellent public health system (with approximately 70,000 doctors), and its 21 medical faculties produce some 2,860 doctors every year. This represents an enviable doctor-patient ratio—with the possibility of sending a quarter of this professional workforce abroad without compromising seriously the delivery of health care in Cuba. As a result, while a quarter of the medical staff is away on internationalist missions, the patient-doctor ratio and—more important—the wide and uniform distribution of the staff throughout the country continue to guarantee excellent medical attention in Cuba. In sum, pursuing and strengthening international alliances is indeed a key factor of this policy—but so too is a genuine spirit of human solidarity. As such, the analytical dynamics involved here do not revolve around making a sharp distinction between some sort of rigid hierarchical prioritization regarding state humanitarianism and status/soft power concerns. Instead, they need to be seen as complementary and mutually reinforcing; in particular, humanitarian policies tend to generate the moral authority from which soft power flows, while soft power's need for moral authority tends to promote and strengthen a dedication to humanitarian endeavors. These two considerations of medical internationalism do not, in other words,

function as disparate policy-shaping variables but are rather inextricably intertwined as two sides of the same medical cooperation coin that can also (as noted in the concluding section of chapter 3) contribute to Cuba's interest in enhancing its effective sovereignty.

It is not, however, fashionable in many foreign policy circles to speak about humanitarian interests, since in the industrialized world we have been conditioned to seek an "angle" to explain apparently selfless intervention. In addition, we are exposed to the philosophical tenets of the U.S. medical system, an excellent example of capitalism at work—with altruism usually being conveniently shuffled off the balance sheets. As a result, we react with skepticism at Cuba's medical internationalism—largely because it is often not in our lexicon. We simply don't understand it. The fact that access to public health is guaranteed in the Cuban Constitution as a human right for all citizens, regardless of income, social standing, or geographic location, is difficult to grasp—as is the lack of any private insurance plan. (It is significant that, despite the United States spending almost 20 times more per capita on health care than Cuba does, U.S. figures for life expectancy, infant mortality, and the probability of dying before the age of five are worse than those of Cuba, according to the World Health Organization).[24] Likewise, nothing that the developed nations do compares to Cuba's guarantee of free medical education to thousands of its own students and, more significantly, to the tens of thousands from poor Third World countries who could not otherwise train to become doctors. The idea that medical students would end their training with a $200,000 debt or that foreign students would be assessed extra tuition fees is simply incomprehensible in Cuba. Many Americans will also be surprised to hear that Cuba is also providing a medical education to over 100 U.S. citizens at ELAM—all of whom are from visible minority backgrounds and who, like their fellow students, have made a commitment to work in underserved communities after graduation.[25] In terms of the need to help other nations less privileged than Cuba, the Cuban Constitution itself notes the necessary commitment to "proletarian internationalism, brotherly friendship, assistance, cooperation and solidarity with the peoples of this world, especially those of Latin America and the Caribbean."[26] This remains a key component in any analysis of Cuban medical internationalism—since it reflects the government mindset some 50 years

in the making. Indeed, the application of this ideological framework has been illustrated throughout this book.

In the West, we pride ourselves on medical aid sent by our governments to strife-torn areas following natural disasters and, of course, our media cover these stories in such a way that we believe that we have, in fact, made a massive difference. Yet, when viewed in an unjaundiced light, these efforts are often tokenistic at best. By contrast, the Cubans have consistently sent far more support than *all* of the industrialized nations combined—and especially so to poor nations (often overlooked by the West). Significantly, too, Cuban medical missions do not depart soon after the worst of the disaster has been dealt with—as is the norm with most groups from the industrialized world—but rather they stay, usually developing a plan to maintain and stabilize the crisis. In Cuba, long-term and sustainable planning are thus common aspects of its response to both emergencies and major systemic needs. And again, at the root of this strategy is an awareness of the needs and a commitment to resolve them.

So, while political scientists often focus on medical internationalism as a tool of "soft power" and seek to draw a cause-and-effect relationship between Cuban cooperation with a Third World country and votes at the United Nations, they should not overlook the genuine humanitarianism and an ideological commitment to the less fortunate, which is also a huge factor in Havana's policy. This is particularly the case in Cuba's support to many African countries that became independent in the 1960s and, like Cuba, faced massive problems in development in the face of a "brain drain." It is in many of these small countries where Cuban support is felt most deeply, and where its practical form of South-South collaboration has the greatest effect. To really appreciate this aspect of Cuba's contribution to humanity, one needs to look no further than its role in Botswana, Burundi, Burkina Faso, Equatorial Guinea, Mali, and Namibia—where millions of medical consultations have been carried out by Cuban doctors. And again principles of human solidarity, of social justice (found as the basis of the Cuban public health system), are just as important as the support of those grateful countries in the Non-aligned Movement or the United Nations. We do ourselves a disservice if we reduce everything to a simplistic formula of "medical diplomacy" and ignore this principled philosophy.

Concluding Remarks

In June 2007, the then-foreign minister Felipe Pérez Roque summarized some of the successes of Cuban foreign policy in recent years. Despite ongoing U.S. harassment, he noted, Cuba continued to develop a successful foreign relations policy. There had been 76 diplomatic missions in Havana in 1991, this had increased to 102 by 2007. One of the keys to this strategy has undoubtedly been Cuba's internationalist support, in particular providing free, or at a greatly subsidized cost, educational and medical services that otherwise would have been impossible for other nations to receive. The figures are daunting and put the record of industrialized nations to shame: by mid-June 2007, some 47,000 students from 130 nations had graduated (at no cost to the student) in Cuba since 1959; more than 42,000 civilians were employed on internationalist missions in 101 countries, of whom approximately 34,000 were performing medical duties. (Less than two years later, these figures had increased, with the graduation of over 52,000 foreign students, while some 50,000 Cuban civilians were involved in missions abroad, including almost 38,000 medical personnel). Just as extraordinary is the number of doctors that Venezuela and Cuba intend to produce for the region within a decade—200,000.[27] And behind it all, a simple philosophy: "We don't give out our left-overs; instead we share what we have."[28]

For his part, Evo Morales, some 14 months into his mandate as president of Bolivia, thanked Cuba for its medical assistance, which had benefitted tens of thousands of his fellow citizens: "This support is not a fairy story—it is real. For me, Fidel Castro has become the most important doctor in the world, a person who thinks about life, and humanity [...] Cuba has shown its solidarity to us by sending 'troops' who save lives—not like other countries which send troops to end lives. That's the major difference between Cuba and the United States."[29] Similar sentiments have been expressed by leaders from around the world, all grateful for Cuba's extensive humanitarian contribution. It is clear that, whether or not this was a long-term strategic goal when originally conceived, Cuba has gained strong alliances throughout the Third World as a result of its enormously successful medical cooperation program that to date has saved many tens of thousands of lives, delivered health care to millions of people (17 million in Venezuela alone), many of whom had never been treated

by a doctor before in their lives, and restored sight to over a million people. Of great symbolic importance is the fact that one of the Bolivians who had his sight restored was Mario Terán, better known as the Bolivian soldier who was ordered to execute Che Guevara in a one-room schoolhouse on October 9, 1967—a remarkable form of symbolic revenge for the Argentine physician four decades later.

It can also be argued that, with the advent of a number of socialist and social-democratic countries in the region in the past two years, Latin America is in the process of a significant sea change. The "pink tide" (seen in elections in Argentina, Bolivia, Brazil, Chile, Ecuador, Guatemala, Nicaragua, Uruguay, Paraguay, Panama, and Venezuela, and near victories of leftist candidates in Mexico and Peru) is a new phenomenon. Significantly, several of the countries have spoken of the need for a "multiplier effect," developing their own human capital and employing the example of Cuba to support other nations.[30] Meanwhile Cuban internationalism in Asia continues apace, with several smaller countries—bereft of support from the industrialized countries—about to receive Cuban medical cooperation. Here, as in all internationalist programs, the recipe is simple: low-cost, sustainable primary health care, with an emphasis on preventive medicine. It works well, too—as can be seen from the 80 percent reduction of infant mortality in Kiribati following the arrival of Cuban physicians. Sadly, Africa remains largely forgotten by the industrialized world. The tragedy of HIV/AIDS continues to decimate the population of sub-Saharan Africa, wiping out an entire generation and leaving grandparents to care for their grandchildren. Largely forgotten by our media is the continuing medical support of Cuba throughout the region—as well as Fidel Castro's offer to supply 5,000 health workers from Cuba—provided the West came up with the medication needed. So far, despite political posturing by the G-8 countries, the silence is deafening.

The comparison with U.S. cooperation—traditionally the largest donor of assistance to the developing world—is inevitable. On the one hand, Cuba, financially supported by Venezuela in recent years in its extensive cooperation programs, continues to provide medical assistance to 73 (soon to be 80) countries. The role of Venezuela as the principal support for Cuban involvement in the Americas is, of course, crucial, and indeed by late August 2007 Venezuela had pledged more than $8.8 billion to help its neighbors. When asked

whether this was a mercenary approach employed by Venezuela and Cuba, Deputy Minister Jiménez responded, "We believe in fair trade. If that means that we export a product that we have a surplus of—in this case medical and educational goods and services—to a friend at a reduced price, and they export to us at favorable conditions something that they have in abundance—petroleum—what is wrong with that?"[31]

By contrast most U.S. aid is distributed through international banks and major agencies to governments, often in the form of debt relief, with the end result that most Latin Americans are unaware of the direct contribution, and the impact is, of course, heavily diluted. Moreover, almost half of what passes for development assistance, in fact, goes to fund military and police programs in the region. Finally, much of U.S. medical aid is also superficial—such as the 4-month, 12-country voyage of the U.S. Navy medical ship "Comfort" to Latin America and the Caribbean in 2007. While the 85,000 patients who received free vaccinations and eye care are understandably grateful for the care received,[32] this clearly pales in comparison with the ongoing, decades-long Cuban contribution. In contrast to the fleeting and mainly symbolic U.S. aid, Cuban development assistance is constant and often the mainstay of national health care systems. The president of Guyana, Bharrat Jagdeo, put it well when he told President George W. Bush bluntly in 2007 that "if Cuba were to withdraw their doctors from Haiti, their health system would collapse."[33] He is completely correct in his assessment.

In April 2007, the *Los Angeles Times* published a long article about the "U.S. medical diplomacy effort in Panama," which suggested that there could be an increase of 50 percent in the number of patients seen by U.S. staff in 2005 (30,000) during a two-week stint there. In all, a military contingent of some 350 had participated in the mission. Their objective in this "high-stakes goodwill campaign playing out across Latin America in poor towns like this one" is simple—"challenging the socialist campaigns of Cuba's Fidel Castro and Venezuela's Hugo Chávez and winning over people."[34] A U.S. navy medical ship was to stop by, and the Bush administration was to underwrite the $4 million cost of a regional medical training center in Panama. But how serious a challenge to the decades-old Cuban campaign of medical internationalism are such token efforts? In this "high-stakes goodwill campaign," it is obvious that the Cuban

approach to massive, hands-on humanitarian cooperation is bound to win the support of Latin America. "Winning over people" was not to prove as easy as Washington had originally thought. A letter to the Guyanese newspaper *Starbroek News* on October 13, 2007, summarized with great clarity popular reaction to the differences in the approach employed by Cuba and the United States to medical assistance for the developing world. The letter started off by thanking the personnel of the U.S. medical ship that had just visited Guyana:

> I know that they did a lot of good work and we all are thankful. However, the Cuban doctors have been giving us tremendous service for decades. Without Cuba's assistance the medical service would be in serious crisis. Over the years Cuba has increased its support. They are helping us in the construction of diagnostic centers, which I understand they will staff. They are training hundreds of students, mainly from poor families, most of them in medicine. Despite this sustained support by Cuba, the media has never given it half the publicity as it has done the U.S. one-off help. I for one would like to say a big "thank You" to Cuba for staying with us approximately three decades.[35]

The following is perhaps one telling vignette that sums up well the differences in approach between the United States and Cuba. A U.S. military physician was approached by a woman who explained that her three children suffered from stomach problems resulting from intestinal parasites and contaminated water supplies. The solution from the reservist: to hand her three boxes of free pills. Undoubtedly the Cuban solution would have been radically different. The medical staff actually live in the community (and do not drop in for two-week visits once in several years). The essence of Cuban medical treatment—both home and abroad—is in preventive medicine. "Too little, too late" would appear a fitting commentary on the U.S. approach to gaining regional support through medical aid.

An unfortunate spin-off of this competition for hearts and minds is the "Cuban Medical Professional Parole" program, an attempt by the Bush administration, announced in August 2006, to encourage Cuban medical staff on internationalist missions to desert their *internacionalista* medical mission and move to the United States, with no questions being asked about their medical credentials. In pursuing this objective, the administration has been assisted by Cuban-American congressmen and by South Florida Cuban exile groups. In all, some 500 Cuban medical professionals, of the approximately 40,000 employed

abroad, have thus far accepted the invitation of asylum—mainly from among the 30,000 working in Venezuela. While this approach might tarnish the image of the Cuban medical staff working abroad, in the last analysis those most affected are the patients, mainly located in poor, underserved areas. As Philip Peters of the Lexington Institute succinctly puts it, "You will have people in those areas who will lose their doctor because George Bush gave them a visa."[36] By February 2007, 45 of the Cuban medical staff had arrived in the United States, one-third of the 480 applicants had been tentatively approved, and 69 had been rejected. Julie Feinsilver, in an excellent study, criticizes this approach and makes a pertinent suggestion: "The fact that the Bush administration is trying to destroy Cuba's medical diplomacy indicates that the program works. Rather than attempt to destroy it, the Bush administration should emulate it."[37]

Notwithstanding the defection of 2 percent, or even 3 percent, of Cuban medical staff abroad, the broad sweep of Cuban medical internationalism around the globe is quite extraordinary. The figures are staggering. In all, they are working in 73 countries where some 36,578 medical workers are employed,[38] and where they are taking care—on a continuing basis—of some 70 million people.[39] Since 1961, some 270,743 internationalists (including 124,112 health professionals) have worked in 154 countries (for health workers, this number is 103).[40] Requests from the following countries were also approved recently—Vanuatu, Laos, Tubalu, Nauro, Benin, Papua New Guinea, and the Solomon Islands—which means that 80 countries will now be covered by Cuban medical care. The "Cuban model" with its mantra of "doing more with less" is the envy of many public health systems around the world—and understandably the bane of the private insurance companies. Community involvement, preventive medicine, practical "outside of the box" problem solving, and promoting a radically different philosophy for physicians are all far removed from their equivalents in the "developed" First World. And yet they work, and work well. The secret lies in the development of a totally new form of revolutionary physician, ably described by Cuban vice president Carlos Lage (himself a pediatric cardiologist): "A revolutionary physician is a person for whom a sick person is not a client, but a patient. A sick person does not represent the means to make a living, but the reason for their vocation. The objective of a revolutionary physician is not to earn money but to save lives."[41]

Medical internationalism has been successful throughout the globe both in terms of diplomatic achievements and in terms of saving lives. It is a combination of skilled diplomacy, philosophical beliefs, and a commitment to make a significant contribution to the health of the planet, particularly in the form of South-South cooperation. Often overlooked—but critically important—is the fact that Cuba's revolutionary ideology includes the need for international solidarity, traditionally an integral component of the ethos for Havana. There is a saying that Cuba either falls short of reaching its goals or else goes way over the top in meeting those objectives. Clearly the latter scenario is true in health promotion around the world. The commitment of Cuban medical staff all over the world has been noted with effusive praise from their patients, and from the leaders of the countries where they work. Fidel Castro summed up well the essence of this model in August 2005 at the graduation of students from the ELAM: "What is the secret of our approach? It lies in the fact that human capital can achieve far more than financial capital. Human capital implies not only knowledge but also—crucially important—political awareness, ethics, a sense of solidarity, truly human feelings, a spirit of sacrifice, heroism and the capacity to do a lot with very little."[42] There is indeed much for the First World to learn from the Cuban threat—the threat of a good example.

Notes

Preface

1. Specifically, he said that "Cuba is a small country, but it has a big country's foreign policy. It has tried to carry out such a policy since the beginning of the revolution, but only in the second half of the 1970s did it have conditions . . . to become a visible and important actor actually shaping the course of events." See Jorge Domínguez, "Cuban Foreign Policy," *Foreign Affairs* 57 (Fall 1978), 83.
2. Nye's concept of soft power is explained and discussed more fully in chapter 1 of this book.

1 Introduction: Cuba as a World Medical Power

1. See Julie Feinsilver, *Healing the Masses: Cuban Health Politics at Home and Abroad* (Berkeley: University of California Press, 1993), 158–159; and H. Michael Erisman, *Cuba's International Relations: The Anatomy of a Nationalistic Foreign Policy* (Boulder, CO: Westview Press, 1985), 78–79.
2. The Special Period refers to the period after the collapse of the Soviet bloc during which Cuba endured a massive economic crisis that, while for the most part ultimately resolved, required the government to deprioritize most nonrelated domestic and foreign policy concerns. The severity of the situation is illustrated by the following per capita GDP data.

GDP Per Capita Index (1989 = 100.0)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
96.0	86.1	77.1	66.1	66.4	67.9	72.8	74.3	75.0	79.3	83.3	85.6

Source: Archibald R. M. Ritter, "Cuba's Economic Performance and the Challenges Ahead," *Canadian Foundation for the Americas—FOCAL* (February 2002), available on the Internet at <www.cubasource.org/pdf/aritter.pdf>.

3. Havana sometimes makes special agreements operating outside the CHDP framework with wealthier countries (e.g., Mideast oil powers) whereby the host nation pays much more generous stipends, with a certain percentage thereof going to brigadistas while the remainder reverts to the Cuban Health Ministry.
4. See Cuban Foreign Ministry, "International Cooperation," at <www.cubaminrex.cu/English/cooperation/cooperation.htm>.
5. MEDICC Report, "Cuba & the Global Health Workforce: Health Professionals Abroad" (2007), available on the Internet at <www.saludthefilm.net/ns/cuba-and-global-health.html>.
6. For additional information on these and related points, see Essam Farag, "Cuban Community Healthcare: A Model for Developing Countries?" *The Ambassadors Online Magazine*, Vol. 6, No. 1 (January 2003), available on the Internet at <www.ambassadors.net/archives/issue12/selected_studies.htm>.
7. Census data indicate that blacks constitute 11 percent of Cuba's population, a figure comparable to that of the United States. But when the 51 percent of the islanders who are classified as mulattos are added to the equation, a heavily African-oriented demographic portrait emerges.
8. Another indication of the Fidelistas' Cubans' growing African orientation was the legendary Che Guevara's guerrilla adventure there. In April 1965, along with approximately 200 Cuban volunteers, he arrived in Africa to join insurgents who were trying to drive Moise Tsombe from power in the Congo (now known as Zaire). Having participated in the fighting for several months, Che's force withdrew in late 1965 at the request of their Congolese allies. Although ostensibly Guevara was operating on his own as a private citizen since he had given up his Cuban citizenship as well as all of his posts in Castro's government, his sojourn there strongly suggests that Africa's status was rising on Havana's international agenda.
9. Paul H. Grundy and Peter P. Budetti, "The Distribution and Supply of Cuban Medical Personnel in Third World Countries," *American Journal of Public Health*, Vol. 70, No. 7 (July 1980), 717–719.
10. The other two were Barbados and Trinidad/Tobago. Unlike the rest of the hemisphere, Canada and Mexico had never succumbed to U.S. pressure to sever their diplomatic and economic relations with revolutionary Cuba.
11. An excellent survey of these developments can be found in John Walton Cotman, *The Gorrión Tree: Cuba and the Grenada Revolution* (New York: Peter Lang, 1993). See especially Chapter 6 on "Cuban Civilian Assistance Programs" where he notes on page 116 that Havana's medical aid contingent peaked in 1983 when there were a total of 3,044 Cuban health care workers on the island (1,675 of whom were doctors).
12. These figures come from H. Michael Erisman, "Cuban Development Aid: South/South Diversification and Counterdependency Politics," in

H. Michael Erisman and John M. Kirk (eds.), *Cuban Foreign Policy Confronts a New International Order* (Boulder, CO: Lynne Rienner Publishers, 1991), 153–154; and Rafael Fermoselle, *The Evolution of the Cuban Military, 1492–1986* (Miami: Ediciones Universal, 1987), 438.

13. These figures come from Julie M. Feinsilver, "Cuba as a World Medical Power: The Politics of Symbolism," *Latin American Research Review*, Vol. 24, No. 2 (1989), 12 and 15.
14. The total 1992–2000 declines for all the countries listed in figure 1.2 are as follows: from $73.055 to $53.737 billion in constant 2000 dollars and from 0.33 to 0.22 as a percentage of GNP. See "Foreign Aid Spending Falls," *Worldwatch Institute* (July 7, 2006), available on the Internet at <www.worldwatch.org/node/4316>.
15. In-depth analyses of this restructuring process can be found in Erisman and Kirk, op. cit. and in H. Michael Erisman and John M. Kirk (eds.), *Redefining Cuban Foreign Policy: The Impact of the "Special Period"* (Gainesville, FL: University Press of Florida, 2006).
16. Calculated from a list of recipient countries found in "Cuba and Global Health Fact Sheet," available on the Internet at <www.saludthefilm.net/ns/cuba-and-global-health-facts.html>.
17. "Cuba and Global Health," with the original source being cited as *Registros estadísticos de la Unidad Central de Cooperación Médica*.
18. Subsequently Bolivia, Nicaragua, Dominica, and Honduras would become parties to the ALBA agreement.
19. William Demas, *Consolidating Our Independence: The Major Challenge for the West Indies* (Distinguished Lecture Series, Institute of International Relations, University of the West Indies, St. Augustine, Republic of Trinidad and Tobago, 1986), 12.
20. Joseph S. Nye, "Think Again: Soft Power," *Foreign Policy* (March 2006), also available on the Internet at <yaleglobal.yale.edu/display.article?id=7059>.
21. Historical information about the international brigades can be found in Verle Johnson, *Legions of Babel: The International Brigades in the Spanish Civil War* (University Park, PA: Pennsylvania State University Press, 1968); and R. Dan Richardson, *Comintern Army: The International Brigades and the Spanish Civil War* (Lexington, KY: University of Kentucky Press, 1982). One of the most famous fictionalized treatments of the subject is Ernest Hemingway's novel *A Farewell to Arms*. Note that the island's close cultural/historical links with both Spain and Hemingway would probably serve to make most progressive Cubans (such as Fidel Castro) highly familiar with and sympathetic to the internationalist ethos symbolized by the Spanish brigades.
22. Quoted from "The Duty of a Revolutionary is to Make the Revolution: The Second Declaration of Havana," in Martin Kenner and James Petras (eds.), *Fidel Castro Speaks* (New York: Grove Press, 1969), 105.

23. See the *Cuban Constitution* at <www.cubaverdad.net/cuban_constitution_english.htm>.
24. Feinsilver, op. cit. A very useful unpublished study is the April 2005 Dalhousie University undergraduate honors thesis submitted by Sarah Stewart entitled "Cuban Medical Internationalism: The Ascension of a World Medical Power," which is based in part on field research undertaken while studying for a semester at the University of Havana.
25. For more information about MEDICC, see its Internet webpage at <www.medicc.org/index.php>.

2 The Cuban Health Care System

1. Cited in René Rodríguez, "Cuban Healthcare in Painted in 'Sicko,' Critics Say," *Miami Herald* (June 23, 2007), available on the Internet at <www.miamiherald.com/457/v-print/story/148897.html>.
2. "Another Michael Moore Controversy," *Latin Business Chronicle* (Miami, June 18, 2007).
3. Rodríguez, op. cit. A recent graduate student has also condemned the health care system as one where "there is no right to privacy in the physician-patient relationship in Cuba, no patients' right of informed consent, no right to refuse treatment, and no right to protest or sue for malpractice [...] Cuban family doctors are expected to attend to the 'health of the revolution' by monitoring their neighborhoods for any sign of political dissent, and working closely with CDR officials to correct these beliefs or behaviors." See Katherine Hirschfeld, "Re-examining the Cuban Health Care System: Towards a Qualitative Critique," *Cuban Affairs*, Vol. 2, No. 3 (July 2007). Her article, however, is rather heavy in ideological commentary, and light in analysis of the medical system.
4. Before the Revolution, Cuba had different forms of health coverage. First, there was a form of social security dating back to 1902, which covered workmen's compensation and maternity care. The government also covered members of the military and their families with separate health care. Additionally, there was a system of Mutualist Health Associations that nearly one half of the population used. It was a form of prepaid medical coverage where a member would pay 2 to 5 pesos per month and receive medical services. The government also partially contributed a subsidy for those who could not afford the cost. See Steven G. Ullmann, "The Future of Health Care in a Post-Castro Cuba," *Center for Cuban and Cuban American Studies* (Miami: University of Miami Press, 2005), 5.
5. Theodore H. MacDonald, *A Developmental Analysis of Cuba's Health Care System Since 1959* (Lampeter, Ceredigion, Wales: Edwin Mellen Press, 1999), 10.

6. Fidel Castro, "History Will Absolve Me," court address, 1953, available on the Internet at <library.thinkquest.org/18355/fidel_castro_s_speech.html>.
7. Susan Schroeder, *A Handbook of Historical Statistics* (Boston, MA: G.J.K. Hall, 1982), 200.
8. Fidel Castro, op. cit.
9. Schroeder, op. cit., 228.
10. MacDonald, op. cit., 161.
11. Ibid., 17.
12. Ana Esther Zulueta Avilés, "Facultad de ciencias médicas en la Isla de la Juventud," *Granma* (August 2, 2007).
13. MacDonald illustrates well this context: "Long before the revolutionary administration had published details of exactly how it was to remedy existing social injustices, large numbers of wealthy people saw the writing on the wall and left. Among them were all but five senior faculty members (out of 140) at the Havana Medical School. Also included in the exodus were at least two-thirds of the ordinary doctors practicing in Havana and Santiago." See MacDonald, op. cit., 47.
14. Cited in ibid., 10.
15. Schroeder, op. cit., 173.
16. Guevara, op. cit., 125.
17. MacDonald, op. cit., 103.
18. Ibid., 103.
19. Ibid., 56.
20. Ibid., 8.
21. Hirschfeld, op. cit.
22. Linda Whiteford and Laurence G. Branch, *Primary Health Care in Cuba: The Other Revolution* (Lanham, MD: Rowman and Littlefield, 2008), 13.
23. MacDonald, op. cit., 141.
24. Ibid., 35.
25. Ibid., 45.
26. Ibid., 147.
27. "At a Glance: Cuba, Statistics." *UNICEF.*
28. Michele Frank, "Well Babies: Cuba's National Program," *Medicc Review* (July 13, 2005), available on the Internet at <http://www.medicc.org/medicc_review/0605/spotlight.html>.
29. Richard S. Cooper, Joan F. Kennelly, and Pedro Ordúñez-García, "Health Care in Cuba," *International Journal of Epidemiology*, Vol. 35, No. 4 (2006), 819.
30. Ernesto "Che" Guevara, "Speech to Medical Students and Health Workers," in *Che Guevara Reader*, ed. David Deutschman (Melbourne: Ocean Press, 1997), 127.
31. MacDonald, op. cit., 141.

32. Agustín Dávila Lage, "Socialism and the Knowledge Economy: Cuban Biotechnology," *Cuba Socialista*, vol. 58, no. 7 (December 2006), Trans. Leonard Morin, available on the Internet at http://www.monthlyreview.org/1206lagedavila.htm.
33. Ibid.
34. Ibid.
35. Tom Fawthrop, "Medical Know-How Boosts Cuban Wealth," *BBC News* (January 17, 2006 and April 4, 2007), available on the Internet at <news.bbc.co.uk/2/low/business/4583668.stm>.
36. MacDonald, op. cit., 16.
37. Whiteford and Branch op. cit., 20.
38. MacDonald, op. cit., 156.
39. Ibid., 180.
40. Ibid., 149.
41. Ibid., 176.
42. Whiteford and Branch, op. cit., 23–24.
43. MacDonald, op. cit., 177.
44. Ibid., 20.
45. Ibid., 145, 179, 189.
46. Clarivel Labrador Presno and Félix Sansó Soberat, "20 Years of Family Medicine in Cuba," *Medicc Review* (July 20, 2005), available on the Internet at <www.medicc.org/medicc_review/1104/pfv/spotlight.html>.
47. Richard S. Cooper et al., "Health in Cuba," *International Journal of Epidemiology*, Vol. 35, No. 4 (May 2006), 118.
48. "At a Glance: Cuba, Statistics." *UNICEF*, available on the Internet at <www.unicef.org/infobycountry/cuba_statistics.html>.
49. Presno and Soberat, op. cit.
50. MacDonald, op. cit., 178.
51. John Harris, "Keeping Cuba Healthy," *BBC News* (August 1, 2006), available on the Internet at <newsvotebbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/2/hi/programmes/newsnight>.
52. "At a Glance: Cuba, Statistics," op. cit.
53. Fawthrop, op. cit.
54. MacDonald, op. cit., 112.
55. Ibid., 17.
56. Ibid., 56.
57. Harris, op. cit.
58. "At a Glance: Cuba, Statistics," op. cit.
59. "At a Glance: United States of America, Statistics," *UNICEF* (July 24, 2005), available on the Internet at <www.unicef.org/infobycountry/usa_statistics.html>.
60. "At a Glance: Cuba, Statistics," op. cit.
61. "At a Glance: United States of America, Statistics," op. cit.
62. Jim Lobe, "Learn from Cuba, Says World Bank" (May 5, 2001), available on the Internet at <http://www.hartford-hwp.com/archives/43b/185.html>.

63. Data taken from Mirén Uriarte, "Cuba, Social Policy at the Crossroads: Maintaining Priorities, Transforming Practice," *An Oxfam America Report* (Boston: 2002), 21.
64. See Ibid., 35–36 for an excellent analysis of the significance of this policy.
65. See "Healthcare in Cuba: 'Medical Apartheid' and Health Tourism," undated article on the Internet for *Cuba International* at <www.netforcuba.org/InfoCuba-EN/HealthCare/MedicalApartheid.htm>.
66. Tom Fawthrop, "Cuba sells its medical expertise," *BBC report* (November 21, 2003), available on the Internet at <news.bbc.co.uk/2/hi/business/3284995.stm>.
67. A personal note might be illustrative here. On May 3, 2007, Dr. Kirk's daughter was treated at the Cira García after she had eaten food that included peanuts. She had a severe allergy and was rushed to the hospital. Within a minute of arriving at the hospital she received an injection of adrenalin, followed by two others (benedraline and dextrose), and hydrocortisone. She also received a prescription for prednisone. The costs were: $0.25, 0.70, $0.50, and $0.95 for the medication injected; $10, $5, and $5 for each of the injections; a $30 fee for the medical consultation; and $1.00 for the prednisone—for a grand total of $55.05.
68. "Nearly 10,000 Venezuelan Patients Treated in Cuba," *Agencia de Información Nacional* (July 12, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
69. The dilemma for Cubans is well portrayed in a 1994 article:

    > "Of course it is a positive gesture," a Cuban friend told me. "But why does this hospital [for the Chernobyl children] work and the hospitals of Cubans don't? At a time when Cubans cannot find aspirins in the pharmacy, it's difficult to justify."
    >
    > Others, who support the project, sidestep the intense deterioration of Cuba's economy. "Those of us who understand the importance of this revolution, understand that international solidarity is one of its fundamental values," one woman told me. "If we are capable of providing for somebody in need, it's our duty. Right now, we do not have very much food in Cuba, but that doesn't mean hat we can ignore the children that have been the victims of such a tragedy as Chernobyl."

    Cited in Alex Tehrani, "Chernobyl Children in Cuba—Radiation Victims Are Treated," *The Progressive* (November 1994), available on the Internet at <findarticles.com/p/articles/mi_m1295/is_n11_v58/ai_15890043/print>.
70. See "Key Address by Dr. Fidel Castro Ruz, President of the Republic of Cuba, at the Inauguration of the Latin American School of Medicine. Havana. November 15, 1999," available on the Internet at <www.cuba.cu/gobierno/discursos/1999/ing/i51199i.html>.
71. Data provided by Dr. Juan Carrizo, rector of ELAM, and provided in "Latin American Medical School," available on the Internet at <www.saludthefilm.net/ns/elam.html>.

72. See "Speech given by Dr. Fidel Castro Ruz, President of the Republic of Cuba, at the First Graduation of Students from the Latin American School of Medicine, Karl Marx Theatre, August 20, 2005," available on the Internet at <www.cuba.cu/gobierno/discursos/2005/ing/f200805i.html>.
73. In a variation of the approach employed at ELAM, there is an even more innovative strategy in medical education now being applied in Cuba:

    "This scaling up [of medical training] began in earnest in Cuba during the 2006–2007 academic year: 12,000 students from other nations—primarily African and Latin American—began medical studies in Cuba under a new program that replicates the 'university without walls' model first piloted with Cuban medical students, then carried to Venezuela. (Some 13,000 Venezuelan students are enrolled in the program there, sponsored by the Cubans and six Venezuelan universities). According to this model, students are based at campuses in the Cuban countryside for their class work, and professors mentor them in clinical studies involving local clinics and hospitals."

    See "Scaling Up," at <www.saludthefilm.net/ns/elem.html>.
74. "Speech delivered by Dr. Fidel Castro Ruz, President of the Republic of Cuba, at the Foundation Ceremony of the 'Henry Reeve' International Contingent of Doctors Specialized in Disaster Situations and Serious Epidemics, and the National Graduation of Students of Medical Sciences, in the Ciudad Deportiva, on September 19, 2005."
75. Ibid.

3 Cuba's Cold War Medical Aid Programs

1. Among the previous works by the two authors on the broad scope of Cuba's foreign relations are: H. Michael Erisman, *Cuba's International Relations: The Anatomy of a Nationalistic Foreign Policy* (Boulder, CO: Westview Press, 1985); Erisman and Kirk (eds.), *Cuban Foreign Policy Confronts…*, op. cit.; H. Michael Erisman, *Cuba's Foreign Relations in a Post-Soviet World* (Gainesville: University Press of Florida, 2000; Erisman and Kirk (eds.), *Redefining Cuban Foreign Policy*…, op. cit. This overview section draws heavily on material in the two Erisman books.
2. For an excellent examination of the impact of the Missile Crisis on Cuban/Soviet relations in particular and Cuban foreign policy in general, see James G. Blight and Philip Brenner, *Sad and Luminous Days: Cuba's Struggle with the Superpowers after the Missile Crisis* (Lanham, MD: Roman and Littlefield Publishers, 2002).
3. For an excellent and highly detailed examination of this episode, see Piero Gleijeses, "Cuba's First Venture in Africa: Algeria, 1961–1965,"

Journal of Latin American Studies, Vol. 28, No. 1. (February 1996), 159–195.

4. Jorge Domínguez, "Cuba's Foreign Policy," *Foreign Affairs* 57 (Fall 1978), 83.
5. An extremely detailed and fascinating account of the evolution of Cuba's involvement in Africa can be found in Piero Gleijeses, *Conflicting Missions: Havana, Africa, and Washington, 1959–1976* (Chapel Hill: University of North Carolina Press, 2002).
6. Armando Entralgo López and David González López, "Cuban Policy toward Africa," in Wayne Smith and Esteban Morales Domínguez (eds.), *Subject to Solution: Problems in Cuban-U.S. Relations* (Boulder, CO: Lynn Rienner Publishers, 1988), 50.
7. Gleijeses, *Conflicting Missions*, op. cit., 53–54. Gleijeses discusses Cuba's involvement in the Zaire, Guinea-Bissau, and other situations mentioned in the quote in much more detail later in his book.
8. This summary relies heavily on the excellent narrative and analysis found in Piero Gleijeses, "Moscow's Proxy? Cuba and Africa, 1975–1988," *Journal of Cold War Studies*, Vol. 8, No. 2 (2006), 3–51.
9. Feinsilver, *Healing the Masses*, op. cit., 161.
10. The information about financial arrangements comes from Gleijeses, "Moscow's Proxy," op. cit., 23.
11. The extremely close Cuban/Soviet cooperation in fighting the Somali invasion did not extend to the Eritrean situation. With the Somalis defeated, Haile Mariam's government turned its full attention to the insurgents in Eritrea with whom it refused to negotiate or compromise. Moscow pressured Havana to use its troops already in the country to help put down the rebellion. The Cubans, however, refused, partly because they did not want to offend pro-Cuban Third World governments that were friendly toward the Eritrean cause and also because involvement would have seriously tarnished their anti-imperialist credentials since they had previously characterized the Eritrean struggle as a legitimate war of national liberation.
12. See Sergio Roca, "Economic Aspects of Cuban Involvement in Africa," in Carmelo Mesa-Lago and June S. Belkin (eds.), *Cuba in Africa* (Pittsburgh: University of Pittsburgh, Latin American Monograph and Document Series 3, 1981), 163b.
13. Quoted in *Facts on File*, Vol. 37, No. 1932 (November 19, 1977), 884.
14. Other moderate-conservative leaders who were elected in the late 1970s or early 1980s were Milton Cato in St. Vincent (December 1979), Kennedy Simmonds in St. Kitts-Nevis (February 1980), Vere Bird in Antigua (April 1980), Eugenia Charles in Dominica (July 1980), George Chambers in Trinidad/Tobago (November 1981), John Compton in St. Lucia (May 1982), and Lynden Pindling in The Bahamas (June 1982).
15. Cotman, op. cit., 118. Cotman's book provides the most comprehensive and data-rich overview available, at least in English, of Cuba's

civilian aid programs—medical and otherwise—to the New Jewel Revolution.

16. Quoted in John Walton Cotman, "Cuba and the CARICOM States: The Last Decade," in Donna Rich Kaplowitz (ed.), *Cuba's Ties to a Changing World* (Boulder, CO: Lynne Rienner Publishers, 1993), 146.
17. Varying degrees of external support for the Sandinistas also came from such sources as Mexico, France, the Socialist International (an association of progressive Western European political parties that included England's Laborites and West Germany's Social Democrats), the Nonaligned Movement, and the UN General Assembly. Among the analyses emphasizing the importance of such diversified external solidarity were Richard E. Feinberg, "Central America: No Easy Answers," *Foreign Affairs,* Vol. 59, No. 5 (Summer 1981), 1121–1146; and Roger Burbach, "Central America: The End of U.S. Hegemony?" *Monthly Review,* Vol. 33, No. 8 (January 1982), 1–18.
18. The security adviser figures are cited in Rafael Fermoselle, *The Evolution of the Cuban Military, 1492–1986* (Miami: Ediciones Universal, 1987), 438. In addition, roughly 5,000 Nicaraguans went to Cuba in 1984 for free professional and technical training in various fields (including health care).
19. Feinsilver, op. cit., 162.
20. Ibid., 162–163.
21. For an analysis of Cuba's Cold War Middle Eastern policies in general and its relations with South Yemen in particular, see Damián J. Fernández, *Cuba's Foreign Policy in the Middle East* (Boulder, CO: Westview Press, 1988).
22. See Feinsilver, op. cit., 163–164.
23. Ibid., 169–171.
24. Edward González, "Complexities of Cuban Foreign Policy," *Problems of Communism*, Vol. 26 (November–December 1977), 2.
25. Anthony Payne, "Giants and Pygmies in the Caribbean," *World Today* (August 1980), p. 293.
26. Susan Eckstein, "Foreign Aid Cuban Style," *The Multinational Monitor*, Vol. 10, No. 4 (April 1989), available on the Internet at <multinationalmonitor.org/hyper/issues/1989/04/eckstein.html>.
27. Roca, op. cit., 171.
28. These figures come from Eckstein, op. cit.
29. Ibid.
30. Roca, op. cit., 169.
31. Wolf Grabendorff, "Cuba's Involvement in Africa: An Interpretation of Objectives, Reactions, and Limitations," *Journal of Inter-American Studies and World Affairs*, Vol. 22, No. 1. (February 1980), 9.
32. This calculation is based on data found on the Internet at <www.fbc.keio.ac.jp/~endoh/downloade.htm>. The trade volume rebounded to earlier 1960 levels by 1970.

33. Edward González, "Institutionalization, Political Elites, and Foreign Policies," in Cole Blasier and Carmelo Mesa-Lago (eds.), *Cuba in the World* (Pittsburgh: University of Pittsburgh Press, 1979), 22.
34. Anonymous high-ranking U.S. official quoted in "Cubans in Africa: Moscow Tests Carter," *Newsweek* (March 13, 1978), 37.
35. Analysts of the U.S. presidency often make a distinction between these two types of power, emphasizing that the popular perception often inaccurately sees the president as possessing the power to command (i.e., to issue orders and directives that will be followed), while in reality the office is generally limited to persuasive power and hence presidents' legacies are ultimately dependent upon their ability (or lack thereof) to wield it effectively.
36. Its tenure did not, however, proceed as smoothly as hoped, the main problem being that Havana's Moscow connection caused it to become enmeshed in the controversy surrounding the USSR's war in Afghanistan, a situation that Cuba itself complicated by voting against a January 1980 UN resolution (supported by the vast majority of developing nations) condemning the Kremlin's intervention. The Third World backlash that this incident generated cost Cuba the seat on the UN Security Council that it had long coveted. Even before the Afghan crisis erupted, Havana had become involved in a hotly contested battle with Colombia for the Council's vacant Latin American slot. Washington strongly backed Bogotá as part of its campaign to undermine Cuba's international prestige. Although Havana led on most of the early ballots (usually by a substantial margin), neither party was able to muster the necessary two-thirds majority. The Afghan crisis, however, radically altered the political equation and it soon became obvious that enough anti-Cuban sentiment had developed to render a Cuban victory impossible. Consequently Havana withdrew from the race (with Mexico emerging as the ultimate compromise selection).
37. The G-77 was formed in 1963, its primary purposes being to provide a forum for developing countries to establish common positions on matters concerning international economic relations and to represent their interests in North-South developmental negotiations. Originally composed of 77 countries, its membership had almost doubled to 133 by the early 2000s.
38. More information and analyses regarding Cuba's involvement in such IGOs can be found in Steven Reed, "Participation in Multinational Organizations and Programs in the Hemisphere," in Blasier and Mesa-Lago, op. cit., 297–312.
39. Julie Feinsilver, "Cuban Medical Diplomacy: When the Left Has Got It Right," *COHA (Council on Hemispheric Affairs) Report*, 10, available on the Internet at <www.coha.org/2006/10/30/cuban-medical-diplomacy-when-the-left-has-got-it-right/>. A version of

this article originally appeared in *Foreign Affairs en Español,* Vol. 6 (October–December 2006), 81–94.

40. Grabendorff, op. cit., 24.
41. Roca, op. cit., 166.

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1. For detailed descriptions and analyses, see Andrew Zimbalist, "Teetering on the Brink: Cuba's Current Economic and Political Crisis," *Journal of Latin American Studies*, Vol. 24 (May 1992), 407–418 and "Dateline Cuba: Hanging On in Havana," *Foreign Policy*, No. 92 (Fall 1993), 151–167.
2. Zimbalist, "Dateline Cuba…," op. cit., 154.
3. For an excellent survey and analysis of these controversial measures, see Joaquín Roy, *Cuba, the United States, and the Helms-Burton Doctrine: International Reactions* (Gainesville: University Press of Florida, 2000).
4. For an analysis focusing primarily on the international dimensions of this process, see Erisman and Kirk (eds.), *Redefining Cuban Foreign Policy…*, op. cit. The domestic dimension is emphasized in Max Azicri and Elsie Deal (eds.), *Cuban Socialism in a New Century: Adversity, Survival, and Renewal* (Gainesville: University Press of Florida, 2004).
5. Two very useful overviews of Cuba's biotechnological development can be found in Dr. Philip Shapira, "Cuban Biotechnology Development: Rethinking Traditional Frameworks," available on the Internet at <www.cherry.gatech.edu/TRP/proceedings/2001/01Burton.doc> and "Cuba Profile: Biological Overview," available on the Internet at <http://www.nti.org/e_research/profiles/Cuba/Biological/index_3482.html>.
6. The term "intermestic" is used by political scientists to characterize issues, processes, and phenomena that involve a merger of *inter*national and do*mestic* considerations. They are, in other words, simultaneously international and domestic in nature.
7. These items were culled from a much longer list appearing in Max Azicri, *Cuba Today and Tomorrow: Reinventing Socialism* (Gainesville: University Press of Florida, 2000), 138–139. See chapters 6 and 7 for a detailed discussion and analysis of economic reforms instituted during the Special Period.
8. For a fascinating analysis of the cultural impact of mass tourism and other aspects of the U.S./Cuban relationship, see Louis A. Pérez Jr., *On Becoming Cuban: Identity, Nationality, and Culture* (New York: Ecco Press/Harper Collins, 1999).
9. This data, as well as table 4.3, comes from John Cotman, "Caribbean Convergence: Contemporary Cuba-CARICOM Relations," in Erisman and Kirk, op. cit., 136–137.

10. An analysis of the Cuban/Venezuelan Neo-Bolívarian alliance can be found in H. Michael Erisman, "Neo-Bolívarianism and Cuba's Evolving Relationship with Venezuela," paper presented at the International Congress of the Latin American Studies Association (March 15–18, 2006) in San Juan, Puerto Rico.
11. For the full text of the agreement, see *Final Declaration from the First Cuba-Venezuela Meeting for the Application of the ALBA*, available at <www.venezuelanalysis.com/articles.php?artno=1433>. For an overview, see also "Cuba and Venezuela Sign Wide-Ranging Cooperation Pact," an *AIN* news dispatch (April 30, 2005) available at <groups.yahoo.com/group/CubaNews/message/37501>.
12. In February 2007, the governments of Antigua and Barbuda, Dominica and Saint Vincent, and the Grenadines all signed a memorandum of understanding with Venezuela indicating an interest in becoming full-fledged members of the ALBA agreement. Reported by Sinay Céspedes Moreno, "Caribbean Nations Join ALBA Initiative," *GRANMA* (February 20, 2007), available on the Internet at <groups.yahoo.com/group/CubaNews/message/62127>. As of early 2008, only Dominica had actually done so.
13. This material comes from Philip Brenner and Marguerite Jiménez, "U.S. Policy On Cuba beyond the Last Gasp," *NACLA Report on the Americas*, Vol. 39, No. 4 (January/February 2006).
14. Yugoslavia also served two leadership terms, but it is no longer an active NAM participant because its membership was suspended in 1992 due to the civil war there that led to the dissolution of the Yugoslavian Federation. Egypt will become the second current member to have done so in 2009. A detailed analysis of Havana's leadership prospects can be found in H. Michael Erisman, "Cuba's NAM Leadership: Promoting South/South Cooperation as a Challenge to the Washington Consensus," paper presented at the International Congress of the Latin American Studies Association (September 5–8, 2007) in Montreal, Canada.
15. See Cuban Foreign Ministry, *A Cuban Vision of the Movement of Non-aligned Nations* (Havana, 2003), available online at <groups.yahoo.com/group/CubaNews/message/15096>.
16. See Agencia de Información Nacional—Habana, "Cuba Set to Offer Proposals at Upcoming Non-aligned Nations Summit" (June 12, 2006). See also Orlando Oramas León, "Cuba to Propose Concrete Action at Non-aligned Summit," *GRANMA* (September 9, 2006), available on the Internet at <groups.yahoo.com/group/CubaNews/message/54684>.
17. Moreno's quote and additional information can be found in Patricia Grogg, "Cuba: All Set for Non-aligned Summit—with or without Fidel," *Inter Press Service* (August 15, 2006).
18. "Summary of the Press Conference Given by Abelardo Moreno, Cuban Vice Minister of Foreign Affairs, Chairman of the Meeting of Senior Officials and the Organizing Committee Spokesperson."

Havana (September 13, 2006), available on the Internet at <www.cubanoal.cu/ingles/Reuniones/130906_1.htm>.

19. MEDICC Report, "Cuba & the Global Health Workforce: Health Professionals Abroad," available on the Internet at <www.saludthefilm.net/ns/cuba-and-global-health.html>.
20. The foregoing information in this paragraph comes from Margaret Blunden, transcript of lecture given at the London Metropolitan University (January 9, 2008), available on the Internet at <http://www.londonmet.ac.uk/research-units/cuba/past-events/pietroni.cfm>.
21. The source for table 4.7 also reported that currently more than 12,000 youths from 83 countries were studying medicine in Cuba. Out of these, 1,500 were from South America, 3,244 from Central America, 489 from Mexico and North America, including 65 from the United States and two from Puerto Rico. Some 1,039 students came from Caribbean nations, 777 from sub-Saharan Africa, 42 from Northern Africa and the Middle East, 61 from Asia, and 2 from Europe.
22. Patricia Grogg, "Cuba-Africa: Decades of Assistance and Cooperation," *Inter Press Service* (July 2, 2004), available on the Internet at <www.aegis.com/news/ips/2004/IP040703.html>.
23. Conner Gorry, "Healing Globally, Empowering Locally: Cuban Medical Cooperation in Africa," *Caminos: Revista Cubana de Pensamiento Socioteológico*, No. 42 (2006). Gorry also noted that as of June 2006, there were 536 students training in medical schools established with Cuban cooperation in the Gambia, Equatorial Guinea, Eritrea, Guinea Bissau, and East Timor.
24. Grogg, op. cit.
25. The quote and case rate information come from Gorry, op. cit.
26. Tom Fawthrop, "Impoverished Cuba Sends Doctors around the Globe," *GRANMA* (November 9, 2006), available on the Internet at <http://groups.yahoo.com/group/CubaNews/message/57184>.
27. The information in this paragraph comes from Hernando Calvo Ospina, "Havana's Medics Work around the World, Cuba Exports Health," *Le Monde Diplomatique—English edition* (August 11, 2006), available on the Internet at <mondediplo.com/2006/08/11cuba>; Fawthrop, op. cit.; and Conner Gorry, "Touring Cuban Field Hospitals in Post-Quake Pakistan," *MEDICC Review*, Vol. 8, No. 1 (2006).
28. Tom Fawthrop, "Cuba's Humanitarian Mission," *The Guardian* (August 16, 2006), available on the Internet at </commentisfree.guardian.co.uk/tom_fawthrop/2006/08/tom_fawthrop_cuban_docs.html>. The description provided here of Cuba's Java mission comes essentially from this Fawthrop report.

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1. See "Harper's Cuba Tack Meets Resistance," a CanWest News Service Bulletin published in the *Vancouver Province* (July 20, 2007).
2. A useful analysis can be found in Luis Suárez Salazar, "Cuba's International Relations with Latin America and the Caribbean: Toward a New Stage?" in Erisman and Kirk (eds.), *Cuban Foreign Policy Confronts a New International Order*, op. cit., 107–118.
3. Ibid., 109.
4. "Mitch: The Deadliest Atlantic Hurricane since 1780" (August 26, 2006), available on the Internet at <lwf.nsdc.noaa.gov/oa/reports/mitch/mitch.html>.
5. Peter Morgan, "World: Americas; Honduras Fights Back after Mitch," *BBC News* (February 11, 1999), available on the internet at <news.bbc.co.uk/2/hi/americas/276122.stm>.
6. "World Bank Releases $201 Million for Storm-Ravaged Central America," *CNN* (November 11, 1998), available on the Internet at <www.cnn.com/WORLD/americas/9811/10mitch.02/>.
7. Martin Koppel, "Cuba Launches International Solidarity Campaign, *The Militant* 62, no. 45, December 15, 1998.
8. "Castro: Cuban Aid Offer Is 'Revenge' against Mitch," *CUBANET* (November 23, 1998), available on the Internet at <www.cubanet.org/CNews/y98/nov98/23e&.htm>.
9. "World: Americas Nations Plead for Aid after Mitch Disaster," BBC News (November 4, 1998), available on the Internet at <news.bbc.co.uk/2/hi/americas/207380.stm>.
10. Laura Gross, "Hurricane Mitch Reconstruction Top Priority for USAID's Administrator's Visit to Honduras" (2000), available on the Internet at <www.usaid.gov/press/releases/2000/pr000121.html>.
11. Cuba's medical brigades vary in size. Typically, they are made up of 3 to 6 medical personnel—2 doctors and 1 nurse to 4 doctors and 2 nurses
12. Leo Burghardt, "Guatemalans Hail Cuban Medical Workers," *People's Weekly World Newspaper* (March 3, 2004).
13. "Cuba's Medical Missionaries Blanket Honduras," *Prensa Latina* [Havana] (February 18, 2005).
14. Morgan, "World: Americas; Honduras . . .," *BBC News* (February 11, 1999), available on the Internet at <news.bbc.co.uk/2/hi/americas/276122.stm>.
15. Ibid. See also Emily Beam, "Medical Diplomacy," *Michigan Daily* (September 9, 2005), available on the Internet at <www.michigandaily.com/home/index.cfm?event=displayArticlePrinterFriendly&uSt>.
16. Koppel, op. cit.

17. Marelys Valencia Almeida, "It Is Time to Solve the Problems in Haiti and Central America," *Granma International* (December 31, 1998), available on the Internet at <www.hartfprd-hwp.com/archives/40/198.html>.
18. Katrina Jones, "Topic: Hurricane George Sweeps Caribbean Islands" (2000), available on the Internet at <projects.ldc.upenn.edu/TDT2000/topics/completed-research/hurricane-george.html>.
19. William Steif, "Cuba a Major Benefactor to Strife-Torn Haiti," in *MINREX: A Look at Cuba*. (April 25, 2004), available on the Internet at <www.cubaminrex.cu/English/Look_Cuba/Society/society_Cuba%20a%20Major%20>.
20. Felipe Pérez Roque. "Address at the III Special Meeting of the Council of Ministers of the Association of Caribbean States," Panama, Panama (February 12, 2004).
21. Derrick O'Keefe, "A Real Humanitarian Intervention: Cuba's Doctors without Borders," *Seven Oaks Magazine* (April 5, 2004), available on the Internet at <www.sevenoaksmag.com/commentary/07 Cuba.html>.
22. Patricia Grogg, "Health-Cuba: Medical Crusade to the Developing World," *Inter Press Service* (August 6, 2004).
23. Roque, op. cit.
24. Ibid.
25. José A. de la Osa, "Cuban Doctors Continue Saving Lives in Haiti," *Digital Granma Internacional* [Havana] (October 14, 2004), available on the Internet at www.granma.cu/ingles2004/octubre/juev14/42hdoc.html.
26. Michel Camdessus, the director of the International Monetary Fund (IMF), stated in 1998, directly after Hurricane Mitch, that he would propose an emergency IMF loan of $65 million in Honduras in December to finance imports. See Fiona Ortiz, "Cuba Minister Visits Storm-Battered Guatemala," *CUBANET* (November 23, 1998), available on the Internet at <www.cubanet.org/CNews/y98/nov98/23e6.htm>.By contrast cash-strapped Cuba possesses tremendous amounts of human capital, which it has shared with countries in the region.
27. Upon graduation, Cuban doctors must pledge themselves to the revolution. As one section of the pledge goes, "We pledge: to strive always to be worthy representatives of Cuban health professionals, devoting ourselves with true love to our profession, with a profound respect for human life, feeling the pain of others as our own, seeing in each patient and their family our own loved ones, and working tirelessly towards excellence in health services." Clearly the work of the Cuban doctors after both Hurricanes Mitch and George demonstrates their commitment to this pledge and to others. See Conner Gorry, "Innovative Project Brings Permanent Medical Services to Honduran Mosquitis," *Medicc Review* (February 1, 2007), available on the Internet at <www.medicc.org/publications/cuba_health_reports/006.php>.

28. "Cuba's Medical Missionaries . . .," op. cit.
29. Koppel, op. cit.
30. Gail Reed, "From the Mountains of Cuba to Haiti: Cuba's Outstanding Medical Graduates Program," *Medicc Review* 6 (2004), available on the Internet at <www.medicc.org/publications/medicc_review/1104/pfv/international_cooperation_report>.
31. The Cuban government website that provides data on the PIS indicates the extent of the medical cooperation of Cuba to date in all countries covered by the program since 1998: 112,439,930 consultations had taken place; 913,863 births had been assisted; 2,407,647 surgical operations had taken place; 9,577,736 vaccinations had been administered; and 1,855,023 lives had been saved. See "Resultados generales del programa integral de salud," at <www.cubacoop.com/CubaCoop/Cooperacion_ProgramaIntegralSalud.html>.
32. Carmen Esquivel, "Médicos cubanos ascienden al volcán de Pacaya," *Granma* (July 7, 2007); and Juan Diego Nusa Peñalver, "Analizan Cuba y Guatemala estrechar nexos bilaterales," *Granma* (February 2, 2008).
33. All data from "Cuban Doctors Make an Impact on Honduras Health Levels," *Agencia de Información Nacional* (September 9, 2007); *AFP Bulletin*, "Histórica visita de Zelaya a Cuba" (October 9, 2007); and Elson Concepción Pérez, "Honduras Thanks Cuba for Its Example of Dignity, Independence and Solidarity," *Granma* (October 11, 2007). All sources accessed via the listserve at <Cuba-L@unm.edu>.
34. Elson Concepción Pérez, "Honduras Thanks Cuba . . . ." A similar sentiment was expressed by Guatemalan president Alvaro Colom as he attended the inauguration of the third ophthalmological hospital in his country: "This hospital is part of the sacrifices made by the Cuban people. This act of solidarity is worth much more, however, because Cuba does not have the economic resources that other countries do. But it does have human resources, and a huge human heart—and that is why we should be exceptionally grateful." Quoted in the Cuban diplomatic bulletin, "Cuba entrega a Guatemala tercer hospital oftalmológico" (April 21, 2008), found at http://www.cubacoop.com/cubacoop/2008/Cuba.html.
35. "Cuban Doctors Help Thousands of Guatemalans to Recover Sight," *Agencia de Información Nacional* (August 7, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
36. Juan Marrero, "Operation Miracle: A True Remedy," *Granma* (August 21, 2007).
37. Quoted in "Cuba Supports Venezuelan Sovereignty Decision," *Granma* (June 6, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
38. Cited in Kovac, op. cit.
39. See "Reflexiones del compañero Fidel: Nuestro espíritu de sacrifico y el chantaje del imperio," *Granma* (April 25, 2008).

40. Information provided in "Más de 11 millones de consultas médicas gratuitas en Bolivia," *Granma Internacional* (April 9, 2008).
41. "Médicos cubanos salvaron las vidas de cuatro mil 300 bolivianos," *WDS Report* (February 5, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
42. "Literacy Program Keeps Benefitting Bolivians," *Agencia de Información Nacional* (June 22, 2007) accessed via the listserve at <Cuba-L@unm.edu>.
43. "400 médicos cubanos atienden a damnificados por desastres naturales," *Agencia Bolivariana de Información* (February 21, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
44. "Cuban Doctors Saving Lives in Bolivia," *Agencia de Información Nacional* (February 5, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
45. See "Cooperación oftalmológica de Cuba permitió ahorro de 80 millones de dólares a Bolivia," *MINREX* (April 17, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
46. See "Médicos cubanos atendieron más de seis millones de bolivianos," *Prensa Latina* (August 22, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
47. When questioned about concerns some Bahamians had expressed about setting up an embassy in communist Cuba, Ambassador Carlton Wright referred to the close ties between the two countries, the possibilities of enhanced trade, tourism opportunities, and technological assistance. He concluded: "You would be irresponsible to have a neighbor on your doorstep and not have relations with them, and this is all that this is about. This is not about ideology and it's not about politics. It's about practicality." Cited in Erica Wells, "Strengthening Ties with Cuba," *Nassau Guardian* (July 23, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
48. Fidel Castro, "Fidel Castro Addresses Cuba-CARICOM Summit" (December 9, 2005), accessed via the listserve at <Cuba-L@unm.edu>.
49. "Statement by the Ministry of Foreign Affairs," *MINREX* (Havana, December 7, 2007).
50. "Presidió Raúl Castro acto de recibimiento a Primer Ministro de Jamaica," *Agencia de Información Nacional bulletin* (May 5, 2008).
51. Cited in Marc Frank, "Eye Surgeons Bring a Ray of Hope to the Caribbean," *Financial Times* (October 21, 2005), accessed via the listserve at <Cuba-L@unm.edu>.
52. "Education Priority, PM Tells Jamaicans Studying in Cuba," *Jamaican Information Service* (September 22, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
53. See "Prime Minister of St. Lucia Arrives in Cuba," *Granma* (May 22, 2006), accessed at via the listserve at <Cuba-L@unm.edu>.

54. Francisco Forteza, "Premier de Santa Lucía se reúne con presidente cubano en ambiente cordial," *Granma* (May 24, 2006), accessed via the listserve at <Cuba-L@unm.edu>. Translation of this and of other material in Spanish is by the authors.
55. "CARICOM Tells U.S. They Will Remain Friends with Cuba and Venezuela," *Caribbean Broadcasting Corporation* (June 25, 2007), accessed via the listserve at <Cuba-L@unm.edu>. Significantly he added: "In Guyana's case, I said to him that the students that we have studying in Cuba, if we were to send those students to the United States of America, it would cost us $70 million [. . .] That is important to me, educating the doctors."
56. Cited in Corliss Smithen, "Harris Reflects on CARICOM-Cuba Relations," *Sun St. Kitts/Nevis* (December 11, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
57. Daniel P. Erikson, "Hugo Chávez: Cuba's Next Kingmaker," *Los Angeles Times* (August 16, 2006).
58. Cory López, "Creció en 2006 el comercio cubano-venezolano," *WDS News Agency* (November 11, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
59. Hampden Macbeth, "The Not So Odd Couple: Venezuela's Hugo Chávez and Cuba's Fidel Castro," press release from the *Council on Hemispheric Affairs* (June 21, 2005), accessed via the listserve at <Cuba-L@unm.edu>.
60. "Cuba, Venezuela Closer to Strategic Alliance," *Prensa Latina* (February 5, 2007), accessed via the listserve at <Cuba-L@unm.edu>. Venezuelan ambassador to Cuba, Alí Rodríguez put it higher—at $3 billion—and claimed that Cuba received 92,000 barrels of oil per day. See "Venezuela comercia con Cuba por USD 3,000 millones, envió 92,000 bd de crudo." *AFP*, accessed via the listserve at <Cuba-L@unm.edu>.
61. "Lage Extols Cuba-Venezuela Solidarity," *Granma* (December 23, 2007).
62. Marta Lomas, "Discurso de Marta Lomas, ministra de Inversión Extranjera y Colaboración Económica de Cuba, April 29, 2006," accessed via the listserve at <Cuba-L@unm.edu>.
63. "Declaración conjunta de las delegaciones de la República Bolivariana de Venezuiela y de la República de Cuba en ocasión de celebrarse la VII Reunión de la Comisión Mixta del Convenio Integral de Cooperación," *Granma* (March 1, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
64. See the speech of Carlos Lage, "Una verdadera integración de dos pueblos latinoamericanos," *Juventud Rebelde* (January 25, 2007).
65. Lomas, op. cit.
66. Data provided by the "Declaración conjunta . . .," op. cit.
67. Lomas, op. cit.

68. Salim Lamrani, "La deuda de Venezuela con Cuba," *Progreso Semanal* (Miami, January 10, 2008).
69. "Cuban Sports Trainers Hard at Work in Venezuela," *Agencia de Información Nacional* (August 8, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
70. Data provided by the "Declaración conjunta. . . .," op. cit.
71. "Ministerio de Agricultura cubano en 28 proyectos conjuntos con Venezuela," *Prensa Latina* (November 22, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
72. Cited in "Afirma Chávez que su socialismo es distinto al de Cuba," *El Informador* (January 29, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
73. Ian James, "Chávez and Castro: The Friendship That May Challenge U.S.," *Associated Press* (September 13, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
74. Ibid.
75. "When critics lightly pass over the thousands of Cuban doctors, and medical technicians, literacy workers and teachers working in Venezuela, they do not take into account the decades of massive social investment it took Cuba to make such exports possible. The accumulated social and educational [programs] that the island now exports has not been quantified nor measured, yet it is a monumental contribution with vast and long-term consequences in the hemisphere." Quote from Robert Sandels, "Cuba-L Analysis: The Other Revolution" (April 21, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
76. Marc Frank, "Chávez Victory Bolsters Cuba's Succession Hopes," *Financial Times*, accessed via the listserve at <Cuba-L@unm.edu>.
77. The role of Petrocaribe, created in 2007, is important. Its objective—as in the Cuban case—is to provide subsidized oil to 16 nations in Latin America and the Caribbean. By August 2007, this had resulted in a saving of $450 million for the nations involved. The Venezuelan government oil agency PDVSA has also helped to install or construct distribution centers in Belize, Dominica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Grenada, and Haiti and has sent generator equipment to Saint Kitts and Nevis, Antigua and Barbuda, Nicaragua, and Haiti. Together with supplying Cuban technicians there are also plans to build or extend oil refineries in Dominica, Jamaica, Guyana, Belize, Haiti, and the Dominican Republic—specifically as a means of reducing their dependence on U.S. refineries. On a much smaller scale, these initiatives, together with the distribution of tens of millions of incandescent light bulbs and the actual reductions in the price of oil by the 16 nations of PetroCaribe, have followed the same thrust as Venezuelan initiatives in Cuba. (Repayment terms for Venezuelan oil are, as in the case of Cuba, extremely generous: there is a 25-year

repayment plan, with an interest charge of 1 percent if the price of crude rises above $40 the barrel. See "PetroCaribe Apuesta por la Seguridad Energética," *Prensa Latina* (August 17, 2007), accessed via the listserve at <Cuba-L@unm.edu>. Another unusual twist comes from an alternative form of repayment: "Countries are allowed to pay off part of their oil bills in goods and services. Dominican president Leonel Fernández said his country hopes to begin an exchange program offering hotel and tourism training to visiting Venezuelans." Speaking in August 2007 to the members of PetroCaribe, Chávez pledged Venezuela's support for the region's nations. He predicted a steady increase in the price of oil but noted, "If we truly unite ... the grandchildren of our grandchildren will have no energy problems." See "Venezuela's Chávez Pledges to Meet Long-Term Oil Needs in Caribbean," *Associated Press* (August 11, 2007), accessed via the listserve at <Cuba-L@unm.edu>.

78. Frances Robles and Steven Dudley, "Chávez May Be Buying Cuba's Future with Oil," *Miami Herald* (August 30, 2006), accessed via the listserve at <Cuba-L@unm.edu>. Other estimates are as high as $4 billion—not in terms of the contractual cost, but rather in terms of value if sold in the international market. See Jorge Piñon, "Venezuelan Oil Subsidies to Cuba Surpassed $3 Billion in 2006," *Cuba Facts*, No. 34 (August 2007).
79. An alternative interpretation emphasizes the ideological dependence of Venezuela on Cuba:

    > It is well known that the political alliance between Venezuela and Cuba is strong, as are the personal ties between Chávez and Castro. Yet the government in Caracas claims that it is promoting a move towards homegrown socialism that is inspired by the Cuban experience, but with a Venezuelan face. A closer look at the policies implemented in Venezuela to consolidate power and enroll the populace in internal intelligence collection and armed defense, policies entrenched in Cuba for some time, may undermine this claim.

    See Eric Driggs, "Is Venezuela Following the Cuban Model?" *Cuba Facts*, No. 33 (July 2007), accessed via the listserve at <Cuba-L@unm.edu>.
80. While Cuban doctors working in the 36 countries covered by the General Comprehensive Agreement (PIS) receive about $150 per month, in Venezuela the salaries are higher—approximately 700 bolivares, or $200. In addition, each month 50 CUCs or convertible pesos (each worth approximately $US1.20) are deposited in Cuba for a designated person to collect. Finally, bonuses for each year successfully completed are deposited and can be drawn when the mission is completed.
81. See Robles and Dudley, op. cit.

82. "Chávez Praises Balanced Exchange with Cuba," *Granma* (November 11, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
83. One benefit that has accrued for Cuba and is difficult to quantify is the increasing popular acceptance of the revolution, as Venezuelans have overcome long-held stereotypes of the process on the island. See Enrique Ubieta Gómez, *Venezuela rebelde: Solidaridad vs. dinero* (Havana: Casa Editora Abril, 2006).
84. Mercedes Ibaibarriaga, "Entrevista a Felipe Pérez Roque," *Boletín por Cuba* (May 18, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
85. Francisco Forteza, "Cuba y Venezuela en proceso integracionista," *WDS Report* (January 25, 2007), accessed via the listserve at <Cuba-L@unm.edu>.
86. Brian Latell has also drawn out the personal influence of Fidel Castro on Hugo Chávez, noting how the Venezuelan had come to Havana in 1998 when Chávez had been released from prison after leading a coup six years earlier. In April 2002, after being arrested in an attempted coup, Chávez sought the support of Castro, who provided him with strategic advice and also lobbied Venezuelan military leaders to free the president. See "The Castro Brothers and Hugo Chávez," *The Latell Report* (October 2006), accessed at http://ctp.iccas.miami.edu.
87. See "Chávez cierra campaña y anuncia la agenda bolivariana del siglo XXI," *La Jornada* (November 27, 2006).
88. Speaking in July 2006, Chávez condemned the claims by the U.S. Presidential Commission for Assistance to a Free Cuba that Cuba was using Venezuela's oil revenues to promote subversion in the hemisphere: "It is precisely now that Venezuela will further support the Cuban people and their revolution. There will be no empire, no matter how powerful, capable of discouraging us from keeping our strategic alliance with Cuba. We feel ourselves increasingly encouraged to keep with that alliance every single day." Cited in "Washington Threatening Cuba and Venezuela, Says Hugo Chávez," *Agencia de Información Nacional* (July 12, 2006), accessed via the listserve at <Cuba-L@unm.edu>.
89. Cited in Daniel P. Erikson, "Hugo Chávez: Cuba's Next Kingmaker," *Los Angeles Times* (August 16, 2006).
90. "Chávez dice si invaden Cuba también correrá sangre venezolana," *EFE News Report* (June 22, 2006).
91. See "Zimbabwe: Hospital Gets Cuban Docs," *The Herald* (Harare, April 23, 2008), accessed via the listserve at <Cuba-L@unm.edu>.
92. Quoted in Raúl Zibechi, "Haití y Tibet: Las miserias del doble discurso," *ALAI* (Ecuador, April 13, 2008), accessed via the listserve at <Cuba-L@unm.edu>.

6 Toward an Understanding of Cuban Medical Internationalism

1. Patricia Grogg, "Economía—Cuba: Modelo para armar," *Inter Press Service* (Rome, May 23, 2008), available on the Internet at <Cuba-L@unm.edu>.
2. See Julie M. Feinsilver, "Cuban Medical Diplomacy: When the Left Has Got It Right," *Council on Hemispheric Affairs* (October 30, 2006), available on the Internet at www.coha.org/2006/10/30/cuban-medical-diplomacy-when-the-left-has-got-it-right/. For the 2006 data on principal exports of Cuba, see www.economist.com/countries/Cuba/profile.cfm?folder=Profile=Economic%20Structure.
3. Linda Robinson, "The Island of Dr. Castro," *U.S. News and World Report* (April 27, 2007).
4. Christopher Marquis, "Medical School for Latins Earns Cuba Goodwill," *Miami Herald* (March 13, 2000).
5. Feinsilver, op. cit.
6. Coverage in Cuban media of the visit of Guinea Bissau president Joao Bernardo Vieira in April 2007 illustrates the emphasis placed upon these themes. The president met with some 400 Cubans who had fought in Guinea Bissau. He visited ELAM, where he noted, "I saw how this beautiful project that offers other countries the possibility to educate their professionals contributes to the unity among the nations of this area. It's part of the work of this revolution." He noted the presence of 21 Guineans studying in Cuba. And he spoke of support for Cuba: "There's no doubt of our alignment with Cuba. After our liberation struggles we have always had your solidarity and support. This is not a debt, but we believe that it is an obligation to be alongside Cuba, and for that reason we always support that position [condemning the U.S. embargo] at the United Nations." See Deisy Francis Mexidor, "Interview with Guinea Bissau President Joao Bernardo Viera," *Granma* (April 10, 2007).
7. See the two *Agencia de Información Nacional* reports of April 30, 2008, "Encuentro del Emir de Qatar con presidente cubano," and "Emir of Qatar Begins Working Visit to Cuba," available on the Internet at <Cuba-L@list.unm.edu>.
8. Feinsilver, op. cit. The most recent official figures (January 2009) indicate that there are 1,196 Cuban medical personnel (including 827 doctors) in 22 African countries. Data found at: http://www.cubacoop.com/Cubacoop/Cooperacion_Resultados Generales.html.
9. "There these doctors are incredibly popular, not only because they are considered highly competent but also because of their nonhierarchical and sociable behavior. Their hands-on, resourceful manner, under what are admittedly tough working conditions, and the fact they can be found even in the most remote rural areas, where

most medics prefer not to go, are also highly recognized." See Katrin Hansing, "Cuba's International Development Assistance: A Model for the Non-aligned Movement?" *FOCALpoint*, Vol. 5, No. 7 (September 2006), 3.

10. This section draws heavily upon a lecture by Margaret Blunden, director of the International Institute for the Study of Cuba Policy Unit, London Metropolitan University (January 8, 2008).
11. Data found at Gail A. Reed, "University of the Gambia: Medicine Seemed the Place to Start," *Medicc Review*, Vol. 7, No. 3 (July 2005), available on the Internet at www.medicc.org.
12. This section is based upon helpful insights provided by Dr. Ernesto Menéndez Cabezas, former head of the Medical School in Gambia.
13. One Gambian student summed up well the practical nature of the medical training provided by their Cuban professors:

    > Above all [. . .] they brought their spirit. From the start it was clear that they were teaching to prepare us, to make sure we understood we had a responsibility to our people, to help them come out of the cycle of disease and poverty and ignorance. They never minced words about that. And so, from the beginning we visited communities and families to get a sense of their problems, and to lay the foundation for ourselves. (Cited in Reed, op. cit.)

14. Information located on the website of the Cuban Embassy in Gambia at emba.cubaminrex.cu/Default.aspx?tabid=13720.
15. This section draws upon Gail A. Reed, "Dusk to Dawn: Fighting Malaria in Gambia," *Medicc Review,* Vol. 7, No. 7 (July 2005), available on the Internet at www.medicc.org.
16. Figures found at "Llegará hoy a Cuba Canciller de Timor Leste," *Granma* (May 6, 2008), available on the Internet at <Cuba-L@unm.edu>.
17. Deputy Minister Yiliam Jiménez, quoted in Gail Reed, "Cuba: More Doctors for the World," *Cuba Health Reports* (April 14, 2008), available on the Internet at www.medicc.org/cubahealthreports/chr-article.php?&a=1066.
18. See W.T. Whitney Jr., "Cuban Medics Prepare to Leave Pakistan," available on the Internet at www.pww.org/article/view/8843/1/315/ and Conner Gorry, "Cuban Doctors Offering Massive Relief in Pakistan," *Medicc Review*, Vol. 8, No. 1 (March-April 2006), available on the Internet at www.medicc.org.
19. See "Timor Leste seguirá apoyando a Cuba en su lucha contra el bloqueo," *Granma* (May 10, 2008), available on the Internet at <Cuba-L@unm.edu>.
20. Interview with the authors, Ministry of Foreign Relations, Havana (May 10, 2007).
21. Cited in DeWayne Wickham, "Thwarting Cuba's Medical Diplomacy Will Backfire," *Gannet News Service* (March 5, 2007).

22. Cited in Jasmin Bonimy, "Christie Stands by Cuba," *Nassau Guardian* (November 14, 2006), available on the Internet at <Cuba-L@unm.edu>. An editorial in *The Bahamas Journal* (May 5, 2005) illustrated the subconscious respect for Cuba because of its humanitarian solidarity in the region:

    > In this regard, no other country in this world can boast to having done as much for as many as has Cuba [...] Cuba last year upgraded its consul general to an ambassador, and the Bahamas—which recently named a resident ambassador to Cuba—plans to open an embassy in Havana in coming weeks. Also, some 300 Bahamians recently received free eye surgery, courtesy of the Cuban government. (available on the Internet at <Cuba-L@unm.edu>)

23. For his part Dominica's prime minister, Roosevelt Skerrrit, revealed his appreciation of Cuban humanitarianism, while at the same time criticizing U.S. policy toward Cuba, again illustrating the link between Cuban solidarity and political support: "We, since 1979, have been benefitting from the goodwill of the Cuban leader and the Cuban people. And to appreciate the contribution of the Cuban people is to have a greater understanding of the struggles they have gone through as a result of the economic blockade that has been placed before them for so many years." Quoted in "Dominica PM Acknowledges Castro's Contribution to Humanity," *Caribbean Net News* (August 1, 2006), available on the Internet at <Cuba-L@unm.edu>.
24. See www.who.int, for pertinent data. Whereas Cuba spends 7.6 percent of its GDP on health care, the United States spends 15.2 percent (all 2005 data)—and yet the Cuban model obtains better health results in some key areas.
25. Tatyana Guerrero-Pazano, a student from New Mexico, is one of the U.S. students at ELAM. She noted in an Albuquerque newspaper the advantages of training in Cuba, stating that "it is inspiring to work in a country with free, universal health care. She said Cuban doctors focus on patients' needs rather than the cost of quality treatment," and concluding that "if we were to focus on health promotion and prevention instead of treating something once it's already developed into a full-blown disease, I think this country and this state would have a lot less of a bill to pay in terms of public sector health care." See Bryan Gibel, "U.S. Students Study for Free at Medical School in Cuba," *Daily Lobo* (September 28, 2007), available on the Internet at <Cuba-L@unm.edu>.
26. See the Cuban Constitution at www.cuba.cu/gobierno/cuba.
27. "Confirman Cuba y Venezuela graduación de 200 mil médicos," *Prensa Latina* (April 23, 2007), available on the Internet at <Cuba-L@unm.edu>.

28. Francisco Forteza, "Canciller cubano: No damos lo que nos sobra. Compartimos lo que tenemos," *WDS News Agency* (Havana, June 27, 2007), available on the Internet at <Cuba-L@unm.edu>.
29. "Cooperación oftalmológica de Cuba permitió ahorro de 80 millones de dólares a Bolivia," MINREX statement of April 17, 2007.
30. Bolivian socialist senator Antonio Peredo has expressed this possibility well: "We will also need to develop the same internationalist spirit, so that one day doctors, artists or athletes from Bolivia can offer their experience and contribute to the development of other nations." Quoted in Cory López, "Un millón de bolivianos atendidos por médicos cubanos," *WDS News Service*, available on the Internet at <Cuba-L@unm.edu>.
31. Interview with the authors, Ministry of Foreign Relations (Havana, May 10, 2007).
32. See the *Bloomberg* news report of September 19, 2007, by Bill Faries, "Bush, Chávez, Castro Wield Scalpels in Fight for Latin America," and the *EFE (Madrid)* news report of September 24, 2007, "U.S.: Hospital Ship Not Reaction to Chávez-Castro Health Efforts," both available on the Internet at <Cuba-L@unm.edu>.
33. *Caribbean Broadcasting Corporation, Barbados Report*, "CARICOM Tells U.S. They Will Remain Friends with Cuba and Venezuela" (June 25, 2007).
34. Chris Kraul, "Catching Up in Medical Diplomacy in Panama, U.S. Doctors Aid the Poor in a Challenge to the Efforts of Cuba and Venezuela," *Los Angeles Times* (April 9, 2007).
35. See the letter from the reader identified as Chitraykha, "Cuba has given us medical help for decades," in the *Starbroek News* (October 13, 2007), available on the Internet at <Cuba-L@unm.edu>. In a related comparison, it is worth contrasting the assistance provided to Ukrainian children by Cuban-Americans with that given by the Cuban government. Mention was made earlier about the 23,000 children who have received medical assistance at no charge in Cuba since the meltdown of the Chernobyl nuclear reactor in April 1986. One article in the *Miami Herald* presented "nine Ukrainian children frolicking with dolphins at the Miami Seaquarium" and mentioned how an organization known as Cuba Democracy Advocates hoped to pay for prosthetics for 30 children from poor backgrounds." As the article shows, there is a strong political rationale for this aid. See Laura Wides-Muñoz, "In New Political Era, Cuban-Americans Help Ukrainian Children," *Miami Herald* (October 8, 2007).
36. Cited in Gary Marx, "Cuba Loses Doctors to Asylum Offer," *Chicago Tribune* (February 11, 2007), available on the Internet at <Cuba-L@unm.edu>. It is perhaps significant that this amounts to a rate of between 2 percent and 3 percent of Cuban medical staff who have taken the U.S. offer and sought exile in the United States. A useful comparison can be made with the annual rate of medical

graduates from Canadian medical schools who emigrate to the United States—about 9 percent. See also Tal Abbady, "Hundreds of Cuban Medical Workers Defecting to U.S. while Overseas," *Sun-Sentinel* (October 10, 2007), available on the Internet at <Cuba-L@unm.edu>.

37. Feinsilver, op. cit.
38. "Aumentará a 80 la cantidad de países con médicos cubanos," *Ahora* (Holguín, March 28, 2008), available on the Internet at <Cuba-L@unm.edu>.
39. See "Médicos cubanos atienden a 70 millones de personas en el mundo," *Juventud Rebelde* (April 13, 2008), available on the Internet at <Cuba-L@list.unm.edu>.
40. "Cuba to Extend Medical Collaboration to 81 Countries," *Granma International* (April 1, 2008), available on the Internet at <Cuba-L@list.unm.edu>.
41. See "Fidel y Chávez son médicos de almas, médicos de pueblos," *Granma* (April 12, 2007), available on the Internet at <Cuba-L@unm.edu>.
42. Cited in Ubieta Gómez, *Venezuela rebelde: Solidaridad vs. dinero* (Havana: Casa Editora Abril, 2006), 76.

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