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# Cuban Medical Internationalism and the Development of the Latin American School of Medicine

by  
Robert Huish and John M. Kirk

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*In response to Hurricane Mitch (1998) in Central America, which claimed over 30,000 lives, Cuba sent medical brigades to the affected region and constructed the Latin American School of Medicine just outside Havana. This medical school offers a free six-year medical education to students from rural and marginalized communities in Latin America, Africa, Asia, and the United States. This establishment is a logical continuation of a long-standing tradition of Cuban medical internationalism that emphasizes investment in human capital. This is a progressive movement not just in foreign policy but also in community medicine that has an important place in dialogues about capacity building and human security strategies for the twenty-first century.*

**Keywords:** *Latin American School of Medicine, Medical internationalism, Human security, Cuban doctors, Human resources for health*

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The 1,300 lives lost and the damage, estimated conservatively at over \$200 billion, caused by Hurricane Katrina in the southern United States in 2005 not only constitute an example of the awesome power of nature but also demonstrate how little attention has been given to preventing such human security disasters. While in this instance the North American media provided scores of harrowing accounts of death and destruction, they have said very little about a far worse hurricane that tore through Central America in 1998. In October of that year, Hurricane Mitch took over 30,000 lives. Within 24 hours some 1,300 Cuban medical volunteers were in the affected region offering relief. They were sent to work in the most outlying areas, where their mission was to save as many lives annually through care and treatment as the hurricane had claimed (Castro, 2005). What made this response truly exceptional was the Cubans' innovation of long-term capacity-building strategies to lessen the impact of such disasters in the future.

In response to Hurricane Katrina, Cuba offered to send, at no cost, some 1,586 medical personnel and 36 tons of emergency medical supplies to help the affected communities. Tragically, Washington turned down this offer, apparently more concerned with saving face than with saving lives.

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Despite the enduring domestic hardship resulting from the collapse of the Soviet Union and frosty political relations with some of the Central American governments, Cuba did not hesitate to offer human security provision to the region and did so at little expense to capacity-building strategies on the island itself (Cole, 1998). Where it was unable to offer material supplies, it offered its most abundant resource: human capital. Its international cooperation in fact extends well beyond regional partnerships. Cuba has 42,000 workers in international collaborations in 103 different countries, of whom more than 30,000 are health personnel, including no fewer than 19,000 physicians. This paper focuses on the development of Cuban medical internationalism, which has provided and will continue to provide tremendous benefits for the developing South and possible lessons for the developed North.

Cuba's medical internationalism is based upon both foreign policy (several decades in the making) and community health care. It is human resource-driven and effectively offers immediate response to disasters, much-needed medical services, and long-term community-based capacity building. Beginning with the small medical brigade sent to Algeria in the 1960s, Cuban medical internationalism has provided tens of thousands of doctors around the globe. It has also developed a unique human resource-based approach to preventive medicine, converting a naval base into a medical school for the free training of doctors from the region devastated by Hurricane Mitch. Continually offering medical services in the world's most marginalized communities, Cuba's medical foreign policy is grounded in sound knowledge and experience of improving the health of communities not through material but through human resources.

Cuba's altruistic foreign policy has been a success because of advances in human resource-based community care. Organizations as the People's Health Movement call for increasing human resources in order to improve public health (San Sebastián et al., 2005). Cuban medical internationalism and especially the development of Escuela Latinoamericana de Medicina (the Latin American School of Medicine—ELAM) offer empirical examples of the success of this strategy. The ELAM is the latest step in a foreign policy initiative that focuses on preventive treatment, accessibility, and, most important, capacity building.

## THE TRADITION OF CUBAN MEDICAL INTERNATIONALISM

Converting a naval academy into a medical school and offering free training for lower-income foreigners may at first glance seem a radical step for a small country (pop. 11.3 million) still recovering from the disastrous effects of the collapse of the Soviet Union. Arguably, however, it is simply part of Cuba's long-standing tradition of global medical outreach. For over four decades Cuban doctors have practiced abroad, Cuban hospitals have healed the sick around the globe, and Cuban medical schools have trained foreigners. To explain how the ELAM came to be, it is necessary to contextualize it as part of a tradition of medical diplomacy and community participation in health care provision.

Sending doctors to underserved or conflict-ridden areas is the backbone of Cuban medical diplomacy. Even in the earliest stages of the revolution, when half of the country's 6,000 doctors fled and its human resources were just developing, a medical brigade was sent to Algeria (Frank and Reed, 2005; Feinsilver,

2006), and wounded soldiers and children were even transported back to Cuba for treatment (Gleijeses, 1996). This was not done for profit but was a consequence of a policy of proletarian internationalism and solidarity with other countries seeking to emerge from underdevelopment. Since then Cuba has provided medical assistance at no cost to dozens of countries in the South.

Between 1966 and 1974, Cuban doctors worked in Guinea-Bissau during its liberation struggle against Portugal (Gleijeses, 1997). When Guinean President Amílcar Cabral requested Cuban assistance, a small military contingent was sent to the region, along with training personnel and a 31-member medical brigade (Gleijeses, 1997). The Cubans provided not only the campaign's heavy artillery but also its only comprehensive front-line health care. Clearly, in both Algeria and Guinea-Bissau—two countries linguistically and culturally distinct from Cuba but involved in similar anticolonial struggles—the Cuban doctors acted as the first and only line of response for many of the casualties of the armed conflict.

Angola was the largest foreign campaign that Cuba has ever embarked upon. While some (e.g., Rozes, 1998) argue that the Cubans ultimately left Angola with a sense of defeat, it is clear that the Cuban intervention was vital in holding off advances from the South African apartheid regime and ultimately led to the removal of colonial governance. As in Algeria and Guinea-Bissau, human security provision went hand-in-hand with the military campaign. In 1977, two years into the Angolan campaign, "only one Angolan province out of sixteen was without Cuban health technicians" (Cohen, 1994: 21). Moreover, Cuban doctors not only worked in these hospitals but also effectively used the facilities to train locals on site.

This commendable record of providing much-needed medical and educational support was not limited to ideological allies. In May 1960, for example, Cuba dispatched a medical team to Chile (headed by the Christian Democrats under Alessandri) after an estimated 2,000 people were killed in an earthquake, and in 1972 it sent doctors to Nicaragua, headed by Anastasio Somoza Debayle, an outspoken enemy of the Castro government, after a massive earthquake there killed 20,000. Doctors went to Iran after a major earthquake in 1990 despite Cuba's strong ties to Iran's foe, Iraq. In 2000 Cuba sent medical personnel to El Salvador following the outbreak of dengue fever there, and in 2001 it donated 1.2 million doses of vaccine to Uruguay following an outbreak of meningitis—this despite the fact that El Salvador had traditionally supported U.S. initiatives against Cuba at the UN Human Rights Commission and Havana and Montevideo had just broken off diplomatic relations, again over the human rights question. In all these cases ideological differences were set aside and long-term humanitarian interests were consistently given preference.

During the Gulf War in 1991, Cuba sent medical teams that stayed in Iraq after international aid organizations had left. In Kosovo a large medical contingent of Cubans provided care for the embattled population. A 40-member medical team spent several months in Guyana in 2005 tending to the needs of the population after massive flooding there. In Paraguay some 50 Cuban doctors and epidemiologists are working to combat infectious diseases, as well as providing general medical services. In 2005 there were 86 Cuban doctors working in Botswana. Others are working in Zambia, mainly in the struggle

against the HIV/AIDS pandemic that is sweeping that country. Cuba has offered to send some 5,000 medical workers to work for free combating HIV/AIDS in sub-Saharan Africa if the West will provide the medications required. So far the silence from the First World has been deafening. Some 75 Cuban medical professionals remain in Yemen. From Botswana to Bolivia (where there were 1,700 Cuban doctors as of 2007), Cuban medical personnel are undertaking internationalist service at minimal cost to the host country. Patients are not charged for services, and the recipient countries are expected to cover only the cost of collective housing, air fare, and limited food and supplies not exceeding \$200 a month (interview, MINREX, March 20, 2007). While Cuban doctors are abroad, they continue to receive their salaries as well as a stipend in foreign currency. Of the 30,000 health personnel working overseas, many are participating in the field hospitals and schools that are training over 40,000 students as doctors, nurses, and health technicians.

The Cuban presence in Venezuela is an example of strong solidarity under multinational political agreements. Cuba receives 100,000 barrels of petroleum daily at preferential rates from Venezuela's offer as a member of CARICOM. Likewise, Havana's pledge to send health personnel to any CARICOM country that requests assistance has seen the contribution of 20,000 Cuban health personnel to Venezuela, working mainly in underserved areas through the "Barrio Adentro" program.

While the doctors working abroad were providing services in the field, the infrastructure capacity for treatment within Cuba was steadily improving during the 1970s and 1980s. Recognizing this, the Cuban government routinely accepted foreign patients with long-term chronic degenerative diseases and persons requiring complex treatment. One such instance followed the nuclear disaster at Chernobyl in 1986. Since 1990, Cuba has provided long-term care for 18,000 victims of this disaster, offering treatment for hair loss, skin disorders, cancer, leukemia, and other illnesses attributed to radioactivity. To this day Chernobyl victims travel to Cuba to receive treatment (Reuters, 2005). It is significant that, despite Cuba's enormous financial difficulties since the demise of the Soviet Union, it has continued to provide treatment to these victims at no cost.

The most recent example of Cuban medical internationalism is a joint venture with Venezuela, "Operation Miracle," designed to restore sight at no cost to poor Latin Americans. This is a collaborative effort within CARICOM to use human capital from Cuba and petroleum capital from Venezuela to improve the quality of life for tens of thousands from the poorest communities in the Caribbean and South America. As of August 2007, Cuba had performed over 750,000 eye surgeries, at no cost, including 113,000 surgeries for its own citizens. Thirty-seven ophthalmologic centers have been established in eight countries (Cuba Cooperation, 2007).

## **CUBAN MEDICAL AID IN CENTRAL AMERICA**

Solidarity with Central America and Haiti is what ultimately inspired the creation of a free medical school for marginalized students. It is the result both of this long-standing medical tradition and of innovative thinking in Havana

in the wake of natural disasters. When Hurricane Mitch struck, some 2,000 Cuban medical personnel were sent to the region over several weeks, and Cuba cancelled the US\$50 million debt owed to it by Nicaragua. It soon became evident that the damage in Central America was so extensive, and the existing health infrastructure so weak, that a radically different approach to the massive health care problems of the region was needed. In December 1998, the Cuban government announced that medical scholarships would be given to students of the affected region so that they could study medicine at no cost in Cuba and eventually take over from Cuban medical staff working in their home countries. Fidel Castro summarized the new policy as follows: "We need to go beyond weeping for those who have died, and engage ourselves in saving those who die in silence every year" (quoted by Valencia Almeida, 1998).

As a result of neoliberal restructuring in Latin America, many of the rural communities throughout the region suffer from a lack of infrastructure and intersectoral support (Ugalde and Homedes, 2005a; 2005b). Untried neoliberal policies "presented as Darwinian fact," as Ralston Saul (2005: 3) puts it, have been "an experiment that attempted simultaneously to reshape economic, political and social landscapes." This experiment has destroyed the very social elements that allowed Cuba to develop its own functioning public health sector. When Hurricane Mitch struck, little could be done at the local level to move beyond emergency health care. What was urgently needed was the establishment of long-term preventive health programs so that the affected countries would not be entirely dependent upon such emergency missions.

The impact of the Cuban medical teams in Central America has been beneficial to marginalized communities. For example, some 795 doctors had spent time in Honduras (EFE, 2003). In 2003, on the fifth anniversary of the arrival of the Cuban medical contingent, the ambassador to Honduras, Alberto González Polanco, provided significant data on the effects of the Cuban presence: some 3.7 million consultations had been conducted by Cuban medical staff, along with 31,627 major operations and 28,346 minor surgical interventions (EFE, 2003). Since the Cubans had offered to train Hondurans free, some 700 Honduran students had enrolled in ELAM. The impact of the Cuban medical professionals had been especially significant in rural areas, where some communities were receiving medical attention for the first time. In the areas they served, infant mortality rates were reduced from 30.8 to 10.1 per 1,000 live births and maternal mortality rates from 48.1 to 22.4 per 1,000 live births between 1998 and 2003 (Riera, 2006). According to the World Health Organization, the national infant mortality rate remains quite high, at 41 per 1,000, and only 55.7 percent of births are attended by skilled health personnel (WHO, 2006a; 2006b). In Guatemala the Cuban contribution has also been notable. The service of some 1,700 medical staff was recognized in 2004 by former President Alfonso Portillo, who bestowed the Order of the Quetzal (the highest official state distinction) upon the Cuban medical brigade. Certainly the medical brigades can and do save lives—but they also inevitably create dependency in the host countries; moreover, they are largely unable to further popular health care provision, which is a key health determinant (San Sebastián et al., 2005).

It has been suggested that Cuba is co-opting governments abroad by "flooding the market" with free doctors (BBC News, 2005). Clearly, its policies

have helped strengthen its diplomatic relationships abroad. For example, when Honduran President Carlos Flores reestablished diplomatic relations with Cuba in 2002, the Cuban commitment to improving the public health sector in his country was undoubtedly a deciding factor. Guatemala, too, has changed its stance toward Cuba in no small measure because of Cuban medical support. Finally, in an important gesture of solidarity, Panamanian President Martín Torrijos accompanied the first patients from his country to Cuba, where they had eye surgery in December 2005. It has also been argued that Cuba needs a huge market for its successful biotechnology products and therefore is creating a dependence upon Cuban medications in the developing world (Fawthrop, 2003; Aitsiselmi, 2002). Finally, it has been said that “doctor diplomacy” is simply a means of bringing in desperately needed hard currency from the countries that pay for Cuba’s medical services (Kitchens, 2005). Given that host countries pay only for the basic costs of visiting doctors and the communities served are in no position to pay in hard currency, this is a naïve claim.

Cubans have complained that their local clinics are shorthanded because of the number of doctors abroad—even though Cuba’s patient-to-doctor ratio of 159:1 is still among the best in the world and significantly better than those of the United States and Canada (250:1 and 450:1, respectively [Cancio Isla, 2006]). Still, medical internationalism is not without its genuine critiques. It has also been suggested that the doctors are really covert agitators bent on spreading dissent in rural areas (Kitchens, 2005). Even some of the less politically charged arguments, which acknowledge Cuba’s genuine internationalist health concerns, hold that the Cuban strategy must have some sort of political motivation (Kitchens, 2005). The idea of a nation saving lives and improving the human condition is alien to traditional statecraft and is therefore discounted as a rationale for the Cuban approach. This analysis fails to take Cuba’s humanitarian record into account and speaks to the selfishness of many industrialized countries, since Cuba provides more medical personnel to the developing world than all the G-8 countries combined.

Most countries receiving Cuban medical assistance have undergone massive restructuring of their social services and public sectors. Decades of neoliberalism have brought Southern economies to a standstill. As Ralston Saul points out, “by the mid-1990s the poorest countries carried debts they could not service without damaging themselves” (2005: 103). In the cases of Guatemala and Honduras, both internal and external restructuring have left the public health care sectors in terrible shape. The very fact that these so-called reformed countries desperately need Cuban assistance speaks to the failure of the neoliberal project. For-profit and centralized services are well beyond the reach of many of the poor in the developing South. Private-sector health provision does not reach the most desperate of populations because of a general inability to pay (Ingco et al., 2004: 179–180). While some argue that economic demand could be generated among the poor with increased wealth, this would not solve the problem of the immediate demand for health care services.

In sum, Cuba has made a major contribution to the lives of millions of people in underdeveloped areas. Its next innovative step in health care came about when the government, maintaining a strong medical presence overseas, decided that in the long run it made more sense to educate Latin Americans and Africans to heal themselves.

## THE ORIGINS OF THE LATIN AMERICAN SCHOOL OF MEDICINE (ELAM)

As the Cuban government came to appreciate, in Central America community health is made sustainable through proactive and participatory methods. To a large extent it had already been pursuing this goal in contributing to the establishment of nine small medical schools in several countries (from Yemen in 1976 to Guinea-Bissau in 2004), but these efforts depended upon local government cooperation and involved small numbers of Cuban professors and medical staff.

In most of the international medical brigades Cuban doctors, working in areas with minimal infrastructure, trained locals as nurses and aides. While this was a step forward in local capacity building, it did not train locals to higher levels of medicine. Recognizing the need to go further, Cuba first opened up its own medical training space to foreign students by offering scholarships. Thousands of young people from around the globe have received free education in the country's 20 medical schools. In the spring of 2004, for example, there were 13,945 foreign students—from 113 countries—in receipt of scholarships (not exclusively in medicine) from the Cuban government (*Granma*, 2004). With the establishment of the ELAM, Cuba's capacity to train foreign students increased exponentially. Since opening the school in 1998, Cuba has offered medical training to the poor of the South on a scale never before seen. The original intake was solely from Honduras, Guatemala, and Nicaragua, the countries devastated by Hurricane Mitch, but soon this was expanded to the entire hemisphere and then to Africa. The ELAM has taken in between 1,400 and 1,700 students each year, with a total of 10,529 registered in 2004–2005, most of whom face discrimination or cannot afford medical training in their home countries (Frank and Reed, 2005). The program accepts, at no charge, students who come from rural or underserved areas of Latin America and lower-income backgrounds and are committed to returning to their home countries to work in areas that are truly in need.

The ELAM has accepted students from all regions in the Americas, including the United States and Puerto Rico. It has also received students from Africa, and 1,500 scholarships are now available for students from East Timor and Pakistan, the countries that received Cuba's Henry Reeve disaster response brigade in 2005. Without a written contract and without the threat of having to repay tuition, after completing a rigorous six-year curriculum these students leave Cuba as qualified doctors committed to returning to their countries to practice. At a time when rising tuition, privatization, and centralization of resources are adding to the exclusionary nature of medical school (Natale and Libertella, 1998), the ELAM has countered the neoliberal mind-set to offer opportunities to and empower the marginalized.

The project has already shown great potential for capacity building and increasing access to medical services for the poor of the Americas. Praising the success of the program and confident that it will have an impact on the quality of life for the poor of the South, Venezuelan President Hugo Chávez has begun the development of a second Latin American School of Medicine with the intention of eventually doubling the number of like-minded medical graduates. If his plan is implemented, the combined output of the two schools could exceed 3,000 doctors per year. While the project is significant in changing the

face and philosophy of community health in Latin America, the full spectrum of possible social, economic, and cultural outcomes is broader. It is obvious that this radically new approach will ultimately save hundreds of thousands of lives and empower a cohort of medical students throughout the continent to pursue community development in a way that has never been witnessed before.

### **ELAM—A RADICALLY DIFFERENT APPROACH TO PUBLIC HEALTH**

The essential objective of the Cuban model is to empower locals to take on community responsibility—to become active stakeholders at the local level, to act as protagonists instead of passive recipients. This is an essential component of the revolutionary credo practiced by Che Guevara and countless Cuban *internacionalistas* for over four decades. The distinctive nature of the ELAM is in large part a response to the rigors of globalization in Latin America. In essence it provides an antidote to the time-honored centralization of medical services, dependence upon costly technology, and fee-for-payment approach. While Cuba offers free education, privatization in both training and accessibility dominates the South. Reforms to health care services within a neoliberal framework have increased inequality and reduced accessibility, especially for the poorest social sectors (Armada, Muntaner, and Navarro, 2001; Laurell, 2001). As Waitzkin et al. (2005) argue, the idea of improving health through wealth has stripped the public sector of the responsibility to uphold traditional approaches to health as a right and health care as a public good. Ugalde and Homedes (2005a) argue that North-driven reforms in the South have had a detrimental impact on the capacity and quality of care of health care workers. As a result of structural adjustments, most Latin American countries have remarkably little capacity to provide even the most rudimentary medical service in outlying poor areas, leaving many countries to cling to the false belief that community health will improve along with national wealth (Mayer, 2001). As Kim (2000) demonstrates, the pursuit of growth and wealth often impedes health.

In pursuit of the efficiency valued by neoliberal discourse, over the past ten years both human and material health care resources have migrated to urban areas throughout the world (Dufour and Piperata, 2004). This centralization and market pressure have left rural areas without sufficient services and present serious challenges for the economically and racially marginalized (Galea and Vlahov, 2005). Health care workers find themselves forced into urban centers in order to repay the debts incurred through their education (Jolly, 2005), and in Latin America many have to take second jobs to supplement their income. Considering that ELAM graduates have no debt upon graduation, have experience in rural and underserved areas as well as in urban settings, and are willing to work in outlying areas, the potential exists for this project to counter some of the trends that have had such negative impacts on public health in Latin America.

Strikingly little attention has been given to the potential impact of the Cuban experiment. Recently, however, interest in learning more about it has begun to develop (De Vos et al., 2005; Warman, 2001). Recent themes in the health care literature, from volunteerism to outsourcing of services, encourage Cuba's

economic strategy of doing more with less. The example of a nation economically crippled by the dismemberment of the Soviet Union in 1989 may very well offer important contributions to the current literature on making public health truly accessible and effective not just in the South but in the North as well. The fact that, despite per capita spending on public health that is a fraction of that of the United States, Cuba has better key health indicators suggests that it may be time for developed countries to examine the Cuban model in detail (WHO, 2006a).

### LIFE AT ELAM

Visiting with ELAM students between June and December of 2005, we organized both individual and group interviews, and students took us through their training hospitals, clinics, and allowed us to visit them in their dormitories. We also attended some student-organized social events. From our interviews and informal discussions with 16 students from years three through six we are able to present insight into professional and social life at the school.

The ELAM consists of students from 29 countries in the Americas and Africa. In 2005, the student breakdown by year was as follows: pre-med, 1,478; first year, 1,595; second year, 1,313; third year, 1,610; fourth year, 1,611; fifth year, 1,424; sixth year, 1,428 (Frank and Reed, 2005). The students represent a sizable percentage of the 12,000 foreign medical students currently studying in Cuba. Some 1,610 students completed their medical education in Havana in 2005, and 49 percent of them were women—a significant development in a continent where the roots of machismo are very deep. The students came from 101 different ethnic groups, 33 of them indigenous to the Americas, and 72 percent could be identified as coming from rural or lower-income backgrounds (Frank and Reed, 2005). Some students with greater academic preparation have been able to follow an accelerated program and graduate in fewer than six years. In August 2006 another 1,590 students graduated with gender and demographic profiles remarkably similar to those of the original class.

The first two years of the program are structured as pre-med and train students in language and science skills, if needed. All courses are taught in Spanish and many students receive intensive instruction in the language. English is also taught to a working-knowledge level so that students can have access to and participate in recent developments in the literature, very few medical findings being published in Spanish. The mandatory curriculum is focused on family medicine and includes an emphasis on preventive medicine. Even in the first year of study students are exposed to community medicine and epidemiology, and in later years these themes are emphasized in courses such as disaster medicine and public health. In years three through six, almost half of the instructional time is spent in clinic and practice alongside other doctors and teachers. In year four, for example, only two of the eight offerings take place in a classroom setting. In year six students spend all of their time in a rotating internship called “pre-professional practice.”

Students are expected to acquire their skills by working alongside Cuban doctors and students in hospitals throughout the country. The overall student-to-patient ratio is about four to one at the medical school and about two to one

(students per bed) in practical classes in the hospitals. In addition to patient contact hours, students are required to take several electives, choosing among courses including alternative and indigenous-knowledge-based medicine and region-specific disease. Students from Brazil may have a keen interest in the elective on malaria or yellow fever, while students from Ecuador may choose to focus on diseases related to altitude or poor nutrition. Courses in acupuncture, massage therapy, traditional medicine, and naturopathy are also available.

While the curriculum contains many areas of study that would be found in most medical schools, there are courses that are a radical departure from traditional pedagogy. In years one and two, while courses on family medicine and cell and molecular biology may seem standard, there is a mandatory course in sports and physical education. In years three to five internal medicine is taught alongside general surgery, pathology, and urology. Students receive extensive training in public health and the history of medicine that approaches the development of medicine critically, examining the relationship of the physician's craft to broader social and environmental determinants of health.

The first textbook students receive, edited by Alvarez Sintes (2001) and published by the Editorial Ciencias Médicas in Havana, has a sizable section devoted to the social and environmental determinants of health. Chapter 1 describes the practice of public health in Cuba and outlines an approach to preventive care. Chapters 5 and 6 focus on the health of the family and the community, explaining the importance of in-home consultations to understand the local conditions that may have an impact on health. There is also an extensive chapter on methods for investigating the demographic and epidemiological determinants of health. Another section is dedicated to effective communication, and the last chapter deals with traditional and Eastern medicines. In the second volume more attention is given to the treatment of accidents, infections, and other issues of clinical treatment.

A day in the life of a student is busy. "We don't get a lot of free time," commented a 26-year-old female from Costa Rica (interview, June 29, 2005). From the third year on, students often take classes in the morning and then tend to patients in the afternoon. For the first two years students live on campus. After that they generally move to other parts of the island and live in the student residences of their host institutions. Accommodation, books, food, clothing, incidental costs, and all associated expenses are covered by the Ministry of Public Health. A monthly allowance of 100 Cuban pesos (US\$4.00) is also given to each student for entertainment costs outside of school.

While some students have come from the most remote communities in Central America, others have come from large cities such as Caracas and São Paulo. A minimum level of education (usually equivalent to high school) and the absence of a criminal record are required for admission. Students who come to the medical school having completed several years of university are able to move directly into the middle years of their training. When we asked students from Venezuela, Ecuador, and the United States why they chose to come to Cuba, many replied that they were unable to afford medical training in their home country. "I was able to afford my first year of medical school in Ecuador just fine. However, I would not have been able to afford the rest of the degree," a 30-year-old female from Ecuador told us (interview, September 15, 2006). "It is possible to afford medical school in Venezuela," a 22-year-old

female from Caracas commented, but very few people can actually afford such an education (interview, June 27, 2005). The overwhelming majority of students interviewed emphasized how important free tuition was for them.

One student, male, 28 years old, from California, mentioned that the ELAM breaks down racial discrimination barriers as much as economic ones: "How many Hispanic or black students have a shot at med school in the States?" he asked (interview, July 8, 2005). Indeed, the majority of U.S. students are from black or Hispanic backgrounds. Furthermore, in other countries, such as Ecuador, indigenous students are few in the country's medical schools (interview, June 29, 2005).

Many students noted the extremely close contact they had with their Cuban instructors. "It's great," commented a 26-year-old female from Costa Rica. "You spend a lot of time with your instructor, and they make sure that you understand the material" (interview, June 29, 2005). The instructors are all Cuban, and many of them have worked overseas in medical brigades. The low student-to-instructor ratio allows for added attention in both class and the clinic. "If you have trouble with something," a 29-year-old male from Costa Rica remarked, "the teachers will work extra for you to make sure that you get it" (interview, June 29, 2005). ELAM pedagogy is focused on giving students as much opportunity as possible to do their best. Students who fail an examination are given the chance to repeat it. If the second attempt is also poor, they are offered extra instruction and a third try. Students who fail on the third attempt are expected to withdraw. "Some people withdraw from the program because it is just too difficult, and some are asked to leave," commented a 30-year-old male from the United States. "Not everyone can be a doctor" (interview, October 18, 2006).

Interaction with instructors is encouraged, and attention is given to areas of weakness. A 29-year-old student from Mexico remarked that if the ELAM were to increase its student intake, it would have to follow up by increasing the number of instructors, because the extensive contact between student and instructor is one of the most valuable attributes of the school (interview, July 16, 2004). Indeed, the pedagogy at the school is based on cooperation, not competition—an approach that is remarkably different from that of most medical schools. "We're not competing to be the best in the class, and we're not fighting each other for jobs afterwards," remarked a 30-year-old male from the United States (interview, October 18, 2006). He went on to say, "Teachers and other students help each other out. I didn't know Spanish when I arrived, but my colleagues, along with my teachers, helped me along with the language as well as with the other studies." Encouraging cooperation and discouraging ranking and direct competition produce a unique learning environment that seems to lend itself well to helping students overcome their challenges in the classroom.

Students had few complaints about the school. Some noted that in the early years, when the program was just developing, the course material was dated and resources were slim. Since 2000, however, many changes in the content and structure of the program have taken place, and students have access to new textbooks and the Internet. Others mentioned that it could be difficult to study for hours on end by candlelight during the frequent blackouts. "Your eyes cannot work after that long looking at a book in candlelight," said one 26-year-old female student from Ecuador (interview, June 29, 2005), "but it is

all right. We have the ability to learn the material, which we all do in the end." Most of the criticisms of the ELAM were centered on the inconveniences of Cuba's ailing infrastructure—limited electricity, running water, and reliable transportation from the school to the city—rather than any specific faults in the medical program.

Students are well aware that they will graduate as sought-after commodities in the global health picture. As Fidel Castro noted at the graduation ceremony, "You are the kind of physician that millions, billions of poor people in the world desperately and urgently need" (Reed, 2005). At the same time, they will be desired by the North, where privatization fueled by globalization has created a lack of doctors in poorer areas. ELAM graduates are bilingual and skilled in family medicine and community-based care—exactly what all health care systems are lacking. Some students recognized that job offers were bound to come from the wealthy urban centers, but all of them were committed to go where their services were needed the most.

The community-focused epistemology has both immediate epidemiological and long-term capacity-building goals. Both require a high degree of community participation. Extremely important of course is the process of recording incidents, monitoring public health concerns, and tracking vaccinations—components that are lacking in the South and critical for the success of preventive public health care in Cuba (Spiegel and Yassi, 2004; Yassi et al., 1999). Effective epidemiological tracking systems and data collection processes require community participation. While this is possible in Cuba, Latin American communities that are enduring violence, racism, or economic disparities may have less capacity for community cohesion and participation. Indeed, the lack of equity and social cohesion throughout Latin America calls into question the transferability of the Cuban system, which has thrived on an equitable social framework. This will prove a major challenge for ELAM graduates upon their return home.

### THE CHALLENGE FOR NORTH AMERICANS

Students from the United States have some of the greatest challenges to overcome not just upon their return home but during their time of study in Cuba as well. While students are confident that they will be able to pass any state medical exam, some are concerned that their state may refuse to recognize the ELAM as an acceptable training facility and automatically disqualify them from practicing. Others worry about finding residency programs that will accept their Cuban training. In order to be licensed, students will have to pass a competency exam as well as having their educational institute recognized. (The first U.S. graduates from ELAM have passed these exams.) The U.S. Department of Homeland Security has recently restructured immigration policy to recognize medical degrees from Cuba and expedite immigration for Cuban-trained doctors with experience overseas (Jakes-Jordon, 2006). ELAM graduates from the United States should have no problem in being recognized, and in fact this new policy may encourage other graduates to migrate to the United States instead of returning home.

Despite Homeland Security's acceptance of Cuban-trained doctors, in 2005 students from the United States enrolled at the ELAM received threatening

letters from the Treasury Department indicating that they could be fined US\$40,000 or sentenced to four years in prison for continuing to study in Cuba. Almost all of them returned home immediately, having been allowed to take their year-end exams early and return to their families until the political turmoil subsided (interview, July 16, 2005; Frank and Reed, 2005). At the same time, Washington increased restrictions on travel to Cuba for all U.S. citizens, with fewer licenses for family, religious groups, or educational delegations such as the U.S. ELAM students. In reaction to the outcry against this tightening of restrictions, Secretary of State Colin Powell pressured the White House to reconsider this process. He argued that it was ridiculous to forbid students to attend school when they were willing to learn medicine in order to practice in underserved areas where other medical students were unable or unwilling to go. Washington has since allowed special licenses for the ELAM students to remain in Cuba but forbidden them to write or receive mail from home. Despite this change, 25 of the original 90 U.S. students did not return to the ELAM, and the Treasury Department's threats, though unlikely to be carried out, still weigh heavily on the minds of the others.

While numerous challenges, most of them political, face the U.S. graduates from the ELAM, challenges exist for all ELAM graduates. The reintegration of graduates into their home countries will ultimately improve care and save lives, but it may not be enough to expand health care provision into outlying areas. The success of the Cuban medical brigades has been dependent upon bringing skilled personnel, resources, and organization into areas completely without them. For ELAM graduates to continue to make this happen, some form of broader infrastructural support and political leadership will ultimately be needed. It is encouraging to see innovative approaches being sought in Venezuela with its "Barrio Adentro" program and its development of a second ELAM.

## CONCLUDING THOUGHTS

As a progressive innovation not just in foreign policy but also in community medicine, the ELAM has an important place in dialogues about capacity building and human security strategies for the twenty-first century. Cuba's long-standing tradition of putting skilled personnel on the ground in underdeveloped regions has done well to improve human security both in times of disaster and conflict and in more normal times. The true measure of success for the ELAM will lie in its graduates' contribution to empowerment at the community level. Cuba's rich heritage of international medical support provides a strong base for this project. The transferability of skills from the ELAM to the field will be an important determinant of success at the community level, as will graduates' ability to cope with failing infrastructure in remote and inner-urban areas.

This campaign of medical diplomacy has had clear political benefits. Solidarity among South-South nations has been extremely important for Cuba's survival, and this decades-old program has been of enormous importance in winning diplomatic allies for Havana. Yet throughout this process important gains

have also been made in furthering an understanding of the importance of participation and capacity building in improving community health. While traditional outreach and missionary medicine have involved rigid hierarchies in the community and especially in the service facilities themselves, from the outset Cuba has approached health in an egalitarian framework. The emphasis is not only on the doctor's craft but also on increasing understanding of health determinants and prevention within communities.

Neoliberalism has been a driving force in changing the face of health care provision and capacity building throughout the world. Cuba's medical internationalism is testimony to another, far different understanding of globalization. It demonstrates that improving the quality of life should not end at national borders but should extend to everyone in need of immediate relief. Empowerment of individuals in communities is an idea drawn from Cuba's experience in medical outreach, and it deserves consideration by the global community. In short, the ELAM demonstrates a radically different way of thinking about health.

What, then, is the essence of the Cuban philosophy that the world needs to know more about? Fidel Castro put it succinctly: "What is the secret? It lies in the solid fact that human capital is worth far more than 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" (Castro, 2005). This is the concept that has defined Cuban medical internationalism and is being put into practice at the ELAM. It will be interesting to see how well the lessons have been learned elsewhere.

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