

growth in *ulama* power in their opposition to the state.”⁴⁸

Finally, not only did the Shah fail to incorporate the *ulama* into the regime, but he also employed state violence as a means to repress them. This violent strategy to repress the *ulama* is significant because it consolidated the *ulama* in opposition to the regime.⁴⁹ Before the revolution the majority of the Shi’a clergy were dormant, and it was only a radical minority, led by Khomeini, that were overtly opposing the regime. However, as noted by Perry, the Shah used secret police to infiltrate the *ulama*, he placed shrines under military control, and he imprisoned, expelled, and executed leading oppositional *ulama*; this excessive use of violence caused the “quiescent, conservative *ulama* such as Ayatollah Shari’atmadari to call for an end to the [S]hah’s dictatorship and to recognize Ayatollah Khomeini as the representative of the popular will.”⁵⁰ Ultimately, the Saudi royal family attempted to integrate and subordinate the *ulama* to the regime, while the Shah attempted to exclude the *ulama* and to eliminate their power.

In conclusion, although both the Mohammad Reza Pahlavi and the Saudi royal family have attempted to diminish the power of the religious elite within their respective countries, the Saudis have enjoyed much greater success in this respect. The cause of this has been twofold. First, the *ulama* in the two countries differ in several significant ways. These differences ultimately endowed the Iranian *ulama* with more power and influence, therefore enhancing their ability to revolt. Second, unlike the Shah, whose attempt to undermine the influence of the *ulama* culminated in a revolution, the Saudi royal family has successfully employed a “carrot-and-stick policy” regarding the *ulama*: they have rewarded them with influence and control over areas of religious importance – such as the ministries of education and justice – while simultaneously eliminating the influence of members of the *ulama* who dissented from the regime, such as those *ulama* who abstained from the condemnation of the Memorandum of Advice. Overall, although there are many parallels between the strategies of the Shah and the Saudi royal family as well as similarities between the *ulama* in the two countries, the *ulama* in both Saudi Arabia and Iran, as well as the strategies employed by the two regimes, have many significant differences. Understanding these differences is critical to understanding why the *ulama* revolted in Iran but not in Saudi Arabia.

CUBAN MEDICAL INTERNATIONALISM: BUILDING SOUTH-SOUTH COOPERATION AND ALTERNATIVE HEALTH SYSTEMS

CAROLINE WHIDDEN

Since the Revolution, Cuba has devoted much of its energy and resources to developmental assistance in countries that have had similar historical struggles, with health care at the forefront of such efforts. Cuba’s international medical aid efforts since the 1960s have involved various dimensions, the most prominent of which are Havana’s Comprehensive Healthcare Delivery Program (CHDP) agreements, in-country medical training programs, bringing foreign patients to Cuba for free surgery and other medical procedures, awarding scholarship to foreign students for full-time medical education, and extending short-term disaster relief. As a result, the Cuban Revolution has succeeded in establishing its position as a major player in international medical diplomacy and its contributions to improving global health are truly commendable. While neo-liberalism frames development in terms of economic growth, Cuba has recognized that the health of a country, particularly of its most vulnerable populations, plays a very fundamental role in development, and has framed domestic and foreign policy accordingly.

The emergence of leftist governments in Latin America and the strengthening of Cuba’s regional identity coincide with increasing recognition of the need for an alternative development model. Cuba has demonstrated a shift away from aid and towards solidarity and the potential for strong South-South cooperation in achieving developmental aims, providing the framework for a promising alternative to the predominant North-South flow of assistance. The argument presented in this paper is two-fold. First, given that the leading causes of death and illness in the global South continue to be preventable diseases caused by a lack of access to basic primary care and poor health promotion, the Cuban model is undoubtedly more suitable to addressing the global public health crisis than the West’s model of health based on hospital medicine and high technology. Secondly, although it is important to build capacity and exchange knowledge within and between nation states rather than maintaining dependency on aid, the most valuable lesson to be drawn from the Cuban experience of medical internationalism is for countries to

⁴⁸ Moaddel, “The Shi’i Ulama and the State in Iran,” 541.

⁴⁹ Millward, “Political dimensions of the Marja’iate,” 9.

⁵⁰ Perry, “The Islamic World,” 125.

ultimately develop sustainable healthcare systems of their own by adopting the Cuban emphasis on community-based primary care. While the Cuban solidarity programs and medical brigades can contribute to the betterment of the people of a particular marginalized community, development at the national level requires strong political determination for good health from the host country.

This paper will analyze and evaluate Cuban medical internationalism and its role in promoting international development specifically in terms of its CHDP arrangements with other countries in the global South and its medical education program for foreign students – the Escuela Latinoamericana de Medicina (ELAM) – being the key institution in this endeavor. These policies will be evaluated in terms of their underlying motivations, their contribution to development at the national and community level, and the challenges they face in achieving developmental aims.

It is important to begin by noting that “[a]lthough 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.”¹ There are only two main works that extensively and broadly discuss Cuban medical internationalism, one published in 1993 by Julie Feinsilver² and the other more recent publication by Krik & Erisman³ from 2009. Both were heavily relied upon for the following analysis. The only source that regularly publishes news and research articles pertaining to Cuba’s international as well as domestic medical policies is MEDICC, a nonprofit NGO founded in 1997. In regard to US media sources, Cuba’s international medical policies have been portrayed almost exclusively in military terms.

Before Cuba was able to engage in medical outreach it first had to achieve considerable success in developing its own health resources and attain health indicators of an international standard worthy of emulation.

Cuba’s ability to conduct medical diplomacy is a logical outcome of having developed a healthcare system capable of accumulating symbolic capital by garnering international accolades for

its outcomes, processes, infrastructure, human resources, and equality of access. Without this domestic medical success, any gesture of providing medical aid to other countries would be neither credible nor much appreciated.⁴

Since it began its policies of medical internationalism, Cuba has demonstrated the ability to send a quarter of its medical staff away on international missions without seriously compromising the delivery and quality of health care in Cuba. Not only is the patient-to-doctor ratio remarkable, but Cuba also has a rather equitable distribution of medical personnel and resources. Although Cuba continues to face poverty-related challenges, including health problems, it has substantially narrowed the gap between its health indicators of infant mortality and life expectancy and those of the US and other developed nations. It has done so by reinforcing its commitment to primary care as key to improving health status. By 1999, a neighbourhood-based family doctor-and-nurse program was in place across the country and covering 98.3 per cent of Cuba’s 11 million people.⁵ The program embedded health services deeper into communities with the aim of more effective health promotion and disease prevention.

Cuba’s first significant international medical outreach occurred in 1960 when Havana dispatched medical teams to Chile to provide humanitarian assistance following the major earthquake disaster. Although Cuba continued to engage in ad hoc disaster relief operations, more comprehensive and long-term projects based on formal arrangements soon became the focus of the Revolution’s medical aid programs. The first of such initiatives occurred in 1963 when Havana and the newly independent government of Algeria entered into an arrangement to send the Revolution’s first international medical brigade composed of 58 doctors and other health workers. This large and unconditional assistance has been attributed to the revolutionary government’s ability to identify fully with Algeria as a poor nation fighting to emerge from and overcome the legacies of colonialism. Since then, Cuba has concluded agreements with approximately 100 other governments, mostly in Sub-Saharan Africa, the Caribbean, and Latin America, with Cuban medical aid involving a grand total of more than 100,000 health professionals.⁶ “The impressive scope and energy of Havana’s efforts can be illustrated by the fact

¹ Michael H. Erisman and John M. Kirk, *Cuban Medical Internationalism: origins, evolution, and goals* (New York: Palgrave MacMillan, 2009), 21.

² Julie M. Feinsilver, *Healing the Masses: Cuban health politics at home and abroad*. (Berkeley, CA: University of California Press, 1993).

³ Erisman and Kirk, *Cuban Medical Internationalism*, 2009.

⁴ Feinsilver, *Healing the Masses*, 91.

⁵ “Medical Education Cooperation with Cuba (MEDICC),” accessed March 1, 2012, <http://www.medicc.org/ns/index.php>.

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.⁷

There is no doubt that Cuba's policy of medical internationalism has brought significant diplomatic benefits for the Revolution and has helped to develop its foreign policy in terms of enhancing its international stature and potential soft power. Feinsilver claims that medical diplomacy has allowed Cuba to accumulate considerable 'symbolic capital' in terms of goodwill, prestige, influence, credit, and power as a result of the initial investment of material capital as well as the time and effort given to these projects.⁸ This symbolic capital can eventually be converted into material capital, which in Cuba's case means both bilateral and multilateral aid, trade, credit and investment.⁹ Particularly in the face of strict US trade embargos that followed the sudden demise of the support it received from the former Soviet Union, medical diplomacy has been key to seeking international solidarity for the Revolution.

Shortly following Cuba's unique response to Hurricane Mitch, for example, both Honduras and Guatemala shifted toward normalizing diplomatic relations with Cuba, and bilateral relations have since expanded with both countries. In 2003, Cuba made a major commitment to Venezuela, a country with one of the greatest income inequalities in South America. The agreement falls under the Bolivarian Alliance for the Americas (ALBA) accords, a body to foster South-South bilateral agreements based on each country's resources. In the case of Cuba and Venezuela, the arrangement is often simplified in the media to 'oil-for-doctors'.¹⁰ While it is difficult to attribute this normalization of relations between Cuba and various countries in Africa, the Caribbean, and Latin America in recent years solely to Cuban medical diplomacy, there is no doubt that it has indeed been the principle factor in this development.

⁶ Erisman and Kirk, *Cuban Medical Internationalism*, 2009.

⁷ Erisman and Kirk, *Cuban Medical Internationalism*, 3.

⁸ Julie M. Feinsilver, "Cuban Medical Diplomacy: When the Left has got it Right," *Council on Hemispheric Affairs* (2006).

⁹ Julie M. Feinsilver, "Cuba's Health Politics: At home and abroad," *Council on Hemispheric Affairs* (2010).

¹⁰ Greg Morsback, "Venezuela basks in oil 'bonanza'" *BBC News* February 17, 2006, <http://www.bbc.co.uk/news/>.

The Cuban Foreign Ministry summarizes the CHDP programs as a cooperative arrangement based on the delivery of health specialists and technicians, generally family doctors, for a two-year term at most.¹¹

These medical brigades work in rural areas or in urban barrios lacking in government or private medical services, so as to not interfere with local physicians. These government-to-government agreements usually entail a commitment from the host country to provide the Cuban medical brigades with lodging, food, domestic transportation, and a modest monthly stipend of usually 100 to 150 dollars. However, according to Kirk & Erisman, Cuba can and often does waive some or all of these provisions, especially the stipends, in the cases where they are difficult for the host country to provide.¹² At the other end of the agreement, the Cuban Health Ministry is responsible for ensuring that

the medical professionals receive their regular salaries, round-trip transportation, and other logistical support.

One critically lauded case of Cuban internationalism is their comprehensive programs in The Gambia, a country that, with strong political leadership in the health care sector and the cooperation provided by Cuba, has been able to improve access to healthcare services and build a valuable malaria treatment and prevention program. One of the poorest countries on the Human Development Index, The Gambia has long suffered from the incomprehensible doctor-to-patient ratio of 1 for every 50,000 people until 1998 when, upon the arrival of Cuban healthcare workers to deliver services and offer training, the ratio decreased to 1 physician for every 21,000 people.¹³ By 2004, four years after Cuba established the University of The Gambia Medical School, the ratio became 1 physician for every 9,174 people.¹⁴

¹¹ Michael, H. Erisman, "Cuba's Overseas Medical Aid Programs And Soft Power Politics," *Annual Conference of the Society of Latin American Studies at the University of Liverpool*, 2008.

¹² Erisman and Kirk, *Cuban Medical Internationalism*, 2009.

¹³ John M. Kirk and Robert Huish, "Cuban Medical Internationalism in Africa: The threat of a dangerous example," *The Latin Americanist* (2009): 132.

¹⁴ John M. Kirk and Robert Huish, "Cuban Medical Internationalism in Africa: The threat of a dangerous example," *The Latin Americanist* (2009): 132.

Yet the political motivation from President Yahya Jammeh after he was elected in the mid-1990s, not only to make health a top priority but also to address health needs from a local perspective, has been critical to these improvements in The Gambia. In 1998, the president proposed a medical institution dedicated to training physicians with a commitment to treating vulnerable populations within The Gambia. Cuban and Gambian professors developed a six-year curriculum focusing on meeting local needs such as integrated medicine, community-based consultations, and disaster preparedness.¹⁵ The partnership allowed Gambian professionals to provide local context to the broad knowledge of disease prevention of the Cuban experts.

The case of malaria in The Gambia is an example of how a particular disease can be targeted as part of a broader public health initiative based on political will of governments partnered with Cuba's role in training people on the ground in preventative care. Donated medicines from international organizations and civil society groups also assisted the initiative. In an interview with MEDICC, WHO Resident Representative Dr. Nestor Shivute argues that the Cuban-supported program's success relies on four main strategies: vector control, access to early diagnosis and treatment, prevention through public education and involvement, and research,¹⁶ all of which are relatively basic, cost-effective methods to disease eradication.

One particular challenge that can arise from this type of medical interventionism is that agreements made between Havana and national governing bodies of recipient countries may not take into consideration the particular dynamics and health structures at the community level. The extent to which Cuban health workers become integrated into a community and interact with local health workers, for example traditional healers or midwives, is difficult to predict and document, as it would depend on the specific local context. Another significant feature of Cuba's medical internationalism, the training of foreign medical students in Cuba to return to their home countries to practice primary health care, could potentially avoid this particular challenge.

The Escuela Latinoamericana de Medicina (ELAM) is a medical school that exclusively receives thousands of foreign medical students from marginalized communities, charges no tuition, and "asks only for a moral commit-

ment that they will serve in vulnerable communities when they graduate."¹⁷ In this sense, ELAM is an example of how a medical school's institutional ethics plays a role in preparing physicians to bring their skills to the vulnerable, valuing community service above personal fortune.

ELAM was formed in 1998 following the devastation caused by Hurricane Mitch that killed over 30,000 and displaced hundreds of thousands across Central America. The already pressing need for health-care services and support in rural areas of Honduras, Guatemala, El Salvador, and Nicaragua escalated into a full-scale disaster. Many countries responded with immediate aid; however, it was Cuba that suggested the creation of an institution that would empower would-be graduates to eventually strengthen the local healthcare workforce of affected communities. This move was significant in that it demonstrated Cuba's commitment to capacity-building as part of its foreign policy of medical outreach.¹⁸ The school later welcomed students affected by poverty and marginalization from 29 different countries, including the United States. Currently, over 10,000 scholarship students from across the global South are studying in Cuban medical schools.

The recruitment process of ELAM students varies from country to country and continues to evolve. Generally the process starts with the help of third-party solidarity organizations that pre-select applicants from humble backgrounds usually from rural areas.¹⁹ The idea is that these students will have a clear understanding of the challenges facing their fellow citizens, and as a result, are very much inclined to remain and contribute to the health of their country. This is a more effective alternative to 'forced-retention' or 'contractual service' requirements for medical graduates in some developing countries since it is based on personal choice as well as positive reinforcement and encouragement. ELAM allows the pre-medical qualifications to vary and also assesses student motivation. Although this allows for flexibility in the selection process, the absence of transparency makes the process susceptible to influences and errors in judgment. Applications are then processed through the Cuban embassy in that country.²⁰

¹⁷ Robert Huish, "How Cuba's Latin American School of Medicine challenges the ethics of physical migration," *Social Science & Medicine* 69 (2009): 301.

¹⁸ John M. Kirk and Robert Huish, "Cuban Medical Internationalism and the Development of the Latin American School of Medicine," *Latin American Perspectives* 34 (2007): 77-92.

¹⁹ Huish, "How Cuba's Latin American School of Medicine challenges the ethics of physician migration," 302.

¹⁵ Kirk and Huish, "Cuban Medical Internationalism in Africa," 133.

¹⁶ Gail A. Reed, "Dusk to Dawn: Fighting malaria in Gambia," *International Cooperation Report MEDICC Review* 7 (2005).

The school's curriculum reflects Cuba's domestic health policies, focusing on community health promotion, preventative care, and identifying and perhaps intervening on the social, cultural, economic and environmental determinants of health rather than just core clinical practice.²¹ Training in traditional and natural medicinal practices is also part of the core curriculum. The education is meant to prepare health professionals to have the confidence and skills necessary to work in resource-poor environments where health care services are most needed, and to understand health challenges in relation to issues of social justice and inequality. ELAM's curriculum and overall mandate promotes "community-oriented primary care as a counter-hegemonic action against neoliberal healthcare structures."²²

The culture of medical schools in the South – which is modeled off that in the North – encourages responsive clinical practice over community-oriented care based on principles of disease prevention and health promotion, building a skill set that is more attuned to the market demand of developed countries and therefore contributing to the brain-drain. In South Africa for instance, between one-third and one-half of all medical graduates migrate to the global North.²³ The Cuban model discourages the notion that migration to Westernized countries is a measure of medical success and encourages a sense of moral duty to serve the most vulnerable. Radically altering the nature of medical education in the global South will likely encourage some medical graduates to remain in their home country where the need for medical care may be greatest. However, this cannot be seen as a panacea for addressing the brain-drain phenomenon. The migration pipeline to the global North is influenced by a multitude of factors, and is fundamentally founded in the enormous issue of income disparity between rich and poor countries.

The leading causes of death in the global South continue to be preventable diseases like pneumonia, diarrhea, and tuberculosis that are caused by a lack of access to basic primary care, infrastructure, and poor health promotion. The Cuban model trains family physicians that can cater to these primary needs, rather than training specialists and tertiary care providers likely to migrate to the North where

these qualifications are best financially rewarded. As such, Cuban medical internationalism, where strategies of disease prevention and health promotion are just as important as clinical competency, is much more effective in addressing the global public health crisis than the West's model of health based on hospital medicine and high technology.

The major limitations of Cuba's health system are due to the state of the economy in terms of shortage of money and inadequate access to physical inputs, medicines, and basic supplies, which is very much affected by the US embargo. "As a result, the Cubans have become very adept over the years at doing more with less"²⁴ and "other means of improving health, such as improved sewerage, potable water supply and housing are even more costly than training and deploying doctors."²⁵

It is difficult to assess the sustainability and stability of these partnerships given that the extent to which Cuba's medical internationalism is a result of self-motivated interests and a tool of soft power in the international political economy, rather than a "genuine humanitarianism and an ideological commitment to the less fortunate,"²⁶ remains unclear and contested. With Cuba's growing popularity within Latin America, especially with the rise of leftist governments and the recent establishment of ALBA, it is possible we may see a progression away from international medical diplomacy if the former motivation is predominant in shaping Havana's foreign policy. It is therefore critical that recipient countries do not depend upon the never-ending altruism of Cuba's medical outreach, but take advantage of the partnership and adopt domestic policies based on the Cuban model of disease prevention and emphasis on community-based primary care in order to establish medical self-sufficiency.

More critical analyses of Cuban medical internationalism are needed, with more specific case studies and local-level research into the effectiveness of these programs in terms of community-level as well as national development. Cuba's international medical outreach seems to make sense, and seems to be working. However, it is important to think critically about the motives, stability, and potential consequences of any type of international assistance, even if it presents itself as an exciting alternative to the frustrating predominance of North-to-South development and disease eradication strategies.

²⁰ Huish, "How Cuba's Latin American School of Medicine challenges the ethics of physician migration," 302.

²¹ Ken Flegel, "A Cuban Revolution in Medical Education," *Social Science & Medicine* 69 (2009): 305-06.

²² Robert Huish, "Going where no doctor has gone before," *Journal of the Royal Institute of Public Health* 122 (2008): 553.

²³ Kirk and Huish, "Cuban Medical Internationalism in Africa," 130.

²⁴ Feinsilver, *Healing the Masses*, 1993.

²⁵ Feinsilver, "Cuba's Health Politics," 2010.

²⁶ Erisman and Krik, *Cuban Medical Internationalism*, 183.