

GOING WHERE NO DOCTOR HAS GONE BEFORE:
The Place of Cuba's Latin American School of Medicine in
Building Health Care Capacity for Ecuador.

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in the
Department
of

GEOGRAPHY

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SIMON FRASER UNIVERSITY

Burnaby, British Columbia, Canada

Spring, 2008

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Abstract

Martin Luther King said that “of all the forms of inequality, injustice in health care is the most shocking and inhumane.” Today, despite the overwhelming quantity of attention and resources given towards global health, social inequity has never been worse as many in the global South remain perilously marginalized from the receipt of sustainable primary-care services.

Amidst this backdrop Cuba developed the Latin American School of Medicine (ELAM) as a response to the global South’s lagging supply of human resources for health. The school has received 11,500 students from 29 different countries, including the United States. Every student receives a free, six-year medical education as part of a moral commitment to practice their skills in areas where they are most needed.

This dissertation explores how ELAM is building capacity to meet the needs of communities in Ecuador, a country that has endured structural adjustments to its public health sectors. It is about sharing the lived experience of certain ELAM graduates to understand if they are able to reduce health-care inequity in their communities despite personal and structural challenges. This is best understood in how graduates practice community-oriented primary care (COPC) within their communities. This study finds that ELAM’s institutional ethics are counter hegemonic to dominant neoliberal tendencies in health-care service provision, but that only with appropriate social and political support will the ethics and skills of these graduates scale up into positive changes in community health.

The study conceptualizes ELAM as an alternative-development project grounded in a tradition of Cuban medical internationalism. It offers insight into the program of

study, discusses the nature of public health care in Ecuador, and then explores the professional experiences of several Ecuadorian ELAM graduates.

This dissertation serves as a preliminary step in understanding how ELAM impacts the accessibility of vulnerable populations to health-care services in Ecuador. It demonstrates the strengths and challenges of ELAM graduates in seeking to strengthen human resources for health. The ELAM story shows how investing in people can work towards overcoming neoliberal health-care hegemony, which has done a great deal to promote health-care inequality rather than ensure social equity.



~
*This one is for Uncle Don,
who always fanned the flames.*
~

~The Delivery ~

After three days of labour, the baby still hadn't been born.

"He's stuck. The little guy's stuck," the man said.

He had come from a remote farm in the country.

The doctor went with him.

Valise in hand, the doctor walked under the noonday sun,
toward the horizon, into that desolate world where every-
thing seems born of accursed fate. When he got there he understood.

Later, he told Gloria Galvín:

"The woman was at death's door but was still panting and sweating, and her eyes were wide open. I had no experience with situations like that. I was shaking; I hadn't the faintest idea what to do. And then, as I drew back the blanket, I saw a tiny arm sticking out from between the woman's spread legs."

The doctor realized that the man had been pulling on it. The little arm was rubbed raw and lifeless: a flap of skin, black with dried blood. And the doctor thought:

There is nothing to be done.

And yet, for whatever reason, he caressed the arm. He rubbed the inert limb with his index finger, and when he got to the hand, it suddenly closed, clutching his finger for dear life.

Then the doctor asked for boiling water and rolled up his sleeves.

Eduardo Galeano
(The Book of Embraces, 1990: 224)

Acknowledgements

On any beach, in any language, a red flag erected in the sand means, “stay out of the water!” On April 29, 2001, while swimming at *Playa Santa Maria*, just east of Havana, I missed that message and ran, full speed, into an angry sea. A wave came up on me, threw my feet in the air, and drove my head into the ground shredding my shoulder to pieces. A bloody mess, I dragged myself out of the water, and collapsed on the sand. Within no time two Cubans put me in the back of their old American car, and we drove off to Calixto Garcia Hospital in Vedado. I kept telling them “¡Necesisto mi carta de seguridad!” I need my insurance card.

“Never mind that,” the driver said.

We arrived at the hospital. A doctor was lounging by the main entrance reading the daily issue of *Granma*. He took me, along with another unfortunate Canadian, who sliced open his foot having treaded over a broken beer bottle, into the surgery and immediately two nurses and another doctor appeared. They put the man with the wounded foot on the table, cleaned him up and then, with cat-gut stitches, sowed him up. Then they turned to me. They cleaned my shoulder and treated it with generous mounds of disinfectant, iodine, and then some skin cream.

We were both treated and out the door in less than 25 minutes. I had \$50 USD on me, and I offered the doctors and the nurses the full amount. They refused it and laughed. It took longer to get a cab back to the hotel than it did to receive excellent medical treatment. At the very same time in Ontario, newspapers were reporting that hospitals were turning away ambulances, physician wait times had never been worse and Canada suffered from a chronic lack of doctors. And yet, in Havana, the capital of an

economically-hobbled country, I received first-rate care for absolutely no cost. Two days later, a nurse even came by the hotel looking for me. “How is the little one with the shoulder?” she asked the front desk.

Thanks to that wave I was thrown upside down and into the world of Cuban medical internationalism. In 2001, I was a student of Geography, History and Philosophy; I knew nothing of health care, medicine or even foreign policy. A few days after the visit to Calixto Garcia Hospital, I, along with a group of Canadian students, visited the Latin American School of Medicine. I met with the staff and students and discussed why the school was built and who it was built for. During my first trip to Cuba, the pundits and politicians back home were screaming for greater privatization of medical services. But from this first-hand health-care experience I came to realize that Cuba, a small and economically-modest nation, may make a world of difference in its radical and badly-needed, approach to affordable health care and universal well being.

I offer this thesis as a means to build understanding of Cuban medical internationalism. This work explains how a service ethic that embraces compassion and altruism developed in Cuban health care, and how it is making its way to the world’s most vulnerable communities with the graduates of the Latin American School of Medicine. While I hold that fateful wave fully responsible for setting this project in motion, I too hold responsible all those who have provided their support throughout this project. Without them this could never have succeeded the way that it did. As the author of this dissertation, my role was actually quite minimal. Those who have invested financial support, provided supervision, built networks, gave their warm beds, or gave their not-so-warm couches, and who always encouraged this dissertation to move

forward, are the ones who have truly made this study possible. I will take a moment here to give them all well-deserved acknowledgements and thanks, and to explicitly state that I hold them accountable for seeing this through.

To the Pierre Elliot Trudeau Foundation: thank you. This Foundation has offered financial and networking assistance to a select few Ph.D. students, such as me, and all they ask in return is that we keep doing what we do. Its support, dedication and encouragement are refreshing ingredients in how to approach graduate studies. There is simply no way that I could have completed this study without the Foundation, and I will be forever grateful to them for it. While I could, at length, praise the Foundation for its commitment to supporting international research, building dialogue and fully supporting its scholars, I need to acknowledge the individuals who make this Foundation such a powerful operation. Foundation President P.G. Forest, former President Stephen Toope, and interim-President Fred Lowry have done so much for the Foundation and its members, and they have been personally involved in helping me to develop and initiate this thesis. I sincerely thank them for their time and encouragement. A very, very special thanks goes to Josée St-Martin, Program Director of Scholarships, who has gone above and beyond the call of duty in handling my travels, untangling confusion, and always offering her support. *Et plus, je veux donner un merci à Bettina Cenerelli, Stéphanie Forest, et Michel Hardy-Vallée pour ses assistances dévouées.* As well, I'll thank my fellow scholars. They are friends and colleagues alike, and I am extremely grateful to have worked and grown with them.

I also thank the Social Science and Humanities Research Council for its substantial financial assistance. I would like to also extend thanks to the Faculty of Graduate Studies at Simon Fraser University for financial awards and to MEDICC for its financial contribution.

Dr. John Brohman has been a dedicated and encouraging supervisor through out this process, and I greatly appreciate his efforts in helping to prepare grants, build theoretical frameworks and go wading through mountains of edits and typos that I dumped upon him. Dr. Jerry Spiegel has played a consummate supervisory and mentorship role throughout this process. Jerry has gone above and beyond the call of duty to provide work-space in Vancouver and valuable professional development and networking in Ecuador and Cuba. Dr. Michael Hayes and Dr. Stacy Pigg have also been insightful committee members who have offered their expertise on crucial theoretical and conceptual issues with this study.

I also extend thanks to my two external examiners, Dr. Robert Woollard, and Dr. Eric Hershberg. Dr. Woollard's questions, comments and encouragement have greatly improved this dissertation, especially concerning the complicated process of making doctors. I also greatly appreciated Dr. Hershberg's comments on this dissertation and his critical insight into economic conundrums that occur in Cuba and throughout Latin America.

In addition I must thank Dr. John Kirk of Dalhousie University for his support and advice in backing this research project and for assistance with publications. Dr. W. George Lovell of Queen's University has continued to be a close ally, offering assistance and advice all throughout. Dr. Susan Babbitt of Queen's University has also been very

supportive in helping me overcome some of the conceptual road-blocks to this study. I am always grateful when she invites me back to Queen's to give public lectures. My Trudeau Foundation Mentor, Dr. Gregory Marchildon of the University of Regina has played an important role to this process through building networks, offering guidance and helping me to understand the complexity of policy matters and knowledge translation. As well, I would like to acknowledge Trudeau Fellows Dr. William Coleman and Dr. James Tully for their insight and encouragement. Also, thanks to Michael Erisman who was eager to act as an external examiner. While not an official examiner for this thesis Mike did, in the end, lend some great advice over some “*cleansing ales*” in some of London's finest pubs.

Je donne un gros merci à Dr. Daniel Weinstock et les chercheurs du le Centre Recherche en Éthique à l'Université de Montréal. Daniel m'a donné support, espace de bureau et un réseau cela m'ont aidé. Les assistances de CREUM sont très gentilles, et j'ai gagné beaucoup comme un membre de cet environnement.

The Honourable Jacques Hébert played an important role in opening doors for this project in Cuba. I am very thankful for his personal encouragement, which helped to bring the idea of this thesis into action, and I extend my condolences to his family for losing him at the end of 2007.

A big thanks also goes to the staff of the Canadian embassy in Havana, particularly Simon Cridland, Ram Kimini, and Alexandra Bugailiskis. Thanks also to Diane Applebaum and MEDICC for their outstanding work in Cuba, and for bringing me on board with their 2007 delegation to Havana. I would also like to thank Duncan and Nora Etches for their assistance in introducing me to the “medical world” in the early

days of this project. Thanks also go to Marina Jimenez and Ken Wiwa for the much-needed press in the Globe and Mail. And thanks to Nino Paglicia for sending the “daily dose” of news and happenings from Cuba. As well, I thank Kathleen Burgess for preliminary editorial assistance and Pavel García for translation assistance in Cuba.

En Cuba, gracias a Alberto Velazquez, Javier Cabrera, Sonia Catusus Cervera, y Dr. Alfredo Espinoza para sus asistencias y colaboraciones. I must extend a large thanks to Cedric Edward and Dania Suarez, two ELAM graduates who helped to put the field work in motion in both Cuba and Ecuador. I most certainly give thanks to each of the ELAM students and graduates that I met. Every one of them is, to me, a true “fugitive of compassion.”

And of course, I give enormous thanks to both sets of parents who, in addition to keeping my old beds reserved for times needed, have always offered their full and unbridled support for this, and many other “scholastic pursuits” since day one.

For most of this dissertation I have lived out of two knapsacks, a post-office box, and on a lot of couches. I owe so many people tremendous thanks for their hospitality in putting me up, and putting up with me, during this long globetrotting process. Without your support I could not have physically managed this. All of the people mentioned here have come through, at least once or in some cases dozens of times, with a warm bed and a good breakfast, and not one single time have these people left me to sleep out in the mud. In Canada, I give thanks to Ira & Linda Matthews, Paul Biln & Brenda Tang, Hugh Barnett & Sarah Moyle, Dan Carney & Anita Schreiber, Daniel & Kerith Stevens, Sean & Kim Connelly, B-Jae Kelly, John Brohman, Jerry Spiegel & Annalee Yassi, Louis-Joseph Saucier, Samuel Spiegel, Kunle Owalabi, Robyn Atkinson, Mark Skinner &

Jennifer Clyndsmith, Jason Luckeroff and James Milner. In the U.S. I thank Michael Ananny, Joseph Irwin, Tom Blair, Jessica Everett, Astrid Christofferson-Deb, and Yana Wirengard. *En Cuba, gracias a Julio Canas y Alexis García para habitaciones y su casa que es mi casa afuera de mi casa. En Ecuador gracias a Fatima Verti, Juan Alberto Gaibor, Georgina Muñoz, y Fany Guamán. En México gracias a Mayra Santos.*

To all of these people, I am guilty of dirtying their sheets, cleaning out their fridges and stealing their toothpaste, and yet not one of them had the “common sense” to call the authorities on such transient behavior. In thanks, I want you all to know that clean sheets, a full fridge and plenty of toothpaste awaits you wherever I am, and whenever you are ready.

Table of Contents

Approval Page	ii
Abstract	iii
ELAM & The Globalization of Solidarity	v
Dedication	vi
Epigraph	vii
Acknowledgements	viii
Table of Contents	xv
List of Figures	xvi
List of Abbreviations	xviii
Chapter 1: Empowering Individuals to Transform Communities	1
Chapter 2: From Critical Space to Apertures of Dissent	51
Chapter 3: An Innovative Methodology for an Innovative Program	71
Chapter 4: If you could save a life, why wouldn't you?	82
Chapter 5: The Tests of the Classroom	126
Chapter 6: As Hollow as a Gourd	179
Chapter 7: The Challenges of the Field	229
Chapter 8: The Surprising Success	268
Reference List	282
Appendix	309

List of Figures:

- Fig. 1: The Public Clinic in La Joya de Los Sachas
- Fig. 2: Mosquito infested water immediately behind the Sachas clinic
- Fig. 3: Map of Ecuador
- Fig. 4: Close up of Sachas
- Fig. 5: Model of the four-stage approach to the Cuban health-care system
- Fig. 6: 2006 Student Breakdown by Country for Students housed at ELAM
- Fig. 7: 2006 Distribution of Students to other Cuban medical schools
- Fig. 8: Under 5 infant mortality vs. GNP
- Fig. 9: A mural of Martí and Bolívar at ELAM
- Fig. 10: Martí's famous quote, posted by the main entrance to the school
- Fig. 11: Main Entrance to ELAM
- Fig. 12: From the Classroom to the sea
- Fig. 13: In Puerto Padre, Las Tunas, Cuba
- Fig. 14: Soon to be ELAM graduates taking a study break at *Ditú Pollo*
- Fig. 15: Some doctors of *Mision Milagro*
- Fig. 16: A demonstration at the Finlay Institute.
- Fig. 17: Manuel Torrigo meeting with members of MEDICC
- Fig. 18: Members of the Henry Reeve Brigade
- Fig. 19: Breakdown of ELAM students in 2006
- Fig. 20: Students leaving an afternoon class
- Fig. 21: Students studying in the school's main library
- Fig. 22: ELAM students in the lecture hall.

List of Figures (continued)

- Fig. 23: The core text book, “*Medicina General Integral*”
- Fig. 24: Rector Juan Carrizo Estevez speaking with the MEDICC
- Fig. 25: The MEDICC delegation at ELAM
- Fig. 26: Participants in the People’s Health Assembly in Cuenca, Ecuador, July 2005
- Fig. 27: A mural of Dr. Ernesto “Che” Guevara keeps watch to the entrance of Cuenca’s medical school.
- Fig. 28: Children in Palta-Bomba, Bolivar, Ecuador
- Fig. 29: Volleyball in Palta-Bomba
- Fig. 30: A poster in the Sachas clinic listing free services
- Fig. 31: The emergency ward in the Sachas Clinic
- Fig. 32: A useless and flooded *consultorio*
- Fig. 33: CENIRMED
- Fig. 34: A private-public partnership clinic in Sachas
- Fig. 35: A map from ELAM indicating the homes of Ecuadorian ELAM students
- Fig. 36: ELAM graduates in Sachas
- Fig. 37: Accommodations in the Sachas clinic
- Fig. 38: Medical outreach to the Amazon
- Fig. 39: Basic dentistry is included in the outreach
- Fig. 40: The medical outreach set up in this little school
- Fig. 41: Right next to the school, an oil pipe runs next to the soccer field
- Fig. 42: The maternity ward in the Zamora hospital
- Fig. 43: Zamora hospital pediatric ward

List of Abbreviations:

ACCF	– Cuban Association of Physiological Scientists
ALBA	– The Bolivarian Alternative for the Americas
BHT	– Basic Health Teams
BMS	– Bristol-Myers-Squibb
CARE	– Continuous Assessment of Risk Evaluation
CARICOM	– Caribbean Community
CENIRMED	– International Centre for Medical Reference
CLAMED	– Latin American Centre for Disaster Medicine
CME	– Continuing Medical Education
COPC	– Community Oriented Primary Care
CDR	– Committees for the Defense of the Revolution
DART	– Disaster Assistance Response Team
ELAM	– Latin American School of Medicine
ENSAP	– National School of Public Health
FIS	– Internationalist Federation of Health
FMC	– Federation of Cuban Women
IFCO	– The Interreligious Foundation for Community Organization (Pastors for Peace)
IFI	– International Financial Institutions
IMF	– International Monetary Fund
INFOMED	– Cuba’s National Information Portal of Health
LMIC	– Low and Middle Income Country
MEDICC	– Medical Education and Cooperation with Cuba

List of Abbreviations (continued)

MERCOSUR	– Southern Common Market
MINSAP	– Ministry of Public Health
MINREX	– Ministry of Foreign Relations
NIEO	– New International Economic Order
NHD	– Neighbourhood Health Diagnosis
NGO	– Non-Governmental Organization
PAHO	– Pan-American Health Organization
PEPFAR	– Emergency Plan for AIDS Relief
SAPs	– Structural Adjustment Programs
TNM	– Traditional and Natural Medicines
WHO	– The World Health Organization

Chapter 1
Empowering Individuals to Transform Communities:
Scaling Up Capacity from Ethics to Counter-hegemony

~There is no medicine like hope, no incentive so great, and no tonic so powerful as the expectation of something better tomorrow.~

Orison Swett Marden

Just at dusk, standing on the rooftop of the public clinic in Joya de los Sachas¹, Cuban-trained doctor Dania Suarez and I watched the gas flares from the petroleum developments shoot up above the rain forest. This clinic, surrounded by thick jungle and standing pools of water ripe with mosquitoes - the kind that make you burn alive with dengue or go mad with malaria (Galardo *et al.*, 2007; Sideridis *et al.*, 2003) received a thirteen-year-old girl who went into labour while we were in the village dining on the indigenous delicacy of *gusanos al carbon*. “I remember treating her nine months ago, after she was raped,” Dania said, her eyes welling with tears.

“She’ll be okay, no? I mean Jacqueline [another Cuban-trained doctor] is taking care of her, and the others are there,” I replied.

Sure enough, the little girl safely gave birth to her little girl. It was the end of another work day in the Sachas clinic. The Cuban-trained doctors at this clinic see days and nights of disasters and miracles. In the only community-based public clinic for a hundred kilometres (Fig. 1)² these doctors, trained at Cuba’s Latin American School of Medicine, “*Escuela Latinoamericana de Ciencias Medicas*” (ELAM), work on the front lines of primary care. The poor and indigent who come to the humble clinic have most, but not all, of their primary-care needs met. While men come in injured from working in

¹ Translated literally as “The Jewel of the Weeds.”

² While the public hospital in Coca is located 40 km to the south-west, and it takes approximately 50 minutes to get to it by bus, there are no other public clinics located in the region.

the petroleum developments (Sawyer, 2004), their wives and children visit these doctors because they are run down from lived-in poverty (Farrow *et al.*, 2005).

“It’s too much,” Dania told me on the roof. Forty percent of Ecuador’s GDP originates from the petroleum industry with a current output over 532,000 barrels per day (Infoexport, 2006). But, for every \$80 barrel of oil pulled out of the ground, about \$2.50 remains in country, and of that, only a few pennies remain in the community (Perkins, 2004). Ecuador’s president, Raphael Correa, has recently proposed to increase the State’s share of petroleum profits in order to finance improved health-care and social services (The Economist, 2007a). But for the time being, with minimal economic capacity, and little political support for public health care, let alone for other necessary public infrastructure, Sachas is a land where egregious economic development runs over dizzying poverty.

“It is too much,” I replied. Not knowing the full extent of lacking social services, environmental devastation and unbridled inequality, I came to Ecuador, by way of Cuba, with a simple question. “How would a select group of Cuban-trained doctors fare in trying to meet the needs of such communities?” The select group is made up of eleven of the fifty-four Ecuadorians who came to ELAM in 1999, and then came home to apply their skills in marginalized communities in 2005. They are a few among ELAM’s first graduating class of 1,610 (Castañeda, 2005). This dissertation is about their story. The eleven Ecuadorian *médicos generales básicos* (general basic doctors) graduated from ELAM, a former naval academy turned medical school that has received over 11,500 foreign students from across the Americas and Africa. ELAM students come to Cuba to receive a free medical education over a six-year period, with all services, books,

accommodation, food and necessities covered by *El Ministerio de Salud Publica* (MINSAP). It is a medical school exclusively for foreign students, and Cuba refuses to charge these students any tuition. Their only debt upon graduation is a moral commitment to offer their services in their home country, preferably in the communities that are desperately under-serviced.

It is an innovative program developed in response to the aftermath of Hurricane Mitch in Central America in 1998. Cuban medical brigades working in the affected region realized that droves of doctors would be required in order to improve the region's human resources for health in primary care (Cockburn *et al.*, 1999; Giraldo, 2007b; Sims & Vogelmann, 2002). Instead of offering its own doctors on an on-going basis Cuba decided to train students from those communities in order to eventually serve them. Soon after, they expanded the school's enrolment from victims of a single hurricane to include victims of structural violence³ from across the Americas and Africa. By 1999 ELAM received 1,929 students from 18 different countries (Castro, 1999).

While Cuba offered thousands of medical scholarships in the past, ELAM's student intake is on a scale never seen before. Although it was initially a regional response to a Central American disaster, ELAM is now composed of students from twenty-nine countries. The course of study runs for a total of six years, not including pre-med training. The first two years are spent on campus, where students enjoy a small teacher-to-student ratio. In the final four years, they train alongside Cuban medical students in thirteen of the country's twenty-six universities. ELAM represents a medical

³ Paul Farmer's (1998) research helps to define and explain this term. Broadly understood, structural violence involves negative impacts against vulnerable populations that lead to increased risk, poor health and loss of livelihood. Economic restructuring, lagging services, and displacement of peoples may not usually be thought of as the focus of violence, but they are imposing structures that can negatively affect a person's well being.

school for the Americas, an element of Cuban foreign policy based in solidarity, a multinational student body dedicated to serving the international community, and a large-scale capacity-building project to give students the practical and ethical tools to serve those most in need.

Some students hail from the most remote and far-reaching places in the global South; others come from wealthy centres. But they have all come to Cuba to participate in a unique approach to building popular health provision. It is unique in the sense that its students receive medical education based on an ethical commitment to serve the destitute and marginalized. Using some important principles of empowerment theory⁴, ELAM builds capacity among its individual students so they may eventually create broader organizational and community-wide structural changes to health care in the locales in which they practice. Organizational changes can be understood as changing the operation of current health-care institutions, while socio-economic structural changes refer to broader systems that govern the operations of health care. Rigour and discipline in medical sciences are important components to the program, but the institutional ethics of service to one's community is taught with just as much thoroughness.

It is hoped that when the graduates return to the field, they will be able to practice in clinics and treat preventable health problems through community-orientated primary care (COPC)⁵. Increasing public accessibility to health care, especially in marginal

⁴ Empowerment theory aims to build the social, economic or political strength of marginalized peoples. It can be considered the emancipatory goal for development projects aimed at allowing individuals to overcome restrictive structures. Empowerment theory has often involved developing skills so that individuals and communities can move away from charity. In development theory this is often associated with the establishment of community-based NGOs. ELAM's goal of training students from marginalized communities in order to serve them can be considered as an empowerment process.

⁵ COPC will be discussed later in this chapter. It can be broadly understood as offering clinical care at the individual level, along with health promotion at the community level. It emphasizes the use of resources within the community, rather than continually seeking outside assistance.

communities of the global South, goes against the neoliberal emphasis on market-led health care, which produces the hegemony of limiting it to those able to pay for it. Such tendencies within global health fit comfortably within the overall dynamic of neoliberalism, which David Harvey (2005) argues is an intentional political-economic agenda of increasing the wealth and power of global elites at the expense of further marginalizing and impoverishing the poor. I intentionally approach this as hegemony, which is pervasive and persuasive in bringing the values of the elite to the poor and vulnerable. In this case these values entail the receipt of health-care through a costly and limited private sector. In defiance of such hegemony, ELAM's mission is to strengthen public health-care services by training a workforce eager to serve the vulnerable regardless of their ability to pay for that service.

It is important to recognize that health-care inequity in the global South, along with most inequities, is a complicated process that goes back centuries. Vulnerable populations have been made so from centuries of colonial and neo-colonial repression (Galeano, 1997; Lovell, 2005). In the 20th century, Keynesian development models saw the exclusion and repression of indigenous and vulnerable populations (Mason, 1997). Since the 1980s, neoliberal hegemony has furthered social inequities and advanced marginalization on top of an extensive history of abuse and repression. It has, to use the expression, rubbed salt into the wounds.

Regarding health care, neoliberalism has produced a hegemony of demanding fees for services, which excludes the poorest people from receipt of quality care. Offering fee-for-service health care is a pervasive process that leaves the vulnerable with no chance of engaging with health-care professionals. Ecuador is among many states that

have allowed such hegemony to dominate the poor, and at the same time, the country has done little to improve the quality of, and accessibility to, the public sector. While some point out that neoliberalism has actually improved accessibility to services in places like Chile and Columbia, (Waitzkin, *et al.*, 2007) the ability for poor individuals to pay for those services has not improved. Accessibility is not a geographical question of arid spatial patterns. It is a geographical problem about people's rights to have access to resources. While spatial accessibility, primary health indicators, and even per-capita wealth are all increasing in the global South, real access, vulnerable-community health, and social inequality are all worsening.

Scholastic studies (Reinhardt, 1999), policy commissions (Commission on the Future of Health Care in Canada., 2002) and popular contributions like Michael Moore's latest documentary "Sicko" have shown the social limitations of medicine when neoliberal trends govern its implementation. It is well understood that when health care is carried out via free-market liberalization, differential ability to pay produces an equally differential accessibility to care. But what is more complex is to understand how the intention of service to others can be compromised despite best efforts at building capacity. Building skills in scientific competency in order to provide medical service is a moral action that could play an important role in improving geographies of health care, especially in the global South. Only, this is all too often hindered by macroeconomic factors that promote the centralization of services and training facilities, which shapes health-care provision in general and medical education in particular (Eckhert, 2002). This movement of capital, people and resources to the North negatively impacts vulnerable communities in the South that may be unable to access critical services, let

along produce preventative ones, as a result of factors such as too much distance or too little capital.

However, for ELAM to train students to serve marginalized communities is counter-hegemonic⁶ to this trend. Cuba's goal is to change the global pattern of human resources for health, so that health-care workers can provide accessible and appropriate services to the marginalized. Physicians all too often leave the global South in order to specialize, and eventually practice, in the North (Boulet *et al.*, 2006; Hallock *et al.*, 2003). But ELAM's medical students leave vulnerable communities to study in Cuba so that they may return home to serve those communities. While the impacts of such migration under the hegemonic system are well known, the impact of ELAM's counter-hegemonic approach is not well understood.

Neoliberals contend that market forces properly distribute quality care to where it is demanded. But with such an approach, demand is dependent upon economic capacity rather than upon actual needs for service. Moreover, value is placed on servicing diseases in a reactionary manner rather than a more proactive approach of maintaining the health of communities through social and proximal⁷ interventions. The counter-hegemony to this paradigm aims to increase the ability for health-care professionals to serve and to ensure that they work to keep individuals, and their communities, healthy before they require costly, and complicated, advanced treatment. ELAM's students are trained to value this as a desirable relationship between the physician and their

⁶ Counter-hegemony emerges when individuals invoke "good sense" through critical dialogue to "break the existing ideological bonds and penetrate the false world of established appearances" (Peet, 1998: 130). While hegemony works to keep common-sense and order in place, a project like ELAM aims towards a counter-hegemony against neoliberal tendencies in health-care provision.

⁷ An intervention made before a patient suffers from illness. It goes in line with how Tommy Douglas put it in his famous 1982 speech where he said, "the ultimate goal...must be to keep people well rather than just patching them up when they get sick."

community. They are taught to treat the broad needs of patients rather than just the conditions of disease. Embracing this ethic is counter-hegemonic to the dominant trend, and it is important to explore how these doctors meet their goals and influence change in the communities they serve.

Against a global backdrop of health-care inequity, ELAM's purpose may be quickly romanticized for its altruistic and ambitious mission. This study is not about novelizing ELAM's mission; it is about normalizing through an exploration of the professional experiences of its graduates. With so many challenges facing health-care accessibility in the global South, can ELAM build confidence for graduates to work in places where public infrastructure has been hollowed, and little capacity exists for physicians to practice in the clinic let alone within the community (Sawyer, 2004)? The clinic in Sachas is half under water, the doctors few, the resources fewer, and many of the patients live more than 25 km away, with little means to actually get to the clinic. And yet, a group of committed doctors have returned from Cuba to this place, and to other parts of rural Ecuador, in order to use their skills for the needs of such communities.

Their stories brought me here, to see how their tests of the classroom transfer to their challenges in the field. Would they make a difference at the community level? Would they cope with poor networks and insufficient resources? Or would they be overwhelmed? By building capacity at the individual level, ELAM hopes to provoke structural change at broader levels. In order to effectively test this claim, this study sets out to determine how ELAM's capacity building actually works in places like Sachas.

Does it train physicians to eventually participate in mainstream health-care hegemony⁸ or does it actually build counter-hegemony to contribute to organizational and social change? This is an important geographical question, as it addresses how societies manage and sometimes alter access to resources – in this case human resources for health within their lived environments.

On the roof of the Sachas clinic, standing right in the middle of unbridled poverty, with a young physician determined to make a difference, I knew that this research would not only address specific academic questions, it would ultimately explore the age-old dilemma of determining whether individuals can change a system or if it will eventually change them. Dania Suarez and Jacqueline Rios both told me, later over a cold beer in the sweltering jungle, that they would likely leave Ecuador to specialize. Ecuador's Ministry of Public Health would not pay them to remain in a rural clinic like Sachas, nor would it be easy for them to find residency and specialization within the country. The determination to help those in need, and the commitment to use their skills to help improve service for the poor, seemed able to carry them only so far. But are ELAM graduates doomed to turn away from their commitments to the marginalized in order to find a place, like so many other physicians, in health-care systems that exclude the poor and limit participation to the elite? Or might they find ways to maintain their commitment, ensuring it does not get passed by?

⁸ This hegemony is built on two notions of "common sense." First, is the blind faith towards the western-biomedical model, and second is the culture of demanding fees for service. As such, I am not arguing that health care, or even medicine, is hegemonic. In fact, I agree with Farmer (2005) that medicine is enabling. Rather, the structures of inequality emanating from the current conditions under which medicine is practiced produces hegemony. Faith in biomedicine and fees for service are held beliefs of the elite, and they do not necessarily meet the interests of the indigent. This common sense transcends into the poorest places on the planet through an intentional hegemony produced by the actions of states and the private sector.

Many countries ignore the potential of ELAM graduates⁹, and do not give them the necessary political and economic support to provide care to the marginalized. Such politics act against Cuba's dream, which came out of Mitch's nightmare, of creating health equity through human resources in the global South. Cuba is striving for a long-term human-security strategy to ensure that medical care is provided to the most destitute of communities by those who are from those communities. If other countries would accept ELAM graduates into their public health-care systems, primary care could be strengthened in marginalized and outlying areas. Most ELAM students identify themselves as coming from modest and humble backgrounds, and 101 different ethnic minorities are represented at the school. They come from communities that are often ignored within national meta-narratives.¹⁰ The question then arises whether these graduates, as skilled physicians, will find a place within their national meta-narratives, or will they be ignored by the existing hegemonic systems?

Almost a year after I met with him in Havana, Cedric Edwards, ELAM's first U.S. graduate, sent me an e-mail that made it sound like hegemony was winning and ELAM's innovation and altruism was faltering. He wanted to let me know that he had finally found a residency position in New York City in 2007, two years after he graduated from ELAM. He graduated two weeks before Hurricane Katrina levelled his home town of New Orleans. He had hoped to return home, but everything he knew was gone. His home was no more, his family displaced. He went to California to stay with friends.

⁹ Several countries have refused to acknowledge a degree from ELAM, while others have imposed restrictions against ELAM-trained students from practicing in their public health-care sectors. Peru, Guatemala, Argentina, Brazil, Antigua, and St. Martin have all, at one point, refused to accept ELAM graduates.

¹⁰ An official discourse that typically represents policies of the nation state, national meta-narratives tend to include dominant groups while purposefully excluding others from the national identity. These meta-narratives are also an important component of hegemonic ideologies.

Volunteering at a hospital in San Diego, he hoped to gain experience that could help his residency application. Even though he had his medical degree, he spent his nights pushing a broom in a church in order to earn money to take the U.S. medical exams, which he completed in late 2006. The residency spaces for internal medicine were competitive, and he doubts that without the volunteer experience in California, and attending an International Health Conference in Ottawa, he would not have been so fortunate. Cedric, like Dania and Jacqueline, returned home where residency restrictions prevented them from continuing to serve their communities. While residency spaces are organized by individual faculties of medicine, their limited number contributes towards a general structure that does more to limit capacity rather than to strengthen it.

The Bigger Picture:

Cedric, Dania and Jacqueline's stories are made of struggle and promise, compassion and tenacity. They are a part of the ELAM graduates from 2005. When they first came to Cuba, some as early as 1999 and others shortly thereafter, Cuban President Fidel Castro envisioned them as "doctors ready to work wherever they are needed, in the remotest corners of the world where others are not willing to go" (Castro, 1999). While willing they are, being able remains to be seen; at least until now.

This thesis is a product of four years of research to understand the professional experience of ELAM graduates. MINSAP envisioned ELAM graduates as providing care in the far reaches of the globe where preventable diseases are often the most common killers (Castro, 1999). In an era when more time, money and attention are dedicated to health-care provision in the global South through philanthropy and NGOs, stark inequities in service remain and preventable diseases claim millions of lives (Garrett,

2007: 15). As well, health-care systems, the world over, are seeking out new and innovative solutions through disease prevention and health promotion in order to overcome the costs and burdens of health-care inequality (Collins, 2003; Iriart & Waitzkin, 2006; Ugalde & Homedes, 2005b; Wilson & Rosenberg, 2002). It would seem that ELAM would unquestionably create positive health-care impacts in the developing South by building human resources for health to serve the under-served. The school has graduated 4,465 doctors between 2005 and 2007, and as of November 2007, had 8,637 students enrolled in the program. But with its graduates sweeping floors and others taking flight from their homes, it may also seem hopeless that capacity-building programs, as innovative and sensitive as they are, can equip committed individuals with the appropriate toolkit to relieve global health-care inequalities. This thesis tries to make sense of this situation to determine if, and how, investing time, energy, capital and hope in individuals can actually create organizational and structural changes in community-oriented health-care provision.

The idea of building human resources for health aimed at rural and marginalized communities has come as a response to the broad practical problem of having too few doctors providing too little care in too few places in the developing South (The World Health Organization, 2006). While healthiness is very much a social condition produced by many factors beyond a physician's craft (Guevara as in Deutschmann, 1997; Hayes, 1999; Wilkinson, 1996), the absence of skilled health professionals has led to immeasurable illness and suffering from very preventable and treatable ailments (Chopra & Ford, 2005; The World Health Organization, 2006). Much has been written in geographies of health-care literature about how health derives mainly from society rather

than from the clinician (Dorn & Laws, 1994; Kearns & Gesler, 1998; Rosenberg, 1998). But when society is grossly unequal, globally or locally, health is put at risk, and access to health-care professionals can have a positive role in improving the quality and quantity of life.

On a global scale, access is not at all equal. Life expectancy is about 80 years in Canada, and only 54 years in Haiti. Eight of every 1,000 live births die in the United States; meanwhile, 283 of every 1,000 children born in Sierra Leone do not live long enough to even reach school age. Switzerland has one physician for every 277 citizens, while Malawi's doctors are expected to treat 50,000 patients each; only 266 physicians practice in this country of 12.8 million. One mother in Europe will die for every 20,000 live births in that continent, yet Africa loses one mother for every 100 live births (World Health Organization, 2007a). In the midst of these harrowing inequalities, and during a time when billions are invested in foreign aid, although very little of that money makes its way to people on the ground, Cuba is trying to make a world of difference by investing in people.

The Practical Problem and the Research Question:

While Cuba has a well-known foreign policy of medical internationalism (Huish & Kirk, 2007) that works to build human security, it is unknown if these capacity-building strategies do, in fact, establish sustainable, long-term quality care in outlying regions. More specifically, it is not fully understood if ELAM helps to establish such care. Very little peer-reviewed literature exists on ELAM. Most accounts come from media, and while some sources are hopeful that it will have a positive impact in bringing health care to places without it (Giraldo, 2007b), others rail against it because the course

books could be newer and the food better (Johnson, 2006), and some see it as “Castro’s vision of an army of medical soldiers” (McCool, 2004). This thesis serves as a first step in moving the ELAM discussion towards a thorough academic exploration by critically analyzing it from its origins to its impact on the lives of graduates.

How does the school work to empower its students with the clinical skills and professional confidence so that they can meet the needs of their communities against the hegemony of inequality? Without fully engaging this central research problem, incomplete knowledge and flawed understanding of ELAM occurs at several levels. By exploring how ELAM builds capacity as counter-hegemony, it is possible to identify the challenges to, and opportunities for, improving rural health care accessibility through human resource training programs. This counter-hegemony should begin with the ethical foundation of the program and then scale-up in the field with the graduate’s ability to practice COPC. It is important to seek out questions that target the role of infrastructural deficiencies, cross-cultural challenges, and skill-set challenges that may impact the transferability of skills and ethics. Effectiveness needs to be understood as the ability of students to apply their ethic and skills in the field, ranging from core clinical competency to furthering community-based medicine. Also it allows for a better understanding of the role of human resources for health in human-security¹¹ provision.

Even within ELAM’s 2005 graduating class, the diversity of nations, languages, ethnicities and gender make it very difficult to measure and identify the constraints for each graduate working in their particular communities. ELAM students have come from remarkably diverse backgrounds, and they will return to just as complex scenarios. It is

¹¹ This will be further explained later in the chapter. It can be taken to mean the provision of policies and actions that serve to protect individuals from real threats to their health and well being.

beyond the scope of this dissertation to try to understand the experience of every student. Instead, this study focuses on ELAM's impacts mostly within the Ecuadorian context. Ecuador, like many places in the South, has, in recent years, adhered to strict restructuring policies. The country went so far as to de-invest in its social services, and it even adopted the U.S. dollar as legal tender. Unique in its own history and geography, Ecuador shares underlying experiences with places that have been socially transformed for the cause of healing an economy at the cost of hurting vulnerable populations.

This thesis is a small study that only engages a handful of ELAM's first graduating class, and their voices can in no way speak for everyone coming out of the program. But, this sample, in and of itself, speaks volumes to the challenges that ELAM graduates face. This study does not measure specific levels of medical competency, nor does it compare ELAM to another school or model. Instead, it builds theory from the lived experience of certain ELAM actors to understand whether or not these graduates are able to apply their skill set in the field despite personal and structural challenges. The mere presence of ELAM doctors abroad is not enough to ensure sustainable quality care, nor is it a sufficient means to measure success; rather, it is their actions and the application of their knowledge and skills working to form counter-hegemony that will determine success.

The Research Problem

The history and development of ELAM is part of a much broader project of Cuban medical internationalism, and is in no way an independent invention. Part of this dissertation highlights the extensiveness of Cuban medical internationalism in order to show ELAM's place within it. From the country's long-standing experience in delivering

primary care to vulnerable communities, MINSAP created ELAM not as an ad hoc response to a national disaster, but as a project sensitive to the needs and realities of the vulnerable. The recruitment, curriculum, pedagogy and student life are all designed to create doctors destined to serve the destitute. The fact that ELAM seeks students who come from places where either too little money or too much discrimination keep them out of national medical schools is an important factor to consider. I offer in-depth analysis of the curriculum of study that has been provided through available information from Cuba's INFOMED and from the school itself. I also include analysis of the student life at ELAM. This has come from a series of individual and group interviews carried out with students in Havana and Cienfuegos. I also provide a window into student life, which according to Becker offers a glimpse into the formation of professional and personal ethics (Becker, 1977).

After discussing life in and out of the class at ELAM, I move on to analyze how the rise of neoliberalism has aggravated global health-care disparities, paying special attention to Ecuador. This richly diverse country, clinging to the Earth's waist and nestled between Colombia and Peru, is a good example of neoliberal transformation. While Ecuador is by no means the most calamitous place on earth, it has been, in the eyes of neoliberal strategists, typical of economic reform and social order (Ignacio Jácome, 2004). These reforms have been a mixture of both internal and external factors, and compared to other developing nations, Ecuador adopted neoliberalism relatively late. Nonetheless, Ecuador's economy may be relatively healthy, but its people are not. And with 30% of its people lacking health care, Ecuador demonstrates a glaring need for

improved health-care service provision despite its so-called economic order and stable governance.

By nature this is a geographical problem. It is a problem of individuals and communities not having appropriate access to resources, which is in large part due to complexities and tensions in the relationship between society and nature. This is, I argue, the heart of geographical inquiry (also Peet, 1998). Geography is inherently about relationships between places and space. A great deal of geographical inquiry has focused on spatial relations and dynamics, and I am comfortable acknowledging that space applies “frictional resistance to the diffusion of power and influence” of places; however, this study focuses more on the dynamics of place and how society – nature relations shape places (Peet, 1998: 2). This is not a cold dichotomy between “man” and “nature,” but an understanding of how society has worked to shape physical nature, and how it has drawn upon its resources to create both beauties and sorrows. It is about how nature has been shaped, and then works to shape society within which it interacts.

Descriptive analysis of the health-care geographies of Cuba and Ecuador demonstrate that the society – nature relations in both places have produced fantastic differences in how individuals, and communities, have access to health-care services, and how those services respond to health-care needs that are shaped in large part by lived-in nature. As Peet suggests, a geographical inquiry should be able to appreciatively understand differences between places, while building understanding of their similarities (Peet, 1998: 3). In this case it is about understanding what challenges the vulnerable face in having access to health care, and how capacity building can work to overcome those

challenges. It is about acknowledging the imbalance of society – nature relations in the present with the hope of working towards equilibrium for the future.

To improve service for the future, ELAM graduated 54 Ecuadorians in 2005. But only 11 returned home to practice medicine at this time. From interviews conducted with eight practicing Ecuadorian ELAM graduates of 2005, in addition to various other key informants, I elicit the experience and the process of integration. While the study centers on the professional experience of the Ecuadorian cohort, I also touch on the experience of other students and graduates from other countries. Through interviews, participant observation and extended analysis, I discuss how effective these graduates are in delivering COPC, and countering neoliberal hegemony.

The Central Argument:

This thesis seeks to understand how the ELAM experience enables graduates to deliver sustainable health-care provision to marginalized communities in Ecuador through their ethical commitment to, and practice of, COPC. From the multi-method research carried out for this dissertation, I argue that ELAM succeeds in empowering individuals with an institutional ethics to serve communities, but that broader organizational and socio-political structures in Ecuador currently hinder these graduates from successfully delivering COPC. The current working conditions and socio-political environment in Ecuador does not allow for COPC values to progress from ELAM graduates to their communities. The Cuban institutional ethics of service, however, has succeeded at the individual level in building capacity, not just for clinical competency, but for starting the process of counter-hegemony against neoliberal values and practices. The ELAM graduates who are dedicated to service represent an aperture of dissent and

resistance against the hegemonic health-care system in Latin America. Their experience demonstrates that counter-hegemonic thought and practice is possible, and that with appropriate socio-political backing in the field, it may also be possible to broadly employ the resultant service ethos in marginalized communities.

ELAM is a remarkably innovative, appropriate, timely, sensitive and ethical capacity-building program that equips the right kind of people to become the right kind of doctors. From engaging both students and graduates, it is clear that they are committed to practicing medicine as a service and to promoting COPC as a counter-hegemonic action against neoliberal health-care structures. Many graduates are frustrated with the Ecuadorian government's hegemonic disinvestment in public health care and its continuing actions that knowingly reduce accessibility through a lack of retention programs and sustainable employment in Ecuador's public health-care sector. From the findings presented within this thesis I see that without broader social support, economic commitment, and political leadership by the Ecuadorian government, the graduates' full potential in promoting substantial change to current health-care inequities will not be realized.

The ELAM experience must be understood rather than romanticized. ELAM graduates face tremendous difficulties in bringing their unique training, ethics and compassion into existing medical systems that have been reformed by neoliberal

structural adjustments (SAPs).¹² But, because of these challenges, ELAM should not be taken as a failure. Rather, it should be seen as a success in that its institutional ethics have stayed with its graduates, and now some are organizing to change the health-care landscape in order to meet their professional skills. This is a bottom-up counter-hegemonic movement, as the graduates are not waiting for socio-political change to come from above. They are pushing to make it happen themselves.

While training greater numbers of physicians has often been praised as a positive action for increasing public accessibility to health-care services (Dhalla *et al.*, 2002; Duffin, 2001; Rourke, 2005; Sullivan, 2003), without understanding the bottlenecks of health-care systems and the role of institutional ethics in training, no guarantee exists to ensure that those in the greatest need will receive the greatest attention. From this research, it appears that the broader social, economic, and political structures of public health-care in Ecuador do not afford ELAM graduates agency¹³ to provide long-term sustainable COPC for the marginalized. Even in ELAM's early stages, it looks doubtful that graduates will be able to drastically improve health-care accessibility under the current conditions. Some cynics have already concluded that Cuba's approach to health care cannot work in capitalist societies (Maingot, 2006). This conclusion may be too short-sighted, as it does not consider whether or not socio-political change is possible within neoliberal States. At this moment some possibility for change exists in Ecuador, as

¹² Structural adjustment programs (SAPs) are imposed by the World Bank and the International Monetary Fund to force policy changes to domestic spending and foreign trade of Southern nations. SAPs are often conditionalities for securing future loans and assistance from these two institutions. These programs encourage market liberalization in order to overcome the fiscal imbalances of the country. This liberalization almost always involves the selling off of social services to the private sector. Due to heavy criticism for their inability to reduce poverty, Poverty Reduction Strategy Papers (PRSPs) have become the new norm for Southern countries to propose their own agendas of fiscal rebalancing to the World Bank and IMF. SAPs will be further discussed in Chapter 6.

¹³ By this I mean an individual's capacity to freely make choices and to enact them in their daily lives. This is the antithesis to structures that determine human actions.

the new government is searching for alternative policies to harness the country's natural wealth and direct it towards improving public health-care services. Clearly, greater structural change is needed within current neoliberal health-care systems in order to embrace the capacity of ELAM doctors, so as to help meet the needs of the vulnerable.

The ELAM experience, to date, can be considered a surprising success, not so much as an ideal model, but rather as proof that another reality is possible; an experience where health care is viewed as a service in order to it a human right. Worldwide, many medical school graduates struggle to find work in the public sector, and they often move towards the private sector and wealthy urban environments (Aluwihare, 2005). Partly because of this trend, Ecuadorian communities remain no closer to establishing sustainable COPC systems. The Ecuadorian ELAM graduates have demonstrated that individuals can have the desire, compassion and ability to serve the needs of the poor, but a transformation of overarching social and political systems is also needed to help meet their expressed ethical commitments. The current state of despair in Ecuador's public health-care sector lies with structural shortcomings and the inability of the system to embrace human altruism, in addition to too few individuals with the skills and compassion to make a difference.

There is not enough research to date to confirm that inadequate or poorly-structured systems inevitably bend good will (Farmer, 1999). And, as some argue, the door remains open to find ways to seek out another possible world where altruism and equity have an important place (Boelen & Hack, 1995; Bond, 2005; Santos, 2006a, 2006b). ELAM challenges the assumption that individuals are naturally inclined to embrace privatization, contribute to centralization, and tolerate dwindling services.

Landscapes of inequity created by such trends are, in the end, socially constructed, and can be changed with the appropriate political and social will. These graduates demonstrate that serving the poor is not undesirable, nor is it impossible that comprehensive medical education be built on humanitarian ethics and altruism. With such minimal support for Ecuador's ELAM graduates, let alone the other 300 new doctors that annually graduate from the country's universities, it may appear inevitable that they will find work away from vulnerable communities. But, by questioning this inevitability, it is possible to envision apertures for change and improvement in both Cuban medical internationalism and Ecuadorian public health care.

To see if organizational and environmental change is possible, I engage a multi-data perspective. In part, this thesis offers descriptive analysis of various aspects of ELAM. Personal accounts and conversations are presented here to offer an insight into the program and the field. Such descriptions via personal accounts and lived realities are important to challenge hegemonic impressions (Blommaert, 2006) of health-care provision. This develops an informed, inductive understanding of the educational and working experience of ELAM's graduates. ELAM may be considered a modernist development project¹⁴ in the sense that it aims to empower individuals to create social change at broader structural levels. Using this approach provides insight into the professional development of an ELAM scholar, and builds understanding of the challenges of delivering COPC in the field. It is a methodology that describes the power struggles facing ELAM graduates, assesses efforts for improving capacity, and questions

¹⁴ Modernist development can be interpreted in many ways. For this dissertation, I view modernist development as Peet (1999) describes it as an intentional top-down intervention aimed at providing the necessary skills and resources to individuals and communities to overcome poverty and human insecurity.

the variable ability of individuals to confront and change neoliberalism's economic determinism of health-care provision.

With ELAM graduates actively organizing to change Ecuador's health-care system, an aperture of dissent against neoliberal hegemony has emerged. While structuralists may question whether individuals do, in fact, have the ability to create counter-hegemonic movements, the ELAM experience shows that individuals do have choices, not just in terms of minor technocratic adjustments, but as actors working to bring equity to an inequitable system. However, it is not possible to embrace the potential for such change if, as John Ralston Saul puts it, "we accept what produced the need for [neoliberalism] as an inevitable force" (Saul, 2005: 30). Current patterns of health-care systems transforming patients into clients and withholding services to the indigent have been justified by many neoliberals as foreordained, unstoppable and inflexible (Navarro, 2007). It is much like the story of Plato's slave doctor who "gives an order based on empirical belief with the air of exact knowledge" (Saul, 2005: 30; Vlastos, 1960). The slave doctor does not question the structures that govern him and his subjects. He believes in inevitability and order is imposed upon him rather than discovering it through critically engaging broader social and political structures (Saul, 2005: 30). Meanwhile Plato's "doctor of free men" searches for the origin and the nature of the illness, rather than following orders or making diagnosis based on preordained knowledge (Vlastos, 1960).

I consider the ELAM graduates to be, in a sense, part of Plato's second grouping. Their ability to understand the origin and nature of health inequalities in their home communities, combined with a commitment to overcome them, may very well comprise a

counter-hegemonic labour force ready to challenge the supposed inevitability of health-care inequity. Their collective experience has shown them, regardless of where they may practice today, how to improve lives through accessible primary care. If more systems embrace their skills, then another geography of health care would be possible for the global South. Their knowledge in medicine and their determination for change may not create transformations overnight, but it may be enough to show that individuals are not inevitably inclined to foster geographies of health-care inequity.

The remainder of this chapter discusses some of the key concepts that this thesis explores, and it offers a summary of the remaining chapters. First, the chapter will discuss exactly why equality in human resources for health is important to geographers, policy makers, and those living in the global South. Second, it defines key concepts for this study, such as capacity building, COPC, and human security. These three concepts are naturally intertwined and can play an important role in creating positive change towards health-care equity in communities.

Why Human Resources for Health Matters:

Health-care inequalities do not just exist between rich and poor countries; rather they affect the human security of the rich and poor of all countries (Mgbeoji, 2006). There is a global health-care dilemma of having patients without doctors, and doctors without patients (Ogilvie *et al.*, 2007). Economic demand brings physicians to wealthy centres, while a lack of economic demand leaves poor communities, areas often where health risks are great, without adequate services. It is a dynamic problem beyond the lack of trained physicians and public health-care workers. One part of the problem is that the world's 1,691 medical schools and 5,492 nursing schools are certainly not filling the

global deficit in health care (Giraldo, 2007a). And the more complicated question is how equipped and confident health professionals are in being able to meet the needs of vulnerable populations. Health workers are individuals who, according to the World Health Organization (WHO), have a primary responsibility to improve health (The World Health Organization, 2006). This is an overly broad definition, as many professions could be considered part of the global health-care workforce. For clarity's sake, let's consider the WHO's argument that the working actions of the individual are directed at building health, so a doctor employed by a mining company would be classified as a health worker, despite working for an unhealthy industry, while an interior decorator at a hospital would not be considered a health worker, even though their actions may contribute to health (The World Health Organization, 2006: 2).

The connection between health and the role of health-care professionals is also subject to debate. Much has been written that considers health to be well beyond the product of a trained professional's craft. From Hippocrates to Ernesto '*Che*' Guevara, health has been understood as the product of one's lived environment. This understanding has developed over time. Medical geography's pioneer, Jacques May, overlooked the role of social content when he said that "parasitology, epidemiology, and medical entomology [should] take into consideration special aspects of the relationship between disease and environment" (May, 1954: 453). Worrying less about actual bugs and viruses, and with a strong concern for the role of society in the production of health, Robin Kearns (1994) suggests *demedicalizing* health geography to move beyond concerns just about disease. Health geography's efforts to understand the links between health and the lived environment, from its early origins to its later cultural turn, have at

times neglected if not criticized the role of the health-care worker. In some cases health-care workers have been blamed for objectifying patients and “turning them into cases” (Kearns, 1994: 112). There is room, I think, to move beyond the characterization of health-care workers as attempting to improve health by treating disease in the clinic so that it is possible to see them more broadly as potential stewards of health within the community.

This stewardship should be about ensuring the WHO’s (1946) understanding of health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.” It is a broad and complex relationship where the health-care professional can have a leadership role to help ensure a healthy state of individuals and to help develop healthy communities. The WHO approach recognizes health as a process of relationships; its constitution makes two important claims that bring health into considerations of rights and human security. It reads: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security” (World Health Organization, 1946). In order to achieve these goals, the development of trained health-care professionals is fundamental in encouraging and maintaining health for individuals and their communities.

The WHO estimates that 59 million persons constitute the paid global-health workforce. However, their numbers are of course very unequally distributed across the globe. Often countries “with the lowest relative needs have the highest numbers of health workers,” (The World Health Organization, 2006: 8). While Africa endures 24% of the

global burden of disease, it only has 3% of the global health workforce at its disposal. Cuba is not alone as a Southern nation that possesses great potential to build capacity for human resources for health. Pakistan, for example, has the facilities to train 5,400 physicians annually, but is unable to recruit qualified students and to then retain many of its graduates. Almost 35% migrate or do not go into any form of practice (Talati & Pappas, 2006). Moreover, the overwhelming majority of these graduates would likely dedicate their skills to the private sector and urban care centres (Thaver *et al.*, 1998), which limits access for rural and indigent populations. Although one doctor exists for every 2,100 inhabitants in that country, Talati & Pappas (2006) admit that Pakistan can not meet its health-care needs due to out-migration and service inequities within the national system. On a global scale, human resources for health vary wildly. Cuba has a doctor to patient ratio of 1:158; Switzerland has 1:277; the United States has 1:390; Canada has 1:467; Ecuador has 1:675; South Africa has 1:1,290; Haiti has 1:4,000; Nepal has 1:4,761; and Malawi has 1:50,000. These broad statistics give a bleak picture as to how equitable the global health workforce is. These ratios of course do not adequately represent the quality of health-care, or the state of health within and between nations, but they do provide a telling glimpse as to the inequality of health care on a global scale. Moreover, with over 75% of the world's physicians and 60% of the world's nurses working in urban areas, the WHO estimates that 4.3 million health workers need to be trained in order to bring all countries up to minimal thresholds of ensuring, for example, skilled attendance at births (The World Health Organization, 2006). Fifty-seven countries are unable to meet this minimal threshold; and while South-East Asia suffers from the greatest shortage in absolute terms, Sub-Saharan Africa requires an increase in

human resource of almost 140% to meet its threshold (The World Health Organization, 2006: 11 - 12).

While the WHO claims that millions of dollars are needed for training and development in order to relieve this situation, it is unlikely that money alone will be enough to overcome current inequities. Simply training a health professional does not, itself, guarantee an improvement in health-care accessibility or health promotion at the community level. It is also important to consider the institutional ethics of training in order to assess whether health-care professionals have the commitment, in addition to the confidence, necessary to meet community needs. Neoliberal structures in low- and middle-income countries (LMICs) increasingly distribute health-care resources based on an ability to pay, and physicians are often trained so that they will be successful in delivering pay-for-service care that rarely considers principles of disease prevention and health promotion. A great deal has already been written about the devastating effects that neo-liberal restructuring has had on the public sector of LMICs (Bloom & Standing, 2001; Bundred & Levitt, 2000). Internally- and externally-driven reforms have weakened public health-care sectors of needed capacity for long-term sustainability, and for expanding critical service provisions to the marginalized (Shah, 2006). Such practices are integral to neoliberal frameworks that encourage privatization, individual consumerism and investment in foreign finance. Investing in public infrastructure is typically neglected by neoliberal policy that elides overutilization and exploitation of public services. Material and human resources, all too often, find their way into the private sector, and the extremely marginalized are not able to purchase health-care services (Aluwihare, 2005).

The draw of physicians out of LMICs has significant consequences, especially for the most vulnerable (Cooper, 2005; Hallock *et al.*, 2003). Workers often face poor management, heavy workloads, lack of facilities, and challenging living conditions (Astor *et al.*, 2005). As Aluwihare (2005: 18) points out, the impacts of physician migration range from the loss of an education pool to service shortcomings, and, hinders clinical and public health research within donor countries. As he writes, “system[s] must [have] a patient focus, [but also ensure] continuing medical education (CME).”(Aluwihare, 2005: 16). Physician renewal is very important to the well-being of public health services. Replenishing knowledge through CME at the national level is vital, especially in poorer countries (Chikanda, 2006).

Poor working conditions at home, and lucrative opportunities abroad, are macro-factors in encouraging migration, but as Astor *et al.* (2005) show, many medical schools in the South furnish their graduates with highly specialized skills that are aimed at meeting market demand and earning prestige in the North. Moreover, medical schools in LMICs that fail to encourage community service compound problems of restricted access to health-care professionals, as many graduates ultimately seek out more prestigious and lucrative options in the North. In Zimbabwe, for example, the national medical school graduates about 100 physicians per year, but between 1995 and 1998, the number of practicing physicians increased by only 51 from 1,575 to 1,626 (Chikanda, 2006). This is a result mostly of brain-drain, but retirement and replacement also play their respective roles. Kirigia *et al.* (2006) have calculated the cost of this brain drain in Kenya to be a loss of almost \$518,000 to the national economy for each nationally-trained physician that migrates out of the country.

Economic demand in the North and the focus of specialization of medical schools in the South drive the migration pipeline (Garrett, 2007). Meanwhile, the real demand for physicians among indigent populations is increasing globally (Talati and Pappas 2006). The problem of fewer skilled health professionals practicing disease prevention and health promotion at the community-level creates a culture of health care that is reactive rather than proactive, institutional rather than communal, and costly rather than affordable.

ELAM serves as a counterpoint to this trend. The school aims to send physicians exactly to the regions where other medical schools, directly or indirectly, are discouraging their graduates from practicing. Encouraging physicians to practice in underserved areas, not through a written contract or forced obligation, but through commitment to a service ethic, is a phenomenon that deserves further exploration in understanding how ethics can ultimately shape geographies of health care.

With domestic health-care systems becoming evermore inequitable, the future of global health can look grim. Even the hope of emboldening biomedical health-care provision in the developing South can be just as problematic as it can be helpful. Western medical practice has a tradition of imposing ideals, methods and technologies inappropriate to local conditions (Tong, 2001). Many critiques of Western medicine in the global South have taken exception to its tendency to be culturally invasive, dependent on extensive material support, and strictly inequitable (Waitzkin & Iriart, 2001).

Even humanitarian outreach programs run into challenges. A *Médicins sans frontières* brigade may work in an outlying part of South-East Asia to provide vaccinations or HIV treatment, but basic elements of primary care may not be offered to

the community by the brigade or by local health-care workers on a regular basis. Such vertical programs are the norm when it comes to providing health-care to the vulnerable through aid rather than through local participation and empowerment. No doubt, the services provided do make a difference, but they do not enable individuals within the community to have control over their own promotion of health and well-being. There is a clear need to evaluate alternatives that aim to give control back to the community. ELAM is an important program in this discussion as it is meant to strengthen human potential from within communities in order to benefit vulnerable populations.

Making Doctors

It is important to consider the educational framework in which ELAM graduates are taught. This involves considering what they are taught, how they are taught, and by whom they are taught by. The practice of making doctors has been widely studied, especially in Northern institutions at least since, perhaps, Abraham Flexner's (1910) report which critically examined the state of U.S. and Canadian medical schools at the turn of the 20th century (Osler, 1962: as in Rae: 2001).

The Flexner report, sponsored by the Carnegie Foundation, was written in response to the growing problem of private medical-school graduates failing to meet minimal standards, and having poor foundations in basic science. Flexner argued for a standardized curriculum involving thorough scientific education, and he called for medical schools to encourage students to develop critical thought and confidence to resolve problems, rather than just cope with them. Specifically, the Flexner report called for a standard four-year curriculum, teaching by research faculty, two years of clinical teaching, a mandatory university affiliation, and entrance requirements involving

knowledge of basic math and science. While some have criticized the Flexner report for limiting medical education¹⁵ (Rae, 2001), it should be appreciated as a moral attempt to improve the quality of medical education so that graduates and institutions could meet the needs of the greater population. Indeed, these recommendations have had an important role in medical education in the North, and they are also well respected by Cuban medical education institutions.

In Cuba, it is well recognized that medicine continually advances, and today some of the challenges for medical education include building greater outpatient care, growing appreciation of the social aspects of medicine, and building knowledge and participation for medicine within the community (Vicedo Tomey, 2002). Nevertheless, the suggestions of the Flexner report are reflected in the Cuban curriculum, especially concerning the attention given to a rigorous scientific education, high requirements for acceptance into the program, and developing critical thought in students. In addition to the five accepted recommendations, Flexner also called for basic sciences to be integrated for the four years, to promote active learning, to limit learning by memorization, to encourage problem solving and critical thinking, and to foster life-long learning (Regan-Smith, 1998; Vicedo Tomey, 2002). Regan-Smith claims that, at least in the North American curriculum, these recommendations have not been as widely accepted as the others. As I will show in Chapter 5, these recommendations are, however, clearly visible in the Cuban curriculum.

It is important to recognize how important Flexner is to the basis of medical education, and it is especially important to acknowledge that the Cuban curriculum is

¹⁵ Due to the closure of many private medical schools, the demand for high entry standards and the implementation of costly tuition.

closely tied to his suggestions. I emphasize this in order to note that ELAM emphasizes the development of skills in science alongside an ethics of service.

ELAM encourages small class sizes and regular interaction between students and faculty both in the class and in the clinic alike. Student engagement – from the lecture hall to the clinic, and even to the ice-cream parlor or café – is important in understanding how ELAM makes doctors. The entire experience plays a role in shaping moral perspectives as to what medicine is, how it should be practiced, and who should be a doctor.

Bringing more clinical practicum into curricula is an idea that is practiced in both Cuban and North American medical schools. The goal is to foster instructor-student relations, and for basic knowledge to be learned in the context within which it will eventually be practiced. A challenge to North American schools is that clinical practicum often takes place in centralized and tertiary centres, which may negatively impact the confidence of students wishing to work in rural areas where resources are fewer and challenges greater. Although Cuban rural medical centres are often better equipped than many rural medical centres in Latin America, the newly designed ALBA program¹⁶ permits some foreign students as early as their first year to train alongside physicians in rural clinics. In this sense, students retain knowledge through practice and problem solving, rather than referring entirely to notes taken in a lecture hall. This is an approach that Flexner himself strongly encouraged.

¹⁶ ALBA is the Bolivarian Alternative for Latin America and the Caribbean is a socially-orientated trade bloc that emphasizes the development of human-security oriented initiatives to improve health and well-being amongst poor populations. Unlike traditional trade networks that aim to eradicate poverty through economic growth, ALBA is an egalitarian framework aimed at overcoming poverty through investing in campaigns of solidarity as much as trade.

Traditional medical-education institutions, while building strong foundations in science, can under-equip graduates with the necessary confidence to serve vulnerable populations. In the U.S., this may in part be due to serious racial discrepancies in admissions to U.S. medical schools (Steinecke *et al.*, 2007). In fact, many of these schools now require race-conscious admissions processes to order to attempt to increase diversity in the student population. A medical student from an ethnically-marginalized community has much higher odds of returning to his / her community, or working in a community with a similar demographic composition (Rourke, 2005). Still, the number of medical students from marginalized communities is not proportional to the existing needs for health professionals in these communities in the North and South alike (Freeman *et al.*, 2007). Building confidence in students that do not identify with racially- or economically- marginalized communities remains a challenge for medical-education institutions.

The practice, or business, of making doctors is complicated. Some major determinants have been recognized as to what will allow a physician to return to, or to seek out, indigent patients. As Freeman *et al.* (2007: 133) demonstrate, State medical schools have a “social mission” to improve access and equality of health-care systems, but this is not always addressed through affirmative action or proactive reintegration strategies. From the literature, it is clear that race, gender and class are major determinants in the intake process for medical schools and, eventually, for who is most likely to become a physician, and where they will ultimately practice. Poorer applicants and ethnic minorities are less likely to make it through the rigorous and costly application process to North American medical schools. Application costs, standardized exams,

previous experience, and the favouring of students from prestigious colleges all have a limiting effect as to who can become a doctor. However, many medical schools are aware of these challenges, and are actively adopting programs to bring economic, gender and racial equity into the admissions process (Rumala & Cason, 2007). As well, while most students enter medical school with high hopes to treat those most in need, it is usually the graduates who come from marginalized communities who will be most likely to return to them (Dhalla *et al.*, 2002). In Canada, for example, only 11% of medical students can be identified as coming from rural areas, while the country's overall rural population stands at 22%. Yet, as Rourke (2005) shows, a medical school graduate from a rural area is five times more likely to return to rural practice than a graduate who was raised in an urban environment.

High tuition also limits students from gaining access to medical schools (Duffin, 2001; Sullivan, 2003). With some U.S. schools charging tuitions around \$25,000 USD a year, students must lean on generous benefactors or incur heavy debt. Even in Ecuador, medical school costs are burdensome for students who come from middle-class backgrounds. In the U.S., it is not uncommon for a medical graduate to bear the burden of \$200,000 in arrears, while in Canada the average debt load has risen past \$150,000 for a four-year basic medical degree (Kwong *et al.*, 2002). There is evolving evidence that co-incident with the abrupt rise in tuition fees in Ontario medical schools with the rise in the average household income in the family of origin of entering medical students. This may indicate that the barriers to entrance are more subtle but no less pervasive than once believed. In Ecuador, it costs on average around \$30,000 - \$45,000 for the entire degree. As a result, graduates often seek employment in higher-paying positions in urban centres,

specialization, and private-sector research immediately sought after school in order to quickly reduce the debt-load.

Cooper *et al.* (2005) argue that the North needs to train more physicians and health-care professionals in order to meet growing demands for their services. They admit that even if the United States constructed 25 new medical schools overnight, the total combined graduation would only meet 80% of American health-care service needs (Cooper *et al.* 2002). Even so, the problem of accessibility cannot be overcome by just simply increasing the output of medical graduates. Social, economic, cultural and gender inequities, combined with the aforementioned negative effects of a hegemonic ethics of medicine, all work to limit universal accessibility. And yet, at the same time, innovative programs are in place to promote “service learning” for students in the classroom, and for educational institutions to “fulfill...their social responsibilities and [to be] accountable for doing so” (Woollard, 2006: 310). By considering these broader factors, we can appreciate how a program like ELAM, which aims to build counter-hegemony, may affect the determinants of who may become a physician, and where they might go after graduation.

Building Capacity:

Capacity building is a fitting framework to study the processes of making doctors. The concept of capacity building has commanded a large place in the development and education literatures for decades now. It can be understood as an enabling process applied to human and material resources to meet national, local and institutional goals (Robinson *et al.*, 1992). It is understood as a long-term process leading to sustainability, rather than a rapid band-aid solution to inequality and under-development. Many Latin

American health-care sectors have well-recorded histories of inequality. Building on this history, neoliberal SAPs, initiated internally or from abroad, have often furthered disparities in the process of trying to reduce national debt.¹⁷ Building capacity in such systems requires appropriate innovation to overcome the historic inequalities and counter-act neoliberalism's furthering effects. The World Bank and the IMF have had a far greater role in determining health policy than PAHO or the WHO in Latin America (Atkinson *et al.*, 2005; Deacon *et al.*, 1997). Coping with restructured public health systems that restrict service provision has typically meant more emphasis on disease prevention and health promotion campaigns. But as Atkinson *et al.* (2005: 167) show, despite rhetoric, no "documentation or evaluation of actual experiences of disease prevention and health promotion within decentralized health systems exists." While the World Bank often lauds decentralization as a means to ensure greater local authority, decision making, and resource retention in capacity building (Frisbein, 1997), little attention is paid to local actors who actually sustain services against those broader social and economic forces of globalization. This is a very real challenge for ELAM graduates who are trained in an ethics of service, but who return to areas where services are barely supported. Often institutions like the World Bank value increased health-care capacity according to the spatial expansion of high-tech resources and the decentralization of technologically-complex practices. Spatial accessibility, despite the obvious inability of the poor to pay for such treatments, is often considered a success regardless of the limited impact they have on the population's health. As Murray and Elston (2005) find, the

¹⁷ The Washington Consensus refers to the joint efforts of the World Bank and the International Monetary Fund to impose SAPs in the global South. Critics of development theory use this term, as many feel that the two institutions are centres of neoliberal hegemony and western imperialism rather than sincere attempts at poverty reduction and promoting social equity.

privatization of maternity care in Chile did lead to an expanded spatial accessibility, but it did not equate with increased equity of such services. Gideon (2006) also found that in Chile, both men and women experienced greater difficulty in accessing services as a result of trade liberalization and other neoliberal measures.

Furin *et al.* (2006) point out that such measures leave vulnerable populations in the global South at serious risk of preventable diseases, while material resources for treatment are often physically, but not economically, obtainable. This is the result of building capacity in unaffordable technologies rather than in accessible services. Truly building capacity for hollow public health-care systems requires incoming physicians to be trained in a multitude of skills such as “public health, health advocacy, program development, economics and ethics” (Furin *et al.*, 2006: 17). While many physicians may have a dedicated interest in improving health-care equality for the world’s poor, their training, combined with local infrastructure capabilities, make this goal difficult to achieve. In order to truly achieve health-care equity, Freeman *et al.* (2007: 133) argue that “disparities will not be completely eliminated until underserved people, communities, and populations—rural and urban—have physicians available locally to care for them.”

For a capacity-building strategy such as ELAM to be successful, it must be aimed at improving local-level accessibility, identifying health challenges and determinants, and envisioning strategies for graduates to successfully overcome them (Chino & DeBruyn, 2006; Johnson, K. *et al.*, 2005; Peake *et al.*, 2006; Sheth *et al.*, 2007; Spiegel *et al.*, 2006; Von Ehrenstein *et al.*, 2006; Wubneh, 2003). Moreover, many capacity-building projects focus merely on producing skilled professionals, rather than going a step further to find

ways for graduates to create positive change, and even counter-hegemony, within special areas (Goto *et al.*, 2005).

While most capacity-building projects may analyze the enabling process of participants, they do not often have a means of measuring success past the end of the program. Programs may meet their immediate goals, by enabling human or natural resources in a particular sector, but conducting follow-up studies in the field can be problematic. There is often little means to precisely determine where human resources will wind up, or if they will remain in the field for the long-term. In order to understand if building capacity in individuals leads to counter-hegemony for communities some follow-up studies must occur in the field.

While Cuba has a good track record of conducting follow-up studies on its various capacity-building projects (Romani *et al.*, 2007), it has yet to produce a follow up program for ELAM graduates working in their home countries (Carrizo, 2007). In a conversation with the school's rector, Dr. Juan Carrizo Estevez, I asked if there was any way to measure success at the community level via follow-up studies on graduates after the program. He replied that nothing was in place, and that with so many graduates, it would be difficult, if not impossible, to measure success through the impact that each and every one has in their communities. Still, the complexity of the problem should not take away from the value of the question. Even if this study interacted with only a small number of ELAM graduates, the questions posed, the methods used, and the overall process of exploring how the program's institutional ethics may progress to the community level are valuable first steps in measuring ELAM's impact on practice patterns in the global South.

Community Orientated Primary Care:

As I see it, the end goal for ELAM is to increase COPC throughout the hemisphere, Africa, and Asia in the near future. Success in this area cannot be determined from the size of a graduation ceremony. It needs to be measured by how well graduates apply COPC in their communities. The institution's mission is to "form solidarity between the Cuban people and others in the world... [it] is a university to create general physicians aimed at delivering primary health care with a professional attention, and a heightened concern for science, humanism, ethics and solidarity; capable to act in their environment according to the needs of the region to create sustainable human development" (*Escuela Latinoamericana de Medicina*, 2007). The Cuban approach of providing primary care for little or no charge, training locals in medical practice and emergency care, and educating communities in the social and environmental determinants of health, are all components of COPC.

But, as Carrizo admits, little has been done to prove the existence of COPC from the professional experience of ELAM's alumni. In attempting to overcome this problem, this study examines COPC as "a model of [health-service] development that integrates public health and primary care in order to deliver targeted prioritized services to a defined population" (Iliffe & Lenihan, 2003: 86). In addition, "the COPC model has been developed mainly in underserved populations to integrate public health objectives and primary care through interdisciplinary approaches, with active involvement of the target population" (Iliffe & Lenihan, 2003: 85). COPC strives to meet health needs at a community level, involves community members in the process, and uses innovative

techniques with the infrastructural resources available to expand access to care and improve individual well-being.

While the notion of targeted prioritized services can be debated, the basis of COPC is to view the community, rather than the individual, as the point of treatment, meaning that social, cultural, economic and environmental determinants are considered to impact health far more than disease-specific agents (Brown & Fee, 2002). COPC is often credited as originating with Kark & Kark's approach to primary care in rural Natal, South Africa in the 1940s. They, according to Gofin & Gofin (2005: 757), "implemented a comprehensive approach to care, taking into account the socioeconomic and cultural determinants of health, identifying health needs, and providing health care to the total community." COPC could be linked with other concepts such as "healthy communities" (Cashman & Stenger, 2003: 1379). It is a widely understood concept in the public-health and global-health literatures and it lies at the heart of Cuban medical internationalism. It is an approach that seeks to improve the quality of life at the community level in order to develop a heightened awareness of risks and health complications. It is a model of primary care that Cuba firmly embraces at home, and attempts to replicate abroad through its foreign interventions.

Human Security:

Identifying and responding to health determinants at the community level ultimately works to provide increased safety and security at the individual level. COPC, as Cuba employs it through medical internationalism, is a working example of human security. It is a concept that has been loosely defined and heavily debated in the literature. Human security can be understood as safety for the individual to ensure

freedom from fear and from want (Ogata & Sen, 2003; Rolandsen, 2005). Importantly, it deals with actual individuals rather than imagined threats. As Cuba has furthered human security via numerous international medical campaigns, the question now is whether or not ELAM can play a role in delivering COPC to communities in Latin America, and act as a positive determinant in increasing human security in the developing South.

Claiming that ELAM may have a role in human security is problematic, as the term itself has yet to achieve universal definition or implementation. I use the concept of human security not for convenience, but because I recognize it is an appropriate concept for foreign policies to adopt in order to deal with the human insecurity that has especially grown with neoliberal globalization and consequent inequalities (Axworthy, 2001). Human security is fundamentally about securing individuals before Nation-States, real needs before imagined desires, and immediate threats before illusory dangers. It balances initiatives to meet needs and provide capabilities to individuals. It is anthropocentric by nature, and stresses an individual's right to health, shelter, sustenance and liberty as essential criteria for its fulfillment.

Owen's (2006) definition includes some of the UNDP goals of guaranteeing basic needs, but he sees the need to define thresholds as to how much human in-security is tolerable. He argues for identifying "critical and pervasive threats to the vital core of individuals" (2004: 382) but to limit threats by their severity rather than their cause (2005: 381). Owen's understanding of human security allows for the assurance of a wide-range of basic needs and rights, but his definition selectively limits States taking action against threats that may not be considered a severe situation of human insecurity. This argument is essentially a compromise of expanding policy language to consider the basic

needs of individuals, while attempting to limit State action to cases that are deemed excessively intolerable to the typical threshold of human suffering.

Health sector reforms and trade liberalization have created human insecurity for the world's poor via inadequate access to safe and available health-care services. Policies linked to trade liberalization and structural adjustments have resulted in the poor and working classes living worse, while the wealthiest people on the planet continue to prosper. Harvey (2005) sees these conditions as evidence that globalization was not a utopia to be realized, but a political project intended to restore power and wealth to the elites of this planet, at the cost of safety and security for the most destitute.

Rather than responding to intolerable thresholds, Cuban medical internationalism works to overcome the structural violence that puts indigent communities at risk in the first place. Structural violence can be understood as social, economic, cultural, and gender structures that prohibit individuals from meeting their full potential (Galtung & Hoivik, 1971). As Farmer (2004) argues, globalization has created structures that not only prohibit individuals from reaching their full potential, but often force the world's poorest people into a condition of continuously rejecting health care due to its high cost, inconvenience, and lack of needed services. Farmer *et al.* (2006) argue that structural violence can be overcome through structural interventions. While it is not the specific job of health-care workers to address structural violence at the policy level, poor policies impact health; so in acting as the guardians of health, they should play some role in distal interventions (when patients are already ill) as well as proximal interventions (before patients suffer illness) (Farmer *et al.*, 2006). Farmer's suggestions require building apertures of resistance against policies that promote structural violence and human

insecurity. While many Northern-based policy circles continue to theorize about human security, Cuba has for many years been actually practicing it by providing badly-needed medical services to its own citizens and foreigners alike.

To develop a better understanding of human security, it is important to build the definition on empirical experiences rather than just on semantics. Chapter 4 of this dissertation provides a thorough case history of Cuban medical internationalism that is a fitting example of human-security provision.

As much as Cuban medical internationalism employs human security through short-term disaster relief it also delivers it through long-term sustainable primary care. Cuba makes direct interventions in humanitarian disasters around the world by offering their own human and material resources. This is emergency relief aimed at providing urgent care for the short term. Often Cuba's efforts to provide relief, such as the deployment of the Henry Reeve brigade in Pakistan, have become entry points to establish long-term health-care strategies. After the Henry Reeve brigade left Pakistan in 2006, Cuba offered 1,000 ELAM scholarships to students in that country. Aside from short-term relief, Cuba attempts to build long-term capacity at the community level, through medical interventions and health education. As Toynbee & Ikeda (1976) put it, "the aim of all education is, or should be, to teach people to educate themselves." Indeed, Cuba's capacity-building strategy for medical education follows this notion; it attempts to meet the needs of individuals by empowering them with the necessary skills to serve their marginalized communities. It is a policy that is not too far removed from the old expression of giving a man fish and he eats for a day, but teaching a man to fish allows him to eat evermore.

The most common critique of Cuba's medical internationalism is that the country is selfishly undertaking such programs for its own political gain, even at the cost of undercutting capacity at home. It would be odd to assume that any country constructs foreign policy that does not suit its best interests. All Nation-States tailor their foreign policy to seek some form of advantage from the acquisition of resources to mustering political support. Perhaps Nye's (2004) concept of "soft power" best describes how Cuban medical internationalism indirectly bolsters the country's global image by providing medical services to the indigent. Unlike hard power, which comes through coercion and payments, soft power is built through a sense of "attraction." With outstanding achievements in health care at home and abroad, many nations in the global South are quite naturally attracted to Cuba as a beacon of inspiration in building healthy societies (Erisman, 2008).

In this sense, Cuba is leading by example, and becoming a global-health power. The strengths and capabilities of a Nation-State on its own soil are often also reflected in foreign policy, especially when it comes to implementing human security (Spiegel, *et al.*, 2008). Hurricane Katrina served as a reminder as to how inadequate the United States is in ensuring human security to its own population. It would not be expected that the values of human security would be prominent in its current foreign policy framework since they are badly wanting at home.

Building capacity for counter-hegemony rooted in human security makes ELAM's mission unique. It begs the questions as to how similar initiatives could be expanded worldwide. Perhaps if national-level policies aimed to ensure that health-care professionals have the chance to serve communities, ELAM's institutional ethics could

begin to flourish globally. ELAM can inform the human security literature that it is not only possible to train doctors from the world's forgotten regions, but that it is also possible for individuals to commit to meeting the needs of the world's most vulnerable populations.

This dissertation is comprised of seven remaining chapters. Chapter 2 develops a theoretical framework on Cuba's approach to health-care provision. It identifies an appropriate theoretical framework of humanist-Marxism to explain the divergent contradictions of modernist and empowerment theories in the development studies literature. Humanist-Marxism and the concept of "alternative development" are important in building a conceptual framework that demonstrates how the theoretical foundations of overcoming underdevelopment through counter-hegemony underscore the purpose of ELAM.

Chapter 3 revolves around methodological concerns and focuses on the study's mixed-data approach involving descriptive interviews, participant observation and document analysis. It identifies the research agenda and the shortcomings of this study. Chapter 4 provides a detailed discussion of Cuban medical internationalism and the role of nationalism in the country's foreign policy. Cuba's revolutionary government has been involved in dozens of foreign interventions that have attempted to build human security through primary care. This is an important historical analysis for this thesis as ELAM, I argue, is not a unique ontological entity, but a product of medical internationalism. Cuba's foreign interventions are based from the experience of its domestic achievements in primary care at the community level. Connecting Cuba's

success in community health at home with humanitarian relief abroad shows how ELAM is an accumulation of these interconnected historical trends.

Chapter 5 addresses the research I conducted with participants of ELAM, and demonstrates how students build an ethic of practicing medicine in the community. This chapter focuses on many aspects of ELAM, from curriculum and pedagogy to student life and the student selection process. Chapter 6 leaves Cuba to focus on Ecuador. The chapter identifies challenges to health-care provision in Ecuador especially the structural consequences of neoliberal SAPs. The chapter is a valuable part of this dissertation as it discusses the historical, and spatial, impact of neoliberal hegemony in Ecuador's health-care sector. It also presents interviews I conducted with health professionals and other members of vulnerable communities in that country. Understanding the nature of Ecuador's SAPs help to identify the challenges and rigidities that ELAM graduates face in bringing the school's institutional ethics to their communities.

Chapter 7 provides data, principally through first-person interviews, about the professional experience of ELAM graduates working in their communities. The chapter focuses on the themes from the interview guide I administered in Ecuador, and also on the anecdotal stories of the graduates who are currently practicing in the field. Finally, Chapter 8 offers conclusions concerning the success of ELAM as a capacity-building project, and especially notes the importance of overcoming organizational and structural challenges in the field. It also discusses options for change given recent moves by ELAM graduates to influence the Correa government to adopt policies more appropriate of their mandate.

Overall, this study examines the professional experience of the first contingent of ELAM graduates working in Ecuador and assesses if the program is appropriate in scaling-up counter-hegemony by first bringing COPC to their communities. The graduates' challenges, successes and prospects offer insight into a unique capacity-building program that has the potential to further dialogue and debate among various epistemologies from physician training to human security. As this study will show, the challenges for ELAM graduates are complex, daunting, and real but, at the same time, they underscore that change may be possible, and that those intangible human qualities of hope, altruism and ambition may overcome structures of despair, inequity and indifference. I agree with Howard Zinn (2007: 11) by hoping that "our future may be found in fugitive moments of compassion." Against the hegemony of for-profit health care, physician flight, and structural violence is the telling experience of the ELAM graduates who may be seen as fugitives of compassion in an otherwise grim global health backdrop.

Even in Sachas this idealism exists. Travelling with the doctors into the jungle villages, we joined another brigade of health professionals who set up a make-shift clinic in a nearly gutted school house. In the soccer pitch, an oil pipe feeding the main line was leaking crude onto the grass. But inside the nearly bare school, the physicians treated patient after patient. They gave them check-ups, asked them about their diets, living conditions and if their husbands were still drinking too much. A ruined soccer pitch due to resource development, a gutted school thanks to structural adjustments, but in the middle of it all were committed individuals trying to make a difference.

F. Scott Fitzgerald (1964) best described scenes like this. He said that “the test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise.” It is exactly the challenge facing ELAM in building apertures of dissent against the current global health-care hegemony.



(Fig. 1) The Public Clinic in La Joya de Los Sachas

(Fig. 2) Mosquito infested water immediately behind the Sachas clinic.



Chapter 2:
From Critical Space to Apertures of Dissent:
The Alternative Development Framework Behind ELAM

~ Like stones rolling down hills, fair ideas reach their objectives despite all obstacles and barriers. It may be possible to speed or hinder them, but impossible to stop them. ~
José Martí

Exploring the professional experience of ELAM graduates is an important geographical inquiry that deals with the process of empowering individuals to help meet, and possibly transform, the health-care landscapes of vulnerable populations. Understanding the professional experience of Ecuador's ELAM graduates contributes to dialogues that seek solutions to social inequalities through the "positive potential of modernity that serves the needs of poor people" (Peet & Hartwick, 1999: 12). Some post-structuralist critics regard capacity-building projects, such as ELAM, as too intervening, too idealistic or too insensitive to truly meet local needs (McGregor, 2007). Rather than unpack ELAM as a cultural discourse to show that it might include or exclude various narratives, this study is more concerned with exploring its strengths and understanding its shortcomings. It is not about trying to understand the various discourses between ELAM's institutional ethics and community needs, as much as building understanding of how to build capacity aimed at overcoming health-care inequity. Peet & Hartwick (1999) call such an approach "critical modernism," whereby development initiatives are critiqued in a way that suggests improvements, while at the same time noting their existing strengths. This is a fitting approach to understand ELAM's role in emboldening human resources for health in the global South. It is a conceptual framework that remains sensitive to geographies of regional political economy that are influenced by globalization's broader trends (Thrift, 2002: 296). Although it would be easy to dismiss

modernism altogether as a ruinous paradigm, Peet & Hartwick (1999) suggest that a critical approach is needed in order to find appropriate interventions that meet the needs of the poor.

Approaching ELAM through the post-structuralist “fetish” of deconstructing texts (Peet, 1998: 227), would ultimately accept a certain discontinuity and chaos of multiple discourses (Harvey, 1989: 44). A purely discursive analysis of ELAM is insufficient to understand how the program works to scale up human security in the global South. I am more interested in understanding how empowerment theory can build spaces of dissent against neoliberal hegemony at the local level. At the global level Cuba’s numerous health-care programs have already worked to gain the admiration of other Southern nations, if not persuade them to modify their public health-care systems.¹⁸ While Cuban medical internationalism is well-recognized, it needs to be more fully explored at the local level in various countries. To understand the connection between empowerment theory and counter-hegemony, it is important to move beyond rigid divisions between structural-Marxist frameworks¹⁹ and post-structural critiques to unpack the institutional ethics of the school and understand its movement towards counter-hegemony. The professional experience of ELAM graduates is best understood through a humanist-

¹⁸ This is particularly relevant in Venezuela, Bolivia and Ghana.

¹⁹ Structural-Marxism regards “nature, human history and thought as ultimately material” (Peet, 1998). As Satre (1976) argues, this approach disallows creativity and agency amongst human-subjects. In geography, structural-Marxism considers the relationship between humans and their lived environment as modes of production that create spatial arrangements on land and life. Many critiques against structural-Marxism have dwelled on its tendency to discredit the role of human agency, and to accept other social factors, such as race, culture and gender, as separate from issues of labour and production. Peet correctly argues that attacks against Structural-Marxism are overblown, as it was a position meant to specify the relation between space and labour. Nonetheless, structural-Marxism has had a large impact on geographical thought, and it is worth mentioning that this study employs a humanist-Marxist approach that entertains the role of human agency, culture and ethics.

Marxist²⁰ lens that seeks out innovative human-centred ways of overcoming health care inequity.

This chapter maps out this dissertation's theoretical framework. It revolves around questions arising from the development studies literature concerning empowerment, participation, and poverty reduction at the community level (Brohman, 1996; Ghai, 1989) I focus on how individual empowerment through capacity building could lead towards the creation of broader spaces of human security, instead of continued neoliberal hegemony. Empowerment is a tricky term, used in a wide range of development studies literature, from right-wing Christian organizations promoting self-help, to the World Bank promoting feel-good "buzzwords" (Cornwall & Brock, 2005: 1046). As I see it, empowerment can occur through interventions that allow individuals and communities to strengthen their skills, resources and capacity to overcome the perils of structural violence at the local level.

While some post-structuralist development scholars would dismiss empowerment theory as just another catch-phrase masking imperialist interventions aimed at ordering societies (Cornwall & Brock, 2005; Escobar, 1995), I believe that some capacity-building projects, notwithstanding these critiques, may have the potential to improve the quality of life for the vulnerable. Following decades of misguided development and inappropriate capacity-building projects in the global South, Peet & Hartwick (1999) are correct in suggesting that it would be a far easier exercise to discredit the whole concept of

²⁰ Humanist-Marxism deals with dialectical materialism, meaning conflict in access to material resources, but sees the cultural production of hegemony as a means of preserving social inequity. This will be further discussed in this chapter. It is important to note that Gramsci did not believe theories of social relations could be based on "materialist foundations alone, nor be worked out from the laws of capitalist development, but required an active practical knowledge of human needs, objectives, and historical consciousness expressed through creative subjectivity" (Peet, 1998: 129). Gramsci thought that modes of production did shape history, but they were not particularly useful in understanding the process of creating social transformations.

development, instead of continuing to seek out its strengths. Rather than simply throw ELAM into a tired, post-structuralist blender of deconstructing texts and power-relations to arrive at a “plurality of interpretations” (Blaikie, 2000: 1038), I am more concerned with searching for its unrealized potentials that aim to improve equality with health care and overcome hegemony.

Post-structural critiques rightly show the faults of modernist interventions. Ultimately, their methods work well to expose the presence of capitalism within the most basic elements of everyday society. It is a fitting epistemology to deconstruct relationships between individuals, communities and capitalism. But, rarely do their methods provide appropriate dialogue for formulating ways of overcoming neoliberal hegemony through engagement with the State or a governing structure. Processes of deconstructing texts in search of power relations often arrive at a point of remaining hopeful of “what might command” local sites of resistance, or to simply impose narratives, or to “resist both altogether and run the risk of being accused of consigning the future to whatever comes along” (Blaikie, 2000: 1039). The arrival point is often with the supportive recognition of local sites of resistance, but Cuban medical internationalism has historically been about more than resisting. It has been about overcoming. Assertions that ELAM and Cuban medical internationalism simply exhibit classical developmental power-relations or that they are merely seeking to make spaces of resistance, miss many important historical particularities about them, and their goals.

Post-structural influence abounds in many aspects of geographical endeavour (Murdoch, 2006). Harvey (1989) rightly points out that post-modernity and post-structuralist methods are a historical condition based on political and economic

production. Space is the privileged realm for post-modernity (Jameson, 1984), and attractive to many geographers seeking to identify power-relations. For Murdoch (2006: 2 – 3) it is about relationships among individuals, and between individuals and communities that govern an individual's accessibility to material and service resources. But as Peet (1998: 217) notes, these relations are often presented as a collection of contemporaneous images that are random and fragmented where the subjects become lost in a "post-modern hyperspace," where they are unable to locate and organize themselves. Presenting conflicting narratives and building spaces of dialogue around such images is an attractive exercise for many geographers. Indeed, the post-structuralist perspective argues for the creation of spaces of dialogue and for grass-roots social organization to resist against the ill effects of neoliberalism.

However, many post-modernist approaches are anti-modern, and as Peet argues, they "confront Marxism with an unnecessary ferocity, explainable largely through the cynicism of middle age, which turns on its own youth with a vengeance born of bitter revolutionary disappointment and a complexity driven by personal regard for individual reputation" (Peet, 1998: 216). Peet sees the arrival at local spaces of resistance as a "negative nihilism," meaning that no purpose, truth, or value exists, and individuals ultimately seek the individualistic "hedonistic...delight" of personal desire before advancing social change (Peet, 1998: 216). The World Social Forum could fit into this category – as it produces critical dialogue, but takes little organized action to overcome inequity (Huish, 2006). ELAM, unlike a movement like the World Social Forum, has a specific agenda and organized actors. Because of this, ELAM should be approached through a social theory that identifies material inequalities between society and nature,

rather than through one that produces multiple subjective accounts of reality and meaning.

Gramsci (1995) would consider that it is not possible to build “good sense”²¹ through dialogue alone, as it will not mobilize societies against hegemony. He claims that a “spiritual need” has to be met. Gramsci believed social revolutions require a broad knowledge of human needs, desires and collective history. He thought that individuals require sufficient access to resources, and that traditional modes of production deny access to these for the vast majority of society. But he also believed that political consciousness could lead to action capable of overcoming social inequities. Humanist-Marxism seeks to understand the creation of counter-hegemony, a cultural knowledge that breaks “existing ideological bonds and penetrates the false world of established appearances” (Peet, 1998: 130). From this point of view, programs like ELAM would have to go beyond just developing skills to actually creating “good sense” against the unjust forces of neoliberal hegemony. For this reason, this dissertation examines the school’s institutional ethics, which not only build valuable clinical skills but also develop good sense of current health-care inequities and the means to overcome them.

ELAM’s institutional ethics, built on the tradition of Cuban medical internationalism, allow its graduates to build the ethical conviction that health care should be brought to all. Gramsci believed that counter-hegemony occurred when enough individuals understood, and personally believed, the need to create social change. This is an extremely qualitative, and hardly measurable, condition – but it is one that can have

²¹ This will be discussed later in this chapter. Broadly understood, good sense refers to knowledge formed through critically engaging governments and power. It is supposedly more appreciative to the needs and capabilities of a society while “common sense” refers to poor knowledge that is imposed from governors or from popular myth.

tremendous impact in building organizational and socio-political capacity to transform health-care landscapes in the global South. ELAM's institutional ethics are not coerced, nor are students forced to serve indigent populations. Critical engagement builds their sense of ethics, and personal compassion takes them to indigent communities. It is, I think, the sort of compassion for humanity that José Martí (1963b) professed, and that Antonio Gramsci (1995) desired.

As this chapter will show, by approaching ELAM through critical modernism, Cuban medical internationalism can be understood as a project of “alternative development” where “development does not continually re-create inequalities of income and power...[but] satisfies locally defined, but universally present, needs” (Peet & Hartwick, 1999: 209) Rather than dismissing Cuba's approach to primary care, medical internationalism, and ELAM as only producing interventions aimed at cultural domination, it is more fitting to see their objectives lying in the humanist-Marxist agenda of overcoming the perils of underdevelopment alongside the inequities of neoliberal health-care provision.

Post-structural Development:

Escobar, using post-structuralist analysis, greatly influenced the path of development studies with his critiques against modernist projects and the fall-out of neoliberal development (Escobar, 1995). A great deal of development-studies literature and Cuban-studies literature follows his approach. His point is worth addressing, as he rightly pointed out the hegemonic qualities of dominant discourses of development theory, and how modernisation aimed to quell the hybridity of culture, ethnicity / race and gender in the global South. Escobar called for a post-development era where all

forms of local and indigenous resistance to modernist development should be embraced, and development projects of any stripe should be rejected. He was not alone, as others such as Esteva and Prakash (1998) argued for similar movements, while Sachs oversaw the creation of a “Development Dictionary,” a tool meant to cripple the entire institutionalization of development studies (Sachs, 1992). Post-development was considered a form of bottom-up cultural resistance, “based on the practice of social movements” to de-link from the governing structures of neoliberalism (Escobar, 1995: 213).

For Nederveen-Pieterse (2000), post-development tends to romanticise cultures rather than empower people. Escobar’s post-development is based on “essentialist” concepts of development combined with a “naïve cultural romanticism,” which Robins (2003) claims emerged from a personal “revolutionary utopianism.” The acceptance, and acknowledgement, of a wide-range of local-level knowledge does not, in itself, move individuals, communities or societies closer to overcoming the structural violence of under-development (Peet & Hartwick, 1999).

The post-development discourse would see Cuba’s humanitarian efforts as dominating, meddlesome and inappropriate. But it is certainly questionable whether communities in receipt of health-care services would share this sentiment. In fact, just recently the Cuban medical brigade that has been based in Guatemala since Hurricane Mitch was awarded Guatemala’s National Human Rights Award for their widespread primary care that has involved more than 22 million consultations and more than 55,000 deliveries (Pérez Roque, 2007). As well, praise has been recognized for Cuba’s other

interventions such as the *¡Si yo puedo!* (Yes I can!) literacy campaign helping some 2.7 million people in 22 countries learn to read.

Post-development's search for multiple identities and meanings within development frameworks can create lengthy detours away from addressing the material inequalities that so obviously impact vulnerable communities. Deconstructing texts may do more to find ways to elicit and embolden identities at the local level rather than finding concrete solutions to counter growing inequities of badly needed services, resources and cultural freedoms. Escobar, himself, admits that attention to how global capitalism produces inequities in material resources, although overlooking the importance of language and meaning, "is commendable in many ways" (Escobar, 2000: 12). With so many preventable health calamities, such as global childhood morbidity from preventable causes occurring at a rate of one child every three seconds (Save the Children, 2007), there is a very urgent need for understanding the impact from programs like ELAM rather than deconstructing its power relations.

As well, post-development's goal of searching for resistance at the local level, by attempting to de-link an individual, culture or society from globalization through the use of language and cultural autonomy does not necessarily cease the spread of neoliberal hegemony. ELAM is not attempting to de-link and avoid neoliberal hegemony; rather it is striving to overcome it and the condition of having too few physicians working for the service of the poor. Ignoring the political project of neoliberalism will not make it disappear. As Harvey (2005) rightly points out, it is not a utopian economic accident, but a carefully designed agenda to ensure inequitable access to resources for the poor and strengthened political power for the elites. Part of its ideological success involves selling

bourgeoisie values as common-sense values for all. Middle class, working class and even the destitute can value the hegemonic system's emphasis on individualism and consumerism, even though it may worsen their condition or put them at risk.

From Building Ethics to Shaping Landscapes: Empowerment to Counter-hegemony:

Neoliberalism promotes the values of a few as being the common sense of all. The commodification of society furthers the interests of the elite while failing to meet the needs of the poor (Harvey, 2006). Accessing resources through the rules of market liberalization is an advantageous practice for the elite, but it can be a matter of life and death for the destitute of the planet. Structural violence occurs when governments, such as Ecuador, actively de-invest in their public sector in order to promote the common sense of the elite as the system for all.

Reinforcing inequity through trade liberalization, privatization and mass consumerism grows into hegemony as it is accepted as the norm rather than as an absurdity. Marxists see this neoliberal creed as hegemony while post-structuralists interpret it as governmentality²² (Barnett, 2005: 11 - 12). For Gramsci (1971: 323 – 324), hegemony succeeds when the production of such common sense goes uncontested, as individuals accept norms and injustices that do little to further empowerment or improve the human condition for the majority (Gramsci, 1971: 323 - 324). To combat hegemony, individuals need to critically engage their surroundings and environment, rather than

²² Many Marxists and post-structuralists consider neoliberalism to be a negative experience of domination. Through the epistemological framework of dialectical materialism, a continuous state of struggle for resources and modes of production, Marxists tend to focus on the political economy of neoliberal policies. Post-structuralist critiques often engage issues of governmentality (self regulation) through spaces of consumption and observation. The governmentality approach, while opening the dialogue to a wider socio-cultural forum, tends to avoid building models to overcome dialectical materialism of the neoliberal condition.

accept uncritically what is told to them by political leaders or simply join the apathy in society towards injustice.

As Birchfield points out, Gramsci realized that hegemony was a necessary part of collective political activities (Birchfield, 1999). Gramsci argues for an alternative “ethical hegemony” through the development of “good sense,” to eventually become the “common sense,” which he defined as “a conception of the world with an ethic that conforms to its [realities]” (Gramsci, 1971: 346). Birchfield (1999: 45) sees this as “Gramsci’s reformulation of Marx’s idea that philosophy should no longer [be about interpreting] the world but [it should be about changing it].” For counter-hegemony to take place within a society, it would have to be tied to the daily routines and beliefs held by individuals.

To combat the hegemony of neoliberal health care, a good sense of human needs and social injustice is needed to appreciate the nature of lived-in poverty that affects people’s health via the less-visible structural violence of globalization (Farmer, 2005). Good sense would also have to overcome the common acceptance of remedial comforts that globalization affords, from improved satellite TV to meager increases in earnings – with the knowledge that such luxuries involve social and environmental degradation in some of the world’s most vulnerable places. When individuals are given the capacity to engage, to obtain knowledge and to challenge the norm, a good sense of realizing that remedial comforts are associated with gross social injustice can emerge and lead to the development of good ethics at a broader level.

Building good sense requires some form of intervention to overcome the common sense that keeps hegemony’s brutal inequality of services and resources intact.

Interventions such as ELAM come from apertures of dissent against neoliberalism. Rather than conforming to U.S. interests, Cuba independently expresses its national sovereignty through multilateral organizations that build human security through public policy. Eschewing the neoliberal framework, Cuba does not employ the typical development power tools of domination aimed at furthering global hegemony. Rather than dismiss its intentions or quickly label it as just another intervention, it is worthwhile to explore the actual contents of the program to see how it builds good sense, and how this eventually takes shape in marginalized communities.

ELAM's "good sense" is found in its institutional ethics of compassion for the indigent, and awareness of the state of global health-care inequality. Already many students have experienced and lived in the hardships of these conditions. But, establishing good ethics does not guarantee counter-hegemony, as Gramsci argued. It is always possible for hegemony's common sense to trump the will and organization of individuals. In order for good sense to evolve into counter-hegemony, political and social support alongside collective organization is needed so that individual ethics can develop into a counter-hegemonic landscape.

Building counter-hegemonic health-care landscapes begins by seeking out where ELAM graduates are able to apply proximal interventions in health-care provision. In Ecuador, a country where 30% of the population is without readily accessible health care, many people endure risky pathologies from dangerous living conditions and rely on costly distal interventions administered via free-market frameworks. This limited access is more complex than just spatial boundaries; it has far more to do with the socio-economic barriers that prevent the poor from receiving services. While some academics

and World Bank officials argue that privatization of services have worked to improve accessibility of health-care services, the demanded payment for service has not worked to improve access to vulnerable populations (Waitzkin *et al.*, 2007). If ELAM graduates can help improve accessibility by offering affordable services, and act as health advocates, it would represent an instance of empowerment by scaling up individual good sense from the institution into the construction of broader landscapes of counter-hegemony. The current levels of inequity are more the result of actively preserving the neoliberal hegemony of providing services to vulnerable populations in receipt for payment rather than an absolute lack of material resources.

Critical Health Geography:

Critical health geographers, for some time now, have found value in the sort of proximal interventions that ELAM graduates seek to deliver. The literature is rich with an understanding that good health is largely produced from overarching societal relations rather than purely from clinical craft. As such, it should not come as a surprise that the Cuban approach seeks to build health at the societal level at home, and the community level abroad. But critiques against this “cultural turn” in geographies of health and health care argue that such theories tying health to social relations are not accepted by mainstream decision makers because they lack empirical content and the needed rigidity for policy makers and pure science to accept them (Meade *et al.*, 1988). Indeed, a tension runs between normative health frameworks and critical geographies of health care that question the biomedical model’s relevance (Jones & Moon, 1987). National health-care policies are reluctant to explore more critical and holistic identities of health promotion

and health care. However, Cuba has for the past three decades practiced holism and disease prevention, and focused its medical education on such principles.

Aside from furthering knowledge about disease prevention and health promotion, health geographers such as Kearns and Moon (2002: 609) argue that “visions for new geographies of health are centrally about the emerging importance of place in the study of health. Place has been seen as an operational ‘living’ construct which ‘matters’ as opposed to being a passive ‘container’ in which things are simply recorded.” They argue for more critical studies that incorporate a “sense of place,” allowing explanation of more diverse, subjective and objective phenomena. Kearns and Moon speak from a post-modern perspective, advocating the expansion of geographies of health and health care using a wide range of texts, and they do not specifically address how constructing such texts can have a real place in reducing inequalities or even informing policy.

However, many studies from within the geography of health and health care have embraced social determinants of health by especially drawing connections to the important roles of space and place. Kearns & Joseph (1997) examine the role of place in health-care restructuring in New Zealand. Hayes (1999) explores how the approach to good health changed from identifying risk factors to studying life-course perspectives. Crampton, Dowell & Woodward (2001) explore how non-government and non-profit care for vulnerable communities impact health. Dunn & Hayes (2000) focus on social inequality as measured through housing characteristics of two census tracts in Vancouver. Rosenberg & Wilson (2000) show how gender and poverty impact health. Indeed, a great deal of research has called for greater attention to be paid to social determinants of health. While not a health geographer, Coburn’s (2004) argument that a need exists to go beyond

income inequality to incorporate questions of class, the rise of neoliberalism, and the variable socio-political composition of societies can be considered important for health geographers who wish to explore these questions through a spatial paradigm. Wilkinson's (1996) work on inequality in society, is also of interest to health geographers as he demonstrates that societies with little inequality experience better public health than those with rigid hierarchies and greater socio-economic differentiation.

Much of this literature has focused on the conditions of inequity, or the effect of social determinants of health, but not all have analyzed the means by which programs may overcome such conditions. The geography of health and health care experienced a type of identity crisis in the mid-1990s with its "cultural turn," and a rich literature emerged as a result. Today this richer understanding of the relationships between space, place and the social determinants of health needs to be further developed by exploring how to overcome hegemonic forces that exacerbate negative health determinants and act to further inequities.

Taking Gramsci to the Field:

ELAM graduates may be on a road towards counter-hegemony, but it will only be realized through their practical application of proximal interventions in the field. Already Cuba's application of soft power is having an influence around the world, but only by understanding the lived experiences of ELAM graduates will we come to understand how overcoming hegemony takes place at the local level. As Peet argues, revisiting Gramsci may do a great deal to advance the theory and practice of development as it is directly rooted in social, rather than discursive relations (Peet & Hartwick, 1999). For this reason, Gramsci's theory is kept close at hand to understand how counter-hegemony can

start with structural changes at the ground level, rather than work its way down from the global level.

This chapter identified alternative development, rather than post-development, as an appropriate theoretical framework that conceives such interventions like ELAM as having the potential to create change at the community level. The next chapter discusses the methodology used to see if ELAM's counter-hegemonic goal of changing health-care landscapes to be more affordable and accessible creates spaces of dissent in the field.

(Fig. 3)
Map of Ecuador
With Select Field
Sites.

White Circle is
Sachas,

Yellow
Circle is Loja /
Zamora,

Black
Circle is Bolivar,

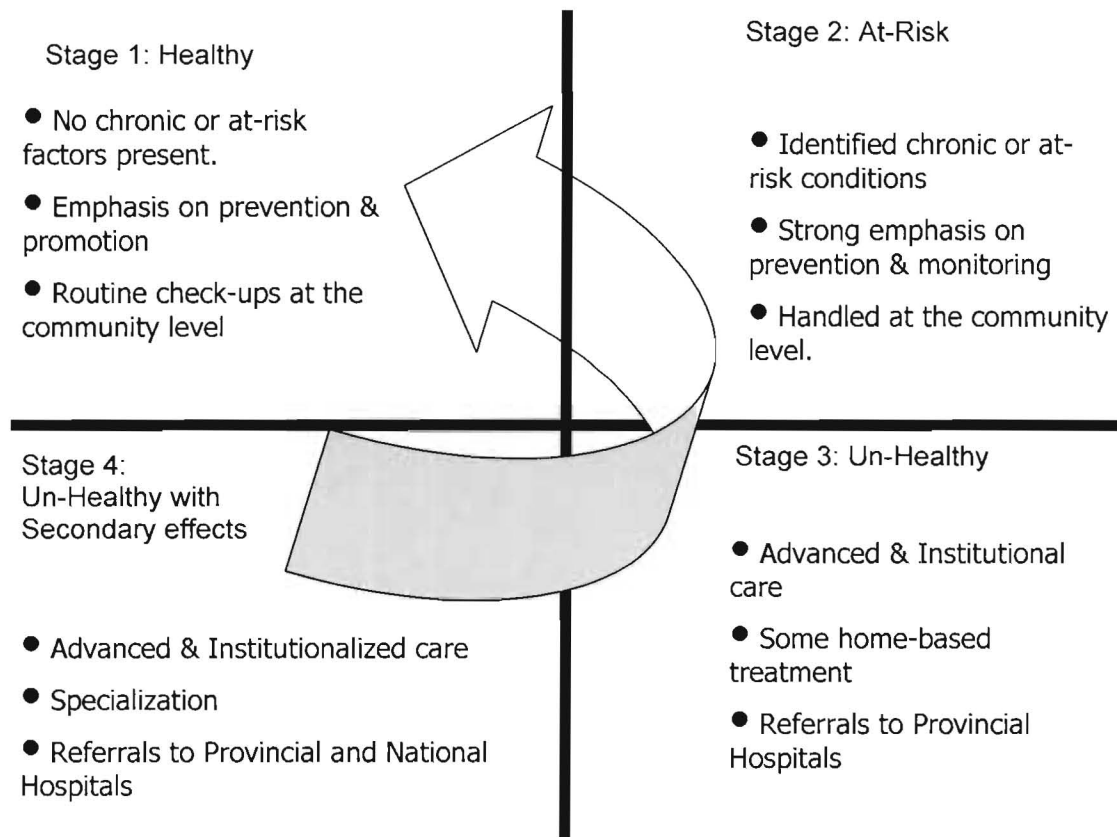
Blue circle is
Imbabura



(Fig. 4)
Close up of Sachas

Source: Google Earth.





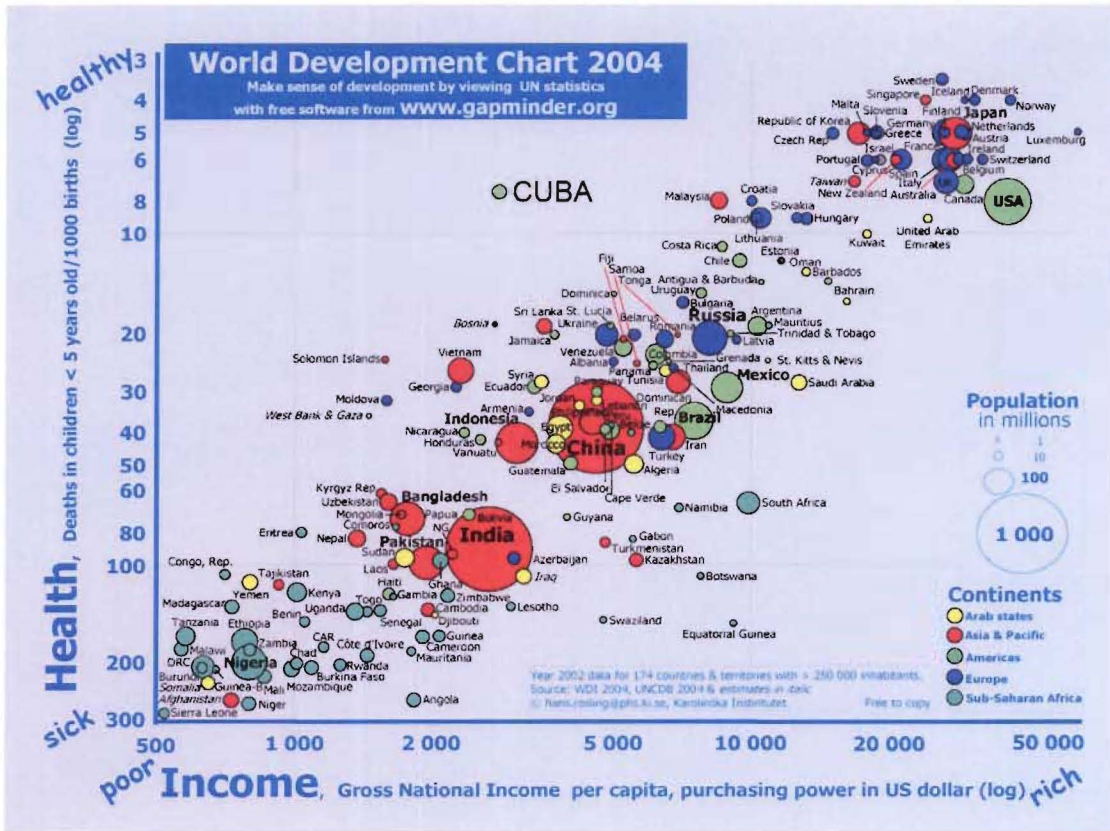
(Fig. 5): Model of the four-stage approach to the Cuban health-care system. Rendered from notes taken with MINSAP officials in Piñar del Rio.

(Fig. 6) – 2006 Student Breakdown by Country for Students housed at ELAM (pre-med, Year 1 and Year 2).

País	Pre-médico			1er. Año			2do. Año			Total
	Masculino	Femenino	Total	Masculino	Femenino	Total	Masculino	Femenino	Total	
ARGENTINA			56			94			56	306
BALOS			20			23			13	56
BOLIVIA						63			120	207
BRAZIL			92			94			85	271
CHINA			-			-			1	1
CHILE						91			49	140
COLOMBIA			44			79			96	219
COSTA RICA			39			46			43	128
ECUADOR			97			91			98	286
EL SALVADOR			60			72			59	191
ESTADOS UNIDOS DE AMÉRICA			8			20			18	46
GUATEMALA			60			78			71	209
HONGRIA			-			-			-	-
INDIA			-			-			-	-
JAMAICA			-			-			-	-
JAPON			71			79			68	218
MÉXICO			72			78			56	206
NICARAGUA			100			55			43	198
PERU			-			-			-	-
PARAGUAY			100			109			54	253
PARAGUAY			60			107			88	255
PERU			57			65			102	234
REPÚBLICA DOMINICANA			40			65			83	188
TRINIDAD Y TOBAGO			40			98			66	204
VENEZUELA						74			125	199

(Fig. 7) – 2006 Distribution of Students to other Cuban medical schools (Years 3 – 6).

Polisclínica	3ro.	4to.	5to.	6to.	MUJERES	HOMBRES	TOTAL
Pinar del Río	75	61	86	94			316
C. Habana	385	856	569	252			2062
Matanzas	38	39	31	82			190
Ylla Clara	194	107	167	296			764
Cienfuegos	68	44	45	85			242
Sancti Spiritus	44	30	14	67			155
Ciego de Avila	48	40	45	1			134
Camagüey	132	98	181	270			681
Las Tunas	48	43	31	36			158
Holguín	40	68	25	3			136
Granma	69	57	79	1			206
Santiago de Cuba	88	45	43	50			226
Guantánamo	26	17					43



(Fig. 8) – Under 5 infant mortality vs. GNP. Note Cuba’s place with a GNP between Iraq and Bolivia, but health under 5 mortality on par with Canada, the U.K. and above the US. Source: www.gapminder.org

Chapter 3
An Innovative Methodology for an Innovative Program:
Using Descriptive Analysis.

~“*Research is what I am doing when I don’t know what I am doing.*”~
Werner Von Braun.

This chapter sets out to explain the research methods for this study. I engage mixed-data through descriptive analysis to discover how ELAM’s institutional ethics promote change and encourage dissent. An academic and popular silence exists over ELAM’s capacity to improve social conditions and to create resistance and affect change for the future. In order to break this silence, I am less concerned about recreating exact carbon copies of conversations with participants from the field, as much as rendering interview notes and experiences that offer informed, descriptive insight into the professional experience of graduates. This approach affords insight into ELAM’s process of developing good sense. A mixed-data approach is appropriate as institutional ethics and feelings of compassion are intangible sentiments, not easily defined or structured into any one method.

When Farmer (1999) asked indigenous communities in highland Ecuador what they would like to see come of his research, he noted that not one person answered “more research.” Considering Farmer’s experience, this dissertation aims at a richer understanding of the ELAM experience beyond calling it “a work in progress” (Giraldo, 2007a). This is about contributing to academic and policy dialogues aimed generally at building capacity and delivering human security in the global South.

Instead of limiting the research approach, the idea of this study was to include as much material as possible, such as first-person interviews, medical literature, third-party documents, and popular media. This multi-data approach aims to build awareness of how

the “subjective and collective experiences” of ELAM graduates, and their communities, play out against larger social structures (Charmez, 2005: 508). It is an approach well fit to descriptively analyze the ELAM story and to theorize about the role of capacity building in global health care.

The Inductive versus Deductive Debate:

Inductive research works from the bottom-up, meaning that specific events are observed, patterned, hypothesized and then theorized. This is an open-ended and exploratory approach, and it has two major epistemological challenges. First, the idea that observation and subjective research methods can elaborate into new theories about how structures and societies operate is troubling. It is as if to say that theory waits to be found, that it has been there all along, and it is only the researcher who has the map and compass to find it (Greckhammer & Koro-Ljungberg, 2005). The second challenge is labelling a methodology as purely inductive. No research project can be free of some theoretical framework that works to shape questions and the research process (Turnbull, 2002: 320). It is quite naïve to think that researchers can, in some way, remove themselves from the contextual reality that they and their participants live in. Indeed, a more appropriate approach is to admit to such limitations, and acknowledge that research questions are built through a balance of deductive and inductive methods.

Descriptive Analysis:

The descriptive analysis in this study allow for a better picture of medical training in Cuba, and health-care accessibility in Ecuador. Farmer (2005: 28) sees such methods in medical anthropology as useful to explain the presence of pain, affliction and evil. Scheper-Hughes (2000) sees them as a type of cultural inquiry especially useful during

times of crisis. Such inquiry, she says, may be done to “vindicate an indifferent God, to quell one’s self-doubt, or to restore faith in an orderly and righteous world” (Scheper-Hughes, 2000). But, it can also have a place in describing processes that allow for remedy, improvement and good sense. Descriptive analysis builds understanding of how individuals and societies fare against inequitable structures. For Farmer, descriptive analysis has, in the past, created cultural texts that link excessive suffering to cultural norms. He notes that this has led to the tolerance of violence as part of cultural tradition, and also to accepting injustices from structural violence (Farmer, 2005: 48). He claims that while this may be innocuous for academics, it can lead to dangerous policy. For example we have seen this overtly occur such as in cases of non-intervention in times of genocide. But it can also take place more subtly when policy shies away from bolstering human security because it deems structural violence to be a normative reality that cannot be altered. Descriptive analysis is not so much about discovering some hidden reality; as Norris (1987: 17) says, it is not about what “a text means to say,” but what it is “constrained to say,” meaning that analysis has more to do with identifying processes and relationships that have not been immediately realized.

As Kincheloe & McLaren (1998) suggest, critical research should aim to undermine systems that appear natural, ordered, and tend to reinforce power relations between advantaged and disadvantaged. This undermining is part of the alternative development framework that aims to counter neoliberalism by bolstering human capabilities, especially among those currently excluded from development. Critical research should do more than point out the flaws of a system. Even creating spaces of dialogue with the intention of filling hearts with hope is not always sufficient to promote

change. Building good sense and embracing ethical compassion for change deserves to be better understood in forward-looking development strategies, and to do this, it is important to employ methods that build these sentiments into informed theory.

This approach to descriptive analysis can be quite useful for qualitative researchers who wish to inductively build understanding of processes for societal change. Its ability to move lived events into conceptual frameworks is useful in exploring, for example, how resistance to hegemony takes shape. Even though the sample size, the number of ELAM graduates I engaged with, was quite limited, their stories offer a unique chance to understand the challenges they face in the field. I based my questions for students and graduates on themes from health-care accessibility literatures in order to identify key attributes of COPC in the ELAM experience. The voices of students and analysis of ELAM's curriculum gives a rich sense of the school's institutional ethics.

Research Design:

The Ecuadorian ELAM graduates were the primary subjects for this study. With 1,610 students from 20 countries having graduated in 2005 and another 1,412 from 24 countries having graduated in 2006, the few first-person interviews conducted with Ecuadorian ELAM graduates can only be taken as a very small representation of this large and truly global phenomenon. Only a small amount of Ecuadorian ELAM graduates returned to their communities in 2005, and pursuing more graduates would involve crossing borders. To do so would involve dealing with the complexities of different places, multiple public-health sectors, and diverse cultures. Wanting to avoid this, I chose to compliment the voices of the ELAM graduates with other voices, actors and key informants to develop a broader basis for understanding.

Logistically, this study demanded a regional focus. Too many graduates, too much distance, and too little time all insisted that the study would create a rich regional text rather than a broad global survey. Finding, let alone getting to all of the ELAM doctors would require tremendous coordination, and it would be far beyond the scope of this dissertation to handle. Moreover, a regional focus on the ELAM experience is important. Latin American and African public health-care networks, while heavily influenced by neoliberal reforms, are a complex collage of service provision, accessibility, and participation. It would be naïve to lump Ecuador, Peru, Brazil, Chile and Zimbabwe into one basket. As Peet (1998) suggests, while global issues are quite present, good geographical inquiry should be content with understanding the nature of such processes at the regional level rather than making broad, but perhaps simplistic, global assumptions. Ecuador demonstrates specific conditionalities within the country, but it also has fallen to neoliberal processes that have influenced many other nations as well. As in so many other Southern countries, Ecuador followed a prescribed package of neoliberal reforms, and it should be considered an important case study to get a sense of how capacity building fares or fumbles in a neoliberal space.

With this regional focus in mind, the research sets out to do the following: First, to understand the methods of student selection, curriculum design, pedagogy, and student life at ELAM. Second, to know the personal histories of the students, and to know who they were before coming to Cuba. This sheds light on the selection process, and who actually comes to ELAM. The final goal is to understand and observe the reintegration process of ELAM graduates into Ecuador. This is perhaps the most important phase of the research program, as it aims to assess the deemed successes and challenges of the

program. Part of this process involved knowing the graduates' goals for the future – if they would stay in Ecuador or perhaps chart a new course away from there or outside of health care entirely.

The Evolution of the Research Agenda:

A great deal of networking and blind luck went into making this research possible. Throughout this study, I have been an active participant in conferences relating to global health and to Cuban foreign policy. From these meetings I was able to develop networks that assisted in locating research participants in both Cuba and Ecuador. Initially I employed a top-down approach to networking and a snowball sampling of actors. Through conferences in Cuba (October, 2003 and November, 2004) and working directly with the Cuban embassy in Ottawa and the Canadian Embassy in Havana, I hoped to receive some form of official permission to conduct the study and to receive assistance in meeting up with ELAM students. In 2007, I discovered that obtaining a research visa as a Ph.D. student is extremely difficult, and it is not surprising that for a long time I did not receive one, despite my long-standing relations on the island (since April, 2001).

Meanwhile, I traveled to Cuba in February, 2005, with Senator Jacques Hebert on an organized delegation. On this trip I met up with many diplomats and State officials who I hoped would be able to offer some assistance in obtaining a visa. While I made many important relationships on this trip, no official visa came from it. In April, 2005, I journeyed to Washington D.C. to participate in the Cuban Action Day, a day of organized lobbying on Capitol Hill. This was another event that fostered rich relationships, but very little came in the way of finding solid pathways to obtain a research visa.

Things did change in April, 2005 when Marina Jiménez from *The Globe and Mail* contacted me for an interview about ELAM (Jiménez, 2005). At this point I had only visited the school once, and I had yet to make any first-person contacts in Cuba. However, I was familiar with Cuban medical internationalism and the history of the program. After our interview, and the publication of the story, Ms. Jimenez put me in touch with Cedric Edwards.

I met with Cedric in front of Copellia Ice Cream in Vedado in May, 2005. Cedric and I met to discuss the school, the program, and my interests in ELAM and its students. He graciously agreed to introduce me to his colleagues. While I said that I wanted to meet specifically with Ecuadorian students, we, in the end, wound up meeting with students from Ecuador, Costa Rica, Venezuela and the United States. With him, I ventured to the medical school at Salvador Allende Hospital in July, 2005 to meet with ELAM students who were in the final weeks of their final year of study.

After meeting a dozen students in Cuba, I traveled to Ecuador to attend the People's Health Assembly to continue networking. While I did establish contacts at the universities in Ecuador, and with Cuban solidarity organizations, I only had the e-mail address of one ELAM graduate. I had Dania Saurez's e-mail. She forwarded me her cell phone number in Ecuador, and when I arrived in 2006, through text messaging, I managed to find her at the public health clinic in la Joya de los Sachas. Dania provided me with most of the names and numbers of her colleagues. Every graduate whom I spoke with was eager to have an interview. It was an ideal time to meet with graduates who had already been working in the field for a year, and who were, in late 2006, trying

to decide what the future would hold for them. By November, 2006, all but two were unemployed, and decisions concerning their futures weighed heavy on their minds.

Leaving Ecuador in December, 2006, I returned to Cuba for one last visit. Dr. Alfredo Espinosa, a senior physician from Cienfuegos allowed me to visit his hospital. With him, I met with several Ecuadorian students in their third year of studies.

I was eventually contacted by the U.S. group MEDICC to participate in a research delegation in March, 2007. Finally, after four years of networking, I was granted an academic visa through this organization, which is based a country that does not even have normal working relations with Cuba.

Throughout all of my encounters, interviews remained semi-structured. For students, I focused on the experience of the training, and life at the school itself. For graduates, I mainly discussed the working conditions in Ecuador, their hopes for the future, and their reflections on having gone through the Cuban program. For diplomats, stakeholders and persons working closely to the policy and practice of ELAM, I focused heavily on what they felt the purpose of the school was and how they saw it evolving in the future.

Interviews were conducted from park benches to smoky bars, from the bedside in the clinic to the classroom itself. The interviews were open ended and I considered my participants to be keynote experts, as much as I considered our discussions and experiences a form of data as well. In most cases, interviews were recorded, but in some cases, and mostly thanks to technical difficulties, interviews were not recorded by electronic microphone, but only by hand-written notes.

Issues of Research Activities and Official permission

Returning to the issue of knowledge translation, I was quite concerned that because I was conducting this research “off the record,” it might be difficult to foster relations with Cuban decision makers and stake-holders of the ELAM program. Certainly the leadership at MINSAP, when it comes to international training, is very well organized, and they may not perceive a need for a third-party study to inform future policy. However, at a Cuban Studies conference in Kingston, Ontario in June, 2006, I was delighted to receive a warm and sympathetic response to my study by the Cuban diplomatic staff and Cuban physicians attending the meeting. Many of the issues I explored in the study, especially regarding reintegration of students into their home countries, have yet to be fully discussed in Cuba, and my sense is that this study can positively inform their dialogue. In March, 2007, I spoke with ELAM’s rector, Juan Carrizo Estevez. I mentioned my research project to him, and he agreed that a strong need exists for broad and comprehensive studies that follow up with ELAM graduates in the field.

Ethics and Confidentiality

At no time did my research compromise ethical boundaries or safety for my research participants. Originally, I wanted to focus on another neoliberal State, Guatemala, as I have had experience working in that country. However, upon hearing rumour that right-wing militant groups were threatening ELAM graduates, I immediately backed away from that field site, as the last thing that the young doctors needed would be a foreign researcher drawing added attention to them.

At all times I ensured and guaranteed confidentiality to my research participants. I gave each research participant a written statement of my purpose and interests, and explained how I would ensure ethical codes of conduct throughout the interview and afterwards with the data collected. For those wishing to remain anonymous, I have not used their last names. In fact, this was only one person.

Shortcomings of the Study:

Perhaps the greatest shortcoming of this study is that not even 1% of the total students from the first graduating class were contacted for this study, which makes the sample a minor representation of a larger and complex phenomenon. In no way can this study speak for the experience of all ELAM graduates, as the volume of graduates and the tremendously diverse lands where they will work create a complex and messy collage of stories and experiences. The study is limited to the experiences of ELAM graduates from the year 2005 who returned to work in Ecuador. At no time does this study try to speak for the stories and experiences of other graduates, unless specifically stated.

The other consideration is that I am not a clinical physician, nor am I a native Spanish speaker. I have received some criticism around why I see myself qualified to conduct this study, as opposed to a clinical physician who would have a far better understanding of what constitutes good primary care. To that I respond that critical thinking and qualitative research skills are not born in the clinic, and the approach that I use may have greater strength as an outside and unbiased observer as opposed to a physician who may be inevitably comparing, rather than just purely observing, conditions in Ecuador to that with which they are familiar. Moreover, while I am able to work in Spanish, I am sure that a native-born speaker would have been able to elicit far more

personal and animated accounts from the research participants. I considered employing an assistant to translate interviews, but I also wanted to develop my own research skill-set in the field rather than lean on someone else.

As well, the voices that are found in this study are represented as best I can. They are not all exact word-for-word translations, as at times some minor accents and expressions have been added to animate the text in order to elicit the emotions and sentiment. This is done with care, to animate rather than distort the analysis.

Through these methods, this dissertation elicits an understanding of how ELAM operates, the institutional ethics that govern its operation, and how the good sense from professional development plays out in their home communities. These methods also describe the challenges and capabilities afforded to students upon their return home. They describe lived events and inductively theorize how capacity-building projects like ELAM fare in meeting COPC goals and building counter-hegemony in marginalized places. It is a critical insight into a narrow population of ELAM graduates, but through these methods, it may have a place in informing broader dialogues of how ELAM graduates handle themselves with hegemonic neoliberal health-care systems.

Chapter 4
“If you could save a life, why wouldn’t you?”
Normalizing Cuban Medical Internationalism

*~”Of all the forms of inequality, injustice in health care
is the most shocking and inhumane.” ~*

Dr. Martin Luther King Jr.

Perhaps it is a strange idea that foreign policy could actually make a difference in the lives of individuals, and especially the poor and forgotten. Even though Nobel Laureate Lester Pearson believed in it, and Lloyd Axworthy advocated for it, human-security provision rarely advances through foreign policy. But according to Fidler, there is an overwhelming, if not unavoidable, necessity to bring health into foreign policy, and by acknowledging Cuba’s examples, it may be possible to further dialogue on how to achieve such human security (Fidler, 2006).

This chapter shows that Cuban medical internationalism, which developed ELAM, is a process of counter-hegemony against global health inequity and under-development. It is important to discuss this history in order to conceptualize the role of human security in medical internationalism, and to develop a better sense of the epistemology that led to ELAM. Certainly it can be labelled “exceptional,” and “altruistic;” however, such praise does not fully explain the events and decisions that put medical outreach into a process of soft power.

Since 1960, Cuba has placed health-care provision into its foreign policy. It is a history of rational choices being made in order to help improve the human condition of marginalized individuals. Still, venues like *The Economist* are quick to overlook the health-care impacts and only judge ELAM as a political campaign, “one of several ways in which communist Cuba is using its medical prowess to win friends abroad” (The

Economist, 2007b). This is a narrow lens that detracts from seeing human-security provision as a rational policy option that serves the interests of the vulnerable and of Cuba. Free of neoliberal hegemony Cuba has routinely invested its resources in human capital for health, rather than de-investing in it (Spiegel & Yassi, 2004). ELAM is just one step in a long process of decision making that invests in people in order to increase popular health-care provision.

This chapter discusses Cuba's current foreign policy and the origins of "medical diplomacy." It discusses the development of Cuba's domestic health-care capacity, and how it found a strategic place in international arenas. Specific programs and campaigns will be discussed to show how Cuba aims to bring primary health-care provision to marginalized communities around the world. The emphasis on primary care played a major role in creating ELAM, as its graduates would be expected to bring such care to their communities. From this discussion it will be clear that Cuban medical internationalism is a rational foreign policy strategy, which, like any nation's foreign policy, aims to serve its own interests by bringing its domestic strengths to the world stage.

The Inspiration:

It has remained a riddle for many scholars as to why Cuba sends its doctors abroad. Some have developed appreciative reasons for the country's international altruism ranging from an expression of President Fidel Castro's leadership (Macintyre & Hadad, 2002), to an act of pan-American solidarity (Huish & Kirk, 2007), to building "symbolic capital" (Feinsilver, 1993), to seeing it as a paradox outside of globalism (Spiegel & Yassi, 2004). Certainly all of these factors play a role in understanding

medical internationalism. However, some critics label Cuba's medical diplomacy as "doing it for political clout" (Falcoff, 2003) or to earn hard currency (Montaner & Ramonet, 2007), and are unwilling to conceive medical internationalism from the standpoint of counter-hegemony.

Most of this group see Cuba's foreign policy as a unique anomaly, rather than a normative process. This stance follows the branch of Cuban Studies that regards the country as in a state of transition, meaning that its current initiatives are only temporary and eventually the global economy will set it straight (Font & Larson, 2006). If Cuba can be approached as a normal Nation-State, rather than as a special post-Soviet State, it is possible to appreciate how national independence, political leadership, and social capital all afford choices. Many scholars gaze at Cuba through the lens of Fidel Castro and communism. This is a naïve paradigm as it typically overlooks important discourses revolving around, for example, José Martí and nationalism, and their role in the social and political cultures of the country (Huish, 2003).

Cuban internationalism is part of a broader orientation that promotes a vision of pan-American solidarity often symbolized through the myth, legend, and iconography of José Martí. The nineteenth-century philosopher has commanded an important place in Cuban national narratives since the early part of the twentieth century. He dedicated his life to the creation of an independent Cuba, and to developing unity south of the *Rio Grande*, in what he titled, "*nuestra América*" (Martí, 1961c, 1999). The revolutionary government grounds many initiatives on interpretations of Martí's thought. He is an important moral inspiration behind the good sense of past projects such as the campaign to eradicate illiteracy (Keeble, 2000), and now he plays a role as the philosophical

guardian of ELAM. Martí iconography abounds in Cuba, and his identity commands a major place in Cuba's landscape (Mayor Lorán, 2007). While there is a statue of him in every school, library and hospital, it is important to go beyond the visualisation to identify connections of Martí's ideas to Cuba's foreign policy. Martí's concept of solidarity, humanism, and the individual's place in nature are all at the heart of Cuban solidarity movements.

Many interventions are, in some way, rooted into Martí's thought, or as Cubans call "*Martiano*." Two major themes are apparent in *Martiano*. First is the emphasis on individual well-being, and the respect for meeting the individual's needs in "Nature" (Martí, 1961a).²³ Second is the call for Latin American solidarity against imperialism (Martí, 1963b). In order to truly build solidarity, as it was understood in the early days of the revolution, the most marginalized communities require control of nature, rather than being controlled by it. This is a later, and more radical departure from Martí's earlier writing on society, where he adhered to liberalism and argued for the mixing of races in Latin America through liberal reforms (Huish & Lovell, 2008). Indeed, his later philosophy of Nature is far more holistic and metaphysical than his earlier praise of economic reforms generating a new America (Martí, 1961b, 1961d, 1963a). As he saw it, individuals without basic needs, including health and education, remain displaced by Nature, and they do not enjoy a meaningful role within society. Solidarity, as resistance to imperialism, would only occur if, and when, all members of a society would have a sense of control over their needs through health, education, and access to resources.

²³ Martí's work on "Nature" is tremendously important to understanding his later, and more radical, understandings of society. The use of the word "Nature" is not taken to mean natural flora and fauna, but as a broader understanding of the connections between humans and their lived worlds.

Much literature, some academic but most not, attributes most of Cuba's policies solely to President Fidel Castro's will, and it is sometimes argued that without him and his personal charisma, the Cuban paradox would collapse. No doubt the President's image and character account for a great deal of nationalist sentiment, but now with Fidel Castro ailing, Cuba has demonstrated that no one man is an island. As Montaner & Ramonet (2007) argue, "Castro has not been on the job since July [2006]...and yet nothing has happened. The regime has not collapsed...the system is showing that it can operate normally under these conditions, and the legal institutions are withstanding the shock of Fidel's withdrawal" (Montaner & Ramonet, 2007: 58). Still, some critics refuse to move past Castro idolatry. Close to twenty years after the economic collapse of the Soviet Union, Cuba's former preferred trading partner, much scholarship remains focused on the inevitable transition into a post-Soviet bloc economic framework (Font & Larson, 2006; Pérez López, 2006; Ritter, 2006; Roy, 2006). As Montaner & Ramonet point out, many of these critics miss the point that Cuban policies and reforms are nationalist inspirations that have not been the result of "foreign ideas driven by foreign troops in Soviet-armoured vehicles" (Montaner & Ramonet, 2007: 58).

Indeed, Cuba's independence from foreign control and its focus on improving access to resources for the poor rather than the elite, often take place through complex policy processes and inter-sectoral collaboration. In foreign affairs as well, Cuban policy is neither unilateral nor whimsical. Rather, the country grounds itself in multilateral policies. It is an active participant in the United Nations, championing numerous multilateral initiatives, including participating as a founding member of the recently established "International Covenant on Economic, Social and Cultural Rights" and to the

“International Covenant on Civil and Political Rights” (Pérez Roque, 2007). It is the current leader of the non-aligned movement, and is seeking entry into MERCOSUR²⁴.

Cuba’s participation with the Caribbean Economic Community (CARICOM)²⁵ is particularly noteworthy. While some sources have labelled Cuba’s contribution of sending 19,000 health professionals to Venezuela as an exchange for oil and foreign currency, the process is far more complex than simply trading doctors for oil (Maingot, 2006; Sylvia & Danopoulos, 2003). In fact, Cuba extends the offer to send doctors to any CARICOM nation if asked. Often the only requirement is for the host country to cover the costs of airfare, housing, board and salaries of the Cuban doctors, costs that at most would amount to less than \$5,000 USD per year per physician (Macintyre & Hadad, 2002)²⁶. Cuban physicians abroad receive their regular salary in *pesos nacionales* in addition to \$100 CUC (*pesos convertibles*)²⁷ per month. This bonus salary is sometimes held until the end of the contract, or is given to the physician’s family in Cuba. This is a sizeable bonus in foreign currency, and it has created tension with the physicians who have chosen to remain in country to practice. Venezuela offers petroleum with reduced tariffs to any CARICOM country, to reduce outlays of national revenue towards energy imports. Indeed, these are two separate policies grounded in international forums that have done well to warm relations between the countries. At the 2005 summit in

²⁴ The free-trade agreement between Brazil, Argentina, Paraguay and Uruguay.

²⁵ The Caribbean Community evolved from the Caribbean Community and Common Market, which came into effect in 1973. Cuba is not signed on as an official member, but has maintained cooperation and economic relations with the group since 1973.

²⁶ \$5,000 USD is a rough estimate. Considering return airfare to cost about \$800 (maximum) for a flight in the Caribbean from Havana; rural area lodging at \$150 per month; and the contract salary for a Cuban doctor working overseas at \$150 USD per month, this is a very rough estimate. Of course, depending on the specific field site, costs can be estimated accordingly.

²⁷ Cuba has two currencies. The *peso nacional* (CUN) and the *peso convertible* (CUC). The CUN is valued at 26 to one CUC. The CUC is used for foreign exchange and can be traded for other currencies. Since 2003, when the CUC replaced the US dollar as the foreign-exchangeable currency, the CUC has increased in value from being equal to the US dollar to being nearly equal to the Euro. Respectively, this has increased the value of the CUN, and has increased the purchasing power of both currencies.

Sandrino, Venezuela the two countries created the “*Alternativa Bolivariana para las Américas* (ALBA)²⁸ multilateral trade and cooperation alliance, of which the goal is to collectively train 100,000 physicians over a ten-year period.

Haiti also benefits significantly from these pan-regional policies as it currently receives over 500 Cuban doctors and, while still receiving exports from the U.S. due to IMF-enforced policy, is able to save money by purchasing oil from Caracas. In a country with only one physician for every 4,000 inhabitants, and more than 7% of its GDP consumed by foreign imports, of which 0.5% is oil imports, these policies offer some financial relief and social benefit.

Cuba works within international law and trade pacts for its own interests, but it also assists other nations in coping with underdevelopment. The supposed economic and political benefits for Cuba are far less spectacular than some believe (Hansing, 2006; Maingot, 2006; Roy, 2006). According to MINREX officials, the economic gains from medical diplomacy with LMIC nations are negligible, as poor countries that receive Cuban doctors pay only for their expenses, and they do not pay Havana fees for services rendered. Other medical interventions in Europe, China, and the Gulf States are responsible for bringing in substantial revenue. Outreach to Africa and Latin America should not be considered a major money-maker for Cuba. Likewise, the political payola that Cuba may garner in forums such as the United Nations is minimal. Most nations support Cuba in calling for an end to the U.S. embargo, and yet this global solidarity has little effect in altering policy (Roman, 1995). The world has built consensus condemning

²⁸ ALBA is designed as a cooperative alliance aimed at overcoming underdevelopment through the sharing of human and material resources. Unlike regional free-trade alliances, ALBA is focusing on building health care and education capacity. The agreement is meant to include nations in Latin America and the Caribbean.

the U.S. embargo against Cuba through multiple U.N. votes that call for the removal of the blockade. Only the U.S. and Israel perennially vote to maintain it. Foreign Minister Felipe Pérez Roque sees this as “proof that the international community rejects the sanction policy;” however, despite this, the policy remains (Gorry, 2004). It is questionable how much political weight is rendered by sending physicians to the poorest countries on the planet. The criticism that gets thrown at Cuba for its medical internationalism is generally impractical, and perhaps has far more to do with wrestling with a broader political psyche which fears that Cuba may in fact have some good ideas (Chomsky, 2000; Spiegel, 2006).

The Homefront:

Since the earliest stages of the revolution, the Cuban medical system has been governed by the philosophy of providing equitable care, and by the reality of coping with an anaemic supply of resources. These two forces have shaped the Cuban health-care experience into a unique system that relies heavily upon human resources at the level of primary care, and does well to lessen its dependency on high-tech and costly procedures. Cuban health care emphasizes human resource-based strategies that focus on disease prevention and health promotion. Franco *et al.* see Cuba’s “better than expected” health indicators for a developing nation to be the result of a well-defined strategy using public health principles to reduce major risk factors (Franco *et al.*, 2007: 247). In 2005, Cuba had, in addition to 70,000 physicians, 447,000 active health-care workers, of whom 70% were women, working on the island. It is a three-fold increase since 1976, and a very noticeable manifestation of how a nation of 11.2 million persons employs 4.6% of its population in the health sector (MINSAP, 2006a).

Instead of approaching medicine as a reaction to illness, Cuban doctors engage patients before the onset of disease. Patients are categorized into four stages to determine appropriate risks, measures, and treatments to maintain and ensure health. Persons in the first category are deemed “healthy,” meaning that they are able to lead their lives unhindered by a medical condition. Primary-care physicians seek to keep people in this category through regular check-ups, testing, screening, and dialogue about possible risks and preventative actions to reduce risk factors.

The second category is for those who are “at risk.” These are patients who can be identified as being at higher risk for developing a chronic or debilitating condition, or who, through their work environment or lifestyle, may be more susceptible to injury or stress. For these patients, the physician’s role is two-fold; first they try to reduce risk factors and return the patient to the first category, and for those risks that cannot be eliminated, the goal is to build dialogue with the patient for appropriate behavioural change to prevent risks from becoming larger health problems (Giraldo, 2006).

The third category consists of patients who are experiencing a health problem, be it disease, injury, or a chronic condition. The physician works with health teams, specialists and tertiary-care centres to try to ensure that the condition does not progress, or might be effectively treated to bring the patient back to the second, if not first, category. As Cuba’s health-care system is vertically integrated from primary care to advanced treatment, the family physician maintains consistent contact and surveillance of the patient, even through referrals to specialists or to out-of-province treatment centres. Patients falling into the third category may be suffering from communicable diseases, injuries, chronic condition flare ups, or temporary discomforts. For this stage, however,

most patients are treated at local health-care centres, and rarely do they require tertiary treatment.

Again, this is a very general categorization, but it differs from the fourth category, which identifies patients with health problems that are producing complications and negative impacts to their lifestyles. This is the most severe categorization, and will often warrant immediate tertiary care to remove complications that can endanger an individual's life or way of life. This could include cancer, cardiac arrest, pulmonary disorders, injuries that have led to severe infections, and loss of limbs or loss of vision from diabetes. Even in this fourth category, the physician works with a broader health team to ultimately bring the patient back to the first category, and to restore health.

This is the general ontological framework of Cuban care. Notably, in all stages from healthy to severely ill, the physician plays a central role with the patient. The process is not just about treatment per se, but about ensuring that individuals are able to regain and then maintain their health. The strength of Cuban health care in human resources has afforded incredible innovation in coping against chronic drug shortages, equipment malfunctions, and poor physical plant conditions (Macintyre & Hadad, 2002). Certainly the worst of this experience occurred immediately following the collapse of the Soviet Union during the *Período Especial durante el tiempo de paz* (the special period in the time of peace), and today many of Cuba's more advanced institutions are enjoying long-awaited facelifts. Nevertheless, resource supplies are limited, in large part due to insufficient acquisition of hard currency, which is further complicated by the U.S. embargo. Among the many limitations, the 1992 Torricelli act specifically prohibits the

sale of medicines and medical equipment to Cuba (Kaplowitz, 1998; Nicol, 1999; Schwab, 1999).

The embargo has had brutal humanitarian consequences for many Cubans. Some necessary life-saving medication for cancer treatment and advanced heart diseases only produced in the United States are forbidden to be sold to Cuba. For example, the prostaglandin, “*indomethacin*” is a drug used to effectively cause closure of patent ductus arteriosus in newborns with particular cyanotic heart defects, and “decreases the need for surgical ligation, decreases the incidence of early, serious pulmonary hemorrhages, and decreases the incidence of serious...intracranial hemorrhage” (Clyman & Chrono, 2007: 217). While Havana’s William Soler pediatric heart centre desperately requires this medicine to treat infants, the patent is exclusively held in the U.S. and Cuba must approach third countries for rarely-available surpluses. While surgical treatments are available, this non-surgical alternative is far preferred, as open-heart procedures generally involve increased risk and complications (Interview: William Solar Institute, 2007). Moreover, while some argue that patent ductus arteriosus treatment may have little long-term benefit (Kabra *et al.*, 2007), Clyman & Chrono (2007: 218) find such claims to be non-evidence based and state, “if pharmacologic treatment is to be used, early treatment is more likely to result in successful ductus closure.”

Moreover, it can be argued that the blockade negatively impacts the health of U.S. citizens. Cuba’s Finlay Biomedical Research Institute developed *Policosanol*, a drug noted as the best developed anti-cholesterol agent (Bradley & Kim, 1994). With high cholesterol and heart disease being major health risk factors in the U.S., neither U.S. physicians nor patients are permitted access to this medication.

Despite the interminable struggle for material resources, the system manages to produce outstanding core health indicators, as recognized by the WHO and PAHO. In this hemisphere, it is tied with Costa Rica, and is only behind Canada for having the longest at-birth life expectancy of 75 years for men and 78 years for women. The country also enjoys an exceptionally low infant mortality rate of 5.3 per 1,000 live births (MINSAP, 2006b). As well, universal vaccinations are in place with over 99% of the population receiving antigens (World Health Organization, 2007). Certainly a broad collection of social and environmental determinants work towards a society's production of health. Further, Cuba employs a model of public health care that goes beyond the clinic to play a stewardship role in improving outcomes and reducing risk factors in communities.

It is important, then, to understand how the "Cuban paradox" came to be. How this economically hobbled nation enduring the longest-standing economic blockade in history managed to outperform every other "developing nation," and even many "developed nations," in its core health indicators, universal service delivery, and international primary care. The answers to this Cuban paradox lie in the historical choices that Cuba has made in developing medical reforms.

A History of Domestic Choices:

The U.S. Department of State *Commission for Assistance to a Free Cuba* argues that:

The physical, mental, and emotional health of the Cuban people is directly linked to their level of empowerment. Healthy individuals are better able to make informed decisions about their own well-being and that of their community. This ability to be involved in the decision-making process leads, in and of itself, to a sense of empowerment (Powell, 2004).

Correct indeed, although the State Department's definition of empowerment as having "free multi-party elections" (Powell, 2004: 8) is hardly enough to guarantee a sense of empowerment that meets human capabilities and potentials (Ghai, 1989). The U.S. State Department remains focused on the Castro / Communism gaze to claim that "the Castro dictatorship had been able to maintain its grip on the Cuban people by repressing the development of independent civil society and keeping the Cuban people on a desperate hunt for dollars and basic necessities" (Powell, 2004: 7). It has missed the fact that Cuba constructed a participatory community-based health-care system that heavily relies on individuals' knowledge of their own well-being and their ability to be involved in personal and community health initiatives. This system, contrary to the belief of the U.S. State Department, has fostered one of the most equitable and healthy societies in the world.

The origin of Cuban health care and physician education goes back over two hundred years. The University of Havana has one of the oldest medical schools in the hemisphere. Even in the nineteenth century, Havana had doctors practicing "medicine in the community" by sending "weekly doctors" to poorer communities who were without regular care. According to Delgado Garcia,

They offered free medical care to all the sick and injured people among the indigent poor. They administered treatment in their patients' own houses, sending them to charity hospitals when necessary. They also acted as forensic doctors, inspected hygienic conditions in public places, and were responsible for food hygiene in the city's markets (Delgado Garcia, 1993).

These altruistic physicians were the frontline of early primary care in Cuba, as they offered their services for free, and relied heavily on the missionary hospitals to treat their patients. Certainly the methods, illnesses, and social conditions are of a unique time and

place, but it is important to recognize that a heritage of primary care for the desperate and poor extends into the colonial history of the country, a time in which Martí lived.

By the 1950s, Cuba boasted the highest number of doctors per capita in the Americas, with about 1,078 patients per physician in 1958 (Oficina Nacional de Estadísticas, 2007). However, accessibility to physicians and health-care resources was desperately inequitable. In 1959, 65% of physicians and 62% of hospital beds were located in Havana and, while half of Cuba's population lived in rural areas, the country had only one "rural hospital" with ten beds (MINREX, 2007). MINSAP estimates that 36% of the population suffered parasites, 14% suffered from tuberculosis, and 30% carried malaria (MINREX, 2007). While there are statistical discrepancies between records taken by health professionals before the revolution, and those measured afterwards when post-revolutionary health professionals ventured out into rural and isolated areas, it is clear that health status in Cuba was incredibly inequitable between rural / urban, and rich / poor. As well, it was difficult for Cuba to improve the health and well-being of its population after one half of the 6,000 doctors left the island between 1959 and 1960. With overwhelming need, and very little human-resource support, let alone infrastructure, the new government chose innovative strategies to work towards equitable health-care provision.

On February 23, 1959, *The Department of Technical, Material and Cultural Assistance to the Farmers of the Rebel Army* was created in order to, among its many operations, offer health care for the underserved rural *campesinos* (peasants). However, the infrastructure and human resources of this department fell far short of delivering universal care across the island (Rojas Ochoa, 2004). In 1960, the Rural Social Medical

Service (RSMS) developed a strategy to increase human resources for health in rural areas. It offered, but in no way demanded, contracts to recent medical graduates for a six-month minimum to a rural medical post (Rojas Ochoa, 2004). Moreover, medical graduates prior to 1959 were permitted to maintain private clinical practice if they chose to do so. More than 300 of the 330 medical-school graduates from 1960 signed up for the rural program. The number of volunteers increased the following year to 386, and fell slightly to 346 in 1962, but 46 dentists also joined the cause. By 1973, 1,265 graduates were enrolled in the service, which evolved from a six-month contract to a two-year commitment. According to Rojas Ochoa (2004), all of the country's medical graduates enrolled for the program by the 1970s because, since 1965, it had become "tradition to renounce private practice in the graduate's oath."

This human-resource expansion fostered the establishment of rural clinics in every municipality in the country. In the early stages, the clinics were geared towards treating many of the communicable ailments and at-risk conditions afflicting the Cuban population, such as, "tuberculosis, leprosy, venereal diseases, pregnancy, children's acute diarrhea, and malnutrition in children" (Rojas Ochoa, 2004). Still, the clinics also offered general primary care, waste disposal and health-condition inspections within the community. In order to deliver primary care to the community, the RSMS health units coordinated with community-based organizations such as National Service to Eradicate Malaria (NSAP), the Health Coordinators of the Committees for the Defense of the Revolution (CDR), the Health Brigades of the Cuban Women's Federation (FMC), and social workers from the Ministry of Welfare. These organizations especially assisted in

facilitating interaction and supervision among physicians when its development of transportation networks and other infrastructure was still in its infancy.

Many infrastructure developments unfolded alongside the human-resource expansion program, but perhaps the most significant was the development of the *policlínicos*. These centers were created to offer comprehensive health care provision for up to 45,000 inhabitants within a maximum 9km radius (Feinsilver, 1993). They were meant to offer advanced services beyond primary care and diagnostics, while remaining focused on community medicine. *Polyclínicos* undertook community-health initiatives such as keeping family records, constructing population groups, implementing disease-orientated prevention and health promotion programs, encouraging community participation, and administering vaccination programs (Hernández, 1971; Rojas Ochoa, 2004).

While the development of *polyclínicos* certainly advanced the quality of care on the island, building a healthy population also arose from other social programs that sought to increase education, public sanitation, and infrastructure (Danielson, 1985; Feinsilver, 1993; Halebsky & Kirk, 1985). As well, disease vector eradication programs, such as the ongoing campaign against dengue, have also been noteworthy in improving population health (Romani *et al.*, 2007).

Still, many shortcomings were identified by the mid-1970s with the *polyclínicos*. Rojas (2004) claims that *polyclínicos* suffered from poor integration; over-emphasis on curative rather than preventative care; inadequate teamwork between health workers; transient physicians; the referral of too many patients for secondary care; and health-care professionals trained in hospitals, not *polyclínicos*, affecting their proficiency in the field.

The 1974 evaluation of *polyclínicos* concluded that they were not having a sufficient community health impact. Curative care and basic clinical practices continued to consume the majority of activities. A new model of *medicina entre la comunidad con los policlínicos comunidades* (medicine in the community with the community *policlínicos*) evolved from this critique. To increase the role of disease prevention and health promotion, five major innovations were proposed, initially tested at the Alamar Polyclinic located in old Havana. These involved:

- 1) Programs giving special attention to women and children's health as well as epidemiology;
- 2) Programs for care of the environment emphasizing food hygiene, and home and workplace safety;
- 3) Service optimization, involving the dispersal of health-care duties through a "health team";
- 4) A management program to track and record shortcomings and successes within programs;
- 5) Teaching and research program to be carried out with students and graduates from the country's now numerous medical schools (Más Hernández, 1998; Rojas Ochoa, 2004).

The development of health teams is an important milestone in the progress of Cuba's primary care. It was understood that all members of a polyclinic staff would be considered members of a health team working together on disease prevention and health promotion strategies. As Presno Labrador (2004) argues, "the [traditional] splintering" of care among medical personnel did not provide truly comprehensive care for families. But as a team of various specialists, nurses and nurses' aides, pediatricians, sanitation

brigades, epidemiologists, and family doctors, they could collectively provide comprehensive attention to the health of individuals and families, rather than just repairing the “damage or illness” of a person (Presno Labrador, 2004). Teams could be responsible for developing sensitive health-promotion strategies for families in their serviced areas, based on personal, family, and constructed risk assessment.

Today the polyclinic commands an important role in community health-care provision in Cuba. More advanced procedures beyond basic treatment and diagnosis are finding their way to *polyclínicos*, taking pressure off hospitals. Medical students, Cuban and foreign, work and train with the polyclinic health teams and currently, with increases in the number of family physicians traveling abroad to work in places like Venezuela, more and more initial primary care is being conducted within the *polyclinic* rather than at the local *consultorio*. This is a relatively new development, because for over 30 years, the initial entry point for patients into the health-care system came from consultation with family physicians at their community *consultorios*, which are small live-in medical clinics typically with one doctor and one nurse, receiving patients from the community in the morning, and closing during the afternoon so the staff can administer house calls.

While Cuba continues to maintain an outstanding doctor-to-patient ratio across the entire island, with about one doctor for every 158 patients, the current efflux of doctors to Venezuela and other countries has actually adjusted upwards that ratio to one doctor for every 179 patients. However, with over 70,000 physicians and 83,000 nurses, it is still the highest national doctor-to-patient ratio anywhere in the world (MEDICC, 2007a). The U.S. Department of State sees this as “an over-surplus of physicians” (Powell, 2004: 83 - 84). Still, the reduction of this so-called “over-surplus” has created

some discontent within the country among patients who have to travel further or wait longer for service. Relatively speaking, the increase in distance would be no more than a couple of kilometers, but Cubans have grown used to having physicians close at hand. As well, physicians who remain in country do not receive salary bonuses in foreign currency and this has created some resentment among doctors.

Accessibility to physicians and nurses remains relatively equitable in rural and urban areas alike, with 99.4% of the population having regular accessibility to physicians, although with some regional discrepancies in the ratio. For example, in Havana there is one physician for every 100 people, while in Havana province, there is only one physician for every 200 people – that this is still better than the national ratio of any G8 nation (MEDICC, 2007a; World Health Organization, 2006). Moreover, no province experiences less than one nurse for every 144 people.

Consultorios are another unique attribute of the Cuban system. The program emerged in the 1980s, titled the “Physician for 120 Families” or the “Community Doctor” initiative; it was, and continues to be, the most accessible program of family medicine anywhere on the planet. Doctors and nurses work together in Basic Health Teams (BHTs) to offer primary care and health assessments to populations of about 700 to 800 people. Bringing a team approach of health-care provision to a more micro-level, BHTs health assessments and promotion programs are based on the socio-environmental conditions of the family. BHTs offer their services in the neighbourhood *consultorio*, as well as performing house calls for urgent care, properly titled “continuous assessment and risk evaluation” (CARE). They also construct “health maps” of social and

environmental conditions that impact families, titled “neighbourhood health diagnosis” (NHD).

CARE, or *dispensarización*, organizes and develops comprehensive medical care for persons especially at risk and tries to bring them into a state of healthiness. This method insists that the BHT must account for every patient in their care, and be able to identify persons considered at risk. For example, “Each hypertensive patient, each diabetic, each expectant mother, and so on, will all receive prioritized and differentiated treatment, in accordance with nationally prescribed procedures and programs” (Reed, 2000). It is a continuous process of assessment, follow-through, and follow-up, which quickly identifies new problems or risks.

NHD focuses more on community participation to analyze current health concerns and to find effective solutions for health at the family level (Presno Labrador, 2004; Reed, 2000). The challenge for BHTs, especially in the early stages of the program, was to maintain diligence in comprehensive treatment, while recognizing the influence of society and the environment on a person’s health.

Relying heavily on education, interaction between other ministries and community participation, the BHTs working alongside *policlinicos* achieved:

the promotion of health through positive changes in the population’s knowledge, sanitary habits and lifestyles; prevention of the appearance of diseases and damage to the population’s health; guaranteed early diagnosis and timely, continuous and comprehensive medical care in the community; developed community-based rehabilitation for physically or psychologically disabled persons; achieved positive changes in environmental cleanup in the neighborhood, as well as in the sanitary conditions of family homes; achieved positive changes in social integration of the community and families; and developed research studies that responded to the health needs of the population (Presno Labrador, 2004).

Community-based and dynamically-integrated health care arguably fostered the so-called Cuban paradox. For a poor, developing country to take an active role in securing the health and well-being of its citizenry, despite severe economic problems, serves as an important testimony to the effectiveness of embracing human resources for health.

In the 1990s, after the fall of the Soviet Union, Cuba's economy all but collapsed and, according to Ken Cole (1998), it baffled economists as to how the nation managed to survive. The country lost 87% of its exports, and its economic growth fell by 35%, a figure that by most economists' calculations would equate with the utter collapse of society (Cole, 1998). A multitude of health crises broke out during this time, from the average Cuban male losing 40 lbs between 1992 and 1993, to 35,000 people experiencing temporary blindness due to a lack of vitamins, and sanitation problems in urban areas.

In this desperate time, health care nevertheless continued to be approached through community-based strategies of disease prevention, health promotion, and early detection. These methods helped to remove expensive demands on desperately scarce material resources by treating patients at the community level rather than in hospitals or centralized institutions, where physical-plant conditions were deteriorating. Presno Labrador (2004) notes that, while the government increased its commitment to train physicians during the period, which it did successfully, needed infrastructure was still hard to come by. No materials were available to build, or repair, *policlinicos* or *consultorios*; MINSAP suffered from desperate shortages of medicines, equipment and advanced diagnostic equipment; therapeutic alternatives were just as limited; and access to new medical literature was also restricted as a result of the embargo (Presno Labrador, 2004). However, despite inadequate material supplies to service the entire population,

MINSAP nevertheless believed that the presence of health experts dedicated to holistic diagnosis, analysis, and education within communities would be able to sustain, if not improve, public health. Besides, Cuba had faced similar challenges in 1959, and with much with less structural organization in both urban and rural areas.

It is widely believed that this commitment to human resources for health was the main reason why health indicators did not appreciably decline during the special period. In fact during this time, life expectancy increased and infant mortality drastically declined. In 1980, the infant mortality rate was 27.5 deaths per 1,000 live births; in 1990, it was 10.7 per 1,000 live births, and by the end of the worst economic crunch in 1995, it was 6.4 per 1,000 live births (Reed, 2000). Today, the infant mortality rate is 5.3 per 1,000 live births. Certainly a multitude of factors influenced this statistic; no doubt technological and procedural advances in obstetrics played a role, but during a time when advances in material and educational resources were impossible to achieve, Cuba managed to improve its core health indicators by a significant proportion. Other countries like Liberia, Malawi, and Angola suffered economic chaos during this time as well, and despite similar advances in obstetrics, their infant mortality rates increased substantially.

In every system, the question of cost arises when dealing with public health-care expenditures. It is problematic to directly compare Cuba's cost of health-care service provision to other countries, as its economy is loaded with direct and indirect subsidies. Nonetheless, MINSAP has kept account of health expenditures since 1959. In 1959, MINSAP's total operating budget was 25 million Cuban pesos, while in 2005, it was 2.5 billion (\$99 million USD). Per capita expenditures were calculated as 3.72 pesos per person in 1959, and rose to 230 pesos (\$9 USD) per person in 2005. Indeed the absolute

cost and share of the health budget in GDP has grown since the onset of the revolution; however, the direct expenditure cost has remained quite low. Even comparing Cuba to other countries in the Americas, via the WHO's figures on total per capita expenditures on health, shows that Cuba spends about as much on health as, for example, Nicaragua or Jamaica. Considering that Cuba's per capita human resources for health exceed those of any other country in the hemisphere, and its health indicators mimic those of the nations that spend the most on health-care services per capita, we must call into question the axiom that popular health rises alongside national wealth (Ruccio, 1991; Wilkinson, 1996).

The development of community-orientated health-care initiatives in Cuba is, as MINSAP admits, in no way complete. Resolving, rather than just diagnosing and assessing more health problems at the primary-care level, is desired (Reed, 2000). Without dependable and continuous access to affordable technological and pharmaceutical resources, this will continue to be a challenge. However, by surviving one of the worst economic collapses in recent history, Cuba managed its population's health through crisis and prevented disaster. In part, because of this success, the emphasis on human resources for health and community-level participation has now become a leading topic in efforts to shape future domestic and international health-care policies. The experience of the BHTs and *policlinicos* demonstrates that despite numerous challenges, a well-organized human-resource-based approach, even with minimal resources, can have a positive impact in community health that seeks proximal treatment through promotion and inter-sectoral collaboration.

The Front Lines:

Since the onset of the revolution, primary care has focused on universal accessibility and has been about ensuring that the benefits of medicine science is brought to the population through an ethics of universal service. The main lessons learned from the domestic experience were that health-care professionals could be trained quickly to apply their skills in poor, underserved areas; that health care should be provided in a team setting rather than through professional silos; that health extends far beyond repairing damage, and requires the maintenance of overall well-being; and that despite desperately few material resources, properly directed human resources, could have a tremendous impact on managing the health of communities even in times of crisis.

Alongside the development of primary care at home, Cuba also did its part to develop primary care abroad. Some have viewed Cuba's foreign medical outreach as not as altruistic as it might seem, and ultimately doomed to failure. Maingot believes that because of existing neoliberal policies, Cuba's approach simply can't work elsewhere (Maingot, 2006). Hansing (2006) claims that "Cuba benefits handsomely from its generosity." Indeed, such analysis underscores the point made earlier that no nation willingly constructs foreign policy that does not suit its own interests. Appreciative votes in the U.N. by other developing countries, and international media attention for its human security initiatives have certainly come to Cuba through this policy; however, as previously mentioned, the impact this has on international relations is questionable. Hansing (2006) argues that Cuban doctors abroad bring in badly-needed hard currency. This is not the case when it comes to serving poor regions in the global South as Cuba only asks for the basic costs of their physicians to be covered, and Cuban medics

themselves have always treated the poorest patients overseas (Feinsilver, 1993). It would be hard to argue that these doctors are reaping personal fortune out of such desperately poor and destitute communities, where living on \$1-2 USD a day would not be uncommon.

A sense of capability, more than the sense of lucrative gains, drives Cuban medical internationalism. By examining the development of international medical campaigns, and taking note of official State discourse to justify them, it is clear that Cuban medical internationalism evolved in accord with two processes. First, it expanded Martí's concept of *Nuestra America* into a foreign policy of pan-American, and pan-Southern, solidarity. Second, it mirrored developments of community-based primary care at home. Certainly as Cuban health authorities witnessed the tremendous benefits that came from having doctors attend to underserved communities, they also realized that it could be possible for physicians to create positive health impacts in other poor countries. This policy would evolve from its origin in a small medical brigade into eventually the largest medical school in the world.

Since 1961, Cuba has had 270,743 collaborators serve in 154 countries, including 113,585 health-care professionals who have served in 110 different nations (CubaCoopera, 2007). Even in the infancy of the Cuban revolution, when physicians were already in short supply on the island, a medical brigade traveled to Algeria in 1961. Despite the overwhelming task of improving popular health at home, wounded soldiers and children were transported back to Cuba for treatment (Glejeses, 1996). Cuba sent the small brigade of doctors, alongside some minor military support, to assist in the country's war of independence. By 1963, 55 Cuban doctors were practicing in Algeria.

The 1961 Algerian brigade was the first in which Cuba's internationalist principles "were put to the test" (Castro, 2001).

Cuba, in fact, had an extensive campaign of medical outreach in Africa. In 1966, Cuban doctors worked in Guinea-Bissau during the liberation struggle against Portuguese rule (Gleijeses, 1997). After visiting Cuba, Guinean President Amílcar Cabral requested Cuban assistance. A small military contingent was sent to the region, along with training personnel, and a medical brigade consisting of thirty-one people (Gleijeses, 1997). Not only did the Cubans provide the only functioning heavy artillery for the campaign, but they also had the only comprehensive front-line health care anywhere in the liberation movement. Clearly, in both Algeria and Guinea-Bissau, two countries linguistically and culturally distinct from Cuba, but facing similar anti-colonial struggles, the Cuban doctors acted as the first and only line of response for many of the casualties of the armed conflict.

Without doubt, Angola is the largest foreign campaign that Cuba embarked upon. Cuba's military involvement in the country was beyond anything the revolution's army had encountered to date, and so too was the medical intervention. As was the case in Algeria and Guinea-Bissau, human-security provision went hand-in-hand with the military campaign, and the Cubans provided much-needed human resources and other infrastructure to this conflict-stricken State. In 1977, two years into the Angolan campaign, "only one Angolan province out of sixteen was without Cuban health technicians" (Cohen, 1994). Moreover, Cuban doctors not only worked within these hospitals, but also effectively used these facilities to train locals on site.

In 2005, on the anniversary of the landing of “*Granma*,”²⁹ Castro spoke about the Angolan conflict, saying that the Cuban involvement, both militarily and medically, represented a continuation of the struggle against imperialism (Castro, 2005c). MINREX does not consider medical internationalism as a political tool, even though it admits that it has warmed political relations with other countries. When Cuba has provided medical attention in conflict-stricken areas, the doctors have been strictly apolitical. During the Angolan campaign, Cuban medics treated South African troops alongside Angolan ones. More recently, when violence broke out in Chad, the Cuban doctors sent to that country remained there despite the risk and violence, and offered medical care to both sides. When Australian troops arrived in East Timor, they occupied a hospital run by Cuban doctors (Gorry, 2006). The doctors explained that they would be willing to treat wounded from both sides of the conflict. They received casualties from the East Timor independence movement, as well as the occupying Australian forces (Torigo, 2007). Also, when former Haitian President, Jean-Bertrand Aristide was removed from office in a coup in May, 2004, the five hundred or so Cuban health care professionals remained in the country and continued to provide medical services despite the violence and social chaos (OCHA, 2004). Indeed, these examples speak well to the fact that Cuban medical internationalism is not politically fickle, even when operating in divided lands.

Official State discourses tie Cuban medical internationalism to assisting struggles against neo-colonialism and imperialism. However, it is worth pointing out that this commendable record of providing badly-needed medical and educational support cannot be reduced—as many believe—to countries of ideological affinity (Huish & Kirk, 2007).

²⁹ The name given to the “borrowed” yacht that carried the 88 guerillas to Cuba in 1957 to start the revolution.

In May of 1960, for example, Cuba dispatched a small medical team to Chile (headed by the Christian Democrats under Alessandri) after an estimated 2,000 people were killed in an earthquake. Moreover, Cuba sent doctors to Nicaragua after a massive earthquake in 1972 killed some 20,000 people. The country was then headed by Anastasio Somoza Debayle, an outspoken enemy of the Castro government. Cuban doctors went to Iran in 1990 following a major earthquake—despite strong Cuban ties to Iran’s foe, Iraq. More recently in 2000, Cuba sent medical personnel to El Salvador following the outbreak of dengue fever there. Cuban medical staff tended to some 10,000 Salvadorans during their 16-week stay. Likewise in 2001, Cuba donated 1.2 million doses of vaccine to Uruguay following an outbreak of meningitis. El Salvador had traditionally supported U.S. initiatives against Cuba at the U.N. Human Rights Commission, while just a week prior to sending the meningitis vaccine, Havana and Montevideo had broken off diplomatic relations, again over the human-rights question. In all these cases, ideological differences were put aside by Havana, and long-term humanitarian interests consistently took preference.

Cuba’s medical internationalism has also evolved from assisting its focus on military or resistance campaigns to aiding in natural disasters. While Cuba enjoys an incredibly effective hurricane preparedness system, many other countries in the Caribbean do not. The Latin American Center for Disaster Medicine (CLAMED) works for emergency preparedness within Cuba, and coordinates with other CARICOM nations. Hurricanes continue to claim lives in Cuba, but the mortality is considerably lower than in other neighbouring countries. Five lives were claimed in Cuba by Hurricane Michelle in 2001, while the Category 4 storm claimed 17 in other parts of Caribbean. When seven

Cubans died during Hurricane Denis in 2005, Fidel Castro, speaking on Cubavision television, demanded detailed answers and explanations for the “inexcusable” loss of life. Still, the interminably hollow infrastructures in other countries often require post-hurricane emergency response to care for victims, and to quell disease outbreaks following a disaster (MEDICC Review Editorial Staff, 2004). In 1974, Cuba sent a medical team to Honduras to aid with the aftermath of Hurricane Fifi that claimed 2,000 lives. In 1998, its medical teams went to Haiti in response to Hurricane George. As well, in 1999, torrential rains left 9,000 dead in Venezuela, and Cuba dispatched medical brigades to assist (Reed, 2004). Even as recently as August, 2007, Cuba sent health personnel to the Yucatan to assist with the aftermath of Hurricane Dean.

In 2005, Cuba offered 1,097 specialists in general medicine, 351 general practitioners, 72 specialized health professionals, and 66 specialists in cardiology, pediatrics, epidemiology, surgery and psychiatry to the United States following the devastation of Hurricane Katrina, which claimed 1,836 lives and caused billions of dollars in damages (Castro, 2005b). Even the first graduating class of ELAM, who finished their program two weeks before Katrina, offered their assistance. Eighty-five graduates offered their services to Fidel Castro in a letter that read:

We have followed the horrific events that have unfolded in New Orleans resulting from the devastation caused by hurricane *Katrina* and listened to your statement on the afternoon Round Table program and we, Hondurans and other graduates from the Latin American School of Medicine (ELAM), are moved by the situation our brothers in the United States are enduring. Thus, as victims of a natural disaster (hurricane *Mitch*) ourselves, we want to express our solidarity with the American people at this tragic hour and join the doctors you have offered to send to this sister nation in response to this critical situation. You can be confident that we are ‘doctors willing to go where we are most needed’. With infinite love and eternal gratitude, The first graduates from ELAM (Castro, 2005b).

The 1,586 health professionals were given the name “*Henry Reeve Brigade*,” after a young American Civil War veteran who served Cuba in the First War of Independence (1868 – 1878). This initial, on-the-spot collection of doctors developed into a highly-organized group trained specifically for delivering emergency services and primary care in post-disaster areas. Regrettably, Washington refused to accept the offer, and while the brigade could have been on the ground in New Orleans just hours after the initial offer, the victims of New Orleans had to wait days before sufficient medical attention and supplies actually reached them.

The brigade’s first campaigns came just weeks after Katrina, when a devastating earthquake rocked Pakistan on October 8, 2005, and Hurricane Stan devastated Guatemala on October 4, 2005. With 840 dead, and another 600 missing, Guatemala was the first country to accept the Henry Reeve brigade, and on October 8th, an additional 300 physicians arrived. By the end of the month their numbers grew to 600 (Gorry, 2005a).

Despite the enormous distances involved, as well as cultural and linguistic hurdles, and a generally cool political relationship, Cuba sent its brigade to Pakistan as an immediate response to the disaster, and was the only foreign delegation to remain on site well after the initial relief efforts had subsided. The quake killed 70,000, injured 69,000 and displaced as many as 3 million people (Gorry, 2005a). Led by Dr. Luis Oliveros, the Henry Reeve brigade went to Pakistan with 130 physicians specialized in disaster medicine, including 15 surgical teams. They were on the ground within 72 hours of the quake. They constituted one of the largest medical delegations in the region. An additional 770 physicians arrived in the following weeks, and by the end of the campaign, 1,481 Cuban physicians and 900 paramedics had served in Pakistan. The brigade

constructed two field hospitals, which collapsed due to snowfall on one occasion, and managed to treat 110,000 patients in the affected region (Granma International, 2006). The small medical team attended “773 major operations, performed 2,436 minor operations, attended 34 births with zero infant mortality, and administered 10,000 immunizations against tetanus” (Granma International, 2006). As well, the teams traveled into the countryside to deliver care in the communities, despite it being their first time hiking through snow-covered mountain roads.

Since its inception, the global demand for the Henry Reeve Brigade has been great. Even during the Pakistan campaign, the Brigade sent another division to Java to assist in the aftermath of another earthquake in 2006. Unlike other comprehensive health programs where doctors remain in country for an indefinite length of time, the Henry Reeve Brigade remains for a fixed period and does not charge the recipient country for its services. Unlike most international relief efforts that offer specific treatment, rather than primary care, the Cubans provided comprehensive primary care in the affected region. General check-ups went hand-in-hand with trauma treatment or sanitation improvement. Moreover, after most other brigades left Pakistan, the Cubans remained. In fact, the Cubans continue to play an important role in Pakistani health-care provision as MINSAP has offered 1,000 ELAM scholarships to train young Pakistanis who would be willing to return to their homes to eventually practice where they are needed most.

Compare this performance to Canada’s support for the same earthquake through its Disaster Assistance Response Team (DART). For the cost of \$15 million, DART’s six physicians, two physician assistants, five registered nurses, thirty medical technicians, and sixty armed soldiers treated only 11,782 people, which included 2,145 vaccinations.

Most of DART's attention went to the distribution of supplies and purifying drinking water. But more importantly, just as the first Cuban doctors had arrived on the ground, Canada had just dispatched a group of "nine experts from Foreign Affairs Canada to identify the best contribution" that Canada could make (Department of National Defence, 2005). Only on October 23, sixteen days after the quake, was DART operational, and it only remained in country until December 4. It is a disturbing comparison as to how a rich country like Canada offered only a minimal contribution, while economically-humble Cuba provided badly-needed services to tens of thousands. However it is an important example of how the Cuban philosophy of primary care, its approach, methods and decisions has tremendous impact in global health disasters – equitable, if not superior, to the efforts of Western medical internationalism.

Beyond natural-disaster relief, other examples of Cuban medical internationalism abound. During the Gulf War in 1991, Cuban medical teams stayed in Iraq, well after other international aid organizations had left. In Kosovo, a large medical contingent of Cubans provided care for the embattled population. Today, some 75 Cuban medical professionals also remain in Yemen. In March of 2005, a 40-member medical team left Guyana after several months of tending to the population following massive flooding there. In Paraguay, a team of some 50 Cuban doctors and epidemiologists are working to combat infectious diseases, as well as providing general medical services. In 2005, 86 Cuban doctors worked in Botswana. From Botswana to Bolivia (where there are 1,500 Cuban doctors), Cuban medical personnel are undertaking medical internationalist service.

Some Cuban health professionals are working in Zambia, mainly in the struggle against the AIDS-HIV pandemic that is sweeping that country. Cuba has also offered to send an astonishing number of medical staff—some 5,000—to work for free combating HIV/AIDS in sub-Saharan Africa, if the North will provide medication for patients there. So far the silence from the North has been deafening and disappointing. Cuba has made similar arrangements with third-party countries to help defray some of the expenses of medical brigades. In Ecuador, the Belgian government is currently providing €7.3 million for Cuban medical brigades providing primary care in Esmeraldas, alongside special programs aimed at combating tropical and sexually-transmitted diseases (Prensa-Latina, 2005). As well, under the CARICOM agreements, and combining Venezuelan financial support with Cuban human resources support, the program *Mision Milagro* (Mission Miracle) had, by 2007, restored the eyesight of over 750,000 persons in Latin America and Africa. As well, the program had established 39 ophthalmologic centres in seven countries. Such cooperation with wealthier countries has allowed Cuba to further to expand its international outreach.

Cuba's medical outreach evolved from temporary relief efforts to comprehensive primary-care campaigns and medical-training exercises, principally in Africa. Other innovative measures have also been taken to treat local needs in places like El Salvador, where Cuba embarked on a massive dengue control and treatment. Cuba also treated 17,743 children from the 1986 Chernobyl disaster, along with 52 victims of the 1987 Goiania City, Brazil nuclear accident for specialized and therapeutic treatment (Reed, 2004). The Brazilian patients experienced a little-known nuclear disaster when two scavengers in a dumpsite broke open a canister of Cesium-137 from an abandoned

private cancer clinic, took the glowing blue powder back to their *favela*, and made everything, and everyone, it touched “glow in the night” (Galeano, 2000). Cynics continue to depict Cuba’s treatment of Chernobyl victims as a “shrewd political calculation” rather than appreciating that any political gain made came through soft power rather than through direct coercion (Tehrani, 1994, Erisman, 2008). However, Goiania City did not make the headlines in Northern media, and it cannot be argued that treatment of 52 poor victims from an unknown disaster has much political clout in international arenas. If anything, Goiania shows how Cuba offers its health-care capacity out of solidarity, and out of Martí’s *Nuestra America*.

Bringing Innovative Ideas Home:

Cuban doctors working abroad often come back with innovative developments in holistic medicine and alternative therapies. Traditional and Natural Medicines (TNM) are now an important part of Cuba’s domestic health-care provision network, and they play a role in primary care overseas. Due in part to the interminable embargo against pharmaceuticals, and partly to Cuban field research into TNM, non-pharmaceutical medicine is playing an increasingly important role in the treatment of patients in Cuba, and the adaptability of their physicians working abroad. Working closely with research programs to test and monitor the effectiveness of TNMs, Cuba has brought this international concept home, not entirely as a complimentary system during economic hardship, but, “rather, it is a discipline within medical sciences that requires profound study and continued practice in the country” (Padron, 2003). In Cuba, TNM is not regarded as a non-academic pariah, but as “scientific and technical...to facilitate incorporation into all levels of health care of the techniques, methods and procedures of

this [medicine]; requiring considerable training of human resources as well” (Padron, 2003).

Cuban medical internationalism has become more extensive, effective and holistic, it is also clear from this historical narrative is that it is incredibly innovative. Adapting TNM represents such an innovation, and working to train doctors regardless of country of origin, language, religion, class or gender could also be considered an innovative as well.

Or is it? Stemming from a philosophy combining solidarity, participation, and altruism, Cuba’s medical internationalism may not be such a strange idea to train poor and marginalized students as physicians. If Cuba could bring its own physician workforce from 3,000 in 1960 to 71,000 in 2007 (Oficina Nacional de Estadísticas, 2007), why then could they not do it on a global scale? It’s an idea that demands confidence in human capabilities and the belief that human empowerment can overcome existing structures of inequity.

Among all of the international medical campaigns, it was the response to Hurricanes George and Mitch in 1998 that spurred MINSAP to realize the need for health care in the developing South was well beyond the work of existing Cuban medical brigades. The immense devastation and tragic loss of life by Hurricane Mitch was aggravated, MINSAP believed, by a desperately hollow investment in appropriate infrastructure, preparedness, and human resources - something that internal and external neo-liberal reforms promoted during the 1990s (Cardelle, 2003; Horton, 2003; Muntaner *et al.*, 2006b; Ugalde & Homedes, 2005a; 2005b; 2005c.).

If Cuba could not send all the required health-care professionals to the affected regions, they could help to build the capacity of locals to become health leaders in their communities. To a large extent, they 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 were localized, depended upon local government cooperation, and involved small numbers of Cuban professors and medical staff (Huish & Kirk, 2007). Following the enormous devastation caused by Hurricane Mitch, however, Havana decided to undertake a new initiative. MINSAP converted a military training academy into a fully-functioning medical school in 1999. MINSAP proposed to accept around 1,500 students per year from the affected regions in Central America and the Caribbean. The goal was to train students to return to the affected region and replace Cuban doctors who were attending to the under-served (Castro, 2005a). The students would be representative of the communities in which they would serve. Women would constitute a large part of the student body, indigenous groups would be present, and students would come from modest and humble backgrounds. Specifically, the school set out looking for students who were between 18 and 30 years of age; had high school or some university training; had no criminal record; could demonstrate physical and mental fitness; and could demonstrate an ethical commitment to return to under-serviced areas to apply their skills (ELAM Web, 2007a; MEDICC, 2007b).

ELAM is the latest, and certainly the largest, step in Cuban medical internationalism. What may seem like a radical program is really not much more than a continuation in the tradition of medical internationalism. It is one that is dedicated to delivering accessible health-care services to the poor and marginalized around the world.

No serious economic need drives ELAM, nor does a clear political agenda, considering that many of the students come from countries with cool political relations with Cuba, or from countries so small that their voices are often forgotten in international arenas. Still, the goal is to empower individuals to build capacity from within their communities.

Exploring Cuban medical internationalism shows three themes important for the purposes of this study. First, as a foreign-policy instrument, medical internationalism delivers human security to vulnerable populations by providing badly-needed services and capacity. Furthering human security is not unique, but Cuba's implementation of it is, as the country's foreign-policy agenda aims to combat the negative effects of global hegemony. Second, the decision to embark on a policy of counter-hegemony is based on rational decisions. Cuban medical internationalism may be a work in progress, but it is no accident. It is, on a global scale, an aperture of dissent aimed at meeting the needs of individuals. Finally, Cuban medical internationalism shows how an alternative ethics guides it. Grounded from the good sense of José Martí, Cuba's policies play a dynamic role on the international stage. Finding ways of assessing this ethic in action can prove to be difficult, but one such way is by exploring how proximal interventions and COPC play out in the field. While this thesis has explored the theoretical, methodological and historical foundations of medical internationalism, the remaining chapters will explore how this good sense is loaded into ELAM and transferred to the field.

Pan-Southern solidarity created the desire, and national independence allowed for the choice, to make innovative decisions aimed at transforming health geographies of the developing South. The U.S. State Department calls for reforms in the philosophy of community-based health-care provision, demanding the involvement of the private sector

to address the problem of surplus physicians (Powell, 2004; Rice & Gutierrez, 2006). But ELAM, it is hoped, will further expand community-based health provision in the developing South to change its geographies of health care in the developing South. The remainder of this dissertation, focusing on data collected from multiple research trips, will provide an insight to see if, in fact, such expansion of COPC is actually possible in neoliberal countries such as Ecuador.



(Fig. 9) A mural of Martí and Bolívar at ELAM

(Fig. 10) Martí's famous quote, posted by the main entrance to the school. "It is the hour to mobilize, and to march united, and we must walk in a tight stream, like the silver in the veins of the Andes."





(Fig. 11) Main Entrance to ELAM.

(Fig. 12) From the Classroom to the Sea.





(Fig. 13) In Puerto Padre, Las Tunas, Cuba, during a public concert a public health demonstrator shows proper condom usage.

(Fig. 14) Soon to be ELAM graduates taking a study break at Ditú Pollo in June, 2005





(Fig. 15) Some doctors of *Mision Milagro*
(Fig. 16) A demonstration at the Finlay Institute.





(Fig. 17) Manuel Torrigo meeting with members of MEDICC (photo by Martine Polycarpe)

(Fig. 18) Members of the Henry Reeve Brigade, including Dr. Luis Oliveros (middle), head of the team that served in Pakistan. (photo by Martine Polycarpe)



(Fig. 19) Breakdown of ELAM students in 2006.

ELAM STUDENTS BY COUNTRY:

AS OF 2006	Premed	1st Year	2nd Year	3rd	4th	5th	2006 Grad 6th
Argentina	56	94	56	62	59	62	49
Belize	20	23	13	7	12	9	9
Bolivia		63	120	80	74	63	64
Brazil	92	94	85	65	60	42	54
Cabo Verde	0	0	1	0	0	28	0
Chile		91	49	50	49	70	54
Colombia	44	79	96	82	82	85	62
Costa Rica	39	46	43	31	35	41	37
Ecuador	97	91	98	123	113	64	58
El Salvador	60	72	59	61	81	111	86
USA	8	20	18	21	13	8	0
Guatemala	60	78	71	58	64	91	158
Guinea Bissau	0	0	0	0	0	2	5
Ecuatorial Guinea	0	0	0	0	0	15	53
Honduras	71	79	68	46	66	96	150
Mexico	72	78	56	93	87	66	38
Nicaragua	100	55	43	46	61	73	99
Nigeria	0	0	0	0	3	95	0
Panama	100	109	54	50	79	75	44
Paraguay	60	107	88	79	116	107	69
Peru	57	65	102	80	49	80	65
Dominican	40	65	83	48	40	40	42
Uruguay	40	98	66	47	45	41	56
Venezuela	0	74	125	128	103	88	56
Totals	1016	1481	1394	1257	1291	1452	1308

Facultad Caribena de Santiago

	Premed	1st Year	2nd Year	3rd	4th	5th	6th
Djibouti	0	0	0	0	19	0	0
Guinea Conakry	0	29	0	0	0	0	0
Haiti	0	119	68	58	178	64	116
Mali	0	68	64	1	51	48	0

	3rd	4th	5th	6th	Totals
ELAM Years 3 - 6 in Cuban schools:					
Pinar del Rio	75	61	86	94	316
Ciudad de la Habana	385	856	569	252	2062
Matanzas	38	39	31	82	190
Villa Clara	194	107	167	296	764
Cienfuegos	68	44	45	85	242
Sancti Spiritus	44	30	14	67	155
Ciego de Avila	48	40	45	1	134
Camaguey	132	98	181	270	681
Las Tunas	48	43	31	36	158
Holguin	40	68	25	3	136
Granma	69	57	79	1	206
Santiago de Cuba	88	45	43	50	226
Guantanamo	26	17			43
Totals	1255	1505	1316	1237	5313

Chapter 5
The Tests of the Classroom:
Analysis of ELAM Curriculum, Pedagogy and Student Life.

~*"The scalpel is the greatest proof of the failure of western medicine."* ~
Gabriel Garcia Marquez

Fidel Castro is given much personal credit for establishing ELAM. Many documentaries, newspaper articles, essays, student testimonies, and even official ELAM documentation have given him credit for this capacity-building project that affects thousands (Castañeda, 2005; MINSAP, 2006c; Suzarte Medina, 2007; Woodford, 2006). Much publicity around ELAM is embedded in overall discourse about Cuban altruism. Themes of solidarity, pan-Americanism, and health care as a human right all abound in most reviews of the school. Other narratives are less favourable, as they take exception with material-resource problems, shoddy food and close living quarters (Johnson, 2006). As argued in the previous chapter, a genuine commitment to achieving global health equity drives Cuban medical internationalism, grounded in a sense of nationalism and pan-American solidarity closely related to Martí's thinking. However, without further discussion of the actual outcomes and potential benefits of the program, this discourse would be incomplete as it overlooks the challenges and rigidities of the program and of the professional experiences of its students.

In the March 25, 2007 edition of Granma, ELAM's rector, Dr. Juan Carrizo, discussed the challenges of reintegrating ELAM graduates into their home communities. The journalist diminished these concerns by saying, "in any event, there is no doubt that the Latin American School of Medicine is a Cuban achievement in terms of health" (Granma International, 2007). It is certainly true that ELAM is a tremendous capacity-building achievement, but praise alone does not easily translate into needed dialogue as

how to overcome the many challenges of the program. One of my general concerns is that ELAM is easily glorified by academics and the media alike, as simply being “outstanding” against a global backdrop of feeble capacity building. Simple affection for ELAM may often avoid important critical dialogue concerning its outcomes, impacts and ability to create social change.

Fortunately, self-critical dialogues of ELAM’s curriculum, practice and performance do take place regularly. In fact MINSAP, *La Escuela Nacional de Salud Pública*, (The National School of Public Health, or ENSAP), and ELAM itself have a plethora of articles and position papers in publicly-accessible INFOMED that examine modifications and challenges to curriculum and pedagogy. While popular sources have approached ELAM as kind of a “brain child” of President Fidel Castro, the school’s community is aware of current operations and future developments. Reviewing the program’s internal discourse on INFOMED, it is clear that ELAM is seen as a work in progress, rather than an unchanging success story that will solve the health-care crisis in the Americas.

This chapter explores in detail the program’s operations. ELAM’s mission is to train “general doctors who are orientated towards delivering primary care in an ethical and humane manner to regions that are in need in order to facilitate human development” (ELAM Web, 2007a). It is a statement loaded with COPC values of expanding health-care services to communities in under-served regions. It is an approach that is badly needed for communities in the developing South, and it is an idea built upon the tradition of Cuban medical internationalism. And yet part of its mission relies on making changes at larger scales. As it builds ethics at the individual level, the program is also in large

part limited to hoping for or envisioning necessary changes at the broader organizational and structural levels largely in other countries. Change at these levels is out of the school's hands, and there is little that the directors or staff can do, directly, to see it through.

Gabriel Garcia Marquez's statement that "the scalpel is the greatest failure of Western medicine", critiques how, all too often, health care is seen as an investment in radical repair rather than preventative measures. ELAM's evolving pedagogy of community health and clinical practice puts greater emphasis on building health through basic means rather than through radical surgery. The principles of this medical ethics, according to MINSAP, include the "preservation and maintenance of health for the people...and to work constantly where society requires it and to always be ready to bring necessary medical attention in an internationalist spirit" (Castro, 1982).

ELAM is a training program sensitive to the health-care needs of under-served communities in the developing South. The tests of the classroom equip graduates with appropriate clinical skills and ethical frameworks to provide badly-needed health-care services to vulnerable communities. To this extent, ELAM fulfils its objective of training physicians in COPC. Structural and social constraints that allow them to, or prohibit them from, practicing in underserved communities are issues that will be addressed in the final chapters of this dissertation.

This chapter analyzes how a service ethic and COPC values are formed through the ELAM program. I begin by discussing how ELAM came about through medical internationalism. As the previous chapter argued, ELAM is a product of this process and not a radical intervention. I then offer a detailed description of who constitutes ELAM's

student body by considering the overall number of students, where they are from, and of what gender – to show how the school’s selection process plays out. I provide a review of ELAM curriculum, and I offer a detailed run-through of the program by year. While I was unable to review the entire six-year medical curriculum, I obtained summaries of topics through INFOMED. Séror praises INFOMED as “a model for integrating health care information, research, education, and services” (Séror, 2006). Indeed, INFOMED serves as an important forum for research and collaboration, as every physician and medical student in Cuba has access to it. I focus specifically on policy papers and articles that call for review and further development of current curriculum. Following this, I give an analysis of teaching methods. Interviewees are from a mix of nationalities and levels of the program. The sample is quite unstructured given difficulties in finding willing participants for interviews. Lastly, from these interviews, I offer a glimpse into the student life outside of the classroom. From all of this, the chapter provides an in-depth understanding into how ELAM makes doctors.

ELAM’s Role in Training a Global Health Workforce:

While ELAM builds capacity for service at the community level in line with the goals of Cuban medical internationalism, training doctors on such a large scale is an exceptional achievement as well. Health-service providers, according to the WHO, personify fundamental values in that: “They heal and care for people, ease pain and suffering, prevent disease and mitigate risk” (The World Health Organization, 2006: 15). For the WHO, health-care workforces are the keystones to advancing health. While technological advancements in research, treatment, and therapy abound, and financial support continues to build through philanthropic organizations such as the Gates

Foundation, many national health-care systems are at the same time anaemic, inequitable, and unsafe. The WHO argues that embracing human resources for health can advance the equity of care for desperately under-serviced regions. As Beaglehole and Dal Poz (2003: 7) argue, strengthened public-health services can promote equity in health interventions and access to resources where, traditionally, they have only favoured the elite. The 2006 WHO report concludes that infant, child and maternal mortality all drastically decrease with a higher concentration and accessibility of trained health-care professionals. As well, greater access to medications and vaccines dramatically increase with heightened accessibility to health-care professionals (World Health Organization, 2006).

Cuba has understood this and has taken action to increase the quantity of health-care professionals, mostly doctors and nurses, to work in under-serviced regions around the world. All too often the demand for their services is overwhelming. In East Timor, for example, violent clashes in August 1999 displaced 75% of the population and left only 35 physicians in a country of about one million people. That made for a doctor-to-patient ratio of one physician for every 28,571 people. By 2004, the number of physicians had increased to 79, according to WHO data, and Cuba sent an additional 182 physicians and technicians to the country. Since then health workers in the country have increased somewhat, but difficult conditions persisted and MINSAP has offered 800 ELAM scholarships for East Timor youth. If all scholarships were filled, and if all graduates returned home, the doctor-to-patient ratio would become one physician for every 1,250 people. A good idea indeed, but is it a reasonable possibility?

Various initiatives and reports, beyond the WHO and Cuba, have determined that training human resources for health is the most effective route to health equity in the developing South (Gerein *et al.*, 2006; Ogilvie *et al.*, 2007; San Sebastián *et al.*, 2005). Even the private sector acknowledges the benefits of human resources for health initiatives. For example, Houston's Baylor College developed an "AIDS Peace Corps" as a five-year treatment project that seeks to send U.S. personnel, along with pharmaceuticals, to African regions devastated by HIV / AIDS to provide services and to train locals in core clinical competency (Hopper, 2005). The program is funded by the pharmaceutical giant "Bristol-Myers-Squibb" (BMS) and company's costly antiretroviral pharmaceuticals are paid for, in part, through philanthropic donations. Such programs do allow for some pharmaceuticals to reach patients in need, but they do little to make such medicine affordable for everyone as a public good. In fact, BMS was one of 41 pharmaceutical companies that sued the South African government for producing lower-cost anti-retroviral pharmaceuticals.

Even though the AIDS Peace Corps and the BMS clinic partnership may be a corporate-driven, pharmaceutical-dispensing network, their organizers place emphasis on building local capacity for human resources for health. They encourage the training of locals on site as technicians and assistants, rather than recruiting Americans to travel to Africa.

In response to U.S. President George W. Bush's Emergency Plan for AIDS Relief (PEPFAR), the Institute of Medicine, a Washington-based policy institute, responded with the "Healers Abroad" proposal to establish a service corps that would travel abroad to provide treatment and pharmaceutical care, while training locals in clinical, technical,

and managerial areas (Mullan *et al.*, 2005). While this report stops short of suggesting the training of locals as physicians and nurses for long-term primary care is absolutely vital, it does argue for increasing local human resources for health in the developing South.

Overall, these programs may in the end do very little to improve COPC on the ground, and they may do much more to secure pathways for the distribution of unnecessarily expensive pharmaceuticals (Burnham *et al.*, 2004; Craddock, 2007). Still, it is important to note their emphasis on enabling locals as health-care workers, even if they are to function largely as assistants. Clearly the need for human resources for health is well recognized by a range of organizations and institutions. As sub-Saharan Africa would have to triple its current workforce and then train an additional million in order to meet acceptable doctor-to-patient ratios, the growing interest in strengthening human resources for health seems to be a timely initiative (Gorry, 2005b; Joint Learning Initiative, 2004). Indeed, it is well known that increasing human resources for health is a positive step towards increasing service provision, regardless of exactly what services are being provided and by whom.

Cuba has collaborated with dozens of national health authorities to try to address the insipid supply of human resources for health. As of 2007, Cuba had 41,000 international collaborators actively working in 97 countries, which included 31,000 health-care professionals working in 71 countries worldwide, from Europe to South-East Asia. Thirty-one African and 29 countries in the Americas were in receipt of some form of Cuban health collaboration. These initiatives included comprehensive health-care programs operating in 27 countries (CubaCoopera, 2007; Granma International, 2007).

Cuba has established numerous medical-education programs abroad, and has offered many scholarships for foreigners to travel to the country at little or no cost. It is a stridently different approach to international health collaboration in that it is free of corporate interests or philanthropic mandates. Unlike the corporate-driven initiatives that target specific diseases and narrow-focused public health targets, the Cuban cooperation efforts focus on building primary care. It is believed that more advanced health calamities and complex public-health challenges can be more appropriately handled if the capacity for primary care exists in the community.

Perhaps one of the greatest differences between Cuba's approach and the other public-private initiatives mentioned here is that the former focuses on primary care, while many other strategies often remain limited to narrow aspects of health-care provision. Third-party organizations tend to focus their attention solely on malaria, HIV / AIDS, clean water, or some other disease-specific care strategy. Unlike many international aid strategies, ELAM's builds capacity through clinical practicum, and community-based educational experiences aimed at embracing overall primary care and broad local needs (Gorry, 2005b). Even the Walter Sisulu University in South Africa, a university aimed at providing low-cost higher education for students committed to rural development, employs Cuban doctors as professors and leaders in clinical practicum education. Cuban physician Mayra Garí commented to MEDICC³⁰ about the effectiveness of regional-specific courses saying that it "puts emphasis on the diseases that are important for that particular country and community...the students learn based on real cases [and] in that way are learning to apply knowledge in the medical context...then, when they go to the

³⁰ MEDICC is Medical Education and Cooperation with Cuba, an NGO out of Atlanta. They offer both news and scholastic publications on Cuban health care.

community or the hospital they know what to do, they become a lot more effective” (in Gorry, 2005b: 15).

In order to provide effective COPC, professionals practicing in remote and difficult regions must remain over extended periods – they cannot quickly flee, or break off relations after a set term. Not only have Cuban medical brigades remained in countries during times of violence or conflict; they have also focused on building sustainable health-care networks by training locals as health professionals for the long-term. For COPC to succeed in marginalized areas, health professionals cannot be in a continual state of transition, as the practice of constantly recycling personnel does not allow for the establishment of long-term relationships.

Cuban medical internationalism is well equipped to deliver COPC as according to Manuel Torigo, director of cooperation at MINREX, Cuban-trained physicians enjoy an ethic that is about [meeting the needs of] the patient rather than the disease. Cuban-trained physicians aim to serve marginalized communities over many years and even decades, rather than through intermittent campaigns. Moreover, Cuban doctors are qualified to train up to three students from the local community as assistants while working on an international brigade. In Cuba, or in other countries, Cuban medical instructors train students in the clinic so that they can develop skills through experience in the clinic, rather than through memorizing lecture notes.

This approach of training students in the clinic, called *morfofisiologia*, is at the heart of the Cuban approach. In addition to the ELAM students in Cuba, students receiving medical training from Cuban physicians abroad spend 70% of their instructional time in the clinic and only 30% in the classroom. Torigo notes:

A lot of students would try to improve their own material situation in which they were raised. But if we prepare them there with the doctor in the community, first of all, we have not removed the student from his environment, and the people around him begin to identify him through the rounds of the physician. It builds better trust.

Torigo contends that developing institutional ethics based on practice gives students clinical experience, and the confidence that they can make a real impact in their own communities. Not all ELAM students will have the opportunity to train in their home communities, but they will have the chance to train at clinics within communities during their education.

Long-term primary care, rather than temporary relief, is the goal of Cuba's foreign cooperation, but MINREX admits that it does not regard its presence abroad as something permanent. Ten years of medical internationalism in Haiti and Central America may seem like a permanent fixture, as does the lengthy presence of the Henry Reeve brigade in Pakistan and East Timor, but the end goal of these campaigns is for locals to take over. In order to facilitate this goal, Cuba looked beyond traditional medical training, as Torigo argues, because the traditional in-class school does not graduate students at "the rate and speed" that is truly needed.

Clinical and community-centered approaches are emphasized by the WHO in order to establish a workforce for equitable primary care (The World Health Organization, 2006). The Cuban approach is aimed at improving general health and well-being, rather than merely donating siloed treatment and diagnosis for specific disease agents. A careful examination of the ELAM pedagogy will better explain this point.

Who is ELAM?

It is difficult to know the exact number of ELAM students, although as of November 2007, the number of registered students was 8,637. The school is in a constant state of flux, so to speak. While the semesters have scheduled dates to start and finish, some students enrol late, or take leaves of absence. As well, MINSAP and MINREX continually expand their scholarship offers to countries like Pakistan, where 1,000 ELAM scholarships have been offered, or to East Timor, where 800 offers have been extended. Some students who have already received some medical training in their home countries may be able to fast-track into Years 3 or 4. These fluxes are relatively minor. However, the larger group of pre-med students complicates drawing a demographic ELAM map by year and country. Pre-med can entail one or two years of study, depending on the student, and it can also include time for intensive language training as well. It is a time to offer assistance to the students to ensure that they have an appropriate toolkit to engage in the six-year program. Some students complete ELAM's pre-med requirements within six weeks, and others can go well into two years. With 1,477 students registered in pre-med in 2005, and 1,016 registered in 2006, it makes for a sizeable portion of the student body that have yet to fix an exact graduation date.

The school's population peaked in 2005 at 11,000 students. Until 2005, ELAM was only absorbing students and had yet to produce graduates. By 2007, with over 4,465 students graduated and 11,500 having participated in the program, others had left the program without graduating, unable to remain in the program or unable to pass through the curriculum. Still, based on data from MEDICC and from MINSAP, it is possible to give an accurate impression of ELAM's demographics for 2005-2006.

As of July 2006, ELAM was comprised of about 9,970 students from 28 different countries. The ELAM campus housed 3,891 students in pre-med, Year 1 and Year 2. The *Facultad Caribeña de Santiago de Cuba*, ELAM's campus in Santiago, receives only francophone students, and housed 348 students from Haiti, Mali, Djibouti and Guinea Conakry in pre-med, Year 1, and Year 2. *Facultad Caribeña* also received 663 students from these countries studying in Years 3 to 6, for a total student population of 1,011. The 5,038 ELAM students in Years 3 through 6 are trained alongside Cuban medical students in 13 separate faculties of medicine across the country, in addition to eight facilities in Havana. ELAM students constituted roughly 90% of Cuba's total of 13,000 international medical students. Medical students not affiliated with ELAM come from around the world, including Europe and Asia. In total, foreign students from 83 different countries are in Cuba studying to become health professionals (Cuban Embassy in Jamaica, 2007). Not every international medical student in Cuba is studying through ELAM. For example, special bursaries for 400 Jamaican students, 138 of who are studying medicine, are not a part of the ELAM project.

About half of the ELAM student body studied in Havana province in 2006. The largest concentration outside Havana was in Villa Clara, with 764 students from a various countries such as Mexico and Nigeria. Camaguey also housed 681 students, while Cienfuegos and Sancti Spiritus, two faculties that received students from Ecuador, received 242 and 155 respectfully. The smallest concentration was in Guantanamo with only 43 students. In 2006, 150 students from Guatemala, 80 from Honduras, and 70 from Haiti completed their sixth year of training in their home communities working alongside pre-existing Cuban medical brigades.

The first graduating class provides a fitting representation of students by gender, age, and race. In the initial graduating class of 1,610 students from twenty countries, the average age was 26. Women constituted 45.9% of the class, and 33 different indigenous cultures could be identified. Seventy-two percent of students were identified as being from rural, or economically marginalized, families.

ELAM accredited 74% of the 2005 class (1,143 students) as having "*un alto rendimiento académico*," meaning that two-thirds of the class performed well above passing standards, and 12% of the class received the *Título de Oro*, Cuba's highest award for excellence in medical education for those who retain an 84.7% average from inception to graduation. Unlike most medical schools, according to two students from the United States, ELAM is not set on creating bell curves. "We could all pass, we could all fail. We're not compared to each other here," said a student from Oakland, California.

In 2006, for all of the medical faculties, including the *Facultad caribeña de Santiago*, the ELAM population by year was 1,697 in Year 1, 1,526 in Year 2, 1,316 in Year 3, 1,539 in Year 4, 1,564 in Year 5, and 1,424 in Year 6. In 2006, ELAM also had about 644 students from 18 different communities in Ecuador. Again, these numbers are not static, and are essentially a snapshot of the program in 2006, but they still tell a particular story of who is attending the school, and how many students are involved in the project. While this dissertation is principally concerned with the 54 students who graduated in 2005, it is worth noting that in 2006, ELAM's Ecuadorian population had about 97 in pre-med, 91 in Year 1, 98 in Year 2, 123 in Year 3, 113 in Year 4, 64 in Year 5, 58 in Year 6. The student population, once heavily concentrated in Central America, the regions devastated by Hurricane Mitch, is now experiencing a higher intake from

South America, including Ecuador. In 2006, 699 students from the region affected by Mitch graduated ELAM, while only 284 were in first year, and another 291 were in pre-med. In 1999, Argentina, Bolivia, Brazil, Uruguay, Paraguay, Ecuador, and Panama boasted about fifty graduates each. However, in 2006, the intake from these countries had doubled, with about 100 students in first year from each of these seven countries, encompassing about half of the first-year student population.

The reason for the 2006 decrease in enrolments among Central American Countries, is, in part, due to Cuba increasing the number of scholarship offers for students from South America. In Ecuador alone, the number of ELAM scholarships offered has doubled from 500 in 2005 to 1,000 in 2007. At the same time, the total number of students from all countries has gone down from about 11,000 in 2005 to 8,637 in 2007. Indeed, ELAM is not recruiting thousands of students from Central America alone. The initial post-Mitch intake has decreased, and now other countries are participating more in the program. This is likely due to two factors. First is the difficulty in recruiting students from marginalized corners of Central America. High-school (*colegio*), let alone post-secondary education, is a rarity in countries like Honduras, and there simply are not enough students from modest means who meet the minimum educational level for ELAM. Second, intake increases in South America can be attributed to the warming of political relations between Cuba and some countries, and active recruiting by grassroots Cuban solidarity organizations. In Ecuador, the initial recruitment in 1999 saw only a few dozen applicants. Today, due to greatly increased demand, only one of three applicants is accepted to ELAM. The increase of scholarships and the dissemination of information about the program to young students through

solidarity organizations, such as *El Brigada Eloy Alfaro*, have radically changed the recruitment process in countries such as Ecuador.

Another noticeable phenomenon is the increased Venezuelan student population, which had only 50 students arrive at ELAM in 1999, but saw its enrolment more than double in 2002. The overall increase in enrolment is the result of close political relations between the Cuban and Venezuelan governments since 2002. Increased enrolment to ELAM, *Mision Milagro* and the *Barrio Adentro* program are all products of this relationship that was formed through pan-regional agreements in CARICOM. But, today, no Venezuelans are enrolled in ELAM's pre-med program. The disappearance of Venezuelans from pre-med is a direct result of the *Barrio Adentro* program, which not only has received over 19,000 Cuban health professionals to work in the slums of Caracas and in some Venezuelan rural areas, but also trains young Venezuelans in pre-med and the primary years of medical school. Venezuelans destined for ELAM begin their medical education working alongside Cuban doctors in their communities and, in later years, have the option of transferring to ELAM. The *Barrio Adentro* program affords Venezuelans the chance to begin their medical education through clinical practicum education within their own communities.

The one country with a noticeably low ELAM intake is the United States. With 500 scholarships offered to American students since 2001, just over 100 students have come to ELAM so far. The first group arrived in 2001, comprised of 89 students from 15 different locations. In 2002, after the U.S. Department of State and the U.S. Treasury Department threatened American ELAM students with \$40,000 fines and a possible sentence of four years in federal prison, all of the eighty-nine students returned home, as

ELAM allowed them to take their exams early in order to ride out the political turmoil from Washington. However, 24 from the original intake of students did not return to ELAM. Nevertheless, enrolment continues to trickle on. As of 2006, 20 students were registered in their first year, and another 8 were taking pre-med. Three hundred and eighty three scholarships are still available from Havana's original offer in 2000, a point that dumbfounded Fidel Castro. In 2006, in a meeting with MEDICC, the Cuban President could not understand why all of these scholarships had not been claimed.

Aside from the political tension, linguistic barriers and prolonged separation from their homes, and as a result of Washington's embargo against Cuba, U.S. students are also required to have completed at least a college-level diploma. While most ELAM students are permitted into the program with only a high-school degree, the directors found that the pre-med curriculum was too advanced for American high-school graduates and, as a result, the program requires candidates from the U.S. to have some advanced education (MEDICC, 2007b). While this can be seen as an additional barrier for American students, it can help to fast-track some, such as Cedric Edwards, who came to ELAM in 2001 and graduated in 2005. To date, ELAM has produced 9 U.S. graduates, with 1 graduating in 2005 and the rest in 2007.

Recruitment:

It is no easy task to seek out and recruit thousands of dedicated students from over two dozen countries. During my attendance with the MEDICC delegation in 2007, one doctor asked Rector Juan Carrizo how ELAM is able to recruit individuals who want to return to their home communities rather than seek out lucrative gains. The Rector replied that the students come with convictions to serve the poor; they have come from humble

means, and when they arrive at the school, ELAM reinforces their ethical foundation of service and humanism so that upon graduation they will focus on their community's health-care problems before any individual monetary gain. Among countries, the recruitment process of ELAM students differs and continues to evolve. Applications to the program are ultimately handled by the Cuban embassy in each country, and qualified applicants are then sent on to ENSAP for final approval. In Ecuador, during the first years of recruitment, students applied through the *Colegio de Medicina - Pichincha* in Quito, which then forwarded their files to the Cuban embassy, who then made the final decision to send on the applications to ENSAP. Jacqueline Rios Mateus (who was introduced at the beginning of Chapter 1) was one of the initial recruits from Ecuador. She, along with her colleague, Dania Suarez, had been in medical school in Quito, but due to the growing costs of living in the city, they were uncertain as to whether they would complete their program. As with most of the Ecuadorian ELAM students in 1999, they had heard about the program through friends or various radio programs. "There was not a lot of public advertisement about this program," Jacqueline said. They both told me that they had an interview with a member from the Ecuadorian Ministry of Public Health and a representative from the Cuban embassy. They presented a portfolio of their credentials, and then received the call to go to Cuba a few weeks later.

Of the ELAM graduates with whom I came into contact in Ecuador, all could be identified as coming from modest to humble means. The students I interviewed came from across the country,(Dania Suarez came from Ambato, Fany Guamán came from Loja, Arlena Rodas came from Zamora, Jacqueline Rios came from Santo Domingo, Maria came from Quito, Ricardo Carrión came from Quito, and Elizabeth Gallo was also

from Quito). All of these graduates, except for Fany, had some medical training at the public universities in Ecuador before moving to Cuba. Fany came to ELAM immediately from a *colegio*. Maria and Fany told me that their parents were both active members of left-wing political parties and, in fact, Maria's father ran in the 2006 national election as a delegate for President Correa. None of them came from indigenous communities; however, in later years, indigenous people from Ecuador became an increasingly large percentage of the ELAM intake. Alicia Cheila, a Quichua woman from Bolivar, told me that her sister was at ELAM, as well as many of her other Quichua friends. Admittedly, my contact group in Ecuador is not representative of the indigenous diversity at ELAM, but the students with whom I met in Ecuador were well educated, and all expressed an inability to pay for a medical education in Ecuador.

Currently, the embassy handles applications directly and rapidly. While waiting in the lobby for an audience with Cuban diplomatic staff, I met Saskia Nuñez Valverde. She was nervously awaiting a meeting with the embassy staff to determine if she would be accepted to ELAM. She said that she had sent in her application earlier, and the embassy had requested a meeting. She heard about the program through a student organization at Quito's Universidad Central. I asked her if I could contact her again about the application process. She agreed to a more formal meeting, but before we could get together, she was on a plane for Havana. She left within three days. The ELAM semester was already in progress, so she joined the program slightly late. On that Tuesday, she was unsure whether or not she would be heading to Havana and, by Friday, she was on a plane. Saskia's departure is an example of ELAM's rapid acceptance process. Another student, Albania Gabrielo Tamayo, said that her interview took place

on April 23, 1999, and on May 8 she was in Havana. This quick turn-around time not only demonstrates the students' eagerness and readiness to depart to Cuba on a moment's notice for a six-year commitment, but also the capacity for ELAM to receive and accommodate the students quickly.

Cuban solidarity organizations, as well as labour movements and leftist political parties in the student's countries, assist in the application process by disseminating knowledge, recruiting students, and helping them with their applications. The involvement of these organizations can have a filtering effect on the applications that are received by the embassy, as applicants from more humble backgrounds, indigenous communities, and rural areas may have better access to such groups. In countries such as Guatemala, Honduras, and Nicaragua, existing Cuban medical brigades help to coordinate applications to the embassy. This is a highly effective recruitment process, as the Cuban medical brigades are already in contact with some of the most humble and needy communities.

In the United States, the application process is handled through the religious organization, "The Interreligious Foundation for Community Organization" (IFCO), more commonly referred to as Pastors for Peace. This organization, directed by Rev. Luscious Walker, volunteered to help with the selection process of all U.S. applicants to ELAM. Moreover, the IFCO, in cooperation with MEDICC, conducts follow-up and offers support for U.S. students at ELAM.

The process by which applications arrive at Cuban embassies is far from standardized, and there is no consistent gate-keeping strategy in place. The one common attribute in the selection process is that most successful applicants should be from modest

means, be between the ages of 18 and 26 (30 for U.S. applicants), be physically and mentally fit, be free of any criminal record, and be willing to practice medicine in underserved communities in their home country. Students who are financially incapable of obtaining a medical education in their home country are favoured. So, too, are students who represent indigenous or minority communities. While a high-school education is required, many ELAM students have received some post-secondary training in their home country. Some students hail from the most isolated regions of their country; others come from the cities.

The definition of humble and needy is loosely defined. In the first stages of the application process in Ecuador, when few knew about the initial 500 scholarships, many applicants could be considered struggling financially, but were by no means destitute. According to Ecuador's embassy in Havana and Cuba's embassy in Quito, since Cuba has offered an additional 1,000 scholarships to Ecuador, and the total number of applicants has tripled, the Cuban embassy has begun to give much more consideration to applicants from indigenous communities, and of truly humble means.

Students who can demonstrate a willingness and ability to return to humble communities stand a good chance of receiving an ELAM scholarship. A student from a humble background who is set on furthering his personal wealth through a medical education would stand less chance of receiving a scholarship than a student from Quito, dedicated to serving indigenous communities in the Amazon.

While embassies are ultimately responsible for sending the *carpeta* (file) on to Havana for final consideration, groups like the IFCO, solidarity brigades such as the Eloy Alfaro Brigade, socialist political parties, and universities all have the task of

disseminating knowledge about ELAM. They are not necessarily gatekeepers per se, except for the IFCO which has the responsibility of directly selecting applicants. Nevertheless, these organizations are more likely to come into contact with applicants sympathetic to Cuba, and who can identify with the social and economic conditions of the marginalized. Spreading the news of ELAM through solidarity groups, political parties and left-wing media narrows the application pool, and the majority of would-be applicants set on using a free six-year degree as a platform for personal gain and fortune are largely filtered out. Profit seekers do not listen to such media, I was told.

On the Other Side of the Desk:

Students are not the only ones who constitute ELAM. ELAM's faculty is comprised of 466 doctors who have had extensive teaching experience, and most have practiced overseas on medical brigades and through cooperation efforts. Teaching at ELAM is considered a prestigious posting for Cuban faculty. Rector Juan Carrizo Estévez claimed that elite faculty come to ELAM: "The best professor of anatomy will teach to a thousand students." The school boasts some of the most highly-decorated researchers in medicine and science in Cuba. Dra. Estrella Rubio Bernal, for example, is professor of biochemistry at ELAM, and was awarded in 2000 the *Premio Annual de la Salud*, one of Cuba's top honours for health research (ELAM Web, 2007b). Another recipient of the same prize was Dra. Lidia Cardellá Rosales, professor in biochemistry and biological sciences. She has published various books and articles on biochemistry and general medicine (Cardellá Rosales & Hernández Fernández, 1999; Valdés Moreno *et al.*, 2002), and is an active researcher with the Cuban Association of Physiological

Scientists (ACCF). She is one of Cuba's most renowned biochemists. Indeed, many ELAM professors are active in research and publication alongside teaching.

All of my ELAM student interviewees expressed a great deal of satisfaction, not only with the thoroughness of the pedagogy, but also with how available faculty were to them outside of class. The students that I interviewed in Cuba, as well as in Ecuador, also expressed much satisfaction for their relationships with faculty. Many said that it was normal to consult professors outside of class or office hours in order to seek additional help. "They want to see you pass and do the best that you can," a student from the United States commented. "I mean you'll have the top researcher in biochemistry, or someone with experience in other countries, as your teacher," Greg Wilkinson told me. "The professors teach us in a way that emphasizes achievement...if you have an exam coming up, the professors may stay late conducting a review, or even come on a Saturday or Sunday if you need extra help," said Eugenia Amaralle from Argentina (Giraldo, 2007b). Moreover, students felt that they could form personal relationships with the faculty, as class sizes at ELAM and in its partner universities, are very small and intimate. Class sizes in Years 3 through 6 ranges between 4 students to 15 students per group. This is due in part to the heavy emphasis of students working in clinical settings rather than just sitting in lecture halls to gain their clinical competency.

Students did not give the impression that classes were informal or contact with faculty was lax; rather, they expressed how comfortable they felt in interacting in a professional relationship with their teachers. "The Cubans are no jokers," commented Abba Hydera, a Gambian student working alongside doctors in that country, adding that "they taught us never to take anything for granted; to study and be disciplined; and their

system was very good for us since it includes almost weekly evaluations. That kept us on our toes” (Gorry, 2005b). Back in Cuba, two Costa Rican students told me that their professors were friendly, but strict. They are very thorough, they said. They said that if they needed help the professors would provide it. But, as they mentioned, the professors would not lower their standards to see a student pass. “You have to know your material,” they said.

Preparing doctors in science, humanism, ethics and solidarity begins in the classroom. For ELAM to produce a “new kind of doctor,” a special kind of professor also is required. Specifically, ELAM’s faculty are evaluated on their ability to involve students in the learning process. ELAM’s vice-director, Midalys Castilla Martínez, emphasizes that the instructors have a teaching ethics to students so that they feel that they are involved (Sariol, 2005). Participatory teaching practice shows students that they are more than able to successfully use their acquired skills. It is an important part of the pedagogy, considering that many students have come from overwhelmingly poor conditions, and are expected to return to them, not merely to cope, but to create improvements. For Castilla Martínez, an inadequate professor would throw too much information at a class all at once. Such methods “lose the motivation of the class” (Sariol, 2005). ELAM professors need to connect with students who have traveled from afar, who have remarkable differences in cultural and educational backgrounds, and who may feel daunted by their perceived personal shortcomings.

Besides the mandate to inspire students, professors who have an ongoing experience practicing in other research, education or assistance centres are sought by ELAM. “Many of our professors are adjunct with other institutions,” says Castilla

Martínez. “The ideal professor will be excellent in scientific and professional aspects, but also it is vital that s/he will be an ambitious educator. If s/he does not have a spirit of service then s/he will not be able to connect with the students” (Sariol, 2005). This type of connection – not just leading by example, but bestowing confidence in the student – creates doctors dedicated to serving communities, which is the ultimate goal of Cuban health care (Alemañy Pérez *et al.*, 2002). This is a crucial role in building institutional ethics and good sense.

In Cuba, medicine treats the patient before the disease (Gorry, 2005b). This is a professional ethics that ensures scientific rigor in medicine is used to meet the needs of the patient rather than just the disease. Medical schools can often professional protectionism through specialization, advanced training in research, and elite networks for physicians to join (Boulet *et al.*, 2006; Hallock *et al.*, 2003). The Cuban approach values scientific integrity, as the best researchers are highly commemorated with honor and title, and yet they are not divorced from service to the community. Abba Hydera commented to MEDICC,

What I’ve found is that practicing in a developing country is not easy. It has its limitations. The facilities for sophisticated diagnostic equipment often don’t exist, for example. But if we can make a diagnosis based on a detailed clinical history and a thorough physical examination - which is true for 85% of cases - then we even have an edge over students trained in Western Europe or the States. And that’s what our training concentrates on (Gorry, 2005b).

Hands-on, intensive diagnostics and treatment is at the heart of the Cuban approach.

I joined Dr. Alfredo Espinosa Brito, *Profesor Titular y Consultante de Medicina Interna,* at the hospital “*Dr. Gustavo Aldereguía Lima*” in Cienfuegos, Cuba. We met at the Cienfuegos hospital to catch up with Ecuadorians who were studying in their 3rd and 4th year of the ELAM program. Espinosa believes that “for medical students, daily

patient visits are an essential activity to build knowledge of the clinical setting,” and to also ensure the ethical daily contact so important for a patient in secondary care. To underline this point, Espinosa invited me to the Cienfuegos hospital to witness, first hand, the interaction of students with their professors and with their patients. Cienfuegos hospital has 120 residents in more than 30 specialties, and offers 71 post-graduate courses. It is responsible for a population of about 400,000 people. In 2006, the hospital received 242 ELAM students for upper-year training, along with an additional 50 foreigners on other scholarships.

After a brief interview in his office, Dr. Espinosa showed me around the hospital. Lecture theatres were modern, well lit, and equipped with power-point and other audio-visual devices. Interestingly enough, many of the classrooms could hold no more than 15 students. They were purposefully designed, according to Dr. Espinosa, for small class sizes and close student-to-teacher ratios. We then moved to the upper floors where students were consulting patients. In groups of no more than 15, Cuban and ELAM students accompanied one professor and an assistant to various beds to diagnose patients, discuss their ailments, and confer over their treatment. There was little doubt that the patients staying in the hospital were definitely in the aforementioned 4th category of health, “ill with consequences.” Some critics have argued that Cuban hospitals are grim places with patients close to death’s door. “Hospitals are not for the healthy,” Espinosa said to me. Considering that the Cuban approach places as much time and attention to the patient in his / her own living environment rather than in the hospital, this would particularly make sense. As depressing as the patient wards were, with so many terminal

patients, the infrastructure was in no way deplorable, four beds to a ward, plumbing, some air conditioning, and good lighting.

Comfortable conditions indeed, but the patients in the ward were in bad shape. And yet a nurse, student, doctor, or relative was by almost every bed doing something for someone. For some, a nurse, others a doctor, and others had family present. Seeing the seriously infirmed, the debilitated, and terminal patients in this ward was depressing, but it is often the story of any hospital anywhere. What I found unique was a sense that no one was left alone; no one was ignored or forgotten. Moreover, the ward was active with students and interims. “We have a lot of students here every day; it is an active place,” commented Dr. Espinosa.

“Let’s go to a much happier place,” he said. “This is my favorite part of the hospital.” We journeyed up to the maternity ward on the sixth floor. In that ward, there were not as many medical students as there were nurses and nursing students. Clean and bright, the maternity ward had recently received about a dozen new and expecting mothers.

Leaving the maternity ward, we returned to the main ward and managed to have a brief conversation with a third-year student from Quito, who said that the teaching environment in the hospital was very inclusive. Andrea was 22 years old and had experience working with indigenous communities in Ecuador. She came to ELAM with the intention of eventually working in Ecuador’s Amazon. I asked her if she had ever been to la Joya de los Sachas. “That’s where I want to go,” she replied. Commenting on the diversity of students from Argentina, Chile, Paraguay, Uruguay, Colombia, Brazil, Venezuela, Peru, Ecuador, South Africa and the Caribbean, she did not feel out of place.

The small class sizes, but even smaller working groups, gave her ample attention from her teachers. She commented on how there was also a chance to consult with faculty and other doctors, and that a strong network among the students made for a positive learning environment. She dwelled on how much time could be taken with faculty. Indeed, close contact with faculty seems to be the norm in Cienfuegos as, during that morning, Dr. Espinosa was sidetracked twice by students and residents seeking advice. Close contact with instructors and learning in the clinics seem to play an important role of building confidence and ethics in this empowerment process.

ENSAP purposefully encourages, in all of its campuses, close contact between student and faculty. As Rojas Ochoa (2003) argues, since 1962 Cuban universities have continually reformed their curricula, making higher education a participatory space rather than just a space to receive knowledge. Courses are divided into lectures, seminars, practical classes, and “education through work” that focus on in-clinic training. For lectures, ENSAP permits class sizes of 10 to 64 students, with the philosophy of health having the highest number of students, while “society and health” along with “hygiene and epidemiology” are the two smallest classes (Rojas Ochoa, 2003). The smallest seminar is “health administration” with a set limit of 9 students. The largest seminar, psychology, has 25. Practical classes do not have more than 25 students, and the class on society and health has only two students per instructor. “Education through work” is conducted with one or two students to cover themes in general integral medicine, hygiene and epidemiology, and administration of health. Class sizes are particularly small throughout the Cuban curriculum. However, the very small class size of one or two students for topics like society and health demonstrates, as I see it, the heightened

importance of this subject material for ELAM. Society and health covers topics that deal with health promotion and disease prevention in the community. It is a class loaded with COPC values, as it encourages building up the health of communities and patients, beyond just treating diseases. Rojas Ochoa (2003) claims that it is still a work in progress, in that even further attention could be paid to public health in such classes. Certainly further time and attention to public health would be beneficial, but the one-on-one class setting lends itself well to instruction on community-orientated health care.

Curriculum:

While small class sizes provide an appropriate space for participatory learning and dedicated instruction, what actually is taught within the classroom is equally important in developing community-orientated ethics. The cornerstone for the Cuban curriculum is the two volume set by Alvarez Sintes (2001), *Temas de Medicina General Integral* (Themes in Integral General Medicine). Every ELAM student receives a copy of this text, and while the school has an extensive library, these two books are the ones that students are expected to keep close at hand during their studies and afterwards into their practice. The emphasis is on the social and environmental determinants of health, as well as epidemiology. The value of disease prevention and health promotion is clear throughout the text, as many chapters inform students as to what most constitute health risks in the community. Chapters such as community health, epidemiology in primary care, demographics, communication, and research methods have a dedicated focus on how to recognize and measure health determinants at the community level.

The first two chapters of the text are dedicated towards understanding how public health operates in Cuba. As Cuba employs an extremely integrated and inter-sectoral

health network, it is important for students to understand how primary care requires the exchange of information and broader support from other sectors and actors. Of the fourteen chapters in Volume I, only five could be regarded as dealing specifically with core clinical competency: health, integral attention to health, family attention, primary care in health, and information on the health sciences (Álvarez Sintes, 2001). This is to say that the majority of the text is either dedicated entirely to, or influenced from, community-orientated care. “You study the health of the community, before health of the individual,” commented a former Mexican student who spent two semesters at ELAM.

The second volume focuses on epidemiology. Indeed, it is a slight departure from most medical schools that dedicate only a few hours of attention to community health and epidemiology. Compared to North American medical programs, as innovative as some are, the Cuban approach focuses directly on the community level before addressing disease at the individual level. The second volume covers various health determinants, ranging from accidents to infections, cardiovascular disease to nutrition. The focus of the second tome is to train students to be able to successfully identify at risk or higher-risk patients in the community. Identifying working conditions, living conditions and lifestyle choices are all part of approaching health through the lens of disease prevention and health promotion.

Another approach in this core curriculum is the time and attention dedicated to TNM. The Cuban approach encourages the adoption of alternative therapies and healing. For example, many Cuban doctors take some acupuncture training during their medical degree. As for the ELAM students, it is understood that many will return to indigenous communities where Shamans are often the most trusted community health providers.

Rather than reject alternative medicines, Cuban medical education embraces them. Alternative medicines are a means of understanding natural forces that influence the health of individuals. This philosophy does well to develop more appreciative routines of disease prevention, health promotion, and rehabilitation into modern health-care systems (Bosch Valdés, 1999). MINSAP actively encourages continued research into, and professional development of, alternative medicines. They propose to “increase the knowledge, and existing uses, among medical technicians and professionals, about TNM” (MINSAP, 2007a). The adoption of TNM into the curriculum has two benefits. First, it gives greater attention to holistic disease prevention and health promotion using available and low-cost resources. Second, it affords physicians the chance to sensitively appreciate and accept non-Western approaches to health. This is often a very important aspect of building COPC in indigenous communities in South America, as more often than not tensions exist between the Western and alternative models of health-care provision.

While *Temas de Medicina General Integral* is the foundation of ELAM curriculum, the classroom builds on these themes to deliver a multifaceted approach to medicine. In the classroom, students are exposed to population health principles, disease prevention, and clinical medicine (Frank & Reed, 2005). Roughly 17% of all in-class hours in the six-year ELAM degree are dedicated to public health, while only 14% of class time is dedicated to primary care. Clinical skills are mainly acquired in the field and clinic rather than in the class. Of the total of 9,521 hours of class time that goes into a Cuban medical degree, 1,584 hours are dedicated to in-class instruction on public health, and 1,388 hours are set aside for in-class training in primary care (MINSAP, 2001). In Years 1 and 2, the number of in-class hours devoted to public-health issues is more than

double the class time spent on core clinical skills. In Year 1, students spend 274 hours on public health and only 154 hours on primary care, and in the second year, students dedicate 108 hours to public health compared to the 76 hours of primary care (MINSAP, 2001). Certainly these themes can blend, but throughout the process, COPC is strongly valued.

Working in the clinic, students are supposed to develop their clinical competency through experience. In the lecture hall, instruction deals with public-health themes alongside traditional scientific curriculum. MINSAP claims that primary-care pedagogy is not equal across the country, as some centres, such as those in Havana, are better equipped to train students in the clinic, while others, such as those in Guantanamo, require further materials and human resources. Also, MINSAP suggests that more time should be given for primary-care instruction in *polyclínicos*, as they combine spaces for practicum-based and class-based learning (MINSAP, 2007b).

While the amount of time dedicated to public health is impressive, and clinic-based learning in primary care continues to advance, it should be noted that training in essential medical sciences commands a sizeable place in the curriculum. The conditional two years of pre-med training is almost entirely dedicated towards building competency in basic sciences and language skills. Meticulous instruction in biomedical sciences continues throughout the program. In Year 1, students cover anatomy, histology, embryology, metabolism, cellular and molecular biology, and medical informatics. Other courses such as the history of medicine, English, and physical education are integrated into the curriculum alongside medical science courses. In the first year, 26% of class time is dedicated to public-health themes, and about the same amount of time is allotted for

courses such as English and physical education. The other half of class time in Year 1 is dedicated to medical science.

In Year 2, the hours dedicated to public health are cut by more than half, and while there is a reduction in overall class time, about 80% is dedicated to medical science (Frank & Reed, 2005). In Year 2, students spend a greater amount of time in the clinics and in small seminars.

In Year 3, when ELAM students join Cuban students in the 13 participating medical schools, almost all class time is dedicated to medical sciences such as pharmacology and internal medicine. Two courses in English are also offered in Year 3. English is taught throughout the program so that students can build competency in English medical terms, which will allow them to read the vast majority of medical literature. However, most of the ELAM students I encountered, except for those from Belize and the United States, still did not command a strong oral competency of English.

In their third year, ELAM students go out into communities across Cuba. They assist physicians and nurses with house calls and participate alongside community health teams and family doctor-nurse teams. At this point, students are given the opportunity to use their multi-disciplinary training to develop community health maps. Through in-house and worksite visitations, the ELAM graduates map out health information about the community. This includes core demographic data, vaccination records, common accident patterns, common communicable diseases, common chronic and degenerative disease, and various risk indicators. It is a skill that builds community-based learning, and participation, and provides a rich understanding of health at the community level. Community health maps are an important part of Cuban health care, as they provide

physicians and nurses with a sound knowledge-base to implement effective disease prevention and health promotion routines based on the data they collect.

Year 4 sees a return to in-class instruction in public health, with 234 hours dedicated to it, mostly through comprehensive general medicine and disaster medicine. Exactly the same amount of time, 234 hours, is dedicated to in-class instruction on primary care. Again, during this time students spend a lot of time working in hospital clinics, and working through practical classes and seminars.

The first semester of Year 5 (Semester 9) is almost entirely dedicated to public health, health promotion, and disease prevention. In fact, 548 hours are dedicated for covering topics such as comprehensive general medicine, public health, psychiatry, disaster medicine, and English. However, Semester 10 offers a heavier biomedical focus, with courses in otorhinolaryngology,³¹ urology, orthopedics & traumatology, ophthalmology, dermatology, forensic medicine, ethics, alternative medicine, and English.

Year 6 is almost entirely dedicated to working internships. The year breaks down into a rotating pre-professional practice – with ten weeks for internal medicine, ten weeks for pediatrics, seven weeks for obstetrics and gynecology, seven weeks for surgery, seven weeks for comprehensive general medicine, and four weeks for licensing exams. Many Haitian, Honduran, and Guatemalan students return to their home countries to intern alongside Cuban medical brigades. Knowing that the realities of practice in Villa Clara are different than those of the Guatemalan highlands, ELAM encourages students to join the medical brigades for two reasons. First, it is a chance for the student to connect with the community and to foster relations so that they can eventually return after graduation.

³¹ Otorhinolaryngologists are more commonly known as ear, nose and throat specialists.

Second, it prepares students to work under conditions of poor infrastructure, hostile politics, and non-existent information networks. Cuban physicians enjoy a tremendous amount of institutional support, and even on international medical brigades they are afforded some level of resource support from the recipient country. However, most ELAM graduates will have to find ways to reintegrate into their local health systems alongside nationally-trained physicians.

Reintegrating graduates is a concern for ELAM. The program of study is designed to afford graduates a level of professional competency in clinical practice so that they can pass any qualifying exam in any country. The WHO and PAHO both recognize ELAM as an accredited medical institute, and any State licensing board should also recognize the merit of the program. However, this does not guarantee that all ELAM graduates will be employed after graduation. Even Rector Carrizo recognizes the challenges, and admits that Cuba is hardly in a position to remedy the politics of licensing foreign health-care systems. ELAM's role is to build good sense at the individual level, not at the administration level within foreign systems (Frank & Reed, 2005). Political and infrastructural hurdles are in large part out of their hands.

Despite the looming challenges of reintegration, ELAM is steadfast in training doctors with the appropriate skill set to meet the needs of the indigent. From a review of articles and policy papers, published between 2001 and 2007, on curriculum reform and development on INFOMED, a majority of them called for greater attention to community health, and modifications to curriculum that emphasize connections between individuals and their lived societies. Even some of the most "pure" medical sciences, like histology and physiology, called for greater understanding of the place of the individual in society.

From coding these articles for community health and social determinants of health, a general theme of emphasizing social determinants of health emerges even within supposedly strict scientific topics.

Cuban medication education goes past siloed learning, and embraces interdisciplinary routines. The connection between science and nature is not a radical innovation, but a continuation from nineteenth-century discoveries of energy transformation, cellular theory, and evolution theory. According to Rosell Puig *et al.* (2005), morphology, as it is taught today, is based on these three theories that are, in themselves, connected to nature and society. As Rosell Puig & Paneque Ramos (2007) argue, changes in society have significantly influenced the teaching of medicine. They regard pedagogy as socially constructed and during the twentieth century, teaching habits typically became increasingly technical, from a colonial to a neo-colonial form of instruction.³² They consider post-1959 Cuban medical education as conforming to an alternative revolutionary framework that broke from the traditional paradigms. Under this agenda, scientific technology “reached out” towards humanity, rather than humanity serving technology (Rosell Puig & Paneque Ramos, 2007).

The *Revista Cubana de Educación Médica Superior*'s approach to physiology shows a clear appreciation for the connection between the individual and society. “The correlation between the biological and social has preoccupied researchers” (Barber Fox & Barber Gutiérrez, 2000). While physiology in the nineteenth century focused on the biological characteristics of the individual, today there is more than enough evidence to

³² By this I mean that medical education moved from a Eurocentric vision of medicine to one that emphasized advancements in health through technology, biotechnology and advanced surgical procedures. I call this neocolonial in order to suggest that other approaches to health and health care abound in the Americas, however many of the traditional and indigenous approaches to health care were discredited in the pursuit of scientific advancement in medicine.

show that the individual is intimately related to society, and the health of the individual depends greatly on the health of the collective society (Barber Fox & Barber Gutiérrez, 2000).

On the other hand if it is recognized that physical and chemical elements in nature exist, biological beings have a greater level of complexity. In the same way, individuals eat to be social, but there are implicit biological processes involved...therefore the health professional and in particular the physiologist will have to understand this interrelation of the biological and the social, not only to intervene on certain social factors that are causing some diseases, but also to understand that all disease has a social repercussion within the individual (Barber Fox & Barber Gutiérrez, 2000).

The Cuban approach to physiology, which is the study of mechanical, physical, and biochemical functions, requires professional training in these core relations, but also requires attention to individuals and their environments. The eating metaphor is important, because while the food itself can cause disease or improve health, the social settings within which this occurs are also as important. For example, if a person consumes pork, it is important to understand the metabolic chemistry in the process, but it is also important to know their modes of consumption – where, when, and how often. The health of a person who eats bacon rarely and in a sanitary environment would likely be different to that of a person who eats multiple servings of ham every day in a dirty environment. Understanding a person's health, beyond just elements of biochemistry, is an important epistemology for Cuban health-care professionals.

In Cuba there is a reform movement within the curriculum to show more evidence-based relations³³ between individuals and society. As Barber Fox & Barber Gutiérrez see it, the lack of evidence-based relations between individuals and nature

³³ A great deal of scholarship connecting individual health to social and economic determinants is done through identifying trends between populations and place. Epidemiology plays a major role in making these connections; however more evidence-based studies are sought within the Cuban curriculum to make direct connections between socio-environmental health vectors and health trends.

prevents a more social approach to physiology. The idea is to show how physiology should pay attention to social and environmental determinants that may impact mechanical, physical, and biochemical functions of individuals.

Approaching the health of individuals as part of broader society, even in a core medical science like physiology, indicates how the Cuban system is community orientated in its understanding and treatment of health. Scientific instruction is a rigorous part of the curriculum, and students are expected to develop a profound understanding of medical sciences. The students told me that they are rigorously examined on their knowledge of biomedical sciences. Sound knowledge of biomedical sciences is the fundamental cornerstone of medical education at ELAM. The scientific instruction offered at the school should not be seen as a radical departure from any other medical school found in the medical school directory of the World Health Organization (2007). ELAM encourages students to appreciate how physical, chemical, and biological relations exist between individuals and society. For ELAM, science is not divorced from public health or from social determinants of health. Rather, it is approached as an essential part of those broader themes.

Within Cuba, the product of this mixed-method training is especially in evidence through the role of family doctor-nurse teams. These doctor-nurse duos offer in-house services to all Cubans. They visit worksites and houses to identify potential health risks, ranging from poor environmental and living conditions to social determinants of health. This allows for doctors to build better understanding of community-level health patterns in order to develop strategies of disease prevention and health promotion. As well, the doctor-nurse teams provide basic diagnostic and check-up services. It is a mixture

between clinical “check-up” routine and active epidemiology. Patients are always within close contact of a health professional, and those professionals can develop appreciative diagnosis based on clinical diagnostics, and by witnessing broader social and environmental determinants. Social and biological determinants are equally embraced by the family doctor-nurse teams in order to identify risks and maintain health. But the question remains as to whether ELAM graduates, working outside Cuba, can find ways to bring such inter-disciplinary community-based methods to vulnerable populations lacking basic infrastructure.

The Student Response:

In 1994 – 1995, prior to the establishment of ELAM, MINSAP conducted a survey among students regarding certain disciplines taught in medical school. It focused on the community approach in the philosophy and practice of health care. Students were asked if they enjoyed classes, found the information important, and if they felt that it prepared them for practice. The survey covered the philosophy of health, biostatistics, psychology, hygiene and epidemiology, and comprehensive general medicine. On a scale of 1 (very negative) to 5 (very positive), the responses averaged between 3.2 and 3.8 for most of the classes. The exception was for comprehensive general medicine, a program of study that weighs heavily on community-orientated primary care, where the average student ranking exceeded 4, and 83% of students had a favorable impression of the course (Rojas Ochoa, 2003). This program is based on *medicina general integral*, from Álvarez Sintés’ (2001) text books upon which ELAM students continue to rely.

Indeed most interviewees for this dissertation and other publications from MEDICC show a sense of appreciation for the *medicina general integral* approach. Dr.

Cedric Edwards, ELAM's first graduate from the United States, commented to MEDICC that:

I received training here in disciplines like acupuncture, homeopathy and herbal medicine, which I didn't receive in the States, nor was I ever aware of it being an integral part of any medical school curriculum in the U.S. Also, in Cuba, there's more emphasis on community-based systems of care, preparation for international service, and disaster medicine - all of which seem to be lacking in U.S. training programs (Frank, 2005).

When asked about some of the limitations of Cuban medical technology, Edwards replied by saying that it would actually make him a better doctor. "You don't want to be dependent on technology...you want to be able to do something to help people, to provide medical assistance without having to rely on something that isn't available" (Frank, 2005). Sitting together over an ice-cream at Copelia, Cedric reiterated the point that technological dependency is a problem for health care in the developing South, and even in some parts of the United States. Here "you are trained to know your patients," he said. "When a physician has physical contact with the patient, knows their history, hears their stories and understands what puts them at risk, it is possible to make an accurate diagnosis." Speaking with MEDICC, Edwards said that he was confident that he would be able to adapt to a more technologically-driven work environment in the U.S. "I should mention that even though Cuba doesn't have...a lot of modern equipment, the training still covers [its] use or application. It's just that we don't get the same level of practice [with such equipment] as we might in another place" (Frank, 2005).

Sarpoma Sefa-Boakye, a 2007 ELAM graduate, also spoke with MEDICC about how an important part of *medicina general integral* is building relationships with patients, and that the Cuban approach trains doctors to listen to their patients' needs, and take the time to do so. He added that "[Cuban doctors] integrate everything, and so they

are physicians, but also psychologists...and they really know how to talk, to understand and to listen. And so, we're really taught how to listen to the patient, to really get to what they want to say" (MEDICC Review Editorial Staff, 2005).

Nontembeko Sweetness Kunene, an ELAM graduate from South Africa, commented on how Cuba's approach to prevention differs from practices in his home country. "[Cubans put] emphasis on primary health care in all areas... [it] actually attack[s] the problem before it becomes bigger for them to handle. [In] the South African health system, we tend to attend more to sick patients...[rather than]...at the base of the problem before it gets to be a problem" (MEDICC Review Editorial Staff, 2005).

Wendy Perez, a 2006 ELAM graduate and a Garifuna person from Honduras, perhaps best described the value of *medicina general integral*:

More than anything, we have learned to be students of science and conscience, to become doctors that are both scientists and conscientious. We are learning to serve people, as it should be, to treat people because of who they are - not because of what they have. We are being trained in the principles of solidarity (MEDICC Review Editorial Staff, 2005).

Part of this, she told MEDICC, came from being able to learn in the clinic, as well as the classroom. Clinical-based learning, according to Perez, endows students with a sense of confidence to handle difficult and complicated health conditions as they happen:

You go to operating rooms, to the wards, there you receive your lessons, you get to know the illnesses. Your knowledge is deeper because you're in touch with reality, not only with theory. And we feel satisfied because the professors give us the attention we need, they know us well, if we have any difficulties they come and ask what's happening, if we have academic problems, they solve our doubts so that we can do better (MEDICC Review Editorial Staff, 2005).

Indeed, according to Luther Castillo, the rewards of a "hands on approach" to care and diagnosis come from the empowerment of the patients themselves. He told MEDICC:

When I went back on vacation, someone told me “I’m 75 years old and I had never been treated by a doctor without showing disgust for me.” They use this term “disgust” to refer to a kind of rejection, you understand? And he said “No one had ever examined me with such delicacy, sitting by my side, holding my hand” (MEDICC Review Editorial Staff, 2005).

Dania Suarez told me that the best part of the Cuban training was realizing the place of humanism in medicine. Being “a humanist doctor,” as she put it, is about practicing medicine for those who need it, regardless of the ability to pay, or regardless from where they hail. Fany Esperanza praised her ELAM education, again referring to it is a “humanist experience.” But some students did find the adjustment to Cuba to be difficult. Albania Gabrielo Tamayo, who went to Cuba when she was 17 years old, and was the youngest member of the Ecuadorian ELAM delegation, said that some of her colleagues complained about the lack of internet, or the poor restaurants in Sancti Spiritus, but she said “we were there to study medicine.” Despite tough conditions, they were willing to take on the training. Ricardo Rodrigo Carrión also appreciated the quality education he received at ELAM and Sancti Spiritus but when I asked him if he would ever go back to Cuba, he replied “never.” In Quito’s Jardin Shopping Centre, Ricardo gave me the impression that Cuba’s humble material resources were not something he desired to be a part of any longer. Elizabeth Gallo extolled ELAM’s medical education as well, but she noted that “when you graduate medicine in Cuba you are perfect for practicing medicine in Cuba. In Ecuador it is a different, they do not practice disease prevention and health promotion. They practice basic medicine.”

Student Life:

Becker notes that student life during medical school is an important component to understand collegial culture (Becker, 1977; Sinclair, 1997). Becker’s point is especially

pertinent to ways in which the values of education play out through students' social networks, as medicine itself is highly dependent upon socializing and networking. Student life at ELAM reveals two key attributes in this area. The first is a sense of pan-American solidarity, as envisioned by José Martí (1963b). The second is an emphasis on cooperation over competition. These two qualities are invaluable attributes for making new doctors for the global South, and they warrant some further discussion.

Dania Suarez was just weeks away from her final set of exams, but still she wanted to go to an ELAM party. She picked me up at 8:30 on a breezeless July evening, and, piling into the back of a Moscovitch, we went out to *barrio playa* to take part in the events. We arrived to a crowd of no less than 600 soon-to-be ELAM graduates. After six years of intensive training, this would be one of the few remaining moments where the students would all be together. Twenty countries were represented that night, and from group to group, Dania kept introducing me to new friends from various countries. "This is Mayra from Venezuela, Carmen from Argentine, Raul from Mexico, Mary from Uruguay, and Anita from Guatemala." After the rum and fruit punch arrived, I knew that I was not going to be able to keep names and countries straight.

I spoke, drank and danced with students from around the hemisphere that night. Some of the islanders and Africans were a bit harder to find in the crowd. The music, dominated by Cuban salsa and *rigotone*, eventually gave way to the odd Peruvian folk song. Then the Hondurans sang the songs of the Garifunas, sung in the original Garinagu. Exams were just days away, and this party was nowhere close to stopping. Sometime after 1:00am I asked Dania, "How do we get home?"

"It works out," she said.

The white coats were kept in the closets that night and, instead, the dance floor was a collage of traditional and modern dress. And somewhere between a round of rum punch and another offering of pork sandwiches, I tried to imagine another place on earth where such a collection of students could be put together. The accents did not match; the faces from Playa del Este were not those from the Cuchamatanes. Belizeans were speaking Spanish with Brazilians, and the Paraguayans were not speaking Guaraní to anyone.

Geography, time, language and culture have divided the hemisphere; but now, in a small dose, ELAM has united it. Bolivians were embracing Dominicans. A couple slipped off into the dark for a bit more privacy. She was from Chile; he came from Nicaragua. Another pair passed by, drunk on each other. “She’s from Venezuela, and he’s from Costa Rica,” Dania told me.

Cedric, from Louisiana, is married to Inmaculada from Equatorial Guinea. Dania is dating a fellow from Colombia, while Fany and Jackie have both met their *Cubanos*. Rector, Carrizo Estévez, says that solidarity is among the goals of the school, and on the ELAM entrance reads a famous quote by Martí: “It is not the intelligence received that gives man his honour, but the way and the spirit in which it is used” (Martí, 1961a). But this party begs the question of whether solidarity is formed through ideological affinity or through personal relationships. Or perhaps it is formed through a combination of both? Without the willingness to travel to Cuba in order to one day attend to the underserved, all the embraces, the laughter, and the love would only be a dream. Like any education, it forms characters and builds skills, but it also unites those who come from different backgrounds and hold common dreams. While some would say that solidarity is built

through “exporting doctors” (Crutcher, 2006), I would say that solidarity comes from establishing such close relations across cultures and places that would seem to be too different to ever come together (Galeano, 1997). The party was a small monument to Martí’s *nuestra América*, and a living testimony to how ELAM forms incredibly rich relationships across languages, time, and space.

While Martí’s vision lives with ELAM, the philosophy of cooperation over competition is just as important in understanding the school. The goal is to ensure that poor and forgotten communities receive quality health care through skilled personnel, which leaves ELAM no incentive to limit the number of graduates for this cause. The attrition rate comes not from a natural rate of decline, but from students who are unable to cope with the intensive curriculum or the way of life. “You have to work hard here...the teachers will help you as much as you need, but if you are unable to pass, you have to go.” “There is nothing wrong with having the whole class receive eighty percent on an exam...but that would only happen if the whole class earned it; they don’t give you a free ride here,” Greg Wilkinson told me. While many universities set hierarchies among their students, the Cuban approach is to afford every student with as much time and attention as possible. In the class this acts to remove competitive pressure, and socially it tends to remove incentives for struggle and conflict. Most medical students in this hemisphere come to realize that competition for residency can be fierce, and they, or some of their peers, may not be able to land a place after graduation.

No doubt this fear still exists among ELAM students; however, the competition is not among themselves, but with the systems to which they will one day return. There is no incentive at ELAM for students to want to see their peers perform poorly. Rather, as

students attested, the emphasis is on supporting each other through their studies, and socializing at parties or at the Copellia.

Some accounts of ELAM student life have focused on the challenging living conditions of eleven students to a room, or to the food being sub-par, but such accounts miss the story that I gathered from the students of how they support each other. I realized this after meeting with Cedric Edwards at Salvador Allende hospital in Havana in July, 2005. Hundreds of ELAM students study and take their residencies at this hospital. A multi-compound, single-storey hospital, its green spaces and colonial architecture resemble a retreat more than a hospital.

Cedric and I started the tour of the hospital in the triage ward. It was a busy place with many patients waiting to be seen. A scuffle of nurses, secretaries and physicians were coming and going from the waiting room, just as would be expected in any other hospital. We then went to a ward that had only one or two beds per room. The patients were elderly, bed-ridden or in wheel chairs. They were in the hospital for a variety of reasons, with no one specific cause. In each room, giant French doors opened onto a tiled balcony. The hospital was spotless. Unlike Cienfuegos, this wing of Salvador Allende hospital was quiet. Nevertheless, each patient had someone close by. Another ELAM student, in her sixth year, stopped us as we were walking out of the building. “Where are you off to?” asked Cedric.

“My patient wants sweets,” she replied. “Yesterday I made the mistake of telling her that I had some cake, so I had to share some with her.”

“Medical students have time to bring patients sweets and cakes?” I asked.

“It’s no big deal,” replied Cedric. “At most we might be responsible for two or three beds at a time.”

The doctor-to-patient contact ratio is so low at the Salvador Allende hospital that the resident ELAM students only have a couple of patients in their stewardship. Such a ratio affords the soon-to-be doctor time to get sweets, but also to get to know the patient as a person. Such bedside manner provides for ample opportunity to get to know the patients’ histories, their families’ histories, and other attributes of their lives. This certainly rests on the willingness of the doctor and patients to communicate to each other. Fortunately, the Cuban system affords the time to create such dialogue.

After leaving the ward, we walked back to the student dormitory. Most of the students were in Years 3 to 6. Some were four to a room, and others six to a room – cramped conditions indeed, but slightly more spacious than the ELAM dorms for first-year students. But this environment seemed to foster collective participation rather than tension. In one room, students were huddled around a lap-top that was acting as a DVD player. A girl from Venezuela had received the machine when her mother visited her a few months earlier. We went up to the top floor of the residence, walking past the lines of laundry in the halls. Another group of girls was cooking a giant pot of macaroni with cheese in their room. Across the hall, someone was playing a guitar. The place could have used a coat of paint, but the dorm was open, collective, and welcoming – with space to socialize and spaces to study.

We met up with some students from Costa Rica and Ecuador and went down to the *Ditu pollo* for a soda and some croquets, a habitual routine for many students seeking a mid-afternoon snack. We stayed for about forty minutes; I went through my

questionnaire, and then we made our way back to the dorm so the students could study a bit before dinner.

I didn't feel anything atypical struck me about the student dorm at Salvador Allende hospital. People were studying, socializing, napping, and making calls home. It was a scene that could be found in any residence. But what was noticeable was the open and communal atmosphere. We could hardly walk more than a few steps without being stopped by someone asking if we were going to the upcoming party, or asking Cedric something to do with the upcoming exam.

Cedric mentioned that he felt there were people here he could count on for support, and that he would be there for his friends as well. As I render it, ELAM is an institution and social space that builds a way of life that exudes cooperation and solidarity, rather than competition and prestige.

ELAM Evolves:

As of 2007, the social setting for international medical students training in Cuba has evolved. Under the ALBA agreement, Cuba and Venezuela have proposed to train 100,000 physicians from the Americas over a ten-year period. Saskia Nuñez wrote to me about her experience as a student in the new ALBA. She, and 400 other Ecuadorians, were studying in a small school in Matanzas. Her first-year class has almost as many students as the entire Ecuadorian ELAM population. In 2006, MINSAP set up small country-specific schools across the country. In their first year, they study theory and basic practices of medicine. However, unlike ELAM where student-patient contact begins in the third year, ALBA brings second-year students into the clinic to work and train alongside their Cuban mentors. It is a program that is much more inline with the

training methods employed by Cuban doctors working abroad, who also train medical students along the way. The impacts of ALBA are a long way off; however, changes in the social and pedagogical practices are already noticeable. ELAM will continue to offer scholarships and carry on its program, but clearly the ALBA program is designed to exponentially increase training capacity.

This chapter has laid out the ELAM experience, from its curriculum to its social life. More, no doubt, could be said about the intimate details of curriculum review, and student life. However, for the purposes of this dissertation, the underlying argument is that ELAM equips its students with valuable skills to be used in the clinic, and a sense of ethics that values COPC as a fitting means to bring health care to vulnerable communities. The training, recruitment, and culture of solidarity and cooperation are all badly-needed attributes for changing the face of health-care provision in the developing South.

ELAM students obtain clinical knowledge through clinic-based learning and dedicated assistance from faculty. They are endowed with confidence and experience that should allow them to practice in regions where there are few people from which to seek advice, and little time to review lecture notes. Most are recruited from the areas to which they are meant to return. Not all will leave with white coats on their backs, and not all came with any shoes on their feet, but all have undergone a selection process, as unstructured as it is, that above all deems them able and willing to serve the underserved. The curriculum, even in the most basic of sciences, reinforces the idea that individuals are a part of the society in which they live, and their health relies on relationships with their communities and that society.

This chapter has looked at the operations of ELAM, paying special attention to the student body, the faculty, the curriculum, and the student life. Clearly, ELAM runs according to a central theme of community-based health care and an ethics of cooperation, outreach, and service. On one hand, the training of thousands of students as doctors is aimed at fulfilling a demand for human resources that neoliberal hegemony has broadened greatly. But on the other hand, ELAM's education is much more than a process of just meeting demands. It focuses on building a culture of physicians committed to service. The lessons learned from Cuban medical internationalism are brought to students in the classroom. Their texts are based on proven methods of primary care that emphasize disease prevention and health promotion, and their instructors are leaders in their fields, with many having served in medical brigades overseas. The counter-hegemony of medical internationalism, along with core-clinical competency, permeates throughout ELAM's culture. At this stage, building confidence in students to practice medicine against the grain of neoliberal norms can be seen as a tremendous success.

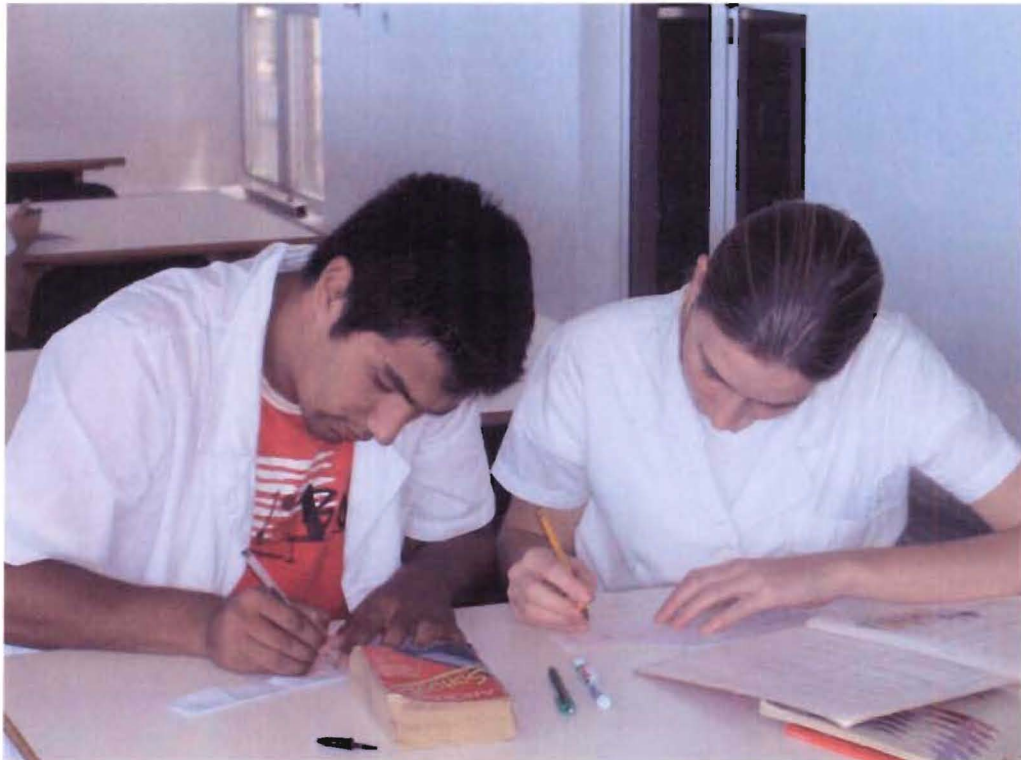
The students have come together from 29 different countries, 101 different ethnic minorities, including 33 indigenous cultures and a variety of languages, to build a culture of cooperation and solidarity aimed at making health care accessible for all. All of these ingredients make ELAM a tremendously appropriate capacity-building project for the needs of the marginalized. The question that remains is whether the program can bring about behavioral change in the field. To see if empowered individuals with the skills, knowledge, ethics and compassion will be able to do this for themselves and their

communities, it is important to first explore in detail the health-care landscapes within which they will work that have been ravaged by neoliberalism.



(Fig. 20) Students leaving an afternoon class

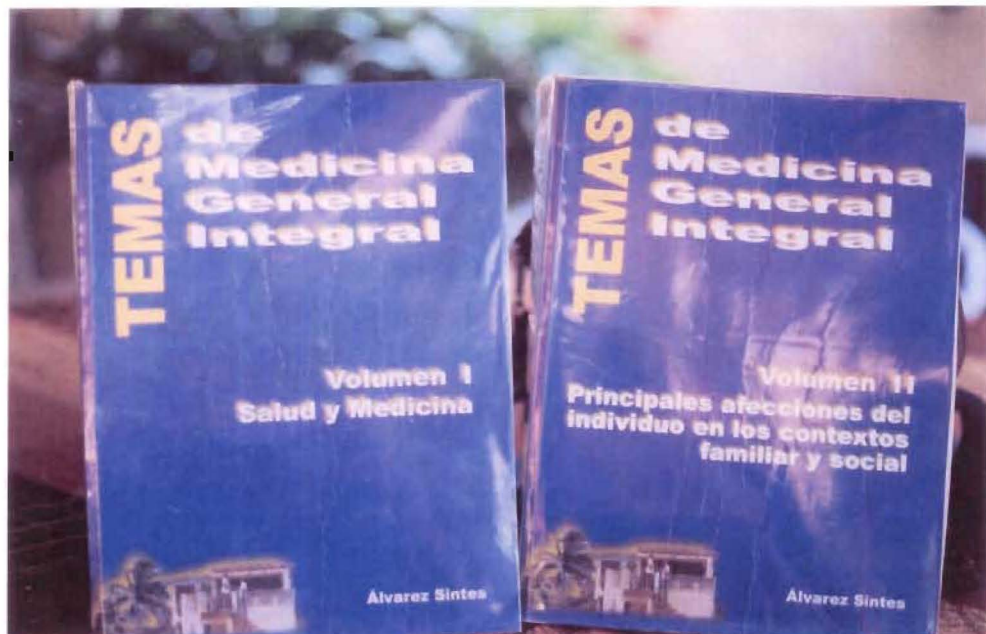
(Fig. 21) Students studying in the school's main library





(Fig. 22) ELAM students in the lecture hall.

(Fig. 23) The core text book, “*Medicina General Integral*”





(Fig. 24) Rector Juan Carrizo Estevez speaking with the MEDICC international research delegation at ELAM

(Fig. 25) The MEDICC delegation at ELAM



Chapter 6
As Hollow as a Gourd:
Ecuador's Health-Care Geographies

~“*They can kill all the flowers, but they cannot stop the spring.*” ~
Pablo Neruda.

Health-care accessibility in rural areas has been a long-standing challenge. In 1973, the first edition of David Werner's *Donde no hay doctor* (where this is no doctor) was published at University of California Berkeley. The book was a basic health-care guide for *campesinos* in Central and South America. Knowing that most peasants do not have regular access to health-care professionals, Werner's book uses basic language and detailed images to guide individuals through various health calamities. The book was meant for community leaders, and many of the treatments call for group-based participation. The guide instructs *campesinos* on how to make stretchers and crutches from the materials found in the jungle. It offers lessons on how to identify the severity of dehydration in infants. It shows the basic steps of assisting with childbirth, including dealing with the all-too-common occurrence of counselling a mother when her child dies during delivery. Werner's small sketch of a woman sitting on a rock gazing upon a small mound of dirt with a flower growing out of it represents a scene that happens all-too-often in Latin America.

Donde hay no doctor makes two major assumptions about the general state of health-care services in the global South. First, as the title indicates, it takes for granted that doctors, and health-care professionals, will simply not be there. Second, it assumes that material resources will also be absent. This assumption is based on the pattern of health professionals being removed from rural landscapes due to a lack of economic demand (i.e. ability to pay) for their services. Using basic tools, crafting crutches from

tree branches, and using your own hands to deliver babies speaks to a reality of poor communities using whatever resources they have at hand, and also it assumes that communities will not be able to purchase what they need and that philanthropy will not help either. The poor of this world, the one billion who do not have access to clean food and water on a daily basis, are forced to make hard choices about accessing professional health care or handling health calamities on their own.

Accessing health care is not politically, culturally or economically neutral. Patients, especially economically and socially marginalized ones, often choose between the receipt of care and their own economic security. A visit to the private clinic in Sachas could cost some petroleum workers a week's wages, as a visit to a private-clinic is \$30 and some petroleum workers make only \$1,500 a year. Even in the North, the poor are faced with difficult decisions in purchasing health care. In the U.S. it can be a question of buying medicine or paying for the heating bill (Heisler *et al.*, 2005). But it is a problem of the poor in all nations, as in places like Haiti purchasing a treatment can come at the cost of not purchasing food (Farmer, 2005).

This is why this thesis, focused on the appropriateness of ELAM's medical training, must also take into account the broader social and economic realities that impact the neoliberal States in the global South, including Ecuador. Werner's book predates the neoliberal reform era, and it points out that inequities in health-care services have evolved through a complex history of colonialism, neo-colonialism, and modernist development projects. Neoliberal health care's hegemony works to worsen the situation, rather than improve it, for the most vulnerable populations by demanding payment for the receipt of services. In addition to the institutionalized exclusion of health-care provision

in the South, neoliberalism's for profit practice ensures that indigent populations cannot receive sustainable access to health care, as they simply cannot afford the costly fees associated with such care.

It is well understood that the mere existence of health-care services does not necessarily equate to a healthy society. Perhaps this is due in part to the traditional discourse of clinical and institutionalized treatment that concentrates on repair of the ill rather than maintaining the healthy. Also, it is due in part to the fact that many health calamities that occur in vulnerable communities are the result of accidents and preventable diseases. Because such health issues can be prevented, the WHO argues that human resources for health are particularly important when it comes to building healthy communities in the South, and the presence of trained health-care workers can have especially positive impacts.

Neoliberalism has ensured that the populations most at risk have the worst chance of receiving sustainable, long-term quality care. It is a two-stage political process. First, the economic benefits of oil and other national resources in places like Ecuador are given to foreign corporations, which take most profits off-shore and do little to reinvest in the local economy. It is classical imperialism. Trade liberalization and the privatization agenda of neoliberalism compound this process by deteriorating already frail public services to dire levels. Countries like Ecuador are not naturally poor; they are usually quite wealthy with natural and human resources. But, under neoliberal conditions, the supposed benefits of this wealth do not filter down towards improving the health and well-being of locals. In the highlands, malnutrition is common, but sustainable food networks, accessible health care, and land ownership for the poor majority are not. In the

Amazon, oil is abundant, as is cancer, but public-health resources are minimal. An ELAM graduate returning to rural Ecuador faces the challenges of coping with landscapes that have few human resources and even fewer material resources, and little social or political support for establishing disease prevention and health promotion in the communities.

ELAM graduates serving in rural Ecuador can help to overcome Werner's first observation that the rural South lacks physicians. But, the second reality – lacking resources – will still be an issue in the absence of active political support. It is important to consider this reality in order to identify the challenges that ELAM graduates face in delivering COPC. The previous chapter argued that Cuban training is appropriate for the needs of the poor, and this chapter identifies some of the broader inequities and conditions that shape health in Ecuador. This chapter contextualizes the social and economic disparity that ELAM graduates will experience in trying to develop sustainable COPC at the community level. It is an enormously important context to identify, because the social and infrastructural support that ELAM students receive in Cuba is far beyond that which they will find in Ecuador.

Ecuador's recent, and not-so-recent, SAPs have caused a reduction in social and political support for the country's public health-care network. While numerous health complications can be associated with this relationship, this dissertation is concerned with how a continual disinvestment in health care for the marginalized has created a culture of disinterest in serving their needs. This occurs at several scales from institutional norms to individual motivations. Ecuador's medical schools have, perhaps unintentionally,

nurtured the culture of disinterest by building an institutional ethics that causes graduates to value success in business, above fidelity in service.

Neoliberalism and Health Care in the Global South:

Globalization is often considered a benign socio-economic force; a rising tide to naturally raise all boats (de Rato, 2006). Proponents claim that open markets, expanding growth, and empowering international capital would have benefits to ultimately improve the well-being of all, including the poor. It was meant as a natural harmonious process aimed at “greater integration within the world economy through movements of goods and services, capital, technology....which lead increasingly to economic decisions being influenced by global conditions” (Jenkins, 2004: 1).

However, rising tides are not docile events. As Saul says, they require skilled crews to navigate the constantly changing conditions, and knowledgeable captains who can prevent their boats from crashing ashore (Saul, 2005). What Saul means is that active state interventions are required to keep existing public goods intact. Approaching globalization as benign is, as Milanovic (2003: 668) argues, based upon a basic error, “a systematic ignorance of its malignant side.” For Harvey, this malignant side is a purposeful political project of the global elite mustering power and resources for their own benefit. Harvey also correctly acknowledges that no one place like Washington or London can be held solely accountable for its spread (Harvey, 2005). It has emerged through a mix of national, regional and international decisions. At times it has emerged largely through overt pressure from Washington and other Northern capitals, and, at other times, mainly through the self-interested focus of national elites. Neoliberalism has taken shape in Beijing and in impoverished regions in Africa to open up free-markets for trade.

But, since the dawn of trade, as Labonté and Sanger (2006: 655) point out, “disease and pestilence have long followed.” Today, neoliberal globalization has opened up trade routes to a degree never before seen, and its “influence extends beyond commercial relations to affect health, social welfare, and culture” (Labonté and Sanger 2006: 655).

These influences often involve worsening pre-existing inequalities and social tensions. In the twenty-first century, on a global scale, social inequity has never been greater between the healthiest minority and the unhealthiest majority. Likewise, the gap between the richest and poorest incomes has never been wider. Such inequity has led to restrictions of accessibility in services and resources alike. The world’s poorest populations are also the world’s most vulnerable, as their economic capacity to afford the necessities of life, let alone health-care services, is seriously compromised. Life on a dollar a day, a measure that the World Bank considers a marker of basic poverty, is a poor marker. A dollar can go a lot further in a poverty-stricken zone with relative social cohesion than it can in other types of areas (Saul, 2005). Regardless, it is obvious that persons living in the global South with minimal income and few resources cannot receive the same level of social services, including health care, as wealthy persons. Moreover, the public health-care systems of the South tend to further such inequity by affording only the most basic of services to all citizens, while their parallel private systems are often flush with resources.

Globalization has ensured that accessibility to health care is not solely determined by spatial inequity, but also by economic and social capacity. The movement of people to treatment centres is only a part of the problem. Deeper socio-economic inequities do a great deal to restrict indigent communities from accessing health-care resources. Wilson

and Rosenberg argue that accessibility is a key issue for health-care geographers, as it involves understanding spatial and social limitations to current systems (Wilson & Rosenberg, 2002). The WHO taskforce on Research Priorities for Equity in Health (2005) regards the characteristics that influence equity as a key research area of health-care systems. Health equity must, as Schrecker and Labonté (2007) claim, “be understood by researchers as creating an absence of disparities in health that are avoidable, unfair, and systematically related to social disadvantage.”

In order to understand the nature of Ecuador’s health-care system, it should be treated within the broader context of globalization, and specifically how the State’s adaptations of neoliberal economic policies have encouraged structural violence against the poor. Moreover, it is important to properly conceptualize neoliberalism. Friedrich von Hayek’s Nobel Prize in 1974 can be given some credit in jump-starting the neoliberal project (Hayek *et al.*, 1994). His argument that the State turns people into “serfs” became popular among conservative economists (Mason, 1997). Hayek’s supporters at the University of Chicago called for structural adjustments to be applied to societies to decrease State power via privatization, and increase dependency on market forces to restore economic order to a “natural” level. This mix of bleeding the State dry and eliciting a narrow-minded interpretation of Adam Smith’s *Wealth of Nations* (1776) fathered the concept of neoliberalism. According to Harvey (2005: 20), neoliberals distort many of Smith’s positions, but remain loyal to the idea that the market is the best device for mobilizing “the basest of human instincts” of gluttony, greed, and the desire for wealth.

Although neoliberals base much of their theory on Smith's work, the ambition to reduce the State to a minimal level clashes with his philosophy. As Streeten (1993) points out, Smith believed in strong State participation in certain areas in society, and at no point did he promote an entirely unregulated market. Smith actually feared that individual desire and elite over-accumulation of resources would tear societies apart (Watts, 2000). Many classical economists, such as David Ricardo and Thomas Malthus, also argued that a completely "free market" is unobtainable, and the State must play an important role in socio-economic planning (Hirschman, 1991). Dialogue between Malthus and Ricardo moved the latter to publish *Principles of Political Economy and Taxation*, (1817), in which he outlined the State's role in assessing value for rents and profits.

Despite these cautions from nineteenth-century economists, Hayek and the Chicago school neoliberals hoped to solve rising economic problems in the South by liberating its market from the "giveaway State, which taxed and borrowed too heavily and gave too much away to the working class and the indigent" (Mason, 1997: 27). At the 1981 Cancun Conference, U.S. President Ronald Reagan and British Prime Minister Margaret Thatcher attacked the popular economic philosophy of Keynesianism, as well as proposals to resolve rising development dilemmas in the South through the creation of a New International Economic Order (NIEO) that would increase foreign assistance and stabilize commodity prices (Cypher & Dietz, 1997). Their answer to economic instability was a strengthened free market, unrestricted and unimpeded by the "ineptitude" of the State. Thatcher and Reagan wanted neoliberalism to be "the central plank for the organization of social, economic and political life" (Watts, 2000: 546). This call from the

two Western leaders triggered an abrupt shift in development theory, prompting the creation of a hybrid style of nineteenth-century classical *laissez-faire* economics, and more modern neo-classical frameworks.

The World Bank and IMF adopted the *laissez-faire* program and concluded that to enhance economic growth, and therefore overall well-being, it was necessary to eliminate trade barriers adopt an outward-orientated economy, and re-structure developing political economies. This policy was built on pre-existing practices of discouraging subsistence farming for large-scale agro-export monoculture. Cash from export crops was supposed to give people purchasing power to buy foodstuffs and other basic necessities from the world market. But no price controls came with the free market, and in most cases, the bottom fell out of cash crops, allowing less capital to make it to the South (Huish, 2007).

World Bank and IMF-driven SAPs, along with voluntary internal restructuring in the 1980s and 1990s, often resulted in political, economic, and societal chaos in participating countries. Nevertheless, the World Bank and IMF continued to see societal problems as stemming from irregularities in the market itself. Their models of balanced economies and fictional countries supposedly proved that the social chaos of the South was the result of a market out of equilibrium (Mason, 1997). One of the typical critiques was that State ownership of resource companies and social services led to inefficiencies (Iriart & Waitzkin, 2006). Even today, IMF country-performance criteria are often measured against theoretical models of economic growth, export capability, and public-debt management that show minimal State involvement in these sectors (International Monetary Fund, 2004).

Structural adjustments were imposed on many countries in Latin America, such as Ecuador, in the 1980s and the 1990s for the sake of improving national economies. Currencies were revalued in order to facilitate debt repayment, and little consideration was given to the impacts of reduced spending power on the indigent. Kurt Vonnegut (2006) drew the image of Ecuadorians, following a structural adjustment in the early 1990s, lining bird cages with their *Sucres* because the currency could serve little other purpose. SAPs were doing more to widen inequity than overcome poverty. Considering this, Galeano (2000) asked: what is the purpose of a healthy currency without healthy people?

In the end, SAPs sought to make available nationally-held assets for foreign investment and fundamentally change the role of the State in national political economies (Iriart & Waitzkin, 2006). In effect, international financial institutions (IFIs) became the stewards of both resources and social programs. From oil and mines to health insurance, it was a period that further opened “the veins” of Latin America to the narrow interests of the private sector (Galeano, 1997). Instead of freeing countries of debt, SAPs managed to utilize pre-existing trade patterns to throw them further into it. As part of debt-management strategies, control over resources and the administration of social services were put in the hands of off-shore investors. IFIs would often manage development projects, from dam construction to airport renovations, which typically used foreign labour and resources to get jobs done, but would use public funds to pay for it all. Such developments bankrupted country after country to the point where further SAPs would be imposed in order to manage additional debt repayments. It is the story of many countries in the global South, with perhaps the worst case scenario being in Sub-Saharan Africa,

where for every \$1 that came into the region through aid, \$0.90 left in debt repayment and \$2 remained unpaid (United Nations Conference on Trade and Development, 2004).

Certainly every country's experience with SAPs is unique, but the overall theme is described by Iriart and Waitzkin (2006: 180) as "increased indebtedness, the opening up of national economies to multinational finance capital, and the restructuring of the State via privatization affecting industrial production, services, and natural resources, as well as decreased public expenditures on social and health services." In regards to health-care spending, most countries had to consent to "open[ing] social security and public funds to management by national and multinational for-profit companies, most of which already maintained well-developed financial activities in international and offshore markets" (Iriart & Waitzkin, 2006: 180).

In Argentina and Uruguay, the once-public health insurance systems turned into private joint ventures overnight, experiencing a rapid decrease in the amount of income they received through annual premium payments. Even as late as 2002, the reforms continued to reduce the numbers of people willing, or able, to pay for such premiums. In Argentina, "national social security institutions that covered 11 million people received 12 percent less income between 2002 and 2003...*The Programa de Atención Médica Integral*, (PAMI), absorbed a 40 percent decrease in income" during that time frame (Iriart & Waitzkin, 2006: 184). But, Oliver (2006) argues that while both Argentina and Uruguay underwent similar processes, Uruguay maintained some public-sector capacity, and fared better in keeping its people insured.

Franco-Giraldo *et al.* (2006) make a connection between such health-sector reforms and changes in major health indicators. Looking at changes in life expectancy

and infant mortality alongside changes in government spending on social services, they found that “adjustments in macro-economic policies had a negative effect on social indicators, specifically those that had to do with health conditions” (Franco-Giraldo *et al.*, 2006: 299). From the point of view of the global economy, SAPs encouraged the expansion and growth of markets; but from the point of view of the poor, they were excluded from health insurance, and they were placed at increased risk of cholera, typhoid, and other communicable diseases from destroyed social infrastructure (Farmer, 2003, Galeano, 2000).

Farmer (1999) contends that such neoliberal policies further structural violence that systematically ignores and violates the needs of the most vulnerable. Musah (2002) makes a connection in Africa between the increase in structural violence through SAPs and falling human security. As well, Willet (2001) regards the unequal distribution of wealth as an important contributor to structural violence, and notes that it has also ultimately undermined human security. As Farmer (2004) argues, globalization has created structures that not only prohibit individuals from reaching their full potential, but often force the poorest people to subsist in a condition of continuously having to reject health care due to its cost, inconvenience, and absence of services.

Most Latin American countries value health as a human right; it is even written into the constitutions of numerous countries. Waitzkin *et al.* (2001) contend that this gives the State the primary responsibility for health in a society. However, IFIs have worked to reduce, and then privatize, health-care services in much of Latin America. As these reductions in services serve the interests of investment capital more than local human needs, especially of the poor, Farmer (1999) labels such policies as structural

violence, as they unnecessarily bring indigent communities into an increased state of vulnerability.

Collins (2003) found that social inequality negatively affects access to health-care services, especially in countries with so-called transitional economies. Chile is often given praise for countering this trend by decentralizing services and relying heavily upon the private sector (Kubal, 2006). But as Murray and Elston (2005) note, issues of accessibility rarely focus on primary care, and they are usually heavily dependent upon pay-for-service by specialists. As in Chile, decentralization and cutbacks often involve a rapid readjustment to the health-care workforce. On a global scale, seventy percent of public-health resources are directed toward paying physician salaries, and budget cuts to this sector often result in adverse impacts to both the efficiency and the quality of primary care (Ugalde & Homedes, 2005b). Certainly many factors contribute to the placement and retention of physicians, but, globally, neoliberalism has furthered inaccessibility by creating health-care networks that are mainly driven by economic demand. Cavender and Albán (1998) argue that this is a significant problem, and that many state-initiated programs, such as ELAM, have been employed around the world for decades to try to level out the physician imbalance between urban and rural areas. Canada and the United States offered incentive programs for physicians to practice in rural areas as early as the 1920s, and in Latin America, Mexico was the first country to offer similar incentives in 1936. With fewer of these programs in existence, and globalization's continual pressure of centralizing material and human resources to wealthy urban enclaves, little incentive exists for physicians to practice in rural areas in either the North or the South.

Above and beyond a reduction in state-driven services, a “culture of management” has engulfed both the private and public health-care provision sectors in Latin America. Saul (2005) rightly points out that leadership as management is ruinous to society. Management strategies are incapable of radical change to overcome social crisis, he argues. Managers seek out technocratic compromises to problems, offering only minor and controlled responses in order to stifle the appearance of any social crisis (Saul, 2005). Iriart *et al.* (2001) identify some key characteristics of IFI management of health in Latin America. Financial managers become the supposed experts on how to deal with crises of inequity at the local level. Their general management strategies tend to adhere to the following beliefs: the crisis in health stems from financial causes; efficiency increases when financing is separated from service delivery and service providers are allowed free competition; the free market should be expanded into health-care services, because it is the best regulator; private administration is more efficient than public-run insurance; and de-regulation offers the client the best freedom of choice (Iriart *et al.*, 2001).

According to Iriart *et al.* (2001), if any subsidization is to occur for services, IFIs will advocate for the subsidization of demand rather than supply; the State’s principal role becomes assisting the market to reach the supply of services. Hence, no financial limitations or interference should cap the profit-making potential of services and treatment. Homedes and Ugalde (2005a) argue this strategy encourages the poor to spend a disproportionate amount of their income on costly pharmaceuticals, thereby moving health care away from disease prevention and health promotion. De Vos *et al.* (2006) contend that market management reduces the capacity for health-care systems to provide

effective care to the public. He contrasts Colombia with Cuba, two countries that underwent their own contrasting versions of economic restructuring during the 1990s. Colombia followed IMF dictates and now has a large part of its health-care sector effectively managed by the IFIs. Cuba, as explained in Chapter 4, maintained health as a public good and reduced its costly dependency on foreign pharmaceuticals and expensive services. At the turn of the 21st century, Cuba improved health indicators and universal health-care coverage. The same certainly cannot be said for Colombia (De Vos *et al.*, 2006).

Other than Cuba, Venezuela is becoming an exception to Latin America's health-care norm. The country still has a heavily entrenched for-profit sector; however, programs like *Misión Barrio Adentro* (Into the Community) offer a public response. Assisted through Cuban foreign cooperation, *Barrio Adentro* is a program run by Venezuela's Ministry of Health and Social Development to increase the accessibility and capacity of primary health-care resources, in response to previous tendencies towards increasing costs and declining services (Muntaner *et al.*, 2006b). Venezuela has about one doctor for every 500 people, but according to the Ministry of Health and Social Development, over 60% of the population was without receipt of primary health-care services at the turn of the century. The goal of *Barrio Adentro* is to improve this ratio, and to generally expand access to the public system. In 2004, *Barrio Adentro* claimed to have one public-sector physician accessible for every 1,200 people (Ministerio de Salud y Desarrollo Social, 2007). *Barrio Adentro* mainly develops participation at the systemic level, rather than the individual level. Communities can request the presence of physicians, youth from those communities can be trained as doctor's aides, or eventually

acquire scholarships at ELAM; and increased dialogue occurs between the State and community. Participation and pursuit of the greatest public good are emphasized in the stewardship for health-care services. Litva *et al.* (2002) found that, in the U.K., behavioral change can occur at the individual level if it is encouraged as part of an accessible public good (Litva *et al.*, 2002). As physicians in Venezuela are finding, the best way to administer health care is through continual community participation, rather than on an ad hoc or case-by-case basis, or by simply leaving individual decisions to the throws of the market. *Barrio Adentro* is an example of this relationship, and it is one that, while in its infancy, seems to have the potential to counter the trends of inaccessibility, unaffordability, and unavailability of public health care so prevalent in other Latin American countries.

Neoliberalism and Ecuador:

Inequality and structural violence largely structure health-care provision to Latin America's vulnerable communities. Admittedly various States and philanthropic organizations alike do try to implement responses to these inequities. Cuba and Venezuela are, however, the exceptions to the rule as they provide broad proximal responses to health risks through the public sector, rather than through narrow reactive responses. Their initiatives to bring doctors to communities, offer universal primary care, and train health professionals to identify and respond to broader social and environmental determinants of health all do well to cope with structural violence in a proximal manner. Ecuador, however, lacks this capacity. Along with many other neoliberal States, it has undergone economic and social transformations for the sake of managing national debt repayment strategies. Ecuador's public health-care system responds to structural

violence in the distal sense; it attempts to repair calamities as, or after, they occur. However, with such a hollow public sector lacking material and human resources, it is questionable how appropriate this approach is to meeting the health-care needs of its population.

Ecuador ranked 83 out of 175 in the 2006 United Nations Human Development Index (United Nations Human Development Program, 2006). The country's human poverty index, a marker to determine the proportion of the population living below a development threshold, is 8.9, which ranks just ahead of Thailand. Twelve percent of children aged 0 – 5 are underweight, and 6% of the population subsists without access to clean water. Larrera and Kawachi (2005: 166) see “social, regional and ethnic disparities, which have historically affected the country, remain[ing] pervasive.” Repeated economic disasters since the early 1980s have also hobbled Ecuador's national wealth. A major economic crisis ensued in 1998 that saw the Sucre, the once-national currency, plummet – and with it, the purchasing power of most households. “In 1998, 63% of the population had a household consumption below the poverty line” (Larrera & Kawachi, 2005: 166). In 2005, per capita income was still below 1980 levels. Low individual purchasing power in a neoliberal context equates to low participation in the popular health sector.

Ecuador's transitional economy and fragile social services provide little security to marginalized populations. This is due in large part to how the country has managed foreign-capital investments and the development of many sectors of its economy, from transportation and energy development to petroleum extraction. The country's most notable foreign development has been Texaco's discovery of massive oil fields in the

Amazon in the 1960s. Sixteen companies, including the national enterprise *Petroecuador*, have been pulling oil out of the 4.6 billion barrel deposit since then. While Ecuador maintains national rights to minerals, oil can be controlled by international investors. In Oriente, the region where Sachas is located, 300 active wells and 29 camps were in production in 2005 (San Sebastián & Hurtig, 2005). In order to attract foreign investment, Ecuador did not impose strict environmental management regulations – a comparative advantage to attract investors wanting to avoid excessive costs for environmental stewardship. As a result, of the over 200 billion gallon extraction since 1967, Jochnick and Zaidi (1994) figure that 18.6 billion gallons of untreated waste, toxic gas and raw crude have been released into the ecosystem. Thanks to this economic strategy the people of Sachas are exposed to excessive environmental pollution, and they have little public infrastructure to remedy its social and health effects.

The right to pollute, along with the right not to invest in infrastructure, has long been understood as a comparative advantage for the developing South. Lawrence Summers, who was Chief Economist of the World Bank, made this clear in his famous 1991 memo that read:

Shouldn't the World Bank be encouraging MORE migration of the dirty industries to the [LMICs]... The measurements of the costs of health impairing pollution depends on the foregone earnings from increased morbidity and mortality... I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable and we should face up to that...The demand for a clean environment for aesthetic and health reasons is likely to have very high income elasticity. The concern over an agent that causes a one in a million change in the odds of prostate cancer is obviously going to be much higher in a country where people survive to get prostate cancer than in a country where under 5 mortality is 200 per thousand (Summers, 1991).

Responses to Summers' memo were vivacious, such as that of Jose Lutzenburger (1991), then-Brazilian Secretary of the Environment, who noted, "Your reasoning is perfectly

logical but totally insane... Your thoughts [provide] a concrete example of the unbelievable alienation, reductionist thinking, social ruthlessness and the arrogant ignorance of many conventional 'economists' concerning the nature of the world we live in." Lutzenburger was subsequently fired from his post, and Summers gained a series of promotions, such as becoming Secretary of the U.S. Treasury and then President of Harvard University. While Summers later called it a ridiculous missive, this mindset is a product of neoliberalism's approach to comparative advantage.

The Summers memo illustrates the impunity with which structural violence results from principles of comparative advantage. For Ecuador the supposed gains of petroleum development come at the expense of brutal health and environmental impacts. Hurtig and San Sebastian (2004) show that each drilled well produces an average of 4,000 cubic metres of waste, including drilling mud, petroleum, natural gas, and formation water. "These wastes are frequently deposited into open, unlined pits called separation ponds, from which they either are directly discharged into the environment or leach out as the pits degrade or overflow from rainwater" (Hurtig & San Sebastián, 2004: 245). Despite a thorough epidemiological study of the health and environmental effects of this development, as well as protests by indigenous communities and activists, the pollution continues in the Amazon, and Summers' approach to development continues unabated (Breilh *et al.*, 2005; San Sebastián *et al.*, 2005). Meanwhile, no capacity is gained to construct a social safety net that deals with these and other health calamities.

Ecuador's oil development exacerbates an already dire situation. First, the foreign companies overseeing oil extraction, such as Halliburton, take an overwhelming share of profit out of the country, leaving desperately few resources to develop social

infrastructure. The country has a historical landscape of inequity that has marginalized peasants and the indigenous since the *latifundio* land-holding systems in the colonial period. Hentschel and Waters (2002) argue that today, with the increased marginalization of communities across the country, from oil development in the Amazon to uneven landholdings in the Andes, the poor's coping strategies have become increasingly heterogeneous. This often involves "temporary migration, increased female and child labour, and decreased consumption" (Hentschel & Waters, 2002: 45). Moreover, the nature of oil extraction negatively impacts the health of poor communities that surround it (Sawyer, 2004; Jochnick & Zaidi, 1994; Kimerling, 2001; Whitten, 2004). Cancer rates, birth defects, dead livestock, and adverse impacts on biodiversity are all part of the environmental and health fall out of petroleum development. At the same time, the State is left with minimal resources to devote to public health. Younger (1999: 347) argues that "even though most social expenditures are progressive, their budgets are a sufficiently small share of GDP and their incidence is...poorly targeted so as to yield only a small reduction in overall inequality." And indeed, Ecuador offers a low level of resources for public health care. Considering this, along with regional variations of wealth, it is not surprising to see gross inequities across the country (Robertson *et al.* 1991).

Ecuador's Health Inequities as Structural Violence

A transitional economy, environmental degradation, and inadequate public resources have deepened negative health factors across Ecuador. Oriente is not alone in experiencing unnecessary degradation and environmental pollution, while enduring under-funded public health-care services. Handal *et al.* (2007) argue that children in

marginalized communities who are exposed to excessive pesticide spraying in flower-growing regions, such as Cuenca, are at increased risk of neurological development disorders. In Quito, Contreras Díaz (2006) found that in one of the city's poorest barrios, *Dos Puentes*, women consigned to cleaning and domestic labour experienced adverse health complications linked to automobile pollution. Larrera and Kawachi (2005) explored the relation between child stunting and economic inequality. Stunting, caused by many factors including malnutrition, affects 26% of children under five in Ecuador. It is especially predominant in the highlands, in provinces such as Bolívar. They found that, at the local level, income inequality could not be associated with stunting, but at the provincial level, clear relationships emerged. They argue that the financial disparities between urban centers and rural areas, especially in indigenous communities in the highlands, leads to a "statistically significant deleterious effect" on stunting (Larrera & Kawachi, 2005: 165).

Ecuador's Amazon is another testimony to health inequality from economic development. In 1993, in Oriente, a group of community health workers conducted an epidemiological study comparing descriptive renderings of health conditions in communities with and without oil developments. "The study suggested that, compared to communities free from oil exploitation, communities in oil-producing areas had elevated morbidity rates, with a higher occurrence of abortion, dermatitis, skin mycosis, and malnutrition, as well as higher mortality rates" (San Sebastián & Hurtig, 2004b: 208). Indigenous groups and local communities claimed that the rivers once abundant with fish had little-to-no aquatic life, while cattle died after drinking from them. "These are typically the same waters that people use for drinking, cooking, and bathing" (San

Sebastián & Hurtig, 2004b: 208). Breilh *et al.*, (2005) claim that the main value of this 1993 study was that it emerged via participatory processes at the community level and, while Texaco ran newspaper ads in 2005 trying to discredit the findings, they have been tested and recognized as valid by non-partisan experts. “Local organizations set the agenda of the research; they were involved in the hypothesis formulation, consulted in each step during the study and responsible of the dissemination of the findings. This process is known as popular epidemiology” (Breilh *et al.*, 2005: 217).

Research such as this contributes toward finding and mapping the health consequences from the oil development. The Manuel Amunárriz Institute of Epidemiology and Community Health has been involved in research to assess the potential health impacts of various physical symptoms. The NGO *Violaciones de derechos en la Amazonía Ecuatoriana* found that women closer to petroleum developments suffered higher incidences of the following symptoms: skin mycosis, tiredness, itchy nose, sore throat, headache, red eyes, ear pain, diarrhea, and gastritis (Abya-Yala, 1994, as cited in San Sebastián & Hurtig, 2004b: 208). Texaco maintains that these conditions are results of abject poverty and the lack of resources, and cannot be blamed on the oil developments (Breilh *et al.*, 2005). But as San Sebastian and Hurtig (2004 & 2004a) point out, diseases not typically related to poverty, such as cancer and various forms of leukemia, are also abundant in the region. Hurtig’s study also notes that the under-reporting of leukemia, thanks to minimal health-care access, is likely means that incidence rates are actually much higher.

Poor health conditions, driven as a result of lived-in poverty and intentional environmental degradation, would have negative impacts on communities regardless of

the presence of a physician. The core clinical competency of clinicians alone could not avert such consequences. They could, with the appropriate training and resources, provide distal treatment to such structural violence, but without broader social and political support, they would be unable to offer proximal care. As Puertas and Schessler (2001: 133) argue, the “goals of health sector reform include improving quality, correcting inefficiencies, and reducing inequities in current systems. The latter may be especially important [for] indigenous populations, which are thought to suffer from excess mortality and morbidity related to poverty.” While improving health care may not be enough to completely overcome health consequences related to poverty, it is important to identify the vulnerability of communities in order for distal and proximal treatment. Puertas and Schessler (2001: 133) figure that health-care reforms for Ecuador should “develop a comprehensive plan for health improvement; conduct research on the appropriate mix between TNM, primary health care strategies, and high technology medical services; train local health personnel and traditional healers in primary health care techniques; improve access to secondary and tertiary health services for indigenous populations; and advocate for intersectoral collaboration.”

Such reforms could be useful to improve health-care equity if embraced in a culture of service and stewardship. Focusing on the Cotopaxi region, a highland area south of Quito, Puertas and Schessler assessed the accessibility of indigenous communities to public health services. They found that about 22% of residents in Cotopaxi have the means of transportation to physically reach medical attention in less than half an hour, while 43% need more than an hour to get to a health professional. Seventy percent of their respondents reported missing work due to illness at least once in

the month prior, and 68% of this group missed up to five days. Sixty-seven percent stated that they received treatment in their homes. Treatment was provided from a range of sources, not all of which could be deemed professional under the WHO definition: Family member (47%); self-care (21.3%); physician (20.8%); *Ya'chag*, *brujo*, *colundreno* (traditional healer) (3.7%); other (7.2%). Only 8% of respondents received care in a clinic.

The results of the Cotopaxi study show that individuals mostly rely on family networks in order to receive health care. The majority of this rural population does not regularly participate in the public health-care system, and relies on more local level coping strategies. Often this involves homemade remedies and shamanism as treatments. While western medicine is retracting in its accessibility, Miles (1998) argues that TNM have gained popularity in Ecuador's urban commercial circuits, especially amongst the poor, as a result of marketing meeting a growing ideology for TNM. Perhaps this holds true in the Cuenca market, where her study took place, but in Cotopaxi, Oriente, or Bolivar, marketing has little to do with the popularity of these products. Rather it is a mix of people unable to afford primary care, others who have no trust of primary-care givers, and some who value family and community knowledge networks for advice. Puertas and Schlessler (2001) identify a number of products that their respondents regularly relied on for treatment: medicinal plants (34.4%), among the most common being chamomile tea (9.2%) and borage infusion (3.8%) (Borage infusion is made from a plant native to Ecuador, used to treat fever); milk alone, or with garlic or chamomile (2%); various compresses (1.3%); and cane sugar liquor (1.7%).

The state does not value TNM against western approaches to health care, but Cuba's MINSAP calls for a greater integration of traditional remedies into core clinical care (Padron, 2003). They do not see such remedies as alien to health care, but rather as complimentary to it. Their approach is to build knowledge, both scientifically and locally, of the potential uses, benefits and risks of TNM. ELAM doctors, through their curriculum, are encouraged to embrace TNM for the public good. Ecuador, however, has yet to demonstrate a similar initiative. Instead, TNM remains localized, outside of the public domain, and occasionally falls into a novelty discourse in places like the Cuenca market. Rather than bridging local knowledge with scientific study, Ecuador's TNM sector is marginalized by a discourse that labels it fit only for the poor and indigenous.

In Guaranda, a small town in the province of Bolívar, I observed a clear division between the cultures of clinical practice and traditional healing. Visiting the community of Palta-Bomba, located on the outskirts of Guaranda, on three separate occasions, I came to realize that the sense of mistrust of service is just as strong within indigenous communities towards the biomedical model, as the biomedical model has misgivings towards TNM. Building trust between these two communities would be a challenging feat for returning ELAM graduates.

I arrived in Palta-Bomba, as a part of a group conducting research for UBC's CIDA-UPCD project, "Sustainably Managing Environmental Health Risks in Ecuador." We were there to weigh and measure some of the town's children to see if there were signs of stunting. Stepping off the bus, it did not take long to realize that many of town's children were hobbled by poverty and poor nutrition. The children had mature faces on little bodies. Our cameras captured their smiling faces, their play, and the fact that these

kids were too small to be this mature. The physicians in the group did the proper weighing and measuring procedures and determined that many of the children were below the average body mass index and height index for their age group.

Hidden hunger³⁴ was rampant in the community, yet community members put on a huge feast for us. They served soup, corn, more corn, cheese, pork and eggs. I could hardly finish, and before I got up to walk off the meal, one of the town's elders came up to me, and asked if I was the one who went to Cuba. "Yes," I replied.

"My son is in Cuba. He is studying there."

"Really? Is he studying to be a doctor?"

"Yes, he has been there for six years."

The man told me that his son would be back in a month, and that I should meet with him. A month and a half later I returned to find Gonzalo. It was not easy. I had no phone number, and only a first name. I was staying with Juan Alberto, a good friend of mine, and his wife. That night, I asked Juan how we would come to find Gonzalo. "Don't worry," he replied. "Tomorrow we will find him." And we did, after about six hours driving up twisting roads and asking every person we saw if they knew Gonzalo. Gonzalo's house was a typical house for Palta-Bomba – sparse with no sure plumbing. A few chickens and a couple of dogs mustered next to us while I talked with the recent Cuban graduate. His mother came out with giant maize and cheese tortillas. Plate after plate arrived. It was hard to believe that hunger, hidden hunger even, engulfs this town. In between mouthfuls I managed to ask Gonzalo, "You studied medicine in Cuba?"

"No."

³⁴ An expression used when there may be food available, but it is of such low nutritional value that the body suffers and health consequences occur as a result.

“No?”

“I was studying agricultural sciences at Villa Clara.”

Gonzalo did in fact leave for Cuba with the 1999 cohort of ELAM students, but his scholarship was for agricultural sciences rather than medicine. Medicine is only one of several scholarships that Cuba offers to students in Latin America. Other subjects include: Natural Science, Social Sciences and the Humanities, Economics, Technical Sciences, Agricultural Sciences, Medical Sciences, Drafting (self-funded), Teaching, Physical Education and Fine Arts (self-funded). In 2006, Gonzalo returned to his home community with a Master’s thesis in hand. Like the ELAM scholarship, his degree was free, and he had made a moral commitment to return to his home to apply his skills and transfer knowledge. Indeed, Gonzalo’s research could be interpreted as a proximal health intervention aimed at food security in his community. His Master’s focused on a potato breed that is adaptable to the Andes, and can flourish with only organic inputs. He figured that promoting knowledge about this type of potato would allow farmers to abandon conventional agriculture that requires costly fertilizer and dangerous pesticide inputs. In a way, Gonzalo’s thesis could have a great deal to do with health, just not health care.

I changed the conversation. We shared stories about Cuba for awhile, and then we included his mother and sister to talk about health-care services in the community. I reached a conclusion pretty quickly – There are none. There is a first-aid station in the school, and not much past that. The road to Guaranda takes about thirty minutes in a truck, as the road is in poor shape. It is washed out in parts and it makes for a treacherous

drive. His mother told me that she takes care of most of the family's maladies with traditional herbs, soups and teas.

“What if someone has an intestinal infection, with severe diarrhea?”

“That can be treated here with what we have.”

“But what if someone was pregnant, and needed a doctor, or say had a very high fever? Would you see the doctor at the free clinic in town?”

“They experiment on us,” she quickly replied. “They try to convince us to take all of sorts of drugs. They discriminate. Someone from the community will not be treated with the same respect as a person from Guaranda.”

Turning to Gonzalo, I asked for his opinion. He said that sometimes it is necessary to take someone to the hospital, but most problems are dealt with in the community. This often involves consulting a shaman or “*colundreno*” to help with the healing process. Fany Esperanza later told me in Loja that the most vulnerable populations in Ecuador are often the ones that rely heavily on the *colundrenos*. The recent ELAM graduate was not overly keen on this trend. While she praised the use of TNM, and noted the value in exploring treatments outside of the biomedical model, she had serious concerns about the *colundrenos* lack of scientific knowledge. “They do not know the basics, such as physiology or histology.” For Fany, and several other ELAM graduates, the problem with TNM in Ecuador is that it has not been standardized and researched well enough to fully understand the biomedical processes, benefits and consequences that come with the practice.

I asked Gonzalo if he knew any of the Ecuadorian ELAM students, and he said that he knew quite a few. “Do you think that they would be able to help out communities such as yours, offering services and advice?”

“They won’t come to us. They will take their degrees and work in the private sector. There is more money for them there. That is where they are all going to go; none of them are working in the communities. There is no other place for them to go.”

Pessimistic about the current situation as he was, Gonzalo talked highly about his time in Cuba. He reflected upon his interaction with the professors, the rigorous study, the friends that he made; but back home, frustration was already engulfing him. Despite his Master’s degree, and his pitch for a new type of potato, he was without work. He admitted that he might have to leave his community in order to find work, and he felt that ELAM graduates would be in the same spot. From the point of view of Palta-Bomba, existing socio-economic structures were offering very little to afford people like Gonzalo opportunities to help meet the needs of communities.

When it comes to meeting the public’s needs, services for pregnant mothers and newborn children are the only components of the public health-care system that are universal. Ecuador’s Ministry of Public Health provides a small set of services free of charge to children less than five years of age, as well as to expecting and recent mothers. It is the only aspect of the public sector that is universally free, but is still marginally accessible. In the Sachas clinic, I noticed a faded and tattered poster hung above the clinic’s only waiting bench. It outlined the free services offered to mothers and their children.

It read: “The Ministry of Public Health’s Act for Free Maternity and Infant Services includes the following services, along with medication, vitamins, examinations and all materials.”

For mothers, the act includes services for:

- Control of the pregnancy
- Complications of the pregnancy
- Normal or cesarean birth
- Pap exams
- Blood donations
- Dental care

For the mother and her partner, the State provides sessions on:

- Family planning
- Education sessions on sexually transmitted diseases.

For the child, the free services include:

- Attention of newborns with or without complications
- Regular check-ups
- Treatment of typical infant diseases
- Treatment of complications during the hospitalization
- Blood donations
- Dental care

And at the bottom of the flyer, barely noticeable as it was faded from the sun, was a small statement telling patients to “Exercise your rights! Visit a hospital, or a health sub-centre.”

Puertas and Schlessler’s (2001) study confirms increased participation in this sector. Their findings show that services covered by the Maternity and Infancy Free Services Act are the one part of the health-care sector that receives social and political support. They found that 34.7% of recent mothers had prenatal check-ups with a physician, 24% were attended to by a midwife, 19% consulted a family member and only 4% did not receive a check-up. However, when it came to the actual delivery itself, only 12% of recent mothers gave birth under a physician’s supervision. Family members were

the principal attendants for 45.4% of the births, midwives oversaw 29%, and nurses attended to only 4%. In all, 90% of the 2,112 births were born alive in this study area in the highlands.

Puertas and Schlessner show two clear trends. First, under the Maternity and Infancy Free Services Act, more individuals, especially women and children, are more likely to seek out health-care services from the public sector. The percentage of mothers who received prenatal examinations from a physician is higher than the percentage of people who received physician treatment for maladies not covered under the Act. The second trend is an incredibly low level of physician attendance to births. While this is still a free service, it is not one that has high levels of consultation. Hospitals are quite inaccessible from rural and especially indigenous communities. If Palta-Bomba is any indicator, a low level of trust towards the public system and physicians would contribute to mothers seeking out home-birth options in their community rather than entering into a clinical setting. Both trends demonstrate barriers based on a lack of infrastructure and socio-political support.

Ecuador's Public Health-Care Capacity

Ecuadorians have little room to “exercise their right” in health-care provision beyond the Maternity and Infancy Free Services Act. Some level of payment is required for all other services, which may be as little as \$1 for a visitation and very little material or human resources are earmarked for service provision. Health care is handled by four different sectors. The Ministry of Public Health covers about 30% of the country's population; the *Instituto Ecuatoriano de Seguridad Social* covers mostly State employees (18% of the population); the military provides coverage to its personnel and their families

(2%); NGOs offer care to about 5% of the population; and finally, the private sector, operating across the entire country, serves an estimated 20% (Cavender & Albán, 1998; Pan American Health Organization, 2006). In 1998, the Pan American Health Organization (PAHO) determined that 30% of the country had no sustainable access to medical care (Pan American Health Organization, 1998). This was up from 10% in 1980. In 2002, PAHO figured that 25% of the population remained unattended, most of whom “are Amerindians, of rural areas located in the central provinces, the Amazon area and in urban shantytowns” (Pan American Health Organization, 2006). PAHO figures that 52% of the population has the financial capacity to access both private and public insurance, while 23% have no financial capacity.

The Ministry of Public Health operates auxiliary health-care posts for small communities of less than 2,000 people, medical sub-centres staffed with physicians and nurses for communities up to 5,000 people, and provincial and national hospitals which operate in major urban centres. For Ecuador’s poor, the sub-centre is usually the entrance point into the public health network. Typically, they are humble structures with a few consultation rooms, limited supplies and some dental facilities (Cavender & Albán, 1998). These facilities are meant to handle basic treatments and a few more complex procedures that would require minimal diagnostic equipment. Physicians do refer patients to provincial or national hospitals for more complex conditions; however, the means of transport is left up to the patient.

Ecuador has one physician for every 675 people, one nurse for every 636 people; but it is nowhere near as harrowing as, for example, Honduras with one physician for every 1,734 people, or Haiti with one physician for every 4,000 people (World Health

Organization, 2007). Still, where Ecuador's human resources are found, and how accessible they are to vulnerable populations, is quite problematic. PAHO estimates that up to 92% of the country's human resources for health are located in urban centres, with only 59.2% of the workforce employed in the public sector (Pan American Health Organization, 2006).

The over-accumulation of resources in urban areas, lacks access for indigenous and indigent communities, and lack of capacity of human resources for health have produced an "anti-model" of health care (Candib, 2004). It is a model that is not equipped to build health, but only to deal with death and illness. Mechanistic and distal, health care is regulated throughout the country, regardless of the private or public sector, by cost-benefit analysis. People are not given the greatest amount of care possible; they are relegated services based on their capacity to pay for them, or how much time and attention the system can afford them. Physicians, Candib argues, perpetuate this anti-model because they are tied to "a system of power and knowledge dependent on the dominant ideology and by consumers [who] see health care as a...good that should bring happiness once acquired" (Herrera Ramirez & Garces, 2003 in Candib, 2004: 280).

Decades of disinvesting in a public sector has resulted in a disinterested public sentiment. A culture of profit by physicians, a culture of cost-cutting by the State, a culture of mistrust among the vulnerable and a culture of consumption in urban areas all work towards limiting the potential for expanding the equity of Ecuador's health-care system. The danger is, according to Mehlman (2005), that neoliberal tendencies to promote individual choice in health care provision can lead to remedies that border on quackery rather than actual care. Farmer (2005) argues that the fact that such individuals

have to choose between TNM and clinical practice demonstrates the poor quality of the public clinical sector, rather than “the quality of the patient’s ideas” about disease. Having the choice to not participate in the public sector, even among members of vulnerable communities who commonly seek out TNM, acts to limit the capacity to improve a system that, as Candib (2004) rightly points out, has become more inclined to repair individuals and save money, than build health and expand services.

A system that repairs people before building health emphasizes the physician’s skill to mend illness rather than to practice health promotion. First, in this system, physicians are practitioners of biomedicine, and their prestige is obtained through their elevated knowledge of science. Second, prestigious physicians should be able to practice medicine for lucrative rewards. Third, primary care, and COPC, does not require elevated scientific knowledge, and hence does not merit large financial remuneration. Primary care, and COPC, is treated as a charitable obligation, and one that is not regarded as noble. A public-sector family physician is not eulogized as highly as a private-sector specialist, and this value system unfolds where physicians are able to gain sustainable employment.

This is a very important discourse, and it has very real effects in the training and development of physicians. Ecuadorian medical schools focus on science, encourage students to seek out for-profit specialization, and community service is just a mandatory, but temporary, right of passage. In a country of about 14 million people there are only 70 residency-trained family medicine physicians practicing. (Herrera Ramirez & Garces, 2003 as in Candib, 2004). Of the 18,335 physicians, not even 1% of them have specialized in family medicine, let alone COPC. The country’s five public medical

schools: *Facultad de Ciencias Medicas - Universidad de Cuenca*; *Facultad de Ciencia Medicas - Universidad de Guayaquil*; *Facultad Ciencia Medicas - Universidad Nacional de Loja*; *Facultad Ciencias de la Salud - Universidad Tecnica de Manabi*; *Facultad de Ciencias Medicas - Universidad Central del Ecuador*; and three private institutions: *Facultad de Medicina y Ciencias de la Salud - Universidad Católica de Cuenca*; *Facultad de Medicina - Universidad Católica de Santiago de Guayaquil*; *Colegio de Ciencias de la Salud - Universidad San Francisco de Quito*; collectively graduate well over 300 general basic doctors each year. Yet, due to lacking residency spaces, almost none of them enter family medicine; a specialty that is most suited to delivering proximal care and COPC goals at the community level.

Ecuadorian medical education is geared towards specialization. The training focuses on scientific rigor and the student's ability to test for diseases using high-tech medical resources at hand. The curriculum is dedicated almost entirely to pathophysiology, while no time is dedicated towards disease prevention and community-based medicine. I met with three medical students from Quito's *Universidad Central*. They were all from Quito, and they all hoped to eventually work in the city. They do not pay tuition at the public institute, but they are responsible for every bit of course material throughout the program of study. Aside from purchasing text books, students must also pay for lab equipment and various other materials. They figure that they spent about \$500 a semester on materials. The students felt that despite the free tuition, the costs of living combined with the incidental costs of the program were quite high, and they had to rely on the support of their families in order to pay for school expenses, rent and subsistence.

They said that the classes were very large, and they spent a great deal of time in the lecture hall until their third year. They also said that the first two years are very difficult, with a great deal of time handling biomedical sciences in the lecture hall (Cazar Garcia, 2006; Garcia Aguilera, 2006). In the Central University the number of the students in the first year is reduced to half in the second year and after six years only a small proportion of students graduate from the program. The students admitted that their program did not offer courses on public health, disease prevention, or TNM.

Degrees can run between six and eight years for the title of *médico general básico*. Basic general doctors must spend one year of obligatory service, regardless of the graduating institution, working for the Ministry of Public Health in rural or indigent communities. After that, general basic doctors must receive a registration license from the *Colegio Médico de Pichincha*, awarded for passing a competency exam and residency, and then licenses to practice are granted by the Ministry of Public Health. It is a fairly typical process to any medical licensing procedure; however, the *Colegio Médico de Pichincha* has a limited number of residency vacancies. Few residency spots are available annually, leaving the majority of basic general doctors searching for placements. Recently, many have taken flight to Chile to find work. Currently Chile's doctors are moving into the private sector while Ecuadorians migrate to the country to work for a lower wage in the public sector. Colombia is another appealing destination to secure a specialization in the more abundant residency spaces.

Ritha Bedoya, a post-doctoral fellow at Ecuador's Facultad Latinoamericana de Ciencias Sociales, said that the immigration to Chile is having a massive impact on Ecuador's human resources for health. Seventy-three percent of the medical technicians

in Chile are Ecuadorian. “They are graduating from our public medical schools in order to serve another country.”

“They don’t try to immigrate to the United States?” I asked her.

“If they did, they would be cleaning toilets,” she replied.

Chile accepts their degrees and uses their skill set. A young Ecuadorian doctor has no chance of working in the United States; this is why there is a great deal of health personnel migration across the borders of countries in South America. Ironically, the State Department has no qualms about issuing green cards, and citizenship, to students with Cuban medical degrees.

The students from Quito’s Central University admitted that they would likely seek employment or specialization out of the country, at least for a while. “You can make a lot more money in Chile,” one student commented. Another mentioned that in Chile your medical degree is accepted, and it is easy to get a residency placement. “The Chilean doctors work in their cities, and we go to work in the rural areas.” Another student mentioned that she is seeking specialization at a medical school in Mexico City because “it is a prestigious institution.” The students also complained that Ecuador does not offer spaces for specialization. The private schools have spaces, but the tuition can be as high as \$10,000 a year. Other countries such as Brazil and Argentina often receive Ecuadorian students for specialization, but the tuition and cost of living are quite high as well.

In a climate that uses its preciously scarce medical resources towards advanced specializations, Candib (2004) argues that the challenge, beyond lacking resources, is establishing the legitimacy and merit of family medicine. Even in Cuenca, where the medical school is a radical exception in its mission to encourage socialized medicine, this

challenge persists. Throughout the campus, murals of Dr. Ernesto Guevara cover the walls. The campus housed the People's Health Assembly in 2005, where it was declared that health is a human right for all, and that empowering human resources for health mattered (San Sebastián *et al.*, 2005). The school's mission is socially orientated and expresses a commitment to improving the human condition, "A faculty committed to the development of human resources for health as a response to the social needs, and to contribute to the human development of the region and the country" (Facultad de Ciencia Médicas, 2007). The school's third stated objective is to participate in programs that give priority to the country's marginalized populations. However, despite all this progressive language also has many limitations as it does not work with the marginalized, but only works through existing programs.

Ritha and I discussed how physicians who are dedicated to serving the public sector manage to make ends meet. A monthly salary for a specialist working in the public health stream is no more than \$350 a month, while a specialist working in the private sector can make ten times that amount. She said that public physicians work in the private sector as well; they have to. If a family doctor can put in eight hours a day, they can dedicate four hours to family practice in the public stream, and the other four hours to their specialization in the private sector. "It is a broken system," she said. Physicians can not delegate their time that evenly and there is no law to ensure that their public service is on par with their private practice. "There is a great divorce between the two systems, and family doctors practicing in the public system are over-occupied with their commitments to private practice," said Ritha. Such a system fractures a physician's skills and time down a line of profit and charity.

In the end, family physicians are left without prestige or remuneration, and because the system has rigorously valued specialization and privatization, very little public understanding exists as to who a family physician is and what they do. In order for Ecuador to overcome this problem, the Correa government would not only have to guarantee more residency placements in family medicine, but actively work to build a popular culture that values family physicians.

The Año Rural - Compulsion or Compassion?

And yet, despite the lure of lucrative business and scientific recognition, every single general basic doctor is obliged to serve a rural or indigent community before they can be licensed. This obligation is called the *año rural*. It is a one-year contract, with two three-week holiday periods included, that is aimed at sending the annual graduating class of doctors from Ecuador's medical schools to rural communities. Specialists are also expected to enter a year of rural service, but they would practice in hospitals, rather than the smaller clinics. On the surface, it may seem in line with the ELAM goal. However, the *año rural* has numerous problems in terms of retaining physicians, building community trust and expanding COPC. Cavender and Albán (1998) studied the program in 1998, and concluded the success of the *año rural* depended a great deal on the physician's attitude towards health-care service in vulnerable communities.

Compulsory service programs have been implemented throughout the hemisphere with the general assumption that the presence of health-care professionals would improve health indicators in marginalized communities (Asturizaga Rodriguez, 1996; Ugalde, 1984). However, some studies have shown that compulsory service is problematic, and may have an adverse effect on developing COPC (Rubel, 1990). For Ecuador's *año*

rural, some problems are easily identifiable. First, the curriculum from the country's medical schools, with some possible variation in Cuenca, is heavily focused on clinical care in urban centres that are furnished with reasonable material resources and information networks. In Bolivar, or Oriente, resources are few, and networks non-existent. Young basic general doctors are thrown into a system for which they were not trained, and, more importantly, a system which their training did not value. Second, the physicians going into the *año rural* are young and inexperienced. Gonzalo's family, which believes that the physicians in the clinic were experimenting on the indigenous, may have a reason to believe so. Young doctors, lacking clinical experience and confidence, could likely give the air of folly, or a lack of confidence, in dealing with new patients. Third, the *año rural* is only a year. For communities that rarely access health-care services to begin with, a perennial turn-over of general basic doctors does not allow for the development of long-term patient-doctor relationships. From the point of view of the doctor, the year of service is an obligatory transition period, but from the point of view of the communities for which the *año rural* is meant to serve, these fly-by-night doctors are all they have. They are the only face of health care many of Ecuador's most vulnerable will ever know. The *año rural* is a program presented as altruistic, but does little to broadly implement empathy for the indigent.

Unless, of course, in the perennial cycle of physicians some dedicated souls embrace a culture of service and try to foster long-term connections with the communities. But even if some young physicians manage to build trust with communities, the Ministry of Health does not often allow them to stay on in these communities. When their contracts terminate they are expected to seek out specialization

and residency. It wouldn't matter, according to Ritha, as she says that the physicians on the *año rural* "have their hearts in the cities." Certainly the year in the field is an eye opener for many; it likely does well to bring doctors to the face of a reality which they have never experienced, but in the end, it is a government law, a compulsorily activity rather than an activity to further prestige. The students from the University Central all expressed a degree of excitement about the *año rural*, but they all admitted to wanting to serve in Quito.

"Do you think that you will practice in the public or private sector?" I asked them.

"Both," they all replied. "We could not afford to remain just in the public sector, but our services will be needed there and we want to help."

One student suggested that if she is admitted to the specialization program in Mexico, in pediatrics, she would not have to commit to the *año rural*.

Understandably, some young doctors would not want to participate in a year of rural service. Cavender and Albán (1998) found that 59% of physicians received no orientation training before the *año rural*, and many felt overwhelmed by the entire experience. From their study, and as I can personally attest to from my experience in the sub-centers, basic medical resources were in short supply. Anything past disinfectant and cotton was hard to come by, and maintaining cleanliness of equipment and observation rooms was also difficult. Aside from the minimal infrastructure and the overwhelming poverty in the communities, some physicians (35%) found the transition to basic living conditions quite difficult, and 38% said that they experienced problems of cultural difference while in the field. Nevertheless, over 90% of respondents felt that that *año rural* was a positive experience that furthered their awareness of the poverty and the need

for improved services in outlying areas. Cavender and Albán (1998) also found that the majority of their respondents expressed great concern over the dependence of TNM in the communities, and their findings show a strong discourse of mistrust by young physicians towards TNM.

The sub-centers in Oriente, Bolivar, and any place where the majority of Ecuador's doctors are not veterans, are staffed with general basic doctors on the *año rural*. They are the front line between the indigent and public health. Under-equipped, under-skilled, and loosely supervised, they are thrown into a new context unfamiliar to what their skills and ethics have been geared to. Rural communities know that the State is sending young graduates whose skills and capacities are still green. This is a clear message to indigenous and indigent communities that the specialists and the senior physicians are reserved for the sector of society that is willing to pay for their superior skills and celebrated merit.

On December 19, 2006, the Minister of Public Health, Guillermo Wagner, was quoted in a large newspaper, *El Expreso de Guayaquil*, as saying that there is an advance in the country's health indicators, but there is also a lack of resources for basic needs (Constante, 2006). The Minister assured the reporter that advances were taking place in moving the country closer towards the millennium development goals. Malaria and some of the base indicators, such as infant and maternal mortality, were declining, in part thanks to the Maternity and Infancy Free Services Act. But nothing was mentioned about improving primary care.

With a quarter of Ecuadorians lacking primary care, and new medical graduates taking flight to other countries, any improved indicator could be deemed a shining

success. Nonetheless, the broader issues that prohibit public health care from reaching out to indigent communities have yet to be overcome. Poor infrastructure, minimal support, transitional medical personnel, mistrust between communities and physicians, and an operating culture that values profit above compassion, are all factors that Ecuador's fifty-four 2005 ELAM graduates had to face. They, too, would come from a system that was different from their work environment. They were trained in a system that embraces social cohesion, participation and the public good. In July 2005, at the party in *barrio playa* in Havana, each and every soon-to-be ELAM graduate I talked to expressed a mix of apprehension and excitement about their forthcoming return home. Delighted to return to their homes, but daunted at what would face them in the clinic, they would go back to skeletal public infrastructure, gutted and disregarded, as is the after-effect of decades of neoliberal decision making.

This chapter has shown the face of neoliberal hegemony in Ecuador's public health-care system. The fractures, the inequities and the culture of mistrust are all significant structures with which ELAM graduates have to contend. Moreover, participating in the *año rural* is hardly an aperture of dissent. The *año rural* does little to expand access, overcome structural violence and counter neoliberal hegemony. It is only a mandatory period of charitable service. Neoliberal decision making has ensured poverty in what could be a wealthy nation. Ecuador has tremendous human resource capital and natural wealth; yet it is unable to provide universal health care, literacy and human security. The reasons for such inequities are complex and deep-seeded to the Colonial era. They are also extremely entrenched, and band-aid policy frameworks will

likely not be able to mend the wounds of centuries of economic and racial marginalization amongst the poor and indigenous.

It can be a bleak outlook when trying to envision human security across such a landscape. But while the culture of mistrust dominates Ecuador's public health-care sector, the participation in services aimed at infants and their mothers remains quite high. This is the one sector of public health care that is treated as a right, and people engage it more than other public services that are not free. It shows that services put into the public good can, in fact, be embraced by the public. The Correa government, in its current search for emboldening public health, must realize that fitting policies could be put in place to expand this public good, and the skills and compassion of ELAM graduates could play a big part in the process.

In August, 2005, the fifty-four Ecuadorian ELAM graduates knew that this is the landscape that they would face. They had known it ever since they came to Cuba in 1999. Could these fifty-four Cuban-trained doctors make a difference in a country where one in four people are without medical care, and where not even 1% of doctors are specialists in family medicine? I am sure that some felt that they would make a difference; maybe they felt that they could make in someone's life a bit better. They returned to Ecuador because they embraced Cuba's ethics of medicine as service, and were trained in the broader determinants of health, after all.

But I also know that most of them felt that they, along with the 300 nationally trained general basic doctors entering into the *año rural*, would not make the slightest bit of difference. That is why only eleven went back.



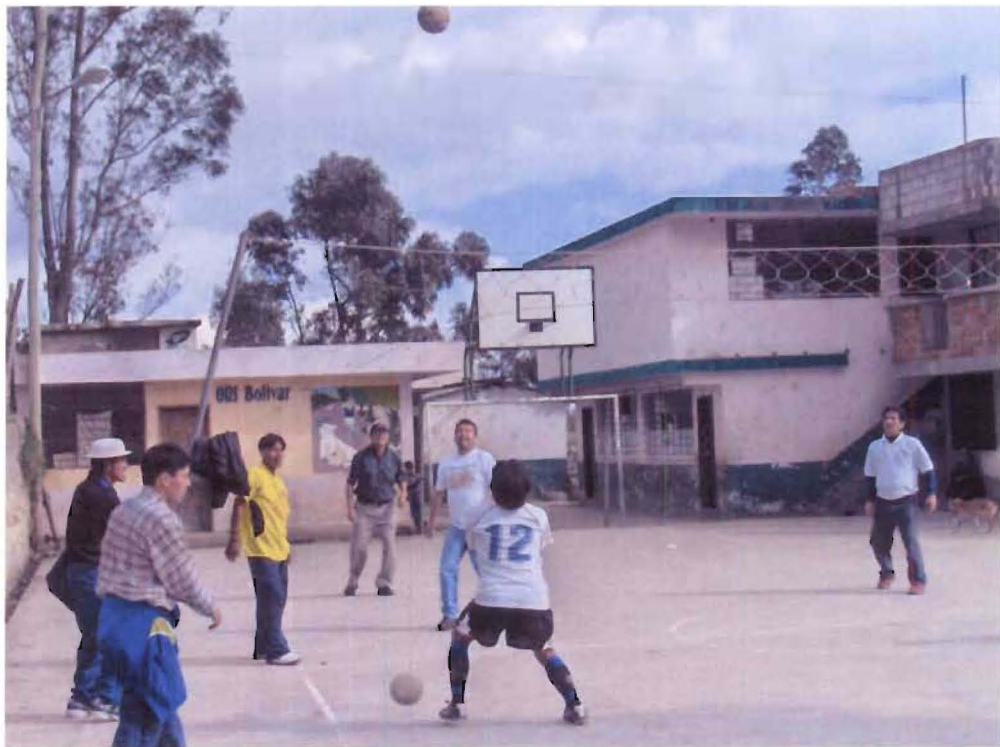
(Fig. 26) Participants in the People's Health Assembly in Cuenca, Ecuador, July 2005
(Fig. 27) A mural of Dr. Ernesto "Che" Guevara keeps watch to the entrance of Cuenca's medical school.





(Fig. 28) Children in Palta-Bomba, Bolivar, Ecuador

(Fig. 29) Volleyball in Palta-Bomba



(Fig. 30) A poster in the Sachas clinic listing free services offered to mothers and children.





(Fig. 31) The emergency ward in the Sachas Clinic.
(Fig. 32) A useless and flooded *consultorio*





(Fig. 33) CENIRMED. As it reads on the front door, they accept Visa.
(Fig. 34) A private-public partnership clinic in Sachas.



(Fig. 35) A map from ELAM indicating the homes of Ecuadorian ELAM students.



Chapter 7
The Challenges of the Field:
Analysis of the Professional Experiences of the ELAM Graduates in their Communities

~ Is it not also true that no physician, in so far as he is a physician, considers or enjoins what is for the physician's interest, but that all seek the good of their patients? For we have agreed that a physician strictly so called, is a ruler of bodies, and not a maker of money, have we not? ~

-Plato

“There are only ten of you?”

“Well eleven, actually,” Dania replied.

“Eleven? I thought that the first graduating class had fifty-four students from Ecuador.”

“It did, and the other forty-three are still in Cuba. And one more, who is actually in Quito now, will be returning in November.”

“But that is only one-fifth of the graduating class! Why did everyone stay in Cuba? I thought the plan was to use your skills to serve the *campos*?”

Dania Suarez told me that only a handful of Ecuadorian ELAM graduates had come home. It seemed that the school’s capacity to promote organizational change through human resources for health was not happening. In fact, close to 700 students from the total graduating class stayed in Cuba after their convocation at one of Cuba’s 22 universities. They did not stay in their host country to work for profit, which tends to happen to foreign medical students educated abroad (Cooper, 2003), but they stayed to continue their studies in a specialization of their choice. Those who remained in Cuba took advantage of MINSAP’s offer for free training in a specialization of their choice in addition to a specialization in integrated family medicine.

In 2005, reintegration strategies for ELAM graduates existed with Venezuela, Ecuador and Paraguay. Other countries such as Guatemala, Nicaragua, El Salvador and

Honduras had less formal arrangements for the graduates to work alongside existing Cuban medical brigades in rural areas. Venezuela had a strategic reintegration plan put into place to see graduates return to vulnerable communities involving a set time of service. After this contract, students could pursue specialization opportunities (Muntaner *et al.*, 2006b). In Ecuador and Paraguay, students were integrated into one-year contracts for service in rural areas, which, in the case of Ecuador, meant participation in the *año rural*. But, after the one-year contract, no formal employment arrangements were established. Other countries like Peru, Antigua, Argentina, Guatemala (despite the presence of Cuban medical brigades), and Brazil all refused to acknowledge the ELAM degrees. However, in 2007, Argentina and Guatemala declared that the ELAM degrees would be accredited. Antigua just recently restated its unwillingness to accept ELAM degrees, demanding that students pursue further training in their national system. The United States, however, showed an overly enthusiastic response to ELAM, by not only recognizing the value of the degrees of their own ELAM graduates, but by also offering citizenship to ELAM graduates from any other country if they applied for residency at a U.S. medical school (Carrillo de Albornoz, 2006).

Other than in Venezuela, no long-term reintegration program for ELAM graduates existed as of 2005, and instead of turning the graduates over to market forces, Cuba offered training for specialization in integrated family medicine³⁵ in addition to a specialty of the graduate's choice. The family medicine specialization would be over a course of two years, and the additional specialization could be anywhere from three to five additional years. The offer was a response to ensure that the ELAM students would

³⁵ Integrated family medicine is the preferred term for this specialization, although it could be considered close to community medicine as the trainees work in rural settings and practice medicine in the community at the *consultorio* level.

not be driving taxis and seeking out private sector employment, as is the case of so many physicians in Latin America (Frenk *et al.*, 1999).

However, this raises two questions about the continued retention of ELAM graduates in Cuba. First, to what extent is Cuba leaning on the retention of ELAM graduates in order to offset the number of physicians that it sends to other countries through comprehensive medical brigades, the Henry Reeve brigade, or other health collaborations? I would contend that the specialization offer was extended solely for the purpose of replenishing Cuban physicians overseas, but no doubt, additional retention of ELAM graduates working in rural Cuba for their family-medicine specialization is a small contribution towards offsetting the absence of 31,000 health professionals committed to overseas service.

Second, how will the ELAM graduates, who are undergoing an additional five to eight years of education in Cuba, manage to reintegrate into their home communities after such extended absences? Specialists are far more likely to work in hospitals, and in urban areas where resources are more abundant. In Ecuador, specialists who are trained overseas must commit to the *año rural*, but at a large hospital, rather than a local clinic. Moreover, what cultural and social challenges would an ELAM graduate experience after being removed from the field for eleven to thirteen years? Most of the Ecuadorian ELAM graduates have fallen into this category. The State has not properly accommodated them, and as such, many have stayed on in Cuba to further their knowledge of medicine and community health-care service. Dania Suarez reminded me of the value of specialization when she said that it is “incredibly important to continue studying and to become the best physician possible.” Her commitment to community

service and her desire to master her medical knowledge opens up a spatial dichotomy that health-care systems in the global South, or the global North for that matter, have not yet fully overcome. How can physicians further their professional education, yet remain available for service to vulnerable communities? This dissertation has already addressed how institutional ethics of many medical schools drive a migration pipeline away from communities. But even with a program like ELAM, dedicated to community service, this remains a challenge. While the Cuban health-care system allows for specialists to work at the provincial level, Ecuador has very little infrastructure to retain specialized human resources outside of the main centres of Quito, Guayaquil and Cuenca.

While the experience of the ELAM graduates carrying on in Cuba is beyond the scope of this study, this chapter focuses on the experience of the small group of graduates who did return to Ecuador.

“Why did you come back?” I asked Dania.

“We made a commitment to Cuba to serve our communities.”

I asked her if perhaps the others are not as eager to work in the remote locations of this country. Or maybe something personal is keeping them in Cuba?

Even Rector Juan Carrizo admits that the work environment awaiting ELAM graduates is not overly appealing. He said that they face landscapes “without electricity, without other doctors, and with many many mosquitoes.” So perhaps, from this point of view, extra time working in Cuba is not such a bad deal?

After six years in Cuba, Dania is one of the graduates who came back home. She returned because she felt compelled to serve, and after the *año rural*, she was left without a job, seeking out specialization options in other countries, including Cuba. Dania and

Albania Tamayo said that they felt a commitment to serve the marginalized. For Jacqueline, Fany, Elizabeth and Arlena, being closer to their families was just as important as the commitment to serve. And for Ricardo, a commitment to serve combined with a desire “never to return to Cuba” brought him home. Community service, pining for home and wanting to get somewhere that had a wider variety of food and other consumption choices all played a part in the return of these ELAM graduates. These are personal choices, not contractual obligations, which makes this a unique case against many of the tried, and failed, incentive plans that contractually bind doctors to serve in rural areas³⁶ (Hutten-Czapski, 1998).

Aside from identifying their motivations, this chapter explores how capable the students considered themselves for expanding COPC goals. It begins by discussing the major themes in my questionnaire that seek out the ELAM graduates’ capabilities in core clinical competency and COPC. Following is a discussion of each interviewee’s case site: La Joya de los Sachas, Zamora, Loja, Imbabura and Quito. I offer discussion of how the Cuban embassy in Quito and various solidarity networks are working to assist the reintegration of students into their Ecuador. Ecuador is politically neutral, if not sympathetic, towards Cuban initiatives, and yet president Correa has not fully embraced the potential of the ELAM graduates. Building better understanding of the ELAM graduates’ experience is one step towards developing appropriate policy actions for future change in Ecuadorian public health.

³⁶ Hutten-Czapski (1998) found that many contractual or forced-service medical postings are often disastrous. Physicians are often frustrated from the experience and marginalized communities are left with a continuous treadmill of new physicians trying to integrate in their communities rather than establishing long-term practice.

The chapter shows that graduates felt confident in their core clinical competency, but they also felt overwhelmed and dissatisfied in their efforts to expand COPC. Moreover, radical provincial differences exist in the reintegration experience, which demonstrates tensions in the public health-care system among provinces. These are tensions of inequity between provinces, and they are ones that can be overcome with appropriate planning and political leadership. The case of the ELAM graduates from Imbabura demonstrates that their reintegration furthered COPC at least somewhat through some minimal education and awareness campaigns at the community-level. From these experiences it is just as possible to assume that ELAM graduates may give up on rural reintegration because of weak infrastructural support, and yet it is also possible to assume that the Correa government has the ability to enhance rural reintegration in order to assist ELAM graduates meet their stated goals.

It's a Private Affair:

While my interviews took me into Ecuador's public health-care system, it was in late September, 2006 that I stumbled upon the for-profit side. Walking along Avenida de Amazonas in Quito, I noticed a sign reading, "Cuban-Ecuadorian Medical Specialists: International Centre for Medical Reference." For a moment, I thought, "Excellent! A collaboration between the two countries, they must have ties to the ELAM graduates!"

But something did not seem right. Perhaps it was the neighbourhood this clinic was in. Amazonas is one of the wealthiest parts of Quito. The foreign automobile dealerships, the large mall, and the lack of sidewalks suggest that the poor have little need to come to this part of town. The vehicles parked out front of the clinic were expensive Japanese S.U.V.'s. There was no Cuban flag, no national iconography, not

even a bust of José Martí or Ecuadorian national hero, Eloy Alfaro. Then, from across the street, I saw the little logo that gave it all away. “We accept Visa.” Was Gonzalo right? Had the Cuban-trained doctors gone to the private sector?

I entered the clinic, officially called “*Centro Internacional de Referencia Médica*,” International Centre for Medical Reference, (CENIRMED). A friend, Fatima, had previously obtained the contact information of the head doctor, and she said that I should go by for an interview. I walked in, and found a long queue of patients. They were waiting for triage. Two nurses were handling most of their requests, and slowly the line-up whittled down. Considering how many people were packed in the foyer, I figured the clinic was overworked. I told the secretary who I was, and she invited me to wait upstairs, and said someone would be along shortly. I sat in the waiting room between four doctors’ offices, each complete with a physician inside. I waited for an hour. Every so often the odd patient would come up to see a physician. Most came out with written prescriptions, and one family emerged from an office with their little child holding a lollipop but bursting with tears, having been freshly stung with a vaccination.

After an hour I had enough of waiting. I knocked on one doctor’s door, but he told me that he was too busy to talk. Ten minutes later he left, hat on his head, and umbrella under his arm. I knocked on another door and interrupted a doctor playing Tetris. He invited me in to have a chat. I asked him about this clinic.

“This is a private clinic; we do not have any relations with the Ministry of Public Health or with Cuba.”

“But your sign reads Cuban-Ecuadorian clinic.”

“Yes, there were some physicians here who once took a couple of specialist courses in Cuba.”

“So, you have no Cuban doctors working here, and no students from ELAM?”

“No, none.”

“But the name of your clinic?”

“It was another group of physicians that came up with it, and besides, patients respect Cuban medicine.”

Later, I noticed a second clinic on Avienda de los Americas that advertised specialists in Cuban medicine. It is a bit of a joke for the private sector to advertise Cuban medicine as a competitive edge, one that can attract clients knowledgeable enough about the benefits of having a physician with Cuban medical education. What is no joke is the inability of the public sector to embrace this comparative advantage. Ecuador’s public system is indifferent to Cuban medical education, and yet the private sector sees the competitive edge in the name alone. It is a bizarre reaffirmation that public knowledge of the quality of Cuban care creates market incentives, and at the same time it does not overcome public sector indifference. And yet both the public and private sectors tend to abhor the principal concepts of disease prevention, health promotion and medicine in the community.

My interviews and visits with eight of the ELAM graduates in Ecuador illustrate well how the public system overlooks their skills and compassion. Aside from spending many days with the ELAM graduates, I asked them a series of questions concerning accessibility to their patients, whether they had additional employment, the role spatial and physical boundaries played in promoting access to their patients, the costs of their

service, who uses their services, how effective they felt their skills were in expanding popular health provision, how confident they were with their diagnostic and treatment skills, if they had networking opportunities with other doctors, if their patients understood the social and environmental determinants that impacted their health, if disease prevention and health promotion campaigns were in place, and if they were able to administer disease prevention and health promotion in their daily routines. Questions of patient accessibility, and the diagnostic capabilities mainly address issues of core clinical competency, while questions of networking, disease prevention and health promotion deal more with COPC values. One interviewee did not enter the *año rural*; instead, she shared her experiences of working in a Cuban *consultorio*, where she was destined to return as part of her integrated family medicine specialty. Her testimony will be discussed following a general synopsis of themes from the other interviews. Dania, Jacqueline, and Elizabeth all worked in the public clinic in la Joya de los Sachas. Fany worked in a small hospital outside of Loja, while Arlena worked in a hospital in Zamora. In these cases, the physicians had some immediate support networks through each other, the nurses and, for Fany and Arlena, senior physicians working in their clinics. Albania and Ricardo worked in tiny clinics in the rural province of Imbabura, where, acting alone, they individually ran rural outposts for isolated populations. From engaging these graduates it is clear that they fared well in their clinical skills, despite lacking material resources in the clinic, but due to insufficient social, economic and political support they were constrained when it came to expanding COPC.

Accessibility:

I asked the ELAM graduates how many patients, on average, they saw each day, if their patients consulted them frequently, if the doctors were able to visit patients' homes, how much time they dedicated to each patient, and if patients had readily available access to them and their clinic. All of the graduates responded that they were readily available to their patients. On a 28-day work cycle, followed by a few days off, the doctors were on call 24 hours a day (*la guardia*), with eight hours a day dedicated to consultations. All of them said that they performed emergency procedures in their "off-hours." The group from Sachas said that they felt tired from the excessive demands outside of the set clinical hours. Living in the clinic, the three doctors were never far from the call of duty.

One evening I was walking with Dania and Jacqueline, having just left a dance club in Sachas. A fight broke out across the road.

"Prospective clients?" I joked.

"Let's hope not," they both said knowing full well that they stood a good chance of mending broken hands and bloody faces later in the evening.

In Sachas, the clinic served about 20,000 patients; in Loja and Zamora, public hospitals and smaller public clinics were responsible for about 500,000; while Ricardo and Albania, both working at two different postings in rural Imbabura, said that their clinics served only 2,000 people. All of the physicians said that a typical in-clinic consultation would run between 15 and 30 minutes. The group from Sachas felt that they could spend up to 30 minutes with a patient, but they admitted that the clinic is routinely packed and oversubscribed, and lengthy consultations are not always feasible. The three

physicians said that they would see up to 30 patients per day. This would constitute a full 7.5 hour consultation period, day in and day out. Others felt that their patient load was not as extreme. In Loja and Zamora, it was between 20 – 25 patients per day, and in Imbabura, the two doctors said that between 10 and 15 clinical visits per day was the norm. While the doctors in Sachas were clearly handling more frustrating work conditions to the point where they felt overworked and stressed, they, along with all of the other physicians, felt that they were accessible to their patients both during visiting hours and for after-hours emergencies.

But in terms of spatial accessibility, all of the respondents said that it was not easy for their patients to get to them. None of them receive patients by ambulance and only in Zamora and Fanny's clinic in Loja, where in both places the bus stops right at the front door of the clinic and hospital, do patients arrive by public transit. In Imbabura, Ricardo and Albania said that some patients arrive by horse. Very few patients arrive by car to any of the clinics. In Loja, Fany estimated that about 5% of her patients arrive in a private car, while the majority of patients come in by foot. The clinics in Imbabura seemed well situated to meet the spatial accessibility of the communities for which they serve, as Albania and Ricardo said that few of their patients travel more than 5 km. In Loja and Zamora, the distance traveled increased greatly, and most patients were more than 5km from the clinic. In Sachas, again, worse conditions prevailed – the three doctors said their patients travel on average about 25 km to the clinic. Most walk and only a few manage to catch the *camiones* (trucks) that come in from the jungle villages once or twice a day. “In the last two months two women died on the road to town,” Dania and Jacqueline told me. Both women were pregnant, and due to complications

they were unable to safely deliver their babies in their villages. Neither could find transport, and neither survived the 25 km walk.

In Sachas, the doctors said that they were never able to visit patients in their homes or their work places. Overworked during visiting hours, and overwhelmed by the distance to the villages in the jungle, the three physicians felt unable to visit and consult patients in their lived environments, which is a major part of building a community health map, a key component of community care in Cuba. In Loja, Fany said that she could make the odd visit to a patient's home, but not often. Albania and Ricardo both said that they had the time and the accessibility to visit patients' homes and they did take the time to construct community health maps with those with whom they came in contact. But not always, and not with everyone.

Costs:

All of the ELAM graduates were employed in the public sector and none of them were working in the private sector, or had an alternative income on the side. Their monthly salary of \$300 plus lodging was their total remuneration. For consultations at the Sachas Clinic, in Zamora and Loja, patients paid \$1 to the clinic. In Imbabura, the patients paid nothing. As part of the rural outpost clinic in Imbabura, the services for community members are free. This is exceptional compared to the other provincial authorities. The Imbabura provincial government is making extraordinary efforts to invest in projects aimed at improving popular health provision, education and municipal services. One of the poorest provinces in Ecuador, it has established a series of innovative development strategies aimed at overcoming conditions of under-development. Some of these initiatives include the limitation of tourism to the region, the

establishment of a provincial council on life and health, and an organization to supply and organize traditional and alternative medicines (*Gobierno Provincial de Imbabura, 2007*). Still, the state of public health in Imbabura is poor, with very little investment in proximal interactions in education and social services. Albania told me that the greatest challenges in Imbabura lie with the wide-spread diseases associated with poverty, and ways of life among illiterate populations. Aside from Imbabura's cost-free care at the rural clinics, the other ELAM graduates said that during the *año rural*, they never turned someone away for the inability to pay the minimal fee.

Effectiveness of Clinical Services:

Part of determining COPC is to know if patients and doctors are effectively utilizing each other's time. In some cases, patients may utilize a service when little real need for treatment or advice exists. Most ELAM graduates laughed at this question. But they all responded by saying that only a small percent of their patients come to their clinic when nothing is physically wrong. I asked them to be clear on this point, so as not to confuse it with disease prevention or health promotion routines. Yes, "some just want to come to talk," said Fany. The amount of misuse of service is not enough to say that it hinders the physicians' ability to expand COPC.

On the question of whether or not doctors were effectively using the patients' time, meaning that their clinical skills were proving to be effective, all of them said that they felt capable of meeting patients' needs and they routinely exceed their expectations. Dania, Jacqueline and Elizabeth all felt that while they were confident that they could meet their patients' needs, lack of basic equipment and other resources prevented them from meeting the needs of the entire patient population. In these cases, they would have

to make referrals to private clinics, or to the public hospital in Coca. While it was possible to make referrals to the private clinic for testing and lab work, it would also be futile because of the patients' inability to pay for services. Fany and Arlena were better equipped to handle more complicated procedures as their hospitals had better infrastructure at hand. Albania and Ricardo both said that their small clinics did well to treat and diagnose patients with the few resources that they had. However, Albania mentioned that she needed to refer patients to NGOs working in the area in order for them to receive diagnostics and treatment that were beyond her capacity. She said that about one in ten patients required care beyond her means to deliver at the clinic, so that referrals to the NGOs would have to be made. While the physicians at Sachas admitted to referring up to 20% of their patients for diagnostics, Albania, working in Imbabura, felt that only one in ten patients required a referral for more advanced diagnostics. However, none of the doctors felt that their diagnostic skills in the clinic, regardless of resources, were inaccurate or ineffective. "In Cuba we learned to treat the patient and not the disease," said Albania. Thorough examinations, inquiries into the patient's lifestyle, family history, working conditions, diet and habits are all means of inquiry to help form sound diagnosis with minimal resources. Dania and Jacqueline felt that their colleagues trained within the Ecuadorian system often did not share this skill set, and relied heavily on referring patients to centralized care centers at the provincial level.

Working in Broader Networks:

COPC requires collaboration and exchange of knowledge among physicians, health teams and administrators. All of the physicians felt that they had someone to talk to about puzzling symptoms or difficult diagnoses. In Sachas, the three Cuban-trained

doctors relied heavily on each other's knowledge, and they said that they were constantly seeking out each other's opinions on various symptoms or treatments. However, when it came to obtaining material resources for the clinic, they were limited to what was doled out from the province, and their requests for improved infrastructure often fell upon deaf ears. Fany and Arlena felt comfortable with their broader support networks in the hospitals. Arlena mentioned that a steady stream of doctors, residents, nurses and students were always at hand for her to seek out advice, but at times infrastructure was not always available. Ricardo, despite his isolated outpost, said that he was able to get in touch with other physicians by phone if he needed advice. Albania said that it was her and her alone, having poor contact with supervisors. Both Ricardo and Albania also answered to supervisors located in other towns.

The ability for physicians to dialogue with each other is important for COPC, as it allows them to identify emerging trends, outbreaks or other popular health issues that may be affecting a community. Part of this also involves dialogue with higher authorities in the public health networks who are in charge of resource allocation and record keeping. When I asked Dania and Jacqueline if they had a boss, they said, "Yes, but she's in Coca, and we rarely see her. What's her name again?" Albania's testimony led me to believe that she was the most isolated of any of the graduates, but the other graduates all experienced clear deficiencies in their networks.

Informed Community Members:

A major indicator to identify COPC is whether or not community members are aware of the environmental and social determinants that impact their health, and if health-care professionals can play a role in actively building that awareness. Effective disease

prevention and health promotion requires willing participation at the community level, as well as sound knowledge of imminent health risks. I was unable to conduct wide-spread community surveys. The resources, time and infrastructure were simply not at hand. Instead I consulted my key stakeholders, the ELAM graduates, asking them how informed their patients were about their personal health issues and the major health issues in the community. Also, I asked how much time the doctors spent working in the patients' homes and work places. In Sachas, the environmental degradation from oil development is a major health determinant (Breilh *et al.*, 2005). In Zamora and Loja, child hunger exists (Larrera & Kawachi, 2005), and in Imbabura, hunger coupled with poor education and lack of sanitation are all key determinants (Angeles *et al.*, 2007). Across all of these regions are major incidences of diseases due to poverty, poor nutrition and non-potable water.

I asked the doctors if community members knew about social and environmental determinants that could impact their health. I also asked if initiatives were in place to further education and awareness on various health indicators, how such initiatives were organized and what role they, as doctors, played in the process. Dania, Jacqueline and Elizabeth said that they could never see patients in their homes. They live too far away, and the demands of the clinic did not give them a moment's rest. They admitted that their patients were generally unaware of their health conditions, let alone the broader environmental determinants. "It is not like Cuba," Elizabeth said, "where people are informed." Dania explained that people are generally aware that oil development has caused problems to the environment, but some villagers living downriver from an oil well will continue to drink and bathe in the water (San Sebastián & Hurtig, 2004b). There are

some educational campaigns organized by the provincial health authority, Jacqueline told me, one against tuberculosis, and another one to educate people about sexual health. “But very little about disease prevention and health promotion,” she said. They felt that the campaigns had some impact in building awareness about specific maladies, but they did little to improve the basic health risks imposed by poverty and poor sanitation. Occasionally they have gone to a public health rally or hosted an information session in the clinic, but past that, very little medicine in the community was occurring in Sachas.

In Loja, Fany told me that her patients knew very little about their own health challenges let alone the broader determinants. “They deal with the *colundreno*,” she said. She said that she was able to visit some patients in their homes depending on the time and distance, but it was not the norm. “This is not Cuba,” she said.

Arlena told me that she had no time to visit patients, and that most of her duties were in the hospital. Few people, she said, had a good idea of what their health conditions entailed and she blamed it on a general lack of education in Zamora. She mentioned that having meetings with community leaders about disease prevention and health promotion was not possible on her work schedule. She said that active public awareness campaigns on HIV/AIDS and tuberculosis were in place, but they were run by the Ministry of Health and various NGOs working in the province.

Ricardo and Albania stood apart from the rest of the group when it came to this series of questions. They experienced the poorest levels of clinical support, but had the greatest potential to educate patients in the community setting. Ricardo said that many people who visit his clinic were quite ignorant to their personal and community health needs. His biggest challenge was to build education with his patients, as many of the

adults had not completed an elementary school education. In his clinic he held information sessions on themes from proper nutrition to effective hygiene. He said that he was lucky because in his town there were a couple of primary schools and a high school that he could work with to organize information sessions. Meetings, or *charlas*, took place regularly, according to Ricardo. The objective he told me was “disease prevention, because it is the most effective form of medicine.” Because the demand of the clinic was not overly excessive, he managed to do house calls for his patients. He also felt that his case was unique, as other provinces had not put resources into disease prevention and health promotion strategies. I asked him if he felt that such routines were effective. “Absolutely,” he said. But he admitted that the poor state of education and infrastructure in the province was the biggest hurdle to overcome. As much as people can be made aware of how to improve health, non-existent economic or social capacities ensure that they continue to live in conditions that hinder good health.

Albania admitted that the under-education and lagging sanitation infrastructure in her community were two enormous challenges to providing both proximal and distal care. Still, she said that she was able to talk to community leaders and NGOs to organize information sessions, but even so, there is little infrastructure for comprehensive disease prevention and health promotion routines. Her primary concern was for infant health, and she tried to organize information sessions on neonatal health with community groups, and with the assistance of the NGOs working in the region. As neonatal care is a guaranteed right in Ecuador, Albania’s desire to see people take part in this existing support network, minimal as it is, was a fitting move. The goal, she said, is about educating people on the value of the prevention of illness, especially for young children. She felt that her efforts

were effective, but since most of the community makes it only to sixth grade and then works in the agricultural sector, they do not receive education and information on proper hygiene in the home, and healthy routines for a mother to practice especially when she is pregnant. Albania said that she did house calls, and that hygiene was the biggest culprit of poor health in the community. Sanitation and clean water were not reliable, and health problems could easily develop throughout the community.

In all of their accounts, the ELAM graduates admitted that they tried to educate their patients in the clinic, the classroom or in the community about the importance of preventative routines. It is a battle of good advice going up against poor infrastructure. While Albania and Ricardo managed to take the message of disease prevention and health promotion beyond the clinic, as their unique small clinics afforded them the opportunity to work in their communities, the others, working in traditional public health infrastructure, felt helpless to do so.

A Decision Not To Go:

The eighth returning Ecuadorian ELAM graduate, Maria, returned to her home in Quito with a newborn child. She had the baby in Cuba, and had decided to postpone her service in Ecuador's *año rural* in order to return to Cuba with her husband. She told me that the greatest challenges with rural health in Ecuador were with educating people. Advancing her own education was her preferred option at the time, as distal interventions were badly needed before proximal ones could be implemented. She was getting ready to return to a small Cuban village about 40 minutes to the south of Havana, where she would live with her family in a *consultorio*. The town has about 5,000 people, she said, and her clinic would be responsible for 1,300 or so. The *consultorio* would be typical of

any other family doctor practice in Cuba, where nurses and doctors work together receiving patients in the morning, and doing house calls in the afternoon.

She praised Cuba's ability to allow doctors to meet with their patients in their homes, especially those too old or too infirmed to make it to the clinic. "There are many good social and family relations there," she said. She preferred the idea of patients knocking at her door at 1:00am rather than working in conditions where they would find it difficult to make it to the clinic, such as in Sachas. She said that in her opinion, "Life in Cuba is not necessarily better, but it is unique." Going back to Havana Province to serve a community was, she felt, another way of paying service to Cuba for receiving a free medical education. With more doctors working overseas, her choice of path would help to quell some of the tensions about Cuba's slowly growing doctor-to-patient ratio.

Postcards From the Field:

The working conditions experienced by the returning graduates are incredibly diverse. I spent time with five of the ELAM graduates in their work sites. I also spent time in other Ecuadorian medical facilities ranging from private and public hospitals in Quito, to private clinics in Cuenca and Quito, to a public clinic in Bolívar. In order to give a better understanding of the rigidities that the ELAM graduates face in expanding COPC, I offer three "postcards from the field" - analysis of time spent in the clinic in la Joya de Los Sachas, the public hospital in Zamora, and with Fany in Loja, where she was involved in a labour dispute with the national health authority during my stay. The sketchings that I am able to render here will hopefully show what a day in the life of an ELAM grad in the field entails, and the differences in their experiences.

Loja:

Fany met me at the bus station in Loja and we went to meet the other medical students. “You’re having a meeting?” I asked.

“No, we’re having a *manifestación*,” (demonstration) she replied. “The medical society will not allow us rights to the hospitals, and we need more pay.”

Ecuador’s Ministry of Health would not allow a *médico general básico* hospital rights to visit patients, and the governing union for the doctors on the *año rural* felt that \$300 a month was too a low a wage for recent medical graduates. Considering that many of these doctors could receive higher wages and benefits in Chile, Ecuador’s non-response was fuelling serious tensions. Fany was the only Cuban-trained physician in the group of about forty young doctors. They had been trained at various medical schools across the country and their posting just happened to be Loja. Fany’s family was from the city, and after the rally, we went to her parents’ home for a meal.

“So, while you are on strike, who is attending to your clinics?”

“No one.”

The collective bargaining had taken every *año rural* doctor off their post, leaving people to seek service in the centralized hospitals.

“There is a bigger problem here, though,” Fany said. “I am a doctor. I can treat and diagnose the ill. I can deliver babies, but the hospitals will not let me, will not let us in. We need to ensure that our titles are recognized. We have many doctors in Ecuador, but they cannot be recognized and accredited by the national college in Pichincha. What a difference we could make if we had jobs and we had hospital rights.”

Fany explained it well. The hospital rights issue was just one problem among a series of poorly-organized health-care labour practices in Ecuador. By denying a doctor in the *año rural* hospital rights, the system transfers custody to another physician with rights, and this adds another layer of bureaucracy and disconnection. In any system, it is generally good advice to see a physician who has hospital rights so that they can do necessary follow-up work and dialogue with specialists about the patient's needs.

Fany's posting was at a hospital located more than an hour away from Loja City. If she needed to refer a patient to a larger facility, her rights to the patient would end there. Already the *año rural* faces the difficulty of building doctor-patient relations with the mandatory 365-day turnover. Only Imbabura seems to have the capacity to offer *año rural* veterans the chance to extend their tenure.

After five days, the doctors went back to work with a slight pay increase. But they continued to lack hospital rights and recognition of their degrees. Either trained at home, or, as in the case of Fany, trained abroad, general basic doctors are not afforded the opportunity to apply their skills in a manner that would work to further expand health-care accessibility in Ecuador.

Zamora:

Zamora is a town where the mountains and jungle meet to produce a suffocating humidity in a lush and beautiful jungle landscape. Arlena Rodas met me at the bus station, in the late evening. I had been on a bus for four hours, buried under a family of three, who snacked on a full chicken dinner during the cramped ride along narrow mountain pathways. Arlena made sure that I was fed, and she found me a decent place to

stay. She said that she would come by the hotel at about 9:00am and show me around town.

“You don’t have to work?”

“I don’t have a job,” she said.

Arlena had already finished her *año rural*, and had yet to be accepted into a specialization or residency. The other ELAM graduates were soon to be unemployed as well. After touring the city, we went to the hospital where she was stationed. She spent her *año rural* working in the hospital’s emergency room.

“How many physicians are usually working in the ER?”

“Sometimes three, but mostly just one.”

The hospital seemed large enough to accommodate at least half a dozen ER doctors alone. It is a massive structure for a town so small.

“Do patients wait a long time for treatment, or do they ever go without?”

“Sure, they wait, but they never go without.”

Going through the ER, already at 11:00am, there was a lengthy queue. About a dozen patients, all walking wounded, were waiting to see the one ER doctor on shift. Nurses were handling the triage, and some patients seemed to be carrying their complaints over to the pharmacist whose office was in the room across the hall.

Arlena took me up to visit the maternity ward. The ward had twelve beds, all with clean sheets, good lighting and air conditioning. Three women were in the ward. One was tending to her little newborn with a doctor closely hovering over her bed. The second was surrounded by family, gifts and diaper bags. The third had her husband by her side. She lay on her back, looking straight into the ceiling with her arm attached to an

I.V. Something had gone, or was going wrong. A young intern and a nurse let me take their picture while they changed the I.V. bag.

The maternity ward didn't give the impression that there was a lack of personnel or resources. Leaving it behind, we went further down the hall to the pediatric ward and to other wards, which were all deserted. The pediatric ward did not have a single child in a single bed. "Is it usually this quiet?"

"Sometimes there are children in here, but yes, it is pretty calm."

In a country with so many endemic health problems, especially among children, here is a vacant pediatric ward because of economic and social barriers. On paper it looks good to have such resources available, and in the public sector no less, but the socio-economic barriers of space and time must not be acting alone on this one. Sure the road to the hospital is no picnic, but it can be negotiated. Only the services in the maternity ward are fully covered by the State. Every other service, from the \$1 consultation fee to a night in a hospital bed, is the patient's out-of-pocket responsibility. It is a basic-needs approach (Nussbaum, 2003), to essential services, and yet it does not experience a more active participation from Ecuadorians. The gratuitous services stop after the age of five, and it would seem that despite the obvious need across the country for health-care services, the poor in need stay away. Neoliberal theory would see this as a factor of choice, rather than as a consequence of social hierarchies. Yet the one aperture in the State's policy that provides free services and universal care has active participation.

We continued to look around the hospital. We visited the dental clinic, the x-ray lab, the cardiovascular clinic, and the ophthalmology unit. The equipment seemed to fulfill its purpose. It was not the latest, but it was not decrepit either. The odd bit of

paint was missing, but then I noticed something else missing amongst both the workers and the patients.

“Arlena, do you receive many indigenous patients?” Seeing how Zamora’s indigenous population is quite substantial, I figured this to be a fair question.

“No, hardly any. They do not come to the hospital. There is discrimination in the system, and they do not come to us.” Gonzalo mentioned issues of mistrust, but Arlena blatantly labeled it as discrimination. After speaking with her about this I understood her to mean that the system structurally discriminates against indigenous culture by not providing guaranteed access to their communities. And she also suggested that health-care workers themselves bear prejudices against indigenous peoples.

We left the hospital to tuck into some cheeseburgers and talk about Arlena’s experiences in Cuba and during the *año rural*.

“The hospital really seems quiet for its size.”

She looked at me, shrugged and said, “Those in need are very far away, and we do not have that many doctors working in the public system.”

The structures of spatial accessibility and human resources certainly do not help the cause, but at the heart of Zamora’s vacant hospital are themes of economic and social discrimination that make this a hospital without sick people, while within the province there are many sick people without this hospital.

La Joya de los Sachas:

The Canadian government does not advise travel in this part of Ecuador. Too many foreigners have been kidnapped thanks to the discontent against foreign oil exploitation. I had to fly in close to the Colombian border, find a taxi and then find a bus

to go an hour further into the jungle. The taxi driver was shocked to get a fare. The Amazon is a rolling broil of humidity and mosquitoes. The lush density seemed to carry on forever. With the oil developments an hour away by bus, most of the *gringos* coming through this part of the country are either employed by oil companies or they are in the service of God. On the bus to Sachas, I managed to hang my GPS out the window to get a read, and to see where the town should be. It was not hard to miss. It is the first major town with a giant oil pipeline sprawling down the main street. The sidewalk gives way to it. Teenagers sit on it at night drinking booze.

I met Dania and Jacqueline for lunch. I had not seen Dania in a year, and the last time we got together was for a beer in Havana a couple of weeks after the ELAM party in July, 2005. “We would invite you stay with us in the clinic, but we have no space. Literally no space; it is so cramped.”

“No problem,” I responded. I found a hotel room; air conditioned no less, with CNN for \$10 a night.

We went to the Sachas public clinic. It was the only public health-care facility for 80 km. The hospital in Coca could be reached with an hour of speedy driving. Other private clinics were in town, and another facility operated as a public-private-NGO partnership. The Sachas clinic was two blocks in from the main pipeline. Dirt roads, riddled with potholes, would just about guarantee a snapped ankle if one were to unexpectedly stumble along after dark. Standing pools of water that were an oasis for mosquitoes surrounded the clinic and the neighbourhood. The clinic was a hive of activity. Doctors, all on the *año rural*, nurses and secretaries were handling the needs of about two dozen patients. Of the six *consultorios*, three were under water, and two were

equipped with only the most basic of examination equipment. The building advertised that at one time it received handsome donations from the EU, but those seem to have fallen short of supplying the clinics with necessary equipment, let alone ridding the flood water. A couple of rusted-out fans tried to keep us cool with little effect.

“This is going to be a busy day,” said Dania. “Why don’t you go back to the hotel, and Jackie and I will come get you for a beer later on. You can come and sit in with us tomorrow.”

The next day I went to visit the two of them in the clinic. Again, the clinic was bustling with patients, most of whom were mothers and young children taking advantage of the free services and vaccinations. Dania invited me into her *consultorio*. A young mother was in there with her child, who was only a week or two old. The mother handed Dania a government folder that keeps records of the free services.

“How many children do you have?”

“Four.”

“Have any died?”

It is a common question in a country with under-5 mortality at 25 per 1,000.

The child had a respiratory condition, and a sizeable rash around her midsection. As well, Dania found out that she was being fed food other than breast milk, including hot food. The mother, who Dania later told me suffered from a mental illness, started on a torrent, complaining about her house, her husband and now this child keeping her up all night. Dania filled out a prescription while keeping focused on the woman’s conversation. In her ranting, the mother revealed all sorts of clues about her way of life. She had no education, lived by humble means, and the husband sounded like a drunk.

Once the mother calmed down, Dania approached her with the prescription and offered detailed instructions on how to give the medicine, and then she repeated the details once more.

After the young mother left, Dania received a middle-aged man who brought in a slew of prescriptions to be renewed. Some were for his wife and others were for his children. He also had a bizarre fungus infection that Dania looked over and then added another prescription to the pile.

Then a prostitute came into the *consultorio*. She brought a standardized card that needed Dania's signature. The form needed a physician's signature to certify that she was free of STDs. For some, prostitution is a way of life in Sachas. Most of the petrol workers are from other parts of the country, and with migratory labour comes migratory sex. The police tolerate prostitution. But every so often they jail or fine the girls who can not produce clean health records.

A steady stream of patients kept Dania busy throughout the afternoon. Then a woman came into the clinic with a large cyst growing over her eye. She had cut her inner eye socket, and it was infected. The infection created a large cyst and it was hindering her vision. It was not pleasant to look at, and the woman, suffering from embarrassment as much as pain, looked to be in a great deal of discomfort. Dania got up from her desk, and put on the white gloves. I asked her if there was anything that I could get for her. I figured, "a cup of coffee perhaps?"

She said, "Yes. Put on the white gloves."

I dropped the pen and paper and put on the gloves. Dania took out a scalpel, one of the few instruments that was available in the clinic, and made an incision into the cyst.

My role was to be quick and ready with clean cotton to keep the fluid out of the eye, and to dab alcohol when needed. After about ten minutes of steady hands and dedicated concentration, we put gauze over the wound, and the woman went on her way with eyesight restored.

By the time the next man came into the *consultorio*, I still had the white gloves on. Before I could switch back to taking notes, Dania had me back at the examination table. The man was diabetic, and thanks to a poor diet he had developed open craters on his body. He was complaining about the one on his buttocks, one that had been previously cleaned and dressed. With alcohol and clean cotton in hand, I cleaned the open hole as Dania pulled out six inches of dressing, once soaked in iodine, which had now been coated with various bodily fluids. The man howled in pain. Pulling out six inches of dressing must have felt more like removing a python, and then, having removed the old dressing, we needed to replace it. I went to find more gauze while Dania cleaned his wound. I found very little, but we managed to ration just enough. I fed Dania the gauze inch by inch, and with the forceps, she pushed the clean gauze, drenched with iodine, back into the hole. The man yelped with pain. There was nothing that we could give him to take his mind off it. Inch by inch, he clenched his fist, bashed them on the bed, kicked, groaned and sweated. After two minutes it was over. Dania finished the dressing. The man got up, thanked us both and hobbled out of the clinic, his teeth still clenched in pain.

By 4:30 pm it was almost time to call it a day and to take a break for some fruit salad. We met with Jacqueline. The patients in the waiting room had dispersed, and the clinic was quiet. Coming out of the back door we met a man with his arm slung over

another fellow. The hobbling man had his foot bandaged, and he could put no pressure on it.

“What happened?” Jacqueline asked.

“I just came from the hospital in Coca.”

We were silent.

“I’ve been shot. I don’t think that they got the bullet out. I can still feel it.”

We took him back inside. His friend laid him out on the bed. Dania, Jacqueline and I put on the white gloves. Jacqueline undressed the foot, and Dania arranged the alcohol and dressing. She brought in a bright light and a magnifying glass as well. With Jacqueline now on the scene, my role was to hold the light and the magnifying glass, and pass the alcohol to the two doctors when they needed it. This man’s foot was blown apart. The wound was open, and the bullet, at least most of it, must have gone through. Bones were torn apart, muscles and nerve endings were destroyed. He would never walk properly again. Still, Dania searched for debris and with the course tweezers and the bulky magnifying glass, she found metallic pieces in the man’s foot. His friend held him down. Dania and Jacqueline meticulously scoured the wound. After about fifteen minutes of searching, picking, cleaning and screaming, Jacqueline redressed the foot.

“There, it is all out,” Dania said. The man, whose face was nearly blue from exhaustion and whose eyes were red from tears, thanked the doctors, and hobbled out of the clinic. We took off our gloves, locked the door behind him and went for that fruit salad. Later that night we took some time away from the clinic and we went to one of Sachas’ less-shady discos. At about midnight we called it quits, and fortunately the two doctors were not interrupted by any grave emergencies through the night.

The next morning we went with an NGO-sponsored medical brigade out into the jungle. A make-shift clinic was set up in a small schoolhouse. Volunteer doctors, pharmacists and dentists were offering free consultations. The school was barebones, and running through the soccer pitch was an oil pipeline. The doctors offered brief consultations, and the medicines on hand were mostly generic antibiotics, donated from the EU.

Jacqueline was on *guardia* (on-call), and we needed to get back to the clinic. She had a young girl in labour. Raped nine months earlier at a New Year's party, this would be the 14-year-old girl's first time giving birth. Dania reminded me that childbirth is risky business in Sachas.

Dania and Jacqueline told me that they cried almost every night in their shared room during the early part of their time in Sachas. And yet they managed to continue on for an entire year. It was a different reality for them than Cuba. The cyst in the eye, the gunshot wound, rapes, routine maternal mortality (one mother dies for every 760 live births) and the diabetic craters are all easily prevented with the right conditions and support. But in Sachas, they become health calamities. The physicians are on a treadmill to repair the ill rather than to maintain the healthy. On one hand, the *año rural* seems like a short blip in time. But working in the Sachas clinic, the contract could seem interminable. And while the ELAM graduates in Sachas felt that they did not expand COPC, they did manage to offer quality clinical care in overwhelmingly hollow circumstances. Despite the hardships, the loss of life, and the gloom of poverty, without their presence, conditions for those patients would have been considerably worse.

In my final days in Ecuador, I met with representatives from the Cuban embassy to talk about the reintegration of ELAM graduates.

“Cuba can not rebuild a country’s health-care sector; we can only train doctors and offer help when asked,” according to First Secretary Jorge Gómez Rodríguez at the Cuban embassy in Quito. Manuel Torriago, from MINREX, later told me the same.

I told the First Secretary about my experiences at the various clinics, and my thoughts on the ELAM program. The challenges lie with the constraints in the field, I said. He agreed, and suggested that now with the Correa government coming into power; there could be room to find solutions to these problems. While Cuba cannot formally rearrange Ecuador’s health-care sector, they can continue to increase capacity, by doubling the number of available scholarships to ELAM for Ecuadorians, and by also expanding the intake of students into the ALBA program. The embassy received only a few dozen applications for ELAM in 1999, and they had been pre-screened by Ecuador’s Ministry of Health. At the time, all of the applications that made it to the embassy were offered scholarships. In 2006, the embassy directly received thousands of applications for 1,000 placements.

“When we take in the applications, there is a large crowd in the street” said Gómez Rodríguez. The popularity and awareness of the program has grown so much since 1999 that the embassy is only accepting about one in three applications. As of 2006, Cuba is furthering enrollment and expanding training through programs like ALBA alongside ELAM. Already Cuba has implemented a reintegration process for ALBA students, where they will spend their sixth year of training alongside existing Cuban medical brigades in their home country. This could be very advantageous in expanding

COPC through the brigades, rather than through existing infrastructure, and it will afford students the chance to practice and connect with their communities as part of their education.

Building upon strengths is important, no doubt, but the question of building capacity within the communities has yet to be answered. By increasing medical training capacity in Cuba, will more doctors like the eight that I followed be able to apply their conviction and compassion in the rural clinics? Or will the majority, like the 43 who stayed in Cuba, remain far from the field?

I talked with the *Brigada Eloy Alfaro*, an Ecuadorian Cuba solidarity group, about this. They said that they keep in touch with Ecuadorian ELAM students while they are in Cuba, and they help to find them suitable places for the *año rural* when they return. They also play an active role in spreading the word about ELAM and now ALBA, and they arrange for solidarity exchanges between members of their group and groups in Cuba. While they do maintain contacts and relations with the ELAM graduates during and after the *año rural*, they do not have the capacity to assist them in finding long-term sustainable work options. Both the brigade and the embassy are aware of the challenges of reintegration. Instead of giving up, they are working to increase capacity on the recruitment end, despite the current retention problems.

The experiences of the ELAM graduates in the field are diverse. It suggests that there are regional variations in the organization and utilization of human resources for health among the provinces some of the differences concern variations in infrastructure in the central hospitals versus the rural clinics, but they are also products of decisions made at the provincial level, as access to a hospital in Loja for example, is far easier than it is in

Sachas. Then there is Imbabura which seems to be making changes that are aimed at building capacity from the bottom up. It is testimony that despite a national neoliberal hollowing of social resources, political and social support can still sometimes be mustered through political leadership in order to overcome the constraints against COPC. With a new national government in power, political change may be possible. In a place like Sachas, a naturally rich landscape where only a few cents of every barrel of oil pulled out of the ground comes back to the community, political support needs to be acquired to improve the restructuring of health-care services so that physicians and patients can go beyond the treadmills of repair and despair.

Having completed their service in the *año rural*, and standing on the brink of an uncertain career path, none of the ELAM graduates seemed the least bit disenfranchised with the idea that medicine should be a service. Ricardo admitted that he might not stick with medicine, and Jacqueline is seeking a pediatrics specialization in Spain, but none of them, not one single ELAM graduate, ever said that they would dedicate their medical skills to the private sector. It is a stark contrast to the medical students from Quito's central university who all said that they wanted some hand in the private sector. Some ELAM graduates admitted that it is financial suicide to stay in the public system, and others noted that specialists working for the public system do receive higher wages, but they all detested the idea of opening a private-for-profit clinic like CENIRMED.

And this comes back to the question of counter-hegemony as to whether individuals, working in trying conditions, can change a system, or if that system will change them. To get at this question, this chapter sought out how the ELAM graduates managed to practice COPC in the field. In the end, very few of them managed to counter

the hegemony of Ecuadorian health care within the time and resources that they had available. The current challenges of mistrust in communities, of being overworked in the clinics, of lacking resources, of poor education and sanitation, and even institutional racism within the public sector are all working against the adoption of COPC at the community level. The ethics of Cuban medical internationalism, which the ELAM graduates embrace, have yet to scale up through their interventions in Ecuador. Organizational and socio-political change has yet to be put in motion, and unless radical social change occurs in places like Sachas, it is not likely that it will. But it does not mean that ELAM's good sense has been dismissed. At this moment, dialectics between the ethics of the graduates and the norms of the system is underway.

It is an important process that is unfolding as Cuba is continuing to build capacity for human resources for health without fully knowing how these health-care professionals will integrate into their home communities. The idea, perhaps, is to continue building capacity in the hopes that increasing the number of graduates will tip the scales, and the system will have to accommodate their compassion. On the other hand, there is no guarantee that such a system will change. From what I have found in Ecuador so far, it seems that the ELAM graduates have yet to change this system, but it has yet to change them.



(Fig. 36) Jacqueline (middle) and Dania (right) tucking into some coconut outside of Sachas

(Fig. 37) Their accommodations in the Sachas clinic.





(Fig. 38) Medical outreach to the Amazon
(Fig. 39) Basic dentistry is included in the outreach.





(Fig. 40) The medical outreach set up in this little school.

(Fig. 41) Right next to the school, an oil pipe runs next to the soccer field.





(Fig. 42) The maternity ward in the Zamora hospital.
(Fig. 43) And its pediatric ward.



Chapter 8
The Surprising Success:
Conclusions on Counter-hegemony, Empowerment and Impact

~ We will only change the world once people start caring about each other! ~
- *Albania Tamayo Maciás*

The experiences of the Ecuadorian ELAM graduates, from building compassion in the classroom to attempting counter-hegemony in the community, has demonstrated a means to improve health-care equity by empowering human resources for health. Ecuador's poor infrastructural resources, lack of community cohesion, and non-existent retention strategy all play a part in hindering equitable primary care based on disease prevention, health promotion and altruistic compassion. Remedying this situation will not happen through shallow policy manoeuvres aimed at managing budgets and resources. What is needed is a socio-political acceptance of the counter-hegemonic ethos that put Cuban medical internationalism in motion. This cannot occur through scattered charitable frameworks or sparse siloed interventions. It needs to take place through an ethic that builds good sense through medical education and COPC.

Until this framework emerges, we are left to ask the ELAM graduates, "What will you do?"

"I don't know," said Dania. "I will see about a specialization in Colombia, or maybe I will go back to Cuba."

"Jacqueline? What are your plans?"

"My father's family are Spanish; perhaps they can help me get into a specialization in Spain."

"Elizabeth?"

“I just submitted my application for the residency exams here in Quito. But there are so few spaces.”

“Fany?”

“I will finish my contract, and apply for specialization like everyone else. I don’t think that I will go back to Cuba; it is a very long time commitment.”

“Arlena?”

“I will apply for residency in Quito. But I would like to return here to work.”

“Ricardo?”

“I have another year to work in Imbabura. But I am not sure if I will stay in medicine. I might return to school after next year.”

“Albania?”

“After my holidays I am going back to my little town, and I will continue on for another year. I will apply for the residency as well, but I am going to work in the clinic.”

At this point this dissertation leaves the lives and experiences of the 2005 Ecuadorian ELAM graduates. They have graduated the program, and all but two of the eight returnees were left unemployed in December, 2006. Fresh batches of recent graduates from medical schools in Ecuador as well as ELAM will follow their footsteps and likely fill in the spaces that they were forced to leave vacant after the *año rural*. Their stories are for another time. And now this dissertation has only to offer conclusions and to hypothesize about the future of Cuban-trained doctors in Ecuador’s health-care geography.

Did ELAM empower the 2005 Ecuadorian contingent so that they could create change at the organizational or structural levels in their communities? Did the school

furnish its students with the appropriate skill set to practice primary care, along with expanding disease prevention and health promotion to their communities? As it turned out, a thorough medical education received in Cuba afforded these young graduates a humanist-foundation approach to see health care as a universally-deserved service, but as a result of broader structures, only a few actually returned to their communities to see it through. And for those who did come back, their efforts succeeded mostly in the clinic, while building disease prevention and health promotion in the community waned. It shows that ELAM graduates embraced the necessary skills, ethics and conviction to venture out to vulnerable landscapes to help those in need. While ELAM built capacity at the individual level, the goal of seeing counter-hegemony through COPC has yet to be realized in Ecuador.

The lack of human resources for health not only contributes to geographies of inequity, but it furthers the general risk of unnecessary suffering and death from preventable ailments. This dissertation looked at how ELAM influences this problem. From the sheer volume of recruits ELAM brought from marginalized communities, and the quantity of graduates it perennially produces, it would seem that the school would have some effect in impacting health-care service provision in the South. Improvements to health-care systems, popular provision and health indicators rely on conditions beyond the simple graduation and placement of a physician. These factors rely on physicians' ability to practice in the field, and for their skills to meet the needs of their communities so that it leads to reducing the risk of negative determinants. Since ELAM graduates were expected to return to areas that lacked both infrastructure and human resources, this dissertation sought out their capacity to practice within a neoliberal clinical environment,

and their ability to expand disease prevention and health promotion into their communities. To build counter-hegemony against neoliberalism's structural violence, more emphasis needs to fall on preventative medicine in the community, outside of frameworks of mass consumption and existing service institutions. This study labeled this practice as COPC, a set of goals carried out by physicians to expand knowledge of routines of disease prevention and health promotion at the community level, and it focused on the question of how appropriate ELAM is for equipping its graduates to further COPC in their communities.

The conclusion of this dissertation is that ELAM does well to foster the appropriate clinical skills and ethics of service for its graduates to meet the needs of their communities. This is done through an appropriate recruitment process, the building of institutional ethics, clinic-based instruction for core clinical competency, and by forming a culture of service for the public good. However, because of the overwhelming structural challenges, especially due to a lack of basic infrastructure, the graduates could not administer COPC goals in their communities – they lacked time, resources and retention strategies. The graduates who returned to la Joya de los Sachas, Loja, and Zamora, were especially unable to practice medicine in their communities because of their in-clinic responsibilities and the lack of social organization in their communities. The two graduates who returned to Imbabura, however, did manage to better dedicate their skills to COPC, albeit on a minimal scale. The inter-provincial differences, between Sachas and Imbabura for example, show that despite hollow resources, policies at the provincial level can be implemented to build positive work environments to help

physicians facilitate more community-orientated care. At this moment, it is simply beyond ELAM's capacity to ensure human security in Ecuador.

While ELAM's stated goal is to train general basic doctors to treat those in great need, and considering the graduates were unable to expand COPC, the program should not be dismissed as a let-down. In fact, I see it as a surprising success, as it has built the good sense of alternative development. ELAM has demonstrated that an alternative trend to medical education in the global South is possible. It also demonstrates an amazing interest in seeking alternatives to the current trend of what is assumed to be inevitable. The large-scale formation of doctors trained in humanism and cooperation rather than capitalism and competition demonstrates that the ethics of health-care service is dynamic, and that current systems are not interminably doomed to cope with physicians who do not wish to serve in economically-hobbled regions.

ELAM doctors are the living reality that a paradigm shift is possible starting at the individual scale. These physicians possessed the conviction to help others regardless of the challenges in the field, and despite the fact that they endured personal sacrifices and hardships. Considering these experiences at the individual level, and keeping in mind that Cuban medical internationalism, as soft power, is building respect among countries in the global South, the question then is how to build the appropriate social and political conditions for institutional ethics and soft power to meet at the community level to overcome neoliberal health-care hegemony.

The Ecuadorian graduates themselves have spoken up to say that ELAM should not be changed to adhere to the Ecuadorian reality, but that Ecuador should be changed to adhere to the ELAM reality. In May, 2007, Ecuadorian alumni from various Cuban

institutions, ELAM included, created the Front of Multidisciplinary Professional Graduates in Cuba, with a goal to lobby the Ecuadorian government to find ways to accept their skills within the public sector. This group consists of a select group of ELAM graduates, now spanning three years (2005 – 2007), labeled the Internationalist Federation of Health (FIS) who seek State support in implementing programs to administer “socialist and humanist medicine” alongside primary care. Their goal is to help create, on a broad scale, the necessary political and social support to build widespread programs of disease prevention and health promotion.

The FIS is a counter-hegemonic action aimed at building human-security provision. Their manifesto states that they will return to Ecuador as doctors, but also as leaders in popular health provision. They are asking President Correa’s government to lead structural changes to the health-care system that will better allow them to practice medicine in the community. By engaging their political leaders they seek opportunities for badly-needed organization and environmental change. The ELAM graduates have realized the challenges that await them. Instead of giving in, instead of finding lucrative places in the private sector, they have organized, vocalized and encouraged the government to radicalize the means of health-care access. Their popular commitment to ELAM’s values demonstrates how this alternative development project achieved the surprising success of fostering a will to counter the hegemony of neoliberal health care.

This thesis has argued for the importance of understanding ELAM as a project of alternative development rather than post-development. Post-structural critiques against Cuba’s domestic health strategy and its medical internationalism do not fully appreciate the counter-hegemonic ethos of ELAM. Designing this dissertation around a graduate’s

ability to further COPC was a fitting, and practical, means of observing how the good sense of institutional ethics could become counter-hegemonic action. As discussed in Chapter 4, this good sense can be understood as a product of community-based care and medical internationalism dating back to the foundations of the Cuban revolution. This dissertation also focused on the state of health care in Ecuador following prescribed neoliberal SAPs. The ELAM graduates' challenges in the field are largely based on overcoming the hollow infrastructure and poor social support given to public health. Their professional experience builds understanding of the constraints and capabilities of ELAM in countering neoliberal hegemony and emboldening public health care provision within neoliberal States.

In Ecuador, tensions in service provision exist among the provinces. Some are better equipped to provide community-based care than others. Provincial variations in the organization of human and infrastructural resources suggest that management and political leadership play an important role in organizing primary care on the ground. Imbabura is particularly important, as one of the most impoverished provinces; it seems to be implementing strategies to improve accessibility to its indigent population. Rich in natural resources, Orellena has been hobbled by bad policies that see its wealth extracted, and its capacity crushed by continual extraction of resources with little investment in public-sector services. Orellena has a natural wealth that could help to fund their public services, but strong leadership would be needed to go against the current of neoliberal policies that demand that oil profits be taken abroad.

Ecuador's political climate is in transition. Correa's government has already taken strong stances against participation in free-trade agreements with the United States.

It has also implemented radical changes to the country's constitution and is working closely with Venezuela, Bolivia and Cuba in forming pan-American solidarity networks through ALBA in order to improve health care and education. “¡Si yo puedo!” is the name given to Ecuador's latest literacy campaign. It is a strategy much like Cuba's 1960 literacy campaign that aims to eradicate illiteracy in Ecuador in the coming years. Ecuador is also receiving increased services from Cuban eye doctors working in *Mision Milagro*. While it seems like the Correa government is encouraging policies to improve popular access to services that will work towards human-security agendas, it is still too early to know if counter-hegemony can be made to survive.

In order to accept the talents and passion of ELAM graduates, Ecuador will have to design fitting placement strategies. Recognition of their titles as basic general doctors is a start. Expanding the residency spaces in the national universities would be a positive step to encourage retention within the country as well. Broader investment in education and municipal services would also help to lay a popular foundation for ELAM graduates to initiate and lead community-level campaigns of disease prevention and health promotion.

Another hurdle down the road will involve the reintegration of the Ecuadorian ELAM graduates who have stayed on in Cuba to obtain a specialization. At the moment, specialists who enter the *año rural* often practice in hospitals at the provincial level. As mentioned in Chapters 6 and 7, the inaccessibility of indigent persons to centralized health-care resources is a complex challenge. Ecuador must find solutions to bring the skills of a forthcoming wave of specialists to the needs of vulnerable communities. In part, this could involve the establishment of less centralized public health-care

substations modeled after Cuba's *polyclínicos*. The need for increased allocations of material resources will be a challenge for such a strategy, as already the hollow resources in rural clinics is harrowing. As well, even if properly supplied *polyclínicos* could be established, say through the use of funds from petroleum revenue, it would not necessarily overcome the existing culture of mistrust between public health and the country's indigenous communities. Investment in encouraging the adoption, exchange and dialogue of TNM would also be a necessary step towards improving accessibility.

At the moment, specialists gravitate towards urban spaces, rural clinics are dangerously lacking supplies, and mistrust against the system abounds in the indigenous communities. These are all trends that require further study for future policies, if popular health provision is to be truly expanded. The ELAM graduates seek health-care equity in their country, and their ethics of service and humanism will afford them the capacity to work towards that goal. The challenge, then, is to ensure that they can find appropriate spaces to practice and build relationships with their communities. For ELAM graduates, success is measured by the ability to serve the needs of the vulnerable, and public policies must be established to allow them to succeed.

Appropriate policies do not have to be a pipe dream. This study has attempted to normalize the ELAM experience rather than novelize it. It is not a theoretical delusion, but a series of decisions, actions and processes aimed at creating social change against health-care inequity. The idea of training doctors from vulnerable communities for vulnerable communities came out of medical internationalism dating back to 1960, built on a culture of Cuban medical philanthropy extending into the middle of the nineteenth century. Aside from the mentioned challenges of infrastructure and community

participation there remains broader political opposition. In 2006, presidential candidate Alvaro Noboa shook his fists on Ecuadorian television, pleading to Ecuadorians that Correa would turn the country towards the misery and poverty of Cuba. I had just returned from the lived-in poverty in Sachas. At a dinner in a very well-to-do household just outside of Quito, I mentioned conditions and hardships of Sachas to my hosts.

“Yes, yes it is terrible. They are so poor,” they said.

“But what if Correa could harness increased oil profits to reinvest in the community?” I replied.

“Oh no, Correa will economically collapse the country. We would be impoverished like Cuba,” replied my hosts.

Gramsci (1995) warns that the comfort of material consumption reinforces common sense amongst the middle class. Zinn (2003) argues that the stability of democratic, but inequitable, societies is critically supported by the middle class because of its tendency to side with the elite in exchange for remedial materialism. In the North and South alike, those with incredible potential to influence political change often side with the abuses of the elite, as they are routinely afforded just enough luxury and comfort to hold them back from taking sides with the poor. I told my dinner hosts that, I had spent a great deal of time in Cuba, I had seen poor people there, but I had never seen poverty. Not everyone eats steak, this is for sure, but no one sleeps in the streets. Patients may bring their own bed sheets to the hospital, but they do not die on the road to that hospital. In Cuba, people do not die of hunger just blocks away from others who die of overeating.

My comments fell on deaf ears. Worse still, all too often, the deaf seem to govern, and their supporters tend to lash out against those who do not agree with the

dominant discourse. In Venezuela and Honduras, private-practice doctors and their respective medical associations have been convinced that communist doctors are stealing their patients / clients, and causing them financial ruin. In Bolivia, opponents to the idea of free eye surgery for the poor threw dynamite at the Venezuelan consulate as an expression of their fervent resistance to the idea of offering free medical care. Even in Uruguay, ophthalmologists have decried the work of Cuban eye doctors working in *Mision Milagro* as being shoddy, unprofessional and unacceptable to national standards (El Nacional, 2007). Cuban doctors working in that country said that it was not the first time they, and their collaborators, had been attacked. Earlier brigades of Cuban doctors were tear-gassed by passionate Bolivian nationalists that felt the Cuban presence was stripping Bolivia of its national independence (Vaca, 2007).

While political leadership aimed at increasing accessibility to public resources is a pressing challenge, the bigger problem is overcoming a consciousness that violently opposes such medical altruism. If this perception is to be challenged, policy makers, doctors and communities must mobilize counter-hegemonic dissent. While ELAM and Cuban medical internationalism offer us empirical examples of alternatives, moments of humanism, as well as policies of cooperation and compassion, their political opponents manifest a political consciousness to discredit and devalue this reality by putting value on the supposed efficiency of privatization. Private doctors protesting a communist invasion in Venezuela and bomb throwers in Bolivia have yet to accept the existence of compassion in health care and humanism in foreign policy. While *Mision Milagro* has restored eyesight to hundreds of thousands, and Cuba continues to expand its

international medical-training programs, a great deal of work has yet to be done to make the hegemonic blind see, and the politically deaf hear.

A means of overcoming ignorance and improving the quality of service may come from Cuba's growing expansion of third-country partnerships. For example, Belgium is funding Cuban-run medical brigades in Ecuador who are combating tropical diseases. Belgian money coupled with Cuban human resources to provide medical care in Ecuador is a good example of how the North can be partnered into future projects. South-South collaboration and solidarity will, I believe, play an increasingly important role in international relations for this hemisphere in this century. The North generally demonstrated a superior capacity to gather funds for aid, while Cuba, and increasingly Venezuela, has demonstrated a superior capacity to muster human resources. At the same time, the North has also demonstrated a relative incapacity to bolster human resources, while Cuba has had only a limited capacity of raising funds for outreach. The Belgian cooperation seems to be an important example for other nations to consider. Not only would badly-needed funds be brought to projects strong in human-resources for health, but apertures for dialogue and understanding could emerge between Cuba and its traditional political opponents in the North. Countries like Canada, Spain and Italy, the ones that have traditionally maintained normal relations with Cuba, could be leaders of such initiatives.

Questions of equity, inclusion, rights and human security are all influenced by how health care is perceived and practiced. The ELAM graduates possess a clear ethics of service and are challenging the Correa government to build health-care capacity and human security. If we have done well, as a global society, to normalize policies that

foster inequity, exclusion, and muster political support for militaristic foreign policies to “breaks bones,” then surely it is possible to embrace an ethos that aims to “heal bones.” The Ecuadorian ELAM graduates who comprise the FIS said that they “are going to construct an Ecuador, to be as great as their dreams.” They want to include the excluded and to equalize inequity.

Geography, the interaction between people and place, is formed and governed by socio-spatial relationships, and the ethical prism that normalizes those relationships plays an important role in shaping how people have access to resources within those landscapes. In Ecuador, appropriate socio-spatial relationships have yet to arrive, but this is not to say that it is hopeless. Cuba will continue to build capacity in clinical skills and good sense, and if the Correa government can find ways to encourage COPC, then spaces of counter-hegemony may very well appear.

As of 2007, over 4,500 ELAM students have passed through the graduation hall. A program with over 11,500 participants produces just as many stories and experiences. If the 2005 Ecuadorian contingent can act as a window, a narrow lens into the broader challenges and underlying themes that all ELAM graduates will face, then there is one final conclusion that can be made about how they will influence change.

I think back to what Cacho El Kadri wrote to Eduardo Galeano (1991) at the end of Uruguay’s dictatorship: “They didn’t succeed in turning us into them.”

The ELAM graduates, unemployed a year after graduation, uncertain about their futures, and so far unable to transform Ecuador’s health-care geography, still maintain their collective conviction that regardless of the obstacles, health is a right and health care should be a service. While Ecuador’s system of neoliberal hegemony demands that

health care be bought, the marginalized be forgotten, and the poor be left without, it did not succeed in turning the ELAM graduates into it.

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Appendix

List of first-person and group interviews:

SELECT FIRST PERSON AND GROUP INTERVIEWS			
	Interviewee	Date	Place
1	Mexican ELAM Student	08/08/2004	Cuernavaca, Mexico
2	Cedric Edwards (ELAM Student)	27/06/2005	Havana, Cuba
3	Greg Wilkinson (ELAM Student)	02/07/2005	Havana, Cuba
4	Cedric Edwards (ELAM Student)	02/07/2005	Havana, Cuba
5	Costa Rican ELAM Student	02/07/2005	Havana, Cuba
6	Costa Rican ELAM Student	02/07/2005	Havana, Cuba
7	Dania Aguilar Suarez (ELAM Student)	03/07/2005	Havana, Cuba
8	Venezuelan ELAM Student	08/07/2005	Havana, Cuba
9	Dania Aguilar Suarez (ELAM Student)	10/07/2005	Havana, Cuba
10	Saskia Nuñez Valverde (ELAM recruit)	14/09/2006	Quito, Ecuador
11	Maria Jose (ELAM Graduate)	14/09/2006	Quito, Ecuador
12	Gonzalo (Cuban-trained agricultural specialist)	18/09/2005	Palta Bomba, Ecuador
13	Gonzalo's Mother	18/09/2005	Palta Bomba, Ecuador
14	Dania Aguilar Suarez (ELAM Graduate)	23/09/2005	Joya de los Sachas, Ecuador
15	Patient #1	24/09/2005	Joya de los Sachas, Ecuador
16	Argentinian ELAM Student	08/12/2005	Havana, Cuba
17	CENIRMED	16/09/2006	Quito, Ecuador
18	Maria Jose (ELAM Graduate)	20/09/2006	Quito, Ecuador
19	Jacqueline Rios Mateas (ELAM Graduate)	23/09/2006	Joya de los Sachas, Ecuador
20	Patient #2	24/09/2006	Joya de los Sachas, Ecuador
21	Patient #3	24/09/2006	Joya de los Sachas, Ecuador
22	Cedric Edwards (ELAM Graduate)	10/10/2006	Ottawa, Ontario
23	Ritha Bedoya (Post-doctoral fellow)	25/10/2006	Quito, Ecuador
24	Fany Esperanza Guaman Eras (ELAM Graduate)	27/10/2006	Loja, Ecuador
25	Arlena Rodas (ELAM Graduate)	06/11/2006	Zamora, Ecuador
26	Dr. Alfredo Espinosa (ELAM Teacher & Physician)	10/12/2006	Cienfeugos, Cuba
27	Andrea (Ecuadorian ELAM Student)	10/12/2006	Cienfeugos, Cuba
28	Elizabeth Gallo Chicaiza (ELAM Graduate)	14/12/2006	Quito, Ecuador
29	Albania Gabriela Tamayo Macias (ELAM Graduate)	14/12/2006	Quito, Ecuador
30	Brigada Eloy Alfaro (Cuban solidarity organization)	15/12/2006	Quito, Ecuador
31	Ricardo Rodrigo Carrion Orlando (ELAM Graduate)	16/12/2006	Quito, Ecuador
32	Juan Carlos Cazar Garcia (Ecuadorian Medical Student)	18/12/2006	Quito, Ecuador
33	Maria Fernando Garcia Aguilera (Ecuadorian Medical Student)	18/12/2006	Quito, Ecuador
34	Martha Valeria Barreto Munoz (Ecuadorian Medical Student)	18/12/2006	Quito, Ecuador
35	Jorge Gómez Rodríguez, (1st Secretary, Cuban Embassy)	19/12/2006	Cuban Embassy, Quito
36	Finlay Institute	19/03/2007	Havana, Cuba
37	Honduran ELAM Student	20/03/2007	Pinar Del Rio, Cuba
38	Bolivian ELAM Student	20/03/2007	Pinar Del Rio, Cuba
39	Rector Juan Carrizo	21/03/2007	Havana, Cuba
40	Manuel Torriago	21/03/2007	Havana, Cuba
41	US ELAM Student from Brooklyn	21/03/2007	Havana, Cuba
42	William Solar Institute	21/03/2007	Havana, Cuba
44	Luis Oliveros Director (Henry Reeve Brigade)	22/03/2007	Havana, Cuba
45	Saskia Nuñez Valverde (ELAM Student)	10/10/2007	E-mail
46	Francisco Suéscum Ottati, Ecuadorian Ambassador to Cuba	12/13/2007	Havana, Cuba
47	Pastors for Peace	various	E-mail, New York

Copy of questionnaire used for first person interviews with ELAM graduates.

The Latin American School of Medicine: popular health provision from the classroom to the community.

ELAM GRADUATE SURVEY: ECUADOR

Robert Huish, Ph.D. Candidate, Pierre E. Trudeau Foundation Scholar
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E-mail: rlhuish@sfu.ca

(1) General / contextual information:

- Can you state your name, your home country and your hometown?
- What did you do before coming to ELAM?
- What was your level of education before coming to ELAM?
- How did you apply to the school?
- Would you be able to afford medical training in Ecuador?
- Are you currently practicing medicine?
- If yes, where?
- If you are currently practicing medicine, are you working with other ELAM graduates?

(2) Accessibility

- If you are currently practicing medicine, please answer the following questions. If you are not practicing medicine at the moment, please continue to section three.
- How many patients are you responsible for?
- Do most of your patients regularly visit your clinic / hospital? If yes, how frequently?
- Do you visit patients in their homes? If yes, how often?
- How much time do you spend treating patients on a daily basis?
- How many patients would you see each day on average?
- How long is an average patient consultation?
- Do you feel over-worked to the point where it compromises your duties? If yes, why?
- In general, do you feel that you are accessible to your patients? If no, why not?
- Please comment on any challenges you face in seeing and treating your patients.

(3) Other occupations

- If you are not currently practicing medicine, are you employed?
- Are you taking classes?
- Where are you living?
- Please comment on why you have chosen not to practice medicine at this time.
- Please continue directly to section eleven.

(4) Spatial Accessibility

- On average, what percentage of patients travel to your clinic:
 - By car?
 - By bus?
 - By foot?
 - By horse or mule?
 - By ambulance?
- How many of your patients live within the town?
- How many of your patients live more than 5km away from your clinic?
- Can you comment on any difficulties or challenges that your patients face in travelling to the clinic?

(5) Costs

- Do you personally charge patients for services?
- Does your clinic charge patients for services?
- If patients do not pay for services directly, who pays for their treatment?
- Who pays your salary, and the operating costs of your medical clinic or hospital?
- Can you offer any comments on challenges patients face in paying for services?

(6) Use of services

- Do you feel that you are able to meet the diagnostic and treatment needs of your patients?
- What percentage of patients do you feel you are not able to meet their diagnostic and treatment needs?
- Please comment on why you feel that you are able to meet, or not meet the diagnostic and treatment needs of your patients?

(7) Misuse of services

- Do you feel that patients misuse your services? If yes, how?
- Do you feel that your patients seek you consultation on medical problems that do not need primary care?
- Please comment on whether or not you feel that your services have been misused by patients.

(8) Effectiveness of skills

- Please comment on how effective you feel you are in meeting the healthcare needs of your patients.
- Please offer any comments on where you feel your strengths or weaknesses may lie.

(9) Accurate Diagnosis

- Are you able to routinely offer effective and accurate diagnosis?
- How often are you unable to offer good diagnosis, and for what reasons?
- Please comment on any challenges you face in making accurate diagnosis to patient's needs.

(10) Functioning of broader healthcare system

- Are you able to work with other doctors or healthcare professionals on a daily basis? If so, who would you work with?
- How frequently do you consult with other doctors?
- How available are medical resources to be used for treatment?
- How available are medical resources to be used for diagnosis?
- How available are other doctors to discuss treatment or diagnosis?
- Are you able to request and receive additional medical or information resources? Is this effective?

(11) Further comments:

- Please offer any additional comments about your working experience since graduating ELAM. Please feel free to offer comments on your working conditions that you feel are either positive or negative. Also, please offer any additional comments or provide stories where your skills have been challenged. Please offer any additional comments or provide stories where you skills have overcome challenges.

COPC Themes:

A *How informed are community members to local health concerns?*

- Are community members aware of local social determinants of health? Why or why not?
- Are community members aware of local environmental determinants of health? Why or why not?
- Are patients well informed of individual health risks?

B *Are there local-level community health initiatives?*

- Are there community health initiatives? What are they?
- Are there regular public health & safety information sessions?
- Who is responsible for organizing these events?
- Who regularly participates in these events?
- What are the goals of such programs?
- Does your medical clinic participate and interact with some / all / none of these initiatives?

C *What sort of organization is there for awareness and prevention programs?*

- What sorts of measures exist for local identification and action over community health concerns?

D *What role does prevention play in local health strategies?*

- Are you able to interact with patients and community members to encourage preventative medicine?
- How effective do you feel this is?
- Can you cite any specific examples?

Letter of information for participants:

Canadá, 28 de agosto de 2006

De mis consideraciones:

Mi nombre es Robert Huish, postulante de doctorado perteneciente al Departamento de Geografía de la Universidad Fraser en Vancouver, Canadá; así como, becario de la Fundación Trudeau de Montreal.

La presente investigación que efectúo se enfoca directamente hacia la Escuela Latinoamericana de Medicina (ELAM) de Cuba. Al momento, me encuentro realizando un estudio sobre la experiencia profesional de los alumnos/as graduados en dicho programa. Los países latinoamericanos están en una constante lucha por proveer servicios médicos de calidad tanto en áreas rurales como marginales. De tal manera, mi propósito es el de averiguar si las diferentes promociones graduadas de ELAM están en capacidad y cuentan con la voluntad de ofrecer dichos servicios tan requeridos. En esencia, estudio la eficiencia en la transferencia y apropiación provista por dicha institución con el fin de comprender si los conocimientos y habilidades adquiridos en Cuba son aplicados de acuerdo a las necesidades del Ecuador.

Por lo tanto, solicito comedidamente una cita con usted a fin de recavar información sobre sus experiencias con ELAM; así como, conocer mejor de su relación con este programa. Considero apropiado llevar a cabo una conversación sobre la importancia de este proyecto de investigación; además, de obtener su perspectiva con respecto a cuáles significarían resultados ventajosos tanto para los/as doctores como para quienes se encargan de elaborar las políticas de salud en el Ecuador.

Favor contactarme al correo electrónico, a continuación: rlhuish@sfu.ca

En Quito contaré con el siguiente número de celular, a partir de mi llegada:
(08) 543 0118.

Quedo a la espera de su comunicación. Agradezco de antemano su gentil atención.

Atentamente,

Robert Huish
Estudiante Phd
Departamento de Geografía
Universidad de Fraser

P.D.: Para más información sobre mi persona y el proyecto de estudio, favor recurrir a la siguiente página web:
www.trudeaufoundation.ca

Letter of Ethical Consent for participants:

Carta de Información

1. Esta investigación es realizada por Robert Huish, estudiante doctorado del departamento de geografía, Simon Fraser University, Burnaby, British Columbia, Canadá.
2. El tema que se investiga se titula “La Escuela Latinoamericana de Medicina: provisión de salud pública del aula a la comunidad.” Básicamente, el propósito principal del estudio es medir la conveniencia de esta extraordinaria instrucción médica, además de determinar la eficacia de sus graduados en la provisión de servicios de salud de calidad en el Ecuador rural.
3. Una parte de la investigación contempla la realización de entrevistas en las cuales se solicitará a cada participante indicar su opinión sobre preguntas acerca del tema investigado.
4. Cada participante será entrevistado solo una vez, con una duración aproximada una hora. No habrá estudios de seguimiento.
5. No existen riesgos físicos, psicológicos, económicos ni sociales conocidos que se asocien con la participación en la investigación.
6. La participación en el proyecto de investigación es completamente voluntaria y los participantes son libres retirarse en cualquier momento de la investigación y por cualquier motivo.
7. No es necesario para los participantes contestar ninguna pregunta o conjunto de preguntas con las que ellos no se sientan cómodos.
8. Una grabadora electrónica se utilizará para grabar las entrevistas.
9. La confidencialidad de los participantes se protegerá (a menos que ellos den su consentimiento para ser citados).
10. Esta investigación formará parte de una tesis de doctorado que será sometida a Simon Fraser University. La comunidad académica y cualquier otra persona interesada tendrá acceso a ella a por medio de Simon Fraser University. Se puede publicar también en forma de un libro y estar disponible al público general.
11. No hay ninguna remuneración proporcionada para tomar parte en esta investigación.
12. Cualquier queja o pregunta con respecto a esta investigación puede ser dirigida a las siguientes personas:

- **Robert Huish**
rlhuish@sfu.ca 1.604.773.6941 (Ecuador: 08.543.0118)
Department of Geography, Simon Fraser University,
Burnaby, British Columbia, Canada V5A 1S6.
- **John Brohman**
brohman@sfu.ca 1.604.291.5841
Department of Geography, Simon Fraser University,
Burnaby, British Columbia, Canada V5A 1S6
- **Department of Research Ethics**
email: dorc@sfu.ca

Copy of Signed Consent Form:

Carta de Consentimiento Informado

1. Título de proyecto: La Escuela Latinoamericana de Medicina: provisión de salud pública del aula a la comunidad.
2. Nombre de participante: _____
3. He leído la carta de información y el investigador ha contestado todas mis preguntas al respecto.
4. Estoy enterado de los objetivos de este proyecto de investigación titulado ‘La Escuela Latinoamericana de Medicina: provisión de salud pública del aula a la comunidad’: yo sé la extensión de mi participación en esta investigación y he consentido el uso de una grabadora electrónica para grabar mi entrevista.
5. Estoy enterado que puedo contactar al investigador Robert Huís, al jefe del Departamento de Geografía de Simon Fraser Univesriy, Ted Hickin, o al jefe de éticas para investigaciones de Simon Fraser University, correo electrónico dore@sfu.ca, con respecto a cualquier queja o pregunta sobre la investigación.
6. Estoy enterado que mi participación es completamente voluntaria y que soy libre de retirarme de la investigación en cualquier momento.
7. He constatado que el investigador tiene la capacidad a proteger la confidencialidad de mi identidad y no utilizar mi nombre ni cualquier otra información de identificación en la investigación.

Escoja por favor una de las siguientes opciones y escriba su iniciales:

_____ Yo doy el consentimiento al investigador a utilizar mi identidad en su investigación.

_____ Prohíbo al investigador utilizar mi identidad en su investigación.

Nombre:

Fecha:

Firma:

Institutional Ethics Approval

FOR CONTACT IN REFERENCE TO THIS REVIEW

Application Number: 37006

Dr. H. Weinberg
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Reference Ethics Policy 20.02: <http://www.sfu.ca/policies/research/r20-01revised.htm>

Notification of Application Status

Investigator Surname	Huish
Investigator First Name	Robert
Investigator Department	Geography
Investigator SFU Email	rihuish@sfu.ca
Investigator Position	Graduate
Title Of Research	The Latin American School of Medicine: popular health provision from the classroom to the community
Supervisor Surname	Hayes
Supervisor First Name	Michael
Supervisor SFU Email	mhayes@sfu.ca
Co-Investigators	
Risk	Minimal
Approval Status	Pending REB (Blue)
Approval Date	October 19, 2006
Approval Start Date	October 19, 2006
Approval End Date	October 19, 2009
REB Date	00/00/00
Grant Information	
Submitted To Agency For Review	Yes
Approved Subject To Ethics Approval	No
Reviewed By Any Other Agency	No
Title Of Grant	
Granting Agency	Pierre E. Trudeau Foundation, Social Science Humanities Research Council
Date Granting Agency Approval Began	September 1, 2004
Date Grant Ends	September 1, 2007

APPROVED
By Hal Weinberg at 2:49 pm, 10/19/06

Page: 1