

ACADEMIC ARTICLE

CUBAN MEDICAL INTERNATIONALISM: A PARADIGM FOR SOUTH–SOUTH COOPERATION

Helen Yaffe

Helen Yaffe is Senior Lecturer at the University of Glasgow specialising in Cuban and Latin American development. Since 1995 she has spent time living and researching in Cuba. Her doctoral thesis examined the least known aspect of one of the 20th century's best-known icons, the economic work of Ernesto "Che" Guevara as a member of Cuba's revolutionary government and his contribution to socialist political economy debates. This was adapted for publication as *Che Guevara: the Economics of Revolution* (Palgrave Macmillan 2009). More recently she has published *We Are Cuba! How a Revolutionary People Have Survived in a Post-Soviet World* (Yale 2020). She has co-produced two documentaries, *Cuba & Covid-19: Public Health, Science and Solidarity* (DaniFilms 2020) and *Cuba's Life Task: Combatting Climate Change* (DaniFilms 2021).

Abstract

In 2023, Cuba assumed the presidency of the Group of 77 + China, the world's largest and most diverse multilateral bloc of countries. The election of Cuba to this role testifies to the island's prestige among the Global South, recognition of its material contribution to developing countries, and promotion of South–South cooperation, particularly in the healthcare sector. Cuban medical internationalism tends to be discussed in the rather lonely and nostalgic category of "international solidarity". While there is a rationale for underscoring its uniqueness in motivation, quantity and quality, doing so also facilitates the censoring or sidelining of this extraordinary assistance in international analysis. In the context of Cuba's presidency of the Group of 77 + China, this article frames Cuban medical internationalism in relation to the United Nations principles for South–South cooperation, and the commitment to healthcare as a human right. It also draws on calculations of the monetary value of Cuba's overseas development aid to provide a comparative assessment of the island's contribution to the global south. After noting the key steps and achievements in the development of Cuba's own

public healthcare system, the article explores the origins of and motivations for Cuban medical internationalism, providing examples of the four forms of assistance which emerged in response to global circumstances, and which endure today. The article then demonstrates how Cuban international assistance is consistent with the UN's Plan of Action to promote cooperation between developing nations. Finally, it discusses the economics of Cuban medical internationalism, and the campaign to discredit and sabotage Cuban medical exports by opponents of Cuban socialism.

Keywords: Cuba, Socialism, Cuban Medical Internationalism, Overseas Development Aid, Global South, Developing Countries, South–South Cooperation, Public Healthcare, Solidarity.

Introduction

In 2023, and for the first time, Cuba assumed the annual rotating presidency of the *Group of 77 + China*, the world's largest and most diverse multilateral bloc of countries. Cuba was elected to the presidency by consensus during the 77th session of the UN General Assembly in September 2022. The vote testifies to the island's prestige among the Global South, recognition of its material contribution to developing countries, and promotion of South–South cooperation, particularly through Cuban medical internationalism. Evidence of that commitment was recently provided by the Cuban Henry Reeve Disaster Response and Disease Control medical brigades, which provided emergency COVID-19 assistance around the world; they joined the 28,000 Cuban healthcare professionals already working in 66 countries in early 2020.

Cuban medical internationalism tends to be discussed in the rather lonely (and nostalgic) category of “international solidarity”.¹ There is a rationale for underscoring its uniqueness, in motivation, quantity and quality. However, doing so also facilitates this extraordinary Cuban contribution to the world to be censored or sidelined in international analysis. Guatemalan researcher, Henry Morales, has reformulated Cuban international solidarity as “Official Development Assistance” (ODA) in order to capture the full scale of this contribution to global development, and to facilitate a comparative assessment with the world's other donors (Morales 2018).

According to Morales, more than 180 countries were beneficiaries of Cuban ODA between 1999 and 2015. With an abundance of data, he details the types of assistance, and the location and number of beneficiaries. In addition, using

1 Since the early 2000s under the Bolivarian Revolution, Venezuela accompanies Cuba in this category of “international solidarity”.

average international market rates and adopting the OECD methodology, Morales provides a monetary value for all medical and technical professional services provided to calculate that Cuban ODA between 1999 and 2015 was over \$71.5 billion dollars, equivalent to \$4.87 billion dollars annually. This means that Cuba dedicated 6.6% of its GDP annually to ODA, by far the highest ratio of international cooperation in relation to GDP in the world. In comparison, the European average was 0.39% of GDP and the United States contributed just 0.17% of GDP in assistance.

The Cuban contribution is more outstanding when we factor in the economic cost to Cuba of the United States blockade since 1962. At current prices, the US blockade is calculated to have cost Cuba more than \$150 billion dollars over six decades, including nearly \$3.3 billion specifically in the public healthcare sector. While the United States is the only country in the world to impose sanctions on Cuba, the extraterritorial imposition of those unilateral sanctions has been so extensive and punitive that the blockade affects Cuba's interaction with the world. The damage is not just to Cuba, but to international partners whose trade with Cuba is obstructed or complicated. However, its negative global impact is also felt to the extent that by reducing Cuba's material wealth it restricts Cuba's capacity for ODA. Since the blockade costs the island between \$4 billion and \$5 billion every year, without this burden Cuba potentially could double its contribution to ODA. The US is clear and open about its desire for regime change, to end the socialist system in Cuba. Where would that leave the millions of lives saved and improved by Cuban internationalists every year?

While Cuba has provided significant ODA in diverse fields, including education, sports, culture, construction, agriculture, technology, fishing, and economic donations, the lion's share has been in healthcare, to which \$3.4 billion has been allocated annually. According to Morales, between 1999–2015, Cuba was the greatest net donor of healthcare in the world, with 31.2% of the total, followed by the United States with 10.6%, the Global Fund with 8.6%, and the World Bank with 7.2% (Morales 2018: 21). As 70% of Cuban ODA is based on healthcare, this article examines Cuban medical internationalism, framing it not in monetary terms, as Morales does, but in relation to the principles of South–South cooperation, as formally defined by the United Nations, the founding body of the Group of 77 + China (G77 +China).

The article starts by outlining the UN's principles for South–South cooperation and commitment to healthcare as a human right, explaining how similar aspirations guided the investments and priorities in healthcare provision by the post-1959 Cuban state. It notes the key steps and achievements in the development of Cuba's public healthcare system, before discussing Cuban medical internationalism, categorizing the different forms it takes and describing the origins of each form. The article then

illustrates how Cuban medical internationalism meets the criteria for South–South cooperation as laid out in the Buenos Aires Plan of Action (BAPA) for Promoting and Implementing Technical Cooperation among Developing Countries (resolution 33/134), which was endorsed by the United Nations General Assembly in 1978.

Context is everything. The election of Cuba to preside over G77 + China represents a rejection by the developing countries of US hostility toward Cuba and the campaign to sabotage Cuban medical internationalism. That campaign seeks to undermine both Cuba’s international prestige and the revenue it receives from medical services exports. The US government accuses the Cuban government of human trafficking and equates Cuban medical personnel going overseas to slaves. This article engages with these accusations, and also discusses the economics of Cuban medical internationalism.

The Cuban programs referenced below are only a small selection from the huge number of international healthcare initiatives carried out by the Cuban state over more than six decades. By the end of 2018, more than 400,000 Cuban medical professionals had served in 164 countries since 1960 (Gorry 2019: 83), more countries than the membership of G77 + China. Just between 1999 and 2015, they had saved nearly 6 million lives, carried out nearly 1.4 billion medical consultations, performed 10 million surgical operations, and attended 2.67 million births attended (Morales 2018: 20). Add to that the beneficiaries between 1960 and 1998, and those since 2016, and the numbers keep climbing. While the scale of assistance has been impressive, equally important has been the mode of assistance, which is entirely consistent with the principles of South–South cooperation, as discussed below.

G77 + China

The Group was founded in 1964 by 77 developing countries, members of the Non-Aligned Movement, to defend their economic interests and strengthen their capacity for joint negotiation within the UN. Today G77 + China has 134 member states, representing nearly 70% of the UN’s membership and 80% of the world population. The bloc has “chapters” with liaison offices in Geneva (where UNCTAD (United Nations Conference on Trade and Development) is based), Nairobi UNEP (United Nations Environment Programme), Paris UNESCO (United Nations Educational, Scientific and Cultural Organisation), Rome FAO (Food and Agriculture Organisation), Vienna UNIDO (United Nations Industrial Development Organisation), and in Washington (Group of 24). Cuba joined in 1971 and has held the presidency of chapters in Geneva (2001 and 2010), Nairobi (2005), and Rome (1987 and 2001), but not the presidency of the Group. In 2000, Havana hosted the first “Summit of the South” for G77 + China. Fidel Castro presided over the event and made an important speech.

The presidency is the highest political entity within the organizational structure of G77 + China. It rotates by region (Africa, Asia-Pacific, and Latin America and the Caribbean) and is held for one year. The President acts as its spokesperson and coordinates the Group's action in each Chapter.

Acceding the presidency at the handover ceremony in New York on January 12, 2023, Cuba's Foreign Minister Bruno Rodríguez Parrilla pledged that Cuba would use its presidency to "foster international solidarity and cooperation in support of the post-pandemic recovery of our nations", committing to cooperative projects from the South in the areas of "health, biotechnology, education, the combat of climate change and the prevention of disasters, which may set an example of unity, complementarity and true political will" (Rodríguez Parrilla 2023). In these areas, Cuba can demonstrate leadership, not just for its domestic achievements but also in terms of international cooperation. In mid-September 2023, Havana will host a summit for G77 + China heads of state with the theme "Current development challenges: Role of Science, Technology and Innovation" (MINREX 2023).²

The Principles of South–South Cooperation

In 2016 the UN's High-Level Committee on South–South Cooperation expounded the following normative principles for South–South and triangular cooperation: respect for national sovereignty and ownership; partnership among equals; non-conditionality; non-interference in domestic affairs; and mutual benefit (UN Secretary-General 2016). Cuban medical internationalism is an outstanding example of how these principles can be put into practice. Cuban healthcare professionals have worked in the majority of the world's nations, but always at the invitation of host authorities (de Armas Águila 2023). The cooperation agreements between Cuba and its hosts are based on respect for national sovereignty, never imposing conditions nor interfering in domestic affairs, and focused on the specific healthcare needs of the recipient country. As Yamila de Armas, President of Comercializadora de Servicios Médicos Cubanos explains, "some are territories where authorities are not able to organize medical services. In some cases, because of very special circumstances, such as meteorological events, epidemics, or other particular things" (de Armas Águila 2023). Cuban overseas medical missions operate under formal principles and practices that foster partnerships on the basis of equality, respect and mutual benefit (Gorry 2019: 84).

2 The Summit takes place after submission of this article, hence the lack of comment.

The United Nations Commitment to Healthcare as a Human Right

The commitment to the principle of healthcare as a human right is endorsed in the Universal Declaration of Human Rights, adopted by the United Nations in 1948. Article 25 states:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Founded in 1948 as the UN's agency to promote health, the World Health Organization (WHO) advocates these principles. The preamble to its constitution states:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (WHO 2023)

In 2023 the WHO remained “firmly committed” to these principles.

The Cuban Commitment to Healthcare as a Human Right

Since 1959 the Cuban state has prioritized health and welfare provision, making unprecedented improvements for the population at home and abroad. Its progress in saving and improving lives is clearly established by comparative data, as cited below. The key features of the Cuban approach, which are relevant to other developing countries, are the following: the commitment to healthcare as a human right; the decisive role of state planning and investment to provide a universal public healthcare system with the absence of an alternative or parallel private sector or “market” for medical services; the speed with which healthcare provision was improved (by the 1980s Cuba had the health profile of a highly developed country having eliminated most infectious and poverty-related diseases); the focus on prevention over cure; and the system of community-based primary care. By these means, Cuba has achieved comparable health outcomes

to developed countries with lower per capita spending, as shown below. In its international outlook, the key features are the consistent defense and promotion of the right to healthcare for the global population and medical internationalism as a core feature of Cuban foreign policy.

The achievements of the Cuban public healthcare system should be evaluated in relation to the situation pre-1959. Healthcare provision in Cuba was divided into contributory, private, and public sectors and the Cuban government allocated around 7.5% of its budget to “health and welfare” (McGuire and Frankel 2003: 23–24). There were over 6,200 doctors, equivalent to 9.2 physicians per 10,000 inhabitants, and among the highest ratios in Latin America. Cuba had one medical school, in Havana, which was highly regarded. However, much of the population had no access to medical services due to poverty, geography, racism, and political corruption. Inequality between rural and urban Cuba was striking. There was one rural hospital on the island. Life expectancy was 59 years and infant mortality was 60 per 1,000 live births (but 100 per 1,000 in rural Cuba). Cuba’s rural infant and maternal death rates were second highest in Latin America (MacDonald 1995: 46). The main cause of death was intestinal parasites, which are estimated to have affected 80% of Cuban children in the countryside.

During the revolutionary movement against the Batista dictatorship in 1950s Cuba, the Movement of the July 26, led by Fidel Castro, committed to rectifying the healthcare deficit. The “Moncada Program” for socio-economic change on the island incorporated the principle of healthcare as a human right. Once in power, the post-1959 revolutionary government quickly introduced universal free access to both education and healthcare (provision and training) alongside other public services, utilities, and infrastructure. Key steps in the expansion of the public healthcare system are listed below.³

- In 1960 a rural medical service (RMS) was established. Newly graduated doctors were posted for one year to underserved populations in remote areas. As well as being clinicians, they operated as health educators, emphasizing prevention over cure. In 1961 a rural dental service was added. A new Ministry of Public Health was introduced and oversaw the nationalization of almost all private services. By 1970, the number of rural hospitals had increased from 1 to 53, with medical and nursing schools across the country.
- In 1962 a national immunization program was launched helping to eliminate polio (in 1962), malaria (1968), diphtheria (1971), measles (1993), pertussis (1994), and rubella (1995). Other national programs were established for infectious disease control and prevention.

3 Information drawn from Keck and Reed (2012, 14).

- In 1974 a new model of community-based “polyclinics” was introduced for comprehensive primary care (obstetrics, gynecologists, pediatricians, internists, and dental services). Training and policy emphasized the impact of biological, social, cultural, economic, and environmental factors on patients. National programs focused on maternal and child health, infectious diseases, chronic non-communicable diseases, and older adult health.
- In 1976, Cuba’s new Constitution, the first introduced by the post-1959 government, established the responsibility of the state to guarantee access to health protection and care. Article 50 stated:

Everybody has the right to health protection and care. The state guarantees this right: by providing free medical and hospital care, by means of the installations of the rural medical service network, polyclinics, hospitals and preventive and specialized treatment centers; by providing free dental care; by promoting the public health campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent the outbreak of disease. All of the population cooperates in these activities and plans through the social and mass organizations. (Constitute 1978: Article 50)

- In 1983 the Family Doctor and Nurse Plan was introduced with clinics set up in every neighborhood facilitating medical attention 24 hours a day. Community medics coordinate healthcare and lead health promotion efforts, emphasizing prevention and epidemiological analysis. They rely on history-taking and clinical skills, reserving costly high-tech procedures for patients requiring them, holding patient appointments in the mornings and making house calls in the afternoons. The teams carry out neighborhood health diagnosis, melding clinical medicine with public health, and individualized “Continuous Assessment and Risk Evaluation” for their patients (Keck and Reed 2012: 16).
- In 2019, Cuba’s new Constitution, approved by national referendum, reaffirmed the state’s commitment to healthcare:

Public health is a right of all people and it is the state’s responsibility to guarantee access to quality medical attention, protection, and recovery services, free of charge. The state, in order to effectuate this right, institutes a healthcare system at all levels that is accessible to the population and develops prevention and education programs, to which society and families contribute. (Constitute 2019: Article 72)

The Achievements of Cuba’s Public Healthcare System

- *Ratio of doctors per person:* By 2018, there were 7.5 doctors per 1,000 inhabitants in Cuba, nearly three times the density of doctors in the US and UK.

This was up from less than 1 doctor per 1,000 pre-1959. The ratio actually fell post-1959 as half of Cuba's doctors, mostly employed in the private sector, left the country. In 1965 Cuba had one doctor for every 1,200 people. In 1985, two decades later, the ratio was 1 to 500. By 2005, it was 1 for 167 people, the highest ratio in the world (Huish 2014: 266).

- *Infant mortality*: By 2017 there were less than 4 deaths per 1,000 live births, down from 60 per 1,000 in the 1950s.⁴ The equality of performance between urban and rural areas is notable and distinctive.
- *Life expectancy*: By 2005 it reached 77 years in Cuba (up from an average of 60 years in the 1950s, but 50 years in rural areas) (Our World in Data 2023 a).⁵
- *Medical training*: There are 21 medical training faculties in Cuba graduating thousands of new professionals, Cubans and foreigners, every year.
- *Human Resources and infrastructure*: By 2020, Cuba had 97,000 doctors, including 48,000 family doctors, of which 26,000 worked in the community, and 84,000 nurses. There were 150 hospitals and 449 polyclinics, 111 dental clinics, 132 maternity homes, 155 old peoples' homes, 30 psycho-pedagogical medical centers, and 12 medical and research institutes (DaniFilms and Yaffe 2020).
- *Value for money*: According to World Bank national accounts data, in 2019 Cuba's GDP per capita was \$9,139 in current US dollar prices, compared to \$65,120 in the United States and \$42,747 in the United Kingdom. Healthcare spending was almost 16% of total government spending in Cuba, equivalent to \$1,032 per capita in current US dollars; it was 22% of total government spending in the United States, at \$10,921 per capita; and nearly 20% in the United Kingdom, which has the National Health Service, at \$4,313 per capita (Our World in Data 2023 b).⁶ Remarkably, with healthcare spending per capita less than one-tenth that in the United States and one-quarter that in the UK, the Cuban healthcare system has comparable results. During the COVID-19 pandemic, Cuba also outperformed many countries in preventing contagion and deaths. On March 28, 2021, one year into the pandemic, Cuba's fatality rate was 0.58 per million, compared to a world rate of 2.25 and a US rate of 1.81. Cuba's worst surge, in the summer and autumn of 2021, saw deaths rise to 7.84. This was below the US peak of 10.7, while the UK twice soared to around 20 (Our World in Data 2023 c).

4 The COVID-19 pandemic and the intensification of the US blockade have taken a toll on Cuba's infant mortality rate which rose to 7.6 in 2021 and 7.5 in 2022.

5 Life expectancy figures were affected by the COVID-19 pandemic, falling from 77.6 years in 2019 to 73.7 years in 2021.

6 See also "Cuba Healthcare Spending 2000–2023" (Macrotrends 2023).

While it is possible to compare Cuba with the US and the UK in terms of health indicators, the comparison is neither sensible nor scientific for two reasons. First, because Cuba is a small island developing state shaped by centuries of colonialism and imperialism, while the UK's wealth was derived from the British empire, which once controlled nearly one-quarter of the world's land surface. The United States has exercised hegemony over the Americas since the 19th century and has been the world's predominant economic and military power since the mid-20th century. Second, because Cuba has faced the longest and most comprehensive set of sanctions imposed in modern history in the form of the United States blockade. Cuba's Ministry for Public Health reports:

[Cuba] is denied the right to acquire technologies, raw materials, reagents, diagnostic means, medicines, devices, equipment and spare parts necessary for the best functioning of its national health system, which must be obtained in geographically distant markets or through a third country, with an increase in costs. Technologies from the United States or with more than 10 percent of components from that country cannot be acquired by the island, which has a negative impact on healthcare.

(MINSAP 2021)

The United States uses its leverage over the international financial system to force global entities to effectively implement its sanctions. In 2019, 88% of international transactions involved US dollars. The *Wall Street Journal* noted that this “gives the US extraordinary power over nearly anyone who imports or exports anything anywhere” (2020). The US Treasury's Office of Foreign Asset Controls issues million, and billion, dollar fines on banks and companies in third countries as punishment for dealing with Cuba, while Canadian, EU, and UK anti-US blockade legislation has not been enforced.⁷ Sanctions have been tightened to suffocating levels since 2019.

Despite this, Cuba has performed better at ensuring access to the essential goods required for survival than most countries in the world. Cuba's system of food distribution has helped it to fight hunger and premature mortality. Its death rate from malnutrition is lower than even high-income economies, including the United States. A recent study by Jason Hickel and Dylan Sullivan took the death rate from malnutrition in Cuba as a base rate in order to calculate the number of deaths from malnutrition in excess of Cuban levels in all countries from 1990 to 2019. Their alarming conclusion was that:

⁷ See Yaffe (2023).

In total, 15.63 million excess deaths have occurred due to malnutrition that could have been prevented with Cuba-style policies. This includes 35,000 in the US; 409,000 in Mexico; 729,000 in China; 1.2 million in Indonesia; and a staggering 3.65 million in India.

(Sullivan and Hicel 2022)

In addition to improving the health and quality of life of its own population, the Cuban government has consistently advocated for, and promoted, the right to healthcare for the global population. Indeed, Cuban programs of medical assistance overseas were initiated very soon after the new government was established, as detailed below.

Cuban Medical Internationalism: Origins and Forms

It is a popular refrain from Cubans that: “we share what we have, not what we have left over”. In fact, the ambition of Cuba’s international assistance has not even been limited to sharing their existing resources, but rather has striven to expand capacity to meet healthcare needs overseas. After witnessing the urgent need for healthcare workers while on tour in Africa in the 1970s, Fidel Castro committed to training the local personnel necessary to build sustainable healthcare systems. It was not until 1976 that Cuba’s pre-revolutionary ratio of doctors to citizens was restored on the island, although health indices had improved disproportionately. By then, Cuban medical internationalism was already established as a key feature of the island’s foreign policy. An important principle of Cuban medical internationalism is that it is focused on people, not political institutions. Cuba has repeatedly provided medical assistance to countries with which it has no diplomatic relations and where governments are politically hostile.

The four prevailing forms of Cuban medical internationalism were initiated early in the 1960s in response to international developments: 1) Emergency response medical brigades sent overseas; 2) Foreign patients treated for free in Cuba; 3) The establishment abroad of public health apparatus to provide free health care for local residents; and 4) medical training for foreigners, both in Cuba and overseas. The following section explains how and why these programs were initiated and subsequently expanded.

1) Emergency response medical brigades sent overseas

In May 1960, Chile was struck by the most powerful earthquake on record. Thousands were killed. Despite the post-1959 departure of half of Cuba’s

physicians, and strained diplomatic relations with the Chilean government, the revolutionary Cuban government sent an emergency medical brigade with six rural field hospitals. Subsequently, between 1970 and 1974, Cuba sent disaster response brigades to Peru, Chile, Nicaragua, and Honduras, in response to three earthquakes and a hurricane. Between 1985 and 1992, they went to Mexico, El Salvador, Ecuador, Nicaragua (three times), the USSR/Ukraine, Iran, and Brazil. Between 1998 and 2005, emergency teams were sent to Honduras (three times), Guatemala, Nicaragua (twice), Colombia, Venezuela, El Salvador, Ecuador, Algeria, Sri Lanka, Indonesia, and Guyana.⁸

Since late 2005, Cuba's emergency brigades have been organized under the name of the Henry Reeve International Contingent, in honor of a US citizen who fought with Cuban independence forces in the 19th century. This name was chosen to accompany the Cuban offer to send medical aid, including three field hospitals, to the United States following Hurricane Katrina which struck Mississippi, Alabama, and Louisiana, leaving 80% of New Orleans flooded. Within days, over 1,500 Cuban volunteer medics were ready, armed with medical backpacks, to be sent to Louisiana. The Cubans were ideal candidates to provide emergency assistance in those conditions, without clean water, electricity, or sophisticated diagnostic equipment. They are trained to operate in such adverse conditions. Between them they had worked in 43 countries, all of them in the Global South. The US administration never replied, and even omitted Cuba from a list of countries which had offered help. Two weeks later, Fidel Castro said: "It hurts to think that maybe some of those desperate people, trapped by the water and at death's door, could have been saved" (Castro 2005).

By October 2005, Henry Reeve brigades were sent to Guatemala following Hurricane Stan, and then to Pakistan-administered Kashmir after a devastating earthquake. The pace of Cuba's emergency disaster response deployment subsequently sped up. In 2017, the WHO awarded the Henry Reeve International Contingent a public health prize in recognition of its emergency medical assistance, by then to more than 3.5 million people in 21 countries affected by disasters and epidemics since the founding of the Contingent in September 2005 (PAHO 2017). The deployment of Cuba's disaster response and disease control specialists was stepped up in response to the COVID-19 pandemic. Within a year of the pandemic, 57 Henry Reeve brigades had treated 1.26 million coronavirus patients in 40 countries. For the first time, Cuban emergency medical brigades operated in Western Europe (Italy and Andorra).

8 John Kirk provides a chronological list in *Healthcare Without Borders* (2015, 120–121).

2) Foreign patients treated for free in Cuba

In 1961, while Cuba was supporting Algeria's struggle for independence from France, orphaned children and wounded fighters were sent to the island for medical treatment. They were followed by many foreigners who received medical care in Cuba, including thousands of young people sent to Cuba to study medicine but who on arrival required treatment in Cuba's hospital for tropical diseases, Instituto Pedro Kouri (IPK), for conditions already eradicated in Cuba, such as malaria, filariasis, schistosomiasis, and poliomyelitis.

There are two outstanding examples of Cuban programs to treat foreign patients *en masse*. The first is the "Children of Chernobyl" program which began in 1990 and lasted for 21 years during which 26,000 people affected by the Chernobyl nuclear disaster, nearly 22,000 of them children, received free medical treatment and rehabilitation, accommodation, food and other facilities in Cuba. At the height of the program, with 2,000 patients arriving annually, there were 50 doctors and 80 nurses working at a dedicated medical facility in Tarará, east of Havana. The Cubans covered the entire cost, despite the program coinciding with Cuba's severe economic crisis, known as the Special Period, which resulted from the collapse of the socialist bloc.

The second is Operation Miracle, set up in 2004, where the Venezuelan government paid for Venezuelans with reversible blindness to travel to Cuba for free eye operations to restore their sight. Over 200,000 Venezuelans traveled to Cuba with a family member, staying for one week after surgery in a Cuban hotel and receiving follow-up care without charge. From October 2005, Venezuelans were treated at home in ophthalmology centers set up with Cuban medical expertise and assistance. Operation Miracle was then extended through Latin America and the Caribbean. By 2017, Cuba was running 69 ophthalmology clinics in 15 countries under Operación Milagro, and by early 2019 over 4 million people in 34 countries had benefited.

3) The establishment abroad of public health apparatus to provide free health care for local residents

Following independence in 1962, Algeria faced challenges similar to those of Cuba, including the departure of (French) physicians. Despite the shortage of medics in Cuba, in May 1963, 55 Cuban healthcare professionals went to Algeria to provide assistance, and the following year another 61 Cubans arrived to help establish Algeria's national health system. The Algerians were charged nothing.

Cuban medics accompanied soldiers throughout Africa in the 1960s and 1970s, establishing mass vaccination campaigns, public health information campaigns,

and treating patients for free. They set up and staffed Comprehensive Health Programs. In Angola they were joined by education brigades, which from 1978 brought literacy to 1.3 million Angolans, while thousands of Cubans, alongside Angola forces, fought off the invading army of apartheid South Africa (Morales 2018: 48). In 1977, Cuba was providing between 45% and 84% of the physicians working in six African countries. By 1988, over 30 countries in Africa were in receipt of Cuban medical support. 76,000 Cuban medical personnel had worked in 39 African countries by 2014.

In 1998 following Hurricane Mitch in Central America and Hurricane Georges in Haiti, Cuba set up Comprehensive Health Programs at the request of the host governments. The cooperation agreement with Haiti committed Cuba to maintain 300 to 500 medical professionals there while training hundreds of Haitians as physicians to gradually replace them. In 2004, nearly 600 Cubans were responsible for the healthcare of 75% of the Haitian population. By 2015, after 16 years, the Cuban medics had saved over 392,000 lives, carried out 24.6 million consultations and over half a million surgical operations (Kirk 2015: 194). Between 1999 and 2007, infant mortality fell from 80 deaths for every 1,000 live births to 33 per 1,000, and life expectancy rose from 54 years to 61 years (Kirk and Kirk 2010: 13).

Venezuela has hosted the greatest number of Cuban medical professionals. By 2014, Cuba had sustained more than 20,000 healthcare workers in Venezuela for a decade, peaking at 29,000. That is one of the diverse and differentiated range of programs of medical assistance developed between Cuba and Venezuela. In 2013, 11,400 Cuban medics were contracted through the Pan American Health Organisation (PAHO) to serve on the Brazilian government's *Mais Medicos* program to employ 18,000 physicians to deliver healthcare to 63 million Brazilians with no, or limited, access to medical care. Thousands more Cubans were attending to underserved populations throughout Latin America and the Caribbean. By 2015, Cuban Integral Healthcare Programs were operating in 43 countries: 5 in Latin America, 7 in the Caribbean, 23 in Africa, 7 in Asia and Oceania, and one in the Ukraine (Jiménez Expósito 2010: 6). Cuban healthcare workers were also providing assistance in the South Pacific, particularly East Timor, and in other regions.⁹

4) Medical training for foreigners

The Cuban state never sought to foster dependence on Cuban professionals. From the 1960s it began training foreigners in their own countries or in Cuba. For example, in 1966 Cuban medics operated in guerrilla-controlled territory during the independence struggle in Guinea Bissau where one foreign doctor

9 About Cuba's role in the South Pacific, see Walker and Kirk (2013, 10–25).

served 540,000 people. The Cubans trained Guineans on site in basic nursing, and some locals went to Havana for further study. Between 1976 and 2010, Cuban medical faculties were established to train locals in 11 African countries. However, as those countries lacked educational infrastructure, schools, and universities, it was concluded that Cuba would have to train people from those countries on the island. By 1984, 1,800 students from 75 developing nations were training in Cuba as physicians, medical technicians, or medical specialists. Of over 3,500 foreign medical graduates in 1991, 500 were from North Africa, and the rest were from Sub-Saharan Africa and the Americas. Between 1999 and 2015, nearly 74,000 scholarship students from 159 countries graduated in Cuba: 50% from Latin America and the Caribbean, 37.5% from Sub-Saharan Africa, 4.5% from North Africa and the Middle East, and, among the rest, 0.2%, or 184 students, from North America. Morales valued this at \$9.3 billion dollars (2018: 97–98).

In 1999 the Latin American School of Medicine (ELAM) was established in Havana. This was a direct response to the severe deficit of medical personnel and infrastructure witnessed by Cuban emergency brigades in Central America following Hurricane Mitch. ELAM quickly became the world's largest medical school, enrolling students from throughout the Global South and even disadvantaged youth from the United States. By 2019, ELAM had graduated 29,000 doctors from 105 countries. Half of them were women, 75% were the children of workers or *campesinos* (peasants or farmers), and they represented 100 ethnic groups.

Forms of Cooperation

Over the decades and in response to specific and changing circumstances domestically and internationally, Cuba has developed a “mix and match” approach to international cooperation. The most common forms of Cuban ODA are: Donations (financial and material), Free Technical Services, Services with Compensation of Expenses, Cuban Medical Services, Compensated Technical Assistance, and Triangulated Services. As Morales points out, “in the same country different forms can converge in such a way that the combinations or sum reached up to 87 countries in 2015” (2018: 44). A brief summary of these forms follows:¹⁰

- Donations: direct contributions from the Cuban government, usually to countries in an emergency or crisis situation. This includes financial

¹⁰ This summary draws information from Morales (2018: 44).

assistance, sometimes debt forgiveness, and donations of equipment and materials, including shipments of supplies.

- **Free Technical Services:** collaboration on the technical-programmatic level at no cost to the recipient country (medical, sports, educational, or technical). This includes Cuban professionals working overseas missions with expenses covered by the Cuban government, scholarships provided for foreigners to study in Cuba, and surgical interventions (including Operation Miracle). This has been among the most common forms of Cuban medical internationalism since its inception, and it remains active, especially in impoverished countries.
- **Technical Assistance with Compensation of Expenses (ATC) or Direct Contract:** Established through reciprocity agreements between Cuba and the recipient countries, through which the costs are shared between them. This form was introduced in the 1990s during the Special Period when Cuba was unable to cover the costs of ODA.
- **Triangulated Collaboration:** A third-party collaborator, such as the UN, other governments, or a bilateral donor, cooperates with the Cuban government and the recipient country, generally in emergency interventions or for specific agreements. Prominent examples include Cuban medical brigades to West Africa responding to the Ebola emergency, and in Haiti following the earthquake.
- **Cuban Medical Services (SMC):** Cuba provides comprehensive healthcare through commercial agreements, distinct from the traditional forms of medical cooperation. This is catered to the needs of the partner and can include: medical services in Cuba, health-related academic and teaching services, border health and medical services, health services associated with optical and pharmaceutical products and natural and traditional medicine, scientific events services, and professional services associated with medical and health services abroad, among others. The export of medical services has become Cuba's greatest source of revenue.

Meeting the UN's Objectives for South–South Cooperation

In 1978, the United Nations General Assembly endorsed the Buenos Aires Plan of Action for Promoting and Implementing Technical Cooperation among Developing Countries (resolution 33/134) (UNOSSC 1978). This has subsequently guided the conceptual and operational principles for programs to promote South–South cooperation. Below is the list of nine basic objectives with their identifying letter as presented in point 15 of this document, with an explanation of how Cuban medical internationalism advances each objective. The objectives are rather abstract and repetitive, as is characteristic of such documents.

- a. To foster the self-reliance of developing countries through the enhancement of their creative capacity to find solutions to other development problems in keeping with their own aspirations, values, and special needs.

Cuba's medical training for foreign students serves to foster self-reliance in developing countries, enhancing their capacity to solve public health problems and meet domestic needs. The Cuban model of community-based primary care, emphasizing prevention and epidemiological analysis, is far more appropriate and effective for developing countries facing resource constraints than the high-tech, high-cost specialist care model of most developed countries. According to Morales, "The Cuban collaboration is considered a pioneer in the search to generate impact, seeking maximum efficiency and sustainability in the short and medium term". This statement is supported by much of the data in his report. For example, in 2015 alone, Cuban medical brigades in 70 countries, attended 131,830,160 patients, equivalent to 11.7 times the population of Cuba (Morales 2018: 44).

Emily and John Kirk compare the efficiency of Cuban emergency assistance to Haiti following the earthquake of January 12, 2010, to teams from Médecins Sans Frontières (MSF) and from Canada and the United States. Within two months,

Cubans have treated 4.2 times the number of patients compared to MSF (which has more than twice as many workers, as well as significantly more financial resources), and 10.8 times more than the Canadian DART team ... the Cuban medical contingent was roughly three times the size of the American staff, although they treated 260.7 times more patients than US medical personnel.

(Kirk and Kirk 2010: 15)

The US and Canadian medical personnel had departed by March 9, while the Cubans never left. In terms of self-reliance, most significant is that alongside those Cuban medics were hundreds of Haitian medical graduates trained in Cuba. By 2011, 625 Haitians had graduated as doctors in Cuba, and 430 of them were working in Haiti, mostly in the public healthcare sector (Kirk 2015: 214).

The Cuban approach evaluates environmental, physical, social, and psychological impacts on individual health outcomes. This is extremely important for developing countries where patient health is hugely affected by the presence or absence of facilities and utilities, such as sewage management and access to clean water, and by socio-economic conditions, such as stressful work conditions and overcrowded housing. The principle implicit in the Cuban approach, that the

state is responsible for meeting the basic needs of the population, has the potential to enhance the capacity of developing countries to find solutions to other development problems.

- b. To promote and strengthen collective self-reliance among developing countries through exchanges of experience, the pooling, sharing, and utilization of their technical resources, and the development of their complementary capacities.**

The beneficiaries of Cuban medical internationalism have been, almost exclusively, populations in developing countries. Postings are primarily in underserved, including remote, areas. The composition of Cuban brigades depends on domestic capacity and the needs of host countries. The Cubans are directed by the Ministry of Health of the host country, which establishes their priorities. (Gorry 2019: 85; Morales 2018: 32). This cooperation involves the pooling, sharing, and utilization of technical resources.

- c. To strengthen the capacity of developing countries to identify and analyze together the main issues of their development, and to formulate the requisite strategies in the conduct of their international economic relations, through pooling of knowledge available in those countries through joint studies by their existing institutions, with a view to establishing the new international economic order.**

Cuba's overseas missions are established through coordination with host authorities. Yamila de Armas explains that every cooperation agreement begins with the request for assistance from other countries, or actors in other countries. "These requests are carefully considered and receive a response according to our capacity to respond ... We share in solidarity with all countries that request it, while also covering the needs of the Cuban people" (de Armas 2023). Effectively the Cubans work in partnerships to formulate a strategy, based on local knowledge of the population's needs and on Cuban expertise, focused on improving health outcomes. To facilitate their quick integration into the host country, explains Morales: "Each professional receives introductory courses on the reality they will face in the receiving country, its problems, its culture, the possible scenarios in which they will have to function, language aspects, among others" (Morales 2018: 31).

Other forms of partnership include bilateral joint ventures, particularly in biopharma, and the hosting of international events with international specialists to share knowledge and strategize for future programs. By 2019, Cuba had biotech joint ventures in Algeria, Brazil, China, India, Iran, Singapore, South Africa,

Thailand, Venezuela, and Vietnam.¹¹ During the COVID-19 pandemic, Cuba and China launched a joint investigation to develop a Pan-Corona vaccine. Cuba provides the expertise and personnel, while China contributes the equipment and resources. The research is taking place at the Yongzhou Joint Biotechnology Innovation Centre, which was established with equipment and laboratories designed by Cuban specialists (Urta 2021).

- d. To increase the quantum and enhance the quality of international cooperation as well as to improve the effectiveness of the resources devoted to overall technical cooperation through the pooling of capacities.**

Cuban medical internationalism is the standard-bearer of international cooperation in terms of quantum and quality. “Cuba provides more medical personnel to the developing world than all the G-8 countries combined” (Huish and Kirk 2007: 82). Cuba’s Compensated Technical Assistance or Direct Contract mode of ODA includes technical programs in the fields of construction (schools, hospitals, factories), in sugar technology and in the production of medicines. (Morales 2018: 26). Between 1999–2015, Cuba was the top donor, ahead of the US and Japan, in the delivery of international technical cooperation, with highly qualified professionals traveling overseas to repair state-of-the-art machinery in hospitals in developing countries.¹²

The mutually beneficial “oil-for-doctors” exchange between Cuba and Venezuela is a brilliant example of technical cooperation through the pooling of capabilities and to improve the effectiveness of resources. The Venezuelan government paid for Cuban medical services with Venezuelan oil at below-world market prices. Based on the resource strengths and socio-economic needs of each country, this “barter exchange” became the model for bilateral and multilateral cooperation between countries within the Bolivarian Alliance for the Americas (ALBA) through which Cuba delivered healthcare provision and training throughout Latin America and the Caribbean (Yaffe 2009).

- e. To strengthen existing technological capacities in developing countries, including the traditional sector, to improve the effectiveness with which such capacities are used and to create new capacities and capabilities and in this context to promote the transfer of technology and skills appropriate to**

11 For more on Cuban biotech deals in the developing world see Thorsteinsdóttir et al. (2004: 5).

12 Carlos Bedoya, “introduction” Morales (2018: 13).

their resource endowments and the development potential of the developing countries so as to strengthen their individual and collective self-reliance.

Through the training of foreign students and assistance in establishing public health apparatus abroad, Cuba fosters and strengthens technological capacities while facilitating the creation of new capabilities in developing countries. Foreign students trained in Cuba are encouraged to return home to deliver public health-care to the underserved communities they originate from.

A key component of Cuban ODA has been the transfer of technology and skills to developing countries. For example, in October 2005 Cuba sent 2,400 Cuban medical professionals to Pakistan-administered Kashmir following the earthquake. In five months, they treated 1.74 million patients from 32 field hospitals which were subsequently donated to Pakistan, with 450 army physicians trained to use them. Cuba also contributed 234.5 tons of medicines and supplies, as well as 275.5 tons of equipment, and provided 1,000 medical scholarships to students in rural Pakistan to study medicine in Cuba.

Also from 2005, under Operation Miracle, Cuba helped establish new ophthalmology centers in 30 hospitals throughout 15 Venezuelan states. The program subsequently expanded so that by 2017 Cubans were working in 69 ophthalmology clinics in 15 countries. These clinics are increasingly operated by local people as their capacity increases through training. By 2019, 6 million people in Latin America and the Caribbean had recovered their sight. Another project with Venezuela was the establishment of the Comprehensive Community Medicine program to graduate 60,000 Venezuelan physicians, at home, with Cuban teaching staff. By early 2019, more than 25,000 doctors had graduated. With combined populations of around 40 million, Cuba and Venezuela are training more doctors than the United States with a population of over 330 million. This is an extraordinary demonstration of the potential for South–South cooperation.

Cuba’s exclusively state-owned biopharma institutions are engaged in technology transfers.¹³ In 2009, the WHO warned that 300 million people in 18 Sub-Saharan African countries needed meningitis vaccines. The scarcity was caused by the high cost, and patents, imposed by big pharma. Only Cuba and Brazil responded to the WHO’s request for assistance. Cuba’s Finlay Institute, which produces Cuba’s Meningococcal AC vaccine collaborated with the

13 For more on the development of Cuba’s biotech sector see “The Curious Case of Cuba’s Biotech Revolution”, Chapter 5 in *We Are Cuba: How a Revolutionary People Have Survived in a Post-Soviet World* (Yaffe 2020).

Bio-Manguinhos Institute in Brazil to manufacture more than 20 million vaccines at cost price (\$1 per dose, compared to \$80 charged by the Sanofi Pasteur). Cuba is the only country in Latin America and the Caribbean to have produced its own COVID-19 vaccine. In addition to donating doses to countries which have requested assistance, Cuba is facilitating technology transfer to at least 15 developing countries which enables them to produce safe and efficacious vaccines in their own countries (Progressive International 2022).

- f. **To increase and improve communications among developing countries, leading to a greater awareness of common problems and wider access to available knowledge and experience as well as the creation of new knowledge in tackling problems of development.**

Cuba participates in multilateral institutions intended to increase and improve communications among developing countries in tackling common problems: the Alliance of Small Island Developing States (SIDS-AOSIS), the Bolivarian Alliance for the Americas (ALBA), and the Like-Minded Developing Countries (LMDC) Group, in addition to G77 + China, over which Cuba now presides. Cuban institutions and organizations frequently hold international conferences for experts in multiple fields to promote knowledge exchange and the co-generation of knowledge, for example, Havana hosted the IV International Health Convention in October 2022.

On the ground, Cuban healthcare workers have conducted public health campaigns to raise awareness and widen access to knowledge. For example, following the outbreak of cholera in Haiti in 2010, Cuban medical professionals established cholera treatment centers and oral rehydration posts, set up tent-by-tent examinations and launched a public health campaign distributing information in Creole (Kirk 2015: 204). Likewise, following the outbreak of Ebola in West Africa in late 2014, in addition to Henry Reeve Contingents to Sierra Leone, Liberia, and Guinea, Cuba organized Ebola training internationally. By January 2015, Cuba had trained over 13,000 people to deal with Ebola in 28 African countries, plus 68,000 people in Latin America and 628 in the Caribbean. A training program in Havana was attended by 278 specialists in infectious diseases from 34 countries, including the United States.

- g. **To improve the capacity of developing countries for the absorption and adaptation of technology and skill to meet their specific developmental needs.**

By 2016, 73,848 foreign students from 85 countries had graduated in Cuba, an average of more than 4,300 every year, of which 34,205 had studied medical sciences at a higher level (Morales 2018: 28). Cuba has 13 medical universities and multiple teaching and research centers, open to foreigners. Training centers are mostly based in Cuba, but by 2016, Cuba was running 12 medical faculties overseas, mostly in Africa, where over 54,000 students are enrolled (Morales 2018: 47). Thus, tens of thousands of medical professionals around the world owe their qualifications and occupation to Cuban programs. By 2014, nearly 40 healthcare centers around the world were headed by ELAM graduates.

However, the return to their home countries by Cuban-trained medics has often been problematic.¹⁴ Many are unable to find positions in public health systems which are underfunded or barely exist; some remain unemployed while others enter the private sector despite it being antithetical to their training. There are also inspirational stories, such as that of the ELAM graduates from the Garifuna people of African and Indigenous heritage who make up 20% of the Honduran population and live in deprived, hard-to-access villages lacking water and electricity. The 69 young Cuban-trained doctors mobilized their community to build its own first hospital. Opened in 2007, by 2014 it had provided nearly 1 million consultations to patients who would have struggled to receive medical care (Reed 2014).

h. To recognize and respond to the problems and requirements of the least developed, land-locked, island developing and most seriously affected countries.

Cuban ODA was established precisely to meet the needs of the least developed countries. Cuban medical training prepares healthcare professionals to work in the most difficult conditions, without access to sophisticated diagnostic equipment. Cuban professors challenge their students to show how they would proceed in environments without access to electricity or hospitals. They are taught to work with, not against, alternative and local healers, respecting local customs, using local medicinal herbs. Living among their patients they are expected to advance the community's health and treat patients as equals.

Cuba is a small island developing state, on the front line of climate change, detrimentally impacted by the United States blockade, and with a GDP below many of the countries it assists. This increases the relevance of Cuba's alternative

14 For more on this issue, see *Going Where No Doctor Has Gone Before: The Place of Cuba's Latin American School of Medicine in Building Health Care Capacity for Ecuador* (Huish 2008).

development path, in which the state plans and controls the distribution of resources to prioritize social development and human welfare, including healthcare.

i. To enable developing countries to attain a greater degree of participation in international economic activities and to expand international cooperation.

Good health is a precondition for participation in any field. When Cuba provides free healthcare, or charges below international rates, it gives developing countries access to vital services they would otherwise not be able to afford. In addition to education and training, Cuba's ODA has also supported the economies of developing countries through construction projects, engineers, technicians, and other specialists. Whether formerly through the socialist bloc, or within ALBA, the Cuban government promotes international trade and cooperation based on mutual benefits. In his speech for Cuba's ascendency to the presidency of G77 + China, Foreign Minister Rodríguez underscored the need to address "structural reform of the international financial architecture; development financing flows ... trade restrictive measures" (Rodríguez Parrilla 2023).

Cuba has frequently hosted events to promote the participation of developing countries in the international arena. For example, in 1979 and 2006, Cuba hosted summits of the Non-Aligned Movement. Havana also hosted the "Summit of the South", the highest decision-making body of G77 + China, in 2000, and the second summit of the Community of Latin American and Caribbean States (CELAC) in 2014.

The Fruits of Cuban Medical Internationalism, 1999 to 2015 (Morales 2018: 20–21)

- Almost 6 million lives saved: 3 million in Latin America and the Caribbean, 2.8 million in Africa, and over 60,000 in other regions.
- 1.39 billion general medical consultations (82 million per year).¹⁵
- 10 million surgical operations (592,000 per year).
- 2.67 million births attended (157,000 per year).
- 2.77 million ophthalmological operations under Operation Miracle (163,000 per year).
- 3.6 million beneficiaries of Henry Reeve Brigades (212,000 per year).¹⁶
- 111,007 pieces of medical equipment repaired by engineers (6,500 per year).
- 73,848 foreign students graduating as professionals in Cuba (4,300 per year).
- 88,242 Cuban sports professionals collaborating outside Cuba (5,000 per year).

¹⁵ This figure is, of course, difficult to objectively, scientifically calculate or prove.

¹⁶ This excludes beneficiaries since 2015, including the over 1.2 million during just the first year of Cuba's COVID-19 brigades.

- 10 million people in 30 countries become literate through Cuba’s “Yo Si Puedo” literary campaign.

No other country, much less another small island developing state, comes close to matching Cuba’s record of ODA.

The Economics of Cuban Medical Internationalism

It is motivated by deep feelings that have nothing to do with advertising. Some will wonder how it is possible that a small country with few resources can carry out a task of this magnitude in fields as decisive as education and health.

(Castro 2008)

We don’t usually publicise our cooperation with other peoples.

He did not, however, provide the answer. Indeed, the silence around the material value of Cuba’s international cooperation motivated Morales to systematize “the qualitative and quantitative contribution” of Cuban ODA. “Cuban collaboration is not registered in any of the mechanisms that countries, especially the developed ones, have to publicise their development aid contributions. Furthermore, for these institutions (OECD, UN, and others) Cuba is politically unknown or an invisible collaborator” (Morales 2018: 76). Morales applied the financial and technical criteria used to determine the ODA of developed countries to Cuba, giving a monetary value to all of the island’s actions. As stated earlier, he concludes that Cuban ODA between 1999–2015 was over \$71.5 billion dollars, or \$4.87 billion dollars annually; equivalent to 6.6% of GDP, and the highest ratio in the world. An earlier study by Edith Felipe, in 1992, calculated that between 1963 and 1989 (26 years) Cuba had contributed approximately \$1.53 billion dollars in international assistance, \$59 million annually.¹⁷ This conclusion was based on a valuation that Morales considers too low, and consequently a significant underestimation. Between 1975 and 1989, Cuba’s annual average contribution to ODA is recorded at 0.58% of GDP, compared to 0.35% from the developed countries.¹⁸

Since 1960, the Cuban government has assumed the lion’s share of the cost of its medical internationalism, a huge contribution to the Global

17 Felipe (1992), cited by Morales (2018: 25).

18 Felipe (1992), cited by Morales (2018: 25).

South, particularly in the context of the United States blockade. From the 1990s, Cuba introduced reciprocal agreements through which the costs are shared by those recipient countries that can afford it. From 2005, with the oil-for-doctors program with Venezuela, the export of medical professionals became the main source of international revenue for the Cuban state. This income is reinvested into medical education and provision on the island. However, Cuba continues to provide medical assistance free of charge to countries which need it. In 2017, Cuban medics were operating in 62 countries; in 27 of those (44%) the host government paid nothing, while the remaining 35 paid or shared the costs, according to a sliding scale (EIU 2017: 25–26). Where the host government pays all costs, it does so at a lower rate than that charged internationally. Differential payments are used to balance Cuba's books, so medical services charged to wealthy oil states (Qatar, for example) help subsidize medical assistance to poorer countries. Payment for medical services exports goes directly to the Cuban government which passes a small proportion on to the medics. This is usually higher than (and additional to) their Cuban salary.

Post-2000, some developed countries, including Britain and France, contributed indirectly toward the costs of Cuban healthcare personnel working overseas. For example, British money to South Africa helped pay for Cubans there, while France did likewise for its former African colonies. This was an example of triangulation with developed countries' assistance for Global South cooperation. However, when this assistance was withdrawn, Cuba could not carry the financial burden. In 2018, the first year Cuba's Office of National Statistics published separate data, "health services" exports earned \$6.4 billion. Revenues have since declined, however, as US efforts to sabotage Cuban medical internationalism have seen successes, particularly in Brazil and Bolivia.

Behind Cuba's earnings from medical exports is significant state investment in creating domestic capacity through medical training and infrastructure on the island. There are also considerable losses to Cuba from not charging recipients or charging below international market rates. During the first ELAM graduation ceremony in August 2005, in a rare allusion to financial aspects, Fidel Castro pointed to international data showing the cost of training 12,000 doctors was \$3 billion. Cuba's plan to train 100,000 doctors from developing nations, he said, was a contribution to poor countries worth \$30 billion. Generally, however, the Cuban government says little about the monetary value of its medical internationalism.

Weaponizing Cuban Medical Internationalism

Critical and cynical commentaries on Cuban medical internationalism focus on the geopolitical and financial gains to Cuba claiming variously that: the revolutionary government is motivated by the need for political allies and advantages in world forums, or soft power; that the Cuban state forces healthcare workers into foreign-service contracts to earn the country export revenues; and that Cuban professionals are only motivated by the higher earnings they receive working overseas. These interpretations are highly politicized, contradictory, and not substantiated by the facts.

The beneficiary nations have been the poorest and least influential globally; few have governments with leverage on the world stage. Recipient populations are often the most disadvantaged and marginalized within those countries. Furthermore, the service contracts which Cuban medics sign before going abroad are voluntary; they receive their regular Cuban salary, plus remuneration agreed upon with the host country. The volunteers are guaranteed holidays and contact with their families during their posting (Gorry 2019: 85). These professionals make huge personal sacrifices regardless of what motivates their decision to volunteer overseas. They leave behind children, partners, parents, homes, their culture, and their communities, to work in challenging and often risky conditions for months or even years. Jesús Ruiz Alemán explains how a sense of moral obligation led him to volunteer for the Henry Reeve Contingent at its foundation. He was on the first brigade to Guatemala in 2005, went to West Africa for Ebola in 2014, and to Italy in 2020 when it was the epicenter of the COVID-19 pandemic.

I have never felt like a slave, never ... The campaign against the brigades seems to be a way to justify the blockade and measures against Cuba, to damage a source of income for Cuba. It is more of the same.¹⁹

That “campaign” began in 2006 when the Bush administration introduced the Medical Parole Program, to induce Cuban medics to abandon missions in return for US citizenship.²⁰ Success was limited, only 2% of Cuban medics defected. Obama ended the Medical Parole Program on his final days in office, in January 2017. The reprieve did not last long; in June 2019, the Trump administration added Cuba to its Tier 3 list of countries failing to combat “human trafficking” on the basis of its medical cooperation overseas, and the US Agency

19 Jesús Ruiz Alemán, cited in DaniFilms and Yaffe (2020).

20 For more on the Medical Parole Programme see H. Michael Erisman (2012).

for International Development established a program to discredit and sabotage Cuban healthcare programs (Latner 2020). On July 12, 2023, the full US House Committee on Appropriations approved the Fiscal Year 2024 State, Foreign Operations, and Related Programs Appropriation Bill which included “exposing trafficking of doctors from Cuba and conditions aid to countries participating in this form of modern slavery”, “prohibits funds to ... labs in adversarial nations like China, Iran, Russia, North Korea or Cuba”, and allocates an additional 30 million dollars this year for “democracy programs in Cuba” focused on regime change.²¹

Cuba’s Vice Minister of Foreign Relations, Johana Tablada, condemns the “weaponization and criminalization” of Cuban solidarity which has wreaked havoc in many countries.

The reason that the US calls it slavery or human trafficking has nothing to do with the international felony of human trafficking. It has to do with the necessity that the United States has to justify a policy that is impossible to hold up to public scrutiny. The United States cannot tell the Third World Countries that it is right to prevent people who need medical services from giving up to those services to the Cuban medical brigades just because ... it doesn’t match their policy to have international recognition and admiration [for Cuba].²²

The United States harasses countries which have agreements with Cuba, says Tablada, revealing that other governments have informed Cuba about US threats to individuals and governments that they will withhold visas and international aid if they accept Cuban ODA. Where countries have relented, as in Bolivia shortly before the COVID-19 pandemic, it has cost thousands of lives, she says. “International aid was not set up in terms of who needed it the most, but it to use as carrots and sticks, to award some and punish others”.

However, as the US was not able to replace the Cuban doctors their efforts to thwart Cuban ODA have been undermined. As Tablada says, “most of the countries that needed medical aid, put their population first, but some of them had to pay a price for it”. As Cuba’s Henry Reeve brigades responded to the COVID-19 pandemic, Cuba scholar Teishan Latner wrote that “efforts to discredit Cuban medical cooperation were an acknowledgment of Cuba’s success in positioning

21 See Committee Approves FY24 State, Foreign Operations, and Related Programs Bill (2023) for a press release covering the approval, and from that site a summary of the bill with the indicate quotes at House Republican Appropriations (2023: 7, 3, 1).

22 This and immediately following reference and quotes by Johana Tablada from DaniFilms and Yaffe (2020).

itself as a global health power through medical internationalism and health diplomacy. If this was ‘soft power’, then Cuba was undoubtedly winning hearts and minds” (Latner 2020: 332). Cuba’s election to the presidency of G77 + China confirms this view. Likewise, the testimony of Cuban medical internationalist Ruiz Alemán describing the “unforgettable experience” of walking a kilometer through Italian streets to public applause at the end of their mission during the COVID-19 pandemic. “I have never seen anything like that!”, he said.²³

Cuban Medical Internationalism as a Paradigm for South–South Cooperation

According to the UN, some 830 million people lived in extreme poverty in 2014, with 795 million suffering from chronic malnutrition. Every day, 6 million children died before reaching the age of 5 and 16 million die daily because of preventable diseases like measles and tuberculosis (Morales 2018: 16). Simultaneously, the world has a deficit of between 4 and 7 million healthcare workers just to meet basic needs. The predominant global approach to medical training inculcates students with the belief that healthcare is an expensive resource, or commodity, that must be rationed through the market mechanism. This is an aspect of the systemic commodification of health care through capitalist market relations. Medical students “invest” in their education, paying high tuition fees and graduating with huge debts. They seek well-paid jobs to repay those debts and pursue a privileged standard of living. To ensure medics are well remunerated, supply must be kept below demand. In addition, increasing dependence on sophisticated medical technology helps keep the cost of medical services high. This is contrary to the preventive, primary care approach adopted in Cuba. The Cuban state’s investment in medical education for Cubans and foreigners raises the supply of professionals globally, thus undermining the privileged status of physicians elsewhere operating under a market system. Critically, the Cuban approach removes financial, class, race, gender, religious, and any other barriers to joining the medical profession.

Cuban “medical diplomacy” has been a cornerstone of Cuban foreign policy since 1960, before the *realpolitik* and economic imperatives of the post-Soviet era. It differs from “global health security” responses anchored in military and defense programs and is motivated by a desire to protect domestic populations from external threats of

23 Jesús Ruiz Alemán, cited in DaniFilms and Yaffe (2020).

disease. Cuban medical internationalism is rooted in the principle of solidarity with the global population. Solidarity is conceived as a two-way flow, distinct from notions of responsibility, charity, and altruism common in aid frameworks, particularly flowing from developed to underdeveloped countries (Huish 2014: 262–264).

The post-1959 Cuban commitment to healthcare as a human right is integral to the broader endeavor to struggle against diverse forms of underdevelopment, imperialism, colonialism, and neo-colonialism. The Cubans view global poverty and poor health as a result of exploitative structural conditions and unequal terms of trade. Thus, Cuban medical internationalism is and has been an essential component of the island's foreign policy. Cuban medical graduates pledge:

to serve the revolution unconditionally wherever we are needed, with the premise that true medicine is not that which cures but that which prevents, whether in an isolated community on our island or in any sister country in the world, where we will always be the standard bearers of solidarity and internationalism.

(Kirk 2015: 276)

In this way, Cuban medical internationalism serves as a paradigm for South–South cooperation.

References

- Castro, Fidel (2008) “La Hormiga y el Elefante”, *CubaDebate*, June 12. Available at www.cubadebate.cu/reflexiones-fidel/2008/06/18/hormiga-elefante/
- Castro, Fidel (2005) “Fidel Castro Speech: Henry Reeve Brigade”, September 19. Available at <http://www.scoop.co.nz/stories/WO0509/S00376.htm>
- Committee Approves FY24 State, Foreign Operations, and Related Programs Bill (2023) “Committee Approves FY24 State, Foreign Operations, and Related Programs Bill”. Available at <https://appropriations.house.gov/news/press-releases/committee-approves-fy24-state-foreign-operations-and-related-programs-bill>
- Constitute (1978) “Cuba 1976 (rev. 2002)”. Available at www.constituteproject.org/constitution/Cuba_2002
- Constitute (2019) “Cuba 2019”. Available at https://www.constituteproject.org/constitution/Cuba_2019
- DaniFilms and Helen Yaffe (2020) “Cuba & COVID-19: Public Health, Science and Solidarity”. Available on *YouTube* at https://youtu.be/lGYHwldJ_gY?si=nUX4U1EAQL7qYlHt
- de Armas Águila, Yamila (2023) Interview with author, July 25, via WhatsApp.
- EIU (Economist Intelligence Unit) (2017) *Country Report, Cuba*, December 21.

- Erisman, H. Michael (2012) “Brain Drain Politics: The Cuban Medical Professional Parole Programme”, *International Journal of Cuban Studies*, 4(3/4), 269–290.
- Felipe, Edith (1992) “La ayuda económica de Cuba al Tercer Mundo: evaluación preliminar (1963–1989)”, *Boletín de Información sobre Economía Cubana del CIEM*, 1(2), febrero.
- Gorry, Conner (2019) “Six Decades of Cuban Global Health Cooperation”. *Medic Review* 21(4). Available at doi.org/10.37757/MR2019.V21.N4.15
- House Republican Appropriations (2023) “Fiscal Year 2024 State, Foreign Operations, and Related Programs Appropriations Bill”. Available at <https://files.constantcontact.com/477ded83801/38edc508-7edb-485b-b1bf-17e4ea9be62b.pdf?rdr=true>
- Huish, Robert (2014) “Why Does Cuba ‘Care’ So Much? Understanding the Epistemology of Solidarity in Global Health Outreach”, *Public Health Ethics* 7(3).
- Huish, Robert (2008) *Going Where No Doctors Has Gone Before: The Place of Cuba’s Latin American School of Medicine in Building Health Care Capacity for Ecuador*. Doctoral thesis, Simon Fraser University.
- Huish, Robert and John Kirk (2007) “Cuban Medical Internationalism and the Development of the Latin American School of Medicine”, *Latin American Perspectives*, 34(6), 77–92.
- Jiménez Expósito, Yiliam (2010) “El Programa Integral de Salud de Cuba. Un Modelo de Cooperación Sur-Sur, Cuba”. Available at www.medigraphic.com/pdfs/revcubsalpubint/spi-2010/spi101g.pdf
- Keck, C. William and Gail Reed (2012) “The Curious Case of Cuba”, *American Journal of Public Health*, 102(8), e13–e22.
- Kirk, Emily and John Kirk (2010) “Cuban Medical Cooperation in Haiti: One of the World’s Best-Kept Secrets”, *International Journal of Cuban Studies*, 2(1) & 2(2).
- Kirk, John (2015) *Healthcare Without Borders*. Gainesville: University Press of Florida.
- Latner, Teishan (2020) “The Campaign to Discredit Cuban Medical Internationalism”, *NACLA Report on the Americas*, 52(3), 332–338.
- MacDonald, Theodore (1995) *Hippocrates in Havana: Cuba’s Health Care System*. Mexico: Bolivar Books.
- Macrotrends (2023) “Cuba Healthcare Spending 2000–2023” Available at <https://www.macrotrends.net/countries/CUB/cuba/healthcare-spending>
- McGuire, James and Laura Frankel (2003) “Mortality Decline in Cuba, 1900–1959: Patterns, Comparisons, and Causes”, Paper delivered at the Latin American Studies Association, Dallas, Texas, March 27–29.
- MINREX (Ministerio de Relaciones Exteriores de Cuba) (2023) “Díaz-Canel Convenes a Summit in Havana of the G-77 + China”, June 14. Available at <https://misiones.cubaminrex.cu/en/articulo/diaz-canel-convenes-summit-havana-g-77-china-1>
- MINSAP (Ministerio de Salud Pública) (2021) “Bloqueo estadounidense provoca cuantiosas pérdidas al sector de la salud”. May 5. Available at <https://salud.msp.gov.cu/bloqueo-estadounidense-provoca-cuantiosas-perdidas-al-sector-de-la-salud>
- Morales, Henry (2018) *Ayuda Oficial al Desarrollo de Cuba en el Mundo*. Latindadd, Edición Peruana.

- Our World in Data (2023 a) “Life Expectancy, 1899 to 2021”. Available at <https://ourworldindata.org/grapher/life-expectancy?tab=chart&country=CUB>
- Our World in Data (2023 b) “Health spending as a share of total government expenditure, 2019”. Available at <https://ourworldindata.org/grapher/health-expenditure-government-expenditure>
- Our World in Data (2023 c) “Coronavirus (COVID-19) Deaths”. Available at <https://ourworldindata.org/covid-deaths>
- PAHO (Pan American Health Organisation) (2017) “Cuba’s Henry Reeve International Medical Brigade receives prestigious award”, May 26. Available at www.paho.org/en/news/26-5-2017-cubas-henry-reeve-international-medical-brigade-receives-prestigious-award
- Progressive International (2022) “Cuba Pledges ‘Lifesaving Package’ of COVID-19 Vaccine Support to Global South at Progressive International briefing”, January 25. Available at <https://progressive.international/wire/2022-01-25-cuba-pledges-lifesaving-package-of-covid-19-vaccine-support-to-global-south-at-progressive-international-briefing/en>
- Reed, Gail (2014) “Where to Train the World’s Doctors? Cuba”. *TedMed* talk, October 1. Available at https://www.youtube.com/watch?v=rS_Ssisz2_M
- Rodríguez Parrilla, Bruno (2023) Speech to Group 77 + China, New York, January 12. Available at www.g77.org/statement/getstatement.php?id=230112c
- Sullivan, Dylan and Jason Hickel (2022) “16 Million and Counting: The Collateral Damage of Capital”, *New Internationalist*, December 22. Available at <https://newint.org/features/2022/12/05/neoliberalism-16-million-and-counting-collateral-damage-capital>
- Thorsteinsdóttir, Halla; Tirso Sáenz; Uyen Quach, Abdallah Darr; and Peter Singer (2004) “Cuba—innovation through synergy”, *Nature Biotechnology*, 22(Suppl 12), DC19–DC24. <https://doi.org/10.1038/nbt1204supp-DC19>
- UN Secretary-General (2016) “Framework of Operational Guidelines on United Nations Support to South–South and Triangular Cooperation”. Available at <https://digitallibrary.un.org/record/826679>
- UNOSSC (United Nations Office for South–South Cooperation) (1978) “Buenos Aires Plan of Action (1978)”. Available at <https://unsouthsouth.org/bapa40/documents/buenos-aires-plan-of-action/>
- Urrea, David (2021) “Cuba and China Developing the PanCorona Vaccine for COVID Variants”, *Cuba Business Report*, March 22. Available at www.cubabusinessreport.com/cuba-and-china-developing-the-pancorona-vaccine-for-covid-variants/
- Walker, Chris and John Kirk (2013) “From Cooperation to Capacitation: Cuban Medical Internationalism in the South Pacific”, *International Journal of Cuban Studies*, 5(1).
- Wall Street Journal (2020) “How Global Trade Runs on US dollars”, January 22. Available on www.youtube.com/watch?v=jsDwMGH5E8U
- WHO (World Health Organisation) (2023) “WHO Remains Firmly Committed to the Principles Set Out in the Preamble to the Constitution”. Available at www.who.int/about/governance/constitution

Yaffe, Helen (2023) “The US Blockade, and the ‘1 cent 4 Cuba’ Campaign to Challenge It”, *International Journal of Cuban Studies*, 14(2), 207–213.

Yaffe, Helen (2020) *We Are Cuba: How a Revolutionary People Have Survived in a Post-Soviet World*. New Haven: Yale University Press.

Yaffe, Helen (2009) “Cuban Development: Inspiration for the Bolivarian Alliance for the Americas (ALB)”, *Journal of Iberian and Latin American Research*, 15(2), 143–160. Available at www.academia.edu/9723188/Cuban_Development_Inspiration_for_the_Bolivarian_Alliance_for_the_Americas_ALBA_