

WE LIVE LIKE THE POOR, BUT WE DIE LIKE THE RICH:  
CUBAN BIOMEDICAL DIPLOMACY AND ITS IMPLEMENTATION WITHIN ECUADOR

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## **ABSTRACT**

Shortly following the Cuban Revolution in 1959, communist leaders Ernesto “Che” Guevara and Fidel Castro made it a top priority to address the poor health of the country’s citizens. By developing a large pool of physicians, Cuba instituted groundbreaking approaches to biomedicine that emphasize prevention and the physician-community relationship. The high physicians per capita ratio also permitted Cuba to develop its now famous system of international biomedical diplomacy. Cuba’s successes domestically and abroad occur within the context of the regional geopolitical environment, in which Cuba is subjugated to extraordinary economic pressures from the U.S. embargo. The superior health of the Cuban national body despite substantial barriers serves as physical evidence to validate the communist principles established in the Revolution. This opposition to Western hegemony has allowed Cuba to become a leader and form partners in the region, such as Venezuela. The Cuban-Ecuadorian relationship is much newer, and is mainly focused on a project in which Cuban physicians are contracted by the Ecuadorian government. While this is the current focus, actions by Ecuadorian President Rafael Correa indicate that Ecuador will use this project to shift his country’s ideology to one that is more similar to that of Cuba. Though still developing, the Cuban-Ecuadorian relationship provides Ecuador with the opportunity to improve its health care system while increasing its regional influence by becoming a co-leader with Cuba in the region.

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS AND DEDICATION</b> .....	iii
<b>ABSTRACT</b> .....	iv
<b>CHAPTER ONE: INTRODUCTION</b> .....	1
<b>CHAPTER TWO: METHODOLOGY</b> .....	10
<b>CHAPTER THREE: BIOPOLITICS AND MEDICINE</b>	
I. Introduction.....	13
II. National identities.....	15
III. Latin America’s Response to Western Hegemony.....	19
<b>CHAPTER FOUR: REVOLUTION AND BIOMEDICINE</b>	
I. Background.....	25
II. Personal Experiences: Strengths and Limitations of the Cuban System.....	33
III. Cuban International Medicine Today.....	37
<b>CHAPTER FIVE: MEDICAL DIPLOMACY AND (INTER)NATIONAL BODIES</b>	
I. Internationalism.....	42
II. Effects of the U.S. Embargo.....	45
III. Cuban (Inter)national Biomedical Education.....	48
<b>CHAPTER SIX: CASE STUDY: CUBANS IN ECUADOR</b>	
I. Ecuador: Health Care Woes.....	55
II. Controversies and Context: The <i>Año Rural</i> Reconfigured.....	61
III. Reshaping the Political Terrain.....	66
IV. Enter Cuba.....	71
<b>CHAPTER SEVEN: CONCLUSION</b> .....	76
<b>BIBLIOGRAPHY</b> .....	80

## CHAPTER ONE: INTRODUCTION

On December 1, 2014, the Cuban government named Ecuador's President, Rafael Correa, an honorary member of the Cuban Medical Brigade that arrived in Ecuador in August 2014. The Cuban Ambassador to Ecuador appropriated placed the ceremony in the greater context of the Ecuadorian-Cuban partnership. Ambassador Rodríguez said, "We are here for two reasons: the first is because there was a Revolution in Cuba that has formed tens of thousands of health professionals, despite the aggressions and the U.S. embargo; and the second, [is] because here, in Ecuador, there is now a government that dedicates substantial material resources to improve the health of its nation (The Rep. of Cuba, "Honor De Brigada")." His rhetoric emphasizes the close relationship Cubans associate between the Cuban Revolution and the state of its health care system. Additionally, he implicitly links the current health care changes in Ecuador to the Cuban health care system formed under the Revolution.

One major result of the relationship is (and will be) the incorporation of Cuban physicians into the Ecuadorian health care system. The Cuban medical system is prestigious internationally, and Cuba is well known for its focus on medical diplomacy, including but not limited to rapid response teams for recent Ebola outbreaks in West Africa. Ecuador's reputation in health care does not typically receive much attention; it is simply grouped together with other developing countries regarding health care systems

and indicators. In my thesis, I am interested in the question of *why* Ecuador would look to Cuba, as opposed to another country, as an example to improve the quality of its national health care system. To answer this question, I look into the broad question of how Cuba has become an effective provider of high quality, free health care, despite its economic circumstances. I investigate this by examining the structure of domestic Cuban health care and how it blossomed under the guidance of Che and Castro following the Revolution. I study the Cuba's tradition of biomedical diplomacy from its beginning, examine the way in which Cuban physicians integrate themselves into and operate within other countries, and investigate the principles that keep Cuban medical diplomacy an essential part of Cuban culture. Following the history of Cuba's international presence, I then look at how Cuba's success biomedically has presented the nation with opportunities that has allowed it to become a leader on specific issues.

I argue that there are four key reasons why Ecuador is partnering with Cuba in health care. First, Cuba is a developing country (in most regards), but has succeeded in the health care sector despite the barriers developing countries face, plus additional extraordinary pressures. Second, the agreement between Ecuador and Cuba will not only improve the quality and access of Ecuadorian health care, but also will impact Ecuador's trajectory and role in Latin America. Third, global recognition for its health care allows Cuba to become a player in international affairs not directly related to health care. Thus, its health care system becomes an even more appealing model for Ecuador because Ecuador may also be able to improve its international standing. Lastly, Cuba also offers Ecuador strong backing in Ecuador's attempt to reestablish its sovereignty by creating domestic and international policies that favor its partners within the global South.

Through this partnership, Ecuador has the potential to gain much from a nation that has done so well with so little.

Cuba has maintained its communist ideology, in contrast to the capitalist United States, and showed that its system of health care is successful, if not superior, to that of its ideological opponent. This opposition to American hegemony realized through biomedical achievement of the national body is a factor that greatly appeals to Ecuador. The cooperation of the countries through entities that foster solidarity, such as ALBA<sup>1</sup>, helps to reinforce Ecuador's recent sociopolitical realignment to the new left. The coalition has been described by one expert as: "A direct challenge to neoliberalism, offering instead regional integration prioritizing, among other things, 'the fight against poverty and social exclusion', the end of 'unequal exchange' in international relations, and a revival of state intervention and political participation, especially by indigenous peoples (Lievesley 6)."

Although Ecuador and Cuba differ by varying degrees in political structure, socioeconomic barriers, infrastructure, and national biomedical policy, Ecuador has turned away from the neoliberal policies from previous decades and shown itself a new leader in the Latin American left. This is seen in Ecuador's constitution, in which it makes several references to *sumac kawsay*, or "living well", and a preamble that emphasizes increased democratic as one method for "living well" (Becker 282). While Ecuador now rejects neoliberalism, Cuba first emerged as the paradigm for many Latin American countries to incrementally reject the interventionist policies of Washington and

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<sup>1</sup> Alianza Bolivariana para los Pueblos de Nuestra América. English translation: Bolivian Alliance for the Peoples of Our America.



forge their own path, often in ways that unite the region. This political movement is seen in countries such as Ecuador, Venezuela, Nicaragua, Bolivia, and Uruguay, known as the “pink tide” that expand upon the leftist foundation Cuba created in Latin America. In recent years, Venezuela, under the Chavez government, has proved that Latin American countries can take on larger roles in Latin America’s new left.

Ecuador, like many other Latin American countries, has a complicated and coup-prone history where the United States has consistently played a role either directly or indirectly. Ecuador’s President, Rafael Correa, has made a conscious effort to distance himself from the United States, allowing Ecuador to forge stronger alliances with other Southern governments, some of which the United States vehemently opposes. His pivot away from the United States, regardless of its underlying motives, has not been well received in Washington. Ecuador is sandwiched between Colombia and Peru, two of the hemisphere's largest illicit drug producers, consequently increasing Ecuador’s geopolitical significance for the United States (Narins 43). Thus, actions that President Correa views as simply protecting his small nation’s sovereignty, Washington interprets as calculated maneuvering to reduce its influence in the region while non-allies replace it.

Ecuador has consistently made itself an ally to other Southern governments, strengthening South-South alliances and countering American attempts to maintain hegemony. Partly resulting from its geographic positioning, but also for its reliance on the United States dollar as its national currency, Ecuador will be able to distance itself from the American economy only so far. Yet under President Correa, Ecuador has shown itself a supporter of similarly exploited or marginalized countries who are unafraid to challenge American interests, such as Iran, Venezuela, and the Palestinian state. Through

Ecuador's consistent stances on various global issues, it continues to align itself with Cuba, while preparing itself for domestic adaptations of Cuban policies, such as the Cuban health care system. The relationship, currently focused on slowly restructuring Ecuadorian health care, not only implies future change in the Ecuadorian national body, but also implicates that parallel political and societal shifts will occur.

Regardless of how strong the relationship becomes, Ecuador will likely never experience a crippling and tense relationship with the United States, as Cuba has. American<sup>2</sup> foreign policy has negatively impacted no other country more than Cuba as a result of the 1963 American embargo, which remains in effect (United States: 4). Decades of aggressive American foreign policy have resulted, in effect, in American extraterrestrial jurisdiction in Cuba, supported by the United States' pivotal role in the global economy. Additionally, the world's increased reliance on technology, including the medical community's, has hindered Cuba's capacity to advance in certain respects. How can Cuba succeed in health care, when resources that are viewed as essential, such as technological infrastructure, may simply be neither available nor reliable? Cuba's achievements in medicine are possible thanks to principals established during the Revolution.

Upon becoming the Cuban head of state after the revolution in 1959, Castro asserted that the state of health care within Cuba was deplorable and in need of significant change. He emphasized that in order to accomplish the goal, the Cuban medical system needed to become a socialized and sustainable system that could provide

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<sup>2</sup> I use the terms "America" or "American" interchangeably with (the) United States. This should not be interpreted as the "America" which encompasses both North and South America, an interpretation some Latin American countries use.

comprehensive care for the national body (Brotherton 2012: 66). I employ the concept of the national body, related to the body politic, as a metaphor for the organic, physical entity that a nation's citizens create, particularly suitable for the context of healthcare. The notion draws on work from scholars such as Mary Douglas and medical anthropology theory. Health care became a core initiative of the entire government in response to the poor state of the national body, which was that of a third world country. In 1960, the infant mortality rate per 1000 live births in Cuba was 37.3, whereas in 2010 the figure was a mere 4.5 deaths (The Rep. of Cuba, Cuba vs. Bloqueo).<sup>3</sup> The rate in Ecuador was 117.7 in 1961 and 21 in 2010, a sign of Ecuador's still underdeveloped state in health care (World Bank). In comparison, the United States' rate in 2010 was 6.43 deaths, still higher than Cuba's (Kochanek and Murphy). Compared to Ecuador, Cuba began with a healthier national body in 1960 resulting from a wealthier population, but its ability to decrease its infant mortality to rates superior to those of most developed countries is an impressive feat. Therefore, in regards to Castro's goal of radically changing—or revolutionizing—the health of the national body, he undoubtedly succeeded. What surprised most of the world, especially developed nations, was (and continues to be) Castro's desire and proclamation for Cuba to be a world medical power.

Cuba's success in health care appears contradictory due to its comparability (or superiority) to developed countries. In 2012 Cuba's incidence of tuberculosis was 9 per 100,000 people, outperforming "developed" countries such as the United Kingdom and Spain, while Ecuador's rate was 59 (World Bank). This indicator often conveys a

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<sup>3</sup> It is important to note that infant mortality rate here measures infant death until they reach one year of age. Therefore, the measure encompasses not only factors that influence the prenatal period and actual birthing process, but also postnatal factors such as nutrition.

country's developmental status, as tuberculosis is nearly nonexistent in developed areas of the world (with the exception of its linkage to AIDS in the developed world). Regarding life expectancy at birth, Cuba's figure is 79 years, the exact same statistic for Costa Rica, Chile, and the United States, among others; Ecuador's life expectancy is 76 (World Bank). Regarding maternal mortality rates, Cuba falls into a favorable range again, with 73 out of 100,000 women dying annually due to complication in childbirth. The average for developing countries in Latin America is 82 and Ecuador's is 110. Cuba is clearly an outlier due to its atypical success in knowledge production and its application in the field of health care, yet is still considered a developing country in many other regards, where it lags behind substantially. Hence the title, "We live like the poor, but we die like the rich," a Cuban quote which reflects the paradoxical state of Cuban health care. Cubans may face hardships common to the developing world, but they will likely live a longer, healthier life, dying of "rich" diseases. Ecuador, on the other hand, presents health care data that corroborates its classification as developing country.

This accomplishment was not realized overnight, but since biomedicine's role as a keystone of the (Cuban) communist ideology in both government and society, its prominence in rhetoric and practice has never diminished. Cuban physicians apply their craft within a system that distinguishes itself as one that contrasts to the global North, specifically the United States. Though, this is only a byproduct of the training that intermingles a deep sense of pride and nationalism into the formal medical education process, not the original intent. With less emphasis on technological reliance, perhaps not always by choice, Cuban doctors employ a skillset that places more value on prevention. Preventative medicine's success requires that physicians be in constant

contact with the communities of their patients, highlighting the importance physician-patient relationship for Cubans. Cuba's now-famous method of training physicians—resulting in revolutionary-tilted biomedicine—has shown to be particularly effective when exported around globe as well. Decades of domestic biomedical success have essentially produced an informal marketing campaign on a global scale, where Cuba has transformed itself into an international biomedical provider. Countries throughout the world, including Ecuador, not only look to Cuba as a source of biomedical care, but also as a model to deliver comprehensive health care to its citizens. Developing countries now have a model to emulate from their own global South, challenging the notion that the health care systems utilized in the global North are the only viable options.

I utilize Ecuador as a case study, to illustrate the complex intersection of international and domestic health care policies, biomedicine, and regional geopolitics. Unlike Cuba, the health indicators of Ecuador reinforce its status as a developing country. I investigate the internal disparities between different populations and then incorporate Cuba—how it will attempt to resolve the maladies plaguing the Ecuadorian national body and the tensions it creates between different groups. I then look at the international political maneuvering by Ecuador and its relationship to the Cuban-Ecuadorian health care partnership. Lastly, I study the legal mechanisms in place to prepare the country for the addition of Cuban physicians, as well as future projects that have already arisen in bilateral talks.

In sum, I argue that Cuba has established a trade system in which it exports medical personnel in return for tangible goods: oil and money, and the intangible: prestige, solidarity, and sympathy. Ecuador has not become a party to the trade system

simply for Cuba's biomedical achievements; rather, the developing relationship is more nuanced. With the creation of the 2008 constitution, Ecuador signaled that the values it once believed in, largely from the capitalist West, no longer accurately reflected the country's trajectory. Ecuador fittingly chose Cuba for the ideals that its physicians embody, (Cuban) Revolutionary principles that reject the current, capitalistic Ecuadorian health care system in favor of one that aims to improve the national body, as opposed to individual populations. Although the Cuban-Ecuadorian partnership is currently focused on health care, Ecuador also uses Cuba's support to assert itself regionally by aligning itself with Cuba and other leftists Latin American governments. In doing so, Ecuador rebuffs Western hegemony and demonstrates itself eager to shape its own destiny, which will very likely include Cuba.

## CHAPTER TWO: METHODOLOGY

The preexisting pool of research and history concerning Cuba's domestic and international biomedical program is vast and easily accessible, primarily due to its success since the Revolution. Although I was unable to travel to the island, various non-Cuban experts in Cuban biomedicine have spent extensive periods of time there, observing and analyzing the system. Most studies are published outside Cuba, which provides experts an environment to formulate conclusions with less bias, an advantage that Cubans are not always given. Though certain themes of my research were not directly related to Cuban politics, Cuban health care is fundamentally political due to the government's complete control of the system. Perceptions of the Cuban government as a whole, from both proponents and critics, are bound to influence their views of the Cuban health care system. Therefore, I incorporate a variety of sources from different individuals, entities, and organizations that hold a variety of views of the Castro regime in order to attain a balanced representation of the past and present status of Cuba's biomedical system.

In contrast to Cuba, the body of history and current knowledge is markedly smaller. As should be evidenced, Ecuador is not known for its biomedical success, but instead for its expected subpar performance. The health of Ecuador's national body matches the expectation for the region, few aspects of it are surprising; therefore, it draws

less attention from the international biomedical community compared to Cuba. The tone of sources also varied between countries. Whereas information about Cuba can be extreme, overly critical or extolling, many Ecuadorian sources are simply dismayed at the state of the Ecuadorian health care system. The information available will likely continue to grow due to recent changes to the system and the newly strengthened partnership with Cuba.

Much of my analysis regarding Cuba and Ecuador's biomedical histories is based upon existing research from anthropologists, biomedical doctors, historians, and political scientists. This provided the proper foundation for Cuba's current role in international biomedicine as well as in Ecuador. In order to show the current health conditions in the two countries, I used information from several international databases as well as census data compiled by each country. To investigate the new Cuban-Ecuadorian biomedical partnership I relied on several semi-structured interviews. I conducted interviews with different individuals who either provided a personal experience, hold a government or institutional position, or who conduct research on health care systems.

Interview questions varied with the each interviewee, but examples include: In your opinion, what is the greatest challenge facing Ecuadorian health care? How could the new penal code (COIP) affect the way in which Ecuadorian physicians practice? What could Cuban physicians offer to Ecuador that its own physicians cannot? What are the most noticeable difference in the curriculum and training of the Cuban medical education system compared to that of other countries? During your time in Cuba, what, if any, differences did you notice regarding health care during the *período especial*?



Since the Cuban-Ecuadorian partnership on health care is still developing, I regularly consulted sources for updated information. This included thorough multi-weekly surveys of two daily Ecuadorian newspapers published online, as well as the Ecuadorian Ministry of Public Health's online press releases. I used the same method for Cuba's national, party-sanctioned newspaper and the Cuban Ministry of Foreign Affairs. Sample search terms include: Cuba, Ecuador, COIP, *médicos ecuatorianos*, *médicos cubanos*, *salud*, *brigada*, and *acuerdo*.

The combination of interviews, raw data, government press releases, and newspaper articles provided an adequate pool of information for this thesis. I faced two main challenges while researching. The first was finding information on the history of health care in Ecuador and the current system. This difficulty during my research proves important, in that it underscores the differences in recognition and assigned value between the two systems. The second issue was locating and contacting Cuban physicians. Contacts who tried to connect me with Cuban doctors in Cuba were unable to do so because the doctors did not feel comfortable. Additionally, since the Cuban medical brigade arrived in Ecuador behind schedule, I was no longer in the country and therefore could not contact them. I expect that as the countries continue to adopt new technology, records of personnel will improve, as will the ability to locate and contact them.

## **CHAPTER THREE:**

### **BIOPOLITICS AND MEDICINE**

#### **I. Introduction**

Two key concepts inevitably play a role in the intersection of biomedicine, globalization, and national identity: the body politic and governmentality. In discussing the latter, Lock and Nguyen explain Foucault's theory as such:

Foucault coined the term 'governmentality' to refer to the way in which the exercise of power by the modern state came increasingly to include the active management of the population to stimulate its vitality, and the adaptation of codes and techniques by individuals to govern their own lives, for instance by adopting a 'healthy' lifestyle... Central to this form of biopower, exemplary of the modern state, is the idea that a 'population' is a living object...(Lock and Nguyen 24, 114)"

In order to apply Foucault's theory, one must also understand his notion of biopower, the overarching idea that has a more literal meaning: having the power, authority, or leverage to subjugate a physical body, or in this sense many bodies, the national body (Lock and Nguyen 24, 114). These terms illustrate the state's ability to shape—sometimes literally—the bodies of its citizens as an expression of national identity and/or government clout. This may manifest itself in various ways, such as the creation of new groups and classifications within the national body (Lock and Nguyen 25). Said categories are often created from nothing. Unrelated bodies are classified and

related in ways to find commonalities that did not “exist” previously. Hacking describes this term as the looping effect. Examples of individuals who are given new categorical identifiers within society include abused children, single mothers, refugees, and senior citizens (Hacking 23). By implementing such constructions of perception, the government is able to redraw societal boundaries, allowing more rights and privileges for some, while marginalizing others. That is, those already in power have the capacity to reshape societal structures either for their own advancement, or for the overall advancement of the national body.

The body politic condenses and combines the aforementioned concepts, but more importantly, it finds the common linkage between them. The body politic theorizes that the national population can be viewed as a single entity that is headed by the most powerful group or individual, typically the national government in whatever form it takes. Because the body politic is a single entity that includes government, any actions belonging to “governmentality” reconfigure each individual body, and therefore the national body. This reshapes both the self-perception and outward reputation of the nation. The notion of conceptualizing government and a nation through the body politic is not a recent development. Hobbes defines it as such: “...a Commonwealth or State, which is but an artificial man, though of greater stature and strength than the natural, for whose protection and defense it was intended; and in which the sovereignty is an artificial soul, as giving life to the whole body... (Hobbes 413) ” The language he uses is intentional, drawing a clear connection between a nation and its physicality. He continues, “Lastly, the pacts and covenants by which the parts of the body politic were at

first made, set together, and united resemble that of a fiat, or the let us make man...

(Hobbes 414).” Eugene Thacker summarizes the concept as such:

The body politic is a response to the challenge of thinking about political order (as a living, vital order). It is formally based on an analogy between the body natural and the body politic (through a narrative stressing unity, hierarchy, and vitalism). This formal relation is historically expressed in terms of political theology (and the questions of sovereignty and the “two nature”). And, despite this formal coherence, it is also a concept defined through its failure (that is, its internal tensions and corporeal variations) (147).

Through the Cuban Revolution, the Cuban government has become a testament to this concept. Its ability to realize biomedical bodily adjustments changing internal and external views has been essential to maintaining power. Its centralized governmental structure under the communist party allows for the implementation of sweeping decisions without the often-problematic political discourse that other countries encounter their attempt to create significant change.<sup>4</sup>

## **II. National Identities and Biopolitics**

The biopower exerted by the Cuban government upon the body politic can be characterized as dominating when the appropriate statistics are applied. According to reliable estimates, Cuba outperforms every other comparable group regarding vaccination campaigns. The unchallenged authority of the communist centralized government under

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<sup>4</sup> The Patient Protection and Affordable Care Act, or Obamacare, is perhaps the most well-known recent example for Americans. Such dramatic and politically charged conflicts are virtually nonexistent in Cuba as well as in other countries where one party maintains all, or most of the power. Interestingly enough are the two vastly different outcomes of government inserting itself into the role of health care provider (or at least financier). In the United States a large portion view Uncle Sam as overstepping his boundaries, regardless of the potential positive outcomes. In comparison, Cuba, though the public plays a very different role, the national public and international spectators have largely viewed government intervention as the path to tangible progress.

Fidel Castro, now under his brother Raúl, is essential in the implementation of programs such as vaccine dissemination which has seen unquestionable success, as seen in the table below<sup>5</sup>:

<b>Figure 1: Target Population Vaccination Rates</b>				
<b>Vaccine</b>	<b>Cuba</b>	<b>All Developing Countries</b>	<b>All Developed Countries</b>	<b>Global</b>
BCG	99	83	83	83
DTP (3rd dose)	99	75	96	78
HepB (3rd dose)	96	57	63	55
Hib (3rd dose)	96	17	80	21
MCV (measles-containing vaccine)	99	75	92	77
Polio (3rd dose)	99	76	94	78

Not only has the Cuban government been effective in its physical bodily reformation, but also in the mental and subconscious of the national body. Brotherton devotes a significant amount of his text to the commentary and analysis of the government's long and successful history of biomedical propaganda. Cuban propaganda becomes embodied in citizens' community-based biomedical actions. These internalized notions are realized with the underlying belief that in order for the health of the national body to maintain its reputation as an international model, all members of society must

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<sup>5</sup> Source: WHO

participate; the national body's success demands the respect and attention from each individual member. This politicized idea of communal responsibility is not new under the Cuban revolution, though it is dramatically magnified as its success is highly touted as a part of national identification for the individual as well as the entire nation.

Most significant is the penultimate column where all developed countries are combined and averaged together. Cuba maintains a higher vaccination rate, a consequence the government's structure, which allows for a rapid implementation of high-impact decisions that affect both the health and *perception* of the national body. A report also concluded that the Cuban National Immunization Program "is known and understood not only by health professionals, but also by the general public, who in turn become spokespeople for broader education on the subject (Reed and Galindo 6)." This is the *perception* to which I refer.

This tendency to police oneself (meaning the national body), in order to maintain a healthy body politic, signifies the strong influence that the health of the island has on its unified national identity. Not only has Cuba reconfigured its national identity with domestic biomedical success, but Cuban biomedical presence abroad also has socioeconomic implications regarding the reconstruction and perception of national identity for the host country. The positive international reputation in biomedicine contributes to a Cuban national identity with which both the government and national body can be associated. Cubans view themselves as a metaphor and living example of the communist value—yet uniquely Cuban—that the national body is a dynamic product of comprehensive, nationalized, and free health care disseminated to the masses. Although there is marked difference between the political ideologies of communist Cuba

and socialist Ecuador (though such differences might be lessening), it becomes quite obvious that they overlap in this belief of leftist political embodiment via biomedical practices. Ecuador has taken serious steps to provide health care to its entire population, in ways similar to Cuba, while also calling it an inherent right in its constitution. Furthermore, Ecuador's choice to incorporate Cuban doctors into the current public health care system points to a growing emphasis on health care managed by the state.

Not only has Cuba demonstrated indicators of its biomedical success domestically, its track record of medical diplomacy makes Cuba an even more fitting model for Ecuador to emulate in terms of domestic health care reforms; but, incorporating aspects from the Cuban health care system into another can be met with hesitation and confrontation. . Feinsilver provides a telling example of internal consequences resulting from the implementation of (external) Cuban physicians:

This more familiar approach [of living within one's community] is changing expectations as well as the nature of doctor-patient relations in the host countries. As a result, Cuban medical diplomacy has forced the reexamination of society values and the structure and functioning of health systems and the medical progression within the countries to which they were sent and where they continue to practice. In some cases, such as in Bolivia and Venezuela, this threat has resulted in strikes and other protest actions by the local medical associations... As Cuba's assistance concentrates more on the implementation of some adaption of their own health service delivery model, the threat will become more widespread. (284)

Feinsilver explains that sections of foreign societies are not always welcoming of Cuban biomedical support. This is seen in Ecuador's current terrain where the Ecuadorian government must sooth domestic physicians' worries (discussed in a later section) while trying to implement its own agenda with the Cuban health care model. Therefore the

insertion of external, foreign individuals into the greater body politic of a host nation brings about a reassessment of the national identity for both countries. Significant change in a topic as essential, often polarizing, as health care in a country—where citizens and government consider it a right—reconstitutes previous ideas of self-perception relating to and stemming from the national body. Whereas Cubans have a strong sense of their national body’s image, one that gives them pride, Ecuadorians do not.

Although the primary reason for Ecuador’s employment of the Cuban health care system is to truly better the overall health of the national body, it would be an oversimplification to claim that this is the only reason for its implementation in Ecuador. Cuba has constructed an international reputation for delivering health care not only to its own national body, but specifically to marginalized populations, which sometimes have little in common with Cuban culture or political ideology. For example, similar to other Andean countries, Ecuador has a various indigenous populations, each with a different set of cultures, traditions and values. Cuba however, has no such native population. Yet, these groups do share the same classification of a “global proletariat,” which the Cuban government aims to and unite. Although this goal towards solidarity is not stated, it is often one that is expressed in both Che and Castro’s public discussions on medical diplomacy and its multiple facets.

### **III. Latin America’s Response to Western Hegemony**

Upon joining ALBA Ecuador’s current president, Rafael Correa, stated, “ALBA is a political project based on solidarity, integration, and being the *owners of our own*



*destiny*<sup>6</sup> (Prevost 131).” President Correa is clearly concerned about his country’s ability to form its own domestic and foreign policy independent of the United States. ALBA, the coalition of leftist governments in Latin America, provides Ecuador the political reinforcement to choose its own path, or follow a path similar to Cuba’s. It seems unlikely that the desire to form a relationship with the United States’ foe is the primary reason for Ecuador’s utilization of Cuban methods of health care. I believe that the Ecuadorian government, headed by President Correa, views Cuba as an equitable partner, rather than the United States, where both core political values and the construction of society are quite different. A platform of Correa’s first campaign was the creation of a new constitution, which was ratified in 2008 by nearly two-thirds of Ecuadorians (Prevost 118). This strong showing affirmed the new trajectory of Ecuador under Correa. Furthermore, the document’s contents themselves uphold the values that align with Cuban and Chavista policies. Similar to Venezuela, the new constitution expands spending in education and healthcare, as well as created two new branches of government, the National Electoral Council and the Council of Citizenship Participation and Social Control (Becker 118-119). In a more recent showing of solidarity, the Cuban Foreign Minister stated, “We confirm the excellent relation between our nations, the Citizens’ Revolution<sup>7</sup> [of Ecuador] and the Cuban Revolution are united for the benefit of our nations and our America (The Rep. of Ecuador, “Cancilleres de Ecuador”).” Ecuador’s

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<sup>6</sup> My emphasis added.

<sup>7</sup> Original Spanish: *Revolución Ciudadana*. The Citizens’ Revolution is a program implemented by the Correa administration under which many government projects fall. It is used more as a marketing or propaganda tool to show Ecuador’s progress, rather than a transformative event such as the Cuban Revolution. Examples are the ubiquitous large signs hung on new buildings the new infrastructure as a result of the “¡Revolución Ciudadana!”

view of Cuba as an ally and model (in certain contexts) is not one-sided. Cuba echoes such sentiments, even referring to the “Citizens’ Revolution” to draw parallels between the two nations.

Ecuador’s opposition to American intervention has thus far not been as overt as that of Cuba. The first major confrontation occurred in 2008, when Ecuador denied the renewal of an expiring ten-year lease of a United States military base in Manta, Ecuador (Romero). Each nation interprets the refusal differently. The United States considers the base in Manta a “forward operating location,” meaning it is used to carry out counter-narcotic missions typically along the Ecuadorian-Colombian border. No other American base exists in the area, so Washington valued it quite highly. Since its establishment, the base has never truly symbolized positive Ecuadorian-American cooperation. The base came about due to a failed attempt to utilize Howard Air Force Base in Panama for similar purposes, leading American officials to turn to Ecuador (Romero). The agreement was signed in 1999, during a severe economic crisis in Ecuador in which the terms of the agreement unabashedly favored the United States. The agreement leased the land to the United States for ten years, without any payment to Ecuador (Romero). In 2009 when the lease was not renewed, American forces left the base and the Ecuadorian government now occupies it.

The United States is not the only foreign power that has tried to exploit Manta’s resources. Manta, a natural deep-sea port, was simultaneously courted in 2007 by a Chinese (Hong Kong, specifically) multinational company, Hutchison Port Holdings, while the American base negotiations were floundering (Narins 45). The economic stimulus that was the American military base quickly became the Chinese shipping

company stationed only a few miles away (Narins 46). Hutchison Port Holdings signed a thirty-year, \$520 million contract with the Ecuadorian government, yet disagreements soon arose. In less than three years the company withdrew from Manta following a dispute with the Ecuadorian government concerning timetables for investments (“Update on Manta Dispute”). Hutchison Port Holdings transferred its facility to the Manta Port Authority and terminated its operations.

Another disagreement between the American and Ecuadorian governments occurred in 2011, when the Wikileaks scandal embarrassed many in the Obama administration and aggravated tensions across the globe, including those with Ecuador. One cable exposed the then U.S. Ambassador to Ecuador, Heather Hodges, who criticized President Correa for his selection of a corrupt high-ranking police commander. She indicated that he was selected for the ease in which the Correa administration would be able to influence him. Hodges lambasted the Ecuadorian president for perpetuating a system of cronyism (“The U.S.-Ecuadorian Diplomatic Row”). She was officially declared persona non grata by the Ecuadorian government on April 5, with the United States reciprocating the action two days later. Tensions have since dissipated and both embassies now house ambassadors.

Ecuador has also been involved in discussions or events that do not deal with the United States directly; rather they challenge American foreign policy in one way or another. Ecuadorian-Chinese cooperation has markedly increased in the past few years, illustrated by projects such as a \$2.25 billion hydroelectric dam and the potential for a \$13 billion oil refinery. This substantial expansion in cooperation has caused China to become the second-largest foreign investor between Canada and the United States,

respectively ("U.S., Ecuador: Cooperation"). Perhaps encouraging more investment from the Chinese rather than American corporations should not be considered an anti-American maneuver, considering Beijing and Washington currently are on fairly good terms. Ecuador, though, has sought out transactions with others who were (are) undoubtedly regarded as American enemies, such as Iran. In 2010 under former President Ahmadinejad, Ecuador negotiated with Iran to purchase \$400 million worth of Iranian fuel. The deal occurred while the United States and the European Union pushed for a boycott on Iranian oil ("U.S., Ecuador: Cooperation"). Prior to the negotiations, then President Ahmadinejad also visited several Latin American Countries, including Ecuador, and pledged to build a refinery within the country (Gill).

Ecuador has continued the trend of aligning itself against of the United States within the Middle East, seen in the most recent Israeli-Palestinian conflict. While the United States maintained its vehement support for the Israel throughout, Ecuador supported Palestine. Coordinated through Egypt, Ecuador sent a number of supplies to the Palestinian state in an overt show of solidarity ("Ecuador ultima con Egipto"). Similarly, Cuba sent supplies days later, also promising to permit wounded Palestinians to travel to Cuba in order to receive proper medical treatment (The Rep. of Cuba, *Cuba* "Envía Ayuda"). It is not to say that Palestine ought not have allies, especially during a humanitarian crisis, but rather actions by Cuba and Ecuador cannot be viewed in a vacuum.

Although their actions are indeed humanitarian in nature, they must also be interpreted following the current global political environment. Ecuador has taken its cue from Cuba in forming relationships with countries that the United States and other

Western powers have little, if any, dialogue. Actions of solidarity emphasize Ecuador's belief that the Western method of politics, government, health care, etc. is not and should not be the only option. Through Ecuador's methodical readjustment of international relations, it asserts its own sovereignty while also publicizing its alignment with Cuban foreign policy in many contexts.

## **CHAPTER FOUR:**

### **REVOLUTION AND BIOMEDICINE**

#### **I. Background**

Therefore, the National General Assembly of the Cuban People proclaims before America, and proclaims here before the world, the right of the peasants to the land; the right of the workers to the fruits of their labor; the right of the children to education: the right of the sick to medical care and hospitalization... Some people wanted to know what the policy of the Revolutionary Government of Cuba was. Very well, then, this is our policy. (Castro)

From the onset of the revolution, Castro made it a priority to provide medical care to his people. In his speech to the United Nations General Assembly in 1960, Castro made his case evident for the importance of (free) health care, calling it an inherent right of the Cuban people, which both created the expectation for it to become a hallmark of Cuban national policy, while simultaneously criticizing his capitalist neighbors present during his long-winded speech. It is unlikely that Castro predicted that the health care system that prospered under his guidance would eventually become more than a mechanism for improving the lives of Cubans; rather, it became a tool—to improve health abroad—or a weapon—to gain support for Cuba’s economic plight caused by the United States—however he chose to use it.

When the revolution began under Fidel Castro, he relied greatly on the help and guidance of Ernesto “Che” Guevara, an Argentinian now held in high regard in much of Latin America. Before becoming a revolutionary, Che studied medicine in Argentina, possibly one source for Castro’s health care emphasis on medicine on the island. The doctor-turned-revolutionary delivered a speech in 1960 specifically geared towards biomedicine and the revolutionary ideology to the Cuban Militia concerning what he titled “revolutionary medicine.” In it he outlines the role of the physician in the revolution within Cuba and around the world:

Nevertheless, the militias have a function in peacetime; the militias should be, in populous centers, the tool that unifies the people. An extreme solidarity should be practiced, as I have been told it is practiced in the militias of the doctors... If we medical workers—and permit me to use once again a title which I had forgotten some time ago—are successful, if we use this new weapon of solidarity, if we know the goals, know the enemy, and know the direction we have to take, then all that is left for us to know is the part of the way to be covered each day (Guevara).

Che argues that the role of the physician or any other health care personnel is that of a warrior, charged with the responsibility to fight to improve health of the *national body*. I utilize this term to evoke the image of a singular, cohesive object as opposed to a *population*, which fundamentally recognizes the individuals that comprise the larger group. Furthermore, the term establishes the national population as an entity with agency within a biomedical context; its singular form can therefore be used as a representation for the overall health condition. In Cuba’s case the national body’s success also influences international perceptions and thus can be used as symbolic capital. The speech mixes sentiments of war, conflict, and nationalism in his language, despite speaking to an audience of doctors. Che’s rhetoric highlights the importance he and Castro placed on

this field of science even as the revolution was in its infancy. Not only are Cuba's leaders admired for their uncompromising stance on free, comprehensive health care provided by the state, but also for their ability to excite and mobilize support within the national body.

Che's remarks prefigure the importance of Cuba's reputation as a "global medical power." Although the Cuban government at this time had not invented this concept yet, its leaders had the foresight to see the potential benefits of biomedical success on the island. These remarks lay the foundation for the pervasive Cuban-state health care rhetoric still seen today. Especially when exposed to a foreign audience, leaders continue to praise the country for revolutionizing national health care, especially its hallmark feature, the *Medicos de familia* system. This comprehensive community health care structure accomplishes the principles that Che and Castro wanted the Cuban government and its physicians to embody and subsequently project onto the national body. However, such a system did not emerge immediately from the revolution, but had roots before Castro took power.

A major antecedent to the current health care system in Cuba was a system known as *mutualistas*, where Cubans who had Spanish ancestry, could opt into a type of insurance where a monthly fee covered all medical care. This system covered roughly 20% of the Cuban population, about and had a budget of roughly 40 million pesos, more than twice the size national government's (Brotherton 2012: 61). The care provided by practitioners within the system was considered quite respectable for the time, above regional standards. The system was comprised of some 242 hospitals and clinics, typically concentrated around urban centers. Even though the system was quite good, it



was exclusive; it was only available to those who met the racial and socioeconomic qualifications. The vast majority of Cubans could not overcome those barriers and therefore had no way of accessing health care on a consistent basis. Despite the system's flaws, the idea of effective and accessible health care delivered to a large number of people was a concept used in the post-revolutionary system.

Once the revolution occurred, permanent structural changes within the larger communist bureaucracy became universal throughout the country. The Ministry of Health and Welfare became the Ministry of Public Health, and the People's Health Commissions was created in order for the new government to have a large source of influential backers to help rally support (Feinsilver 32). The latter was a conglomeration of members from various unions and large organizations brought together in order to support national health care programs, such as vaccination campaigns (Feinsilver 32). The first national vaccination operation took place in 1962, and members of the People's Health Commissions were indispensable in vaccinating the entire population against Polio (Feinsilver 32). By 1963 Cuba successfully eradicated Polio from its population, several years before the United States was able to do the same (Brotherton 2012: 71). Although the difference in population size is notable, such an accomplishment shortly after the new government's formation is commendable. Such large-scale efforts would never have succeeded without the unified support of the People's Health Commissions, a forum in which non-medical community leaders and medical personnel could voice their concerns and produce a unified strategy. This notion of grassroots support of Revolutionary goals is captured by Castro in 1961, "With the Revolution, everything; against the Revolution, nothing (Pillar 203)." By mobilizing the support of the national

body to improve its own health, the government began delivering on its promises from the Revolution while proving that success was only achieved through the collective. The government set the precedent that no major projects could succeed without the help of the people, especially in regard to health. No longer did each Cuban body belong only to himself, but collectively they comprise the health of national body, which becomes a mechanism to validate the Revolution.

The development and implementation of core health care values began in the late 1950's, but it was not until the 1976 Cuban Constitution and the 1983 Public Health Law that the following principles were formally adopted:

- Health care is a right, available to all equally and free of charge.
- Health care is the responsibility of the state.
- Preventive and curative services are integrated.
- The public participates in the health system's development and functioning.
- Health care activities are integrated with economic and social development.
- Global health cooperation is a fundamental obligation of the health system and its professionals. (Cuba)

The realization of these aspirations is found in the creation and subsequent success of the *Medico de la familia*<sup>8</sup> system, which formally began in 1984 after the previous system, was deemed outdated and inefficient by the government (Ochoa: 56). The original system, the Rural Social Medical Service, began in 1960 with the creation of a law that incentivized new medical school graduates to practice in low-access areas. The program offered graduates a competitive salary and a government medical position after

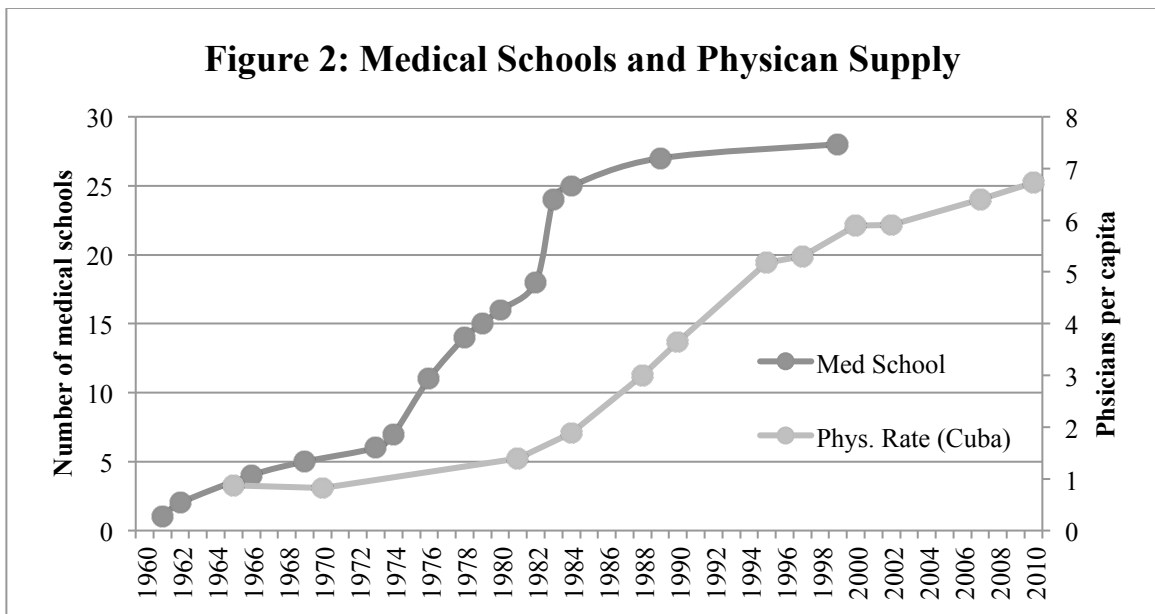
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<sup>8</sup> English translation: Family doctor.

completing a six-month rural post (Ochoa: 56). This model had no trouble attracting physicians, as the “voluntary” program eventually saw 100% of graduates opting in to a two-year term of service. This, along with improvements across the entire health care system, helped to greatly improve the health of the national body. It especially improved in the health of the maternal and infant populations. Prior to the Revolution, the infant mortality rate was 70 deaths per 1,000 live births (Brotherton 2012: 71). The number plummeted; by 1980 it improved to 17 per 1,000 live births (World Bank). Officials and health care providers found themselves in an unfamiliar position, with the ability to focus on maladies previously given less priority. The dramatic improvement in once pervasive ailments moved the focus to prevention and treatment of “first world illnesses,” such as cardiovascular disease, high blood pressure, and cancer (Brotherton 2012: 80). This system emphasized the importance of universally accessible health care to all Cuban citizens, not just those in urban centers.

With the implementation of the *Medico de la familia* plan, also referred to as the “Physician for 120 Families” model, the country shifted its mentality from a system in which a large pool of specialists cured specific illnesses to one in which most physicians were general or family practitioners to provide comprehensive and preventative care to a very localized population. This plan functions thanks to the more than 76,000 Cuban physicians who work domestically, or 6.9 physicians per 1000 Cubans (WHO). The constant “over”-production of doctors, Cuba has maintained a robust health care work force to supply the ambitious program. Cuba’s lack of resources does not seem to have greatly impacted Cuba’s ability to educate a large number of medical students.

Another testament to Cuba's early dedication towards health care, the government expanded the biomedical education system as the need increased. The figure below shows the relationship between the increasing physicians per capita ratio and medical schools.<sup>9</sup>



Appropriately, an increase in the number of medical schools foreshadowed an increase in physicians per capita. Several years after the Revolution, in 1965, the physicians per capita ratio were only 0.88 and only increased modestly throughout the following decade. The 1970s marks the beginning of the education system's expansion, triggering the subsequent spike in physicians. In the 1980's the number of physicians exploded: 1.9, 3.0, and 3.6 in 1984, 1988, and 1990, respectively (WHO). A rapid increase could not have been expected prior to the 1980s, unless had the government decided to retrain Cubans from other sectors. That decade marks the point in which children born in or

<sup>9</sup> Source: World Bank and Carreño de Celis et al.  
Physician ratio is the number of physicians per 1,000 citizens.

shortly thereafter the Revolution were able to complete their entire medical education and begin practicing medicine.

The pre-revolutionary system of health care was by and large replaced viewed as a success, measured quantitatively by nations and impartial observers across the world. Yet, it is not without its flaws, and critics raise questions that might expose some of its inefficiencies. A major objective of the *Medico de la familia* system is that its physicians become embedded within their small community. The argument is that once illnesses or disease-causing behaviors are discovered, their spread can be eliminated much more quickly in a community where the physician is a respected and well-connected figure. Yet, the family doctors' skillset and knowledge can narrow from being consistent exposure to a small and constant population of only 120-150 families. This could cause them to either losing their capability to treat or potentially misdiagnose relatively simple cases. Additionally, superior health care provision and mass biomedical education campaigns over an extended period have created a national population with greater biomedical knowledge than most.

The current system is comprised of a hierarchical web of medical services that provide varying levels of care throughout the country. It incorporates the entire range of medical doctors, from physicians trained in community medicine, to those subspecialists in large urban-based hospitals. The basis of the entire system is built upon the neighborhood physician (from the *Medico de la familia* program) whose responsibility is to first diagnose the patient. If the patient needs more specialized care, he is referred to a local polyclinic, each covering roughly 30,000 people. Each polyclinic is staffed with several primary care specialists, several internists, a pediatrician, an obstetrician-

gynecologist, a dentist, a nurse, and a social worker (Brotherton 2012: 69). The structure of the system aims to improve efficiency via a pyramidal organization in which patients referrals are now directed “up the chain” in a methodical way in order to prevent an inundation of cases in the large hospitals (Labrador: 1). Though it should function smoothly in theory, the rigid hierarchy has inbuilt flaws, specifically in regards to accessing specialized care. Under the current constraints, citizens who know they need to seek treatment from a specialist must still navigate through the bureaucracy, starting with their neighborhood doctor. As the following narrative illustrates, in certain cases, Cuba’s system might overemphasize access to care delivered by the *Medico de la familia* model, greatly limiting direct access to biomedical care delivered by specialists.

## **II. Personal Experiences: Strengths and Limitations of the Cuban System**

My conversations with a Cuban expat, Carmen, who has lived in the United States since 2002, highlight the bureaucracy encountered once a patient needs treatment from a specialist. After a period of six years of being unable to return to Cuba to visit her family, Carmen now makes regular trips to the island. She has strong opinions concerning health care, confirming that (Cuban) biomedicine plays an integral and fundamental role in revolutionary culture on the island. It is necessary to acknowledge the bias Carmen has against the Cuban government and communist party, ubiquitous among Cubans who have fled their native country, most of who immigrate to the United States. Therefore, I present her opinion and narrative as a significant, yet specific, instance to provide insight into the inner workings of Cuban health care, which are not always ideal. Importantly, she also interacted with the health care system before, during,

and (briefly) after the *período especial*<sup>10</sup>, a reference point in Cuba's modern history.

The *período especial* was the period of time following the dissolution of the Soviet Union in 1989. It was marked by severe economic crisis, and Cuba faced severe shortages in food and energy, forcing the government to ration the little that was available. In December of 2004, Castro declared that Cuba was finally moving out of the *período especial* (Guerra and Vega 117).

Carmen explains that her grandmother, ill with Parkinson's disease, was in need of care from specialized physicians located in only a few, select hospitals. "If you didn't have someone to get you into the hospitals, you were in trouble," she explains, displaying her pessimism with the system which is supposed to provide equal care to all. To navigate the Cuban state's biomedical system, Carmen emphasizes the importance of being "well-connected," or *socialismo*—where citizens must rely on networks of kinship and other forms of formal and informal relationships to acquire the health care access they need—in conjunction with the bureaucratic structure of state-sanctioned system (Brotherton 2012: 31). After meeting with several different doctors at different hospitals with little success, Carmen's grandmother did receive quality treatment. However, this was only possible resulting from the connections that Carmen's brother-in-law, has formed during his career as a dermatologist. Fortunately, she was able to receive treatment at a hospital reserved for government officials and military personnel from the country's expert in Parkinson's disease, but, according to Carmen, this level of care is not one which all Cubans can attain. Brotherton provides a similar narrative where a Cuban

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<sup>10</sup> English translation: the Special Period. This term is one that was incorporated into language by Cuban officials. Though the phrase's connotation attempts to ignore the great struggles faced, it carries a negative undertone for all Cubans.

man voices his concern that family physicians lack a depth of knowledge to treat complex cases. His proposed solution is loosening tight regulations to direct access to specialists (2012: 107).

Carmen's strong stance against the Cuban government is common among Cubans who have fled the island, most of who immigrate to the United States. She sees many of the actions taken by the government to be secretive and difficult to understand. Carmen voices concern about Cuba's many international medical programs and the government's lack of transparency regarding how revenue is used:

What I see [now] is that they are selling our doctors but the resources that are coming in are not being used towards health for Cuban people. They're being used for something else. I don't know where it's going because I don't see anything getting fixed. The streets are full of holes, and people are not getting food. So I really don't know where this money is going. You know that money is not going to the doctors; you know that. This money is going straight to the government, and it's not going to the hospitals in Cuba either. I don't know where it's going, because as far as I've seen, I didn't see that money going towards health care. Otherwise these hospitals would have top of the line stuff.

While Carmen acknowledges that she does not know where exactly income from bilateral agreements goes, she alludes that someone must be benefitting from the profit, perhaps high-ranking government officials. While this could be a possibility, there are few accounts or commentary indicating that Cuba is a country where corruption is blatant and rampant. While government employees and officials appear to receive perks, both official and unofficial, it is not comparable to countries where government officials unabashedly steal from state coffers. Furthermore, Transparency International's 2014 corruption perceptions index score for Cuba was 46, placing it in the top third of all countries in the Americas, which illustrates its relative "cleanliness" in terms of



corruption.<sup>11</sup> Therefore, poor investment strategies or mismanagement of funds in the weak Cuban economy could also be an answer to the alleged disappearance of funds.

Contrasting the difficulties and inefficacies above is the response from the Cuban medical community to a neuropathy epidemic. This rapid and comprehensive response proved the efficacy of the *Medico de la familia* program during the *período especial*. The average daily caloric intake sharply dropped from 2,899 calories (pre-crisis level) to 1,863 calories during the worst part of the crisis, from 1990 to 1995 (Franco 1837). The quick change in diet triggered a neuropathy stemming from a lack of vitamin B1, usually consumed through corn and other root vegetables (Mills 11). Family doctors around Cuba became the keystone of the effort. They were given the appropriate tools and resources from the country's experts and directors to treat patients: new training on early symptoms and a vitamin supplement (Mills 13). Although the availability of foodstuffs what uncontrollable, a quick, unified response by the Cuban medical community prevented a larger disaster. By utilizing Cuba's army of physicians deployed in neighborhoods through the country, the incidence of neuropathological illnesses declined (Mills 13). In sum, these accounts show that the structure Cuba's health care system has is not perfect, and perhaps is not well-suited for certain illnesses, such as non-communicable diseases that only affect a small portion of the population. However, as a whole, the system is quite effective in identifying population-wide illnesses and quickly delivering a uniform response across the country.

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<sup>11</sup> Transparency International ranked 175 countries and territories in 2014. A 100 point scale is used, with 100 indicating no corruption. For comparison, Canada is ranked first in the Americas with a score of 81. Ecuador, 33, is in the bottom third and Venezuela, 19, is last.

### **III. Cuban International Medicine Today**

International service and experience is, surprisingly, an integral part of the entire Cuban health care system due to a high level of support and the honor Cubans receive while doing such work on behalf of the government. Furthermore, it is an essential part of the Cuban biomedical pedagogy, in which philanthropic values are part of the program. The importance of international service is evident in the large number of Cubans who travel abroad on behalf of the state. Approximately 20,000 physicians are practicing abroad, which equates to roughly 1 out of every 560 Cuban citizens (De Albornoz 464). This compares to the approximately 1 out of every 27,600 Americans who is working abroad with either the Peace Corps or USAID, the two largest governmental entities dedicated to foreign service (Peace Corps; *USAID Staffing*). This notable difference shows that the Cuban program is mainstream. Cubans work abroad as a part of their national identity, representing the Cuban government in a direct and intentional manner. The American programs, however, are entities in of themselves. Their employees or volunteers are representatives of the organization, rather than the U.S. government. This allows participants to separate their work from American foreign policy or actions, whereas Cubans cannot.

Cuba portrays a level of altruism that any sovereign state seeks to reach, especially on the international stage. Even considering the many instances where Cuba delivers goods and services pro bono, it would be remiss to suggest that Cuba does not benefit from agreements made. Now that Cuba controls the market on medical “mercenaries,” Cuba’s profits from international biomedical agreements and aid packages will only continue to grow. Cuban officials have smartly emphasized the “revolutionary”

aspect of “revolutionary medicine,” and its physicians embody and incorporate it into their practice of medicine. Cuba portrays itself as the principled and ethically-minded communist state in contrast to the capitalistic West that does not provide medical aid in this manner. Cuba’s actions commodify the initially intangible revolutionary principles Che and Castro extolled. By utilizing the vast physician population within Cuba as a source of financial gain, the nation also receives an income of symbolic capital, what Feinsilver defines as “goodwill, influence, and prestige (86).” Perhaps even more significant, these can later be converted into financial and political capital. The institutionalized system of exporting human capital as well as scientific knowledge has consequences both explicit and implicit. The Cuban government emphasizes this system of international altruism exists for ideological reasons; but aren’t countries paying for the *biomedical services* provided by Cuban physicians, not Cuban Revolutionary dogma? No, whether foreign governments acknowledge the fact or not (the United States does), it is impossible to separate the services delivered from the ideological basis on which they are founded. The biomedical training and culture within Cuba combine science with the beliefs of the government. This is a principal part of how Cuba has seen long-term success in delivering its medicine abroad.

Soon after the new revolutionary government began work on improving health care domestically, the international realm became a new interest for Cuban officials. International medical brigades began as early as 1960 to Chile following an earthquake (Feinstein 2010: 87). Many of these early missions went to countries in Africa such as Algeria and various parts of sub-Saharan Africa following natural disasters or during periods of conflict (Brouwer 2009: 33). Cuban medical teams that went to such areas

began to notice and feel that many of the disaster sites would need medical attention long after the initial shocks of the disaster dissipated. What first began as medical missions to areas affected by disaster converted into a program to provide free medical services for a longer period. Only three years later, the first instance of an extended presence of Cuban physicians occurred in Algeria following its independence (Brotherton 2012:169).

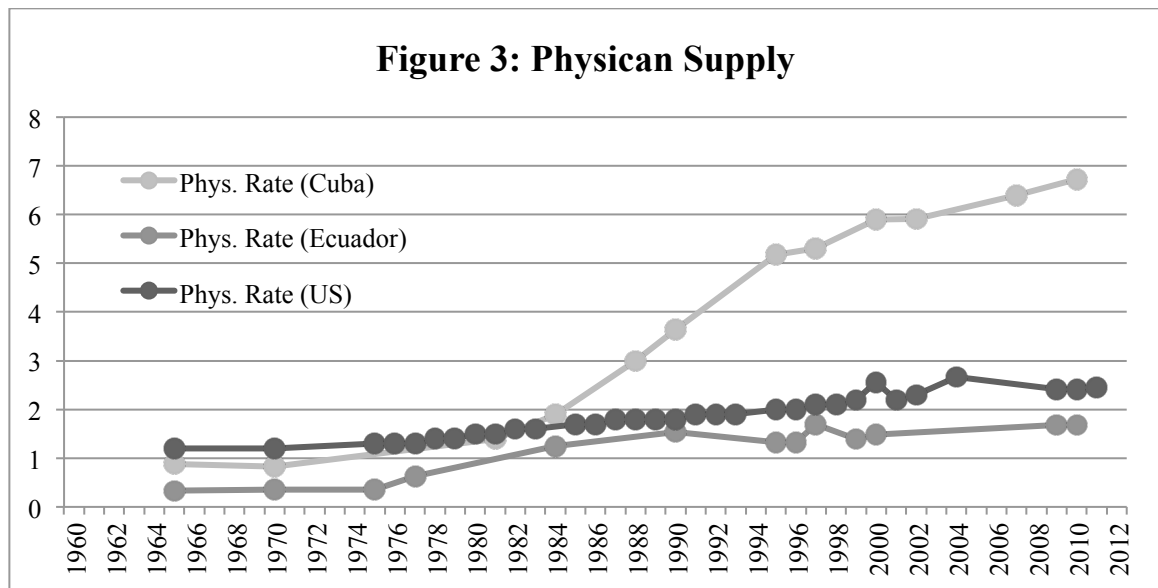
By 2005, Cuba had sent over 200,000 medical professionals to 94 different countries since the first medical brigade to Chile (Harris 36-37). Data from the Cuban government and confirmed by the World Health Organization (WHO) estimates that there are currently more than 50,000 Cuban-trained health care workers<sup>12</sup> in 66 countries ("Cuban Medical Team Heading for Sierra Leone"). During Ebola outbreak in western Africa, Cuba was the first country to send a group of physicians and health care providers, approximately 200, to help combat the virus' spread. During a joint Cuban-World Health Organization press conference the Director-General praised the Cuban government saying, "Cuba is world-famous for its ability to train outstanding doctors and nurses and for its generosity in helping fellow countries on the route to progress (WHO Welcomes Cuban Doctors for Ebola Response in West Africa)." The financially strapped country again revolutionized medicine, in a way that no other country could, by capitalizing on a seemingly endless supply of physicians already being produced in "excess" from Cuba's medical schools as a source of national revenue. Although Cuba first began sending medical personnel abroad free of charge, the government found that perhaps it could be a lucrative venture as well, complicating the initial humanitarian

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<sup>12</sup> This number includes non-Cubans who received health care training at one of the several Cuban universities that teach both Cubans and foreigners alike.

underpinnings of the program. Yet, that is not to imply that Cuba no longer provides its services *pro bono*.

Most reputable sources report that Cuba currently has approximately 20,000 Cuban physicians practicing abroad, with slightly more than half stationed in Venezuela (De Albornoz 464; Brouwer 2011: 37)<sup>13</sup>. This number is in addition to the more than 76,000 Cuban physicians practicing within the country, or over 6.9 physicians per 1000 people, a figure second only to Monaco (WHO). Figure 3 illustrates the relative physician supplies of Cuba, Ecuador, and the United States.<sup>14</sup>



Cuba clearly broke away from the group in the 1980s, while Ecuador and the U.S. have only made slight gains. With only slightly more than 11 million people, this ratio provides Cubans with a dramatic excess, relatively speaking, of medically trained personnel; therefore, commodifying this vast resource of highly skilled human capital is

<sup>13</sup> The date of this statistic is key, as it dates to Venezuela before President Chavez’s death. Ensuing economic, political, and social instability threatens Cuba’s desire and/or ability to maintain such a high population there.

<sup>14</sup> Source: World Bank  
Physician ratio is the number of physicians per 1,000 citizens.

quite pragmatic. Another potential source of Cuba's large physician pool is the prestige it offers. Since all salaries are managed by the national government, the lure of high pay seen in other countries is not present. The prestige of the medical profession, which is arguably universal, is perhaps even higher for Cubans, resulting from the overwhelming positive reputation domestically and abroad.

Although the United States' Centers for Disease Control and Prevention (CDC) and State Department played an active role in strategic efforts, no American government department has sent health care personnel to administer to the infected population. The Cuban government has publicly stated that it is open to a joint Cuban-American strategy and action, considering that the United States is the largest financial supporter in the cause. U.S. Secretary of State John Kerry made no mention of meeting with Cuban officials to create a united front, but he did acknowledge Cuba's large-scale effort (Castillo). The intersection Cuba and the United States seem to dance around raises questions about the American rationale for avoiding cooperation with Cuba. It is only logical that they come together to better utilize their resources in the fight. The White House has sent officials from the CDC, USAID, and State Department to West Africa charged with response efforts of "surveillance, contact tracing, data management, laboratory testing, and health education." As of November of 2014, the US had committed more than \$350 million, with the Department of Defense prepared to pledge another \$1 billion (The White House). But Cuba's physical donation of hundreds of Cuban health care workers has gained much attention. Cuba's response with actual physicians who come in direct patient contact, undermines the more distant strategic and financial American response.

## **CHAPTER FIVE:**

### **MEDICAL DIPLOMACY AND (INTER)NATIONAL BODIES**

#### **I. Internationalism**

By marketing itself and establishing a strong reputation of high medical aptitude, Castro was able to access nearly any “inferior” national body, through the implementation of its system of medical diplomacy. In turn, this allowed Cuba to circumvent both the American anti-communism ideology leading up to and during Cold War era, as well as the American hegemonic system of foreign intervention in the 1990s via the “Washington Consensus”(Russell 44). Cuban physicians not only deliver Cuban biomedicine to targeted bodies, but also act as ambassadors who practice their profession in a politicized environment. Cuba has never explicitly stated that the objective of its medical diplomacy missions is to ignite socialist or communist revolutions within other nations, but one must take into account the populations in which these Cubans serve. Most often, foreign governments, such as Ecuador, contract them to practice within populations who have traditionally been ignored due to a combination of factors: race, ethnicity, geographic location, and/or misperception. Thus, these devalued groups are more vulnerable and therefore open to foreigners who provide them with biomedical care that they have been unable to access previously.

Cuba currently receives much of its financial compensation from Venezuela, receiving \$9.4 billion from the trading partner in 2008. Fifty-nine percent of this income is the wages paid by the Venezuelan government to Cuba for the services of medical personnel and other professionals such as teachers (Mesa-Lago 10). Clearly, Venezuela demonstrates its solidarity with Cuba through its commitment to compensate Cuba in such a significant way. Yet perhaps even more notable is Venezuela's daily exportation of nearly 100,000 barrels of crude oil at a greatly discounted rate (included in the \$9.4 billion), illustrating the strong ties forged between the late Chavez and Castro. This bilateral network created between the two charismatic leaders has led to a translation of socialist or communist ideals into tangible products. Cubans are able to live a more comfortable, modern life (relatively speaking) with a more reliable source of energy, while marginalized Venezuelans are allowed greater access to (Cuban) health care in localized settings. The agreements between Venezuela and Cuba are not simply trade agreements between two countries. These are actions of solidarity between two developing nations who now rely on each other heavily.

I argue that this gifting of oil has greater symbolic value due to the significance Chávez placed on his country's valuable resource. Through Chávez's implementation of a socialist agenda, including negating previous neoliberal reforms supported by the United States, Venezuelan oil has become a symbol of reconfigured Venezuelan nationalism created and grown under Chavez. Chavez's Venezuela has come to be associated not only with oil, but with oil that comes from a country that consistently challenges the West. It is only fitting that Cuba import *Venezuelan* oil that is intrinsically richer than the typical chemical properties normally allow. Cuba appears continues these



trade agreements not only for financial gains, but also the intangible benefits produced, which may be reconstructed and used alongside traditional means of financial capital. Cuba creates a reputation for itself as a country that others can mimic and rely on for medical resources—both tangible (physicians) and intangible (knowledge and ideology).

In 2006 Cuba received roughly \$2.3 billion in revenue by providing medical services abroad, including exporting of physicians. This accounted for approximately 28 percent of total export revenue that year (Feinsilver 2010: 98). Ritter calculates that the combination of health workers, pharmaceuticals, and other biotechnology in 2007 accounted for about 37 percent of total exports (as cited in Andaya 368). A strikingly less conservative report estimated that Cuba received \$9.9 billion in 2009 in exchange of sending medical personnel<sup>15</sup> abroad (Kirk 86). The most recent figure available estimates that Cuba receives \$7.6 billion annually (Walter). It is impossible to ignore the influx of money these physicians provide the Cuban government with, despite the fact that it is not the main rationale for maintaining a system of medical diplomacy.

Critics of the Cuban international medical system argue that financial compensation is the basis of and motivation for sustaining the program. These arguments do merit attention, considering Cuba receives a significant compensation for many of its international medical programs. However, this was not the initial impetus of the program. This source of income grew over time, and has now amounted to a notable sum. Any shrewd country or business knows to capitalize on a resource when available, and during the special period, Cuba was especially needy. It since has continued to be an

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<sup>15</sup> I use this more generalized term to signify physicians as well as other medical professionals such as dentists, nurses, nurse assistants, etc. Some data collected utilizes this broader category to capture data rather than specifics concerning physicians.

important source of income. Simply because there is financial motivation, it does not meant the idealistic goals are contradicted or negated. In sum, Cuba can profit from the program while maintaining its integrity.

## **II. Effects of the U.S. Embargo**

Why is Cuba so concerned about maintaining a reputation of superior health care? For one specific perspective, I again turn to my interview with Carmen. Fortunately, Carmen has also been able to rely on her mother's older historical perspective to supplement her own memory, offering a survey since the Revolution's beginnings. Regarding the current status of domestic health care in Cuba, in her opinion, Carmen definitively argues that it has deteriorated, but it is one of the few things Cubans can still be proud of. She attributes the system's decline to the fall of the Soviet Bloc and the subsequent crisis of the *período especial*. Cuba abruptly stopped receiving money, medical supplies, technology, and knowledge (through personnel who would travel to Cuba). Even though the embargo has existed since the 1960's, only until after the *período especial* did it become a life-threatening issue. It compounded the crisis by discouraging countries and companies around the world from selling to Cuba through various trade laws.

According to a joint report from the Washington Office on Latin America and Oxfam America, Cuba's shortage of biomedical technology was inevitable. Carmen, explains that when Cuba was supported by the Soviet Union, the lack of access to medical supplies was merely a large inconvenience, rarely life-threatening. Unsurprisingly, the American legal restrictions enforced, which have no legal standing in

Cuba, produce the desired effect (by American officials) of not only applying to American citizens, but also any foreign national who conducts business with any United States citizen or business. One such example is the instance of a foreign vessel that docks in Cuban waters or ports. Regardless of intent or purpose (such as refueling), that vessel is legally unable to dock in an American port for the purposes of engaging in trade for six months (United States: 17).

Therefore, Cuba's largest hurdle in preventing it from entering the modern era is the United States' embargo. Through the complex and well-planned humanitarian-based system (with clear political underpinnings), Cuba has gained overwhelming support in pressuring the United States to lift the embargo across the geopolitical spectrum:

It [Cuba's recognized success via medical diplomacy] also has contributed to Support for Cuba and rebuke of the United States in the UN General Assembly, where for the past eighteen consecutive years members voted overwhelmingly in favor of lifting the U.S. embargo of Cuba. In fact, only Israel and Palau have supported the U.S. position, and the Marshall Islands and Micronesia abstained. With equal voting rights for all members of the UN General Assembly, Cuba's medical diplomacy with such a large number of member states is a rational endeavor, however humanitarian the impetus may be (Feinsilver 2010: 97).

As seen though the UN General Assembly annual vote, Cuba has overwhelming support to lift the embargo. Feinstein emphasizes that without such a monumental expression of goodwill and humanitarianism realized in Cuba's medical diplomacy, there would be little to no support for lifting the embargo.

The embargo is not simply an inconvenience, but greatly limits what goods and technologies are available on the island. The key role American pharmaceutical and biomedical companies hold within the global biomedical community limits the resources

available in Cuba. Prostaglandin, the preferred drug by obstetricians for inducing labor was previously only produced by Upjohn (no longer in existence), an American pharmaceutical company, forcing Cuban physicians to rely on other medications which carried higher risks for both the infant and mother (“Myths And Facts” 2). The director of one Cuban maternity hospital explains that the “replacement” drug, an oxytocin, is incredibly inferior compared to the prostaglandin standard. Oxytocins carry greater risk for both mother and child, with risks of uterine rupture, amniotic fluid embolism, and fetal distress or fetal compromise (Reed and Frank 144). Other barriers to modern biomedical care within Cuba include replacing faulty parts to equipment or non-reusable materials (such as X-ray film) (“Myths And Facts” 2). Cuba has little recourse to procure materials it cannot from the United States. One tactic is to produce American owned pharmaceuticals within their own production sites. Unlike other countries, the United States has no leverage to prevent Cuba from breaking American patents. There are simply few remaining sanctions the White House could implement to discourage such actions. Therefore, if the technology exists in Cuba, domestic production is one avenue to acquire goods. The other, more frequent, option is to purchase products from companies not based in the US who are willing to sell to Cuba. The prices are often higher due to the trade-related repercussions they face from the United States.

Despite the economic barriers the U.S. embargo employs, Cuba has made the best out of the situation, at least in regards to health care. By displaying both its medical skill set and ideology, the world overwhelmingly approves of the former, creating the perception that the United States refuses to move out of an outdated mindset, regardless of the embargo’s toll upon Cuba’s silent citizens. Another advantage for Cuba is the attraction

of partners in solidarity, such as Ecuador, that view Cuba's strong stance against the United States as a sign of courage and fortitude. This maneuvering by Cuba is not coincidental but a calculated process in which the Cuban government positions itself as the humble "healer of the world," but still mistreated by its powerful neighbor to the north.

### **III. Cuban (Inter)national Biomedical Education**

The sheer number of physicians Cuba educates in its medical schools is a testament to the Cuban biomedical education process. Even more noticeable is the fact that Cuba retains most of the physicians it educates. Brain drain<sup>16</sup> is a serious problem that Cuba has been able to combat, and it now helps fellow developing countries ward off. Cuba uses its international medical school, ELAM (*Escuela Latinoamericana de Medicina*) to translate the country's success in health care domestically into an international program from which other countries can learn (Brotherton 2012: 172).

Many students who attend ELAM come from developing countries where brain drain is a concern among governments. Specifically, brain drain plays a significant role in physician migratory patterns from the global South (where they are born) to the global North (where they eventually work) (Aluwihare 15). The temptations for physicians from underdeveloped countries to emigrate, economically speaking, are not surprising. Typically, physicians decide to migrate to "richer" countries located in the global North, in order to "better themselves financially—usually a major factor; for greater job satisfaction, research, and other facilities (Aluwihare 16)." However, research shows that

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<sup>16</sup> A term originally developed by the Royal Society to explain the phenomenon of British scientists moving to the United States mainly due to better financial compensation.

other factors encourage the potentially migrant population to leave the country, and other forces that lure the same population out, known as push and pull forces. Without the combination of both forces, the likelihood of significant migratory patterns is greatly diminished (Mejia 15).

The lack of technology and resources are usually considered a severe disadvantage within the field of medicine. In an interview that I conducted, one Ecuadorian physician criticized the educational formation of Cuban physicians, citing their poor technological skills as the reason for failing to quickly incorporate themselves into foreign health care systems. Health care is not immune to the US embargo, and its effects are visible through the lack of modern equipment and technological knowhow. However, in areas where Cuba simply cannot succeed, such as technology, it makes up for in other ways of knowledge production. Although it is not developing cutting-edge health care technology, it maintains a committed pool of researchers and educators. Cuba would not be able to train its large population of physicians who are effective by many measures. Some argue that the incorporation of biomedical technologies into the health care field does not always guarantee positive results, particularly in societies where access to such technologies is not pervasive. Moral and ethical dilemmas arise when clinicians and government officials must choose who receives certain treatments and who is left out (Good 395). Therefore, perhaps the seemingly detrimental lack of technology within Cuba releases its practitioners from a burden others must often face in developing countries.

The number of Cuban physicians who have chosen to defect to either the United States or their host country is quite small when compared to the total number that have

practiced abroad 1960s. In 2006 American officials created a formal system that allowed Cuban physicians practicing outside of Cuba to enter the United States. The Cuban Medical Professional Parole (CMPP) Program allows for Cuban medical professionals and their families to leave their posts abroad and migrate the United States where they can reside and apply for permanent residency. Within the few years, the program has gained traction. In 2014 (fiscal year) 1,278 Cuban medical professionals were admitted into the United States under the CMPP (NYT Editorial Board). However, once cleared to enter, this does not give physicians or nurses license to practice in the U.S.; frequently, Cubans chose a profession that requires less schooling than their original, as the accreditation process in the U.S. for some foreigners is lengthy and expensive. More important is what these actions reveal about the United States' underlying motives. The United States' attempt to take in the medical professionals does not exist in a vacuum; the consequences of a defection do not affect Cuba and the United States alone. American efforts imply that the humanitarian efforts that the Cubans staff are either not valid or insignificant. The potential reduction of the pool of Cuban physicians by the United States for reasons largely stemming from pride is unlikely to meet sympathy in the foreign governments who utilize the resource.

The prestige and desire to help marginalized groups in other countries via biomedical practices is the primary motivation for traveling abroad on behalf of the Cuban government. Che's speech centering upon *el hombre nuevo* both predicate and reinforce such sentiments felt by Cuban physicians:

Meanwhile, the economic foundation has done its work of undermining the development of consciousness. In order to build communism, simultaneously with the material foundations, *the new man* must be made.

Hence, it is very important to choose the correct instrument for mobilizing the masses. This instrument must be moral in nature, fundamentally, without forgetting the proper use of material incentives, especially social nature.

As I said, in moments of great peril it is easy to boost moral incentives; in order to maintain its validity, it is necessary to develop a consciousness in which the values acquire new categories. Society as a whole must be converted into a gigantic school.

This figurative and literal creation of *el hombre nuevo* is realized through the biomedical actions by Cuban doctors stationed in foreign areas, an indirect result from this concept fundamental to the Cuban health care system both domestic and abroad. Che's idealistic theory does have direct consequences upon the biomedical educational system that relies on a pedagogical cycle based upon reciprocity to society at large. "Having accepted the state's gift of medical training, new generations of socialist doctors were honor bound to reciprocate through their self-sacrificing and unending commitment to the uplift of the masses and their dedication to the ideals of the revolution" (Andaya 363). Here, the idea of what it means to be a physician while embodying *el hombre nuevo* relates to the greater mission under communist Cuba. The humanitarian philosophy that Cuban medical personnel come to represent has a direct effect in maintaining the revolution. Cuban physicians are socialized into a specific community that prides itself on the embodiment of Che's ideologies, perpetuating the environment for future generation of physicians. Furthermore, not only does it continue Che and Castro's mission, but it serves as a mechanism for propagation to the global South.

Once such example is the system of medical training through ELAM that redefines traditional medical training by educating students from nontraditional



backgrounds who will become physicians solely for developing countries. Many of these new physicians will practice in areas such as Africa and Asia, where they will learn how to modify their techniques to specific localities (Kirk 81). Thus, through Cuba's continued exportation of biomedical services to allies and non-allies, the island's government also contributes towards the local biomedical (public) health base of knowledge when other governments borrow and modify specific educational processes that remain fundamentally Cuban.

Cuba educates many of its medical students at ELAM, an institution that transplants the Cuban biomedical mission permanently onto foreign soil. In 1999, following Hurricane Mitch, ELAM was established in Cuba, charged with the mission of educating not only Cuban students, but aspiring physicians from across Latin America (Feinsilver 2013: 114). Since the school's founding, it has graduated nearly 20,000 students since the first graduation in 2005 (The Rep. of Cuba "Historia de la ELAM"). Once students complete their education in Cuba, they return to their home countries to practice. Although the school has educated students from 74 different countries, its mission is to target disadvantaged students within the region, with students come from countries already associated with Cuba, such as Ecuador and other ALBA members. (The Rep. of Cuba "Historia de la ELAM").

In July 2014, 31 Ecuadorians graduated from one of Cuba's medical schools in Santiago de Cuba, excited to come back and practice in Ecuador ("31 Ecuatorianos Se Gradúan"). In an interview with a public health instructor who has spent extensive time conducting research in Cuba, Dr. Williams, she noted that the defining quality that the Cuban medical education system offers its students is not the biomedical training

specifically; rather the ethical code and ideology which is imbedded within the Cuban curriculum. Dr. Williams, an American public health expert who has spent extensive time in Cuba, emphasized that Cuban physicians are trained that the best place to practice their skill is the place where it is most needed. Even better is the community doctor who is already an integral part of that community—a homologue to Cuba’s own *Medico de la familia* program. One of the recent Ecuadorian graduates emphasized his comprehensive biomedical formation, “Physicians of science and morals graduate from this beautiful island, prepared to serve those most in need, in any part of the world (“31 Ecuatorianos Se Gradúan”).” Ecuador as a nation benefits from students who leave their training with viewpoints as these; they are the students more likely to serve in Ecuador’s most needed areas. For this reason the Cuban system places a strong emphasis on not only educating its own students, but students across the global South.

Today there continues to be a notable concentration on students from Bolivia and Venezuela, as formal agreements specifically benefitting students from these two countries give these students a priority (Feinsilver 2013: 114). In 2006, Bolivia accounted for more than 20% of the total foreign medical student population at ELAM. Perhaps due to the even stronger ties between Castro and Chavez, the Venezuelan president attended the first graduation from ELAM, where he made the grand announcement that there would be a Cuban-Venezuelan agreement to open a second Latin American medical school in Venezuela with the combined goal of producing 100,000 physicians within ten years (Feinsilver 2013: 114). Venezuela, and even Bolivia, has a relatively long tradition of formal agreements between itself and Cuba, often lying outside the scope of health care. On the other hand, Ecuador is fairly new in

its alignment with Cuba, but new bilateral agreements have shown that plans biomedical cooperation on a significant scale are already solidified. With the passing of Chavez and the ensuing instability under President Maduro, Ecuador has the potential to become the new Venezuela for Cuba.

## **CHAPTER 6: CASE STUDY:**

### **CUBANS IN ECUADOR**

#### **I. Ecuador: Health Care Woes**

The present health care system in Ecuador consists of a hodgepodge of four separate systems which attempt to provide healthcare to the entire country: public, social security, military, and private, that have been described as “fragmented” and “duplicated” (USAID). Regarding medical education for physicians within Ecuador, the system is not nearly as comprehensive as that of Cuba’s. Medical students are in an environment where specialization gains prestige. Whereas family doctors fight negative perceptions in many countries of the global North, the distinction between specialists and general practitioners in Ecuador is even greater. Simply put, general practitioners within Ecuador are considered poorly trained and looked down upon by their peers (Candib 278).

Herein lies the problem—the medical community does not provide the symbolic prestige that general practitioners deserve, which has negative consequences for the Ecuadorian national body. These physicians are not provided with any further training after their graduation from medical school, unlike in Cuba, the United States, and Europe. Therefore, comparatively, they are rather poorly equipped. This has led to a disproportionately small pool of general practitioners able to provide health care to Ecuadorians in rural areas (Candib 278). The only exception to this pattern is the

obligatory *año rural*, where Ecuadorian medical students must practice for one year in a rural determined by the Ecuadorian government. Afterwards, the more “prestigious” path is to specialize in another field of biomedicine (Candib 278). Discrimination towards the rural population and distrust between socioeconomic levels also play roles in influencing where physicians choose to practice. In contrast to Cuba where socioeconomic differences are relatively small, Ecuador is still a society based upon ethnicity, geography, and socioeconomic status.

In Ecuador, as in many countries, divisions along class lines are sharp: the top 10% earns more than 35% of total income, whereas the bottom 20% only earn 4.3% of total income in the country (World Bank). The distinction between rural and urban citizens provides even greater insight into Ecuador’s health care woes. In cities and suburbs, 17.6% of citizens fall below the national poverty line. In contrast, closer to half, 42%, of rural Ecuadorians live below the national poverty line (World Bank). The indigenous population is slightly more than 1 million Ecuadorians, approximately 7% of the national population. Geography is closely related to ethnicity; 78.5% of the indigenous population lives in rural areas, making nearly 15% of the rural population indigenous. Although this might seem low, the only larger demographic in rural Ecuador is the mestizo population, which comprises 65% of the rural population (The Rep. of Ecuador, *Census*).

It is essential to reiterate that Ecuadorian census data regarding race are self-reported and therefore statistics may not accurately illustrate the reality of population demographics. Ecuadorians who are indigenous, for all intents and purposes, who do not want formally identify as such, may choose to classify themselves as any other ethnicity.

Indigenous to mestizo is likely the most common pattern of “crossing over,” due to the wide range of physical characteristics within the mestizo category. From an outsider’s perspective, many Ecuadorians who consider themselves mestizo might appear indigenous and even speak Kichwa, the main indigenous language. Racism towards the indigenous population and the societal stratification that the whitening of skin plays, are ways in which some indigenous might find the “mestizo” classification more appealing. In 2005, nearly 40% of the indigenous population was considered to live in extreme poverty, compared to only 8.2% of the mestizo population (*Perfil De Sistema De Salud* 9). Rural (often indigenous) Ecuadorians suffer from higher rates of illness and disease, a testament to their low socioeconomic status. A 2005 study concluded that 23% of children under five years old were chronically malnourished, and in rural Ecuador, it rose to 31% (3). Maternal health is also in poorer condition in rural areas; only 26.4% of rural women received postpartum care in comparison to 44.4% of their urban counterparts (4).

The broken medical education system perpetuates the inequalities between the rural and urban populations, where the former are in greater need of health care, evidenced by their poorer measures of health. In terms of access to improved sanitation sources, 86% of rural areas have access, while 96% of urban areas have such access (WHO).<sup>17</sup> Since coming to power in 2007, President Correa has sought to correct these imbalances. When first taking office, he instituted a ten-month state of emergency in which the government added an additional \$225 million to improve health care centers (clinics and hospitals), equipment, and to hire 4,500 extra staff members. The president

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<sup>17</sup> Improved sanitation facilities include flush/pour flush to either piped sewer systems, septic tanks, pit latrines, ventilated improved pits latrine, pit latrine with slab, or composting toilet.

also planned to integrate the public health care sector by combining the social security system with the existing system under the Ministry of Health (Silva 228).

Despite attempts to diminish differences between rural and urban zones, the disparities still exist. Regarding ease of access, two main types of facilities staffed with physicians exist in Ecuador: the health center and the health subcenter. The former contains diagnostic equipment, such as medical imaging equipment and a larger staff, while the latter is staffed by a single physician, a dentist, and a nurse with only basic resources. According to the Ecuadorian Ministry of Health, there are 783 rural and 599 urban health subcenters. This shows a real effort to improve access to the rural population, which increased from 669 in 2001 (The Rep. of Ecuador, “Statistics” 2011: 19; 2001). However, the larger health centers are located nearly exclusively in urban areas. There are only 9 rural health centers compared to 193 urban ones. Such a large difference in access to facilities with relatively simple diagnostic equipment emphasizes the imbalance. The same data shows that out of the 24,247 physicians in Ecuador, only 8.4% work in a rural setting where nearly one-third of its citizens reside. Additionally, only 15% of all medical cases involving a physician took place in a rural area.

Correa acknowledges the great disparities within the health care system, partly blaming the mindset of Ecuadorian physicians, who tend to align themselves with capitalist values. In September 2013, the Ecuadorian president signed a formal agreement with the Cuban government to import 1,000 Cuban physicians specializing in family practice, or community medicine, to boost the longstanding shortage in Ecuador (Array). This bilateral agreement pays Cuba \$30 million annually, upsetting many Ecuadorian physicians. The Ecuadorian physicians argue that such a large sum could

have paid for many more Ecuadorian citizens to be trained in community medicine rather than paying for a smaller group of foreign physicians. Correa maintains that it will not replace local doctors, but rather supplement the pool of physicians available (AFP). In November of 2013, the Ecuadorian government confirmed that this agreement was going to materialize, announcing that the first 200 Cubans would arrive sometime in January of 2014.<sup>18</sup> They will help in forming part of the 5,000 physicians (1,000 who will be Cubans), charged with providing medical services to the areas that are in dire need (“200 Médicos”).

During my semi structured conversation with a general practitioner, Dr. Garcia, at a small private clinic, Dr. Garcia also expressed concern about the large number of Cubans entering the public health care system in her country.

I don't think that it is necessary for Cuban physicians to come to Ecuador. Here we have sufficient personnel, very capable and committed to their work. We have open doors for colleagues who wish to practice within our country, working honestly and responsibly, but we don't want extemporaneous professionals to come and experiment on our people.

The medical profession has a long tradition that its central principal is the notion of care and compassion for mankind, evidence by the Hippocratic oath. Throughout my conversations with Dr. Garcia, I am confident that she too values this tenet, but she also values her profession as an Ecuadorian. Even though the arrival of Cuban physicians undermines the job security of Ecuadorian physicians, Dr. Garcia also sees their arrival as a potential threat to the Ecuadorian patients they will serve. Furthermore, she emphasizes

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<sup>18</sup> They did not arrive until August 2014. 96 arrived to join another 120 who had already been in Ecuador. The latter group does not appear to have arrived resulting from talks during 2013, but some unspecified time prior (The Rep. of Cuba “Reciben a nueva”).



that the Correa administration should not spend money abroad, but should instead invest it within its own population.

The Ecuadorian Federation of Doctors (*Federación Médica Ecuatoriana*) also emphasizes the point that the logical approach is to educate one's own citizens before contracting a foreign service. I argue, though, that President Correa is not as concerned with *who* is providing medical attention to his impoverished citizens, but rather that they are *receiving* the attention they need as quickly as possible. Although, by using Cuban physicians, President Correa continues to strengthen the Ecuadorian-Cuban relationship. Additionally, Cubans “specialize” in providing this type of biomedical care—community medicine—in environments accustomed to shortages and few resources.

In sum, physicians who prefer to practice in an urban, affluent setting are given little incentive from society to relocate to an area where the population might be stereotyped as “backwards.” The problem is compounded by the fact fewer resources are available in rural areas. Therefore, the disparities between rich and poor, urban and rural, as well as between ethnicities, provides President Correa with the political ammunition to go forward with the Cuban-Ecuadorian agreement. Correa is laying down the foundation for health care reforms in Ecuador that will potentially model the domestic system Cuba has in place. The agreement also serves as a clear signal that Ecuador intends on forging even stronger ties with Cuba, and recent developments indicate that more cooperation will indeed occur. In November 2014, the Ecuadorian Foreign Minister traveled to Havana where he met with his Cuban counterpart. Upon leaving, they announced that Ecuador would be building three new production plants with Cuba's help. The new

plants will manufacture agriculture goods, medicines, and vaccination, an indication that the biopolitical ideologies of both nations in the future will continue to converge.

## **II. Controversies and Context: The *Año Rural* Reconfigured**

As the Correa administration continues to revamp and restructure the Ecuadorian health care system to emulate that of Cuba's, one aspect of the current system that has been criticized is the *Año Rural*. There are two straightforward remedies for the current problems within the system. One would be to provide the young physicians stationed in the various clinics with the necessary equipment and supplies for greater efficacy in their work. It is probable that this is already a goal that the government will continue to work towards, regardless of any additional changes. A second change involves a personnel readjustment—instead of placing recently graduated doctors in settings that add additional pressures, employing physicians who are more experienced and already accustomed to such pressures could produce higher measures of health—importing the Cubans. The Ecuadorian government claims that the primary rationale for their arrival is to increase access to biomedical care to areas with poor access (“Médicos De Ecuador Se Oponen a Contratación De Galenos Cubanos”). The actual placement of these new imports has yet to be publicized.

Ecuador began its rural medical program in 1970 with the passage of legislation that created the *medicatura rural*, now known as the *año rural* program (Cavender and Albán 1937). Unlike other governments that have systems that provide varying incentives for working in a rural setting, Ecuador's law took a different approach. It required that all recently graduated medical students fulfill the program's requirements

before applying for national certification (1938). Because licensure occurs after, the physicians within the *año rural* program are technically practicing unlicensed, refining their craft on populations with no other biomedical access. Such a system devalues the rural (often indigenous) population by relegating their biomedical needs to a lower classification. True, the Ecuadorian government does acknowledge the disparities between the populations, but the system is structured so care is not delivered efficiently. It continues to rely on physicians who simply do not yet have the adequate training to properly tend to their local patients. The stated goal of inserting Cuban physicians into these areas could potentially alleviate some pressure from the young Ecuadorian physicians while improving the Ecuadorian governmental image within the population. The effort to staff clinics with long-term doctors, relatively speaking, portrays a better image than the current stop-gap approach where physicians are not allowed time to become rooted within the community.

A survey of physicians during their *año rural* year during the 1990's reinforces this notion of poor preparation. 57% of respondents reported no type of orientation prior to the beginning of their service. Additionally, another 16% acknowledged that they did participate in an orientation program, but they found it unsatisfactory (Cavender and Albán 1940). Any physician with Ecuadorian citizenship who wishes to practice in Ecuador is subject to this mandate. Upon returning to Ecuador, students who attended foreign medical schools, such as at ELAM, are required to complete their year of service. However many of these students return already with a specialization, which translates in to being assigned to a large urban hospital, ultimately defeating the purpose of the *año rural* (Huish 2013: 134). Dr. Garcia explained to me the various problems with the *año*

*rural*; her opinion is not unique. Dr. Garcia affirmed the goal of the program, for physicians to repay the people of Ecuador, particularly the marginalized, with their newfound skills. She was quick to tell me that fortunately, she completed her stint for the *año rural* in the greater Quito area. This only reemphasized the notion that the idealized foundation for the program can become lost on new physicians.

Although the program began decades ago, its set up perpetuates the marginalization of those always already susceptible to such treatment. Though physicians have received all their formal training, they are only beginning the equally valuable process of informal training. President Correa has made a concerted effort to remove barriers for the indigenous communities, but this system appears to contradict some of those efforts. Concerning increased agency, the indigenous communities appear to have made gains in the national political discussion, though similar results have not been witnessed in terms of biomedical access. Without consistent access to public biomedical care that is comparable to that provided in urban areas, measures of success in other sectors, such as education, will never realize their full potential in rural Ecuador.

In order to grasp the challenges within the current *año rural* system it is best to investigate the universal issues that most countries face concerning physician employment in a rural setting. Compulsory requirements to serve in a specific medical setting are often both ineffective and problematic, while intangible aspects such as training opportunities, career development prospects, and living and working conditions are characteristics that matter more than tangible benefits such as wage increases (Serneels et. al 342). For instance, in Vietnam, physicians who were raised in a rural area were twice as likely to return to practice in one when compared to their urban

counterparts, which can be attributed to the moral responsibility they felt they owed to their communities (Vujicic et. al 972). That is not to say that financial incentives are negligible in physical recruitment. A meta analysis on physician geographic location that incorporated financial lures towards rural areas concluded that “...financial-incentive programs have placed substantial numbers of health workers in underserved areas and that program participants are more likely than non-participants to work in underserved areas in the long run, even though they are less likely to remain at the site of original placement (Bärnighausen and Bloom).”

Thus, by perpetuating an ineffective system in which rural service is compulsory without addition financial compensation, the Ecuadorian government could potentially dissuade physicians from choosing to practice in such a setting permanently. The added combination of little personnel support, few biomedical resources, with no financial supplementation creates a program where neither the patients nor the physicians are often entirely satisfied in terms of biomedical results. The same survey did emphasize that 94% of participants did feel that their year of service during the *año rural* provided for a rewarding experience overall. Many respondents alluded to a sentiment of greater cultural awareness, resulting from their stint in an unfamiliar area (Cavender and Albán 1943). Therefore the system does provide some form of benefit, though not in the envisioned biomedical sense which is a primary impetus for major change to the system.

The *año rural* has persisted mainly for the increase in biomedical access that the service provides to rural areas populated by the lowest socioeconomic group. In 2013

31% of Ecuador's population lived in a rural area compared to 25% in Cuba.<sup>19</sup> The average is 21% in Latin America and the Caribbean.<sup>20</sup> Within the past decade Ecuador has greatly augmented its pool of physicians, but those results have not translated to greater biomedical access to its disenfranchised citizens in rural Ecuador. From 2002 to 2013 Ecuador increased its physician workforce by 54.8% to nearly 32,000, however the percent change of physicians practicing in a rural setting via the *año rural* was only a mere 0.7% increase (Ecuador 22). Physicians are on a one-year rotation, meaning a completely new set of replacement doctors arrives annually. One would expect such a sharp rise in the overall physician caused by a spike in medical students; thus, an increase of 0.7% seems disproportionately low. Similarly, the percentage of rural physicians<sup>21</sup> did not proportionally increase with overall physician growth. Including both general practitioners and specialists, only 8.4% of physicians work in a rural setting, a low figure considering that the rural population is nearly one third of all Ecuadorians (49). The market for specialists is primarily concentrated around urban centers, further reducing the likelihood that physicians will practice in rural settings. With 75.1% of physicians being specialists, the remaining pool of general practitioners, those who typically provide the first phase of care in rural areas, is markedly reduced (49).

For reasons not stated by the Ecuadorian Ministry of Public Health, no major domestic effort has been made to recruit more physicians to rural areas. In a similar

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<sup>19</sup> It should be noted that since 1995 Cuba has reported a rural population of 25%, indicating that either population statistics are not regularly updated or the government tightly controls internal movement.

<sup>20</sup> "Latin America" here only includes developing countries, eliminating certain high income economies in the Caribbean such as Trinidad and Tobago and the Bahamas.

<sup>21</sup> The term "rural physician" is distinct from the *año rural* program. The former is the classification for physicians who simply work in the rural setting, not the recently graduated medical students belonging to the latter.

fashion, no real changes have brought any positive results to fruition within the *año rural* program; the stagnant data signals that the ministry is shifting tactics to increase biomedical access. Consequently, the Correa administration has chosen to rely on Cuban physicians as contracted staffing; that is, as an external source to occupy the areas in which many nationals do not want to practice. In sum, the Ecuadorian government appears to have come to terms and accept the flaws within the current system, but has chosen to maintain the status quo to some extent. Instead, the Ecuadorian Ministry of Public Health is reconfiguring another system around the *año rural* program instead of restructuring it from its core. Perhaps this new interface between the *año rural* program and practice of stationing Cubans in similar environments will effectively improve the former by increasing the physician to rural Ecuadorian ratio. This would help to reduce the number of patients seen by Ecuadorian physicians, potentially improving the quality of care. Thus, if implemented carefully, few changes could be made within the *año rural* program, but the biomedical results and physician experiences could overwhelmingly improve thanks to the greater health care environment in which it operates.

### **III. Reshaping the Political Terrain**

It is impossible to discuss the current political climate in Ecuadorian health care without including a recently implemented law, *El Código Orgánico Integral Penal* (COIP), which redefines what crimes are punishable by imprisonment. The law is prefaced with the following motives:

Ecuador has recently suffered profound economic, social, and political transformations. The 2008 constitution places the obligation for the national judicial system to be revised. The mixture of different legal systems within Ecuador, including various legal bodies that are difficult to unite, has generated a

perception of impunity and lack of confidence (The Rep. of Ecuador, *Código Orgánico Integral Penal* 9).

The law was passed and is beginning to be implemented with relatively little attention, with one major exception. There has been significant criticism from individual Ecuadorian physicians, along with the more organized and louder voice of the Ecuadorian Federation of Doctors. Their primary concern is Article 146, which codifies sentences of incarceration from three to five years for medical malpractice (61). Many doctors worry that suits against them could become common practice, evidenced by threats of resignations and various protests (Sosa). Jail sentences will only be applicable if the cases are tried in a criminal court. In a recent interview conducted by a national Ecuadorian newspaper with the Executive Secretary of the Ecuadorian Federation of Doctors, Dr. Álvarez, he downplayed the notion that a large number of criminal cases would be mounted against Ecuadorian physicians (*Interview with Executive Secretary*). He stated that his concern emerged from the high potential of civil law suits, in that they would be an easier case for patients to win. He estimated that doctors could be fined upwards of \$1,000,000. In nearly any developed country that sum would be large, although it is an estimate so it could be much larger. Considering the relatively low salaries of Ecuadorian physicians, such a steep fine is severe.

A compounding factor that physicians will face is the absence of any system of malpractice insurance. Although some argue that this is one mechanism that keeps overall health care costs down, it is also viewed as a necessity when the prevalence of civil malpractice cases rises within a country. Without a fallback for physicians, many of them view the new law not from the viewpoint of those who have been mistreated by the



system, but rather an attack on their profession from the Correa administration. Dr. Álvarez also provided a scenario, which is highly likely to occur in Ecuador. He questioned if the COIP could be applied to a situation in which a doctor was unable to provide basic, albeit lifesaving, care in an emergency setting due to a lack of resources. Could the doctor be held liable in such a situation? Should such clinics or hospitals still be accredited and kept open? Subsequently, the public dialogue has been highly charged and filled with accusations and misinterpretations of facts. Perhaps even more troubling for the opposition is not what is explicitly expressed within the law, but rather its ambiguity. Article 146 only takes up approximately one-half of a page within the law, but has the potential to have the largest impact. Therefore one goal of the Ecuadorian Doctors' Union is that the law provides a more detailed description of what the article entails.

The spirit of the COIP in of itself is not being contested—various doctors as well as those outside of the medical community agree that Ecuador has a history of physicians evading the repercussions of mistakes for which they ought to be responsible. Virtually all seemed to agree that the creation of a malpractice law was a step forward, but that the letter of the law is still inadequate. The Ecuadorian Doctors' Union and the Correa administration are currently in discussion to find a viable solution (Interview with Executive Director).

As mentioned before, there has been a constant flurry of rumors and threats in the national news of physicians publicly talking about resigning in protest against the COIP. In January of 2014, President Correa combated such threats in an announcement stating, “We have 750 doctors available who are able to come to the country to work... The

Ministry of Public Health will start to prepare and the Secretary for Higher Education, Science, Technology, and Innovation will recognize their diplomas (“750 medicos podrían venir”).” A similar instance occurred in February, where more than 1,000 Ecuadorian physicians marched and protested in front of the Ministry of Public Health in Quito. Again the Correa administration responded with strong rhetoric claiming, “3,000 doctors from countries who are our friends will replace those [Ecuadorian physicians] who resign (Sosa).” Public spats between the government and physicians only exacerbate the tensions that already existed. The arrival of 200 Cuban doctors in August of 2014 had been planned for approximately a year prior, but one cannot help but see the threat made by President Correa and new foreign doctors hired by the Ecuadorian government while tensions remain high. There is no definite, clear link between the creation of the COIP and the recent acquisition of Cuban physicians by the Ecuadorian government. However, I argue that the two situations cannot be easily separated when the entire biopolitical landscape is taken into account.

In a newsletter from the Ecuadorian Doctors’ Union published in September of 2014, a section titled “The Strategy of Importing Cuban Doctors” reacts to the official arrival of Cuban doctors in August. The brief article claims that, according to President Correa, there are around 800 foreign doctors working within the country, the majority being Cuban (Pacheco). It elaborates on the Ecuadorian government’s supposed reasoning for their employment and refutes it:

The justification was that the Ecuadorian professionals did not accept jobs in isolated and far away places. Nevertheless, almost all of the Cuban physicians are in major cities; the remote locations and suburbs continue to lack health care access. That is evidence that the true objective of the [Ecuadorian] government is to maintain an atmosphere of fear of dismissal through firings in order to continue the exploitation of Ecuadorian physicians (Pacheco).

The union continues its criticism by taking aim at the Cuban government for abusing the labor rights of the Ecuadorian people, in an apparent attempt to delegitimize the greater theme of Cuban international medicine. This attempts to paint Cuba as a hypocrite, claiming it is a party in the Ecuadorian health care capitalistic market by “forcing out” local practitioners. Correa’s strong action against Ecuadorian doctors might be a deliberate way to prove his government’s legitimacy. The union portrays Cuban physicians as mercenaries who are easily hired out irrespective of local geopolitical consequences for nationals. Yet, as I argue in the following section, Cuba and its doctors view themselves more as missionaries, delegates charged with embodying Che and Castro’s revolutionary medicine potentially leading to a shift in political ideologies and cultural beliefs that align with Cuba’s.

#### **IV. Enter Cuba**

The early evidence of a serious bilateral relationship between Ecuador and Cuba began soon after President Correa shifted his foreign policy away from American interests. In 2009, approximately two years after taking office, the two nations signed an initial, open-ended agreement in Havana concerning matters of health (The Rep. of Ecuador, *Convenio Marco De Cooperación* 1). The agreement’s scope is fairly wide due to its exclusion of specific methods of implementation for such health-related agreements; or, this could indicate intentions of long-term cooperation. The bulk of the law provides the legal groundwork for personnel exchanges regarding health care as well as health care education. Each country is made responsible for various factors of the law,

but the burden of Cuba is noticeably greater. According to the agreement, Ecuador must merely provide support to the groups and organizations that bilateral cooperation efforts would need; “support” is not qualified at any point. The role of Cuba contrasts with Ecuador’s vague supportive responsibilities. Cuba must provide scholarships for Ecuadorian students to study medicine or other health-related professions. Additionally, Cuba is required to send experts and specialists to Ecuador to provide assistance to the Ecuadorian Ministry of Public Health. No mention of finances is made, nor any other form of compensation that Ecuador might owe to Cuba.

In 2013 and 2014 two new labor-related laws were created to provide a more concise legal mechanism for the arrival and incorporation of foreign medical professionals into Ecuador. Neither law specifically mentions Cuba (or any country), but I argue the laws essentially exist for the bilateral Cuban-Ecuadorian relationship more than any other group of foreigners. The former law creates a system in which either Ecuadorians living abroad or foreigners with a terminal degree can apply for scholarships to teach, research, or “to transfer knowledge of specialized themes” in Ecuador (Ecuador, Secretary for Higher Education 3). In my research, the Ecuadorian government, beginning under Correa, has cited no other country more frequently as a model and source of support more than Cuba. In recent high-level talks in Havana concerning future joint endeavors, the Ecuadorian Minister of Foreign Affairs highlighted the relationship between the two countries. “There exists a strong relationship of cooperation between our countries. Cuba offers us important support in the areas of health, scientific development, and technology,” he noted (The Rep. of Ecuador “Cancilleres de Ecuador y

Cuba”). Thus, the new labor laws are only a portion of the entire operation that will incorporate Cuba into Ecuadorian health care.

The newer law concerns the more technical aspects of international partnerships, requirements for visa type 12-XI, but is equally important. The law specifies persons eligible for visa type 12-XI must be medical professionals or scientists. Importantly, the new visa law only pertains to *nonimmigrant* science-related professionals, meaning their intended length of stay is definite. Unless the Ecuadorian government announces new agreements with other countries, the cohort of Cuban physicians will be a main beneficiary, if not *the* main beneficiary, of the law. The visa information is prefaced with articles from the Ecuadorian constitution as supporting evidence. The constitution states, “That Article 387... establishes that the State will be responsible for promoting the formation and production of knowledge, strengthening the ancestor wisdom, promoting technological and scientific investigation, all in order to contribute to the fulfillment of *Buen Vivir*<sup>22</sup> or *Sumak Kawsay* (Ecuador, Secretary for Higher Education 19).” In sum, it is the responsibility of the national government to advance both theoretical and practical knowledge within the scientific (biomedical) community. This concept of the constitution is an addition that did not exist in previous one, and it need not be overlooked. The state, by law, is required to expand the pool of biomedical knowledge, a charge it appears to be taking quite seriously. Although Cuba and Ecuador have had a semblance of an established program, only now can the national government fully endorse and expand into a large-scale comprehensive biomedical program staffed by

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<sup>22</sup> Specific phrase adopted by the Ecuadorian state under the new constitution. English translation: living well (as opposed to living better).

foreigners.<sup>23</sup> I propose that the creation and approval of these laws by the Ecuadorian legislature, spearheaded by the Correa administration, cannot be considered coincidental. Superficially, the new labor laws are vague in their lack of specificity concerning their target population, but so far Cubans are the only foreigners en masse to see the fruits of the laws.

The Ecuadorian state appears confident in the caliber of a Cuban diploma, as already automatically recognizes degrees from universities in Cuba, Chile, and Peru as valid; but, this automatic approval is not completely agreed upon. Those applying to the Ecuadorian program from any of the aforementioned countries will therefore have no trouble in demonstrating the quality of their education. A source of discord regarding the weight a Cuban medical degree should carry, comes from Ecuadorian physicians. Although Cuba routinely receives international acclaim for the superior quality of its medical training, there are those in opposition. In my interview with Dr. Ortiz, dean of a well-established medical school in Guayaquil and former director of a large Ecuadorian hospital, he speaks to the quality of Cuban medical training. Dr. Ortiz explains that as dean, one responsibility is handling searches and contracting professors for the medical school. Dr. Ortiz recalled that for several years he received frequent emails, one or twice per week, from Cuban physicians with their resumes and cover letters attached:

As of late I'm receiving very few [emails], for several I didn't receive one, that is, resumes from Cuban physicians that are ready to come and teach anything. What I wanted to mention is that the resumes from the Cubans who offer their services to come as professors caught my attention, but we didn't hire any. One of the reasons we have not been moved to hire them is because they do not inspire much confidence. That is due to the amount of degrees and specializations that they

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<sup>23</sup> A reference to *Operación Milagro*, a program established before the Correa administration in 2006. Cuban physicians provides basic eye care and procedures at their clinic in Latacunga.

have. For example, people with three or four specialties, specialties very different: Psychiatrist and surgeon, or pediatrics and neurology, but not a pediatric neurologist. For us, as a university, it does not give us much confidence. It doesn't seem that the formation there [Cuba], while yes it is serious, the practice and experience...I highly doubt it could be good quality. I have never seen resumes like the Cubans are sending.

Two aspects of this situation are of particular interest, the first being that these physicians are actively seeking employment outside of Cuba. This could mean that some Cuban physicians are actively seeking permanent employment outside of Cuba. Typically, Cubans practicing abroad do so through bilateral agreements created by Cuba, not individuals. It remains unclear as to whether the Cuban government would approve these situations or if individuals would need to defect. Second, Dr. Ortiz and his staff might already perceive the Cubans as a threat to their employment, regardless of their arrival process. I use this excerpt to show that not all unequivocally agree that the complete formation of Cuban physicians is a high caliber, in contrast to statements made by reputable entities, such as WHO. Furthermore, Dr. Ortiz makes the subtle distinction that perhaps the theoretical or classroom-based pedagogical formation is reliable, but the essential hands-on knowledge might be lacking. Thus, their formal educational formation will not be assessed accurately, regardless of the quality.

The opinions expressed by Dr. Ortiz should provide insight into the politics of educational institutions and potential reactionary stances they might take as more Cubans enter the health care system. These attitudes contradict the legal steps the Ecuadorian government has already taken to permit the arrival of Cuban medical personnel. The tension between the government and private sector only reiterates that Cuban physicians will be employed by the Ecuadorian state. Therefore, the atmosphere of welcome the

Correa administration has created both legally and rhetorically does not necessarily reflect the atmosphere of the actual Ecuadorian health care system.



## CHAPTER SEVEN: CONCLUSION

The phrase “We live like the poor, but we die like the rich,” allows Cubans to accurately articulate the complexities of the society in which they live. “Luxuries” that the rest of the world has access to (whether it is affordable is another matter) are not always available in Cuba. Ironically, it is the Cubans who have access to some of the best biomedical care in the world, at no charge. Cubans take comfort in the knowledge that they while they fall short in material goods, they have a privilege that few other countries share. The island of only 11 million inhabitants has made surprising accomplishments through the provision of accessible and comprehensive health care that is efficiently delivered—a feat no other developing country has been able to achieve. The superior health of the Cuban national body has been realized despite the United States’ failed attempts to dismantle the communist government. True, the U.S. embargo has undoubtedly limited the availability of new technologies, but Cubans have persevered, demonstrated by the system’s ability to adapt and change to an unrelenting American foreign policy. Cuban health care has not suffered serious, or prolonged, decline in the standard of care; it still experiences a progress unique in of itself.

Cuba’s motives for delivering health care abroad and educating a targeted population in revolutionary medicine have been called into question. Does Cuba focus on international health care to gain political ammunition or out of an altruistic concern for

fellow man? Dr. Williams agreed that the question is often posed, but responded, “Does it really matter?” Cuba will never admit that it keeps international humanitarian efforts ongoing to better its international perception. Though, perhaps it does not matter what its motives are. Either way, its actions do gain them political goodwill and sympathy. Cuba utilizes its biomedical strength via such projects to reshape foreign national bodies into ways that embody some of Cuba’s revolutionary principals. By forming robust bilateral relations in health care, Cuba has changed the way in which governments view their own challenges. By addressing the maladies present within their own national bodies and taking steps to eliminate them, countries are then allowed the opportunity to solidify their national ideology and act accordingly.

On the other hand, Ecuador has no added barriers from foreign countries, and its citizens have access and freedoms that Cubans have lacked since the Revolution. Though, Ecuador still remains a stratified society, particularly evident in the health-related disparities between ethnicities, as well as between rural and urban areas. Both its quality of care and access remain below Cuba’s standards. Not only does Cuba have superior health care indicators, it also commands more attention in the geopolitical region, drawing in other Latin American countries associated with the “Pink Tide” to become partners. Members of these new networks, ALBA being the prime example, have much to gain from an alliance with Cuba. Ecuador has successfully shifted its alliance towards Cuba without causing any major, prolonged rifts in its relationship with the United States. Even better, it has benefitted from its Cuban alliance while simultaneously established itself as a new Ecuador in Latin America.

President Correa emphasized when he assumed the presidency that his sovereign nation will no longer play a role to support the American dominance in the hemisphere. The country instead has taken steps to model itself after countries that greatly contrast to the United States. Ecuador seeks to mimic Cuba in the ideological and physical provision of health care. If the plan to utilize Cuban physicians is successful, this success will not only mean the improvement of the Ecuadorian national body. Success will also affirm Cuban international health, with the principles of the Cuban Revolution at its core. It will also validate President Correa's trust in Cuba and spur growth in the Cuban-Ecuadorian partnership.

When I began my research in fall 2013, it was not evident that there was a strong relationship between Cuba and Ecuador. The two governments had various, minor agreements, but nothing substantive or long-term. Though, the partnership was foreshadowed by indirect actions such as Ecuador's growing relationship with Venezuela and its member status in ALBA. Even though that the first wave of Cuban physicians has arrived, it remains to be publicized where they are stationed and what the results of their labor will be. Their work must be deemed effective and valuable in order for the partnership in health care to grow. If major problems appear early, it could jeopardize the remaining hundreds of Cubans slated to arrive.

Another factor that could affect the overall Cuban-Ecuadorian relationship is Venezuela's role within the region and relationship with Cuba. Since sliding into internal turmoil after Chavez's death, Venezuela's new leader, Nicolás Maduro, appears unable to maintain the country's leadership role in the region and preoccupied by domestic affairs. Maduro's need to focus on Venezuela's domestic problems could potentially weaken the

Cuban-Venezuelan relationship. Additionally, the widespread violence could cause the Cuban government to withdraw physicians out of safety concerns. The remaining void left by Venezuela could provide Ecuador the opportunity to grow its prominence in the region as well become a stronger trading and ideological partner with Cuba. Thus, there are numerous factors that have the potential to strengthen Ecuador's ties with Cuba, or to derail the current partnership on healthcare. More time is needed to see if the relatively new relationship will continue its current path in which culture, goods, and ideologies are exchanged, or if it will digress into a relationship based mainly on trade.

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