

Ebola control: the Cuban approach

For the World Health Report 2006 see http://whqlibdoc.who.int/publications/2006/9241563176_eng.pdf

More than 160 Cuban doctors and nurses arrived in Sierra Leone on Oct 2, 2014, to support local teams in controlling the Ebola epidemic. 300 more are being trained in Cuba at present and will be on their way to Liberia and Guinea in the coming weeks. The worldwide response to the Ebola epidemic has been slow and small. More nurses and doctors are certainly needed, not only from Cuba, but also from other countries.

The Cuban health-care system is capable of responding to international crises quickly. After the 2010 earthquake in Haiti, more than 1000 health-care professionals were deployed. Cuba has provided free medical training for Haitians, graduating nearly 1000 doctors, with a further 400 in training at present. The Cuban approach to a crisis is not just a high-profile acute-phase response, but also involves going to where services are most needed, working with local communities, setting up infrastructure, with a long-term view.

Cuban medical education is backed by a rigorous accreditation system, which includes medical schools established in partnership with other Latin American and African countries.¹ The Cuban approach emphasises prevention and social responsibility. Although conventional medical education trains all doctors to a particular level at which they can choose their specialty, primary care being one of these, the Cuban model (curriculum runs for 5 years with a 1 year internship) trains all doctors to become primary care and community practitioners first; further specialisation comes later. This approach is especially relevant in low-income countries where a commitment exists to universal health coverage with few financial and human resources.

The stated goals of the Cuban medical education system are to scale up physician training to meet

the needs of the whole population; recruit and train scientifically prepared and socially committed students; and match competencies, knowledge bases, and the scope of responsibilities to the concrete health needs of people in Cuba and other countries where these future physicians might serve.² Moreover, the Cuban approach delivers better health outcomes at lower cost than most health-care systems.³

During the past 50 years, the Cuban Medical Cooperation programme has worked in more than 100 countries. In 2013, more than 50 000 Cuban health-care professionals (19 000 of them medical doctors) were present in 66 countries, mostly in rural and remote areas. Since the establishment of the Latin American School of Medicine in 1999, it has trained over 20 000 doctors from Latin America and the Caribbean, Africa, and Asia, offering free scholarships to students coming from rural, remote, and low-income families.

The transferability of the Cuban model of training in Africa is now well established, with medical schools established in Angola, Equatorial Guinea, Guinea-Bissau, Eritrea, and Tanzania, and partnerships with existing African universities in 25 countries. To date, these initiatives have graduated over 560 doctors, with a further 5700 in training. The Cuban model might well deliver better value for money in Africa and is redressing the inequity in rural-urban distribution of doctors.

Worldwide, medical education has not kept pace with health challenges; it is fragmented, outdated, and produces ill-equipped graduates for patient and population needs.⁴ The effects on the health-care system are profound: poor teamwork; predominant hospital orientation at the expense of primary care; and weak leadership to improve health-care system performance. A redesign of professional health-care education is necessary.

In May, 2014, the World Health Assembly called for a Global Strategy on Human Resources for Health

in response to slow progress in expansion of the workforce since the World Health Report 2006. Universal health coverage will only be achieved if health-care workforce challenges are addressed,⁵ and yet, examples of effective action are few. The Cuban model of medical education—supporting the rapid expansion of the health-care workforce in partner countries and responding to worldwide crises, such as Ebola—provides a rich case study to inform the Global Strategy on Human Resources for Health.

In their analysis of the Cuban health-care system, Cooper and colleagues⁶ stated that “If the accomplishments of Cuba could be reproduced across a broad range of poor and middle-income countries the health of the world’s population would be transformed.” Surely the time has come to put this statement to the test.

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For details of the Haitian medical training see http://medicc.org/ns/documents/MEDICC_Field_Notes_from_Haiti.pdf

For the Global Strategy on Human Resources for Health see http://www.who.int/workforcealliance/knowledge/resources/strategy_brochure9-20-14.pdf?ua=1