TWO DISTANT ISLANDS UNITED BY A COMMON GOAL:
IMPROVEMENT OF THE PUBLIC HEALTH SYSTEM
PREFACE

It is of great satisfaction for both Regional Offices of WHO, AMRO and SEARO to document Case Stories of horizontal cooperation between Member States across WHO Regions, particularly when the achievements are so significant, and when proven strategies like the Primary Health Care approach are applied in the quest for extending Universal Health Access to the population.

Cuba is definitely a leading country in the AMRO Region in terms of its equitable public health achievements, starting with polio control and elimination and continuing with maternal and child health, and now with the effort to control chronic diseases and monitor risk factors. Cuba’s willingness to support other Member States in achieving better health outcomes is also widely recognized and appreciated.

Timor Leste, as a relatively young Member State that had to face reconstruction of its entire health system and health work force after independence, was in dire need of international support from countries that could understand the challenges and support the building of national solutions to those challenges with relevant and appropriate approaches and technologies. WHO has been supporting the development of human resources for health and facilitating the access to health information through for example, the ePORTUGUESe platform as well as through the Blue Trunk Library.

As the Agreement between Cuba and Timor Leste for health development reaches its tenth year of operation, WHO is proud to have witnessed and accompanied these efforts that have been mutually beneficial for both countries, and of supporting the documentation of this particularly successful endeavor of technical cooperation between Cuba and Timor Leste, leading to a sustainable health system.

WHO encourages other Member States to continue their solidarity efforts to help each other reach the health goals that have been established collectively, in the best spirit of collective self-reliance, guided by a heightened awareness of our deepening inter-dependence in a globalized world.

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Cuba and Timor-Leste seem so remote from each other even the mere mention of the name of one evokes thoughts of an exotic place for the other. There are substantial differences in languages, idiosyncrasies and cultures, however they appear to have overcome those dissimilarities and have reached a good fusion between the Caribbean and South East Asia for the common goal of improving Timor-Leste’s public health system. The two islands have become protagonists of an international solidarity exchange between the global south with one important focus: sustainable quality health care.

After ten years working together, Cuba and Timor-Leste realized that they have much more in common than the tropical weather. Empathy for each other’s populations seems to exist from high-level politics to the grassroots level, between teachers and students, doctors and patients. The Timorese First Lady, Isabel Da Costa Ferreira expressed, “we have a history of suffering in common and the same fight for freedom. This makes it so that both countries have a friendship, like brothers. This happens to be the starting point of the solidarity between the two countries”.

The Cuban Ambassador in Timor-Leste, Luis Julián Laffite, agrees with the First Lady stating that, “there is a big similarity between Timor-Leste and Cuba because both are tropical weather islands, even if they are 25,000 kilometers away, both have the same tropical diseases”. Both Timor-Leste and Cuba are developing countries that have championed self-determination. In the aftermath of their struggles, the initial situation in both countries, with respect to health infrastructure and medical professionals, was very poor.
The embryo of health cooperation between Timor-Leste and Cuba was formed in the XIII Summit Conference of the Non Aligned Movement held in Malaysia in February 2003. There, three leaders met: the Cuban president at the time, Fidel Castro; the then President of Timor-Leste, now Prime Minister, Xanana Gusmão; and the Foreign Affairs Minister at the time, now head of the United Nations Integrated Peacebuilding Office in Guinea-Bissau, José Ramos Horta.

In April 2004, the collaboration between the two islands was concretized with the arrival of the first group of 15 Cuban doctors in Timor-Leste. Nevertheless, the bilateral agreement was not signed until December 2005. The agreement, which focused on a sustainable health system, included the provision of both Cuban doctors and professors to teach as Medical Faculty. The Timor-Leste representatives for the agreement were Mari Alkatiri, at that time Prime Minister, and Rui Maria de Araújo, Minister of Health from 2001 to 2007.

The request for Cuban doctors to come to Timor-Leste began in 2001, as Rui Maria de Araújo explained. A letter from the World Health Organization/Timor-Leste office was sent (even before the country was recognized as independent) to the Pan-American Health Organization/Cuba office expressing Timor-Leste was interested in requesting Cuban doctors to serve in the country.

INITIAL SITUATION

In order to understand the original conditions that surrounded the agreement, it is necessary to have a look at the background. Timor-Leste was a colony of Portugal up to late 1975, when they declared their independence. Indonesia invaded within days of the Timorese declaration of independence and a 24-year fight for resistance against the Indonesians ensued. The conflict resulted in hundreds of thousands of deaths (an estimated of 24 percent to 28 percent of the Timorese population) from execution, famine, and lack of the most basic medical care. There were hundreds of thousands of refugees in the mountains within Timor-Leste as well as outside the country.
By the time a referendum to grant Timor-Leste’s independence from Indonesia was passed in 1999, the country was destroyed. Most of the infrastructure, including homes, irrigation systems, water supply systems, schools, buildings and nearly 100 percent of the country’s electrical grid were devastated. The United Nations (UN) directly led the country until 20 May 2002, when Timor-Leste officially became an independent nation. The security mission, established to help the island’s barely functioning government and infrastructure systems, ended in 2005.

In 2006 internal tensions threatened the new nation’s security when a military strike led to violence and a breakdown of law and order. This led to the need for a new peacekeeping presence. The UN peacekeeping mission ultimately left the country in December 2012.

For one and a half years (from the 1999 referendum to 2001) there was no Ministry of Health. Since the UN was in charge of the administration of the whole country, health was one division within the UN structure.

Rui Maria de Araújo describes the early circumstances, “in 1999 when the international cooperation of the UN, the WHO and the Word Bank started, we did an assessment. 70 percent of the health structure had been destroyed, 80 percent of the health workers had returned to Indonesia. The health status of the population was in a very bad shape. Infant and maternal mortality were very high; malnutrition, infectious diseases and communicable diseases were also very high. The UN appointed the WHO to establish a healthcare network. At that time, there was no an organization
to handle the health issues in Timor-Leste. A few Timorese doctors and senior nurses took the initiative to organize a ‘Timorese Health Professional Working Group’ that became the counterpart of WHO at that time. It was only on the 20th of September in 2001 that the Ministry of Health was created”.

When the cooperation agreement between Cuba and Timor-Leste was signed, the healthcare system needed to be reconstituted from the ground up. As Rolando Montero, Coordinator of the Cuban Medical Brigade, explains, “the country had no health infrastructure and equipment, they just had 50 doctors (this was a very small number in proportion to the country’s population), the population had no access to health services, with a life expectancy of 57 years, and a high infant and maternal mortality rates. With regards to hygiene, the population had no fundamental education. The population mostly relied on traditional medicine”.

**PERMANENT PRESENCE OF THE MEDICAL BRIGADES**

Currently, the Cuban Medical Brigade in Timor is composed of 140 collaborators of which 110 are medical doctors. It has a big training component, with 107 out of 110 physicians involved in the medical education process in Timor. In fact, being a professor or assistant professor is one of the requisites to becoming a part of the Brigade. Hence, from its inception the cooperation between both countries was clearly geared towards sustainability.

According to data provided by the Cuban Medical Brigade, since their arrival in Timor 10 years ago, they have seen 8,971,195 patients. Of these, 53.1 percent where for medical consultations and 46.9 percent were home visits. Additionally, the Brigade has attended 55,880 births, and performed 82,805 surgeries (of which 19,653 were major surgeries). The Cuban Brigade calculates that, as a result of their work, a total of 22,944 lives have been saved.
The Brigade is present at the Guido Valladares National Hospital, located in the capital Dili, in addition to five reference hospitals, all primary care centers and several district and sub-district health centers. At the primary care centers, general practitioners perform most of the medical consultations, but many specialists (internist, pediatrics, obstetricians, and dermatologists, among others) are involved in consultations.

In addition, students complete part of their practical training at the primary care centers.

Cuban doctors keep track of data about the population they take care of. Thus far, the data shows that the most common problems are: malnutrition, intestinal parasitism, acute respiratory infections, acute diarrheal diseases, tuberculosis, malaria, and dengue. Other common conditions are non-communicable diseases like hypertension and cancer.

The most common risk factors are lack of hygiene, and consumption of coffee, tobacco and alcohol. Doctors have come to an agreement about the low perception of risk by the population due to scarce health education, thus enhancing education to patients is a primary goal of their mission. Another common risk factor is betel quid consumption.
This addictive psycho-stimulant inhibits hunger and plays an important role in Timorese cultural practices. It is often chewed during social gatherings. In addition to its stimulant effects, the International Agency for Research on Cancer reported that the betel quid causes oral cancer, cancer of the pharynx and cancer of the esophagus.

An additional common problem is trauma related to motorcycle accidents. As a matter of fact, the majority of the Intensive Care Unit patients at the National Hospital are admitted post-surgery after having suffered road traffic injuries.

A considerable segment of the population that had no access to doctors during the Indonesian occupation and the first year of independence, have been attended to since the arrival of the Cuban Brigade. This includes a large portion of the population outside of the urban area of Dili. The Cuban Brigade has established services in all 13 districts of Timor-Leste, covering 72 percent of the population. Some specialties, in the Timorese public health system are only served by the Cuban Medical Brigade. Such specialties include, for example, pulmonology, neurology, psychiatry, urology, nephrology, radiology, neonatology, oncology, vascular medicine, gastroenterology, microbiology, oral and maxillofacial surgery, otorhinolaryngology, pathological anatomy and forensic medicine.

Cuban cooperation with Timor-Leste is not an isolated agreement. Since May of 1960, Cuba has offered medical cooperation to 108 countries. Over 40,000 Cuban health professionals provide health services in Latin America, Central America, the Caribbean, Africa, Asia and the Pacific. The countries with the most presence of Cuban health professionals are Venezuela and Brazil.

Cuban first-line health care, based on the family medicine concept, is part of the Cuban Integrated Health Program. Priority is given to the placement of professionals in rural areas of the hosting countries.
EMPOWERING WITH EDUCATION FOR SUSTAINABILITY

The best course of action to maintain the same results of the Cuban Medical collaboration is through offering East Timorese health care workers academic training. In 2004, the first group of 18 Timorese students went to Cuba to begin their first five years of education. In 2009, they came back to Timor-Leste for their sixth year and the resident medical internship, and in 2010 they graduated from medical school. More than 700 Timorese students have travelled to the Caribbean island to begin their careers there.

The General Medicine School in Timor-Leste was opened on December 5th 2005, with 55 students. Timor-Leste is not the only country where Cuba has been included in the structure of a medical school abroad. Currently, 49,000 students are enrolled in decentralized academic training programs in Angola, Bolivia, Eritrea, Gambia, Guinea Bissau, Guinea Equatorial, Nicaragua, Tanzania and Venezuela.

At present there are 256 students enrolled in the Timorese General Medicine School, divided into four districts with the majority of them, 205, in Dili. The educational program lasts six years and graduates are trained as family doctors. Cuba pledged to train 1,000 Timorese and to date they have reached 81.9 percent of their goal, with 819 doctors (802 graduates and 17 graduates to be). Those graduates represent 85.4 percent of the general physicians of the Timorese system.
The National University of Timor Lorosa’e is an autonomous institution that was founded in 2000. The Medicine and Health Sciences Faculty was created in 2010 and the School of General Medicine is part of this Department together with the Nursing School, the Midwifery School and the Health Technologies School. Only the medical training is linked to the Cuban collaboration, however.

Joao Martin Soares, Dean of the Faculty, is also a professor of the Medical School, together with the Health vice-minister, Maria Do Céu. Martin Soares explained that the Faculty accepts 100 to 150 students every year. Ana Valdez Vento, Director of the Medical School, gave further details about the General Integral Medicine Program stating, “it includes education at the work place in order for the students to be prepared to work as soon as they graduate”. There is a seven-week rotation period in Primary Care Centers. There are currently 62 students (that belong to the third, fifth and sixth year) at the National Hospital who are completing rotations in several medical specialties.

All classes are taught in Spanish. From 2005 to 2010 students were only receiving a four-week Spanish class session and this was a big obstacle, not only according to students but also to professors. However, starting in 2010, Spanish classes were incorporated during the entire first year as part of the basic studies or the pre-medical school, as well as Portuguese and English. Malaria, chagas disease, tetanus and tuberculosis are some of the areas of study that have been included to the Timorese curriculum since they are already either eradicated or controlled in the Caribbean region.

Regarding the room from improvement in this educational process, both, the Dean of the Faculty and the Director of the School, agree that is necessary to increase the pedagogic material. Students will benefit from a Biomedical Laboratory for Basic Health Science, printed books, anatomical models, anatomical charts and posters. The Dean explains that they have already received some help, “the Nursing School and the Midwifery School have received some specific help from WHO and United Nations Population Fund”.

The Timorese First Lady thinks that the human resource training at the university is the most beneficial outcome of the cooperation agreement. She gives details about the advantages stating, “there is a financial benefit to the students’ families, they do not need to send the students abroad with an enormous cost, considering that the majority of the population is poor. This is also an incentive for high school graduates to choose medicine. In addition to this, the country is getting the know-how to receive medical students in the future from the Asia Pacific region”.

Medical students and graduates are very thankful to the Cuban and Timor-Leste governments for the opportunity; they feel that they are the fruit of the cooperation agreement. “They sent me to study and then serve my country, and I’m here to serve my country”, expressed one of them.

A barrier for new graduates is their young age, not only because the Timorese doctors not trained by the bilateral cooperation agreement are older, but also because they perceive the new graduates as too young and lacking experience. The best student of the 2013 class, Marcelo Amaral Mali, explains his point of view, he believes that there has been a modification in the perception, “New things are questioned in this country.” Amaral gives details about his personal experience, “I went to the National Hospital to bring a family member and he was handled by a graduate of my school –up to that moment he had a bad perception of Cuba trained doctors. After the visit, he was very satisfied and would like to have that doctor every time he goes to the hospital”.

Since the medical field requires specialization and a continuous educational path, the Cuban government has expressed the intention of receiving 30 Timorese graduates in Cuba every year to continue their education. There is currently an ongoing selection process to choose 12 Timorese graduates.

ACHIEVEMENTS OF A TEN-YEAR COOPERATION

María de Fátima Días is a community leader that has donated part of her house to open the Remack Primary Care Center where the first group of Timorese students did their sixth year medical practice. She has acted as a liaison between the two governments and now between the doctors and the community since she speaks fluent Spanish. Días states, “I am very grateful to the Cubans because there have been no child or maternal deaths in almost eight years in the area where this facility is located. But we have to change the mentality of every family; we have to work to change bad habits. If church, government and community work together, we can achieve that”.
The community leader explains the adaptation in the process through the years, “at the beginning the Timorese population was resistant to Cuban doctors and did not want to welcome them in their houses when they visited the community, but now they trust them. The population in general was afraid of the doctors because in our culture when someone feels sick it is because of a curse, so they turn to healers (dukun)”. The religious/culture variable is an obstacle to medical doctors. A large part of the population turns to healers for critical situations like a trauma, so when patients arrive to Primary Care Centers or hospitals their condition have often become irreversible.

The Timorese First Lady has also expressed that she has noted a positive change in infant mortality, especially in comparison to the period of the Indonesian occupation. Nonetheless, the First Lady underlines that this doesn’t mean that “the current situation can be defined as good […] Cubans doctors have been working with heart, passion and the spirit of service in brotherhood. They accompany the Timorese population most in need. With kindness and affection they help our population, this results in providing a feeling of being families. Now they talk to Cuban doctors with trust”.

The transformation of the population’s perception was also mentioned by Marcela Zamora Cisterna, a missionary that manages a boarding school that hosts 66 girls in the Oecusse enclave. He described that, “At the beginning, there were some people that saw Cubans as potential influencers of politics, but after a few years they realized that the Cubans just came to serve the Timorese population”.

An optimistic view is also given by Professor Siripen Kalayanarooj, from the WHO Collaborating Centre for Case Management of Dengue/DHF/DSS in Bangkok, Thailand. He stated that, “I came here in 2005 during the dengue outbreak and at that time I saw only a few doctors from Timor-Leste; most of the doctors where from Japan, Philippine, Indonesia and they came to work here temporarily. But now, in 2014, I am happy to see there are young Timorese doctors everywhere; and more equipment. Everything has been improved. Even the laboratory results now come back quickly”.

In September 2010, in front of the UN General Assembly, José Ramos Horta (not only former Timor-Leste President but also Nobel Peace Prize Laureate) proposed to nominate the Cuban Medical Brigade for the Nobel Peace Prize for its humanitarian mission.
After having heard a number of positive opinions about the Cuban Brigade, it is necessary to have a look of facts through numbers. Various health indicators have improved in Timor-Leste since 2003, when the Cuban Medical Brigade arrived. Timor-Leste has achieved a reduction of a critical indicator. According to the Demographic Health Survey (2009 - 2010), the under-five mortality rate has dropped from 98 to 64 per 1,000 live births. Consequently, Timor-Leste has already achieved the Millennium Development Goal for the reduction of under-five mortality rate by more than two-thirds (96 is the national target).

Similarly, the infant mortality rate was reduced from 60 deaths to 45 deaths per 1,000 live births, according to the Demographic Health Survey, achieving and surpassing the country Millennium Development Goal target of 53. Conversely, the maternal mortality rate is off track in reaching the Millennium Development Goal, even though it dropped from 789 to 557 maternal deaths per 100,000 inhabitants.

Rui Maria de Araújo expressed, “the health system is lucky to have more than 800 doctors trained through the cooperation. Even though we acknowledge that these doctors need more exposure and experience but the basics are there, so in terms of human resources the results are good”. In terms of service provision, he believes that “the decrease in infant mortality rate and under-five mortality rate were influenced a lot by the presence of the Medical Brigade. In public health it is very hard to say if the results are due to medical services or the improvement of social determinants. My question is: Are these improvements due to the combination of all of these factors or is just due to factors unrelated to health care services? I think, even if it is not due to the presence of the medical services and the Cuban Brigade, without them we would be behind. I do believe that the health services provided, with the support of the Cuban Brigade, have had a lot influence on bringing down these mortality rates”.

To assess the progress, it is necessary to take into account data concerning other Millennium Development Goals, like combating HIV/AIDS, malaria and other major diseases. Comparing WHO data between 2006 and 2013, malaria declined from 220 to 0.9 per 1,000 habitants. Furthermore, deaths were reduced from 58 to 3 per 1,000 habitants. HIV remains relatively uncommon in Timor-Leste.

The National HIV/AIDS and STI’s Control Program, of the Timorese Ministry of Health, estimates that 394 persons were diagnosed for HIV cumulatively and at the end of 2013, there were 368 people living with HIV. The first case of HIV was detected in Timor-Leste in 2003.
On the other hand, according to the Global Tuberculosis Report, in 2012 the incidence rate was 498 per 100,000 of the population. Reliable data previous to 2007 is not available to make a comparison. According to the Tuberculosis Report in the South-East Asia Region, the notification rates of new smear-positive cases has been increasing since 2007 and this reflects efforts made in TB control in recent years; however, the increasing trend for all forms of TB has been reverting in 2011 and 2012.

Moreover Leprosy and Poliomyelitis has been declared eliminated as a public health problem in Timor-Leste. On top of those specific achievements, overall life expectancy increased. According to WHO, life expectancy was 58 years in 2002 and 67 years in 2012.

It is important to mention that these health accomplishments are a result of the work of several stakeholders, including not only the World Health Organization, but also the Australian Department of Foreign Affairs and Trade; the United Nations Children’s Fund; the United Nations Population Fund; the World Food Program; the Delegation of the European Union to Timor-Leste; the United States Agency for International Development; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Portuguese Ministry of Foreign Affairs; and the World Bank, and Korea International Cooperation Agency. In addition, various NGOs have contributed to improve health in Timor-Leste such as, Mercy Corps, Marie Stopes International and Health Alliance International. All the development partners involved hold meetings every three months in a cluster called Health Development Partners Group.
MULTIPLE DEVELOPMENT CHALLENGES

Although Timor-Leste seems to be a country that has taken off from a development perspective, it continues to faces immense difficulties. Timor-Leste is one of the 10 poorest countries in the world, so this compounds the complexity of the public health situation. As Herculano Seixas Dos Santos, head of the Noncommunicable Diseases Department of the Timorese Health Ministry, explained, it is necessary to improve health determinants such as drinking water, sanitation, nutrition, and housing and not only the direct health-related indicators.

Seixas is one of the biggest success stories of the Medical School. He is trained as a physician and holds a highly demanding public position. He is an example of self-improvement and socio-educational advancement, the economic support of his ten siblings, and the pride of his farmer parents.

Timor Leste, with its 14,874 square kilometers, has a territory bigger than the Minor Antilles and some of the Greater Antilles. The Demographic Health Survey estimates that the population in 2010 was 1,066,582. The two main sources of foreign currency are coffee and hydrocarbons. More than 50 percent of the Timorese population is still living in poverty. The United Nations Development Program estimates that poverty is concentrated in the countryside, where more than 70 percent of the people live. Timor-Leste also faces a human capital shortage, necessary not only to build a strong economy but also for the effective functioning of institutions.
Most Timorese depend on subsistence crops for their livelihood; mainly corn, rice, coffee and tuber, and as a result experience periods of food insecurity. Additionally, because of traditions and customs, protein consumption such as buffalo, pig and goat, is related to important events like funerals or weddings. When there is a marriage, the husband needs to give his wife’s family livestock, so they raise it in order to use it as a dowry.

Malnutrition is one of the pressing population problems and a strong health determinant. Timor-Leste remains one of the countries with the highest prevalence of stunting (58 percent) and severely stunted grown (33 percent) among children who are under five years. The weight-for-age indicator for malnutrition shows that 45 percent of children under age five are underweight, and 15 percent are severely underweight.

Furthermore, 27 percent of women were found to be malnourished (with BMI <18.5), 15 percent have short stature, and 21.3 percent are anemic. Malnutrition in women is a serious public health concern in Timor-Leste. It results in heightened risk of adverse pregnancy outcomes and perpetuates malnutrition in their children.

Rolando Montero gives details, “nutrition is a multifactorial problem. Poverty is directly linked with resource scarcity and lack of food, this leads to a diet low in calories, proteins and vitamins. Those factors are added to ignorance, illiteracy, ancestral customs and habits acquired as a result of colonial domination and the Indonesia occupation.

An obstacle to tackling health challenges is the underdeveloped media. Mass media can be used not only as an agent to change behaviors and habits, but also for prevention, promotion and health education. The population does not have a habit of reading newspapers. Therefore, TV and radio can have a multiplier effect for any communication campaign the Ministry of Health, the Cuban Medical Brigade or a health development partner undertakes.

Others factors that negatively affect the Timorese population’s health are: low sociocultural, educative and sanitary levels, overcrowding, and deteriorated housing conditions, low birth control (the country has one of the highest birth rates in the world), and environmental pollution. The population has poor access to potable water and deficient sanitation, including an inadequate disposal of solid and liquid residues, and contamination from open defecation (about 8 percent of urban households and 37 percent of rural households still practice this).
A connoisseur of the Timorese reality, Rui Maria de Araújo, considers that “one big problem is that health is not part of the public policy agenda, which can be noticed in policy actions and their implementation that do not address health impact. You clearly see a disconnection between sanitation, public health and the work in infrastructure. All these roads and all these sewage systems are built without taking into account and bringing health issues into discussion [...] If we want to change things and make the best use of resources, we should really understand that any decision has to do with health.

An example of the disconnection is that when opening a health center in remote areas, you suddenly realize that the public service network is not there, that there are no phone lines, and no links to the water, so how are we going to do it?”.

**BABEL’S HOSPITALS**

An additional challenge for all areas in Timor-Leste is the difference in doctrines, technologies, perceptions, adherence to standards, guidelines and protocols. Doctors, nurses and technicians in hospitals particularly, are Chinese, Filipino, Cuban, Timorese and Indonesian, among others. Every group is used to a different health system and has a different protocol.
Another difficulty is the language gap due not only to the differences in nationalities among the health workers but also among the Timor-Leste population. There is a vast ethno-linguistic diversity. There are about 20 indigenous languages in addition to the official languages, Tetum and Portuguese, as well as the working languages, Indonesian and English.

A number of doctors and nurses commented on the language barriers, expressing that they have trouble communicating. On the other hand, others mentioned that they do not find it difficult to communicate because they learn the language and they find the medical vocabulary easy to translate. Cuban doctors are supported by the students that they train when they perform visits in Primary Care Centers or patient’s houses.

**RAMIFICATIONS OF THE AGREEMENT**

In December 2012, a new cooperation agreement was signed and some other activities were added to the original agreement including a consultancy for elaboration and implementation of a Primary Care System Program, a program for environmental hygiene and vector control, rehabilitation services, and a program for managing medicines and equipment, among others.

Currently, the Cuban Medical Brigade is involved in planning a Primary Care System Program, taking the Cuban model as a starting point and adapting it to the Timor-Leste local reality. The Cuban System emphasizes primary and preventive care, addressing diseases and problems before they become major. Primary care in Cuba is provided by general practitioners/family doctors, community nurses, dentists, pharmacists, midwives, etc.

Primary care is usually the first point of contact for a patient. It is focused on basic health needs, establishing personal relationships between the health personnel and the community, and providing continuous care along the life cycle. At Timorese Primary Care Centers, patients who need post-treatment visit and who do not show up receive a doctor’s visit at home. In addition, physicians regularly visit every family covered by the center where they practice.
To address more complex conditions, primary care includes a secondary level of referral services, and a third level of specialized consultants. According to the 2008 World Health Report (WHO), in order to overcome the strong inequities in health outcomes, in access to care, and the cost of care, it is necessary to turn to a primary care model since it offers the best way of coping with the common illnesses of the 21st century, especially chronic diseases. Problems such as malnutrition need to be solved with the community as an active participant, so primary care assumes even more importance.

The Timorese Health Minister, Sergio Lobo, expounds that the main benefit from the bilateral cooperation “is the transformation of the mind frame, to focus on primary health care and promotion, before we were more clinical and treatment oriented [...] after a long struggle and discussion we reached an agreement; we have to move towards this general integral medicine and primary care”.

The Minister also expressed that this approach is going to correct a side effect of what has been done until now, “the country has worked in specific areas: for example mother and child care, malaria, tuberculosis, HIV. It was based on separate objectives and as a result of that our system is fractured. A lot of money has been spent here, but in terms of our institutions we’ve got nothing”.

Another new assignment of the Brigade is the design and implementation of an oncology national program and cancer prevention system and the opening of an Oncology Service Center at the Guido Valladares National Hospital. Two Cuban specialists have proposed a program along these lines that includes from Primary to Tertiary care levels.

At present, patients that need a cancer treatment are transferred to Singapore since there is no infrastructure, technology or human resources available at Timorese hospitals to manage oncology cases. In addition, currently patients affected by other pathologies need to go abroad to receive treatment. For example, they need to travel abroad for the specialties of neurosurgery, nuclear medicine, burn care or invasive and interventional cardiology, and some nephrology care (Timor-Leste only has the capacity for the treatment of 32 dialysis patients).
THE FUTURE

According to the Cuban Ambassador, the cooperation agreement does not have a final date, “our presence here depends on Timor-Leste’s necessities and its government”. Regarding the possibility of adding other specific projects to the original agreement, the Cuban diplomat states, “we have already explained to them that we can cooperate on the production or purchase of medicines, vaccines and devices; as well as our disposition to bring 200 nurses to strengthen the Timorese doctors’ health care teams”. Related to the First Lady’s opinion, the government could increase the areas of cooperation. After a cost-benefit analysis and a previous evaluation, a psychosocial and genetic diagnosis program and a pharmaceutical production program can be added to the initial activities of the agreement.

The WHO Timor-Leste representative, Jorge Mario Luna, believes there is an opportunity to integrate the Cuban Brigade’s work with the WHO activities in the curriculum of the Medical School. On the other hand, he also identifies the opportunity to improve the working conditions of primary care doctors in order to decongest the work of National Hospital and Reference Hospitals, since it is estimated that 75 percent of the cases can be dealt with at the Primary or Secondary level.

According to Luna, there are other areas and activities that can benefit from the Timorese Ministry of Health’s support, for example “the Health Information System of the Cuban Medical Brigade, which is very detailed and has all of the data referring to the families covered by every health center.” Cuban doctors keep data and classify the population they take care of. They categorize demographic and sociocultural aspects of the community in every Primary Care Center, including a situational chart with data referring to: families and individuals served, the population pyramid-age, most common pathologies, and their health status or level risk. Luna explains that, “they have statistics about births, illnesses, deliveries attended at home, domiciliary visits, vaccinations, all in one format”.

In Rui Maria de Araújo’s opinion, “the agreement should look into having new Timorese doctors in the field, strengthening the cooperation to support it and make it more sustainable. We have to combine an entry strategy from the government of Timor-Leste and an exit strategy from the Cuban government. How? In places where Timorese doctors can be appointed, Cuban medical doctors must be taken out and replaced, creating a network to strengthen the services. The Cuban Brigade could start thinking about doing more specialized services. Cubans can take care of the curative levels, because even for
a Primary Care System, it is important to keep all the needs of the system in mind, the curative side is still important. The potential for further cooperation is here”.

Maria de Araújo goes one step ahead and says, “if Qatar, with the gas and oil money, can hire the Cubans to a world class hospital, why should we not do that in Timor-Leste? During the last five years, we spent already US$25 million sending people to be treated in Indonesia and Singapore, why don’t we build a hospital here with cutting edge technology, instead of sending patients abroad. That’s my view, even if I’m not in a position of shaping the policies and decisions […] It would be a great mistake if this country down of the road said ‘enough is enough’, about the cooperation agreement with Cuba”.

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**STRONG ELEMENTS**

One of the main achievements of the Cuban health system has also been accomplished in the countries where the Brigades are present: reductions in infant mortality rate. Cuba has the same or lower infant mortality rate (5 per 1,000 live births) as Canada and the United States. According to Cuban Central Unit of Health Collaboration, infant mortality dropped in some of the areas covered by the Cuban medical team, including Guatemala, Gambia and Haiti. This trend was also present in Timor-Leste where the indicators have also improved.

An additional asset Cuban cooperation (other than the detailed data gathered in the Health Information System, mentioned earlier) is their comprehensive coverage, both geographic and demographic, with presence in the most remote areas. Furthermore, the collaboration agreement by design takes into account the aspect of sustainability, since a lack of human capital is one of the main Timorese problems. High education is a meaningful contribution to satisfy the demand for a skilled work force and the scientific and technological development of the country.
Expressing gratitude for the international solidarity Timor-Leste has received, the First Lady states that, “Timor cannot live without them”. Nevertheless, as Mrs. Da Costa expresses, in order to obtain better results from aid, “the support must not only be a project but to place importance on how to save lives, without taking their dignity away. This way, the population does not feel like a poor one that needs help, but it instead feels like a human being, treated as a brother, which is the way the Cuban Medical Brigade approaches it. Sometimes I have felt that the NGOs, International and/or Multilateral Organizations produce propaganda about poverty and sickness, and the poor people do not receive support and continue with their problems.”

She continues with the reflection, “what is not working properly? There is a lot of solidarity and cooperation and the poverty and hunger are not being eradicated, why? I have no answer for this, but from my experience they make poverty something to talk about. Poor people are treated like objects, not only by the international actors but also by the political leaders that continue to live in luxury, even if they speak in the name of the poor. This is not good for human dignity. There is a need to change that mentality”.

CRONOLOGY

February 2001 Request of Cuban Doctors from Timor-Leste through WHO/Timor-Leste
September 2001 Timorese Ministry of Health was created
May 2002 Timor-Leste officially became a sovereign State
February 2003 Meeting in Malaysia: Fidel Castro, Xanana Gusmão and José Ramos-Horta
April 2004 First Cuban Medical Brigade arrived to Timor-Leste (15 doctors)
2004 The first group of students went to Cuba to start the Medicine Courses
December 2005 The Cooperation Agreement was signed
December 2005 The Medicine Faculty in Timor-Leste was opened