



South-South Cooperation: A Challenge to the Aid System?



The Reality of Aid

SPECIAL REPORT ON SOUTH-SOUTH COOPERATION 2010

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The Reality of Aid Network

The Reality of Aid (RoA) Network exists to promote national and international policies that will contribute to new and effective strategies for poverty eradication built on solidarity and equity. Established in 1993, the Reality of Aid is a collaborative non-profit initiative involving non-governmental organisations from North and South.

The Reality of Aid regularly publishes reliable reports on international development cooperation and the extent to which governments, North and South, address the extreme income inequalities and structural, social and political injustices that entrench people in poverty.

The Reality of Aid has been publishing its reports and Reality Checks on aid and development cooperation since 1993.

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Preface

The world's economic landscape is rapidly evolving. The first decade of the 21st century has ushered in rapid growth in the economies of emerging giants from the Global South, eclipsing the performance of the old industrial centers in the North. China is widely expected to overtake Japan as the second largest economy in the world this year. India's economic output is expected to surpass the gross domestic product (GDP) of Canada by next year. Brazil is the fastest growing economy in all of the Americas.

With economic stagnation looming on the horizon in the developed world, poor countries are increasingly looking towards other developing economies for greater trade, investments and development cooperation. The growth of regional cooperation or regionalism has also escalated as a by-product of globalization.

A number of middle-income countries from the South have recently moved from being net aid recipients to being net donors even as the vast majority of the world's impoverished population are still found in these countries. With the rapid growth of development assistance from so-called "emerging donors" from the South, there is increasing interest in South-South Cooperation especially within official government circles.

From a dedicated article extolling the importance of South-South cooperation towards aid effectiveness in the Accra Action Agenda (AAA), expectations are high that good practices in South-South cooperation will contribute important learnings towards the building of a new aid architecture that promotes effective development cooperation.

This new report from the Reality of Aid Network contributes to the growing literature on the subject by taking a critical look at the nature, shortcomings and potentials of South-South development cooperation from a Southern civil society perspective.

The report is a specialized selection of researches ranging from the emergence of new global donors such as India, China and South Africa as well as the establishment of a new international financial architecture in South America to the impact of these trends on the diverse economies of Asia, Africa and the Americas. It presents the general condition of the Southern continents along with the specific experiences of Zimbabwe, Uganda and the Philippines, and illustrates the viability as well as the deficiency of the rising South-South development cooperation. The report also contains two researches on the noteworthy contribution of Cuba in Timor Leste and South West Pacific and its ongoing cooperation with Venezuela.

This report provides development actors important lessons, not just for improving South-South cooperation but also for enhancing the development effectiveness of international development cooperation as a whole.

Antonio Tujan, Jr.

Chairperson

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Reality of Aid Network

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Cuban Health Cooperation in Timor Leste and the South West Pacific

Tim Anderson
Aid Watch-Australia

Abstract

Cuban doctors and their large-scale medical training program came to Timor Leste in 2004, then to Kiribati, Nauru, Vanuatu, Tuvalu and the Solomon Islands over 2006-2008. By its size and focus, this 'South-South' program, more than any other, is transforming the health systems of those island nations. Cuba's 'solidarity aid' in health and education is famous in Africa and Latin America, but only more recently spread to the Southwest Pacific. By 2008 there were around 350 Cuban health workers in the region, with 870 East Timorese and more than 100 young Melanesians and Micronesians engaged in medical training.

We may identify several particular benefits in this program. First, the health training is at a well recognised international standard of technical excellence. Second, the program is oriented to the needs of developing countries, focusing on rural, primary and preventive elements, and making more use of human resources than expensive technology. Third, the program is systematic, aiming to build public health systems, and not simply provide project aid or individual training. Fourth, the ethos of training prepares students as public spirited community health workers rather than medical entrepreneurs; this in turn helps reduce the impact of the chronic 'brain drain' or the loss of trained professionals through migration.

Challenges are also posed by this program, for both the developing recipient-country and

aid agencies. In the first instance, there must be a flexible incorporation of and investment in the newly trained doctors, investment in infrastructure, a commitment to ongoing training and to coordination of other health projects and programs. In the second case, aid agencies should note the Cuban commitment to language training and systemic programs, and look for opportunities to articulate with the island nations' newly developed human capacity.

Main Text

Cuba, a socialist developing country, recently brought a substantial health aid program to the Southwest Pacific. Cuban doctors and a large-scale medical training program came to Timor Leste in 2004, then to Kiribati, Nauru, Vanuatu, Tuvalu and the Solomon Islands, over 2006-2008. By late 2009, more than a thousand young students from Timor Leste and the Southwest Pacific Island nations were studying medicine with Cuban professionals, most of them in Cuba. This 'South-South' program will transform the health systems of the participating island nations. South-South cooperation, an important theme of developing countries in the non-aligned movement (NAM) since the 1960s, means that developing countries can assist each other in capacity building, rather than rely on dependent and asymmetrical relations with the big powers. This report will review the Cuban approach to South-South cooperation and its health aid programs and discuss some wider lessons and challenges.

Cuban South-South cooperation

The ideas behind Cuban 'aid' - with its emphases on social and international solidarity and on the development of rural health systems - began during the revolution of the late 1950s. The Argentine-Cuban doctor Ernesto 'Che' Guevara, for example, had been influenced by Latin American ideas of 'social medicine' (e.g. Allende 1939) but also by his own experiences throughout the continent. Observing the malnutrition of rural children, he wondered, "What would have occurred if two or three hundred peasants had emerged, let us say by magic, from the university halls? .. [they] would have run to help their brothers" (Guevara 1960). These were ideas he and other Cuban leaders acted on.

Revolutionary Cuba sent doctors to Algeria in 1963, at a time when Cuba itself had a health worker shortage. Cuba's initial aims were to help African independence struggles and assist with 'self-help strategies'. This fraternal approach was valued by many African countries:

"[the] special relationship with Cuba could not be duplicated by any type of cooperation offered by the European powers, China, the Soviet Union or the United States."
(Grabendorff 1980: 6)

Cuba's solidarity aid was thus linked closely to support for independence and self-determination.

The consolidation of Cuba's own health system eventually led to large numbers of trained health workers as well as health indicators that were at the top of the developing world.¹ Thousands of Cuban doctors were sent to African and Latin American countries, and the country's practical health cooperation became the lead element of its foreign relations.

Analysts have differed over the extent to which Cuban medical aid is an assertion of 'soft power', with some saying it creates a 'symbolic capital' which can be drawn on for material or political benefit (Feinsilver 2006). The author sides with those who suggest that the Cuban medical aid is more deep-rooted and complex. Cuban medical internationalism appears at its root a principled humanitarian project which, at different times, may have diplomatic, trade or political benefits but is not formulated simply to that end (see Kirk and Erisman 2009: 170-183). It is also important to note that the recent wave of health programs has been linked to Cuba's 'battle of ideas' (see Kapcia 2005), a broad program of 'revolutionary morality', designed to build support for decent social programs.

At the South Summit in Havana in the year 2000, Cuba submitted more than half the 120 South-South cooperation projects presented to the Summit. The small island state's capacity to share its modest resources was praised by African leaders and by the United Nations (UN) Secretary-General, Kofi Annan (Gonzales 2000). However, the United States (US), intent on overthrowing the little socialist nation on its doorstep, has consistently opposed all Cuban health programs.²

The idea of South-South cooperation expanded in the Latin American and Caribbean region, when in 2004 Cuba and Venezuela created ALBA, the Bolivarian Alternative for the Americas. Literally thousands of Cuban health workers helped build Venezuela's 'Barrio Adentro' (a local clinic-based health system) as an example of what could be achieved through a South-South cooperation "in which the principles of solidarity and complementarity were predominant" (Muntaner et al 2008: 307). The nine-member ALBA is said to be

an “unequivocal path” towards South-South integration (Ronda Varona 2006: 321).

Within developing countries, there has been some hesitance over having some relations with Cuba. The Cuban educational aid in Jamaica and Namibia has been observed to have a common theme of ‘ambivalence’ about accepting Cuban aid because of local professional jealousies and fear of jeopardising relationships with the US. However, Cuban training clearly helps develop self-sufficient education and health capacity and is usually an offer “too good to refuse”. It also has some specific post-colonial advantages. These South-South programs: “arguably demonstrate one approach to the ‘radically new relations’ that are necessary to the decolonization process of building independent capacity and quality in education and other fields ... [they] successfully tackled some of the deepest problems of the colonial aftermath” (Hickling-Hudson 2004: 305-9)

Reciprocal benefits have been noted, in particular, the Cuban teachers gained from the experience of teaching in different cultures and languages. (Hickling-Hudson 2004: 308)

By late 2009, “more than 172,000 Cuban doctors and other professionals” had worked in the country’s international programs. Between 1999 and 2009, Cuba’s medical brigades opened 160 hospitals and 750 health centres and were said to have saved more than two million lives. Further by late 2009, more than 21,000 students were being trained in medicine by the Cubans (*Escambray* 2009). The scale of this program is unparalleled in the world. Dr. Margaret Chan, the director general of the World Health Organization (WHO) said that Cuba’s medical colleges are “a commitment and a contribution to a better training of the health professionals

that the world needs today” (*Escambray* 2009).

Cuba assumes a global shortage of health workers in a world of commodification and privatisation. It also recognises a global shortage of health services in rural areas and a serious ‘brain drain’ (emigration of skilled professionals) affecting developing countries. Some emigration to wealthier countries is inevitable. Cuban doctors themselves, for example, leave the country at a rate of about 2% of total number of practitioners. (Jiménez 2007). In most developing countries the figure is much higher. For example, from the 1980s to the end of the 20th century, Ghana lost 60% of its doctors while post-independence Zambia lost over 90% of its locally trained doctors (Kirk and Erisman 2009: 114). The story in the Pacific is only a little better. One study found there were “almost as many” Fijian born doctors in Australia and New Zealand as in Fiji while Australia and New Zealand also had more nurses and midwives from Samoa, Tonga, Fiji and Niue than those working in those island states (Negin 2008).

This emigration might be reduced by the nature and ethos of training. Former Timor Leste Health Minister Dr Rui Araujo observes that Cuban medical training maintains an ethos distinct from that of other much ‘elite’ notions in medical schools. It appeals to the students’ community spirit, and formally briefs students that they are being trained “to serve the public and not trade the services” (Araujo 2008). Such an ethos may help reduce Timor Leste’s ‘medical brain drain’.

Cuban health programs

Cuba therefore emphasises investment in people, and in developing a public service ethos in its health workers. It is also flexible about how this

is financed. For example, in poorer countries like Timor Leste, the Cuban government pays the salaries of the Cuban doctors. But in wealthier countries like South Africa and Venezuela there is a host government contribution (MEDICC 2008). Cuba itself maintains high levels of education, which for Cubans is free for life. As one Cuban analyst observes: “In the Cuban strategy of creating ... the health system, building human resources has been the most important factor. Human capital development today, in all spheres of the country, is notable; but it is most notable in the health sector” (Rojas Ochoa 2003).

In developing health aid programs, Cuba is able to draw on an experience that closely resembles those of many other developing countries. In the early 1960s, most private doctors had left the country. In the 1990s, with the collapse of its main trading partners, the country suffered serious economic depression. With the US economic blockade since the early 1960s, shortages and higher prices for many imports remain a problem. In other words, Cuba is a country that has had to ‘make do’ with fewer resources, relying on its dedicated professionals, its ‘human capital’. This experience adds to the Cuban understanding of the needs of other developing countries.

In its health aid programs, Cuba follows a common pattern, with some adaptations. First, there is a bilateral agreement between governments, including agreement on the number of Cuban doctors to be deployed and the number of medical scholarships to be offered. This embeds a long-term plan with the aim of replacing the Cuban doctors with graduate students from the host country within 10 years. The individual Cuban doctors work on two-year contracts and are flown home for a holiday in the middle of the contract period. Generally

the host country provides accommodation, food, workplace and a monthly allowance (of perhaps US\$200) while the Cuban government maintains the doctors’ regular salaries (Jiménez 2006; MEDICC 2008). There are other benefits for Cuban doctors, including bonuses when they return home.

In the case of wealthier countries, such as Argentina and South Africa, there is a contribution from the governments to the doctors’ salaries (MEDICC 2008). In the case of Venezuela, there is a commercial agreement between the Venezuelan and Cuban governments for exchange of various goods and services, including health services. In the case of Timor Leste, some aid money was at first used to contribute to the costs of the doctors, but as of 2006 “the Cuban government pays the wages of all its doctors and charges our medical students nothing” (PMC 2006).

Cuban doctors in a host country work under the local department of health effectively as public servants. This is different from ‘project aid’ through companies or non-government organisations (NGOs), which typically operates outside the public sector. While the Cuban Health Department’s preference is for their doctors to go to the rural areas, this depends on the local government’s policy. The Solomon Islands Government, for example, requested and received an initial three specialist doctors and a surgeon for the capital’s hospital (Mamu 2008). In Timor Leste, the 300 Cuban health workers (mostly doctors) were more widely distributed (Klaak 2008). In Timor Leste, as in many parts of Latin America, the approach has been to send doctors to areas where primary care services have been absent, and to have them focus on preventive health, supplemented by clinical medicine (MEDICC 2008).

In the case of countries without strong medical colleges, the local government transports its students to Cuba's colleges, and brings them home for holidays, if they can afford it. In the case of the Solomon Islands students, in a friendly 'South-South' gesture, Iran paid for their transport to Cuba in 2008 and again in 2009 (Solomon Star 2009). In some cases (including in Timor Leste), the Cuban doctors will help create or build the capacity of local medical colleges. All medical students in Cuba are on full scholarships, which include tuition, board, food, other services and a small allowance of US\$4 to US\$5 a month. Some governments (e.g. Timor Leste) pay their students an additional allowance, while others (e.g. Kiribati) do not. Non-Spanish speaking students study Spanish and science in their first year in a 'pre-medical' course. In some countries, including Timor Leste, the in-country health program is supplemented by a literacy program in the local language.

In the 2000s Cuba expanded its medical training network, making use of Venezuelan facilities and helping develop the training capacity of medical colleges in several other countries. This approach made use of small-group learning and computers. Much of the academic side of Cuba's medical course has been digitised. Dr Yiliam Jimenez, Vice-Minister of Health and Director of Cuba's health cooperation programs says: "We are returning to the tutorial method, supplemented by information technologies and other teaching aids, so that students from low-income families can go be educated in classrooms and clinics in their own communities, where their services are so sorely needed" (Reed 2008). From the third year onwards, students attend hospitals or clinics as well as classrooms every day. Such teaching methods are not unique, but the systematic nature and ethos of the training is distinctive.

The key elements of Cuban health programs may be summed up this way. First, there is no doubt about the technical excellence of the training. Cuba's own health outcomes, commendations by the WHO and the US recognition of Cuban medical training testify to this.³ Second, the programs are developing-country oriented, more labour intensive than capital intensive and with a focus on rural and preventive health. Third, they are systematic programs, aimed at building sustainable health systems – not just projects which deliver some services. Cuban doctors deliver health services at very little cost while local students are being trained. Cuban trainers provide assistance and further training when the new generation of doctors return to their countries to begin practice. Fourth, the public service ethos and large-scale training tend to create socially conscious and dedicated professionals, which may in turn mitigate 'brain drain'.

Programs in Timor Leste and the South West Pacific

The Cuban program in Timor Leste grew from a meeting between Cuban and East Timorese leaders at the Non-Aligned Summit in Kuala Lumpur in 2003. Some students were sent to Cuba for training at the end of that year and a small group of Cuban doctors arrived in Timor in April 2004 (Medina 2006). Throughout 2005, the numbers of doctors and students increased. After a visit to Havana by Prime Minister Mari Alkatiri, Cuban President Fidel Castro made an offer of one thousand scholarships to Timor Leste, along with a brigade of 300 health workers. President Castro's rationale for the increased offer was to generate a doctor to population ratio of 1:1,000 (Araujo 2007 & 2008). This revised program gave Timor Leste the largest health aid program outside Latin America.

A group of Cuban doctors was attached to the National Hospital of Timor Leste, but the majority of them were sent to the districts and to small clinics at sub-district level, thus starting the core of a rural doctor-centred health service including the practice of house visits (Rigñak 2007). Here they have provided most of the personnel for immunisations, tuberculosis treatment, general treatment, and skilled assistance at childbirth. Between April 2003 and mid-2008, the Cuban Medical Brigade carried out more than 2.7 million consultations. It is estimated that they have saved more than 11,400 lives (CMB 2008; Anderson 2008).

East Timorese students departed for Cuba in waves from 2003 to 2006. In December 2005 a Faculty of Medicine was inaugurated at the National University so that training could take place in Timor (CMB 2008). This university at first operated through groups of students attached to the small groups of doctors posted at each of the hospitals and district health centres (Rigñak 2007). In 2007-2008 they gained access to three classrooms within the National University, with computer facilities. In early 2008 there were almost 700 students studying in Cuba, and another 150 in Timor (Rigñak 2008).

The students in their first two years struggled with the Spanish language, but the teachers were highly regarded (Guimaraes 2007; Marques Sarmiento 2007). Promotion rates were near 100% and reports from the medical trainers were all good (Betancourt Gonzalez 2007; Infante Sanchez 2007; PMC 2006). In September 2009 the first 18 East Timorese students returned home after six years in Cuba to complete their

final year of studies while practising as interns in the country's regional hospitals. It is expected they will graduate from their own Faculty of Medicine in 2010 (Rigñak 2008).

Following Timor Leste, Cuban health programs grew within the region. Twenty students from Kiribati were studying alongside the Timorese students when the author visited them in 2007 and 2008. They were joined by another 11 in 2009 (Granma 2009). In 2008, 50 Solomon Islands students began their studies and were joined by another 25 in 2009 (Mamu 2008). Other smaller island states followed. The Papua New Guinea government received an offer of a health cooperation program in 2006 (Jiménez 2006; Balaguer 2006) but at the time of writing this program had not yet begun.

A summit in Havana with South Pacific nations in September 2008 emphasised the Cuban commitment to the Pacific. Former Cuban Foreign Minister Felipe Pérez Roque said Cuba and the South Pacific nations “confront common challenges in their efforts for development, building human resources, the risks of climate change and increases in the price of fuel and food” (CubaMinrex 2008). Vice President Esteban Lazo, meeting with the President of Kiribati, the Prime Minister of Tuvalu and several foreign ministers and ambassadors, said the encounter would “lay the foundations for our relations” (ACN 2008).

In late 2009 additional groups of students arrived in Cuba from the Pacific Islands so that the total numbers from Timor Leste and the SW Pacific rose to more than a thousand (See **Table 1**).

Table 1: Medical students studying with Cuban trainers, as of December 2009

	in Cuba	at home
Timor Leste	680 (1,000 places offered)	190
Solomon Islands	75	
Kiribati	32	
Vanuatu	25	
Nauru	18	
Tuvalu	20	
Tonga	3 (6 places offered)	

Sources: CMB 2008; Granma 2009; and personal communications with the students, at December 2009

Lessons and Challenges

The principal lesson from the Cuban health programs seems to be the potential of large-scale, systematic programs with a strong, mass training component, and a public service ethos. Coordination and integration of health services is also a key feature. There are of course a number of challenges posed by these programs, both for the recipient country and for the broader 'aid' community.

For Timor Leste and the Pacific Islands countries, the challenges seem to be in organisation and retention. Health departments must plan for the incorporation of more health professionals and, as in the case of Timor Leste, a huge number. Hopefully, the service ethos of Cuban medical education will be important in reducing the 'brain drain' and in encouraging the new doctors to keep working at village level, but this has to be underwritten by local political will. There is a need, therefore, to continue investing in infrastructure and human resources as well as preparing for a flexible incorporation of incoming graduates and interns. In the case of Timor Leste, there is a need to support and develop the Cuban-created Faculty of Medicine within the National University. East Timorese authorities might also consider opening up their college to the other Cuban trained graduates from the Pacific Islands.

For other development cooperation partners, the challenge is to measure their own programs alongside the Cuban program, especially as regards the commitment to training and the ethos of training, and to look for complementarities. Some reflection on the nature of 'capacity building' seems called for, particularly in view of the common over-reliance on highly paid consultants at the expense of large-scale training (see AusAID 2008: 33-34). In addition, the Cuban practice of linking language instruction to medical training deserves attention. There is often an expectation that students from the islands will be proficient in the language of tuition without assistance. Another important challenge is coordinating with health departments and the incoming graduates from the Cuban programs.

The international community is often ignorant or sceptical of Cuban health programs. Fear of offending the US, or fear from local professionals that their work conditions will be undermined, has led to negative reactions in many countries (BBC 2006; MEDICC 2007; MEDICC 2008). Nevertheless, within a few years, the great majority of health workers in Timor Leste and much of the South West Pacific will be Cuban trained and Spanish speaking. That is a great gift to those island countries, and a reality the international community must accept and work with.

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Endnotes

- ¹ By 2004 Cuba surpassed the USA in infant mortality rates (UNDP 2006)
- ² The US has imposed a commercial, legal and diplomatic blockade on Cuba since 1961. The UN overwhelmingly condemns this blockade every year. Nevertheless, the US penalises commercial relations with Cuba by any company having 10% or more US ownership. Special US Treasury licenses are required by US citizens who wish to visit Cuba.
- ³ The US Educational Commission for Foreign Medical Graduates (ECFMG) recognises medical certificates from the 14 Cuban colleges listed in the International Medical Education Directory (IMED).

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