

# SOLIDARITY AID: THE CUBA - TIMOR LESTE HEALTH PROGRAM <sup>1</sup>

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Quietly, just after independence, Cuba and Timor Leste began one of the largest health aid programs in the world. Cuba's doctors and its health cooperation programs were well known in Latin America and Africa, but much less known in the Asia-Pacific. By 2008 there were nearly 300 Cuban health workers in Timor Leste, while around 850 Timorese students were studying medicine in Cuba (700) and in the newly created Faculty of Medicine in Timor Leste (150). The Cuban program brings with it enormous opportunities but also a number of challenges.

This paper considers distinct views of 'capacity building' in aid and health aid, contrasting the 'big money' approach, project aid and mass training. It explains Cuban health programs and the development of the Cuba-Timor Leste health program, before considering some of the challenges posed by the Cuban program. This discussion makes use of existing literature, health indicators and interviews with doctors, students and families in Timor Leste and Cuba, as well as observations of clinics and colleges.

## 1. Health aid and capacity building

'Capacity building' is a concept often referred to in development, aid and poverty reduction discussions; but the expression is used in different ways. These differences relate to the means, as well as the ends, of improving a country's capacity.

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Neoliberal approaches to ‘capacity building’ have focussed on building a narrow group of public sector skills, related to financial and economic management. World Bank discussions of ‘capacity building’ have referred to “the strengthening of public institutions, with emphasis ... on public financial management, decentralization, and governance” (IEG 2008). These emphases have been criticised as presenting ‘capacity building’ as something technical, even capable of resolution by external direction. The Bretton Woods Project (2003), for example, characterises the World Bank’s ‘trade-related capacity building’ for Least Developed Countries as simply “doing it for them”.

In aid discussions, the concept of ‘capacity’ is often buried in assertions over broad aggregates (‘big money’); the need for investment in particular sectors. When discussing health aid and poverty, for example, the OECD argues for “scaling up resources and private investment”. It says: “scaling up financial resources for health should be a priority” (OECD 2003: 14). This idea is supported by a committee of World Health Organization on ‘Macroeconomics and Health’, chaired by former World Bank official Jeffrey Sachs. That committee said:

“The level of health spending in the low income countries is insufficient to address the health challenges . . . donor finance will be needed to close the financing gap . . . [this will mean] approximately \$27 billion per year in donor grants by 2007 (Sachs 2001: 16).

In other words, the overall problem is aggregate resources, expressed in dollar terms. Naturally enough, given its constitutional commitment to private foreign investment, the World Bank almost invariably stresses ‘private participation’ (e.g. World Bank 2008) in that ‘scaling up’ process.

AusAID similarly measures aid in dollar aggregates, but introduces notions of procedural fairness and efficacy through the competitive tendering of contracts.

“AusAID competitively contracts aid work to Australian and international companies. These companies use their expertise to deliver aid projects and often train local people to continue the projects long after the end of the contracts” (AusAID 2008).

That is, training of ‘local people’ could be an outcome of this process. In summary, in the case of a particular ‘country budget’, there is distribution of pre-determined project funds through a sort of quasi-market process, mainly to Australian companies, but also to some university agencies, NGOs and the occasional international company. At the end of these finite projects (usually one to three year contracts) the training of local people could be one outcome.

The Cuban approach to aid is different. First, they regard cooperation as a matter of solidarity between peoples, not of financial flows or financial leverage. Inaugurating a new Latin American School of Medical Sciences (ELAM), in the wake of terrible Caribbean hurricanes in the late 1990s, Fidel Castro (1999) noted that emergency aid lasted just a few weeks, then people were left to get on with their lives, and deaths. Castro had been strongly influenced by the self-determination ideals of Cuban independence leader Jose Marti who wrote: “Our own Greece is preferable to the Greece that is not ours; we need it more ... Let the world be grafted onto our republics, but we must be the trunk” (Marti 1892). These ideas contributed to the idea of helping other developing countries build their own professional capacity. “This institution” Castro said “is an attempt at a modest contribution of Cuba to the unity and integration of the peoples” of Latin America (Castro 1999).

Cuba emphasises investment in people, and is flexible about how this is financed. For example, in poorer countries like Timor Leste, the Cuban government pays the salaries of the Cuban doctors. However 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. One analyst says:

“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).

The commitment to high levels of investment in ‘human capital’ has not been directly related to Cuba’s economic performance. The regional branch of the World Health Organisation notes that, despite financial hardships of the 1990s, Cuba expanded its commitments in both domestic health and its international health programs (PAHO 2007). ‘Capacity building’ here is thus seen as a commitment to investment in people.

## **2. Cuban Solidarity Aid**

Cuban health programs have been based on Cuban medical worker postings in mostly rural-based primary health care services, combined with the training of large numbers of local students to replace the Cuban doctors. The WHO (2006) says there is a worldwide shortage of health workers; Cuba has committed itself to help address this deficit. The country’s capacity to do this draws on its achievements at home. By the mid 2000’s Cuba had more than 70,000 active doctors, over 28,000 of whom were working abroad (Table 1). Only from this base can we understand the enormous overseas commitment. Cuba itself has a network of family doctor centres, policlinics and hospitals, a world class pharmaceuticals industry and a free-access

public health system which emphasises health promotion, prevention and education. This capacity has been built up over several decades.

Cuban Physicians	70,594
of which family physicians	33,769
Cuban health professionals serving abroad, July 2006	28,664
Countries which have medical students in Cuba	80+
Numbers of foreign students on medical scholarships in Cuba	21,000+
Source: PAHO 2007: 277; MEDICC 2008	

Cuba's achievements in health are well known. It has the best indicators in Latin America and, despite relatively low incomes levels, several of its critical health indicators (infant mortality, life expectancy, HIV infection, low birth weight infants) match or surpass those of the USA (UNDP 2007: Tables 6, 7 & 10). With health indicators more like those of wealthy countries, Cuba demonstrates what can be done with a sustained commitment to public health (Table 2).

By 2007 Cuba had complied with three of the MDGs (for 2015): universal completion of primary school, eliminating gender disparity in school and reducing by 2/3 the mortality of children under 5 (PAHO 2007: 264).

	Infant Mortality (iii)	HIV+ (% 15-49)	GDP p.c. US\$ PPP	One y.o. vacc. Measles (iii)	Doctors per 100,000 popn (ii)
Cuba	6	0.1	5,700 (i)	98	591
USA	6	0.6	41,890	93	256
Australia	5	0.1	31,794	94	247
Mexico	22	0.3	10,751	96	198
PNG	55	1.8	2,563	60	5
Timor Leste	52	<0.2	Na	48	10

Source: UNDP 2007; (i) Cuban income figures adjusted by UNDP to account for subsidised or free goods and services; (ii) figures for 2000-2004 ; (iii) Infant mortality and Measles vaccination rates are elements of the Millennium Development Goals

When in 2003 Cuban infant mortality rates fell below those of the USA, the World Bank was forced to respond. Posing the question 'how has Cuba done it?', the Bank suggested important elements may have been: "the sustained focus of the political leadership on health for more than 40 years", "universal and equitable health care", concentration on rural areas, emphasis on a sole provider public sector, the policlinics, mass immunisations, health monitoring, community health programs and highly motivated staff. The World Bank questioned, though, how such a high level of doctors "can be sustained during economic hardship?" (World Bank

2004: 157-8; see also Anderson 2007). Cuba's consistent commitment to health combined with its more recent strong economic growth makes that question redundant.

In developing health aid programs, Cuba is able to draw on an experience that closely resembles that of many other developing countries. In the early 1960s, most doctors left the country and there were few resources. 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,<sup>2</sup> shortages and higher prices for many imports remain a problem. This is a country that 'makes do' when there are less resources, relying more on trained human resources, their dedicated professionals. This capacity is probably important in mutual understandings, when addressing the health needs of other developing countries.

In its health cooperation 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 in, and the numbers of medical scholarships offered to students from, the recipient country. This is a longer term plan with the aim of replacing the Cubans doctors, by graduate students from the host country, within ten years. The individual Cuban doctors, however, work on two year contracts (they are flown home for a holiday in the middle) from their own government. Generally the host country provides accommodation, food, workplace and a monthly allowance (generally US\$150-200) while the Cuban government maintains the doctors' regular salaries (Jiménez 2006; MEDICC 2008). In the case of wealthier countries, such as Argentina and South Africa, there is a contribution from those governments to the doctors salaries (MEDICC 2008). In the case of Venezuela, there is a commercial agreement between the two 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 direction of the local Department of Health, effectively as public servants. This is different to other 'project aid', which often operates outside the public sector. While the Cuban Health Department's preference is for their doctors to go straight to rural areas, generally working in pairs, this depends on local government policy. The Solomon Islands Government, for example, requested and received an initial three

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<sup>2</sup> The USA has imposed a commercial, legal and diplomatic blockade on Cuba since the early 1960s. Special US Government licenses are need by US citizens to travel to or sell any items to Cuba.

specialist doctors and a surgeon for the capital's hospital (Mamu 2008).<sup>3</sup> In Timor Leste the Cuban doctors are more widely distributed (see Table 3). The general approach is to go to areas where primary care services are absent, and to focus on preventive health, supplemented by clinical medicine (MEDICC 2088).

In the case of countries without strong medical colleges, the local government transports their students to Cuba's colleges, and brings them home for holidays if they can afford it (most can't). In some cases the Cuban doctors will help build up the capacity of local medical colleges. All medical students in Cuba are on full scholarships, which includes tuition, board, food, other services and a small allowance of 4 or 5 dollars a month. Non-Latin-American students study Spanish and science in their first year, in a 'pre-medical' course. In some countries, including Timor Leste, the health program is supplemented by a literacy program, in the local language.<sup>4</sup>

Apart from the health program in Venezuela, which is a commercial deal, Cuba's biggest aid program is with Bolivia. Around one thousand Cuban doctors work in Bolivia, and there are more than 5,000 young Bolivians studying medicine in Cuba. Apart from those two countries, as at May 2006 large groups of Cuban doctors were working in several countries including: Guatemala (448), Haiti (426), Honduras (347), Timor Leste (278), Ghana (188), Namibia (143), The Gambia (134), Belize (113), Mali (109) and Botswana (93) (MEDICC 2008). The numbers of medical students trained to replace these doctors, averages about 2 to 3 times the numbers of doctors (Jiménez 2006). A large number of countries have smaller numbers of students, including around a hundred US students on medical scholarships, arranged through the US-based solidarity group 'Pastors for Peace' (IFCO 2008).

In the 2000's Cuba expanded its medical training network, making use of Venezuelan facilities and helping develop the training capacity of medical colleges in several countries. The newer approaches make use of small group learning, led by resident Cuban doctors, local facilities and IT. Dr Yiliam Jimenez, Vice-Minister of Health and Director of Cuba's health cooperation programs says:

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<sup>3</sup> The Solomon Islands will eventually receive 40 Cuban doctors, and 50 scholarships (Mamu 2008).

<sup>4</sup> Since 2008, the Cuban literacy method 'I Can Do It' (Yo Si Puedo) has audio-visual facilities in every Suco in Timor Leste. Classes began in Portuguese, but since 2008 Tetun materials have been in use.

“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).

More recent initiatives in Cuban health cooperation include: HIV-AIDS projects in Africa; the large scale ‘Barrio Adentro’ project for mass health services in Venezuela; the ‘Operation Miracle’ program, which provides hundreds of thousands of free eye operations across Latin America; and the Henry Reeve Disaster Response Contingent, to send personnel and mobile hospitals to areas hit by natural phenomena such as earthquakes and hurricanes (MEDICC 2008). For example, Cuba sent 2,500 doctors to Pakistan for six months after the large earthquake in 2005 (Akhtar 2006).

The Cuban approach has distinct priorities, and thus sees distinct challenges. Cuban officials calculate very seriously the numbers of professionals from developing countries that are lost through migration to wealthier countries (e.g. Balaguer 2006). This ‘brain drain’ is a constant challenge for human capacity building. The World Bank has calculated that developing countries lose substantial quantities of their skilled workers. In the entire Sub-Saharan Africa region, 20% of skilled workers have migrated. In Nicaragua and El Salvador the skilled worker migration rate is 29-31%; in Ghana and Mozambique it is 45-47%; in Jamaica and Haiti 83-85% (Schiff and Ozden 2005). Rates for doctors are higher than those for other professionals. One South African doctor said his country was losing 80% of its doctors, first to the private profession, then to migration (MEDICC 2007).

However the World Bank says, despite its scale, this ‘brain drain’ is not necessarily a problem, as it is compensated for by family remittances; the situation is “complex”. Remittances, it is said, reduce poverty and increase spending on education, health and other investment (Schiff and Ozden 2005). The Cubans see the problem differently. Remittances are most often directed into consumption. A critical mass of human capital remains the foundation of a wide range of social and productive capacities. Some emigration is inevitable – Cuban doctors themselves, for example, leave the country at a rate of about 2% (Jiménez 2007).<sup>5</sup>

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<sup>5</sup> In the case of Cuba it is not simple emigration, as the US has specific laws to encourage Cuban professionals to ‘defect’. Unlike emigrants from other countries, Cubans get an instant ‘green card’ on arrival in the US. Fidel Castro (2007) estimates total ‘brain theft’ of all professionals from Cuba to the US between 1959 and 2004 has been 5.16%.

This rate of emigration can be slowed by the nature and ethos of training. Former Timor Leste Health Minister Dr Rui Araujo notes that Cuban medical training (including the training within Timor) maintains an ethos distinct from that of much other '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).

### **3. Development of the Program in Timor Leste**

The Cuban program grew from a meeting between the then Cuban President Fidel Castro and the then Timor Leste President Xanana Gusmao, at the Non Aligned Nations Summit in Kuala Lumpur, in February 2003. A group of 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).

However in mid 2005 the numbers of doctors and students were increased, following a visit to Havana by the then Foreign Minister Jose Ramos Horta. A further visit to Havana in December 2005 by Prime Minister Mari Alkatiri, accompanied by Health Minister Rui Araujo, led to an increased offer of one thousand scholarships to Timor Leste, and a brigade of 300 Cuban health workers. Fidel Castro's rationale for the increased offer was to generate a doctor to population ration of one to one thousand, taking into account expected population growth (Araujo 2007 & 2008). This scaling up of the program made Timor Leste the largest health aid program outside Latin America; it also seems to have been a vote of confidence, by Cuba, in Timor Leste's first post-independence government.

While a large component of Cuban doctors were attached (with other foreign doctors) to the National Hospital, the majority were sent to the Districts, and to small clinics at sub-district level, thus starting the core of a rural doctor-centred health service (Rigñak 2007). Here they provide most of the personnel for immunisations, TB treatment and skilled assistance at childbirth. Timor Leste had never before had resident doctors at the sub-district level (Medina 2006). Despite the large commitment in Dili, the presence of twice as many doctors outside the capital (CMB 2008; see Table 3) introduced a new pattern of health services to the country, including the practice of house visits, at village level. The maintenance of such rural health services, apart from the substantial extension of primary health services, could have important implications both for rural development and rates of urbanisation.

<b>District *</b>	<b>Cuban health workers</b>
Aileu	8
Ainaro	14
Baucau	27
Bobonaro	19
Covalima	17
Dili (of which: National Hospital)	78 (45)
Ermera	9
Liquica	7
Lautem	10
Manufahi	7
Manatuto	10
Oe-cusse	16
Viqueque	10
Sources: CMB 2008; See also Kla'ak 2008: 4; *Note: every sub-district had at least one, and in most cases 2 or more, Cuban health workers	

Human resource inputs were thus substantial. The health outcomes from these inputs is difficult to measure at this stage, given the limited state of Timor Leste's records (Araujo 2008). However some estimates have been made, first by the Cuban Brigade themselves. Between April 2003 and mid 2008 the Cuban Medical Brigade had carried out more than 2.7 million consultations. It was estimated that they had saved more than 11,400 lives and had helped reduce infant mortality (CMB 2008; see Table 4).

Consultations	2,720,444
Of which: (house visits)	(1,013,127)
Childbirths attended	17,352
of which: (caesarean)	(848)
Total surgeries	19,099
Major surgeries	5,181
Anaesthesias	24,130
Clinical laboratory tests	193,942
Physiotherapy cases	12,983
Vaccines administered	27,643
Estimated lives saved	11,406
Source: CMB 2008	

One important documented contribution of the Cuban doctors was their maintenance of health services during the 2006 political crisis. The displacement of tens of thousands of people into camps in and around the capital posed a major challenge for health services. A number of foreigners left the country; the Cubans did not. This difference in dedication was noted by the then Prime Minister José Ramos-Horta, who said:

“During the worst of the crisis in May, June and July [2006] our Cuban doctors stayed unconditionally in the villages and hospitals with the patients and the people, providing the much-needed moral, medical and psychological support” (PMC 2006).

The point was repeated by Foreign Minister Zacarías Albano da Costa, when he visited Cuba, and the students there, in May 2008 (Granma 2008).

An Australian study of health services during the crisis also noted this contribution. The National Hospital “was able to remain open throughout all periods of the crisis; and for a period at the height of the violence in late May and early June the hospital drew heavily on the Cuban Medical Brigade to maintain its activities (Zwi et al 2007: 17). The CMB also regularly attended the IDPs, during the crisis (Rigñak 2007). They provided the only 24 hour services and were the major source of mobile services. The CMB “contributed crucial “surge capacity” when mainstream services were stretched” (Zwi et al 2007: 21, 33)

The longer term element in the program is represented by the Timorese medical students, whom their Cuban trainers call ‘the doctors of tomorrow’ (Infante Sanchez 2007). Students departed for Cuba in waves from 2003 to 2006, the largest groups leaving throughout the crisis of 2006. However 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 really operated through groups of students attached to the small groups of doctors posted at each of the hospitals and district health centres (Rigñak 2007 & 2008). In 2007-08 they gained access to three classrooms within the National University, with computer facilities. As at early 2008 there were almost 700 students studying in Cuba, and another 150 in Timor. There will be some small new intakes in 2009, within the Timorese faculty, as the Cuban offer of one thousands scholarships remains (Rigñak 2008).

By all accounts the students are doing well. I visited two groups of medical students in November 2007 and, while groups in their first year struggled with the Spanish language, the facilities and teachers were well regarded (Guimaraes 2007; Marques Sarmento 2007), promotion rates had been 100% and reports from the medical trainers were all good (Betancourt Gonzalez 2007; Infante Sanchez 2007). The Timor Leste Government has had similar good reports:

“Timor-Leste’s 498 students in Cuba are considered to be the best among thousands of overseas people studying medicine in terms of results and discipline, according to Vice–Minister of Health Luis Lobato” (PMC 2006)

There is no doubt Cuban training is of a high standard. Fourteen Cuban medical colleges are recognised in the US (ECFMG 2008), and US graduates from Cuba medical colleges are now registered and practising back at home (Edwards 2008). The first group of Timorese students are due to arrive back in Timor either in mid 2009 or early 2010, to begin their one year internship within their country's health system (Rigñak 2007 & 2008).

Following Timor Leste, Cuban health programs have grown within the region. Twenty students from Kiribati were studying alongside the Timorese students, when I visited them in late 2007; they were to be joined by another 20 in 2008. In early 2008 a group of 25 Solomon Islands students travelled to Cuba to begin their studies; they will be joined by another 25 (Mamu 2008). The Papua New Guinea Government had an offer of health cooperation in 2006 (Jiménez 2006; Balaguer 2006), but at the time of writing this program had not yet begun. A summit with South Pacific nations in September 2008 emphasised the Cuban commitment. 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). Cuban 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). Despite the political tensions in Timor, this program has maintained bipartisan support. One symbol of this has been the willingness of former Health Minister Rui Araujo to act as special adviser to his successor, current Health Minister Nelson Martins. The current Minister says Cuba has provided a collaboration in health and education that was “irreplaceable” (Nusa Peñalver 2008)

#### **4. Challenges of the Cuban program**

Several challenges are posed by Cuban health cooperation program in Timor Leste. There are challenges for Timor Leste and for other development cooperation partners, as well as for other health professionals and collaborators in the region.

For Timor Leste the main challenges seem to be in organisation and retention. The Health Department has to plan for the incorporation of several times more health professionals than currently exist in the country. How will they employ and place eight or nine hundred new doctors? Can they be encouraged to not leave the country, taking their skills with them to wealthier countries, thus adding to the developing world's ‘brain drain’? There are certainly

worse problems to have, but it is nevertheless a major political and administrative challenge. Current Health Minister Nelson Martins says that a five year plan sees the new doctors being located, at first, at sub-district level, and maintaining the popular Cuban practice of house visits (Martins 2008). Former Health Minister Rui Araujo thinks the service ethos of Cuban medical education will be important is combating the brain drain, and in encouraging the new doctors to keep working at village level (Araujo 2008). There is a big difference between, say, 5% or 50% of one's doctors emigrating.

Other development cooperation partners should check their own programs against the Cuban program, as regards the commitment to training and the ethos of training. Some reflection on the nature of 'capacity building' seems called for. In addition, the Cuban practice of linking language instruction to medical training deserves attention. All Timor Leste students have to learn a world or large regional language to study abroad, but there is often little help with this. Some Australian expectations, for example, that Timorese students will simply learn English by themselves, seem quite unrealistic.

Finally, other health professionals and collaborators can either coordinate with or seek to avoid the Cuban programs. There is a worldwide phenomenon of jealousy from health professionals to the Cuban programs. The fear of status and work conditions being undermined has led to reactions in many countries, including Bolivia (BBC 2006), Venezuela, and Honduras (MEDICC 2007; MEDICC 2008).

On the other hand, there seems to be ample room for coordination between health aid professionals, through some goodwill and reflection. One Christian health aid worker put it this way:

"It is the friendship of the poor and not the rich, the weak and not the strong. It is strange that the best example of Christian behaviour and good deeds comes from a secular country. This is an intriguing mystery; one that deserves pondering by those of us who profess to be Christian" (Anon 2008)

The opportunity is to reflect on and find new opportunities to work with both the Cubans and those students who have been given a unique opportunity to study medicine and help their own people. These remarkable Cuban health programs deserve serious study.

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