FROM HAVANA WITH LOVE: A CASE STUDY OF SOUTH-SOUTH DEVELOPMENT COOPERATION OPERATING BETWEEN CUBA AND SOUTH AFRICA IN THE HEALTH CARE SECTOR

by

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ACKNOWLEDGEMENTS

I would like to offer my thanks to the numerous individuals who offered very generous help and support throughout the course of my dissertation. I would first like to thank my supervisors, Professor Kenneth King and Dr Paul Nugent for their time spent helping me navigate my way through the dissertation. I also offer my thanks to the ERSC for my scholarship (Award No. PTA-030-2002-00334), and to the University of Edinburgh Development Trust for their support with financing the fieldwork. I should also like to thank many of my contacts in South Africa who spent many hours talking with me and helping me locate other sources of data, of these I should mention Dr Simon McGrath of the HSRC; Professor Ian Couper at the University of Witwatersrand and the Rural Doctors Association of South Africa; Professor David Morrell at Livingstone Hospital, Port Elizabeth; Ambassador Swanepeol and Mr Pieenar at the South African Department of Foreign Affairs; and Megan Cox at Benedictine District Hospital, Nongoma. In addition I offer my thanks to those healthcare workers, civil servants, and researchers who offered help, advice and support to me during this work. Finally I should thank the host families belonging to Servas1 who very kindly allowed me to live with them and through this develop an understanding of their life and culture.

1 Servas is an international network of hosts and travellers which aims to promote peace and understanding between different cultures through personal contact and by joining in the daily life of hosts. For more information see http://www.servasbritain.u-net.com
Chapter 1 Introduction

The life of a single human being is worth a million times more than all the property of the richest man on earth... Far more important than a good remuneration is the pride of serving one's neighbour. Much more definitive and much more lasting than all the gold that one can accumulate is the gratitude of a people (Guevara 1960: 1).

1.1 General Preamble

Whilst poverty, oppression and deprivation continue to rise in many parts of the developing world, the provision of international development aid is coming under increasing economic and political pressure. Given that North-South aid flows remain low, exacerbating existing inequalities and problems in the South, it is essential that consideration be given to the means of enhancing such aid.

Whilst most literature focuses on conventional North-South flows of aid, and South-North flows of debt repayment, developing nations are increasingly seeking their own solutions to development problems. Such sentiments, as expressed in the 1963 Organisation for African Unity Charter, have led to the signing of many bi- and multi-lateral agreements between members of the G77. This process of South-South development cooperation has been largely ignored by scholars and governments in the North, with recent reviews of aid modalities disregarding non-conventional aid flows (for example Degnbol-Martinussen & Engberg-Pederson 1999, Randel & German 1998a).

This paper will seek to explore issues relating to South-South development cooperation, in particular the impacts of one programme.

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2 This despite George Bush and other world leaders recognising these problems as being root causes of current terrorist tensions and activity, and their rhetoric concerning the need to tackle poverty and ignorance so as to reduce the threat from disaffected groups excluded from accessing the riches of the West.

3 The G77 is the Group of 77 plus China, an equivalent of the G7 but covering countries in the developing world seeking to find ways of cooperating to enhance their development. Their statement, “The Havana Program of Action”, from the first meeting in Havana in 2000 is available at http://www.dfa.gov.za/events/multilateral/action.htm.
whereby Cuba provides skilled physicians to South Africa's health service, and medical training to South Africans from deprived backgrounds.

1.2 Structure of this Paper

This paper will begin with an exploration of South-South cooperation, and the contexts within which Cuba and South Africa operate within the world arena. Subsequent chapters will explore the motives and aspirations Cuba and South Africa hold, and present a consideration of the health contexts of these countries. By considering the perceived impacts of the scheme from the perspective of governments, health workers, and the general public in South Africa, this will illustrate how the project is functioning and its location within wider health care issues in South Africa. The final chapter will draw together the evidence to offer an evaluation and critical appraisal of the project.

1.3 Why Cuba?

Cuba's role in South-South development cooperation is unusual. It is a small, 44,281 square mile island, with a population of 11 million. Yet since 1969 it has maintained a proactive internationalist foreign policy on a par with much larger world states. A central tenet of Cuban foreign policy is internationalism, “the solidarity with, and aid to, sister nations in Africa, Asia and America” (Krook 2003), and Cuba has been an important member of the Non-Aligned Movement, sharing its founding principles of ending colonialism, neo-colonialism and racism (Adams 1981).

Cuba has established medical cooperation links with 53 countries across the world (Davis 1999), suggesting that there is a special dimension to Cuba's assistance. Western literature's preoccupation with Cuba's military interventions during the 1960s and 1970s means that Cuba's humanitarian interventions have gone largely unnoticed in the West, and “[t]he Cuban revolution has been consistently misinterpreted in – or ostracised from – the mainstream development literature” (Weinstein 1979: 4). The longevity of Cuban involvement in South-South cooperation, plus her domestic situation, which has witnessed a recent upsurge in government actions against anti-Castro elements, and
position in world politics mean that Cuba provides an interesting base from which to consider this aid modality. Whilst Cuba’s language on development coincides with the conclusions of Degnbol-Martinsussen and Engberg-Pederson (1999: xv); that foreign aid is a vital “part of a solidarity effort to achieve greater equality between countries, the people in the developed and developing countries, and between people within developing countries”, this dissertation will also look to uncover any other possible motivations.

14 Why South Africa?

For long a pariah state, South Africa emerged from apartheid in 1994 and has become a popular recipient for Western aid agencies. South Africa’s need for development aid is obvious; the inequalities inherent from the apartheid era have left a legacy where over 50% of the population live below the poverty line of $2.40 a day (Department for International Development 1998: 2). The need for development assistance in the health care sector is of interest as South Africa was the first country in the world to conduct a successful heart transplant operation in 1967 (Kovel 1997). Their public and primary health care initiatives of the 1940s also inspired the US to develop their own network of community health centres (Yach & Tollman 1993). These indicate that parts of their health care system have, at times, been at the forefront of world medicine.

Hidden behind these successes have been inequalities in spending and resource allocation, providing a health care regime for the black population which was much inferior to the world class regime mentioned above. The problems of these shortcomings, a retrenchment of social service expenditure due to the Structural Adjustment Policy, and increasing staff shortages in public sector healthcare mean that South Africa is struggling to meet its pledge for health care for all. Surrounding this are South Africa’s commitments to stand by those who supported the ANC in exile, and to staunchly uphold the values of NEPAD (see section 2.3.4). These provide a fascinating backdrop against which to situate an inquiry into South-South cooperation. In addition, South Africa, as the leading economy in sub-Saharan Africa, is beginning to offer South-South cooperation assistance to other African countries. Their experiences as a recipient of this aid modality could
prove influential in their future actions as a donor, with wider implications for this aid modality.

1.5 Research Questions

This dissertation will seek to answer a number of questions relating to Cuba-South Africa health care cooperation. These are:

1. Why is Cuba as heavily involved in South-South development projects as it is?
2. How does the US blockade of Cuba affect their involvement?
3. What are the motivations for Cuban doctors to become involved in such scheme?
4. What are the reasons behind South Africa's involvement in this scheme?
5. How is the project viewed by the South African government and her people, and what future do they see for it?
6. What has been the impact on the ground of the agreement?
7. What are health care professionals' perceptions of the scheme and its consequences?
Chapter 2: Aid, Development and Cuba

Solidarity is not a one way thing, it goes all ways (Achmat 2003)

2.1 The Current Aid Environment

International development assistance, the transfer of resources on concessionary terms from one entity to another (Cassen & Associates 1986: 2), is provided with a degree of inherent self-interest. It is used in attempts to alleviate poverty, promote economic growth and service provision, but also to foster social and policy change to meet the desires of donor agencies.

From the first major international development assistance project, the 1948 Marshall Plan, to the present, aid has been provided with reference to donor’s political, economic and strategic interests. The aid regime of the US exemplifies this. Successive Cold War presidents pursued a policy aimed at preventing the spread of communism, and from the 1950s onwards sought to emphasise their development policy as a global moral and humanitarian obligation. The former colonial powers of Britain and France claim their aid agendas as a moral obligation to their former colonies to achieve economic and social development (Degnbol-Martinussen & Engberg-Pederson 1999). In reality, much of these policies are a façade, with hidden policy promoting continued access to natural resources and markets to favour their own economic progress, and furthering strategic interests.

The end of the Cold War saw a remodelling of the world order, one which removed the East-West dichotomy and produced a renegotiation of state relations across the globe. With these renegotiations came a change in aid relationships, as many recipient states experienced political, economic and social turmoil. Allied with a change in donor focus, from the political to the socio-economic, this meant donor states increasingly abandoned any notion of non-interference in recipient state affairs and sought structural and social adjustments as provisos for granting aid. At this time a global recession, increased competition for aid resources, and conservative economic hegemony coincided with rising poverty and debt within recipient countries, and the
marginalisation of many states from global trade circles, produced a decline in available aid (Hayman 2002 - Unpublished).

International aid flows reached a peak in 1992 and since then dropped significantly to 0.22% of world GNP, US$47.6 billion, in 1997 (figure 1), according to Randel and German (1998b: 4). World Bank figures show a similar pattern, with a drop to $36 billion in 1997, before a modest rise to $41.6 billion in 2000 (World Bank 2001). Recent aid modalities have focused aid on three main areas; long-term development, meeting the needs of the poor and facilitating policy reform. It is the interaction of this final factor with donor's political interests motivations which has caused confrontations between donors and recipients.

Figure 1: World Aid as a % of GNP (Randel & German 1998d: 7)

The practice of using aid to encourage policy reform in recipient countries is undoubtedly one of the reasons why Cuban support is viewed favourably by many developing countries. Cuba not only lacks the baggage of a colonial power's history, but there is widespread acceptance of Cuba’s official strategy of non-interference with sovereign government affairs.
2.2 South-South Development Cooperation

To contextualise this agreement, consideration must be given to the wider aid modality of South-South development cooperation.

With the paucity of North-South development aid, the importance of other forms of development support has grown. One of these is South-South development cooperation, whereby countries in the developing world share assistance, expertise and support in an effort to promote economic development and self-reliance (Ghimire 2001: 100). This principle is not new. It can be seen in Che Guevara’s belief in the need for proletarian solidarity and mutual support between oppressed people (Grabendorff 1980: 9), and in Stewart’s comment (1987: 1204), that “There are very great potential gains from schemes for the South as a whole”. Recently, this has been revived by the Group of 77 in 2000, declaring that,

South-South cooperation is a crucially important tool for developing and strengthening the economic independence of developing countries and achieving development and as one of the means of ensuring the equitable and effective participation of developing countries in the emerging global economic order. (Group of 77 2000: IV.1)

The viability of such cooperation is evidenced in Cuba’s long history of interventions in Latin America, the Caribbean and Africa. Also, Asian investment in Africa, where foreign direct investment from Malaysia into South Africa “transcends traditional North-South FDI patterns in developing countries … gives some credence to arguments about emerging South-South development linkages” (Padayachee & Valodia 1999: 290). Whilst this is a positive indication, one must not to transpose lessons from this experience to inappropriate contexts, where

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conditions in both donor and recipient states are different and operating within a different global context.

One of the potential strengths of this approach is the awareness of involved parties of the pitfalls inherent as a beneficiary of foreign aid. Donors often fail to recognise the heterogeneity within recipient states and communities, resulting in poorly prescribed policies. As South-South donors will have experienced these problems, there will be an increased awareness of such factors in policy formation and implementation. The project under consideration illustrates this, as dialogue during the formulation stages resulted in the programme targeting specific problem areas in the South African health service. Rather than simply recognising the shortage of medical staff in South Africa, the agreement has focused on the more pressing problems in rural areas, where the shortage of staff and expertise is greatest.

The South African government appears keen to pursue this aid modality. The Directorate International Health Liaison has the pursuance of South-South cooperation through multilateral initiatives, namely the G77 South, and bilateral programmes with Brazil and India, listed as international priorities for 2001/2 (Makwakwa 2001).

Other forums are also being utilised to promote these possibilities, with a variety of states involved. The "Partners in Population and Development: a South-South Initiative" emerged from the 1994 International Conference on Population and Development and, whilst neither Cuba nor South Africa are involved, similar ideals, concepts and aims are being employed. Perhaps the most relevant forum concerning this discussion is the New Partnership for Africa's Development (NEPAD), the founding principle being the belief in the need for African solutions to African problems. This agreement follows the Lagos Plan of Action, which showed an awareness of the need for South-South cooperation, and the probable failure of World Bank beliefs that African development would occur as a "by-product of the world economic development and...[that it could] only materialise

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5 The "Partners in Population and Development: a South-South Initiative" is a multilateral forum in which 19 developing countries, headed by Thailand seek to find ways in which increased cooperation will catalyse enhanced development in the South. Further details can be found on their website: http://www.south-south.org
through the free play of the forces of the market” (Benachenhou 1983). However, the Lagos Plan failed to promote South-South cooperation and left Africa reliant upon, and vulnerable to fluctuations in, the Western dominated global market (Hulugalle 1990: 38). New impetus has been generated by NEPAD and Cuba’s role in many African countries coincides with the ideals of NEPAD.

The spirit of cooperation is often present among developing countries, even if the financial means to do so are not. If it can be shown that such cooperation works efficiently, more agencies may be inclined to follow the lead of the Japanese Development Agency, JICA, who are looking to help continue the mobilisation of Cuban doctors to work in Guatemala (Wakai 2002). Alternatively other developing countries may be encouraged to cooperate in such policies, as happened at the summit of the Group of 77 in Havana in 2000, where the richer African states agreed to provide finances to pay for an extra 3,000 Cuban doctors to work on the African continent (Gonzales 2000: 322).

2.3 Cuba in International Development

2.3.1 Cuban Internationalism

2.3.1.1 The Ideological Basis of Cuban Internationalism

The skeleton of our freedom is formed but it lacks the protein substance and the draperies; we will create them. Our freedom and its daily sustenance are…swollen with sacrifice. Our sacrifice is a conscious one; it is in payment for the freedom we are building (Guevara 1968: 22).

An integral part of the Cuban revolution has been the spirit of internationalism based upon Fidel Castro’s speech at the Moncada trial in 1953, in which he outlined his vision of a commitment to global

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6 Fidel Castro, at the Moncada Trial, following his detention following the failed attempt by the 26th July group to take over the Moncada Barracks in 1953, Castro made his ‘History Will Absolve Me’ speech in which he sowed the seeds of later internationalist policy by saying “Cuban policy in the Americas would be one of close solidarity with the domestic people on this continent and... those politically persecuted by bloody tyrants oppressing our sister nations would find generous asylum, brotherhood and bread in the land of [Jose Marti]” Krook D. 1998b. Cuban Opinions on Internationalist Efforts in Angola http://playagiron.org/print.php?file=havana.
struggles against imperialism. Inspired by Bolivar, Marti, Nasser and Nehru, Castro led a humanist revolution (Smith 1985: 334), before his formal declaration of Marxist-Leninist beliefs in 1961, to “upholding the duty of the proletarian solidarity” (Krook 1998b: 2). This further committed Cuba to an internationalist path, as the “[u]nsolved social, economic, and political problems at home never kept Castro from extending aid to other Third World countries” (Eckstein 1994: 171). Thus, internationalism is the extension of post-revolutionary Cuba’s goal of an egalitarian society, shaped by solidarity and ambitious social programmes redistributed wealth and benefited the majority of the population (Gonzales 2000: 317).

From the outset, Cuba’s foreign policy has been concerned with the survival of the revolution. Through her internationalism, Cuba has carved out a position as leader of the developing world, as seen in her chairing of the Non-Aligned Movement, providing protection against US threats or Soviet abandonment, allowing a strengthening of ties with progressive African governments, and decreasing dependency on the Soviet Union, to achieve greater autonomy and influence in the world order (Krook 1998a, Leogrande 1982b: 167-168). These moves proved vital when the Soviet Union ceased their huge economic and political support of Cuba in the 1990s due to domestic problems.

The expansion of Cuban internationalism into Africa was facilitated by the eagerness of the Argentinean doctor, Ernesto ‘Che’ Guevara, Fidel Castro’s close ally in the 1960s, to export the revolution and ferment conflict against oppressive regimes elsewhere in the world. Even before Che travelled to Africa in 1965 and began developing contacts there, Cuba’s stated foreign policy included pursuing internationalism in Africa. Initially expressed at the 15th UN General Assembly, Cuba voted with African states in opposing the West’s favoured President Kasavubu in The Congo, thereby linking “the Cuban revolution to the hopes and aspirations of Africa, Asia, and indeed all of the underdeveloped world” (Glick 1964: 238). Cuba was also the only Latin American state to fully support sanctions against apartheid South Africa at this assembly, indicating her commitment to opposing colonialism and supporting national liberation movements. These, and other examples examined below, illustrate the role of internationalism in South-South cooperation.
2.3.1.2 Cuban Military Based Internationalism

Following 1959, revolutionary Cuba offered internationalist military support to progressive governments and national liberation movements across Africa, including in Guinea-Bissau, Mozambique, Congo-Brazzaville, Angola, Ethiopia, Sierra Leone, Libya, Laos, and Tanzania. The 1970s saw an increase in such activities, as both the threat from the US increased and Soviet interests became closer to Cuba's own agenda (Krook 1998a). These overtures were often welcomed, a process aided by Cuba's position as a Third World country as many in Africa believed that Cuba would be more sympathetic towards their plight than Western agencies. This response aided the rapid establishment of diplomatic links with 40 states, including the establishment of 30 embassies in Africa (Krook 1998a).

One example of such intervention was Cuba's role in Angola. Following support during the 1960s, Cuba sent a military force to the country at the behest of the leader of the MPLA, Augustinho Neto, in 1975. Under threat from militaristic opposition groups, the MPLA exercised their prerogative under Article 51 of the UN Charter and approached Cuba for support (Krook 1998b: 2). Cuba remained embroiled in the conflict until a peace agreement was negotiated following the defeat of the South African backed UNITA rebels at Cuito Cuanvale in 1988. Cuban intervention in Angola was principled, occurring at the behest of the liberation leader, continuing only as long as requested and without exploiting the resources of Angola. Whilst initial involvement may have courted favour with the Soviet Union, Russian knowledge of, and possible support for, an attempted coup in Angola illustrates Cuba's acting to fulfil their moral duty (Katz 1983).

Such military based actions by the Cuban government were roundly criticised by the US government as military adventurism, with Cuba portrayed as a Soviet pawn in international politics. Whilst much debate remains concerning this, Cuba's military actions coincided with her

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7 Only brief consideration is given here to Cuba's military internationalism as this is broadly documented elsewhere, whilst humanitarian internationalism is not. For more details concerning such episodes, and the motivations behind these actions see Erisman HM. 1995. *Cuba's International Relations: The Anatomy of a Nationalistic Foreign Policy*. Boulder: Westview Press. 203 pp., Feinsilver JM. 1989. *Cuba as*
interests, not those of the Soviet Union, and remained consistent with the aims of the Non-Aligned Movement. As Adams (1981: 122) observes, “Cuba's African policy appears to have been principled, responsive, and independent”. Such a basis laid principled foundations from which Cuban humanitarian assistance followed.

2.3.1.3 Cuban Humanitarian Internationalism

Cuba's first African humanitarian mission was to Algeria in 1963, when 56 Cuban doctors were seconded as proletarian internationalists following earlier military involvement in the liberation struggle and border conflict with Morocco (Feinsilver 1989: 11, Gleijeses 1998: 159, Grabendorff 1980: 5). The subsequent expansion of Cuba's humanitarian missions was rapid, as the 1970s saw development assistance given equal priority to military assistance in Cuban foreign policy (Erisman 1985: 69). In 1975 there were fewer than 100 Cuban medics working in other Third World countries. In 1977 there were 795 Cuban doctors abroad, and by 1980 this had risen to over 2300, with 1500 of these physicians (table 1) (Grundy & Budetti 1980: 717). This extraordinary ability to produce this number of physicians was due to the Cuban commitment to health care as a priority of the revolutionary government, and subsequent investment.

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Cuba’s involvement in health sector development, facilitated by its desire to become a medical superpower\textsuperscript{8}, has affected many countries. Following Hurricane Mitch in 1998, Cuba sent 2,000 doctors to Central America to help deal with the aftermath (2001), despite significant damage to the island. Cuba’s Comprehensive Health Programme for Central America, the Caribbean and Africa has also placed 2174 doctors abroad since 2001 and provided places for 3400 Latin American medical students in Cuba (Wakai 2002: 92).

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<td>0.33</td>
<td>10645</td>
</tr>
<tr>
<td>Guinea</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>73</td>
<td>41</td>
<td>188</td>
<td>22.0</td>
<td>5.1</td>
<td>27127</td>
</tr>
<tr>
<td>Libya</td>
<td>55</td>
<td>30</td>
<td>55</td>
<td>55.0</td>
<td>0.62</td>
<td>11273</td>
</tr>
<tr>
<td>Mozambique</td>
<td>650</td>
<td>357</td>
<td>2586</td>
<td>14.0</td>
<td>2.8</td>
<td>1068</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>220</td>
<td>67</td>
<td>510</td>
<td>13.0</td>
<td>9.9</td>
<td>19412</td>
</tr>
<tr>
<td>Sao Tome</td>
<td>?</td>
<td>47</td>
<td>59</td>
<td>80.0</td>
<td>0.084</td>
<td>1424</td>
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<tr>
<td>Tanzania</td>
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<td>797</td>
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<tr>
<td>Zambia</td>
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<td>11</td>
<td>472</td>
<td>2.3</td>
<td>5.4</td>
<td>11441</td>
</tr>
<tr>
<td>Guyana</td>
<td>18</td>
<td>18</td>
<td>120</td>
<td>150.0</td>
<td>0.81</td>
<td>6750</td>
</tr>
<tr>
<td>Jamaica</td>
<td>17</td>
<td>17</td>
<td>570</td>
<td>3.0</td>
<td>2.2</td>
<td>3960</td>
</tr>
<tr>
<td>Laos</td>
<td>12</td>
<td>12</td>
<td>46</td>
<td>26.0</td>
<td>3.5</td>
<td>76087</td>
</tr>
</tbody>
</table>

Table 1: Distribution of Cuban Doctors working overseas in 1980 (Grundy & Budetti 1980: 718).

Cuba has sent an incredible number of personnel abroad on technical assistance programmes, with 76,771 civilian Cuban volunteers and 40,000 African graduates from Cuban universities working on the

\textsuperscript{8} A medical superpower can be considered as a country which provides a world class health service, with excellent health indicators and is at the forefront of biotechnology research.
African continent in 2000 (Gonzales 2000: 322). In 1999, Mali, Niger, Chad, The Gambia and Burkina Faso all approached Cuba for doctors, and up to 200 were sent to each country (Gonzales 2000: 319). In 2000 Cuban doctors were at the forefront of maintaining emergency health care in Zambia when medical staff went on strike (15/01/2000). In 2001, Namibian also recruited 80 doctors and 12 pharmacists from Cuba, following earlier cooperation (Hamata 2001).

2.3.2 The American Embargo

Revolutionary Cuba’s sovereignty has been impinged from the start by the US embargo imposed on 7th February 1962 by President Kennedy, following the 1961 Foreign Assistance Act (Purcell 1998: 38), and maintained ever since. During the Cold War this was defended under ‘national security interests’. However, the end of the Cold War saw the US strengthen the blockade with claims of legitimation through humanitarian concerns and as a means to regime change. This was conducted through two main pieces of legislation: the Cuban Democracy Act, 1992, and the Cuban Liberty and Democratic Solidarity Act, 1996.

Since 1959 this embargo has cost Cuba heavily, from 1959 to 1987 the financial loss amounted to $11.5 billion, and between 1987 and 1992 a further $29.5 billion (Schwartzman 2001: 121). In 1993 the impact of the Cuban Democracy Act was to increase the cost of shipping to Cuba by 42% and cost the island $1 billion (Purcell 1998: 46).

Even though these acts are illegal, and have been condemned at the United Nations General Assembly for the last eleven years, the US maintains this policy. With scant evidence of the effectiveness of

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9 For more a detailed discussion of the American embargo and its legality and rationale, and further sources of information see Appendix 1: Sources for Further Discussion of the American Embargo.

10 It is illegal, under international law, to prevent the sale of foodstuffs and medicines to any country, including in times of war, something which this legislation violates, and has been ruled as illegal by the Organisation of American States Judicial Body, and violates World Trade Organisation rules.

sanctions in encouraging political change, the reason for this continued enforcement is due to the pivotal role of Cuban exiles in the US. Concentrated in Florida and New Jersey they strongly influence the return of 36 seats to the House of Representatives, and 40 electoral votes in the Presidential elections (Purcell 2000: 97). As a consequence, American Presidential candidates court their votes through anti-Cuban policies.

When reflecting upon the willingness, and ability, of Cuba to provide health professionals to other countries one must take cognisance of the hardships caused by the embargo. Only the pre-eminence of the Cuban health care system has averted a humanitarian tragedy resulting from a lack of food, clean water and medicines, due to the impacts of the blockade on the island (Chomsky 2000: 147, Oramas 2003).

2.3.3 Cuban Motivations and Aspirations

Development aid is typically promoted in an aura of altruistic help and solidarity with recipients, fitting with Cuba’s internationalist foreign policy. However, the reasons behind this policy must be interrogated since the domestic cost between 1963 and 1989 is estimated at $1,537.2 million, equivalent to 0.7% of Cuba’s GDP for this period (Eckstein 1994: 197). This figure is considerable when one considers the impacts of the US trade embargo and the collapse of the Soviet Union. The UN target for country’s Overseas Development Aid allocation is 0.7% GDP, a figure which many developed countries have so far failed to reach, yet Cuba has achieved.

Many have questioned Cuba’s internationalism, claiming that the island was subservient to the Soviet Union during the Cold War. However, this is highly unlikely for a number of reasons, not least the often antagonistic relationship between the foreign policies of the two states. Whilst the two states shared a Marxist-Leninist ideology and a desire to ferment Marxist revolutions in the Third World, relations were often strained, especially over conflict in the Horn of Africa and Cuba’s criticisms of the level of Soviet involvement in many African states. Others believe that Cuba’s involvement was motivated by the need to secure potential allies across the developing world in the face of threats from the US. Whilst elements of these are likely constituent motivations
for Cuban internationalism, the continuation of such ventures to the present suggests that there are other factors involved.

Cuba's aid regime is also dependent upon broader foreign policy interests and commitments. It has no former colonies to hold moral obligations to, nor does it have the power to invest aid in pursuit of national security considerations. Cuban policy holds certain similarities to Nordic policies, with a clear belief in the obligation to offer solidarity and support to their less fortunate brethren (Degnbol-Martinussen & Engberg-Pederson 1999: 9). Cuba also portrays history, and the moral debt the island owes to the African slaves imported to the island after 1524, as motivating factors for her involvement in Africa. The influence of this community on the island is still evident today, as Cuba's “national character and culture are strongly moulded by the past” (Marshall 1987: 7). So whilst not holding a moral obligation to a former colony, the Cuban government feels morally obliged to those exploited in her development as a Spanish colony.

Cuba also benefits economically from internationalist interventions. Whilst some have suggested that Cuban Cold War actions were rewarded by the Soviets, there is little evidence to support these claims. However, Cuba does recognise the economic rewards of internationalist ventures from other sources. The export of human resources has offered the island the opportunity to earn hard currency when other means have been closed to it (Feinsilver 1989: 19), one which has been even more important following the collapse of the Soviet Union.

In the 1970s a series of overseas construction programmes earned Cuba large amounts of hard currency. Projects in Libya and Angola in 1979 earned the island $140 million, 18% of their foreign exchange trade that year (Eckstein 1994: 189). In 1980 the export of human resources earned the island $100 million (Feinsilver 1989: 19), and in 1981 the donation of a construction facility to The Congo led to a contract for highway and urban construction for Cuba in return (Eckstein 1985: 380). During the 1970s Cuban aid also opened up trade markets, producing a 560% rise in trade figures for the first half of the decade, and 117% in the second (Eckstein 1994: 191).
From the late 1970s Cuba began charging recipient states for services rendered, on an ability-to-pay basis, claiming that this would facilitate Cuba in extending offers of assistance to other states (Eckstein 1985: 379-380). In the case under consideration this is likely to be a factor, as the Cuban government receives 37% of the salary of each doctor working in South Africa. In addition to this, Cuba could be using medical diplomacy, “collaboration between countries on health matters for the purposes of improving relations with one another...[which produces] humanitarian benefit while simultaneously developing improved relations” (Feinsilver 1989: 18), to assist other policy spheres and enhance potential trade and other cooperation.

Krook’s (1998b) insightful work on Cuban internationalists in Angola illustrates the reasons for individuals ‘volunteering’ to participate. These include the opportunities for travel, secure employment and wages, preferential housing on return to Cuba, and that often those who declined to go were subsequently stationed in undesirable domestic areas. Whilst these comments refer to Cuba’s involvement in Angola, some remain relevant today. The motivations for individual doctors arise from the consequences of the high doctor to patient ratio in Cuba, which means that wages are low and opportunities to gain experience limited. Consequently, working abroad offers economic benefits and professional advantages through the development of greater skills and experience. Additionally, the Cuban ethos emphasises non-material over material wealth. The accruing of symbolic capital through involvement with internationalist projects will then help individuals enhance their standing in the egalitarian society. As Bourdieu (1995: 179) and Feinsilver (1999: 3) observe, symbolic capital can be convertible into material capital. This can be seen in Cuba where returnees receive priority access to better housing and scarce consumer goods, a valuable reward given the economic and social conditions in Cuba (Krook 1998b, Roca 1982: 192).

2.3.4 South African Motivations and Hopes

South Africa’s motivations are in part ideological. When elected, President Mandela emphasised that South Africa would stand by those countries, including Cuba, which had supported the ANC during the struggle against apartheid. Within this belief lies a determination not to
drain other developing countries of skilled personnel they can ill-afford to lose, as is happening to post-apartheid South Africa (figure 2). With the agreement, as the Eastern Cape Health MEC Bevan Goqwana observed, “The advantage of being helped by Cuban doctors is that we are not draining the human resources of our neighbouring countries,” (Hansson 02/04/2001).

South Africa’s acceptance of Cuban support also results from the common perception among many developing countries that Cuban aid is not tied to imperialistic ambitions. In keeping with the principles of NEPAD, Cuban involvement is viewed as self-help development, free from dependency (Grabendorff 1980: 5). As Nelson Mandela said in 1995 “Cubans came to our region as doctors, teachers, soldiers, agricultural experts, but never as colonizers” (Mandela 1995).

The Cuban agreement falls within a broader policy designed to optimise donor synergy and benefits resulting from specific aid modalities. South Africa regards developed Europe as being her most important source of development assistance (Mamoepa 2001a: 31), and as a key player in fostering both North-South and South-South development partnerships. In order to optimise the benefits gained from aid flows, South Africa is seeking to expand her aid portfolio and exploit the comparative advantages offered by Cuban support. At the same time South Africa is embarking upon an intensive drive to improve the skills situation in the country through the Human Resource Development
Program\textsuperscript{12}. This is especially important in the public sector and the agreement with Cuba, which provides for South Africans to be trained in Cuba and for Cuban doctors in South Africa to pass on their skills and knowledge, can be viewed as an integral component of this mission.

2.3.5 South African – Cuban Cooperation

Cooperation between Cuba and various states and political parties in Africa has been evident from the infancy of the revolutionary government in Havana. Cuba played "a pivotal role" in the struggle against apartheid and colonialism in the sub-region (Mamoepa 2002), and continues to invest resources in capacity building on the continent.

Relations with South Africa under apartheid were highly antagonistic towards the minority government in Pretoria with Cuba supporting the MPLA in Angola, and the exiled ANC from the 1960s onwards. During apartheid a close friendship developed between Fidel Castro and Nelson Mandela, something which has subsequently encouraged relations between the two parties\textsuperscript{13}. The first sign of cooperation between the majority South African state and Cuba came in 1993 when two Cuban doctors, as part of Doctors of the World, established a primary health care system in the Botshabelo area of South Africa (Davis 1999). Following the election of the ANC in 1994, relations between the two states developed rapidly, with respective embassies opening in Pretoria in 1994 and Havana in 1995.

These close relations were characterised by the signing of the first health agreement between the two governments in November 1995. This agreement was expanded in January 1997, and renewed again on March 30\textsuperscript{th} 2001. Building on these foundations the South Africa –

\textsuperscript{12} Further details of the South African government's Human Resource Development Programme can be found through the South African Department of Public Service Administration's website, http://www.dpsa.gov.za.

Cuba Joint Commission was established to promote cooperation and trade between the two states following the visit of the Minister for Foreign Affairs, Nkosazana Dlamini Zuma, to Cuba in February 2001 (Mamoepa 2001a: 41, Mamoepa 2001b). The joint commission also contains provisos for the continued expansion of cooperation in the health care sector including the areas of medical training, the transfer of technology and expertise, and the conduct of scientific research, biotechnology and biopharmaceuticals (Department of Foreign Affairs 2002, Mamoepa 2001a: 42). In addition to this, other bilateral agreements have been signed, covering human resource development in health, education, science and technology, sports and culture.¹⁴

These bilateral relations have also led to the establishment of further multi-lateral development cooperation projects involving South Africa and Cuba in assisting other African states. These include the trilateral medical assistance project involving South Africa, Cuba and Nigeria in Mali to supply medical staff and expertise (2002), and Cuba's offer to help South Africa manufacture their own generic copies of drugs and to waive the patents on drugs developed in Cuba (31/03/2001).

2.3.5.1 The Intergovernmental Contract:

The South Africa – Cuba agreement on health is integral to the South African government’s multi-pronged approach to health care and staffing, and the government’s overall strategy on human resource development. The initial cooperation agreement was signed in 1995, under the then Health Minister Nkosazana Dlamini Zuma, seeking to broaden assistance in the provision of Cuban doctors to South Africa, and cover cooperation in health research, academic collaboration, health policy and programmes, biotechnology, vaccine production and pharmaceutical development (Harvey 2001). This enabled South Africa to recruit Cuban doctors to work in rural constituencies in South Africa, initially on a one year contract but renewable for up to three years. Subsequent additions to the agreement in 1997 provided for South African students from disadvantaged communities to undergo medical training in Cuba, paid for by the South African government, with the first of these returning to work in South Africa in 2002 (Tshabalala-

¹⁴ For a list of bilateral agreements signed see Appendix 2
Msimang 2002b), and for Cuban lecturers to work in South Africa (Department of Foreign Affairs 2002).

Under this agreement an initial batch of 254 South African medical students travelled to Cuba in 1996, under sponsorship from their home province. Upon completion of these studies the students return to South Africa and serve the public health service in their sponsoring province for an equal number of years as were spent training. The first of these graduated in 2002 and returned to South Africa, whilst further groups of students continue to travel to Cuba to undergo training (Tshabalala-Msimang 2002a, Tshabalala-Msimang 2002b). The first groups of Cuban doctors arrived in South Africa in 1996 and by January 2001 353 Cuban doctors were in South Africa, alongside a further 22 medical lecturers, with the fifth group arriving later that month, bringing an additional 75 doctors and 14 lecturers (Harvey 2001). The arrival of a sixth team of doctors meant that the end of 2002 saw over 450 Cuban doctors and lecturers working in South Africa under this agreement (Mamoepa 2002).
Chapter 3 Health Care Policy

The way a society looks after its weaker members – the sick, the elderly, the mentally ill and the handicapped – vividly reflects its fundamental values (Marshall 1987: 133)

Health care policy is a key component of any state’s social welfare and development policies. A good level of health is required to provide an efficient and effective labour force for economic expansion and social development. In developing countries, lacking the interlinking safety nets found in developed societies, health care is even more important as “disease in a single individual has a massive ripple effect, impacting negatively on the health of an entire family and community” (de Gruchy & Baldwin-Ragaven 2003).

3.1 Cuban Health Policy:

Today the whole world – including our enemies – acknowledge that our public health and education are impressive achievements, never before attained by any other country of the so-called Third World (Castro 1985: 22).

In order to understand why South Africa is turning to Cuba for medical support, one must consider the nature of Cuban healthcare policy, and why Cuba can offer such support.

3.1.1 Cuban Health Care before the Revolution

Cuban health care before the revolution underwent an important transition when Cuba was occupied by American soldiers at the end of the Spanish-American war in 1899. Until this time life expectancy was low, with poor sanitation and health care across the island. By the time of the Platt Amendment in 1902, and the withdrawal of American troops, huge advances in sanitation produced a decline in mortality rates. For the next thirty years Cuba was “a virtual colony” of the United States (Chomsky 2000: 85), and benefited from rapid economic
growth facilitated by American investment and the dissemination of medical advances across the Florida Straits.

The Platt Amendment was abrogated in the 1930s and the reliance upon sugar exports meant the economy stagnated in this period, resulting in a deterioration of social welfare. The effects of these developments were compounded by the inequitable distribution of resources leading to a two-tier health system in urban areas. Mutualist health foundations provided a form of privatised health care for those who could afford the fees, and the state provided for those who couldn’t.

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated life expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>City of Havana</td>
</tr>
<tr>
<td>1900</td>
<td>37.2</td>
</tr>
<tr>
<td>1901</td>
<td>39.1</td>
</tr>
<tr>
<td>1905</td>
<td>36.4</td>
</tr>
<tr>
<td>1910</td>
<td>41.3</td>
</tr>
<tr>
<td>1915</td>
<td>39.2</td>
</tr>
<tr>
<td>1919</td>
<td>41.5</td>
</tr>
<tr>
<td>1920</td>
<td>50.8</td>
</tr>
<tr>
<td>1925</td>
<td>54</td>
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<tr>
<td>1930</td>
<td>58.8</td>
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<td>55.8</td>
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<td>1950</td>
<td></td>
</tr>
<tr>
<td>1953</td>
<td></td>
</tr>
<tr>
<td>1955</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Estimated life expectancies, Cuba, 1900-1958 (Diaz-Briquets 1983: 19, Feinsilver 1989: 23)

For the urban elite, life expectancy in the 1950s was over 60 years (table 2), and Cuban mortality rates were among the most favourable in the developing world (Diaz-Briquets 1983: 103). However, these advances were achieved at the expense of the poor and rural communities who
benefited little. Whilst the doctor to patient ratio in 1958 was respectable, with one physician per 1000 citizens (Danielson 1985: 47), these were concentrated in the urban areas (figure 3), and this aggregate figure needs to be treated with caution when considering the true nature of health care in Cuba. As a consequence, Cuban society remained highly unequal, with huge differentials in access to resources and social provision exacerbated by the corruption of the Batista regime from 1952 to 1958.

![Population Per Physician, Cuba, Province of Havana and City of Havana](image)

Figure 3: Population per physician, Cuba, 1899 to 1953 (Diaz-Briquets 1983: 50, Feinsilver 1989: 23) * Data for City of Havana in 1943 and 1953, and data for City of Havana in 1953 unavailable.

### 3.1.2 Cuban Health Care after the Revolution

Health care [a]s a basic human right and the responsibility of the state (Feinsilver 1989: 1)

Following the overthrow of the Batista regime in 1959 the revolutionary government in Cuba invested heavily in health care, with a view to becoming a world medical power. Cuba's committed comprehensive social medicine programme[^15], within a framework of social and political

[^15]: The social medicine programme is based upon "the pursuit of an integrated and implemented understanding of both health needs and health services, giving attention to physical environment and human biology, but emphasizing (1) optimal consideration of social, organisational, and economic
policy considerations which see health as a social problem requiring a social solution (Nikelly 1988), has resulted in an improvement of health indicators, such as life expectancy at birth (table 3), to the level of many countries in the developed world (table 4). These achievements, which have been acclaimed by the World Health Organisation and the Pan-American Health Organisation, have been cultivated despite economic hardships resulting from slow economic growth, the collapse of the Soviet Union and the US blockade.

<table>
<thead>
<tr>
<th>Year</th>
<th>Life Expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>64</td>
</tr>
<tr>
<td>1965</td>
<td>67.2</td>
</tr>
<tr>
<td>1970</td>
<td>70</td>
</tr>
<tr>
<td>1980</td>
<td>71.8</td>
</tr>
<tr>
<td>1982</td>
<td>74</td>
</tr>
<tr>
<td>1994</td>
<td>75</td>
</tr>
<tr>
<td>1997</td>
<td>76</td>
</tr>
<tr>
<td>2000</td>
<td>76.9</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Country</th>
<th>1997</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>78.18</td>
<td>78.93</td>
</tr>
<tr>
<td>Cuba</td>
<td>76.05</td>
<td>76.47</td>
</tr>
<tr>
<td>France</td>
<td>78.36</td>
<td>78.86</td>
</tr>
<tr>
<td>Japan</td>
<td>80.42</td>
<td>81.07</td>
</tr>
<tr>
<td>Mexico</td>
<td>72.43</td>
<td>72.97</td>
</tr>
<tr>
<td>Norway</td>
<td>78.14</td>
<td>78.6</td>
</tr>
<tr>
<td>South Africa</td>
<td>54.72</td>
<td>47.81</td>
</tr>
<tr>
<td>Switzerland</td>
<td>79.08</td>
<td>79.7</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>77.09</td>
<td>77.33</td>
</tr>
<tr>
<td>United States</td>
<td>76.13</td>
<td>77.07</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>44.54</td>
<td>39.93</td>
</tr>
</tbody>
</table>

Table 4: Comparison of life expectancies at birth, 1997 and 2000 (World Bank 2003b).

...factors insofar as they relate to health needs and effective services; (2) attention to and measure of health status and health services within defined social and geographical categories; and (3) achievement of social equity in health”. (page 46 in Danielson R. 1995. Medicine in the Community. In Cuba Twenty-Five Years of Revolution, 1959-1984, ed. S Halebsky, JM Kirk, pp. 45-61. New York: Praeger).
This progress was initially hindered by the emigration of half the 6,000 doctors in Cuba around the revolution. Subsequently, Cuba relied upon support from neighbouring states to supply medical staff until they were able to train enough doctors to meet their needs. By the mid-1960s Cuba had achieved basic medical coverage for the entire island for the first time, and by 1975 this had extended to 56 rural hospitals (Diaz-Briquets 1983: 106). With Cuba’s primary health care policy implemented by physicians, and mass inoculation and hygiene campaigns (Davis 1999), a large number of doctors were required.

From 3,000 in 1959, Cuba had 25,567 practising doctors in 1986 (1 per 399 inhabitants), and 60,248 medical graduates in 1995, a figure predicted to rise to 65,000 by the year 2000, with 10,000 on internationalist service leaving a ratio in Cuba of 1 per 196 inhabitants (table 5) (Davis 1999, Feinsilver 1989: 6-7). These figures compare exceptionally favourably with developed countries, with the doctor to patient ratio in Britain standing at 1 doctor per 518 inhabitants, and one per 510 residents in Canada (Rock Around The Blockade 2003, Tasz 1995). It is this requirement for such a large number of doctors to maintain Cuba’s health care system, coupled with Castro’s aim for Cuba to become a world medical power, and the desire of many young Cubans to train as doctors that has led to Cuba overproducing doctors.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population per physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>676</td>
</tr>
<tr>
<td>1980</td>
<td>580</td>
</tr>
<tr>
<td>1982</td>
<td>580</td>
</tr>
<tr>
<td>1983</td>
<td>524</td>
</tr>
<tr>
<td>1987</td>
<td>400</td>
</tr>
<tr>
<td>1994</td>
<td>300</td>
</tr>
<tr>
<td>1998</td>
<td>189</td>
</tr>
</tbody>
</table>


16 These inoculation campaigns have managed to eradicate poliomyelitis (1962), diphtheria (1969), and measles (1993), tubercular meningitis, neonatal tetanus, German measles and postpartum meningonephritis, with a prolonged and steady decline in the incidence of tuberculosis. Davis J. 1999. South Africa need for doctors why turn to Cuba? http://www.unisa.ac.za
The support of the Soviet Union, from 1959 until the collapse of Communism in Eastern Europe in 1989, undoubtedly facilitated Cuba’s health care advances in this period. Soviet support from 1961 to 1979 alone amounted to between $8.25 billion (Díaz-Briquets 1983: 117) and $20.5 billion (table 6). In addition to this Cuba’s trade with the Soviet Union, and the Soviet supply of oil to Cuba, were conducted at rates preferential to Cuba, thereby providing further support to the island’s economy. During this time Cuba’s economy grew at a respectable 3.1% annually until 1989, allowing Cuba to invest heavily in health care, with government health care spending reaching $227.3 million in 1989 (Davis 1999, Giles 1997: 29).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Amount or %</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soviet economic aid to Cuba</td>
<td>$16.7 billion</td>
<td>1961-1979</td>
</tr>
<tr>
<td>Soviet military aid to Cuba</td>
<td>$3.8 billion</td>
<td>1961-1979</td>
</tr>
<tr>
<td>Cuban current debt to USSR</td>
<td>$5.7 billion</td>
<td>1961-1979</td>
</tr>
<tr>
<td>Cuba’s percentage of total trade with USSR</td>
<td>66%</td>
<td>1977-1980</td>
</tr>
<tr>
<td>Soviet share of Cuba’s trade deficit</td>
<td>51%</td>
<td>1961-1980</td>
</tr>
<tr>
<td>Percentage of Cuba’s sugar exports to the USSR</td>
<td>56%</td>
<td>1975-1979</td>
</tr>
<tr>
<td>Percentage of Cuba’s oil needs supplied by the USSR</td>
<td>98%</td>
<td>1967-1975</td>
</tr>
<tr>
<td>Percentage of Cuba’s foreign trade carried by Soviet ships</td>
<td>45%</td>
<td>1975</td>
</tr>
</tbody>
</table>

Table 6: Soviet – Cuban economic relations during the 1960s and 1970s (Mesa-Lago 1982: 4).

The fall of the Soviet Union produced a decrease in Cuba’s GNP from 1989 to 1994 of 35%, and a further 75% in 1994, as well as a loss of 85% of Cuba’s $13.5 billion export trade (Giles 1997: 29). The health care budget consequently fell to $56.9 million in 1993. However, with a resurgence in the economy since 1994 this level rose to $187.6 million in 1996, but fell again in 1997 to $130 million (Davis 1999, Giles 1997: 29). This has meant that since 1989, calorie intake in Cuba has dropped by a third, and GNP has fallen 240%, resulting in the reappearance of malnutrition related illnesses. Yet Cuba still provides free health care to a population which is 98% literate (Buxton 1998: 31).
The impact of the blockade has also been severe. A recent survey by the American Association for World Health concluded that “The US embargo of Cuba has dramatically harmed the health and nutrition of large numbers of ordinary citizens” (Philips 2003). In contravention of international law, the embargo also cut licensed sales of food and medicine to Cuba by 90% in one year (Chomsky 2000: 147), as many US pharmaceutical companies dare not trade with Cuba for fear of reprisals under the Cuban Democracy Act. The impacts of reduced access to hard currency, increased shipping costs and increased prices of medicines have meant that “the Cuban health care system relies on its major asset: a substantial, caring and educated workforce” (Buxton 1998: 30). This asset has meant Cuba has been able to develop alternative income sources for health care, through ‘sun and surgery’ and internationalist ventures.

The promotion of ‘sun and surgery’, or medical tourism, has allowed the government to access hard currency by exploiting its competitive advantages - state-of-the-art treatment in the Cuban climate and environment. Through this, Cuba attracted 7,000 such ‘tourists’ from Western countries in 1996 alone, bringing US$25 million into the Cuban economy. Whilst the Cuban American National Foundation attacks this use of staff (CANF 2003), this income helps mitigate the budget deficit resulting from American sanctions and finances wider social service provisions. At the same time Cuba is able to generate symbolic capital by treating patients from the West, capital which may later be transferred into material capital (Bourdieu 1995: 179). One such case is the 8 year old British girl who was successfully treated in Cuba, at the expense of the Cuban government, after treatment in the UK had failed (Feinsilver 1989: 21).

3.2 South African Health Policy:

3.2.1 Pre-Apartheid Health Care

The first ‘Western’ health care began to develop in South Africa with the establishment of hospitals on the Cape of Good Hope for the sailors of trading companies. It wasn’t until the 19th century that the first government hospitals for black patients were developed in Pietermaritzberg and King William’s Town, in order to ensure black
allegiance to the British government and to improve the health of the miners. Until this time, black patients relied upon missionary hospitals, including one at Nongoma in KwaZulu Natal, now a state run hospital. In the middle of the twentieth century, white concern for the health of the black population increased, due to the threat of the spread of disease in urban areas, and the economic repercussions of any potential deterioration in labour supply. However, despite the strong criticisms of the Glickman commission in 1942, the government did not act to improve conditions (Torkington 2000: 6-10), as black and rural health care remained of secondary importance.

3.2.2 Apartheid Health Care

Health systems operate within the socio-economic conditions of the state (Coovadia 1988: 45), and in apartheid South Africa this was reflected in bias of staff and facilities towards the white, urban, middle class populations. In 1981, there were 3,920 medical specialists and 16,787 general practitioners registered in South Africa, distributed so as to provide one doctor for every 330 whites, one per 730 Indians, one per 12,000 coloureds and one per 91,000 Black Africans (Kale 1995a: 1119, Seedat 1984: 84). These figures, for all but the white population, compare poorly to a ratio in Cuba of 1 physician per 580 citizens in 1982 (Feinsilver 1989: 23).

The longstanding inequalities of this four-tier health system meant there were huge disparities in resource provision between and within provinces. Differences in doctor : patient ratios illustrate this, with the urban ratio standing at 1:1237, rural areas 1:5396 and homelands 1:13000 (Pick 1996: 1488), the higher staffing and expenditure in urban areas reflecting the concentration of the white population here (tables 7 and 8). These differences manifested themselves in inequalities in health indicators, such as infant mortality rate; white 12.6, coloured 50.7, and urban black 86 (Andersson & Marks 1988: 670). Manipulation of health care budgets was also used to encourage Bantustans to take independence. By the mid-1980s, 50% of the South African population lived in Bantustans, which only had 3% of South Africa's doctors, a situation saved from collapse by South African doctors carrying out national service and the presence of foreign doctors working there (Baldwin-Ragavan et al 1999: 22).
Health services were, and still are, delivered through two sectors – public and private. During the 1960s and 70s the private health care sector consumed one-third of the 5% of South Africa’s GNP spent on health care, employing 40% of doctors to treat 20% of the population. This became more extreme in the 1980s when 60% doctors were employed in the private sector, still treating 20% of the population (Benatar et al 1997: 1537). By 1992/3 this had increased, such that the private sector received 58.2% of government expenditure, employing 59% doctors, 98% dentists and 89% pharmacists, covering only 7 million in private health care schemes and 2 million in work schemes (Bloom & McIntyre 1998: 1532).

Public health services were administered through 14 separate departments, one for each of the four homelands, the six ‘self-governing’ territories, and four national departments for each of the racial groups (Kale 1995a: 119). This led to a duplication of structures and inefficient implementation, and a health care system with a multi-tiered care regimen so that

While whites enjoy standards of living and suffer diseases similar to those in developed Western countries, the health of the majority of blacks is undermined by the social conditions which have provided prosperity for the whites, who control the productive resources of the country. …For
the vast majority of blacks, disease is determined by physical
impoverishment, which is the result of the policies of
apartheid. (Andersson & Marks 1988: 668)

Consequently, by the late 1970s disease patterns for the white
population were similar to the developed world, whilst for the black
population they matched the patterns of the developing world (Seedat
1984: 10-11).

Using Malthusian premises, apartheid health care for the black
population focused upon reducing fertility rates and contraception,
rather than health care (Andersson & Marks 1988: 668). This was
evident in the distribution of health care funding in the late 1970s, with
90% being spent on curative care, which primarily benefited the white
population, and only 2% on preventative medicine which would largely
benefit the black population (Seedat 1984: 12). These biases were also
manifest in the medical syllabus, which prepared students for working
in the westernised environment of whites-only hospitals, but not for
rural or blacks-only hospitals

3.2.3 Post-Apartheid Health Care

The government is committed to providing basic health care
as a fundamental right (Burger 2003: 340).

In the post-apartheid era “health sector reform in South Africa, as
elsewhere, has been shaped by attempts to remake the state” (Pillay
2001: 747), and can be witnessed in the bureaucratic restructuring and
the redistribution of resources to develop a more equitable society.
Following their election victory, the ANC wanted to base health service
provision upon the British National Health Service. However, the new
federalist constitution of South Africa made this difficult. So there has
been devolution of powers, and a redistribution of resources, due to the
inequitable distribution of expenditure and physicians at the end of the
apartheid era (tables 9 and 10), between racial groups, from curative to
preventative health services, and from urban to rural areas. Enshrined
within the new constitution “access to health care is acknowledged as a
basic human right” (Baldwin-Ragaven et al 1999: 2). Encompassed in
the 1994 Reconstruction and Development Programme and the 1997
White Paper on Health, health policies have set about tackling the legacy of apartheid, seeing it as “the right of all human beings, without distinction to sex, social group or economic or political standing, to the necessities of life, which include health care and health information” (Bryant et al 1997: 109).

<table>
<thead>
<tr>
<th>Province</th>
<th>Present (ZAR000)</th>
<th>Equitable (ZAR000)</th>
<th>% Change Required for Equitable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>2,109,396</td>
<td>872,966</td>
<td>-58.62</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>248,164</td>
<td>210,502</td>
<td>-18.8</td>
</tr>
<tr>
<td>Orange Free State</td>
<td>992,657</td>
<td>971,226</td>
<td>-12.23</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>1,613,057</td>
<td>2,162,996</td>
<td>+34.09</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>2,481,641</td>
<td>2,705,145</td>
<td>+9.01</td>
</tr>
<tr>
<td>Eastern Transvaal</td>
<td>372,246</td>
<td>903,772</td>
<td>+142.79</td>
</tr>
<tr>
<td>Northern Transvaal</td>
<td>620,410</td>
<td>1,778,595</td>
<td>+177.65</td>
</tr>
<tr>
<td>PWV Area</td>
<td>3,350,216</td>
<td>1,830,547</td>
<td>-45.36</td>
</tr>
<tr>
<td>Western Transvaal</td>
<td>620,410</td>
<td>1,137,466</td>
<td>+83.34</td>
</tr>
</tbody>
</table>

Table 9: Budget allocations, 1993/4 by province (Torkington 2000: 12)

<table>
<thead>
<tr>
<th>Province</th>
<th>Number of GPs per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>9.74</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>2.98</td>
</tr>
<tr>
<td>Free State</td>
<td>3.43</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>5.54</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>3.93</td>
</tr>
<tr>
<td>Eastern Transvaal</td>
<td>2.71</td>
</tr>
<tr>
<td>Northern Transvaal</td>
<td>1.41</td>
</tr>
<tr>
<td>Central Transvaal</td>
<td>6.94</td>
</tr>
<tr>
<td>Western Transvaal</td>
<td>4.07</td>
</tr>
</tbody>
</table>

Table 10: 1992 distribution of GPs by province, per 10,000 population (Torkington 2000: 11)

In 1994 the Government of National Unity opted for a primary health care philosophy, with the key objective being to “increase access to integrated health care services for all South Africans with a focus on rural, peri-urban and urban poor” (Bloom & McIntyre 1998: 1535). With this commitment user fees for children under 6 years old and pregnant mothers were removed in 1994, a step followed in 1997 by their abolition for all South Africans (Wilkinson et al 2001). However, recent research has shown that despite such policies some increases in
disparities between provincial budgets have occurred (Pillay 2001: 754), suggesting that reforms aimed at equality in health service provision are proving problematic.

Despite this, the policy reflects a holistic approach to health care, much in line with Cuba's, recognising the social and economic factors in disease pathology, that “poverty affects health by making you vulnerable to illness” (de Gruchy & Baldwin-Ragaven 2003). Such thinking can be traced back to Engels' (1999) work on The Condition of the Working Class in England in 1844, and whilst his concern was with the urban poor in England, the same principles can be applied to the health conditions experienced by the disadvantaged communities in South Africa under apartheid. Whilst the end of apartheid has brought an end to the ‘social murder’ as described by Engels (1999: 38), these problems remain to be tackled by new health care policy.

South African health expenditure is high, with 8.5% of GDP spent on the health service, having risen from 6.4% in 1995 and away from the Structural Adjustment Policy target of 5% by the year 2000 (Kale 1995b: 1397). However, only 40% of this spending has been upon public health services, the rest being funnelled into the private care system (Bloom & McIntyre 1998: 1529). Private sector provision covers just 23% of the population, whilst employing 62% of doctors (table 12), an increase of 4.5% since 1995 (table 11) (Schneider & Gilson 1999: 265). What South Africa needs is not simply an increase in the number of doctors, but more importantly an increase in doctors in the townships and rural areas.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Overall Total</th>
<th>Number in Private Sector</th>
<th>% in Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>17,438</td>
<td>10,067</td>
<td>57.7</td>
</tr>
<tr>
<td>Specialists</td>
<td>6,342</td>
<td>3,657</td>
<td>57.7</td>
</tr>
<tr>
<td>Dentists</td>
<td>3,748</td>
<td>3,330</td>
<td>88.8</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>15,794</td>
<td>14,841</td>
<td>94.0</td>
</tr>
<tr>
<td>Nurses</td>
<td>119,922</td>
<td>16,586</td>
<td>13.8</td>
</tr>
<tr>
<td>Total</td>
<td>163,244</td>
<td>48,481</td>
<td>62.4</td>
</tr>
</tbody>
</table>

Table 11: Health personnel in South Africa, 1995 (Torkington 2000: 27)
One of the key challenges facing South Africa today is the problem of the 'brain drain', which is of great concern as many professionals are emigrating (Table 13). This is occurring as health care professionals are both actively 'poached' by Western countries to fill vacancies there, whilst others leave South Africa due to problems with salaries, conditions of employment and the dangers posed by the prevalence of HIV/AIDS, which stood at 19.9% in 1999 (World Bank 2003a). Emigration is costly for South Africa, the 600 South African medical graduates working in New Zealand in 2000 were trained at a cost of ZAR600 million (US$37 million) to the South African taxpayer (Bundred & Levitt 2000: 245, Horton 2000: 177). The scale of the problem can be envisaged when one considers that 26% of medical graduates between 1990 and 1997 emigrated (Bateman 2001: 544). South Africa, not wanting to actively contribute to the brain drain of neighbouring states, banned the recruitment of medical staff from other OAU member states in 1995, in an effort to curtail the medical carousel17.

---

17 The medical carousel is a process whereby medical professionals move from country to country seeking better conditions of employment and salaries, such that doctors from Africa look to move to Europe or Canada, and many Canadian doctors move to the USA. This is then complimented by a number of doctors from these countries seeking to exit the environment in the UK or USA and work in a developing country for a while. Hence, one gets a shuffling of medical staff between countries, each seeking to improve their own standing.
Table 1: Professional Emigration From South Africa to Five Major Recipient Countries (Crush 2001a: 5)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>312</td>
<td>291</td>
<td>198</td>
<td>189</td>
<td>366</td>
<td>274</td>
<td>308</td>
<td>420</td>
<td>310</td>
<td>2658</td>
</tr>
<tr>
<td>New Zealand</td>
<td>25</td>
<td>24</td>
<td>12</td>
<td>49</td>
<td>93</td>
<td>349</td>
<td>209</td>
<td>297</td>
<td>286</td>
<td>1344</td>
</tr>
<tr>
<td>Canada</td>
<td>94</td>
<td>85</td>
<td>63</td>
<td>69</td>
<td>136</td>
<td>224</td>
<td>173</td>
<td>170</td>
<td>118</td>
<td>1132</td>
</tr>
<tr>
<td>USA</td>
<td>56</td>
<td>68</td>
<td>80</td>
<td>81</td>
<td>153</td>
<td>216</td>
<td>235</td>
<td>254</td>
<td>258</td>
<td>1410</td>
</tr>
<tr>
<td>UK</td>
<td>275</td>
<td>331</td>
<td>296</td>
<td>349</td>
<td>661</td>
<td>450</td>
<td>368</td>
<td>422</td>
<td>444</td>
<td>3596</td>
</tr>
</tbody>
</table>

In a bid to curtail the loss of skills through this process the South African government is considering increasing salaries and incentives, in a bid to retain medical staff in South Africa (Association 2003). However, the health budget is dependent upon the performance of the economy as a whole, and with unemployment running at 30.5% in September 2002 (Maumela 2003), and a large proportion of the population classed as ‘dependents’, these changes are heavily constrained. The difficulty in attracting workers to the rural areas exacerbates this problem, as the Eastern Cape health department has observed, “We’re trying to attract local professionals but they don’t want to work in these areas” (Dyonana 01/04/2003).

Consequently, community service for all newly qualified doctors was introduced in 1997, requiring them to undertake one year’s service in the public sector (table 14). This plan was introduced with the intention of improved health service access for all South Africans, by developing an equitable distribution of doctors across the state (Reid 2001). In 2002 this led to 1742 newly qualified doctors, pharmacists and dentists being deployed (Tshabalala-Msimang 2002a). However, until 2001 only 25% of those involved were placed in rural areas, with posts in urban hospitals being filled first (Naude 2001: 284), thereby defeating the original purpose.

40
### Provincial Distribution of Community Service Doctors from 1998–2001

<table>
<thead>
<tr>
<th>Province</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>1</td>
<td>125</td>
<td>110</td>
<td>143</td>
</tr>
<tr>
<td>Free State</td>
<td>4</td>
<td>93</td>
<td>74</td>
<td>86</td>
</tr>
<tr>
<td>Gauteng</td>
<td>7</td>
<td>169</td>
<td>132</td>
<td>144</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>4</td>
<td>233</td>
<td>261</td>
<td>276</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>0</td>
<td>79</td>
<td>105</td>
<td>116</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>0</td>
<td>17</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Northern Prov</td>
<td>1</td>
<td>155</td>
<td>140</td>
<td>155</td>
</tr>
<tr>
<td>North West</td>
<td>1</td>
<td>77</td>
<td>86</td>
<td>99</td>
</tr>
<tr>
<td>SAMHSu</td>
<td>0</td>
<td>38</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Western Cape</td>
<td>8</td>
<td>119</td>
<td>135</td>
<td>148</td>
</tr>
<tr>
<td>South Africa</td>
<td>26</td>
<td>1105</td>
<td>1115</td>
<td>1241</td>
</tr>
</tbody>
</table>

Table 14: Distribution of community service doctors, 1998-2001 (Strachan 2001)  
* 2001 figures based on number of applicants at time of Strachan’s writing.

Another element to these health care dilemmas is the role of traditional medicine, or muti. Under apartheid, traditional medicine was banned but continued to be practised underground. Today, evidence of its now legal use abounds, from the stalls at the village market in Nongoma, to the role of ancestors in Xhosa rituals in the KwaZulu-Natal township in Port Elizabeth, to the flyers being distributed on the streets of Pretoria. In an effort to incorporate traditional knowledge into current health policy, and to facilitate better patient referral, cooperation between practitioners of traditional and modern medicine is being encouraged.

The employment of foreign doctors in South Africa is not a new phenomenon, as mentioned above (section 3.2.2) foreign doctors were working in the Bantustans under apartheid, and in 2002 there were 7,203 foreign qualified doctors working in SA (Burger 2003: 344). It is in light of this framework of history, development and problem that Nkosazana Dlamini Zuma, as Minister for Health, introduced the government-government agreement with Cuba, in an effort to achieve the government’s pledge to provide access to health care for all. This dissertation will therefore consider the motivations for, and the success, or otherwise, of the agreement with regards the impacts of providing health care in South Africa.
Chapter 4: Results and Analysis

as we did in Cuba, like in our country, in that way to try to give the best of us to every patient, every day, every hour – Ernesto Castallo, 01/07/03

4.1: Government Motivations and Reasons Behind the Agreement

The reasoning behind the conception of this agreement has been explored in some detail above (sections 2.3.3 and 2.3.4), reasoning which was reinforced by many of those spoken to in South Africa. As Coovadia (1988: 52) predicted, the transition to democracy has produced a re-organising of health care power structures, an attrition of the privileged position of professionals and resulted in many health care staff leaving to work abroad (figure 4). These factors have facilitated the deployment of Cuban doctors in the current environment. The shortage of trained personnel in the country, with 4222 vacant medical public sector posts in July 2002, and predicted to rise to 7876 in 2011 (table 15) (Hall & Erasmus 2004: 4, 20), was viewed as a serious problem by many,

we are under-doctored, very badly, especially in the public sector. The public service here caters for about 80% of the population, we've got about 40% of the doctors – David Morrell, 01/07/03.

<table>
<thead>
<tr>
<th>Total employ</th>
<th>Growth in demand</th>
<th>Replacement demands</th>
<th>Total number of positions to be filled</th>
<th>New South African Graduates</th>
<th>% Supply</th>
<th>% Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>29655</td>
<td>32585</td>
<td>2930</td>
<td>19387</td>
<td>14441</td>
<td>64.7</td>
<td>35.3</td>
</tr>
</tbody>
</table>

Table 15: Supply and demand of doctors in South Africa, 2001-2011 (Hall & Erasmus 2004: 20)
Figure 4: Health care professional emigration before and after the transition to democracy (Hall & Erasmus 2004: 13).

South Africa’s eagerness to enter into a cooperation agreement with Cuba is seen by some as political payback for the support given to the ANC in exile, and was questioned by several respondents. It would appear that the close historical ties between the two parties have influenced the relations between the two states, with the then President Nelson Mandela observing,

\[\text{We are deeply indebted to the Cuban people for the selfless contribution they made to the anticolonial and antiapartheid struggle in our region (Mandela 1995).}\]

This sentiment was further emphasised by the Ambassador Swanepoel, Director Central America, Andes and Caribbean, Department of Foreign Affairs who mentioned that,

\[\text{historically there were very close ties between the African National Congress and Cuba, and this has impacted on relations between the new democratic South Africa and Cuba} \]

– Pieter Swanepoel, 11/07/03

However, the cooperation agreement is based upon far more than any sense of moral debt owed by South Africa to Cuba, or the friendship between Mandela and Castro. South Africa is in dire need of medical
staff. Cuba is one of the few countries in the world which overproduces doctors, and was very quick in offering support to the democratic South African government. Whilst the South African disease environment is different from Cuba’s, the Cuban doctors experience of practising in rural areas means that they can provide an effective and efficient service in South Africa.

They are used to functioning in Cuba with few resources, much worse than us, so here they are very adequately suited to a rural setting as, for example when the orthopod [orthopaedic surgeon] is in theatre he doesn’t have all the equipment he needs, or all the materials he needs, but he makes do with what he’s got and somehow get the patient functioning again with what he’s got as he’s used to this kind of setting back in Cuba—Samantha Nadaraju, 08/07/03.

Whilst attempts to contact representatives of the Cuban government failed, it would appear that they have a multitude of motivations. One of these is the inherent sense of proletarian solidarity and commitment to internationalism, a sentiment which underlies many of the decisions made in Cuba. A second factor would appear to be the financial and symbolic rewards Cuba gains from the medical diplomacy it employs with relation to South Africa. The government in Havana receives the 37% tax on the Cuban doctor’s wages that would normally be paid to the South African government. The subsequent recycling of capital through the island economy, of monies repatriated by doctors working in South Africa further enhance the island’s economy.

In addition, Cuba’s offer to enter the generic drugs market “could generate huge amounts of support for Castro from poor countries as he is seen to strike a blow against the capitalist drug companies” (Office for the Coordination of Humanitarian Affairs 2001: 2). This has the potential of becoming a vital source of foreign currency for Cuba, much needed with the economic downturn in face of the US blockade and the collapse of the Soviet Union.

Other economic benefits to Cuba arise from the continued expansion of the Joint-Bilateral Commission with South Africa, which covers many issues and facilitates trade and the development of skills and human
resources. Increases in Cuban exports to South Africa, and a shift in trade balances to favour Cuba can also be seen since 1994 (table 16), although any relation between this and the development cooperation is unproven. Cuba also garners South African support against the US embargo,

the International Commission on Human Rights every year they have a resolution, a resolution really that is in support of the embargo the United States has got against Cuba, we do not support that, we historically have voted against the resolution and in doing so because we feel that the domestic situation in Cuba does not justify the punitive measures that are being taken against Cuba – Pieter Swanepoel, 11/07/03

<table>
<thead>
<tr>
<th>Year</th>
<th>To SA</th>
<th>To Cuba</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>8661474</td>
<td>2707749</td>
</tr>
<tr>
<td>2000</td>
<td>6468079</td>
<td>2740054</td>
</tr>
<tr>
<td>1999</td>
<td>6879203</td>
<td>3975079</td>
</tr>
<tr>
<td>1994</td>
<td>14306167</td>
<td>40940811</td>
</tr>
</tbody>
</table>


The future for the scheme would appear to be assured. In the current global environment, the economic, material, and symbolic benefits, alongside the solidarity garnered through such South-South cooperation offer Cuba tangible benefits. Both the Department of Foreign Affairs and medical professionals expressed the belief that the agreement will be required for several more years. The long term view of these parties was that the best future for the South African health care was for South Africa to produce and retain enough of their own medical professionals to meet their needs. Until such time, it was agreed that the employment of Cuban doctors was a sensible and efficient use of resources,

for now I think that it is one of the easiest and quickest solutions to our problems... I think in the long term we have to do more to try to keep our own South African doctors here, rather than importing people – Samantha Nadaraju, 08/07/03
4.2 Perceptions of the Agreement

There is an obvious dichotomy in perceptions of the agreement, between those with experience of working with or around Cuban doctors, and those whose exposure has only been to media portrayals and word of mouth. The initial press reaction concerning the importation of Cuban expertise was highly negative, much of it fermented by the atmosphere of xenophobia in South Africa and also by medical professionals concerned about their job security. Whilst some of this criticism has abated over the years, stories relating to Cuban doctors remain apathetic at best; with the media focusing upon mistakes and confrontations, such as the four patients dying whilst being treated by Dr De La Parte in 1997 (Arenstein 1997), and the two Cuban doctors in Mpumalanga who sold off South African state property and absconded with the proceeds in 1999 (1999).18

These perceptions are also fuelled by the spread of horror stories and gossip, as a number of stories relayed by Helen, a hostel operator in Port Elizabeth, regarding substandard operations, amputations of incorrect limbs and poor treatment and confusion due to language problems illustrated. This negative portrayal in the media, and concomitant perceptions of lay people elicited a concerned response from Megan Cox, a community service therapist working at Benedictine Hospital,

that’s something I don’t understand, if you’re not working in a rural hospital maybe you’ll have a negative view but when you’ve got a choice of absolutely nothing or a doctor actually being present there in the consulting room, I’d choose to go with a doctor being in the consulting room – Megan Cox, 07/07/03

A surprising belief of several respondents was that Cuban doctors were depriving South Africans of employment. Given that Cuban doctors are present to mitigate the shortage of medical staff working in the public sector, especially in rural areas, the basis for this perception is dubious.

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18 Numerous articles can be found in the South African media relating to the performance of Cuban doctors, for further examples go to http://www.mg.co.za, http://www.dispatch.co.za, and http://www.iol.co.za.
As other respondents who have experience of working in the health sector observed,

It’s not like they’re taking jobs away from anyone, there’s nobody there to fill those posts... I don’t see people knocking on the door here asking for a job – Megan Cox, 07/07/03

anyone who says they are taking jobs away from South Africans, that is a misconception, it is totally untrue, inaccurate – Ian Couper, 25/06/03.

It is likely that the belief that Cuban doctors are taking jobs away from South Africans, is based upon ignorance, coupled with xenophobia and a common belief that immigrants to South Africa are denying many South African’s employment. The problem of xenophobia is widely recognised and, since 1998, the African government has been attempting to address this through the ‘Role Back Xenophobia Campaign’. However research by the South African Migration Project found that “The majority of South Africans are attitudinally hostile to outsiders but that they are not yet prepared to translate those attitudes into action; at worst they are latent “xenophobes”” (Crush 2001b: 6). This attitude was often expressed by people once they had found out the area of my research, commenting along the lines of ‘Maybe then you can tell us why they’re here’.

Others tended to be more philosophical about the situation, often because of personal exposure to public health care facilities or a different lived experience. Waldo Adams, ‘coloured’ self-employed tour guide in Port Elizabeth, expressed gratitude for the help being given by the Cuban doctors, whilst lamenting that South Africa had to rely upon outside support because skilled South Africans were unwilling to work for their own country. This second sentiment was echoed by the majority of the 21 informal interviewees, with many understanding their desire to emigrate in order to earn a higher salary and to escape negative aspects of

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19 The use of the term ‘coloured’ has been used as discussions with Waldo also covered his perception of identity. He saw himself as South African and rejected the coloured identity foisted on him under apartheid, as such this term is used as Waldo himself uses it, as a descriptor to try and give greater insight into his lived experience resulting from this labelling.
life in South Africa. Waldo also mentioned that many who worked in the United Kingdom did so for the duration of the two year work/holiday visa available to South Africans, and returned to South Africa following the visa’s expiry. This fits with the observations made by many others, that doctors would often work abroad both in order to gain broader experience and skills and to pay back the costs of their education, before returning. This is borne out by research showing that 25% of emigrants expect to remain outside South Africa for less than 5 years, and that only 12% never expect to return (Mattes & Richmond 2000: 26).

Interestingly many lay respondents tended to express initial hostility towards Cuban doctors in South Africa, but would become more positive as the discussions progressed. One respondent in Pretoria, a teacher, initially gave very negative responses towards the work of the Cubans, agreeing with another respondent, Quinton, a driver, that they were causing problems in the labour market. However, once the discussion went further, this respondent became more positive about the role of Cuban doctors. Part of the reason for her initial hostility may result from the implications of ongoing discussions relating to the recruiting of Cuban teachers to work in South Africa.

The feeling of insecurity amongst many white professionals in South Africa could have been exacerbated by the potential threat from Cuban teachers being brought into South Africa. This could have encouraged the portrayal of Cuban doctors in a negative light, thereby casting aspersions on the suitability of recruiting Cuban teachers. The overall feeling of many was summed up well by Sebastian, a teacher in Cape Town, observing that he felt many people’s attitude was one antipathy towards the Cuban doctors.

Respondents from the medical community in South Africa were much more positive towards the Cuban doctors. Whilst there were some criticisms of the scheme, rather than the work of the doctors themselves, the overall impression was that the South African medical community were very grateful for the work they were doing.

"rural hospitals in South Africa [would not survive] without Cuban doctors, they wouldn’t, they can’t get other staff … if"
you were to take the Cubans away the hospital just wouldn’t function – Megan Cox, 07/07/03

Whilst this positive perception is not universal, letters in the media have indicated that, with exposure to the work of Cuban doctors, some critics perceptions have changed (For example Xako 14/08/1998). Some do remain critical, believing that it is not the most efficient policy for the government to have embarked upon to solve this problem, and that

Instead of importing expensive and inappropriate Cuban doctors, we should be training a core of nurse practitioners from the rural areas who want to work in their places of origin (Gazi 04/10/2000).

This objection is somewhat misplaced, as the agreement contains provision for the training of South African doctors in Cuba, with a view to the long term sustainable staffing of the South African health care system.

These concerns are likely to be related both to the manner in which the white population of South Africa have been socialised into an American perception of Cuba (van der Linde 1996: 16), but also from the demonisation of Cuba as a consequence of the war in Angola in the 1980s. Through education and the media Cuba was portrayed in a negative light, and

Castro to us had been taught, that he was one of the devils of the twentieth century, you know, Gadaffi, Hitler, Castro, that was what we were fed at school, at white schools – David Morrell, 01/07/03.

For the black and coloured populations, Castro is often considered as a hero of the oppressed and is popular with many, this being voiced by Waldo Adams who was much more positive about Castro than many of the white respondents. With the white population holding these deep-seated views of Castro and Cuba, it is likely that many white South Africans would have a negative predisposition towards the employment of Cuban doctors. Only through education and information about the
nature of the agreement, its rationale and impacts have, and will, these sentiments be overcome.

The training of South African doctors in Cuba was also viewed positively. Four of the South African medical professionals interviewed expressed enthusiasm for this, believing that this could help to overcome the language problems encountered by both Cuban and some South African doctors operating in rural areas. These arise as many South African doctors in rural areas do not originate from these areas, and do not speak the local languages, so rely upon local nurses as interpreters for consultations. This element was also considered a good way of tackling the recruitment problems, by drawing upon the trainee’s sense of affinity to their home area,

They will want to go back to whatever town they came from and work in the hospital there? Yeah, I think that could do a lot – Megan Cox, 07/07/03.

Understanding the South African government’s perception of the agreement proved to be slightly problematic. The failure of the Department of Health to respond to numerous approaches, despite their interest in conducting research into the agreement themselves, meant that this perception had to be derived from the meeting with the Department of Foreign Affairs and government press releases. The overall impression generated through the course of the interview with the Department of Foreign Affairs was very positive. Whilst unable to address issues relating directly to the performance of doctors, it was evident that the Department was exceedingly satisfied with the scheme, and were in the process of expanding cooperation with Cuba on the back of this success.

Press releases from the government regarding the scheme were universally positive, with successive Health Ministers, Dr Zuma and Dr Tshabalala-Msimang releasing such statements. Dr Zuma rejected allegations in 1998 that she was planning to expel foreign doctors from South Africa, and rather values their work (Hlongwane 1998), whilst Dr Tshabalala-Msimang clearly articulated the integral role Cuban doctors were to play in his department’s staffing strategy (Tshabalala-Msimang 2002b). These two examples are indicative of the government’s official
line on the scheme, seeing the agreement as an effective way of tackling the skills shortage currently blighting the health service.

4.3 Individual Motivations

The Cuban doctors on the scheme hold a number of motivating factors for their involvement. The economic benefits of volunteering undoubtedly encourage participation, with one Cuban doctor observing that “we don’t need to hide this, we all came to try to improve our economic situation”. None of the doctors mentioned any economic or material reward for their internationalist duty upon their return to Cuba, so this potential motivation cannot be assessed. However, a number of them mentioned that the economic potential afforded them by this work meant they could enhance both their own standing, but also that of their family. Some were also keen to emphasise that their work would also aid the Cuban economy. These benefits, therefore, are not only seen in terms of personal gain, but also as a form of proletarian solidarity by helping their families and the wider population in Cuba,

to know that our help it goes to our country and want to know that it is helping whilst we are here. It is popular…there is support for the spirit of internationalism – Dr Millano, 08/07/03

In addition to his [Dr Gonzales, based at Ekombe hospital, KwaZulu Natal] first concern – providing medical care to those who need it – the doctor said that “my visit here permits me to help my country and my family (Rosenberg 1999).

The economic value of working in South Africa for the doctors is high. In Cuba the level of pay they receive is very low, around $20 per month according to one of their colleagues in South Africa. In South Africa the salary in 2001 was R6425 per month (21/02/2001), roughly $500 per month, with 37% going to the government in Havana. Even during the selection process certain of the applicants were prepared to admit economic benefits as a motivating factor,
I asked them all why they wanted to come to South Africa, and a lot of them gave the reasons that were exactly the same, they want to care for people, knew there was a shortage of staff, and then, the answers were very stereotyped and it came to one woman and she gave the same answer as everyone else, and I said, ‘Come on, I’m not stupid, you’re coming for the money aren’t you?’ She looked at me and laughed and said ‘Yes, I’m coming for the money’...You know, that is very much a part of the tradition of Cuban medicine, post-revolution, and they are keen to do that and keen to share their expertise and be of service. So, yes, there’s the economic aspect but, yes, there’s also the desire to help and contribute to society, which is I think is something that their ethos is a part of Cuban culture and philosophy, certainly post-revolution, and then the third thing is building up experience – Ian Couper, 25/06/03

The sincerity with which this internationalist sentiment was expressed, both directly and indirectly, and the vehemence with which it was repeated suggest that this is an important factor in individual motivation,

we don’t work for money or reward, there’s an international, internationalist duty – Dr Gonzales, 01/07/03

Whatever other reasons there may be for the doctors coming to South Africa there does seem in addition to be a genuine sense of wanting to help and to make a difference for people in other societies (Couper 2003: 3).

As human actions and beliefs are predicated upon, and influenced by the social beliefs they are acculturated in. In the case of Cuba, the dominant acculturation processes are orientated towards the pursuance of socialist goals, including the ideals of internationalism and proletarian solidarity, and so individual actions follow from this. Also mentioned were the possibilities for personal advancement, again fitting with the Cuban ethos of self-improvement and non-material wealth.

4.4: Wider Context and Impacts
Part of the reason for the level of Cuban involvement in South-South cooperation relies not upon their enthusiasm to become involved, but upon the willingness of recipient or partner countries to operate with Cuba. In addition to the historical links involved, there is a more widespread factor permeating much of the developing world's considerations. As mentioned earlier (section 2.3), the history of colonialism and Cuba means that Cuba is viewed as separate from the role of exploiter, that many Western donors remain tainted with. This was illustrated by Ambassador Swanepoel, when discussing the wide context of the agreement he commented that Cuba's motivations were, opposed to what Southern Africa has been exposed to for many years, and that is colonialism. Colonialism basically took out of Africa what it could, and enriched a few countries. The Cubans are not in it for that very same reason, they're in it for exactly the opposite reason. They go out from a small country with limited means, they have certain skills and they share these skills with other countries, and again not just countries in Africa, but I've seen them in Latin America. I've just returned from the Caribbean, where they're very active in the Caribbean as well. As far as, at least from a South African perspective, we consider as quite a noble cause, or a noble goal that they have, because they're not trying to enrich themselves and see what maximum benefit Cuba can get from it. They go out and they have very qualified people and people are sharing those experiences with people in other countries — Pieter Swanepoel, 11/07/03.

This statement contains many intertwined motivations for both Cuban government and Cuban doctors. The Cuban government is certainly involved out of a sense of moral duty, and is not attempting to exploit South Africa by charging extortionate amounts for the services of doctors. Whilst they are sharing their knowledge and skills with South Africa, one must recognise the benefits both Cuba and the doctors are gaining from this experience. These benefits are financial, symbolic and practical, through the continued development of skills and expansion of knowledge. The key difference between Cuba's actions and those of colonial and neo-colonial powers, is that Cuba's relationship with South
Africa is not exploitative, but rather seeks to promote development for both parties.

With regards NEPAD and South-South cooperation, Cuba's role is having a very positive effect in two ways. Firstly, South Africa views Cuban intervention as integral to the goals and success of NEPAD, both as a role model in providing support to fellow developing states and as an example of what can be achieved without reliance upon the developed world,

we see Cuba really as playing a very, very important role in NEPAD, in the sense that here you have a developing country, but a country that is putting its means at the disposal, not just of South Africa, but of Africa – Pieter Swanepoel, 11/07/03

The second element is the stimulus it appears to have given South Africa in pursuing similar policies elsewhere, much as Cuba endeavoured following her reliance upon external support in the early years of the revolutionary government. The embodiment of this can be seen in South African aid policy, with the emergence of tri-partite medical programmes involving South Africa as a donor, including one running in Mali in conjunction with Cuba and Nigeria, and also from the sentiments expressed by Mr Louis Pieenar, Deputy Director: Cuba and the Andean Community;

we are also turning to areas such as Latin America and the Caribbean where we could then also assist, because we have been assisted, we have been helped, that gives meaning to the so-called South-South cooperation – Louis Pieenar, 11/07/03.

In fitting with the overall framework of NEPAD, to enhance the skills base and build the capacity of the African continent, the cooperation agreement with Cuba on health care provides this for both parties. The training of South African students in Cuban medical schools is one obvious example of the improvements in skills levels, but there are others. The community service doctors, at Benedictine Hospital, also indicated that they were learning from operating beside the experienced
Cuban doctors. At the same time, all five of the Cuban doctors commented that they were developing new skills and improving their knowledge from working in South Africa.

This transfer and accumulation of skills forms part of the government's wider Human Resource Development Policy, which has grown out of government perceptions of problems with skill levels and emigration. Alongside the agreement with Cuba, South Africa has been attempting to structure schemes to allow South African medical professionals to work abroad on exchange whilst retaining their services in the longer term. One example is a new scheme operating with Kings College Hospital in London, which provides for nurses from London and South Africa to undertake a two year exchange. According to Dr Simon McGrath, Director of Further Education and Training Research at the Human Sciences Research Council in Pretoria, this is with a view to allowing South African staff an opportunity to work abroad, earn enough to pay back their tuition fees and gain experience before returning to work in South Africa. At the same time it is hoped that staff working alongside British nurses in South African hospitals will benefit from the experience and knowledge of these nurses.

Linked to this, a common complaint concerned the recruitment of South African doctors by countries in the West. Whilst emigration of skilled personnel from South Africa in general is a major problem, as noted by several respondents, including Peter a construction company owner in Cape Town, this is of particular concern in the health sector (section 3.2.3). In a bid to curtail recruitment by foreign governments and medical boards the South African government has successfully lobbied in both the UK and Canada, where measures have been taken to counteract this problem according both the South African Department of Foreign Affairs and Dr Simon McGrath.

This direct recruitment is a cause of angst for many.

It does irritate me how much these countries try to recruit from us through our journals, and I think we should jolly well recruit back without any qualms – Ian Couper; 25/06/03.
Public understanding of the motivations for doctors to leave South Africa was high, but this was strongly tempered by a feeling that these professionals were abandoning their country. Sebastian suggested that with a lack of a sense of South African identity there was little to hold South African doctor's affinity to their country. Others placed part of the blame for emigration at the door of the government's affirmative action policy, opposition to which is high amongst white professionals, with 83% opposing it (Mattes & Richmond 2000: 31). This, they claimed resulted in many white professionals being passed over for jobs and leaving to find employment abroad. Until the issue of emigration and the retention of South African doctors can be tackled, there will continue to be a shortfall in the number of practitioners in South Africa and a need to import doctors from abroad.

The presence of Cuban doctors has also brought with it a greater awareness, and application, of the ideas of holistic primary health care. This has been a component of the ANC's health care strategy from the inception of democratic government. The experience of Cuban doctors of working within such a framework in Cuba has allowed these principles to be applied in rural areas from the outset. Dr Olive Shisana, the Director of the Human Sciences Research Council in South Africa, during a discussion in Edinburgh in June 2003 commented that through their work with local communities the Cuban doctors had been developing a much broader understanding of the local disease conditions and encompassed health care within addressing wider issues.

The assistance rendered by Cuba in this agreement cannot be seen in isolation from other sources of aid to South Africa's ailing health system. Since 1994 South Africa has become a favoured destination for aid from many agencies, with the health system in particular benefiting greatly from aid flows (table 17). The preoccupation with quantifiable data, i.e. measurable in economic terms, means that it is highly problematic to try and offer a comparison with the aid Cuba is providing, and may also help to explain the lack of consideration given

20 The South African government introduced a policy of affirmative action following the demise of apartheid in an attempt to facilitate greater employment, and promotion, of black South Africans in organisations in South Africa by introducing quota targets for the proportion of people from different racial backgrounds at various levels of employment within an organisation.
to Cuba’s development assistance in Western literature given this preoccupation.

<table>
<thead>
<tr>
<th>Agency/country</th>
<th>Period</th>
<th>Funding (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>European Union</td>
<td>1994-1996</td>
<td>28.3mn</td>
</tr>
<tr>
<td></td>
<td>1998-2000</td>
<td>74.3mn</td>
</tr>
<tr>
<td>DFID (UK)</td>
<td>1994-1999</td>
<td>8.2mn</td>
</tr>
<tr>
<td>JICA (Japan)</td>
<td>1994-1999</td>
<td>3.0mn</td>
</tr>
<tr>
<td>WK Kellogg Foundation</td>
<td>1986-1996</td>
<td>3.7mn</td>
</tr>
<tr>
<td>Belgium</td>
<td>1995-1996</td>
<td>1.3mn</td>
</tr>
<tr>
<td>Flanders</td>
<td>2 years</td>
<td>0.7mn</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>One off</td>
<td>4.1mn</td>
</tr>
<tr>
<td>Finland</td>
<td>1997-1999</td>
<td>1.9mn</td>
</tr>
<tr>
<td>WHO</td>
<td>Annual budget</td>
<td>1.5-2.0mn</td>
</tr>
</tbody>
</table>

Table 17: Foreign aid to the South African health sector (From Schneider & Gilson 1999: 267).

Whilst it would seem that the technical assistance offered by Cuba to South Africa has been effective in helping meet the basic needs of the population, the difficulty of comparing this effectiveness with that of other development aid projects will mean that generalisations from this case study will be impossible to draw.

4.5 Costs of the Agreement

The benefits from this agreement come at a price, socially and economically. The economic cost of the scheme runs to many millions of Rand. In 2001, the cost to the Eastern Cape alone amounted to R1.8 million per month, for 95 Cuban doctors (21/02/2001), who were paid the standard South African salary for their post. The economic cost is offset slightly, as all Cuban doctors are registered under the agreement as medical officers, even if they are specialists, and so receive lower salaries.
The key social cost is borne by many of the Cuban doctors who have to live apart from their families for the duration of the contract. Those doctors who travelled to South Africa in the first four groups were able to bring their families with them. Those travelling more recently travel alone, and find themselves in a new and alien environment without the familial support network. Whilst this condition within the agreement is imposed by the Cuban government there are echoes of past labour policy in South Africa, of migrant mineworkers travelling to the mines for prolonged periods of time without their families. Concern over this element of the agreement was raised from the outset by Professor Morrell during the first selection visit, and it appears that his comments to Minister Zuma at the time may have influenced the provision for the initial groups to bring their families with them,

we’ve got a very bad history in this country with regards the migrant labour system. So that our people left their homes and came to the mines and the cultures fell apart and so on, giving problems of lawlessness and things like that. And the other aspect of our present contract is that these guys have to leave their families behind in Cuba. I objected to this part of the agreement when I was there, but it came from their side, but that worries me – David Morrell, 01/07/08.

However, South African influence over this is limited, as it is imposed by the donor country rather than the recipient government.

With the first four groups being allowed to bring their families with them, those arriving in South Africa later felt it was unfair that they were not extended the same provision. This was expressed by the Cuban doctors at Nongoma, who also felt that having their families with them would improve the standard of work they provided,

we are not allowed to bring our families here, so we are not as effective as we could be. We are thinking about our families, our children, if they were here so you feel in a familiar environment so you are focused upon your work – Dr Duval, 07/08/03
One of the highly emotive issues to have emerged from the agreement has been concerned with Cuban doctors breaking the terms of the contracts and seeking to apply for South African citizenship. This issue has been covered in the media in South Africa and is a source of contention for many of those involved. One of the doctors interviewed was involved with this. Claiming his main motivation was to remain in South Africa as his new family were here, he was adamant that he was not attempting to break his connections with Cuba, but wanted to remain Cuban and in line with his current contract repatriate a portion of his salary to Cuba every month,

What I am not trying to do is to break my contract, or contacts, with Cuba. What I am saying is that if I am doing my job here, and my family is here that I should be able to stay here...I don't want to lose my nationality, I want to remain Cuba, no matter where I live I am Cuban – Cuban Doctor 2003

This issue has only recently emerged, the future developments of this process and its impacts upon the future of the agreement cannot be fully considered here.

4.6 Local Context and Impacts

The context in which the agreement is operating is exemplified by the conditions found in the public sector hospitals in South Africa, illustrating why South African doctors are reluctant to work there. Both of the hospitals visited exhibited similar conditions. Whilst both were kept very clean there was a run-down air to them, with poor facilities. In this respect, the staffroom at Livingstone Hospital is indicative of the rest of the building. The room itself was fairly small, and contained a bed, three aging easy chairs, a small television, small microwave, fridge, water boiler and coffee plus a telephone. This basic level of furnishing appeared to be indicative of the rest of the hospital.

Benedictine Hospital in Nongoma provides health services for the surrounding district and employs eleven doctors, plus a further nine vacancies, and suffers from regular water and power shortages. Of the eleven employed there are four community service doctors, one Burmese
and one Chinese medical officer in addition to the five Cuban doctors. Without the five Cuban doctors, there would only be two experienced doctors at the hospital, a situation which would prevent the provision of health care services appropriate for a district hospital.

The impact on the ground of the agreement proved difficult to consider without the skills and resources to access the local population. However, it is clear that on the whole it has been positive, with the Cuban doctors being posted to rural hospitals and providing services which would not be available otherwise. South African doctors made it clear that without the work of Cuban doctors many of the services provided would cease,

there’s no doubt that they’re [Cuban doctors] of tremendous importance, and still are, despite what the public might think, it’s as simple as that. If he went, or if I lost Castallo, my partner [in anaesthesia], or Sanchez we would be in dire trouble – David Morrell, 01/07/03, Livingstone Hospital, Port Elizabeth,

without them [the Cuban doctors] I don’t think this hospital [Benedictine Hospital] would be functional – Heera Bhagat, 08/07/03.

In some instances their presence is allowing for operations to be carried out for which patients would normally have to be transferred to regional or national hospitals,

Our orthopaedic surgeon [at Benedictine Hospital], he is doing like, specialist stuff that doesn’t even get done in some regional hospitals, and he’s doing it here in the bush – Samantha Nadaraju, 08/07/03.

One issue which was raised on many occasions was that of language. Whilst the selection process includes a language proficiency element, and the Cuban government are employing English tutors to improve the doctor’s levels of English before travelling to South Africa, some problems persist as Dr Thomas commented, whilst
I have been studying more than 15 years, every year, studying English but it is not the same. Even the accent – Dr Thomas, 08/07/03

The doctors at Benedictine Hospital were forthcoming with the view that their proficiency in English had improved dramatically over the two-and-a-half years they had been in South Africa. Most of the consultations are conducted through a local nurse who translates between English and the local language, although this can result in many misinterpretations and misunderstandings during diagnosis and treatment.

At the same time, there is evidence from Nongoma and elsewhere, that many of the Cuban doctors are learning the local African languages such as, Xhosa, Zulu, and Tswana, and communicating to some extent directly with the patients in their mother tongues.

...to communicate for work we have to go to speak in English the first time, then in Zulu, I now speak some Zulu – Dr Millano, 08/07/03.

This is a process which Dr Shisana commented upon and is seen as a very positive step, one which many other doctors, both South African and foreign, do not take.

With the improvements made in language ability and adaptation to the local disease environment in South Africa, the three doctors interviewed at Nongoma, felt that it would be beneficial if they could remain for a longer period of time. This was reinforced by several of their colleagues, when observing that it takes time for anyone to adjust to a new health care system and the corresponding bureaucracy and organization.

The positive impacts of the scheme do appear to outweigh the negative experiences and costs, and are growing over time, as individual doctors adapt to the local situation and lessons are learnt within the programme. For the individual doctors, their language skills improve rapidly during their time in South Africa and it has been shown repeatedly that they adapt readily to the different cultural, professional and disease environments in which they are working. The rapid assimilation of skills shown by doctors in South Africa, and by those with previous experience
of working on other internationalist ventures, such as Dr Gonzales in Angola, illustrate that a lack of context specific knowledge could be overcome rapidly with in-country, context specific training courses (Couper 2003: 2). In conjunction with this, the Cuban government are providing additional training to doctors leaving on internationalist missions. In South Africa greater cognisance of the skills and experiences of each doctor is being given when allocating them to the hospitals, in order to increase the efficiency and effectiveness of the care provided.
Chapter 5 Conclusions

The prolonged role of Cuba in providing military and humanitarian support for over 50 years to developing countries would appear to show that South-South development cooperation is viable and sustainable. The expansion of recent medical programmes into trilateral partnerships suggests that the current aid environment is conducive to such a development approach. At the same time, the growing interest of JICA in funding such partnerships would support moves to expand this modality in line with the principles of NEPAD. By facilitating the developing world in finding solutions to their own problems, the subsequent benefits allow skills and expertise to be developed and shared in appropriate contexts whilst operating free from legacies of colonialism and neo-colonialism.

Whilst this appears so, the particularity of the programme under consideration prevents supporting generalisations to be made. South Africa has a shortage of trained medical staff working in the public sector, and especially in rural areas. This is a field in which Cuban doctors are trained and experienced, thereby benefiting the situation in South Africa, whilst Cuba has an excess of doctors. Although the long-term aim is to tackle issues of rural development and professional emigration the short to medium term requires intervention. At present, this is being successfully provided by the Cuban government through the intergovernmental agreement on health care.

Cuba’s involvement in South-South development programmes results from a number of factors. Their willingness to assist other developing countries is based in part upon the ideals of the revolution, of proletarian solidarity and internationalism. However, it would be naïve to dismiss the importance of other factors. Cuba needs foreign exchange, and the export of human and intellectual resources allows this. Through this scheme, Cuba earns 37% of the South African medical officer salary paid to each Cuban doctor working there. Such actions also provide increased international standing and support, and improve Cuban human resources as those involved gain experience and skills subsequently repatriated to Cuba. Cuba therefore benefits economically, materially, symbolically, technically, and politically from such engagements.
The US blockade also plays a role. By trying to isolate Cuba politically, this has encouraged Cuba to develop moral and political support networks across the developing world. As with apartheid South Africa, the embargo has encouraged Cuba to develop her own resources and become more self-reliant. So, whilst the embargo has cost the Cuban government billions of dollars and impacted upon their ability to provide the level of social welfare they have committed themselves to, Cuba has utilised her human and intellectual resources as a means to overcoming these problems. To some extent therefore, the hardships resulting from the blockade encourage Cuba to remain involved in South-South cooperation.

As with their government, the motivations of the Cuban doctors are multiple. All five of the doctors interviewed recognised this, acknowledging the financial benefits of working in South Africa and the opportunity to develop their own skills and experience as factors. What came through most emphatically was the sense of moral duty, of internationalism and a desire to help others. This was not rhetoric from Castroites, but also expressed by those who appeared to hold more negative views of the Cuban government. Consequently, this revolutionary spirit appears to have permeated throughout the Cuban medical profession, and is an important aspect in this cooperation.

The South African government is involved primarily due to the desperate shortage of public health service staff, which emigration and recruitment by Western countries serve to exacerbate. South Africa's policy of not recruiting from other African states means that this scheme offers a way for the government to recruit medical staff without exploiting neighbouring countries. The cooperation with Cuba has arisen from the historically close relationship between the ANC and the revolutionary government in Cuba, coupled with the ANC's policy of standing by those who supported it through the anti-apartheid struggle.

Whilst it is not seen as a panacea for all ills of their health care ills, nor as a long-term solution, government officials were very positive about the short- to medium-term role for such cooperation. This view echoes that of South African medical professionals, that the employment of Cuban doctors is an efficient and sensible short- to medium-term
strategy, but with the long-term strategy based upon South African personnel.

The views of members of the general population were generally much more cautious. Many respondents initially expressed hostility towards the employment of Cuban doctors in South Africa, some expressing the belief that Cuban doctors were taking jobs away from South Africans. However, as discussions progressed many respondents contradicted their earlier assertions and became more positive about the work of Cuban doctors. It would appear that the negative perception of the intergovernmental agreement arose from two factors; predominantly negative media coverage of the agreement, and ignorance about the scheme leading to fear and hostility. This second factor is one which is potentially highly problematic in South Africa, given the growing problem of xenophobia, violence and intimidation towards non-South Africans working in the country (Hammett 2001 Unpublished-b).

Discussions with health care professionals exposed a widespread belief that the presence of Cuban doctors, certainly in rural areas, has allowed for the provision of an otherwise unobtainable level of health care. Evidence from Benedictine Hospital shows that their presence has been highly beneficial to the learning experience of South Africa doctors working here, and that,

without them [the Cuban doctors] I don’t think this hospital would be functional - Dr Samantha Nadaraju, 08/07/03.

Similar sentiments were expressed about the need for Cuban doctors at Ekomba hospital and at Livingstone hospital, and from this the vital role they are playing in supporting the South African health care system as a whole.

Whilst there are some who have expressed doubts over the need for, and competency of, Cuban doctors working in South Africa, those who have worked in the same facility as Cuban doctors have been very positive about their experiences. Using the idiom put forward by German and Randel (1998: 20), that “aid dollars should be allocated on the basis of a reasonable likelihood that the spending will make an
impact on the lives of poor people in the foreseeable future”, the allocation of aid through this programme is successful.
Appendix 1 Sources for Further Discussion of the American Embargo

As stated earlier, the American embargo against Cuba has been in place since 1962 and was strengthened greatly in the mid-1990s with the passing of the Cuban Democracy Act (1992) and the Cuban Liberty and Democratic Solidarity Act (1996). The acts encompass a number of titles which are briefly outlined here.

**The Cuban Democracy Act (1992):**
This Act contains provisions preventing the subsidiaries of US companies trading with Cuba, restricting which US citizens are allowed to spend money in Cuba, and preventing any shipping vessel which has docked in a Cuban harbour from docking in an American port for 180 days after leaving Cuba. The Act permitted academics and journalists to visit Cuba, in an attempt to strengthen civil society (Purcell 2000: 83-84). The Act also allowed the withholding of US aid to any country trading with Cuba, and gave the US President the ability to support Cuban dissidents in attempts at regime change in Cuba (Eckstein 1994: 94).

**The Cuban Liberty and Democratic Solidarity Act (1996):**
The Libertad Act was introduced in an effort to reduce the amount of foreign investment in Cuba by non-American firms, and as such contained extra-territorial reach. Containing four titles this act was passed following the shooting down of two planes belonging to the Cuban exile group, ‘Brothers to the Rescue’, which had repeatedly violated Cuban airspace.

**Title I: Strengthening International Sanctions Against the Castro Government.**
This title prevents the President from taking major steps towards the normalisation of relations with Cuba without an act of Congress, to seek international sanctions against the island, and to limit the import of goods made in a third country but containing Cuban inputs.

**Title II: Assistance to a Free and Independent Cuba.** This sets out the requirements for a lifting of the embargo, namely the organisation of free and fair elections in which neither Fidel nor Raul Castro stand.

**Title III: Protection of Property Rights of United States Nationals** This gives US nationals and corporations the right to sue any individual or company which ‘traffics’ in property expropriated from either a US
national or corporation following the Cuban revolution of 1959. It should be noted that this title has been suspended ever since it was passed due to immense opposition from many states including Canada, Mexico and various states in Western Europe.

**Title IV: Exclusion of Certain Aliens** This denies US visas to executives of companies trafficking in expropriated property, and bars entry into the United States to senior officials, major stock-holders and their families of said companies (2003).
Appendix 2: South African – Cuban Bilateral Agreements

Signed Bilateral Agreements between Cuba and South Africa (Mamoepa 2001b)

* Promotion and Reciprocal Protection of Investments - December 1995
* Declaration of Intent on Cooperation in Health - October 1996
* Trade Agreement - April 1997
* Sisterhood Agreement between Gauteng and the City of Havana Province
* Declaration of Intent for Cooperation in the Field of Labour - February 2000
* Declaration of Intent on Cooperation between the Foreign Ministries - March 2000
* Party-to-Party Agreement of Cooperation between the African National Congress of South Africa and the Communist Party of Cuba - November 2000
* Joint Commission Agreement - February 2001
* Air Services Agreement - March 2001
* Arts and Culture Agreement - March 2001
* Science and Technology Agreement - March 2001
* Sports Agreement - March 2001
* Merchant Shipping Agreement - March 2001
* Agreement of Cooperation in the Field of Water Resources - December 2001
Appendix 3: Methodology

A3 Methodology and Research Strategy

A3.1 Methodological Considerations

As contextual conditions are central to understanding the functioning of the programme, and there is potential for rival interpretation (Gilson et al. 2003: 32, Stake 1998: 89), a case study format allowed for “a detailed examination of an event which the analyst believes exhibits the operation of some identified general theoretical principle” (Mitchell 2000: 170).

This case study will not seek to make generalisations regarding the applicability of such development projects in the wider aid context. As Denzin (1997: 217) has suggested, one cannot presume that the subject of one’s study is unified and located in a context similar to any other. Consequently, this work will illustrate how this programme is functioning and encourage debate on improving the current agreement and stimulate debates regarding South-South cooperation.

As research is conducted within a nexus of power contexts and relations which pervade all human relationships (Giddens 1998: 584), research is subjective, and “there is no power-free research nirvana to be reached” (Field 2001: 99). Therefore locating myself in the context of this work is vital, since any researcher’s “particular relation to the object of his study contains the makings of a theoretical distortion in as much as his situation as an observer, excluded from the real play of social activities by the fact he has no place (except by choice or by way of a game) in the system observed and has no need to make a place for himself there, inclines him to a hermeneutic representation of practices, leading him to reduce all social relations to communicative relations and, more precisely, to decoding operations” (Bourdieu 1995: 1).

My work is imbued with the belief that “research has a directly political function; to describe and so expose the unacceptable with the aim of shifting policy and practice” (Mayall et al. 1999: 5), working, as Chomsky and Harvey believe, to be the voice of the oppressed (Hamnett 2001 Unpublished-a). Hence, my work is subjective, and I would contend
that Bourdieu’s belief that “Methodological objectivism, [is] a necessary moment in all research” (Bourdieu 1995: 72) is false. Whilst, until now, the agreement has been constituted outside of my own individual history it is constituted by the personal histories of the architects and participants. Subsequent to this work, my individual history could also influence the agreement. I disagree with Keat and Urry’s (1975 196-205) proposition that value-judgements are objective. These judgements are contingent upon the acceptance or otherwise of social theories, which are also related to value-judgements made on other issues, from different political views and personal perceptions, and are therefore subjective.

In such light, I will not seek to hold a position of methodological objectivism, but instead recognise how my individual history will affect my navigation and narration of this work due to the interaction of my ideological beliefs and *habitus*. Only by recognising and understanding my own limitations, beliefs, and view of the nature of social research will I be able to provide as honest and detailed account as is possible (Hammersley & Atkinson 1983: 17).

**A3.2 Research Strategy**

An adaptive and diverse methodology and research strategy was employed, informed by consultation of literature pertaining to qualitative and quantitative research methodologies and contact with representatives of various agencies in South Africa. The resultant framework provided a structure around which to derive specific research questions and the methodology to be employed. Consequently, I utilised three main methods to collect and coordinate data: existing literature, in-depth interviews and informal interaction. Through the co-ordination and convergence of these multiple data sources this example can be contextualised and a more nuanced insight offered.

**A3.2.1: Identifying Sources of Information and Informants**

In order to identify potential data sources a number of processes were utilised (Mason 2002: 52). Literature was located through systematic

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21 The construction and rationale of the research design can be found in Appendix 3
searches, utilising South African government department websites, internet search engines, databases, citation indexes, and bibliographic searches.

Key informants were located through agencies and government departments related to health care in South Africa. Many of the informal contacts were identified through membership of Servas\textsuperscript{22} and by living and travelling with local people. Through one informal interaction I was able to contact Megan Cox, a community service occupational therapist at Benedictine District Hospital. Through Megan I was also able to interview three Cuban doctors, Dr Millano, Dr Duval and Dr Thomas, in addition to two community service doctors, Dr Samantha Nadaraju and Dr Heera-Gaurie Bhagat at Benedictine Hospital.

Contact with Professor Ian Couper, Professor of Rural Medicine at the University of Transkei, although based at University of Witwatersrand, was established through the Health Professionals Council of South Africa. Professor David Morrell, an anaesthetist at Livingstone Hospital, Port Elizabeth was contacted through the South African Medical Association, and through him two Cuban colleagues, Dr Castallo and Dr Gonzales, were also contacted.

In order to both develop an understanding of the South African government's perception of the programme the Department of Health and Department of Foreign Affairs were approached. The Department of Foreign Affairs were very forthcoming and a meeting was conducted with Mr Louis Pienaar, Deputy Director for Cuba and the Andean Community, and Ambassador Pieter Swanepoel, Director of the Central America, Andes and Caribbean section of the Foreign Affairs Department. The Department of Health were not as responsive, and despite numerous approaches I was unable to arrange a meeting with them.

\textsuperscript{22} Servas is a world wide voluntary organisation of host families to which I belong. Through this organisation I was able to stay with a number of South African families during my research period, all of whom offered the opportunity to talk with them about their perceptions of the agreement, but also provided additional contacts within the South African population.
Contact with official Cuban representatives proved equally problematic. Approaches to the Cuban embassy in London, and repeated attempts to contact Jaime Davis, the Cuban co-ordinator of the scheme in South Africa, failed to elicit a response. Consequently, my only insight into the agreement from a Cuban perspective came through interviews with five Cuban doctors at two hospitals in South Africa, as detailed above.

Some may question the validity of responses from Cuban doctors, claiming that they might have been saying what they thought I wanted to hear, or that they were worried of possible repercussions for openly criticising their government and the scheme. However, all five interviewees were given the option of not having the interview recorded, of stopping the recording at any point during the interview, and to make comments which would not be attributed to them. It should be noted that some of those I spoke with did criticise parts of the agreement and did not appear to have concerns about doing so. Hence, I feel that their responses give a valid insight into the agreement.

A3.2.2 Literature

The use of existing literature, in the form of both documentary and archival sources, allowed me to develop an understanding of key issues pertaining to this topic. Primarily, they provided information on the state of health care and government policy in Cuba and South Africa. They also provided an insight into current aid modalities against which to locate this work, as well as the social, economic and political environment in which it is situated. Many of these documents proved to be exceptionally useful, although all have had to be carefully contextualised as they have been produced either within, or concerning, an environment which is highly politicised. Consequently, much of the documentary and archival material is heavily biased. None of the sources used were treated as literal recordings of events as they were “written for some specific purpose and some specific audience other than those of the case study being done...and the documentary evidence [and archival sources] reflects a communication among other parties attempting to achieve some other objectives” (Yin 1994: 82). Awareness of this allowed for such biases to be recognised and mitigated.
A.3.2.3 Collecting Primary Data – Informal Interactions and Formal Interviews

Whilst considering the general public’s perceptions of the role of Cuban doctors in South Africa, informal interactions were utilised. These were used initially with a view to providing the basis for questionnaires. However, the benefits of allowing free discussions with respondents quickly became apparent. By following this methodology respondents were able to uncover new areas of concern, phrase their responses to a very emotive issue in their own words and to change the sentiments implicit in their responses over time.

Through these interactions, and living with South African families and medical professionals, I was able to access information not available in official texts. Through this hidden text I found that “what people say in casual conversation is a far richer source of information on a whole range of experiences than I could get from organised interview approaches” (Torkington 2000: 203). By drawing upon ethnographic interviewing principles (Spradley 1979 67-68), this allowed an exploration of the wider context against which perceptions of the scheme under consideration were based.

By travelling onboard long distance coaches in preference to internal flights or backpacker buses, this allowed me to meet a range of South Africans and to discuss with them the issues relevant to my work. Through these encounters a total of 21 informal interviews were conducted, in a number of towns and cities and on journeys with a range of respondents, from white teachers through to black musicians.

Whilst recognising the benefits of the above methods, semi-structured interviews were conducted with government and medical representatives, as an informal and unstructured approach would have been unsuitable. These enabled predetermined questions to be addressed, whilst allowing exploration of new issues raised by informant’s responses. Such interviews were conducted with twelve respondents, and form the backbone of this work.

23 The full text of the formal interviews conducted with doctors and government officials may be made available through contacting the author.
A.3.2.4: Collecting Primary Data - Other Methods

Direct observations allowed consideration of the condition at hospitals and the quality of accommodation provided for doctors at the facilities. These observations provide supporting evidence for comments made about the problems facing South African health care services.

Whilst intending to use questionnaires to elicit responses from local communities served by Cuban doctors, and a broader cross section of South African society, this method was not used. For patients at the Livingstone Hospital questionnaires would have been unsuitable, as the patients had little or no contact with the Theatre department based Cuban doctors. At the rural hospital in Nongoma, the local Zulu speaking community contained very few patients able to communicate effectively in English. Whilst medical staff use interpreters to communicate with patients I was unable to do so as the staffing levels at the hospital were such that I was unable to find a translator for my questionnaires. This was compounded by the fact that this population was predominantly functionally illiterate, meaning that any questionnaires would have had to be conducted verbally, exacerbating these problems.

As discussed above (section 4.1.2.3), informal interactions were used to gauge the public perception.

A.3.2.5: Ethical Considerations

Where possible interviews were recorded, dependent upon the respondent granting permission, and the location being conducive to making a recording. This allowed greater attention to be focused upon the substance of the responses, as well as non-verbal communication. Fortunately all twelve interviewees involved in the semi-structured interviews gave their permission for their responses to be recorded. Whilst problems were initially encountered with the reproduction of one of these interviews, as the recording was muffled, digital enhancement of the tape made a transcript possible.

For these respondents offers to furnish them with copies of the dissertation were made to demonstrate that I was not an exploitative
interloper, but rather wanted to offer something back to the researched community (Hammersley & Atkinson 1983: 80). These were in addition to submitting copies of respective interviews to them, so that they could raise any concerns before submission of the dissertation.

Informal interactions were not recorded as these often took place in situations in which it would have been impossible to use a recording device. In addition, the formality and connotations of asking permission to record these discussions would have been inappropriate, as there was little chance to build rapport with the respondents beforehand.

Due to the variety of environments and power relations that were negotiated, impression management was an important issue, requiring adaptation for each context. Due to the method of travelling employed it was impractical to carry a suit for the meeting with Ambassador Swanepoel, so a smart shirt and trousers had to suffice, as for meetings with the health professionals encountered. This attire was worn in order to present a more formal and professional image for these encounters. The discussions with the general public were approached in casual clothing as I wanted these to be conducted in an informal and friendly manner.

A3.2.6: Overcoming Potential Problems

The different local and national contexts, and differing roles of my interlocutor meant, that language was an important issue. All encounters with research informants are mediated by, and predicated upon language, permitting or hindering communication and allowing a way for the researched reality to be (re)constructed in subsequent work (Spradley 1979: 17). The different situations resulted in meanings and behaviours being translated into alternative contexts and my own perceptions and language.

One of the main problems encountered with this research was the duration of the fieldwork, exacerbated by the required travelling. The almost constant movement around South Africa precluded the development of deep relationships with respondents, thereby preventing the development of rapport with any community. In addition, the failure of the Department of Health to respond to my
numerous approaches before travelling to South Africa meant that identifying and contacting of research sites could only be conducted whilst in country.

This inability to identify and access research sites before arrival, linked to the inherent unpredictability of working in the field, meant that a flexible research schedule was adopted.

A3.2 Fieldwork sites

Decisions relating to the location of fieldwork sites were complicated. Individual hospitals were selected because I was able to contact staff working at them and through these ‘gatekeepers’ access these environments.

Fieldwork was conducted in a number of areas. Formal interviews were conducted with sources at the University of Witwatersrand, Johannesburg; The Health Systems Trust, Johannesburg; the Department of Foreign Affairs, Pretoria; Benedictine District Hospital, Nongoma, KwaZulu Natal Province; and Livingstone Hospital, Port Elizabeth.

A3.2.1 Benedictine District Hospital, Nongoma, KwaZulu Natal

KwaZulu was designated as a Bantustan under apartheid and as such suffered from extremely low levels of government support, with the 1992 health budget for the region equalling that of a single Johannesburg hospital (de Gruchy & Baldwin-Ragaven 2003). Rural KwaZulu is home to over half the 8 million population of KwaZulu Natal, yet in 1992 only received 4% of the provincial health budget allocation. Whilst the national average doctor : patient ratio stood at 9 per 10,000, in Natal it was 39 and in KwaZulu Natal as a whole it dropped to 5, as 3,859 doctors were based in the predominantly urban Natal region and only 124 across rural KwaZulu (Torkington 2000: 11).

Benedictine District Hospital is situated in the rural Nongoma area of northern KwaZulu Natal. It serves a population of 230,672 (2000 figure), of which 98.34% live in rural settlements, spread over an area of 2184 square kilometres. In total only 6771 inhabitants are employed,
with 64.72% of individuals having no individual annual income, and 29.8% of households receiving no official annual income. Access to sanitation, 55.67% of households have no sanitation, and 39.66% relying upon pit latrines, and water, only 2% of households having an on-site water source, 12.27% relying upon communal taps, 10.06% on boreholes and 71.16% on natural water sources, rivers and streams, are major constraints to health. As a consequence, of the 347 communities in the Nongoma area, 95.8% fall below RDP standards and 235 below survival conditions. The hospital itself has 470 beds in use (table 18) and employs 537 staff, including 5 doctors under the agreement with Cuba and 4 community service doctors (table 19) (KwaZulu Natal Department of 2002: 4-6).

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorised Number of Beds</td>
<td>598</td>
</tr>
<tr>
<td>Beds in Use</td>
<td>470</td>
</tr>
<tr>
<td>Bed Occupancy Rate</td>
<td>78.6%</td>
</tr>
<tr>
<td>Admissions (per annum)</td>
<td>13245</td>
</tr>
<tr>
<td>Cost Per Patient Per Day</td>
<td>R569</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>87128</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>7.8 Days</td>
</tr>
<tr>
<td>Out Patient Department Head Counts</td>
<td>82286</td>
</tr>
<tr>
<td>Bed Per Population Ratio</td>
<td>2.27/1000</td>
</tr>
<tr>
<td>Perinatal Mortality Rate</td>
<td>42.67/1000</td>
</tr>
<tr>
<td>Low Birth Weight Rate</td>
<td>10.02%</td>
</tr>
<tr>
<td>Maternal Mortality Rate</td>
<td>4/100 000</td>
</tr>
<tr>
<td>Still Birth Rate</td>
<td>42.67/100 000</td>
</tr>
<tr>
<td>Institutional Delivery Coverage Rate</td>
<td>73.26%</td>
</tr>
<tr>
<td>Clinics Referring</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 18: Profile of Benedictine Hospital, Nongoma (KwaZulu Natal Department of 2002: 4).
<table>
<thead>
<tr>
<th>Category</th>
<th>Employed</th>
<th>Total Employed</th>
<th>Number pr 1,000 people</th>
<th>Vacant</th>
<th>Vacancy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer</td>
<td>23</td>
<td>18</td>
<td>1:13,000</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Medical Specialist</td>
<td>1</td>
<td>1</td>
<td></td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Dentist Professional</td>
<td>0</td>
<td>0</td>
<td></td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Professional Nurses</td>
<td>130</td>
<td>130</td>
<td>1:421</td>
<td>54</td>
<td>41%</td>
</tr>
<tr>
<td>Staff Nurses</td>
<td>105</td>
<td>105</td>
<td></td>
<td>21</td>
<td>20%</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>150</td>
<td>150</td>
<td></td>
<td>35</td>
<td>23%</td>
</tr>
<tr>
<td>Student Nurses</td>
<td>125</td>
<td>125</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1</td>
<td>1</td>
<td>1:69,000</td>
<td>2</td>
<td>66.6%</td>
</tr>
<tr>
<td>Managers and</td>
<td>2</td>
<td>2</td>
<td>1:3,088</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Administrative Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 19: Human Resource Profile of Benedictine Hospital, Nongoma (KwaZulu Natal Department of 2002: 6).

A 3.2.2 Livingstone Hospital, Port Elizabeth, Eastern Cape

Livingstone Hospital is a regional hospital situated on one of the major roads leading east out of Port Elizabeth. As a state run regional hospital it offers a range of health services, from out-patient through to casualty, to the general population in Port Elizabeth and surrounding areas. Whilst a strategic plan for Benedictine Hospital was sourced, one for Port Elizabeth was not, so detailed figures for the hospital were unavailable.


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