



Planning From the Future

Component 2. The Contemporary Humanitarian Landscape:

Malaise, Blockages and Game Changers

Background Paper # 1:

The Cuban Way:

Can Revolutionary Medicine Revolutionize the Humanitarian System?

Nicola Dahrendorf

August 2015

Table of Contents

Contents

Acronyms.....	3
Planning from the Future – The Project	4
Component 2 – The Humanitarian Landscape Today	4
Component 2 – Why Cuba?	5
Introduction	5
1. Cuba – In Context	6
Underlying Philosophy and History of Cuba’s ‘Humanitarian’ Approach	6
Domestic Management of Emergencies	7
Export of Cuba’s Health Capability	7
Cuba’s National Civil Defence System (DCN)	8
2. Examples of Cuba’s ‘Humanitarian’ Actions and Assessment of Impact.....	10
History of Cuba’s ‘Health Diplomacy’	10
Financing Health Diplomacy	12
Exporting the Right to Health	12
Haiti	14
Venezuela.....	15
Pakistan	16
Ebola	16
Controversy around the ‘ <i>Cubanisation</i> of Health Care Services’	16
3. Cuba and Other Latin American Players.....	17
Regional Alliances and Cooperation	17
Brazil	18
Venezuela.....	19
4. Lessons and Conclusions	20
Implications for Humanitarian Action	20
Lessons to be Learned from the Cuban Experience	22
Focus on the Local	22
Management and Communication Structure	23
Investment in Human Capital	23
Ideology / Philosophy.....	23
Conclusion	24
References	25
About the Author	26
Notes	28

Acronyms

ABC countries	Argentina, Brazil and Chile
ALBA	Bolivarian Alliance for the Americas – <i>Allianza Bolivariana para los Pueblos de Nuestra America</i>
CBDM	Community Based Disaster Management
DCN	Cuba's Civil Defence System
ELAM	Latin American Medical School
GHD	Good Humanitarian Donorship
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic Social and Cultural Rights
IMF	International Monetary Fund
INGO	International Non-governmental Organization
INV	National Institute of Housing
MINUSTAH	UN Mission to Haiti
MPLA	People's Movement for the Liberation of Angola
NGO	Non-governmental Organization
SSC	South-South Co-operation
UNICEF	UN Children's Fund
WHO	World Health Organization

Planning from the Future – The Project

Kings College (London), The Humanitarian Policy Group at the Overseas Development Institute (HPG/ODI) in London and the Feinstein International Center at Tufts University (FIC) are partnering on a 15-month research project on **‘Planning From the Future: Crisis, Challenge, Change in Humanitarian Action’**. The research looks at the past, present and future of humanitarian action:

- HPG leads the analysis of the blockages in the past and how these have led to changes in the humanitarian architecture (Component 1).
- FIC identifies the key blockages and game changers in the humanitarian landscape today (Component 2) – and at urgent measures to reform it that could immediately be taken (Component 3).
- Kings College looks at the future and asks whether improvements contemplated today will be adequate to meet the growing vulnerabilities, dimensions and dynamics of humanitarian crises in the longer term (Component 4).
- The three partners will then come together to provide a synthesis of their findings and recommendations in a final report to be issued in early 2016 (Component 5).

Component 2 – The Humanitarian Landscape Today

Despite impressive growth, institutionalization and professionalization, the humanitarian system is facing an existential crisis. While time-tested tools, funds and capacities are readily available, the system has succumbed to a widespread malaise and is not delivering. Recent crises from Afghanistan to Somalia, Haiti, Sri Lanka and Pakistan as well as current emergencies – Syria, South Sudan, Central African Republic, among other less visible crises – question the very foundations of humanitarianism and of the galaxy of institutions that pursue humanitarian goals. The intractable nature of many crises and the instrumental use of humanitarian action to cover up political failures of the so-called international community are leading to a growing realization that the humanitarian system as presently constituted is not fit for purpose – and growing dissonance about what the purpose should be.

As part of Component 2, FIC is producing a series of papers that capitalize on recent or ongoing research. These will include ‘Case Studies’ that will analyze blockages and game changers affecting humanitarian action in recent crises – Somalia, South Sudan, Syrian, the Sahel, Afghanistan and perhaps others – and what these crises tell us about the state of the humanitarian enterprise. We will also be preparing ‘Background Papers’ on emerging or under-researched policy, operational or systemic issues that need to be better understood because of how they affect the changing humanitarian landscape. In addition to the paper on the Cuban approach to humanitarian issues, we will be producing papers on the

challenge of protection, humanitarian reform, China and organized humanitarianism and perhaps others.

Component 2 – Why Cuba?

As part of the exploration of the blockages, game changers and other pathologies affecting the humanitarian landscape, we felt it was necessary to better understand approaches that are not part of the – still Western dominated – official or organized humanitarian system. The Cuban approach is interesting because it shows that a small country, acting outside the dominant system, using its own state resources, and intelligently leveraging those of friendly states, can have an important innovative impact in the delivery of emergency medical assistance. This raises interesting questions about the purported universality of a system that is still largely ‘of the North’, whether indeed the future might not see the emergence of more diversity rather than isomorphism and more challenges and alternatives to the dominant system. Whether the future will bring more convergence or diversity, the Cuban and other non-Western approaches provide useful insights that need to feed into current debates on the future of humanitarian action.

Introduction

Cuba’s contribution to and involvement in humanitarian activities provide an instructive and challenging lens through which to investigate alternative courses to Western dominated humanitarian action. Cuba’s participation in a range of humanitarian emergencies, primarily through its exportable medical expertise, dates back to 1960. More recent significant engagements took place in Haiti, Congo, in response to the Ebola crisis in West Africa and now in Nepal.

This paper provides an initial exploration of potential lessons and useful practice that can be identified based on Cuba’s evolving and innovative work in over sixty countries. In essence, this seems to represent humanitarian action with strategically targeted activities that appear to be firmly rooted in a long political history of socialist ideology and political culture. Interventions are localised and directed through a highly centralised government. In addition, there are various spheres of influence around Cuba’s health diplomacy, closely entwined with the political and ethical stance taken by other Latin American countries, especially Brazil and Venezuela.

The key questions this policy brief aims to explore are:

- What is the relationship between external and internal national structures in how they shape strategies and delivery of ‘humanitarian aid’?
- What are the ethical and political frameworks underpinning Cuban humanitarian activities? How do they differ from Western (European/US) frameworks?

- Is there a ‘Cuban’ or ‘Latin American’ model from which the rest of the world could learn?

The paper is structured along the following lines: first it examines the underlying philosophy and history of Cuba’s approach in [Part 1](#), exploring its uniqueness and the characteristics of national structures and governance that allow for an effective response internally in disaster mitigation and responses as well as health care. It then scans Cuba’s activities ([Part 2](#)), particularly in South Africa, Honduras, and the Gambia, and explores how it exports its medical expertise and education to over sixty countries, as well as some of the controversies surrounding these activities. [Part 3](#), examines Cuba’s relationship with other critical players, such as regional alliances, the Cuban – Venezuelan partnership and the role of Brazil as a major Latin American and international contestant. Before concluding, [Part 4](#), attempts to identify lessons from the Cuban experience that might be examined further.

An important *caveat* is that this paper does not do justice or investigate the wide range of material around Latin American foreign policy, the complex relationship with the US; nor does it explore Cuba’s multifaceted political connection with countries to which it exported its expertise. For example, Cuba’s engagement with Congo dates back to when it unambiguously took sides with Patrice Lumumba in 1960, then beleaguered by US, UK and Belgian foreign policy priorities. The paper argues that Cuba’s activities are impressive and effective, yet highly political acts. Their manner and goals cannot be separated from the history and ideology of Cuba’s centralised political system and culture. This in itself is arguably no different to US or UK humanitarian engagement. However, this paper aims to illustrate that Cuba’s actions show a direct and candid connection between foreign policy priorities and their implementation through humanitarian activities. At the same time, Cuba’s actions appear to be both successful and useful and are not marred by Western-dominated humanitarian structures and layers of accountability.¹

1. Cuba – In Context

Underlying Philosophy and History of Cuba’s ‘Humanitarian’ Approach

Much of Cuba’s effectiveness in the provision of health care and its internal disaster mitigation and risk management has to be placed in the historical and political context, as it is the product of nearly 60 years of centralised socialist government. The philosophy and culture underlying Cuba’s provision of health care both internally and externally is that the *Right to Health* is viewed as a fundamental human right and is inscribed as such in the Cuban constitution. It is closely allied with the fundamental constitutional premise of the *Right to Life*. A strong political culture and ideology of promoting solidarity and altruism underlines this approach. This political culture is defined as a distinctive and patterned way of thinking about how political and economic life is to be carried out and is closely

allied with the fundamental ideology that has arisen out of the Cuban revolution. The Cuban example is a form of civic culture, in that citizens are aware of central government.

On the face of it, Cuba's actions are altruistic – but opinions over Cuba are divided. Dissent from central government controlled policies is clearly frowned upon. According to 2014/15 reports by Human Rights Watch, Amnesty International and Freedom House, restrictions on freedom of expression and assembly are widespread, as are arrests for political dissent.² This begs the questions as to whether the implementation of Cuba's health diplomacy model is only possible in a highly and centrally controlled political environment.

Domestic Management of Emergencies

Key words in the Cuban rhetoric are: trust and solidarity. The population has faith in its government to prioritise human safety over unbridled economic development, and the municipal leaders who assume key positions in times of emergency are those who already play pivotal roles in community life, and are therefore already trusted.³

Cuba's unique mechanism appears to be based on the equation $\text{Risk} = \text{Hazard} \times \text{Vulnerability}$ and Cuba's socio-economic model reduces vulnerability, ergo risk. This is achieved by a combination of investing in social capital, through enabling universal access to government services and promotion of social equity. The resulting high levels of literacy, added to a developed rural infrastructure, greatly increase population preparedness in times of disaster. State ownership of assets clearly plays a key role in service provision in times of emergency and allows for ongoing public works maintenance.

Cuba's legal framework also has an important part to play, with civil defence training for all adult citizens enshrined in law. In addition, physical planning and land use regulation to protect citizenry, rather than simply turn a profit, are legally embedded.

Export of Cuba's Health Capability

Cuba's export of community-based and prevention-focused medicine suggests a bold approach to developing the human resources critical to making healthcare a global right. Cuba's extensive global health initiative presently consists of some 28,000 Cuban health professionals now staffing public health systems in over 60 countries. The country boasts a workforce of over 60,000 physicians, which makes it one of the best-resourced countries in the world. At the same time, young medical students are now involved in, what is arguably the world's largest medical school, the Latin American Medical School (ELAM), numbering some 30,000 students from the Americas, Africa, Asia and notably the United States. This represents an extraordinary challenge to rethinking the potential of international health cooperation.

In terms of Cuba's participation in international disaster relief, the three key factors that emerge are its widespread medical presence in developing countries; its willingness to

maintain medical relief after the initial emergency has passed; and, its willingness to train indigenous doctors to return to their country of origin to practise. To a large extent, favourable trade agreements with Venezuela (from 2002 onwards) have economically enabled this practice.

The Cuban formula of health diplomacy has its fans. Former US President Jimmy Carter said, ‘... of all the so-called developing nations, Cuba has by far the best health system. And their outreach programme to other countries is un-equalled anywhere.’⁴

Following the Cuban revolution (1953–59), enormous emphasis was placed on building rural hospitals to allow better access to health services in order to combat widespread poverty. Incrementally, the health care system established a convincing internal structure that became exportable. As Dr Fitzhugh Mullan, former Congressman, now at George Washington Medical School⁵ explained, the Cuban health care system is ‘as intelligent a use of scarce healthcare dollars’ as anyone can imagine. Jimmy Carter pointed out that the percentage of health care spent on the Cuban medical system is a fraction of what the US and European countries are spending, with an outreach that extends both domestically into remote rural areas as well as internationally through its health programmes.

The foundation of Cuba’s *modus operandi* is a socio-economic model that aims to reduce vulnerability and invest in social capital through universal access to government services and promotion of social equity. High levels of literacy, developed infrastructure in rural areas and access to reliable health care function as ‘multiplier effects’ for national efforts in disaster mitigation, preparation and response.⁶ In essence this consist of a strong centralised government, coupled with community mobilisation, solidarity, clear political commitment to safeguard human life, and a population that is disaster-aware.

It is evident that a cornerstone of Cuba’s political culture is universal access to services. Cuba has proven to be good at reducing vulnerability and hence risk. It has engaged with the four main methods for mitigating hazards available to poor countries: physical construction, improved prediction, methods to counter climate change and a countering of environmental degradation.⁷ As a result, Cubans have better access to education, health, and physical infrastructure than the majority of populations in the rest of Latin America. This access reduces the vulnerability of the population as a whole. The government’s policies aimed at reducing social and economic disparities have inevitably reduced vulnerability. Added to this, considerable investment in human capital, which provides the country with a wealth of trained and available professionals, has been made for more than 40 years.

Cuba’s National Civil Defence System (DCN)

Cuba’s Civil Defence System (DCN) plays a vital role in Cuba’s indisputably effective system of mitigation, in terms of disaster prevention, management and risk reduction. Cuba is in a

unique geographic position, literally in the line of fire of major tropical storms emanating from the South Atlantic. In September 2004 and July 2005, Cuba dealt with two of the most powerful storms to strike the Caribbean in the last century. Hurricane Denis in 2005 saw ten deaths amid huge damage to the island, and five dead in the US. Hurricane Yvonne in 2004 did not claim a single victim in Cuba.⁸ In both cases, through Cuba's DCN, the government managed to evacuate over 1.5 million people and empty out entire flood-prone coastal areas. The DCN organised the population, and its preparedness began at municipal level, some 48 hours prior to the storm. This preparation is aided Cuba's highly sophisticated meteorological system with 15 provincial offices, which share information with US scientists and tracks storms' progress. Cuba also boasts a sophisticated system for controlling its own population and managing their movements.

A 1976 government mandate requires that all adult citizens receive civil defence training, for an obligatory two days per year for all those eligible. The High Command of the DCN is charged by law with overseeing Cuba's compliance with measures of civil defence and all relationships with international aid and cooperation in times of disaster. The system appears to be as much a concept of organisation and control as it is a system of measures and procedures. Laws, regulations and directives specifically address disaster mitigation, preparedness and response. The Cuban DCN builds on the existing assets of political and institutional leadership to mobilise the grassroots, assigning roles in risk reduction to people in all sectors of community.

At its heart, it is a clear system of values, as well as mechanisms, procedures and concepts that can be broadly summarised as follows:

- Social cohesion and solidarity (a self-help system of citizen-based social protection at the neighbourhood level);
- Trust between authorities and civil society – a political commitment to risk reduction coupled with good coordination, information sharing, and cooperation among institutions involved in risk reduction. Attention is paid to the most vulnerable population and to lifeline structures (concrete procedures to save lives, evacuation plans, and so on).

Over the past forty years, the central government appears to have made major investments at different levels:

- in human development – building a professional human resources base;
- an effective risk communication system and institutionalised historical memory of disasters, laws, regulations, and directives to support all of the above;
- economic development that explicitly takes potential consequences for risk reduction or increase into account;
- in institutional capital – creating capable, accountable, and transparent government institutions for mitigating disasters;

- investment in land and housing – of particular note is the investment in physical planning and land use regulations, which are firmly embedded in governmental structures; land use regulations, building codes and hazard-proof infrastructure are a vital part in disaster mitigation;
- housing construction, led by the National Institute of Housing (INV) (Once a disaster hits, the INV coordinates with the provincial and municipal authorities, the DCN and the Ministry of Economy and Planning to evaluate residential damage. It decides which houses to rebuild, which should be structurally strengthened, and which repaired.⁹ INV municipal and provincial employees design a working plan for every house affected, allocating the distribution of the scarce resources.); and
- investment in rural areas – the government has focused attention on rural areas to prevent mass migration to cities and subsequent overpopulation; vulnerable city populations are closely monitored in terms of risk.

Cuba evidently engages in a wide platform of activities to reduce risk and increase preparedness for disasters. Underpinning all of these capabilities is both a centralised and far-reaching disaster response mechanism a strong health care architecture creating a well-functioning system reaching into remote rural areas. The Cuban system of disaster response ensures inter-institutional cooperation in pooling and distributing resources in response to the need. These needs are identified through careful planning and collation of evidence through risk mapping and revisions of emergency plans.

Due to its centralised structure, all citizens are and can be co-opted into a number of activities. For example, all must take part in annual two-day exercises. Radio and TV play a major role in preparedness. All transport is co-opted and pooled. Anyone adversely affected by a hazard is a known entity in the system and their case is followed up accordingly. People did not enter the service system when they were affected; they were already part of the system.

As the government is the major employer as well as in charge of recovery, it can assign employees from diverse workplaces to leave their work and carry out tasks for disaster recovery, such as a neighbourhood clean-up. On the flip side, it is hard to ignore the extent and degree of central government control down to the local level over individual lives.

2. Examples of Cuba's 'Humanitarian' Actions and Assessment of Impact

History of Cuba's 'Health Diplomacy'

The Cuban revolution transformed the health experience of the majority of the population. It created new models for social and economic development based on ideals of

internationalism and solidarity. Essentially, Cuba has responded to emergencies in Latin America and Africa since the beginning of the revolution and assisted countries building a public health infrastructure.¹⁰ It is remarkable to note the will to make this commitment during a major brain drain with half of Cuban doctors leaving for Miami and few left to teach in medical schools.

Emergency Cuban medical brigades were first sent to Chile in 1960. In 1962, Cuba assisted a newly independent Algeria in establishing a public health infrastructure. In 1972, Cuba sent emergency medical teams to a Somoza-controlled Nicaragua after the earthquake. Significant support was provided to the People's Movement for the Liberation of Angola (MPLA) in Angola through ideologically aligned Cuban troops, and followed by medical teams; this led to a 16-year commitment in that country to reform its health system.¹¹ The Angolan example highlights that medical or 'humanitarian' actions were combined with other forms of presence and support; for example, at the height of the Cold War, Cuba had military advisers working in 13 countries and civilian advisers in some 27 countries.¹²

The philosophy behind Cuba's health diplomacy appears to be built on a number of premises:

- to go where doctors and health workers are most needed;
- to show solidarity with the vulnerable and poor;
- to invest in human and social capital; and
- altruism.

Cuba's health diplomacy also provides a certain degree of international positioning. As such, it is a form of international relations that operates by accruing goodwill. Interesting parallels and distinctions can be drawn with, for example, the US Peace Corps. The US created a volunteer organisation whose stated purpose through the passage of the Peace Corps Act (21 September 1961) is

... to promote world peace and friendship through a Peace Corps, which shall make available to interested countries and areas men and women of the United States qualified for service abroad and willing to serve, under conditions of hardship if necessary, to help the peoples of such countries and areas in meeting their needs for trained manpower...

While the focus of the US Peace Corps is broadly on socio-economic development, it comprises a group of volunteers who provide technical assistance across a range of disciplines, from education to information technology to agriculture. That it promotes so-called American values is overtly recognised. In the same vein, the Cuban system represents a centralised structure that through the export of expertise overtly fosters diplomatic relations with other countries.

South Africa provides an interesting example of the impact of Cuban doctors in the midst of an epidemic and depletion of its indigenous health care system. Post-apartheid South Africa was in the midst of a major AIDS crisis, and a major professional exodus took place of South African medical and scientific skilled personnel, mostly to Europe but also to the US. At the time, 29,000 posts were vacant. It is unclear exactly how many doctors Cuba sent¹³ but Cuban medical personnel interviewed about their South African experience¹⁴ talked of 'painful levels of poverty', given the shortage of health personnel and equipment in isolated areas, which led to an 'almost insurmountable workload'. However, their ability to implement a system, providing access to reliable health services at little or no cost proved extremely effective in remote areas, especially those hard-hit by HIV/AIDS.

The Gambia represents another example of Cuban assistance that turned out to be extremely effective, especially in Cuban health personnel's' conduct of a country-wide anti-malaria campaign and erection of a system to almost eradicate the disease. Following the Cuban intervention, bed-net use apparently increased to 60 per cent, and malaria cases declined, according to WHO, from 600,000 in 2002, to less than 200,000 in 2012. The infant mortality rate has also dropped substantially.

Financing Health Diplomacy

But Cuba is not alone. The country has received financial assistance for its medical missions in countries such as Honduras, Haiti, Niger, Rwanda, and Mali from the governments of Germany, France, Japan, Norway, Australia, and others, as well as from multilateral agencies such as the World Health Organization, the Pan American Health Organization, and UNICEF, and from many international organisations in countries such as the US, Canada, Spain, and Belgium. From 2008 to 2010, Cuba reported receiving \$713 million in aid, though it is unknown how much was for international health projects. Following the January 2010 earthquake in Haiti, for instance, Norway donated around \$2 million to Cuba for supplies for its medical brigade in Haiti.

Exporting the Right to Health

The particular brand of Cuban community based, preventive medicine and health policies is embedded in Cuba's medical training. This has become an additional exportable service.

Cuban physicians work not only in difficult and remote areas both domestically and internationally, but Cuba also offers extensive medical training to other countries. In part, this can be viewed as providing a degree of sustainability to enhance community resilience. The intervention of Cuban doctors in South Africa has led in part to a change in the South African medical curriculum. Medical school is now augmented by a one-year community service requirement for all doctors. This is, once again, not without controversy. South African medical personnel objected because they saw it as undermining their advancement and medical education. Obtaining a medical degree was perceived as paving the way

towards a better life, and in some case the way out of poverty for many families. By being forced to undergo community health service, this pathway was delayed and perceived as not allowing doctors to pursue their chosen specialisation and possibly make more money sooner.

This highlights fundamental tensions over different ways of implementing the right to health.¹⁵ Cuba has taken the practical application of the right to health seriously, and it is enshrined in the country's constitution. This merits a brief examination of how Cuba positions itself within the international human rights landscape. The Cold War polarised countries' positions on human rights. In 1966, the twin covenants of the International Convention on Civil and Political Rights (ICCPR) and the International Convention on Economic Social and Cultural Rights (ICESCR) were promulgated. But the language of progressive realisation and maximal available resources suggests different standards for different countries. The Cuban approach appears to be based on the need to situate state obligations within a global political economy in which international institutions and states often exercise inordinate influence over developing countries' economies and policies. The right to health demands (as do all human rights) 'international assistance and cooperation'.¹⁶

However, on 28 February 2008, Cuba signed both international conventions, having refused to endorse them for the past three decades, albeit with reservations. The first of these reservations relates to the rights of workers to have independent trade unions, as this was considered fit only for capitalist countries, according to an edict by Fidel Castro in 2001;¹⁷ the second reservation concerns the right to education, which is considered to open the door to privatisation.¹⁸

Cuba's export of health expertise and education seems to adhere squarely with the stipulated obligations for states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realise the right to health. States must, for instance, adopt a national health policy or a national health plan covering the public and private sectors; ensure the provision of health care, including immunisation programmes against infectious diseases and services designed to minimise and prevent further disabilities; ensure equal access for all to the underlying determinants of health, such as safe and nutritious food, sanitation and clean water; ensure that public health infrastructures provide for sexual and reproductive services and that doctors and other medical staff are sufficient and properly trained; and provide information and counselling on health-related issues, such as HIV/AIDS, domestic violence or the abuse of alcohol, drugs and other harmful substances. Effective and integrated health systems, encompassing health care and the underlying determinants of health, are also key to ensuring the right to the highest attainable standard of health.¹⁹

A concrete illustration of this is the Latin American Medical School (ELAM) in Havana, opened in 1999 and now apparently the largest medical school in the world. Students come not only from critical Latin American countries, such as Nicaragua, Uruguay, Paraguay, Peru, and Venezuela, but also from Mali, Nigeria, Jamaica, St Kitts and notably the US. The basic premise is to provide training in community based medicine for students to return and reinvest in their respective communities and to enrol students from isolated and poor communities across the globe who would otherwise not have access to medical school (including from deprived urban areas in the US – all on full scholarships). This in itself represents a courageous concept as, for example, many African Americans managed to obtain full scholarships to ELAM. One might argue that this essentially represents not only a less-developed country training a developed country, but also one that has been ostracised by a country (US) that now needs Cuba's help to deal with its own internal poverty and lack of access to fundamental services for its own citizens.

The fundamental goal of ELAM's teaching philosophy is to create a tie between medical students and their community, and train doctors of and for the community. It provides access to study for those who would normally not be able to afford or be able to gain access to tertiary education, let alone medical schools. Venezuela has followed Cuba's influence of making healthcare more accessible. Micro medical schools have been set up in rural areas of Venezuela. Through this initiative, the concept of the doctor has changed and 'the medical school is taken out of its ivory tower and taken to the community.'

Haiti

Cuba's medical contribution to Haiti has been described as 'one of the world's best kept secrets', and also as a form of 'health care diplomacy'.²⁰ Since Hurricane Georges in 1998, Cuba has played a very important and discreet role in providing medical assistance, especially in remote rural areas not accessed by most international NGOs. This became particularly apparent in the aftermath of the Haiti earthquake in 2010 and the cholera outbreak in early 2011. The intervention appeared to be based on Cuba's national public health policy and doctors trained in community health, a resource that appeared to be lacking in the international arena.

An important aspect was that Cuba agreed to maintain hundreds of doctors in the country for as long as necessary and that those doctors would work wherever the Haitian government posted them. Cuba also agreed to train Haitian doctors in Cuba, if they would later return and take the places of the Cuban doctors, a process of 'brain gain rather than brain drain'.²¹ Significantly, the Haitian students were selected from non-traditional backgrounds and were mainly poor. It was thought that because of their socioeconomic background, they fully understood their country's need for medical personnel and would return to work where they were needed. The fact that they were already embedded helped with transport issues to remote areas straight after the quake.

After the earthquake struck Haiti on 12 January 2010, a serious health crisis already existed on the island. Haiti had fewer than 2,000 doctors to assist its 9 million citizens. In fact, the 344 Cuban doctors who were in country prior to the earthquake were often the only ones available in rural areas. Cuban doctors worked alongside 547 Cuban-trained Haitian doctors. They were backed up after the earthquake by the Henry Reeve Brigade, (named after a US doctor who joined the Cuban international brigade in the Spanish Civil War), which was formed in 2005 as an emergency response team. An assessment of the medical response shows that the Cuban teams were the largest and best organised in Haiti. It illustrates the flexibility of the Cuban model. They were able to respond and assess the situation quickly including bringing 185 Haitian students, who were studying in Cuba at the time, back to Haiti. The strength of the Cuban-led team – apart from their medical expertise – lay in their approach: local knowledge, their integration into the community and their ability to communicate in Creole, that they were primarily led by Cuban-trained Haitian doctors.

Venezuela

Venezuela was afflicted by considerable health (and arguably numerous other) inequalities at President Chavez' election in 1998. The public health infrastructure built up in Venezuela during the 1960s had deteriorated due to corruption and lack of funding. A two-tiered system existed, with private clinics and plastic surgeons focused primarily on serving the middle and upper classes. With doctors not wishing to live in the countryside or work in the public sector, over 50 per cent of Venezuela's 24 million people were underserved.

Cuban-Venezuelan medical cooperation began on 15 December 1999, after Venezuela suffered a powerful rainstorm that resulted in massive flooding, landslides and extensive loss of life. The new constitution guaranteed healthcare as a right. It also designed a primary health care system, called *Barrio Adentro – Inside the Neighbourhood*. An interesting illustration of the contrasting approaches lies in the fact that only 29 Venezuelan doctors volunteered to participate in the new system; however at its peak, some 23,000 Cuban doctors were working in this programme.

Briefly, *Barrio Adentro* is based on the concept of preventive community and family medicine that was developed in Cuba. It is designed around the family doctor's office located in each neighbourhood. All services are free and provided by a doctor and nurse team. Specialised secondary health services were taken out of hospitals and brought into communities through diagnostic centres and rehabilitation rooms to treat emergencies. The rule was also to diagnose and treat chronic conditions and attend to long-term injuries and conditions complicated by years of neglect.

Pakistan

Another noteworthy example is the shift in relations between Cuba and Pakistan following Cuba's assistance after the 2005 Kashmir earthquake. The Cuban government dispatched over 2,400 doctors and paramedical staff, established 32 field hospitals and provided relief to camps in the North West Frontier Province, Azad Jammu and Kashmir. In addition, the Cuban government sent enormous amounts of medical equipment and medicine. Approximately 30 amputee patients were evacuated to Cuba for treatment. As a consequence, in 2005 and 2006 the Pakistani Higher Education Commission sent 354 students to Cuba to study medicine and surgery on scholarships. This provided an opportunity for Pakistani students to undergo medical training not normally available in their own country and Cuba made 1,000 scholarships available to Pakistan. In itself, this represented a watershed as it was the first time that Muslim students studied in Cuba.

Ebola

Cuba was the first country to respond to WHO's call for medical staff to help with the Ebola crisis and sent 53 medics to Liberia and 35 to Guinea Bissau. Cuba dispatched 165 doctors to Sierra Leone, the largest number after the UK. In some treatment centres, Cuban staff were working with the US NGO, Partners in Health. An estimated 12,000 medical staff volunteered internationally during the recent Ebola outbreak,²² with only Médecins Sans Frontières making a comparable contribution of staff.²³

Controversy around the '*Cubanisation of Health Care Services*'

In a number of countries, the arrival of Cuban medical teams was not without controversy, especially in some Latin American countries. The examples of Honduras and Venezuela represent a useful illustration of how different value systems evolve through diverse social and political cultures and organisation and thereby affect the provision of and access to basic services such as healthcare.

In **Venezuela**, when Hugo Chavez came to power, the new Venezuelan constitution underlined the government's duty to provide health care for *all* Venezuelans. The aim was to provide a new public health system in poor, isolated and rural areas, with up-to-date equipment and high-class diagnostic capacities. The main problem that arose was that Venezuelan doctors were unwilling to go and live in remote areas in rural communities. When Cuban doctors arrived, major demonstrations took place against their presence in Venezuela. Temperatures were running high with accusations of 'the *Cubanisation* of our health system'. The debate raged around issues of bonus pay for doctors, which had been undermined by 'the invasion of the so-called Cuban doctors'.

In **Honduras**, similar issues surfaced following the devastation of Hurricane Mitch. At the time, this natural disaster was described by a Honduran government minister as setting

back the country's health system and communication infrastructure by forty years. Cuba's emergency team, consisting of 14 emergency health workers, was one of the first to arrive. Once the emergency was over, Cuban doctors were asked to remain in country. Their comparative advantage and selling point was once again that they were able and willing to work in isolated rural areas, where Honduran doctors refused to go or were only willing to remain for short periods. Honduran medical personnel demonstrated and doctors objected, stating that the invitation to Cuban doctors to return undermined their professionalism. However, clearly Cuban doctors had won 'the hearts and minds' of the Honduran population, with radio phone-in programmes apparently jammed with requests for Cuban doctors and many Hondurans describing their own doctors as elitist, unaffordable and inaccessible. The Honduran Medical Association later admitted that it had been rejected by the population and had lost credibility.

3. Cuba and Other Latin American Players

This section provides a short (and by no means exhaustive) outline, setting Cuba's humanitarian diplomacy within the Latin American political panorama to illustrate the intricacy of funding and spheres of political and economic influence that fuel Cuba's 'humanitarian' activities.

Regional Alliances and Cooperation

Essentially two distinct Latin American political groupings exist, consisting of Argentina, Brazil and Chile (the so-called ABC countries), and the Bolivarian Alliance for the Americas (ALBA – *Allianza Bolivariana para los Pueblos de Nuestra America*) led by Venezuela. The latter have also been labelled as the 'Latin-American axis of evil'.²⁴ The ABC and ALBA countries display marked differences in their approaches – a prominent illustration is their involvement in Haiti both before, but especially in interventions after the 2010 earthquake.

This is closely linked to the discussion around the pros and cons over the role of South-South Co-operation (SSC). There is a danger to be caught up in clichés in this debate, with two apparently dominant views: that SSC is more attuned to the needs of recipients and communities, given the similarities of experiences between Southern partners; and that SSC has no concealed motive that would usually characterise North-South corporation. SSC is historically rooted in the non-aligned movement and is often held up as an instrument for building alternatives to traditional North-South relations, which are seen as reproducing inappropriate models that reinforce Southern independence.

ALBA was created in 2004, with the underlying ideological approach of 'collaborative advantage as opposed to competitive advantage'. The aim was to develop an alternative model of regional integration. As a result, ALBA is already developing a number of policy instruments, such as a regional energy infrastructure, a 'development bank of the South'. independent of traditional, Northern-dominated development institutions such as the

World Bank or the International Monetary Fund (IMF), a digital television network and a single currency.²⁵

ALBA's alternative model of development is based on two key principles: international cooperation and more participative forms of democracy.²⁶ The former is guaranteed, because ALBA constitutes a trade and solidarity bloc that is socially oriented rather than strictly in search of profit maximisation. ALBA appeals to principles of social justice, well-being and human development as well as solidarity between the poorest peoples of the Americas.

Strong arguments state that despite the extremely innovative approaches, as displayed by the Cuban example above, both ABC and other programmes share some of the problems of North-South cooperation and do not differ fundamentally.²⁷ Some crucial issues include: difficulties in assessing and reporting results; no accountability to recipients of aid; and a tendency to perpetuate dependency as a result of weak strategies to buttress local capacities, particularly those of the host state.

Perception plays a very strong role in this. For example, in Haiti and in Congo, sympathy for ALBA was widespread, as ABC countries were viewed as being too close to Northern donors, whose economic policies and conditional aid had undermined the Haitian economy and, importantly, Congolese political history since the assassination of Patrice Lumumba.

Aid by ALBA countries can rival Western and ABC countries' assistance in quantitative terms; of particular significance are the energy and infrastructure sectors. Neither receives traditional donor support. For example, Venezuela is the largest supplier of oil at concessional rates and is building an oil refinery as well as an electrical plant to lessen Haiti's energy dependency. Under the ALBA umbrella, Cuba and Venezuela have invested considerable resources to strengthen public health services, training thousands of doctors and establishing dozens of clinics and hospitals in rural areas.

But the picture and the interrelationships are complex, in that Brazil is also building a hydro-electric complex in the central plateau area of Haiti. Furthermore it funds Cuba's contributions to the health sector, both now and during the cholera outbreak in Haiti in 2011.²⁸ Therefore, while a certain degree of competition exists between ABC and ALBA countries, they managed to partner in Haiti through a form of triangular cooperation. An observation from a Western humanitarian perspective is that funding sources are complex, intertwined with economic, political and ideological interests.

Brazil

Brazil has emerged as an increasingly important and committed player, both in terms of humanitarian assistance and its contribution to UN peacekeeping through police, military and some civilian personnel. This has become particularly evident over the past decade. The political backdrop is that during President Lula's tenure, Brazil increased its

international humanitarian engagement. Much of it was driven by an intention to reduce poverty and inequality in the Latin American and Caribbean region. As a result, Brazil sent troops to UN peacekeeping missions and increased South-South foreign aid and technical cooperation. One prime example is the engagement in Haiti, where the Brazilian military has been leading the UN Stabilisation Mission, MINUSTAH, since 2004. Furthermore, Brazil provided funding for transport and subsistence to Cuba's medical teams to provide public health activities in Haiti.

Of note is that Brazil's foreign budget rose massively from US \$3 million in 2007 to over \$95 million in 2010. A slight decrease is apparent in recent years. This may be linked to important internal changes that have taken place in recent years, with the shift to Dilma Rousseff's presidency since 2011, and also a recent economic downturn.

Venezuela

Venezuela and Cuba have a long and complex relationship, which has moved through and beyond the Cold War era into a post-Chavez period. Post-Chavez Venezuela is prompting subtle shifts by emphasising the need to account for its investments as the Maduro government is struggling to gain liquidity and establish legitimacy.

Under a bilateral agreement, Cuban professionals are paid by Venezuela to provide health care free of charge to large underprivileged populations in Venezuela and other ALBA countries as well as medical training in Cuba and Venezuela. Under this agreement, the host government provides each *internacionalista* furnished housing, domestic transportation, and a monthly stipend, generally between \$150 and \$500, for food and personal expenses. Cuba covers logistical support and sometimes airfare, and pays the family of the collaborator back home their regular peso salary, a scant \$22 to \$25 a month on average for a doctor, and a hard-currency bonus of around \$50 to \$120 monthly.

Venezuela sends Havana around 100 thousand barrels of crude oil per day. Cuba pays 50 per cent of the balance due in ninety days with the services of its collaborators; the rest may be deferred, with Venezuela financing it for seventeen to twenty-five years at 1 per cent interest after a two-year grace period.

The large expansion of the international medical aid programme resulting from the Venezuela agreement is reflected in Cuba's 772 per cent increase in export services from 2003 to 2010 (the latest year for which statistics are available).²⁹ By 2005, these export services had surpassed tourism revenues; since 2008, they have been more than three times that of tourism revenues and are generating far more income than any other industry.³⁰

4. Lessons and Conclusions

Implications for Humanitarian Action

From this exploration of Cuba's activities, significant questions arise for wider humanitarian action, namely: to what degree can Cuba's activities be considered 'humanitarian' *per se*, in the sense adopted by Western humanitarian donors and organisations – and to what degree is the country providing technical support for service delivery? To what extent does Cuba's engagement in service delivery enable a more informed humanitarian engagement?

As the brief illustration of Cuban-Venezuelan interaction above highlights, much of the objective here seems not to be humanitarian *per se*, but more akin to diplomacy or the construction of long term, government-to-government relations, and to some degree, the exportation of a certain ideology. But the approach relied on humanitarian emergencies as the 'foot in the door'. In some sense, the degree of criticism would be high if similar interests were overtly perpetrated through Western humanitarian action. The Cuban government has, as have others, engaged in humanitarian action in the pursuit of political or other objectives. Yet Cuba's humanitarian actions are regarded as effective, timely and targeted.

Dr Paul Farmer, the founder and director of Partner's In Health and Professor at Harvard Medical School with a long involvement in Haiti and more recently in West Africa, underlined an important distinction in approach between Western countries and the Cuban-Venezuelan method, as to **whether 'health care is considered a right or a commodity'**. The Cuban approach is clearly that access to health and the right to life is an inalienable right that the international community is morally bound to deliver for citizens everywhere. This is also exemplified in its approach to education. The first priority for ELAM is to target candidates from poor communities who know what it means to live without essential medical care.

The definition of humanitarian assistance as proposed by the Good Humanitarian Donorship (GHD) broadly states that:

Humanitarian assistance is generally accepted to mean the aid and action designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of man-made crises and natural disasters, as well as to prevent and strengthen preparedness for the occurrence of such situations.

This definition distinguishes humanitarian activity from other forms of aid and foreign assistance by putting it under the umbrella of humanitarian principles (of humanity, impartiality, neutrality, and independence).

There appears to be no data, statistics or evidence of ‘monitoring and evaluation’ that justifies or explains Cuba’s activities, except for the demonstrated impact in terms of saving lives (e.g., in Pakistan, Haiti, West Africa during the Ebola epidemic) or the provision of medical services and restructuring of medical systems when governments themselves were unable to provide for structural and political reason (e.g., in South Africa, Gambia). In Western parlance, one of the gaps that appears to have emerged in regard to Cuba’s ‘humanitarian’ activities is that it is unclear whom the Cuban government is accountable to – except to a higher ideology – and how it measures its impact. A clear record of what has been spent and what has been achieved is not apparent. Therefore, quantifying the impact of Cuba’s work in the immediate term is difficult. However, the reform of the public health system in South Africa or Algeria clearly represents a tangible impact, as does the alleviation of cholera in Haiti or the proliferation of rural clinics in Pakistan. Cuba’s humanitarian activities are not *separate* but *part of* foreign assistance and foreign policy objectives. They also *do* fall squarely within the criteria of two humanitarian principles, as they stand at present:

- Humanity: ‘saving lives and alleviating suffering wherever it is found’, and
- Impartiality: ‘acting solely on the basis of need, without discrimination between or within affected populations.’

However, framing Cuba’s activities is more challenging and complex in regard to:

- Neutrality: ‘acting without favouring any side of an armed conflict or other dispute where such action is carried out’, and
- Independence: ‘the autonomy of humanitarian objectives from the political, economic, military or other objectives that any other actor may hold with regard to areas where humanitarian action is implemented’.

The case for Cuba’s medical intervention is that it primarily responds to natural disasters, albeit with profound social consequences. In the case of conflict, it does not purport to adopt a neutral stance; indeed Cuba takes sides, such as in Angola with the MPLA – but broadly speaking, the side it takes is always that of the poor, vulnerable and disenfranchised. It works with governments who invite Cuba to respond because of its skills, its approach and, often, its local expertise. These are also governments with whom Cuba has an existing political relationship or one where relations are deepened through Cuba’s medical assistance. Hence health diplomacy is *the* tool.

In essence, Cuba represents a state run system, which *instrumentalises* humanitarian assistance as part of foreign policy. The question arises of how different this is in reality from the *instrumentalised* assistance provided by Western donors and their implementers, UN agencies and INGOs. One might argue that Cuba is upfront about its political agenda and ability to expand its sphere of influence through a genuinely exportable and useful

commodity, a sophisticated health care system, medical education and an effective health response mechanism. There is no rhetoric but action.³¹

In places where Cuba ‘intervenes’, an interesting contrast can be seen with ‘less-developed’ countries in receipt of structured foreign assistance. An illustration is offered by the political background and inter-dependence of two Latin American countries, such as Honduras and Cuba. Honduras is a recipient of World Bank and IMF loans. In 2014 alone, Honduras received US \$113.2 million as a standby arrangement and \$75.4 million as a standby credit facility, amounting to \$188.6 million or 100 per cent of the country’s quota.³² The IMF and World Bank insist on caps on social spending. At the same time, 80 per cent of the Honduran population live in poverty. This has, according to some analysts³³ led to the privatisation of the health sector and undermined governance of the public sector by reducing the role and remit of government. The Cuban argument is that once assets are privatised, the state’s access to them to provide services in times of emergencies is limited by its purchasing ability. When the state no longer possesses the assets, it does not have the ‘elbow room’ to maximise their use for maintenance and mitigation.

Lessons to be Learned from the Cuban Experience

A number of lessons can be identified with implications for Western-dominated humanitarian work, based on Cuba’s approach to healthcare and disaster response, both internally and in its export of expertise. Much of it resonates with ongoing debates in the existing humanitarian system around sustainability, creating community resilience and community based participatory approaches applying the Do No Harm principles. The application of a Cuban-Venezuelan approach relies on working at a local-government level in a neo-liberal political system, and using community and grassroots potential. However, arguably, given the almost sixty years of history, Cuba’s particular approach to exporting health services, cannot be easily replicated.

The following suggests some of the main characteristics with potential implications for humanitarian response (this is not an exhaustive list).

Focus on the Local

- The Community Based Disaster Management (CBDM) approach applied domestically in Cuba focuses on strengthening capacity and building skills for risk reduction at the community level. Cuba demonstrates a rare example of successfully building CBDM into a national risk reduction programme.
- Using local government: The ground is fertile for extending the authority and decision-making powers of local government to disaster mitigation, preparedness, and response. Where a level of trust between the population and local governments exists, this social capital can and should be built upon to ensure people’s

cooperation with local disaster preparedness and response measures. This extends to the proliferation of efficient medical services into remote rural areas.

- Community leaders and grassroots structures can be involved and used, with roles in risk reduction assigned to people in all sectors of the community.
- On-going community risk mapping can be used to build up a picture, which is constantly being updated, of who is most vulnerable, where they live, and who can help them.
- Domestically, local emergency plans can be created, and local disaster simulation plans conducted on a regular basis.

Management and Communication Structure

A centralised decision-making process, firmly rooted in its political system is also key for emergency situations, alongside a decentralised implementation process, providing the agility and adaptation equally necessary for effective emergency preparedness and response. This also means that local groups are taking orders from someone familiar to them, not a stranger brought in for the duration of an emergency. In real terms, this involves years of preparatory work. The question arises about what to do if this is not possible or has not been the case. Is the Cuban model really exportable and applicable outside its particular historical and political context?

- Essentially, the structures that run everyday life are the structures also used for implementing 'civil defence' measures and are easily packaged in ways that can be understood by everyone.
- Plans are updated continually at all levels, from community to national.

Investment in Human Capital

- The Cuban example raises the possibility that effective aid or support consists of concrete, practical measures to save lives that might ultimately depend more on the intangibles of relationship, training, and education than on high-cost procedures and resources.

Ideology / Philosophy

- The ideology of the 'collaborative advantage' as opposed to the competitive advantage drives ALBA. Even if it is not present at a national political level, it can and does seem to work at a local level in times of crisis.

Conclusion

The Cuban approach subsequently adopted by the Venezuelans is in essence a grassroots movement that has evolved over nearly sixty years. It is based on a participatory process, and as examples from South Africa and Honduras have shown, can invite fierce resistance from non-Cuban doctors and national medical associations who are invested in a private system of medicine. Essentially, the Cuban and Venezuelan medical systems are social development programmes, they are not just about healthcare. The goal is the transformation of the community through the practice of socialism and through a committed investment in human and social capital. Above all, the export of highly effective service delivery is a political act embedded in a defined ideology and political culture, based on a highly centralised government.

This exploration of Cuba's 'health diplomacy' has raised more questions than answers. One of the fundamental questions that remain outstanding from a Western-driven humanitarian perspective is whether the Cuban 'model' is indeed a model. Is it transformational in essence and therefore not purely a life-saving model? It is also unclear what the future of the Cuban 'model' might be and how it will grow or not and what kinds of tension will emerge between the Western model and more indigenous approaches, such as the Cuban one. Hence the answer to the question: 'Can revolutionary medicine revolutionise the humanitarian system?' is probably 'No', but it can augment, assist and highlight what is possible and do-able in terms of effective service delivery through an ideological and politically centralised and highly professional system.

References

- ALNAP (2010) The role of national governments in international humanitarian response. Meeting paper, 26th annual meeting, Kuala Lumpur.
- Artaraz, Kepa (2012) Cuba's Internationalism Revisited: Exporting Literacy, ALBA and a new Paradigm for South-South Collaboration, *Bulletin of Latin American Research*.
- Baranyi, Stephen, Andreas E. Feldman & Lydia Bernier (2015) Solidarity forever? ABC, ALBA and South-South Cooperation in Haiti, *Third World Quarterly*, 36:1, 162-178.
- Binder A, Meier C (2011) Opportunity knocks: why non-Western donors enter humanitarianism and how to make the best of it. *Int Rev Red Cross*, 93(884).
- Blue, Sarah A. (2010) Cuban Medical Internationalism: Domestic and International Impacts, *Journal of Latin America Geography*, Volume 9, Number 1, 31-49.
- Bustamante, Michael J. and Julia E. Sweig (2008) Buena Vista Solidarity and the Axis of Aid: Cuban and Venezuelan Public Diplomacy. *The Annals of the American Academy of Political and Social Science*, 616(1): 223-256.
- The Carter Centre, President Carter's Cuba Trip Report, 21 May 2002, <http://www.cartercenter.org/news/documents/doc528.html>
- Disaster News Network. How does Cuba do it? <http://www.disasternews.net/news/news.php?articleid=1567> (8 August 2003).
- Feinsilver, Julie M. (1993) *Healing the Masses: Cuban Health Politics at Home and Abroad*. University of California Press: Berkeley.
- Gaviria, Izaskun (2003) *Lesson from Cuba: Natural Disaster Prevention, Mitigation and Recovery*, M.A. diss., Brandeis University.
- Hall, Anthony and James Midgley (2004) *Social Policy for Development*, Sage: London.
- Harvey P, Harmer A (2011) International dialogue on strengthening partnership in disaster response: bridging national and international support. *Humanitarian Outcomes*, London.
- Institute of Bioregional Studies <http://www.ibspei.ca/programs.htm>
- Kirk, Emily J. and John M. Kirk (2010) Cuban Medical Cooperation in Haiti: One of the World's Best-Kept Secrets, *Cuban Studies*, Volume 41, 166-172.
- Kirk, John M. and H. Michael Erisman. (2009) *Cuban Medical Internationalism: Origins, Evolution, and Goals*. Palgrave Macmillan, New York.
- Lavell, Alan (2002) 'Risk Management and Reduction in the Caribbean: Considerations on the State of the Game and on new Challenges for the Future.' <http://www.onu.org.cu/havanarisk/documents/AllanCARIBANALYSIS2.pdf>

- Ministry of Science, Technology and Environment (INSMET) (2001) Cuba: Actions for the Adaptation to Climate Change.
http://www.onu.org.cu/havanarisk/EVENTOS/cchange2/climate_met.PDF
- Opinio Juris (2004) <http://opiniojuris.org/2015/01/25/guest-post-response-kevin-jon-heller/>
- OXFAM America (2004) Cuba, Weathering the Storm: Lessons in Risk Reduction from Cuba. Martha Thomps with Izaskun Gavi.
- Pelling, M. and High, C. (2005) Understanding Adaptation: What Can Social Capital Offer Assessments of Adaptive Capacity?
- Perez, Christina (2012) Revolutionary Doctors: How Venezuela and Cuba Are Changing the World's Conception of Health Care, Socialism and Democracy, 26:2, 135-139.
- !Salud – saludthefilm.net, directed by Connie Field, produced by Connie Field and Gail Reed, MEDICC – Medical Corporation With Cuba, @MEDICC2014.
- Tomasini, R. and Van Wassenhove, L.N. (2009) 'From Preparedness to Partnerships', Case Study Research in Humanitarian Logistics, International Transactions in Operational Research, Volume 6, pp. 549–559.
- Trujillo, Monica, Ordóñez, Amado and Rafael Hernández (2000) Risk-Mapping and Local Capacities: Lessons from Mexico and Central America. Oxfam GB: Oxford).
- Uriarte, Miren (2002) Cuba. Social Policy at the Crossroads: Maintaining Priorities, Transforming Practice, Oxfam America: Boston.
- Vanderbush, Walt (2009) The Bush Administration record in Latin America: Sins of Omission and of Commission, New Political Science, 31:3, 337-359.
- Waugh, Jr. W. and Streib, G. (2006) 'Collaboration and Leadership for Effective Emergency Management', Public Administration, Volume 66, Number S1, pp. 131–140.
- Werlau Maria C. (2013) Cuba's Health-Care Diplomacy – The Business of Humanitarianism.
- Wisner, Ben (2001) At Risk: Natural Hazards, People's Vulnerability and Disasters <http://www.theguardian.com/world/2001/nov/14/cuba.socialsciences>.

About the Author

Nicola Dahrendorf is a Social Anthropologist and a Lawyer. She has extensive experience within the UN, (UNHCR, UNICEF and UN DPKO), NGOs (Conciliation Resources, Save the Children and Oxfam), the UK Government (DFID and Stabilization Unit), and in academia with the School of Oriental and African Studies (SOAS) and King's College London. In the

UN, she worked primarily in humanitarian emergencies and peacekeeping operations in Haiti, DRC, Rwanda, East Timor, Bosnia and Cambodia. At DFID she worked as Regional Conflict Adviser for West Africa and recently as a Senior Security and Justice and Conflict Adviser on call for the UK tri-departmental Stabilization Unit, on Somalia, South Sudan and Nigeria. Her overall professional focus has been on humanitarian emergencies, peace-building, protection of civilians and on sexual and gender-based violence. She is now working as an independent consultant and is a Senior Visiting Research Fellow at King's College, London.

Notes

¹ This aspect could and should be further explored in a longer paper.

² See Human Rights Watch: www.hrw.org/world-report/2015/country-chapters/cuba; Amnesty International: www.amnestyusa.org/OurWork/Countries/Americas and also Freedom House: <https://freedomhouse.org/report/freedom-world/2015/cuba>

³ Blue, Sarah A. (2010) Cuban Medical Internationalism: Domestic and International Impacts, *Journal of Latin America Geography*, Volume 9, Number 1, 31-49.

⁴ President Carter's Cuba Trip Report, The Carter Centre, 21 May 2002

⁵ <http://www.ibspei.ca/programs.htm>

⁶ *Weathering the Storm*, Oxfam America Report, Oxfam America, 2004

⁷ *ibid*

⁸ <http://reliefweb.int/report/haiti/hurricane-dennis-leaves-five-dead-us-23-caribbean>

⁹ Gaviria 2003, 14

¹⁰ Perez, 2010

¹¹ Cuba's Strange Mission in Angola, James Brooke, *NY Times*, 1 February 1987

¹² *Ibid*. See also Cuba in Africa, Pamela Falk, *Foreign Affairs*, Summer 1987:

<https://www.foreignaffairs.com/articles/africa/1987-06-01/cuba-africa>

¹³ <http://www.sahistory.org.za/topic/cuba-and-struggle-democracy-south-africa>

¹⁴ <http://saludthefilm.net/quotes/>

¹⁵ Article 25 of the 1948 Universal Declaration of Human Rights defines the right to a 'standard of living adequate for the health and well-being of himself and his family, including ... medical care and ... the right to security in the event of ... sickness, disability ... or other lack of livelihood in circumstances beyond his control.' The right to health was included in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 (2) explicitly sets out a right to health and defines steps that states should take to 'realize progressively' 'to the maximum available resources' the 'highest attainable standard of health,' including 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases' and 'the creation of conditions which would assure to all medical service and medical attention in the event of sickness.'

¹⁶ Article 2, ICESCR

¹⁷ *Opinio Juris*, 2008, Kevin Jon Heller, 2 March 2008

¹⁸ *ibid*.

¹⁹ Source: The Right to Health, OHCHR Fact Sheet No. 31, www.ohchr.org/Documents/Publications/Factsheet31.pdf

²⁰ Baranyi, 2015

²¹ Werlau, 2013

²² <http://www.telegraph.co.uk/news/worldnews/ebola/11375422/Cuban-doctors-take-leading-role-in-fighting-Ebola.html>

²³ <http://www.newyorker.com/news/daily-comment/cubas-ebola-diplomacy>

²⁴ Vanderbush, 2009

²⁵ de la Barra, 2006

²⁶ Brennan and Olivet, 2007

²⁷ Baranyi, 2015

²⁸ *ibid*

²⁹ Exports of goods and services (% of GDP) in Cuba were last measured at 19.96 in 2011, according to the World Bank. Exports of goods and services represent the value of all goods and other market services provided to the rest of the world. They include the value of merchandise, freight, insurance, transport, travel, royalties, license fees, and other services, such as communication, construction, financial, information, business, personal, and government services. They exclude compensation of employees and investment income (formerly called factor services) and transfer payments

³⁰ Baranyi, 2015

³¹ Questions as to which approach is more effective or more devious might be explored in a further discussion paper.

³² IMF: <http://www.imf.org/external/country/hnd/index.htm?type=9998#30>; World Bank: <http://data.worldbank.org/indicator/DT.ODA.ALLD.CD>; <http://www.ibtimes.co.uk/imf-approves-118-6m-aid-honduras-lempira-rises-two-month-high-1478144>

³³ Perez, 1010; Honduran Minister of Health Interview, !Salud, 2014