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South – South Cooperation in healthcare in Kenya: political, socio-economic implications of Cuban specialist physicians working in Kenya

By

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Abstract
South-South co-operation has been touted as an alternative global trend to drive development in the global South. It is viewed as a way for governments to identify the challenges they are facing and then prioritise and actualise solutions. In the spirit of developing self- reliance in the global South, these initiatives have gained traction as a tool of development. Many countries have leveraged cordial bilateral ties that exist between them to utilise the expert knowledge of their counterparts in order to tackle developmental challenges. This involves sharing knowledge, skills, expertise and resources. This paper examines the implications of South – South Cooperation between Kenya and Cuba in the health sector. This has been presented by the Kenyan national government as a solution to the impasse with Kenyan doctors. The acrimonious beginning of this initiative raises issues about the how these doctors can function effectively in their new roles. It also raises issues which have been highlighted by various stakeholders such as: the economic burden on the national government, the socio-cultural implications of dealing with people in the grassroots, the safety of the doctors in remote locations and the future of the deployment of Kenyan specialists in the counties. Using this entry of expatriate doctors as a case study, this paper will use secondary data to investigate the reality of South- South cooperation beyond the agreements made in a top-down format. This will also highlight the place of this co-operation in the planning, development and implementation of development plans in the Global South. This will also serve as an avenue to answering the question: what are the underlying effects to the Kenyan health sector?

Key words: Kenya; Health care; Expatriate Doctors; South-South Co-operation

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Introduction

South - South Cooperation: Origins and Evolution

Development co-operation is a subset of South-South Co-operation (SSC). Other aspects such as trade and investment are considered forms of SSC. Development co-operation from Southern powers should be understood as official transfers of money, goods and services to developing states specifically for their development and welfare (Mthembu, 2008). These transfers usually come from official government ministries and are usually concessional in nature. SSC has been given impetus by energy and food crises, climate change and pandemics which have enhanced partnerships through interregional, regional and sub regional mechanisms. Other concerns pushing SSC are the volatility of the financial markets, scarcity of food and high energy prices. Insecurity and finding alternatives to seeking emergency assistance from the International Monetary Fund (IMF) by seeking support amongst themselves also pushes the SSC agenda. The real significance of SSC lies in the character of the relationship that is expressed by the exchanges (RAMC, 2010). It enables developing countries to assist each other in capacity building rather than relying on North-South dependant and asymmetrical relationships.

The 2008 Accra Agenda for Action (AAA) of the 3rd High Level Forum on Aid Effectiveness affirms that

> …South-South Co-operation on development aims to observe the principle of non-interference in international affairs, equality among developing partners and respect for their independence, national sovereignty, cultural diversity and identity and local content. It plays an important role in international development... (RAMC, 2010:2).

Historically, SSC emerged from a common struggle of former colonies to attain genuine independence and development. It is also known as 'Solidarity Aid' (Anderson, 2010). The Bandung Conference of 1955 brought together twenty-nine countries in a bid to promote economic and cultural co-operation between Asian and African states (Gray and Gills, 2016).

Statement of the Problem

The attention paid to SSC has coincided with increased interest in global health diplomacy – formal multilateral and bilateral decision making around health and the interaction between health and foreign policy concerns that involve co-operation among a range of state and non-state actors (Birn, et al., 2017). Developing countries are seeking alternative solutions and pathways to development. In the spirit of self-reliance and cost-effective interventions, South-South Co-operation (SSC) has emerged as a plausible contender to drive sustainable development in the global South. This paper will attempt to address issues arising from the integration of Cuban specialist doctors in the Kenyan healthcare system. The promise of devolution for effectively devolving healthcare to the counties and their grassroots has yet to

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bear fruit. The retention of certain powers and responsibilities at the centre and the decentralisation of corruption has affected effective implementation making the work of healthcare professionals difficult. Universal Health Care is part of the incumbent government's development agenda. The sourcing of Cuban doctors seeks to address the gaps in the system. However, there are issues arising that have great implications on the Kenyan healthcare system. These include political and socioeconomic implications which this paper seeks to examine

Objectives or Research Questions

The overall objective of this paper is to examine the implications of SSC in healthcare in Kenya. This based on an agreement between Kenya and Cuba to boost provision of health services in the Kenyan healthcare system. Other objectives are to examine the political implications of SSC in healthcare in Kenya; to examine the socioeconomic implications of SSC in healthcare in Kenya and finally, to examine the underlying effects of the SSC in healthcare in Kenya.

Review of Related Literature

Central to the concept of North and South are the different economic, political and social structures which generate a specific level of development, which can be measured by a variety of indicators like GDP per capita, productivity, unemployment, illiteracy rates and infant mortality (Kruger,2008). The history of developing countries also plays an important role in this context since it was the experience of colonial subjugation and oppression which contributed to the formation of a common and anticolonial identity in the South. The South as former colonial states gained significance at the end of the Second World War and the beginning of the Cold War competition between the United States and Russia (Kruger, 2008). This was because of their strategic importance for control by these emergent ideologies of capitalism and communism. This led to the establishment of the modernisation theory which dominated the understandings of the relationship between the North and the South. Modernisation is viewed as a process through which developing countries acquire those features that are indicative of development in developed countries. These are usually viewed as part of the universal and linear process of moving through the stages of development as argued by scholars such as Rostow and Lewis. The modernisation theory argues that in order to develop, developing countries must set aside traditional institutions and values and embrace those that have worked in developed countries. These include capital accumulation technological progress, limiting population growth, urbanisation and democratisation. This advice sought to establish a virtuous circle to ensure economic growth, democratisation and better living standards.

The ideas on which South-South Co-operation (SSC) are based have their beginnings in the Dependency theory. This theory was developed by the Latin American scientists in the 1960s (Birn, et al., 2017). They were influenced by earlier Marxist theories and discussions that took place within the United Nations Economic Commission for Latin America (ECLA) and observed that the terms of trade for exporters of primary goods were not improving. This theory focuses on the fact that oppression and exploitation of the South by the North has contributed to the underdevelopment of the South (Kruger, 2008; Jules et al., 2008). It also focuses on the specific history of colonialism which distinguishes the countries of the North from those of the South. The experience of colonisation and its exploitation has massive implications for the economies of the South because they were integrated into the international division of labour as the exporters of a few agricultural products and other raw

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materials. This means that their economies were highly dependent on their orientation towards the markets of the North (Kruger, 2008). Calls for delinking from North-based institutions and for the launch of the self-centred development strategy which concentrates on the needs and demands of the domestic population. This theory highlights SSC as an alternative to the status-quo; one that is subversive in nature that seeks to strengthen developing countries politically and economically (Huish & McLennan, 2019). It also seeks to by-pass the existing systems and have developing countries co-operate amongst themselves to avoid experiencing deteriorating terms of trade**.**

In the post-Cold War era, realist and neorealist theoretical paradigms have been applied to the rationale for South–South Co-operation. The realist approach views SSC as a strategy to secure power and a ploy utilised by reginal powers such as the Brazil, Russia, India, China and South Africa (BRICS) to bring weaker states under their control to raise their global portfolio (Jules et al.2008). The liberalism approach viewed SSC as a rational action taken by state actors to take advantage of any trade-offs and incentives and to put constraints to conflict. State actors are looking to maximise their interests. The 'new' policy agenda emergence has reignited interest in SSC because of the recognition of the international power that the global South wields; the importance of non-state actors such as non-governmental organisations (NGOs) and the need to promote development in the South (Jules et al., 2008). From a functionalist point of view, SSC is viewed as an objective process that can be arrived at through development interventions. It becomes a tool of South –South transfer by becoming a technical concept or a development technique (Jules et al., 2008).

Chaturvedi (2016) opines that although there is a long history of countries of the North collaborating with those of the South, there is a new compact. This new agreement is between countries of the global South. It is not about imposing conditionalities but is based on the principles embodied in the idea of SSC. It offers opportunities for growth and economic expansion through human capacity building and the strengthening of institutions. The earlier development agreements were based on implementing the Structural Adjustment Programmes (SAPs) (Chaturvedi, 2016). These are based on the premises of the North-South agreement, as also noted by other scholars, also expands on the ideas of the Marshall Plan. This was the compact arrived at between the Western European countries to assist their recovery following the devastation of the Second World War. The end of colonialism also yielded opportunities for greater North-South Co-operation and the fledgling beginnings of South-South Co-operation. SSC seeks all-round development and emphasises the need for self-reliance. SSC has expanded from its highly localised beginnings to become a complex web of interactions. These extensive cross-continental linkages have developed due to trade liberalisation measures and continued political engagements. This has been exemplified in an increase in trade; where South-South trade as a share of world trade has grown from 8.1 percent in 1980 to 26.7 percent in 2010 (Chaturvedi (2016).

Forms of North-South Co-operation

North-South Co-operation (NSC) is a product of the end of the Second World War and the rising discontent of colonies of the great powers of the North. At the end of the second Great War, the Marshall Plan was affected in Western Europe to assist in the reconstruction of European states. It draws its basis on the ideas that the North controls capital resources and technical skills which are lacking in the South. With the end of colonisation, a new phase in the practice of global politics took centre stage. The ideological parallels of communism and capitalism sought to influence political and socioeconomic activities in the newly independent states. Through various agreements with former colonies based on the ideological masters

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they attached themselves to, projects and programmes to boost local development were mooted. These signed compacts included aid in the form of bilateral and multilateral agreements. The North therefore promotes international development by providing economic, financial, and technical assistance to the South.

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Table 1: Forms of North-South Co-operation (RAMC, 2010)

Type	Main Modalities	Instruments
1. Financial/In kind Transfers	Grants	General budget support Investment projects Core support for NGOs Contributions to multilateral institutions Multi donor funds
	Loans and equity and quasi-equity investments	Concessional Loans Multi donors trust funds Aid for trade(loans) Loans with lower concessionality than ODA Syndicated loans Equity investment Mezzanine finance Risk-mitigation instruments
	International levies and some other innovative finance	Solidarity levy on airline tickets Pilot advance market commitments for vaccines Caribbean catastrophe Risk Insurance Facility
	Public Private Partnership	GAVI Global Fund
	Public Climate Finance	Mitigation Projects Certified Emission Reduction Trading
	In kind transfer	Food aid Non-food commodities
2.Capacity Support	Organisational and Human Resources	Decentralised co-operation University co-operation Institutions and capacity building programmes
	Technology Co-operation	Co-operation among research centres
	Sharing policy experiences	Policy advice Capacity and institution building
3.Policy Change	In-country	Scholarship programmes Refugees in donor countries Administrative costs Debt relief Promotion of development awareness
	Changing global rules	Exceptions in TRIPS Transition period for developing countries concerning patents regarding pharmaceutical products Trade preferences, reduction of trade duties; Duty-free, quota-free for developing countries
	Policy coherence	Monitoring of national improvements by donors

Source: Author 2019

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Forms of South-South Co-operation

South-South Co-operation exploits the gaps left by traditional North-South development co-operation. It positions itself as a viable alternative and complement to traditional forms of development assistance. It enables countries in the South to find niches and opportunities to assist their neighbours and spread their spheres of influence They are then in a better position to embrace the challenges of serving as a nuanced source of developmental aid. One of the earliest examples of SSC is the G77, which is a negotiating bloc that was established in 1964. It has a current membership of 131 countries and is the largest pooling of developing countries. The main aim of the collective is to provide a platform for countries of the South to secure and promote their common economic interests. This negotiating bloc positions issues of the South in the forefront and promotes SSC (RAMC, 2010). Another form of SSC is through economic integration as evidenced by the Bolivarian Alternative for the Americas (ALBA). This collective was launched in 2004 as alternative to the proposed Free Trade Area of the Americas, which was the brainchild of the United States of America. As a part of the regional integration between Latin America and the Caribbean states, it espouses the ideas of promoting social welfare, equity and mutual economic aid. Project assistance is achieved through various infrastructural projects.

The TAZARA railway constructed between1970-1975 was the largest Chinese infrastructural investment in Africa. Other projects have included road and rail projects in Ethiopia and the Standard Gauge Railway (SGR) undertaking in Kenya. Developing countries have also embraced sectoral support for various sectors of their economies. Cuba has supported agriculture and food security initiatives of the World Food Programme (RAMC, 2010). They have contributed agricultural and fisheries experts and technicians to share their knowledge. They have signed agreements with other developing counties to assist them in embracing emerging technologies best suited to local environmental conditions on order to boost crop yields. The Indian Technical and Economic Co-operation was founded in 1964 by the Indian government to upgrade the skills, build the capacity and empower developing countries. Through training, project-related activities, seconding of their experts to other countries and the use of study tours, one hundred and fifty eight countries have benefited from their schemes. Educational exchanges have also been utilised as in the case of Brazil implementing these programmes in Portuguese-speaking countries such as Angola, Mozambique and Cape Verde. The main aim of such programmes is school capacity building and fighting illiteracy. Concessional loans are also commonplace in SSC. They are used for capital development and make sense for the recipient countries as they are able to improve conditions at home. In 2009, Cambodia received a forty million (40) US dollar concessional facility from Thailand to upgrade a national highway. Other forms of SSC have been unconventional and have involved the payment for goods and services in kind. Venezuela PetroCaribe is an oil alliance between Venezuela and Caribbean states. It was launched in 2005 to enable Caribbean nations purchase oil from Venezuela on favourable terms. They would only be required to pay a fractional amount upfront and then pay the rate based on a concessional agreement for twenty-five years. They were also able to pay using produce such as bananas, rice and sugar.

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Table 2: Forms of South-South Co-operation (RAMC, 2010)

1. Economic Integration
2. The formation of negotiating blocs within multilateral institutions
3. Military Alliances
4. Cultural Exchanges
5. Humanitarian Assistance
6. Technical Co-operation
7. Provision of Concessional Financing for development projects and programmes
8. Budget Support
9. Strengthening Balance of Payments

Source: Author 2019

Discussion of Findings

Traditional North-South Co-operation (NSC) is based on political and strategic considerations of donors more than the economic need and policy performance of recipient governments. Donors from the North usually give more assistance to former colonies (Alesina &Dollar, 2003). Other considerations that affect the disbursement of aid include the voting patterns of recipient countries. Neumayer (2003) reports that countries such as France, Germany and Japan base higher disbursements on whether recipient states import large quantities of their exports. Ultimately, the prime motivation is self-interest of the donors rather than the recipient needs. Furthermore, NSC attaches macroeconomic and governance conditionalities even though they are signatories to the Paris declaration that recognises the principle of country ownership of aid. This violates the sovereign right of recipient countries to determine country priorities and strategies for development. When developing countries find these conditionalities stifling, they often turn to their Southern donors who apply more flexible terms. This leads to quicker disbursement and more predictable financing for projects.

Many of the Southern donors tend to ignore the appalling human rights records of some developing countries. This has angered Northern donors who consider these failings as an essential lens through which to view the ability of recipient governments to harness resources and benefit all segments of their societies. They also turn a blind eye to the social and environmental effects of SSC which has far-reaching effects. For example, in Cabinda, Angola where the Chinese exploitation of oil has affected the ecology, the numerous accidents occurring at Chinese-owned copper mined and their harvesting of rare hardwood from Mozambique's semi-arid forests (RAMC, 2010).

Tied aid from North means that much of their technical assistance and food aid programmes remain heavily tied. This is also an issue in SSC from BRICS countries where they tie project assistance to the purchase of goods and having contractors from donor states. This has manifested itself in African countries through Chinese projects where materials and contractors are all sourced from the donor country. This practice serves as a severe obstacle to the growth and expertise of locals. An ECOSOC (2008) study found that tying aid usually inflates the cost of development projects by 15-30 per cent. They also note that some of the tied aid from Southern donors has been found to be better priced and of appropriate quality for developing countries.

As the world grapples with issues of the extinction of flora and fauna, the sustainability of development initiatives also comes to the fore. SSC development initiatives that rely on the utilisation of raw materials face an uncertain future. Once the resources are depleted or there

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is a lack of raw materials to trade with, then problems arise. Also, these initiatives do not assist in generating additional employment. They may have short term gains which may further impoverish poor countries. What is required is a national policy that would contribute to holistic development of a sustainable economic system in developing countries.

Both NSC and SSC do not mention citizen participation in steering development initiatives. Often, they are implemented once agreement are reached by the top levels of government. Parliamentary participation is also limited and may be applied as a rubber stamp. The input of other actors is limited and may also act as a factor in the unsustainability of these development initiatives. This lack of citizen participation is further compounded by a lack of accessible and comprehensive information on SSC. Most of the developing countries do not have a central co-ordinating agency to manage and monitor development assistance at the national level. There are high levels of secrecy on both sides of SSC partnerships whereby they do not release official statistics of their activities. Finally, despite the prevailing weaknesses, the emergence of SSC is an opportunity for greater engagement amongst the Southern states. It serves as a platform to leverage unique alliances and histories to forge a more balanced and nuanced form of development co-operation.

Cuban South –South Co-operation in Healthcare

The Cuban health assistance program has been used a lot in Africa and the Americas as part of South- South Cooperation (SSC) or regional co-operation. In Africa, it dates back to 1963 when a medical team was sent to Algeria. They have also provided support in Namibia, Angola, Uganda and South Africa. They have also aided in the creation of medical facilities in Yemen, Guyana, Ethiopia, Guinea-Bissau, Uganda, Ghana, The Gambia, Equatorial Guinea and Haiti (Castro, et al., 2014). This Cuban programme is driven by the key principle of international solidarity. This has been witnessed by medical assistance to countries that have faced natural disasters such as Chile, Nicaragua and Guatemala. It is also situated in the context of SSC that draws from associations of the Non-Aligned Movement (NAM). This was borne out of the divisions of the Cold War. The Cuban government under Fidel Castro vigorously campaigned for co-operation among developing countries. It is understood to be in this context that Cuba provides HRH for Africa. Another key aspect of Cuban internationalisation is the lack of discrimination based on politics and policies. They are ready to help people despite any differences that exist like in helping during wars of independence and natural disasters (Castro, et al., 2014). They prefer to use the term 'collaboration' or 'co-operation' rather than aid. They believe that is more important to work with individuals and communities to introduce sustainable systems of healthcare run by local people themselves.

Cuban aid emphasises social and international solidarity and on the development of the rural health system. Ernesto 'Che' Guevara who was a doctor was influenced by the Latin American ideas of 'Social Medicine' (Anderson, 2010). He had seen how children in rural areas were severely malnourished and wanted to help them. It is also linked to independence and self-determination – that fraternal approach that is greatly valued by Africans. There are various schools of thought on the extent to whether Cuban medical aid is a type of 'Soft Power' or whether it can be considered as a way of creating 'Symbolic Capital' that can be used at a later date as a source of political or material benefit (Feinsilver,2006). Others believe that it is more rooted and complex '...Cuban medical diplomacy appears at its root to be a principled humanitarian project which at different times may have diplomatic, trade or political benefits but is not formulated simply to that end.''(Kirk and Erisman, 2009:170).

The recent wave of health programmes have been linked to Cuba's 'battle of ideas', which is a broad programme of revolutionary morality that seeks to support decent social

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progress. Many countries are reluctant in receiving aid of any kind from Cuba because they are afraid of jeopardising their relations. This project has specific post-colonial advantages such as aiding in the decolonisation process of building an independent capacity and quality in education and other fields (Hickling–Hudson, 2004). It is a project that has reciprocal benefits. There is difficulty in ensuring that health workers of the right quality and the availability are there in developing countries. This can be attested to by the Kampala declaration and agenda for global action from the Global Forum on Human Resources for Health that was held in 2008. There are global shortages of health workers which are driven by insufficient training opportunities, migration and attrition. Cuba has been an important advocate for South-South Co-operation (SSC) and globalisation is one of the drivers of the country's involvement in healthcare programmes. Cuba maintains the largest health operation programme in the world with over thirty-eight thousand health workers in over seventy-four countries. Their programme involves sending doctors on multi-year contracts to countries that have shortages in supporting the delivery of healthcare. The Cuban model of healthcare is centred on prevention and provision without disregarding the curative continuum; meaning that curative and preventive practices go hand in hand (Anderson, 2010).

There are cost-sharing agreements associated with these programmes. Wealthier countries are expected to pay more for the services of Cuban doctors. In other instances, these services are provided in exchange for other resources; for example, the exchange of their services for the supply of oil from Venezuela in 2000. Others pay salaries such as Argentina and South Africa with a portion of those salaries paid directly to the Cuban government. For example, in 2007, in South Africa the doctors were earning between USD$3000-4000 where thirty seven percent of their pay went directly to their government (Asante, et al., 2012).

The medical assistance programme was launched in the Pacific in 2008 to aid the region to achieve the Millennium Development Goals (MDGs) and Universal Health Care (UHC).Sometimes language difficulties cause the contracts to be terminated as in the case of Nauru and Cuba in 2004 when eleven doctors who had been sent to Nauru had to leave (Asante, et al., 2012). There is a lack of official support from the governments of the PIC on the impact of these health workers on health indicators in the region. Media reports still show that they have made valuable contribution to the health care delivery processes and systems. Concerns have been raised in the Pacific countries where these doctors have been working: Kiribati, Solomon Islands, Tuvalu and Vanuatu. These issues include language barriers, quality of care and clinical competencies. Doctors associations such as the one in Papua New Guinea raised concerns about the quality of practice and poor clinical standards which led to opposition to their recruitment. Scholars have hinted that opposition by health professionals in these countries could be motivated by self –interest, inadequate consultation and the presence of unemployed local doctors (Anderson, 2010; Asante et al.2012).

Most of the Southern contributors of aid prioritise giving aid to neighbouring states due to historical and cultural affinities that make co-operation more productive. These programmes can also be used to promote local stability and security while enhancing the stature of the donor country and influence within the region. Capacity development is one of the areas of SSC that has direct benefit to the people living in developing countries. Education, health and technical co-operation make up the majority of the less affluent donors like Brazil and Cuba. The kind of technical co-operation is not affected by the economic wealth of the donor countries. They rely on their varied degrees of capacities and experiences that can be shared (Anderson, 2010).

Cuba assumes that there is a global shortage of health workers due to commodification and privatisation. Also that there is a shortage of health services in rural areas and a 'brain

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drain'. There may be a difference in the training and work ethic of Cuban doctors which makes them view their roles as doctors in terms of a community spirit and that they are trained to serve and not to trade services. The education system in Cuba creates higher levels of human capital development in all spheres of the country. Due to the difficulties that Cuba has gone through since the 1960s when donors left and in the 1990s with the collapse of its main trading partners and the country suffered serious economic depression. The US economic blockade since the 1960s also contributed to shortages and higher prices leading to difficulty in imports.

The Cuban health aid programmes are based on bilateral agreements between governments.It includes the number of doctors to be deployed and the number of scholarships to be offered. This is part of a long-term plan to replace Cuban doctors with local doctors within a decade. The second step involves an agreement with various stipulations being agreed upon and signed. In this agreement, the Cuban doctors work under the local Health department as civil servants. This is different from project aid where they operate outside the public sector. The Cuban health department prefers that their doctors are deployed to work in rural areas. The Cuban health aid programme has the potential to be large-scale and systematic with a critical mass of a medically trained component. It also has the potential to further deepen a public service ethos in the other countries. It provides avenues for host countries to improve their co-ordination and integration of health services. They are also able to look at this project as a capacity building process to access these doctors and use their expertise instead of relying on highly paid consultants.

South-South Co-operation in Healthcare in Kenya

Political Implications

Kenya is one of the main beneficiaries of SSC in Africa (UNDP, 2017). These flows have been from Indonesia, China, Cuba and Turkey with collaborations in the provision of water, health care, and agricultural aid. The incumbent government has utilised the bilateral agreement between Kenya and Cuba to deal with existing and emergent problems. The first issue was the disagreement between the national government and Kenyan doctors. The doctors were unsatisfied with the prevailing conditions in the national health system. This was in terms of the remuneration offered to those working in hardship areas, the working conditions, the lack of proper equipment and medication. This dispute served as the impetus for the government to find Cuban physicians as an alternative.

The government is also seeking to effectively carry out a programme for Universal Health Coverage (UHC) especially in rural areas. These doctors pooled from the agreement have served as a critical mass to exploit in order to ensure that underserved, remote areas of the country are included. In terms of engaging with other countries in the global South, both Kenya and Cuba gain a modicum of political capital. In Cuba's case, this engagement has provided a source of political capital which the regime can rely on. This is despite American opposition to the emergent rising of the Cuban state. This improved co-operation also enables Kenya to build political clout within the country and outside its borders as it begins to flex its muscles by seeking less reliance on traditional bilateral arrangements.

The issue of the security of these physicians has come to the fore following the abduction of two male physicians on their way to work in Mandera. Although we may not be fully aware of the discussions around the issue, it does raise concerns about their safety especially along Kenya's porous borders. The securitisation of communities as a result the constant threat of the Al Shahab does not seem to have deterred this daring action. It may also serve to strain the relationship between the two states. The question of capacity to respond to

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insecurity along the border plagues both economic, health, administrative and educational activities in these far-flung areas.

Socio-Economic Implications

Economically, the Kenyan government has used a lot of funds to set up the programmes. The bilateral agreement had components for the Kenyan trainees in Cuba to be paid and the Cuban doctors exported to Kenya also required remuneration. These costs incurred in Kenya come in terms of salaries, housing, transport, travel and security. It is however important to note that although funds have been used in these two areas, it cannot be compared to the costs of other 'tied aid' arrangements with the global North. Blue (2010) argues that the lower cost of their programmes are below the market rate. Increased earnings in hard currency have been a boon for both the Cuban government and the individual doctors. Feinsilver (2008) reports that medical services were about twenty-eight percent (28%) of total receipts and net capital payments in 2006. This was more than what was earned from the export of cobalt and nickel. The ability to purchase consumer goods such as domestic appliances and computers has improved the living standards of the households of the doctors.

This programme serves as a way of further empowering Cuban female doctors. This is line with the government's affirmative action agenda which seeks to empower women who have suffered discrimination in the face of economic difficulties in their country (Blue, 2010). In Kenya, it acts a way of promoting healthcare in remote parts of the country. In this way as a nation, we are able to get a glimpse of how Universal Health Coverage can play out all over the country. This model of low cost, contextualised healthcare ensures that people receive treatment as close as possible to where they live. It addresses the needs of localities in terms of the prevalent conditions in an area. This has been evident in areas of Northern Kenya where patients have suffered from eye problems and they have received specialists in those specialities.

Opportunities and Challenges

As Kenya grapples with developmental challenges in various sectors, this arrangement could serve to allay some of the concerns in the health sector. Although Kenya spend hefty sums of money on the health sector, there seems to be poor prioritisation and the scourge of corruption affecting service delivery. Our own local physicians are either unwilling or unable to serve in many areas of the country. The reasons given for this include poor working conditions, insecurity and poor remuneration. The problem arises when foreign doctors receive greater support and facilitation than their local peers. The opportunity and challenge in this situation arises from the fact that it would be incumbent to train our own critical mass of doctors rather than relying on a foreign component who may be affected by barriers such as those of language, food and practice.

SSC serves as an opportunity for the global South to generate its own models of healthcare that are cost effective and take into account the local needs and nuances. An integrated healthcare system is important as it accounts for financial, staff and logistical constraints. Healthcare in rural areas will be improved and aid in reducing deficits in the availability and accessibility of care in those areas. It also feeds into national ideals to address marginalisation of certain communities such as the arid and semi-arid lands (ASALs). The challenge arises in providing adequate security for the physicians. The kidnapping of the Cuban doctors in Mandera highlights the need to secure borders and ensure that professionals providing humanitarian care must be protected. Improved access and availability of healthcare is key for realisation of the ideals that quality healthcare is a right and not a privilege.

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Developing human capital is an opportunity Kenya will gain from the training of Kenyan doctors in Cuba. Interactions between local doctors and Cuban doctors at their health facilities opens up the understanding for the challenge's Kenyan doctors face. They are able to learn from their colleagues who operate in situations where facilities are severely constrained due to long-running American embargoes. Kenyan doctors must be able to situate themselves in the entire project to ensure progress and continuity of healthcare. Quality of healthcare is important as has been raised in Pacific countries (Asante et al., 2012). This must be one of the challenges the government must address to ensure the highest quality of care.

It also opens spaces for a reduction on traditional donors whose assistance in tangled up in conditionalities that do more to take funds away from the needy rather than designing locally – informed health solutions. The political and social capital gained from these arrangements are important for diplomacy. It should be viewed as a win-win situation for both partners in international relations. As Cuba and Kenya build a partnership in healthcare, this is an opportunity to open up greater trade frontiers and improve trade in the global South. This could provide an opportunity for accessing medical equipment that meets the constraints in local areas.

There is also an opportunity for Kenya to learn from the affirmative action of the Cuban project. Their ethos opens access for individuals from marginalised groups such as women and Afro-Cubans to practice their craft. In line with the constitutional provisions promulgated in 2010, marginalisation of certain communities could be addressed by increased opportunities for such individuals to train in Cuba. This is important in fostering greater inclusion and ownership of the ideals of local healthcare developments. Cultural immersion provides an opportunity for Cuban doctors to gain local experiences and assist in improving existing paradigms.

In order to improve the quality of service provided, it would be challenging for the Kenyan government to invest in improving medical infrastructure. Quality service depends on the availability of required equipment, medication and facilities which these doctors can use. There is further need to improve transportation to make facilities accessible and improve the output of the doctors. Finally, in order to maintain Kenyan national values and goals, the government must ensure that over time, Cuban doctors must be replaced with local talent. This is important in building independence and local sufficiency in providing nuanced healthcare that meets local needs.

Conclusion and Lessons Learned

There is a lack of information on SSC in healthcare and this paper attempts to fill that gap. It is important that scholars begin to research and address the emergent issues in SSC and provide literature for study. The Cuban-Kenyan bilateral agreement offers several lessons that can be learned. First, as has been mentioned by other scholars (WHO, 2014), it is important to document SSC in manner that is accessible and utilisable. Proper documentation enables accountability of the programmes. It is also an opportunity for other pending arrangements to learn and avoid existing pitfalls. These formal documentation and negotiation must move from the personalities of the leaders to deeply addressing any issues that would adversely affect the host countries more. Pragmatic thinking is key for is essential to ensure that these arrangements become a win-win situation for both countries.

Learning from the Cuban experience is an opportunity for Kenya to inculcate the public service ethos in all its training programmes. This is important in ensuring that young graduates are ready to return to underserved communities and serve. It would break warped thinking amongst Kenyans and other individuals who think less about service and more about

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their own comfort. Large scale training programmes are important for building capacity in various sectors in various countries of the global South. Prioritisation of capacity building is key in the development agenda of developing countries. It will also reduce any dependence on highly paid consultants who are a burden to the tax payer. It is also imperative for countries of the global South to understand that healthcare does not have to be profit-driven and privatised. Instead, governmental investment in healthcare is key in improving the living standards. Finally, SSC is more than financial support and countries in the global South can offer anything else they excel at in their collaboration just as Cuba has done.

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