



Cuba Africa - Promoting integrated health services

Organization(s):

Cuba's Ministry of Health Cuba's Ministry of Foreign Affairs

Country (ies):

Cuba (provider) African countries (recipients) Angola, Botswana, Burkina Faso, Burundi, Cape Verde, Chad, Congo, Djibouti, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Equatorial Guinea, Guinea-Bissau, Guinea (Conakry), Lesotho, Mali, Mozambique, Namibia, Niger, Rwanda, SADR (Western Sahara), São Tome and Príncipe, Seychelles, Sierra Leone, South Africa, Swaziland, Uganda and Zimbabwe

Overview:

Cuba's assistance in international health care is evidenced in its Health Programmes in Africa as South-South Development Cooperation. The objective of enhancing the capacities of medical personnel in Africa is pursued through the Integral Health Programme (PIS) initiated by Cuba in 1998. This Programme, which is primarily earmarked for rural areas, involves the sending of medical personnel to African countries. More importantly, Cuba is greatly involved in the international campaign against HIV/AIDS in Africa.

Background:

Cuba's medical assistance to other countries in general dates back almost to beginning of military intervention in the 1960s by achieving equal priority to military assistance in the 1970s. There was some expansion of the programme after end of Cold War 1995 Cooperation Agreement with post-apartheid South Africa.

The Integrated Health Program (PIS)

Since 1998, Cuba's structural collaboration in the field of health has been reorganized in the "Integrated Health Program (Programa Integral de Salud, PIS) for Latin America, the Caribbean and for Africa." This cooperation program is free for the receiving country. The PIS is focused on first line health services. Depending on local needs, the development of integrated health care at the primary level can be complemented with technical assistance to improve the performance of local hospital services, with training programs for local human resources, or with essential drugs programs. Most of the doctors working in this program are family doctors from all areas of Cuba. Their work is reinforced with that of specialists and academicians, according to local needs.

Implementation:

Cuba's international assistance is carried out through the department of cooperation of the Cuban

Ministry of International Affairs. In this case, the main objective is to ensure the basic right to health care on a structural and durable basis to populations that have been excluded from free access to basic health care. Programs are long running, and Cuban family doctors—each for at least two years—go to rural or peripheral urban areas where no or very few local doctors are working. The PIS was first implemented in Central America, which was still in the aftermath of Hurricane Mitch at that time, but was soon extended to other continents. In 2004 the PIS covered 24 countries: 1,560 Cuban health workers worked in 6 Latin American countries, 1,290 in 15 African countries, and 28 in 3 Asian countries.

Triangular Cooperation in the PIS.

In most cases, the financial burden of salaries and equipment of the PIS has been assumed by Cuba. The exceptions are so-called tripartite initiatives. In this triangular cooperation, the Cuban government provides the human resources for a partner country, while a third party ensures the necessary material and financial support. Cuba has been promoting this approach actively. For example, within the framework of activities of the World Health Assembly in Geneva in 2005, the Cuban delegation presented its PIS program and invited other governments to cooperate. The director of cooperation of the Cuban Ministry of International Affairs, Yiliam Jiménez, emphasized that Cuba was not looking for financial support, but rather for an integrated effort of solidarity and to improve the well-being of the populations of the receiving countries.

One of the places where this tripartite cooperation with international organizations, governments, and international nongovernmental organizations (NGOs) has been extensively developed is Haiti. The Pan-American and World Health Organizations (PAHO/WHO) support the epidemiological surveillance and immunization programs, while the Official Development Assistance (ODA) of France and Japan ensures material backing of different initiatives of the Cuban collaboration program.

Also in Haiti, Cuba has been developing joint initiatives with a dozen NGOs from Canada, the United States, Spain, France, and Belgium. Throughout Latin America, and in Africa, this tripartite collaboration is booming. The German ODA supports Cuban health initiatives in Honduras, while Japan does the same in Honduras and Guatemala. Germany is also supporting activities in Niger, while Switzerland collaborates in Mali. The WHO is financing the development of a medical faculty in Gambia, and the PAHO is supporting medical training of foreign students in Cuba itself. A new and equally significant evolution is South-South cooperation: South Africa supports the Cuban health cooperation in Mali, while Libya and Nigeria finance Cuban health activities in Burkina Faso, Niger, Mali, Chad, and Sierra Leone.

Outcomes:

The main objective is to ensure the basic right to health care on a structural and durable basis to populations that have been excluded from free access to basic health care. PIS responds to needs articulated on the basis of special national and local analysis on one hand as well as have contexts or relate to issues that have some commonality or complementarity. It involves exchange of knowledge and expertise in both directions between the donor and recipient countries. It also brings mutual benefits on a reasonably equitable basis. It provides good value

for money compared with alternative modes of operation and creates room for prevention as part of the policy mind-set. More importantly, it encompasses the involvement and consent of an empowered civil society.

PIS have facilitated international experience intended to reinforce the revolutionary ethos and help politicize Cuban youth. It is valuable professional development for Cuban health workers. They are faced with a different reality; they learn many things, in particular about interpersonal relationships; and they return home with a more comprehensive and solid formation. And this benefits us all. These people work in other countries for two or three years, but then they return home and work here for 20, 30 or 50 years. So, we're not only giving, we are receiving benefits as well.

In 2000 Group of 77 meeting, richer African states agreed to provide finances for an extra 3000 doctors on the African continent. In 2000, Gambia Medical School in Banjul and Bata School of Medicine in Equatorial Guinea set up on Cuban model; medical academics already teaching elsewhere. By 2000 there was said to be 40,000 African graduates of Cuban universities, many of them doctors, working in Africa. In 2005 there were 777 students from sub-Saharan Africa studying in medical schools in Cuba.

Cuba's collaboration intended to meet specific needs and shortages in the transition process in case of South Africa by targeting of specific problem areas, eg Walter Sisulu University medical school in the Transkei. Apparent consistency of philosophy, as Government of National Unity opted for a new focus on primary care, and the incorporation of traditional African medicine.

Aid Effectiveness:

Heavy Cuban emphasis on non-interference in domestic policies does not in any way limit its potential for effective south-south development collaboration.

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Capacity Development:

PIS responds to needs articulated on the basis of special national and local analysis on one hand as well as having contexts or relate to issues that have some commonality or complementarity. It involves exchange of knowledge and expertise in both directions between the donor and recipient countries. It also brings mutual benefits on a reasonably equitable basis. It provides good value for money compared with alternative modes of operation and creates room for prevention as part of the policy mind-set.

PIS Focuses heavily on capacity building within the health sector, rather than infrastructural projects. It is located within a distinctive discourse of South-South solidarity officially repudiating the self-interest and power imbalances usually implicit in donor-recipient relations. Explicitly it is free from political conditionality.

Further more, emphasizing prevention and health living conditions, rather than curative medicine, as in the colonial legacy. It is early contribution to the concept of South-South development cooperation.

Duration: Two years per batch, but still on-going

Budget (Optional): Year Budget

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