

**The Cuban Health Programme in Gauteng province:
an analysis and assessment of the programme**

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A mini-thesis submitted in partial fulfilment of the requirements for
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Keywords

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Abstract

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Many parts of South Africa face a shortage of doctors within the public health system. While the PHC system is driven primarily by nursing staff, there is a need for doctors to provide certain services at primary and secondary levels. In 1996, as part of its efforts to address the shortage of doctors, the DoH began recruiting Cuban doctors to work in South Africa. This programme, now underway in eight of the nine provinces, falls under a government-to-government agreement aimed at strengthening the provision of health care in the areas of greatest need: townships and rural areas.

The programme has demonstrated tangible success. However, it has also been criticised in some sections of the medical community and the media, where it has been portrayed in a controversial light. All this underlines the importance of an analysis of the programme, but to date, no such evaluation has been carried out.

This research assesses the Cuban Health Programme in Gauteng province. On the basis of this thorough assessment, the government can take steps to improve the national programme, using Gauteng as a case study.

This study was conducted in July 2004, employing qualitative methods to develop an in-depth understanding of recruitment and induction processes in Cuba and South Africa, the scope of practice of Cuban doctors, professional relationships, adaptation to the health system and broader society, and other factors. The researcher also conducted a review of official documents.

Gauteng began with two Cuban doctors at the outset of the programme in 1996. The number peaked at 32, and has since dropped to 15. All of these doctors were interviewed in the course of the research, along with five managers and five peers. The study revealed that all the interviewees, except one manager, firmly believe that the programme has achieved its objectives, and should continue. Peers and managers commended the high quality, comprehensive and caring approach of the Cuban doctors, and say they are satisfying a real need. The Cuban doctors, however, believe that because they are providing mostly curative services, they are under-utilised.

Flowing from the research are a series of recommendations. These include a proposal that the government recommit to the programme and ensure its continuity, and review the current role of the Cuban doctors, taking into consideration their willingness to provide training and expertise in preventive interventions.

The research also identifies a number of areas that warrant further research, including an assessment of the Cuban Health Programme in other provinces, and exploration of the continuous caring and patient-centred approach implemented by the Cuban doctors despite the curative orientation of the South African health system.



Declaration

I declare that *The Cuban Health Programme in Gauteng Province: an analysis and assessment of the programme* is my own work, that it has not been submitted for any degree or examination by any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete reference.

Carmen Mercedes Báez

November 2004

Signature



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List of Abbreviations

CMO	-	Chief Medical Officer
DoH	-	Department of Health
HPCSA	-	Health Professions Council of South Africa
PHC	-	Primary Health Care
WHO	-	World Health Organisation
US	-	United States
GP	-	General Practitioner
FOCUS	-	Friends of Cuba Society



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CHAPTER ONE: INTRODUCTION

Problem statement

In South Africa a great many rural areas, urban townships and informal settlements have limited access to doctors within the public health system. While the PHC system is based primarily on the services offered by trained nurses, there is a need for medical doctors to provide certain services at primary and secondary levels, and to provide necessary back-up to the nursing staff. The national DoH is committed to ensuring that the quality of service in the overwhelmingly black rural and under-served urban areas is brought to a level as good as that in the mostly white and historically better-served parts of the country (DoH: Achievements and Highlights Report of 1997, 1998).

As an interim strategy to redress the imbalances in access to quality health care, the DoH had recruited 300 Cuban doctors by 1999. They were all selected by the former Interim National Medical Council, which assessed and approved their clinical and language skills. Generally the doctors have met with a very positive reception. They fill a much-needed gap in many rural areas – regions that otherwise would have no doctor (Van Niekerk & Sanders, 1999).

When the programme began in 1996, the Gauteng Health Department started with two Cuban doctors; today it has 15, working mainly at primary level. The role of the Cuban doctors in Gauteng has evolved beyond their clinical duties, and they have been involved from the beginning in research conferences organised by the Gauteng Health Department. Some have been promoted and are now occupying managerial and advisory positions. Furthermore, a national project of community outreach has been started, based on a pilot project with Cuban doctors in Meadowlands, Soweto, with proven results and lessons learnt.

The Cuban doctors programme in South Africa is well established, diverse and generally accepted. Reports concerning its impact on health services have generally been positive, but there has also been an identifiable strain of negative, one-sided reporting. The presence of Cuban doctors was, from the beginning, portrayed in the media as controversial, the main issues raised being the appropriateness of the kind of training received by the Cubans in relation to the conditions in South Africa, and the possible constraints imposed by their limited fluency in English. Cuban doctors in South Africa successfully treat thousands of patients a year. However, media coverage has however tended to focus on matters such as the death of four patients who were being treated by Dr De la Parte in 1997 (Arenstein, 1997).

Beyond the limited analysis offered in media reports, no comprehensive and in-depth study of the efficacy of this programme has been undertaken. Yet it is important for both the government and the public to have a well-informed understanding of what

has worked and what has not, and to be able to take steps to improve the programme for the benefit of all.

In November 1999 the national DoH compiled a report on the Cuban doctors programme at national level (Department of Health, 1999). It is composed of provincial reports and fortunately, for the purposes of this research, and in comparison with all other provinces, the report from Gauteng was comprehensive and explicit. It was also backed up by information gathered by quick appraisals that, although not being sufficiently representative, can be used as a baseline for this research.

To date, no in-depth evaluation has been conducted in South Africa outlining the impact of this programme and taking into consideration the views of the Cuban doctors themselves. Furthermore, no comprehensive evaluations appear to have been carried out in any other countries (mostly in Latin America and Africa) to which Cuba has sent health workers, although limited assessments have been made of particular aspects of this support, and additional information has been provided by reports from the doctors themselves (Davis, 2003).

Since this is the first research study undertaken on this topic in South Africa, it will serve as a basis for future broader research of the same programme nationally. Its potential impact can be summarised as follows:

The research can inform government decisions – specifically those taken by the Gauteng Health Department – on the allocation, placement, induction and conditions of service of doctors. It can also be used to improve service provision as a result of improved understanding of shortcomings in the system (communication between peers and managers, referral systems, transport, etc.). It can be used as a platform for a broader national evaluation of the programme. Such a national evaluation would contribute to a better understanding in the academic and medical communities of the presence of Cuban doctors in South Africa, and to the knowledge base of the international health community about Cuba's internationalist projects in developing countries.

Research question

This research explores the development, quality and functioning of the Cuban health programme in South Africa, taking Gauteng as a case study, in order to provide an empirical basis upon which to both assess the programme and make recommendations to optimise its implementation.

It aims to identify the limitations and constraints, as well as examples of good practice, of the Cuban doctors programme in Gauteng; to give feedback and recommendations for action to the national and Gauteng health departments, as well as other relevant parties; and to inform the development of collaborative strategies to optimise the management and impact of the programme.

Research design

The mini-thesis will describe the recruitment process and criteria for selection of Cuban doctors by the Cuban health authorities and the HPCSA; describe and evaluate the induction and conditions of work of Cuban doctors; document the experiences of Cuban doctors working in the peri-urban and urban areas of Gauteng, at different levels of care, with a specific focus on both constraints to as well as good practice in health care; assess the views of peers and health managers who have worked with the Cuban doctors; and generate recommendations for actions to improve and optimise the programme in South Africa.

The research commences with an analysis of the rationale for the Cuban doctors programme and the environment created since its implementation. The subsequent chapters will explore the perceptions of the Cuban doctors and a number of people who are working directly or indirectly with them. This will illustrate and provide information to reflect on the impact of the eight-year-old programme. The final chapter will sum up the conclusions and provide recommendations to the relevant health authorities.



CHAPTER 2: LITERATURE REVIEW

1. Sources of information

To obtain information about Cuban health programmes worldwide the author searched databases, both locally and internationally, using mainly Internet facilities. Institutions that have produced relevant information in the field and other sources were contacted. The author also read the official agreements and contracts between Cuba and South Africa.

Two websites in particular -- those of the national health departments of South Africa and Cuba -- were consulted extensively. Through an Internet search engine, Google, the websites of various programmes in other countries were found and reviewed. A CD-Rom produced by the Cuban DoH was acquired and provided valuable information.

A number of official documents were reviewed to provide useful background information about the programme. These included the official agreement between the two parties; the contracts issued to Cuban doctors, local unpublished evaluations, as well as relevant speeches, statements and news articles.

The website of the National News Agency (AIN) in Cuba (www.ain.cubaweb.cu) has web pages for the Cuban Health Collaborations in the following countries: Ghana, Gambia, Niger, Venezuela, Paraguay, Honduras, Guatemala, Belize, Haiti and Guinea Bissau.

It so happened that separate but related research carried out towards the end of 2003 became available after this review was conducted. However, due to the importance of the other findings, they have been included in the present work. The study in question (Hammett, 2003) considers the impact of the inter-governmental agreement between Cuba and South Africa in the health sector. Although it focuses primarily on South-South economic co-operation, it also presents an evaluation of the programme in rural areas, and many of its results run parallel to those of the present research.

Finally, it is important to mention that the great majority of available information on Cuba's international medical programmes exists in Spanish. The fact that the researcher is fluent in Spanish has obviously been an advantage.

2. Findings of literature review

Substantial evidence-based research on the results achieved by Cuban doctors in different countries is scarce. One possible explanation for this is that the countries concerned, many of them in Africa, had scarce resources or research capacity to commit to such efforts – particularly when the public health benefits appeared to be so obvious.

However, while the multitudes of poor people who have been treated by Cuban doctors in dozens of countries can attest to the value of such programmes, in other quarters things are not so simple. As one scholar has noted: "If you write attacking Cuba, no evidence is necessary, but if you write the truth, in favour of Cuba, then there has to be documentation" (Gleijeses, 2002).

The results of the literature review can be summarised as follows:

2.1. The historical links between Cuba and South Africa

On May 11 1994 Cuba and South Africa established full diplomatic relations. That same year, then President Nelson Mandela stated that, in accordance with South Africa's policy towards countries with which it has normal diplomatic relations, it would endeavour to foster trade and economic, cultural and sporting links with Cuba that would be mutually beneficial (Umsebenzi, 2002).

It is important to note that the Cuban presence in South Africa, whether in terms of doctors or teachers, is justified on the basis of real need, but it is also based on a long historical and political relationship between the South African liberation movement and the Cuban revolutionary government. As Mandela stated in his address at the opening of the Southern Africa-Cuba Solidarity Conference in Johannesburg on October 23, 1995:

“Southern Africans are deeply indebted to the Cuban people for the selfless contribution that they made to the anti-apartheid struggle in our region. Cubans came to our region as doctors, teachers, soldiers, agricultural experts, but never as colonisers. They have shared the same trenches with us in the struggle against colonialism, underdevelopment, and apartheid. Hundreds of Cubans have given their lives, literally, in a struggle that was, first and foremost, not theirs but ours. As Southern Africans we salute them. We vow never to forget this unparalleled example of selfless internationalism. As government, we are firm in our view that it is in the interest of South Africa to have diplomatic relations and multilateral ties of co-operation with Cuba” (Mandela, 1995).

2.2. Why Cuban doctors in South Africa?

Beyond this historical political relationship, the rationale for bringing Cuban doctors to South Africa is based on a real need. This has been identified in the process of national health care planning.

The National Audit of Health Human Resources, conducted in 1997, found that there were 17,728 practising doctors in South Africa, of whom 10,067 were in the private sector and 7,665 in the public sector. It noted that "it would appear that there are an adequate number of doctors and nurses in South Africa but that the major problem is maldistribution", and that "unless drastic measures are introduced to correct the maldistribution with its urban bias, educating and training more health personnel from these categories will not necessarily solve but may even further exacerbate the problem" (Van Niekerk & Sanders, 1999).

2.3. The Cuban health system

Pre-revolutionary medical care in Cuba was almost exclusively private. Doctors did not practise in rural areas because it was not profitable. Doctors routinely accepted bribes for hospital beds. In 1959 there were only 6,000 doctors in the whole of Cuba, half of whom fled to the United States within weeks of the revolution – transferring, in the process, some \$1-2m from the Cuban hospital fund to personal bank accounts in Miami (Stephen, 2000).

The revolutionary government invested heavily in health care, establishing the family doctor programme and declaring PHC and community health promotion priority areas. Today, there is a family doctor and nurse for every 120 families on the island. Despite the hardship imposed by the 40-year US blockade, Cuba, whose economic parameters rank among the poorest nations, has the same life expectancy and infant mortality as Britain and the United States (Davids, 2001). In 1998, the WHO presented Cuban President Fidel Castro with its Health for All award in recognition of Cuba reaching all the health goals set for developing countries to achieve by 2000 (WHO, 1999).

Cuba's commitment to a comprehensive social medical programme is part of a framework of social and political policies that see health as a social problem requiring a social solution (Nikelly 1988).

After the revolution, the training of Cuban medical students and residents proceeded initially along traditional lines, with physicians entering specialities of their choice after a one-year period of obligatory service. During the mid-1970s, the Ministry of Public Health developed a programme of "Medicine in the Community." For this programme, professors and residents in the primary care specialities maintained a regular base in local polyclinics (Perez et al, 1991).

Despite these changes, dissatisfaction persisted at community level. As a result, in 1984 the government initiated the programme of *Medicina General Integral*, or Integral General Medicine (Figueroa, 1998) In this programme, before they choose generalist or specialist careers, all residents receive three years of training in family medicine. This includes rotations in each primary care speciality (internal medicine, paediatrics, and obstetrics and gynaecology), as well as a longitudinal continuity experience based in a local neighbourhood and supervised by family physicians. During their residencies, and afterward if they choose to remain family practitioners, physicians live in the communities that they serve, usually in an apartment within the same building that contains their consultation rooms. In general, a family practitioner provides primary care and preventive services for 700 to 800 patients who live in the immediate vicinity of the practice (Waitzkin, 1999).

Each family practitioner is required to see every patient in his or her catchment area at least twice a year. The physician maintains a record of preventive services and conditions for all patients in the catchment area; this record is updated and reviewed at least monthly with a clinical supervisor, who is an academically based family physician. The monitored services and conditions include prenatal care, immunisations, cancer screening by Papanicolaou smears and mammography, risk

factors such as smoking and hypertension, and follow-up for chronic conditions, as well as psychosocial problems and sources of stress in the family or at work. Under this surveillance system, it is expected that all patients in the catchment area receive preventive services appropriate for their age, gender, and risk factors(Waitzkin, 1999).

Family physicians are supported by a system of laboratories, referral centres, and consultation resources, based in local polyclinics and municipal hospitals. When patients require admission, they enter a municipal, provincial, or national hospital as their conditions warrant. Unless a patient is transported to a provincial or national hospital outside the local area, the family physician travels personally to the referral hospital. There, he or she meets with specialists who assume responsibility for the patient's inpatient management, coordinates inpatient services to assure continuity after discharge, and maintains frequent contacts with the patient to enhance the long-term patient-doctor relationship. For emergencies, especially in urban areas, patients can decide to bypass the local family physician and can receive services directly at the emergency rooms of referral hospitals. In this situation the emergency room staff attempt to contact the patient's family physician for subsequent follow-up.

Through this organisational structure, Cuban health policy favours local primary care services, within an organised system of consultation and referral for more specialised care (ISCO/Pastors for peace, 1998).

The focus on community-based family practice facilitates public health activities and epidemiological surveillance. Data concerning acute and chronic illnesses pass sequentially from family practitioners to the municipal, provincial, and national levels of the Ministry of Public Health. This surveillance system is computerized and linked throughout the country by modem and electronic mail. Computerized surveillance has been implemented at all provincial levels and is being extended to municipalities and rural health centres (Feinsilver, 1999).

In Britain there has been growing interest in the Cuban health system, with its huge advances in health care since 1959. A new Anglo-Cuban PHC initiative was launched this year with a study tour to Cuba for English PHC workers, including GPs, in March, followed by a visit to Britain in October by leading Cuban public health officials (Boseley, 2000). For Britain's National Health Service, this is an opportunity to examine a health service which has provided Cuba with health statistics to compare with the best in the industrialised nations at, as sees it, only a fraction of the cost incurred elsewhere (Pietroni, 2000).

However, while Cuba spends less per capita on health than the UK (Pietroni, 2000) it in fact spends more as a percentage of its gross national product. Cuba has also invested heavily in research. For example, the Cuban meningitis B vaccine, which now forms part of its universal childhood vaccination programme, has been exported free to Latin American countries (Levins, 2003).

2.4. The “export” of Cuban doctors

Cuba has a strong tradition of its citizens serving abroad (Beberley, 2000). Reasons for this range from internationalist sentiment to an attempt to find an economic solution to the crisis produced by the decades-long US blockade.

It is important to understand why Cuba has been sending doctors all around the world since 1963, just a few years after half of the doctors on the island deserted to the United States. The most important motivation is based on the socialist principle of “helping those in need” (Riera, 2002). In addition, Cuba has been able to export PHC practitioners and specialists for periods of service in other developing countries because the production of physicians came to exceed the country's internal requirements (Cuba's physician-per-population ratio is 1 per 255, as compared to 1 to 430 in the United States). Decisions to send doctors abroad have been taken in response to official requests from the respective governments. By 1996, more than 10,000 Cuban physicians had served abroad, with as many as 1,500 working overseas at a single time (Waitzkin, 1997).

Given that Cuban doctors have been working abroad for more than four decades, it is probable that there are a range of motivations for such programmes. Cuban President Fidel Castro suggests as much. In 1999 he said:

To date, without counting the cost, 26,000 doctors have carried out their humanitarian labours under highly difficult conditions, in virtually inaccessible locations, receiving the immense gratitude of many poor people who were treated by a doctor for the first time. One example of the Cuban health brigades' dedication is that the first heart operation performed in Tanzania was by a Cuban medical team in 1978 (*Cuban Health News*, 1999).

(The large gap between Waitzkin's 1996 estimate and Castro's 1999 statement suggests either a glaring contradiction or a sharp spike in the number of doctors serving abroad in the intervening period. One explanation for this might be a rapid increase in the number of doctors doing short-term service in response to earthquakes and other natural disasters in several Latin American countries. However, the research has not interrogated this.)

Castro would later say:

Thanks to the intensive educational programmes that have been developed over many years, Cuba now has significant human capital, and human capital is decisive; I would say that it is even more important than financial capital. And our country has sufficient medical personnel to cooperate. Africa needs thousands of doctors in order to provide one doctor per 5,000 inhabitants; our country has one doctor per 168 inhabitants (*The Brunswickan*, 2003).

2.5. The Cuban health collaboration in South Africa

In November 1995 representatives of the Republic of South Africa and the Republic of Cuba signed an agreement in Havana regarding the recruitment of medical doctors. Article I of the document states: “As a request of South Africa, through its national DoH, Cuba shall assist in the identification, recruitment and allocation of medical doctors in accordance with the provision of the agreement.” The purposes of the

agreement are outlined in Article II as follows: a) to provide health services to rural and other disadvantaged communities within areas where such services are inadequate b) to develop adequate services in hospitals and other institutions throughout the said provinces and c) to train and encourage local medical doctors to work in such areas and institutions (Agreement between the Government of the Republic of Cuba and the Government of the Republic of South Africa regarding the recruitment of medical doctors, 1995).

Between February and July 1996, 96 Cuban doctors arrived from Cuba. Gauteng received fewer doctors than other provinces - only two - because it was felt South Africa's most urbanised province did not need such support (1996, author's personal communication with a top health department manager). The Western Cape, then run by the National Party, declined the offer of Cuban doctors, mainly for political reasons. Gauteng has since increased the number considerably, employing 32 Cuban doctors as at December 2003 (currently there are 15 but another 10 have already been recruited and are expected to arrive soon). Most are family doctors or PHC specialists.

The Cuban doctors went through different processes of adaptation – encountering everything from hostility to hospitality from different sectors of society. Today, a massive national programme that started from scratch and without precedent has accumulated an enormous amount of experience, both good and bad (Cornish, 1999).

2.6. Controversies around the programme

There have been both positive and negative assessments of the performance of the Cuban doctors in South Africa. One journalist, for example, quoted a nurse who was working with one of the doctors as saying: "The Cuban doctors' attitude towards health as a service is also starkly different from the attitude of South Africa's mostly white and privileged doctors, who serve a compulsory year as interns and then in their vast majority go into private practice or go overseas. The Cubans will fill the gap while South Africa trains new doctors and puts in place a system that gives greater emphasis to preventive health care and clinics close to the communities they serve" (Dixon, 1998).

Health Ministry spokesman Vincent Hlongwane said in 1997 that Cuban doctors have had a profound impact on the nation's care.

We believe without their contribution, a lot of lives would have been lost. South Africa is a place where two nations live side by side. There are those who are privileged, and they are whites, mostly. Then there are the people the Cubans are helping. Many of them would not be able to even see a doctor if the Cubans weren't here to help" (Campbell, 1997).

But in spite of the satisfaction expressed by government and patients, many local doctors, various associations and the media have vehemently criticised the Cuban presence.

For example, the Afrikaner Forum discussion magazine states: "To add insult to injury, the ANC has decided to import Cuban teachers, engineers and doctors, while white South Africans in these professions struggle to find work due to Affirmative

Action” (van Rensburg, 1999). This statement comes from an ultraright organisation and targets the broad intent of government policy. However, it ignores the fact that most Cuban professionals are deployed in the public sector, where many South African professionals are reluctant to work.

The “independent” media has also analysed the Cuban collaboration. Joel Kovel writes for *Z Magazine*:

Seven thousand miles away, another kind of struggle unfolds, in a society much wealthier than Cuba, and one no longer a pariah. Here, however, South Africa’s quest for integration looks very much like a curse. Why should this richly-endowed and advanced country, with world-class universities, great urban centers, and immense mineral resources, need to import Cuban doctors? Cape Town, after all, was the site of the first heart transplant. Isn’t that ‘developed’ enough? Why can’t they supply their own physicians for their rural poor?

The reasons, according to Kovel, are that the gap between rich and poor in South Africa is perhaps the worst such chasm in the world, and that South Africa is being subjected to a structural adjustment programme, so health-care is being ravaged, driving doctors out of public service, indeed out of the country, and creating the need for the generosity of Cuba (Kovel, 2004).

Local newspapers have also been vocally hostile, often publishing misleading information about the programme. For example, one article claimed that Cuban doctors were unable to communicate and lacked proper training (Business Day, 1996). Yet all Cuban doctors working in South Africa have passed an English and medical examination set by the HPCSA.

2.7. Protectionism by South African doctors

The presence of Cuban doctors has caused some anxiety in the South African medical fraternity (Cherian, 1997).

The Rural Doctors Association of Southern Africa (RUDASA), although recognising that the presence of Cuban doctors has alleviated crises in a number of provinces, cites two shortcomings that they say “have become increasingly obvious”. A position paper prepared by RUDASA in 2001 states:

Since Cuban doctors are trained as specialists, their lack of generalist skills makes it difficult for most Cubans to handle the wide scope of rural practice in South Africa, unless they are family physicians who are prepared to learn anaesthetics and procedural skills. Secondly, the cultural and language differences make communication difficult.

A throwaway comment in the Stellenbosch University magazine reflects a common prejudice, fed by comment from the medical fraternity in the media: “Despite the little Cuban doctor disaster, South Africans have some of the best medical treatment available in the world” (Hatton, 2000).

Several incidents that unfortunately remain undocumented, but which have been communicated personally to the researcher, appear to show clear signs of the defensive attitude on the part of many South African doctors towards their Cuban counterparts. At the Bothaville Hospital in the Free State, local doctors refused to talk or write notes of referrals to Cuban doctors in English, insisting that they should learn Afrikaans. In another hospital in the same province, the local doctors questioned the skills of the Cuban doctors, even calling them “killers” (Anonymous 2002, personal communication with author).

2.8. Recruitment of Cuban doctors

The Registrar of the HPCSA, Boyce Mkhize, has emphasised that the recruitment of Cuban doctors followed proper procedures and responded to South African standards: “Our involvement with the evaluation of Cuban doctors is but one example of our resolve to maintain high professional standards” (Dispatch Online, 2001).

In 2003, Professor Ian Couper of Wits University’s Department of Rural Health travelled to Cuba to examine a new group of doctors on behalf of the NPCSA. On returning to South Africa, he wrote, in an unpublished letter, about the recruitment process:

The process starts in Cuba. The Cuban Ministry of Public Health was involved in pre-selecting candidates from all around the country. I am not sure how they conducted that process but I do believe there were many, many more applicants than were presented to us for consideration. The biggest group were specialists in General Comprehensive Medicine as it is called in Cuba, which is the equivalent of Family Medicine in SA, with about 130 applicants from that discipline. There were also substantial numbers of surgeons, general physicians and paediatricians.

According to one analyst:

The use of Cuban doctors in rural settings is one important example. This experience also provides a useful learning experience. Imported personnel need to be carefully recruited and publicly certified to ensure that their skills meet local standards and induce local confidence in their abilities. (I am informed that the medical profession *has* exercised its certifying powers responsibly and that the level of malpractice complaints against Cuban doctors is not abnormally high) (Cohen, 1997).

2.9. Induction of foreign doctors

Dr RW Richards from the Institute of Medicine in Nepal adds another factor when he analyses what it means to be a “good doctor”. He argues paradoxically: “A good doctor in Cuba is a good doctor for the Cuban people. There is a unifying base of knowledge and an underlying set of skills, competencies and proclivities, but the context of practice is an overwhelming factor” (Richard, 2000).

Proper induction of foreign doctors into any country’s public health system is essential. In Mozambique, where the disease profile during the 1980s was of a

developing country at war, and where human and material resources were scarce, the implementation of policies depended on the quality of the introduction of those policies to professionals coming from different schools and systems (Báez, 1989).

Báez, et al (1993) emphasise that for foreign doctors, the induction period is a fundamental step to ensure adaptation and adjustment in any system. As the clinical manager of a provincial hospital, Baez had to incorporate into the hospital and into the district system doctors from six countries (Vietnam, England, Peru, Cuba, Nigeria and China). Three elements were essential for incoming doctors to succeed:

- The existence of a culture of using and respecting national guidelines by all health workers;
- Leadership: health managers have to be able to show that the procedures, management and treatments indicated are scientifically sound, appropriate and suitable for the conditions of the country; and
- The example given by the national cadres in working in collaborative fashion with the foreign doctors, including learning from each other's experiences.

2.10. How recipient countries see Cuba's doctors

Despite all the criticism aired by the South African media and a medical community that may have felt itself "invaded", most of the countries that have benefited from Cuban medical help are deeply grateful. There is sufficient documentation of such recognition. However, it is also important to note that the media and medical associations of countries where there is a sharp political polarisation have adopted a tone and attitude similar to their South African counterparts when Cubans have volunteered to assist. This has been the case in the wake of recent earthquakes and flooding in El Salvador, Venezuela and other Latin American nations. In such politically polarised societies, the attitudes towards Cuba's impressive achievements in public health are inevitably coloured by the attitudes towards the Cuban revolution (Gleijeses, 2002).

In Latin America there are numerous examples of gratitude towards the Cuban medical programmes (Borrego, 2003). In Venezuela, the municipalities of Caracas have expressed their thanks for the work of the brigade of Cuban doctors in the area, according to the Venezuelan media (Napoles, 2002). In Caazapa, Paraguay's most remote rural area, a community that had never before seen a doctor now enjoys the presence of a Cuban doctor (Borrego, 2003)

In Africa, the Cuban presence has generally been deeply appreciated. In the Keta District of Ghana, in spite of the supernatural powers that Torgbui Dzelu IV, a traditional leader, is believed to possess, he mentioned in one interview: "When I am sick, I look for the Cuban doctors at the district hospital and I also advise everybody to do so. The community feels them as part of our family." The presence of the Cubans is said to have decreased the infant mortality rate from 27,7 in 1000 live births to 9,8 (Santana, 1998).

Leaders of the West African nation of Gambia have said they are impressed with the medical services Cuban doctors provide to their people and would like Cuban medical

personnel to train Gambians. A visiting Gambian secretary of state for health said recently that there were 156 Cuban doctors working in his country. He asked Cuba to increase the number to 250 and extend the period of cooperation for another two years. The Gambian official said the Cuban doctors volunteered to work in remote areas where others did not want to go to. Their help has reduced infant mortality by 34% and resulted in improvements in other areas. Cuba has established Gambia's first medical school, which has 25 students (Velazquez, 1999).

In Namibia, Health and Social Services Deputy Minister Richard Kamwi said that the Cuban doctors employed in that country range from general practitioners and dentists to gynaecologists. He said the Ministry had delegated North-West Region Health Director Dr Naftali Hamata and Under Secretary Nestor Shivute to recruit and interview the doctors to ascertain their "professional competence" and language proficiency. He further said: "So far we are quite satisfied that these doctors meet those standards which we hope will remove those barriers which normally hamper them (Cuban doctors) in treating patients" (*The Namibian*, 2001).

Mozambique has only 500 medical doctors for its population of about 17 million -- an average of one doctor for 34,000 inhabitants. A health ministry officials says that of the 500 doctors, only 200 are Mozambicans and the rest are foreigners. There are 53 Cuban doctors working in the southern province of Maputo, the central provinces of Sofala, Manica and Zambezia, and Nampula and Cabo Delgado in the north. The Cuban doctors are contracted under an agreement signed in Havana in 1995. (Velazquez, 1996). Co-operation with Cuba also covers medical training, both at Maputo's Eduardo Mondlane University and in Cuba (1996, AIM).

Three young female doctors are the first Cuban doctors to work in the Agadez desert in Niger, where they attend to a population of 3000 people (Garcia, 1997).

In 1975, the acclaimed Cuban writer Alejo Carpentier said that journalists are those who "animate the great novel of the future with their eyewitness accounts and features" (De la Osa, 2001). Recently, the Pablo de la Torriente publishing house has taken on the editing of eight books by an equal number of Cuban journalists, containing features and eyewitness accounts written on the spot, tracking the day-to-day content of Cuban medical cooperation in El Salvador and other countries. This project arose from a need to fill the gap in terms of qualitative documentation on the Cuban presence in the world (Pablo de la Torriente Brau publishing house, 2001).

2.11. Cuban doctors in Gauteng

Gauteng has benefited substantially from the Cuban doctors' presence. In 1989 there were 0,9 doctors in Gauteng per 1,000 population, compared to about 6 per 1,000 in Cuba. There was clearly a need that Cuba could satisfy. But what made the Cuban doctors' deployment even more justified was the key role they could play in transforming the province's health system.

Before 1994 most medical services in Gauteng were hospital based. Free PHC for mothers and children under six years of age was introduced in 1995 and free PHC for all in 1996. The first Cuban doctors arrived in 1996 and have been rendering PHC

services in townships and rural areas since then, not only in clinics but also through community outreach work (Gauteng DoH, 1996, 1997, 1998).

In 1996 PHC services were provided to 2.7 million patients and, in 1997, to 3,6 million. In 1998, the attendance at clinics was approximately 400,000 per month and about 4,1 million patients received free health care in Gauteng. In 1998, 190,751 of these patients were examined by Cuban doctors or referred to them by nurses, and 25,916 of these patients were seen during extended hours at PHC facilities at old-age homes (Cuban doctors programme - Evaluation of impact. Gauteng DoH, 1999). In Gauteng, the Cuban doctors played a key role in the transformation of the system, orientating it more towards PHC (Bismilla, 1999).

The Gauteng health MEC outlined his department's view in a speech in 1999:

The department has avoided regarding Cuban doctors simply as people to fill posts and has attempted to utilise them strategically in the development of comprehensive PHC for this province in areas of great deprivation.... The doctors have made a significant contribution to delivery of PHC services in the transforming of our health services over the past three years. Your dedication and professionalism serves as a model in PHC in our efforts in restructuring the health services of our provinces (Gungubele, 1999).

2.12. Other studies

In 1997 and 1998 respectively, the Cuban Collaboration Office in South Africa produced two reports with statistics produced by the Cuban Embassy, based on information provided by Cuban doctors. The doctors' reports include details such as the number of patients observed in intensive care units. This forms part of the culture of the Cuban health system -- to be accountable, and to manage programmes based on statistical information. "We are doing this in Cuba and anywhere else where Cubans are working" (Davis, 2000).

In addition, the researcher had access to one national report measuring the impact of the programme. This report was produced by the provinces in 1999 at the request of the national DoH, and is a compilation of responses to questionnaires by the provincial authorities. Some provinces sent the questionnaire to the regions or districts, others seem to have been answered by one person involved or in charge of the programme (e.g., North West).

In general, the opinions regarding the Cuban doctors were positive in all the provinces. Several hospitals mentioned the problem highlighted by the medical community that some Cubans are too specialised for the scope of work in the rural South African hospitals, however they were prepared to broaden their scope for the needs. Some provinces had supported the Cubans to develop skills they lacked (e.g. in anaesthetics). Problematically, the survey was in the form of a questionnaire that seems to have been filled in by whoever was available and with little district-wide consultation. It also asked for a considerable amount of quantitative information that most districts did not have.

Interestingly, the most comprehensive report came from Gauteng. Maybe the difference was partly attributable to the fact that the Gauteng report was backed up by statistics and by an assessment of community perceptions of the Cuban doctors working at Khutsong Health Centre in the Carltonville District region in 1998. The findings of the Khutsong survey showed that the community attending the facility appreciated having a doctor available, and 51% mentioned the capacity of the Cuban doctors to communicate in a local African language, mainly Tswana.

This type of rapid appraisal can only provide an indication of what was taking place in a particular site. One of the recommendations was to expand that type of assessment to all clinics where Cuban doctors were working. No evidence of this extension has been found.

The other research located was not an assessment of the programme but a documentation of the community outreach programme run by the Cuban doctors in Soweto (Santana, 1998).

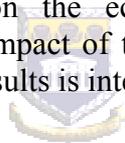
3. Hammett's research

“From Havana with love: a case Study of south-south development cooperation operating between Cuba and South Africa in the health care sector,” by Daniel Patrick Hammett, Centre of African Studies, University of Edinburgh, has recently been published. It includes the following findings:

- The cooperation agreement is based upon far more than any sense of moral debt owed by South Africa to Cuba, or the friendship between Mandela and Castro. South Africa is in dire need of medical staff.
- While the South African disease environment is different from their own, Cuban doctors' experience of practising in rural areas means that they can provide an effective and efficient service in South Africa.
- There is an obvious dichotomy in perceptions of the agreement between those with experience of working with or around Cuban doctors, and those whose exposure has only been through media reports or word of mouth.
- The Cuban doctors in South Africa list a number of motivating factors for their involvement. The economic benefits of volunteering undoubtedly encourage participation. These benefits, therefore, are not only seen in terms of personal gain, but also as a form of solidarity.
- The programme fits into the framework of the New Partnership for Africa's Development by enhancing Africa's skills base and building local capacity.
- Respondents from the medical community in South Africa were much more positive towards the Cuban doctors. Their criticisms tended to focus on the scheme itself rather than the work of the individual doctor.

- The presence of Cuban doctors has resulted in a greater awareness, and application, of the ideas of holistic PHC.
- The key social cost is borne by many of the Cuban doctors who have to live apart from their families for the duration of the contract. However, South African influence over this is limited, as it is imposed by the donor country rather than the recipient government.
- The doctors' proficiency in English improved dramatically over the period they had been in South Africa. At the same time, there is evidence from Nongoma and elsewhere that many of the Cuban doctors are learning the locally dominant African languages such as Xhosa, Zulu and Tswana, and communicating to some extent directly with the patients in their mother tongues.
- Discussions with health care professionals exposed a widespread belief that the presence of Cuban doctors, certainly in rural areas, has allowed for the provision of an otherwise unobtainable level of health care.
- While it is not seen as a panacea for all of their health care ills, nor as a long-term solution, government officials were very positive about the short- to medium-term role for such cooperation.

Hammett's study, while focused on the economic dimension of south-south cooperation, helps to illuminate the impact of the Cuban doctors on South Africa's rural areas, and the similarity of the results is interesting.



CHAPTER 3: QUALITATIVE RESEARCH

1. Why qualitative research?

Where a quantitative researcher might seek to know what percentage of people do one thing or another, the qualitative researcher pays much greater attention to individual cases and the human understanding that features in those cases (McBride and Schostak, 1990).

As quoted earlier, Richards argues: “A good doctor in Cuba is a good doctor for the Cuban people. There is a unifying base of knowledge and an underlying set of skills, competencies and proclivities, but the context of practice is an overwhelming factor” (Richards, 2000). These factors are unveiled in this study by qualitative research methodologies that unpack issues and mine information from the Cuban doctors programme in a relatively better-off province like Gauteng.

It could be argued that quantitative research is more precise, but with individual human beings it is not possible to be so precise; people change and the social situation is too complex for numerical description. The qualitative researcher has to be more circumspect (Hammersley, 2000). As we have seen above in the studies done in South Africa about the Cuban collaboration, quantified evidence can be very powerful and can and must be routinely gathered and used for managerial decisions, but it can also hide a great deal about people. This is why the number of operations performed each month by a Cuban doctor in Sebokeng hospital, for example, without regard to the conditions of work, the relationships with peers and managers, and other factors, would not be relevant for the purpose of this research.

Unlike quantitative research, qualitative researchers are usually more interested in the nature or processes within a phenomenon or an experience rather than its distribution. It makes sense therefore to recruit participants who have some exposure to the phenomenon under study, such as the peers working with the Cuban doctors and their managers. Similarly, those cases that have more exposure to the experience are likely to be more useful informants (Pope and Mays, 1995).

Qualitative researchers are concerned with “building” theory from the ground up, based on the experience of practitioners; to research face-to-face levels of interaction; to focus on the everyday or routine. It is simply not enough to say, as some authors suggest, that “qualitative research methods are purely exploratory”. It is true that qualitative research does tend to be used to uncover values, beliefs and experiences that might otherwise be inaccessible in other research approaches. However, qualitative research can also be confirmatory in that it can demonstrate the causes of certain findings from surveys. In qualitative research combining data collection and analysis is important.

This research concentrates on Gauteng, but it might be interesting to conduct it in other provinces, with other Cuban doctors and conditions. This is called generalisation.

Interviews form by far the most common method of data collection in qualitative research. This is usually described as “in-depth” interviewing since the aim is to gather information which has a number of characteristics. Firstly it is from the perspective of the respondent, not the researcher. It is true that by nature, in-depth interviews are driven to some extent by the researcher. However, rather than lead the respondents through a series of prepared questions, as far as possible, the researcher attempts to elicit from the respondents meaning and depth of coverage. Secondly, the researcher uses prompts and probes (“Why do you think that is?”, “Can you tell me more about that?”) to get beyond the initial responses. Lastly, the management of the interview is such that researchers often actively pursue unanticipated issues that emerge (Robson & Blackwell, 1993).

2. Access to official documentation and participants

The research protocol was presented to the UWC Ethical Committee for approval. The committee was concerned about revealing the identity of the province where the study would take place because, being a small sample, it could create a risk for some participants, who might face retaliation for candid expression of their views. Some changes suggested by the committee were included and emphasised to prevent such consequences. In the end, the study retained the name of the province, as the author requested.

Since the collaboration programme is an inter-governmental programme, both South African and Cuban authorities were approached to secure approval for this research, to obtain access to participants and relevant non-confidential documentation.

Access to Cuban doctors was facilitated by the Cuban authorities, who also provided some documentation. Appointments were made with each Cuban doctor telephonically, based on a list provided by the Gauteng co-ordinator (one of the Cuban doctors) They helped with identification and organised meetings for interviews with managers; and managers, in turn, helped to identify the Cubans’ peers. Initially, the author planned to ask Cubans to identify their peers, but made this shift because it helped to avoid bias.

The Gauteng Health Department authorised access and granted an access letter to be presented at various facilities. Relevant documentation was also acquired from the archives of the department.

The phase of consultation of documentation obtained took place from February to May 2004. The researcher conducted field work in June and July 2004, visiting all Cuban doctors in Gauteng, their peers and managers at their respective workplaces. Three were visited at their homes for reasons of mutual convenience.

3. Sampling

All 15 Cuban doctors working in Gauteng clinics, community health centres and hospitals were interviewed. These doctors are distributed within the metros and districts as follows: Johannesburg Metro (2), Tshwane Metro (1) and Ekurhuleni Metro (3), and West Rand (3), Metsweding and Sedibeng Municipalities (6).

It was not possible to interview peers in the way planned (one peer per district) due to the non-existence of doctors at clinic level. In most cases, Cubans work on their own at clinic level with the exception of two community health centres. Therefore, three peers that work with Cubans at different district hospitals and two doctors in community health centers were interviewed.

The definition of managers was somewhat complex because there are two levels of managers: Cuban doctors report to managers of the clinics where they are working for day-to-day issues, but the regional chief medical officer handles matters such as leave, work permits and accommodation. While clinic managers are in direct contact with the doctors, the regional chief medical officers see them far less frequently -- in some cases only twice a year. In this category, two doctor managers were interviewed and 3 nurse line managers.

The sample did not include, as initially planned, the views of doctors recently returned to Cuba because attempts to trace them in Cuba have failed.



4. Interviews

Most of the clinics and other facilities are in remote areas, and Cuban doctors helped the researcher by collecting her at identifiable points near their workplaces so that she would not get lost.

A set of guidelines (see Appendices 1-4) structured as open-ended questionnaires was used for each group to ensure that key questions were answered across all regions while allowing flexibility for other issues to arise. The first interview from each group was used as a pilot and adjustments were made accordingly.

Following the ethical procedure agreed, all Cuban doctors were informed that although the researcher would keep their names confidential, by implication confidentiality would not be complete due to the relatively small sampling universe, and there could be a risk of retaliation for whatever they might say. They were therefore offered the choices of not participating in the research at all, or of answering only some questions. All, however, agreed to participate fully in the research.

All interviews with Cuban doctors were conducted in Spanish to assure fluidity and the kind of confidence that generally accompanies use of one's first language. The interviews were recorded and translated by an assistant into English. For the compilation of the data, the author was obliged to double check the quality of each translation. All this might also constitute a method of indirect verification. The

interviews conducted in English (managers and peers) were transcribed by another assistant.

The compilation of the information was done by the author in Excel tables for each category: doctors, peers and managers. All aspects were captured using coding created for all responses. This coding indicated when the author should go back to listen to tapes or read manuscripts to confirm data and/or to choose appropriate quotes. In cases where issues were not clear, the author phoned the participants for clarification. This was time consuming but ensured the validity of data. During this process of compilation themes were identified that emerged through the interviews. These topics were used to present results and allow the interpretation and analysis of the processed information. Recommendations emanated from completion of this process.

The exploratory character of the study, combining face-to-face interaction, data collection and analysis, enabled the researcher to develop, using grounded theory, an explanatory building process where ideas, concepts and theories were grounded in and informed by the data collected (Glaser, 1967). To avoid data saturation, as informed by the literature review, during the course of the fieldwork, the researcher had to select one manager specifically for his well-known discordant views on the Cuban doctors programme.

In conclusion the author has tried to provide a clear and accurate picture of the methods used as suggested by Patton (2002): a detailed account of the research process and focus of the study, as well as the role of the researcher; a description of the basis for selection of informants, as well as a description of them; and a detailed description of the data collection and analysis strategies.

CHAPTER 4: RESULTS

This chapter profiles the Cuban doctors in Gauteng, discusses their conditions of work, relates how they were recruited and inducted into the programme, reviews their scope of practice (from community clinics to hospitals) and their interaction with programme management. It examines their work beyond their immediate clinical duties, their relations with peers and managers, their adaptation to South Africa, and the opinions of the programme held by the doctors and their South African peers. All of this is essential to understanding the development, quality and functioning of the Cuban health programme.

Unless otherwise noted, all quotations in this chapter are taken from the researcher's interviews.

1. Profile of Cuban doctors working in Gauteng

1.1. Characteristics

All Cuban doctors working in Gauteng are specialists: 13 are specialists in Family Medicine (equivalent speciality in South Africa), one is a surgeon and one an internal medicine specialist. Their range of medical experience varies from 10 to 41 years.

In Cuba, three of these individuals hold academic posts; of these, two also hold managerial academic responsibilities. One is a provincial manager (deputy director in the Provincial Department of Epidemiology), one works in public health services in the industrial sector, seven work in community health centres, and the other six in community consultation rooms.¹

In Cuba, most of them are involved in training of junior professionals and other categories of health workers. Eight of them have previously worked in other countries as doctors – five of them in other African countries (two in Zambia, two in Angola and one in Ethiopia). All of them had some knowledge of English before coming to here: one studied in the United States, two learnt at home or in private study, and 12 are medical English graduates from their respective medical schools. All retain their positions in Cuba.

¹ In 1985 the Cuban government introduced a new community health care approach, posting family doctor specialists to consulting rooms (mini-clinics with accommodation for both doctor and nurse) at community level. Throughout the island, these clinics provide comprehensive promotive, preventive, curative and rehabilitative services to an average of 120 families each. The rationale behind this primary health care system is the emphasis in promotion of good health and prevention of disease for every Cuban citizen. It also reduces the bulk at other levels of care (Waitzkin, 1997).

The doctors offer a range of reasons for having come to South Africa, from “helping others as part of the Cuban internationalist culture”, to exposure and professional development, to economic reasons. One explained:

I came to South Africa because since from the time we started studying this career, as part of our education we were told that there are countries that are poorer than we are, which need our medical assistance. So I thought that when I finished my speciality, I would go to any part of the world, especially to an African country. That’s why I came here.

Another Cuban doctor remarked:

I feel useful. I am doing something important as I did in Cuba, but there is a difference. In Cuba I am useful to patients. Here I continue to be useful because I acknowledge the role we are playing here and the contribution we are making to Cuba in buying medication such as insulin and other (medical) products for our patients.

1.2. Contractual conditions

In Gauteng there are 15 Cuban doctors working in terms of the contract under the state-to-state agreement reached between South Africa and Cuba. Until last year there were 32. Some of those who left rescinded the contract; others went home for personal reasons (family problems, illness, etc.) before their contracts expired; and four abandoned their contracts with an intention to remain permanently in South Africa.

Regardless of the fact that all of them are specialists with a number of years of experience, and of the responsibilities they hold in Cuba, all Cuban doctors participating in the bilateral cooperation programme are categorised (and paid) as Principal Medical Officers.

The Cuban authorities classify the doctors according to when they arrived in the country. Six groups of doctors have come here since 1996. Groups 1 to 4 work under different contractual conditions than Groups 5 and 6. The first groups are not restricted in terms of when their contracts have to end, and they were entitled to bring their families with them. They have been in the country for 6-8 years. Groups 5 and 6 signed three-year contracts and were not allowed to bring their families along. Group 5 left at the end of 2003 without being replaced. Group 6 will leave before the end of this research (November 2004) and for now no replacement is planned.

The conditions of their contracts specify that part of the doctors’ salaries (57%) will be transferred to Cuba. All Cuban doctors send this agreed amount from their net salaries (i.e., gross salary, based on civil service scales, less income tax) to Cuba. Fifty three percent of this contribution (30% of net salary) benefits Cuba in general by supporting social development, particularly in health and education. The other portion (47%) of the amount sent to Cuba (27% of net salary), is paid into a personal savings account, from which doctors’ families have access to a fixed monthly amount.

2. Recruitment and induction

2.1. In Cuba

The recruitment process in Cuba was run by provincial and national health authorities. Eight of the 15 Cuban doctors in Gauteng learned about the programme through formal communication channels, three were directly invited to join the “mission” in South Africa and four about the possibility of coming to South Africa through the grapevine.²

All 15 passed different levels of examinations. Three were examined by the HPCSA only, another three by their national authorities and the HPCSA, and nine by provincial and national authorities and the HPCSA. One underwent two rounds of examination because he failed the language proficiency component in the first round. One doctor described his/her experience as follows:

It was communicated in all polyclinics that people with basic English and who were interested could present themselves for the mission in this country. So all those interested submitted their names to the director of the polyclinic, who then submitted these names to the Provincial Department of Collaboration. Here they co-ordinated an examination in English with the Faculty of Medicine. Those who passed this examination go to a national examination with Cuban professors, and later with the South African professors.

Most of them found the examiners from the HPCSA correct and ethical. However, two doctors said this was not the case, and felt the examiners had inadequate skills (by Cuban standards) and/or exhibited racist behaviour. Said one:

The group that examined me was heterogeneous; one was excellent and very professional, the other was called ‘mad’ even by his colleague. To me he was not ethical in the way he directed his examination and questions. I cannot complain because other groups who examined other Cubans, were too racist and hard.

The exam had two parts; a theoretical and language section, and a practical clinical case. Most of the practical section dealt with cardiovascular illness, diabetes and hypertension. Only one of the doctors interviewed was asked about community health issues. Remarkd one doctor: “What the Medical Council asked in the examination was completely irrelevant to the needs of this country.”

In terms of induction, most of them received some preparation in Cuba. The first groups had a more thorough and lengthy period of induction compared to the later groups. Some provinces prepared their doctors for periods of six months or more in medical English, with rotation in all specialities. Most were introduced through short

² “Mission” is the term utilised by Cubans who volunteer to go abroad to work in health, education and other programmes. Participants are not drafted against their will; rather, they sign up for internationalist assignments.

seminars to South African history, geography, languages, ethnic groups, and economy, as well as something on health but not in much depth. It took an average of six weeks between the time the examination took place and their departure for South Africa.

2.2. In South Africa

The first and second groups of doctors were enthusiastically welcomed by crowds at Johannesburg International Airport, and by health staff and communities at the clinics and hospitals to which they were assigned. One doctor recalled his reception at a clinic: “The chief nurse said to me ‘if one day you need a shoulder to help you, come to me and I shall help you’.”

However, no special reception greeted the groups that followed. Similarly, in relation to local induction, there was a remarkable difference between the first four groups and the latest two. The first four went through a 10-day programme organised by the District Health Service Directorate at provincial level, which included introduction to systems, and visiting the different health regions and institutions. A doctor from the second group said: “We had three months of training, where they taught us management of all these things. How patients were referred, how to manage the cases and they gave us the different protocols of the treatment that they have.” But the later groups were taken straight to their place of allocation, and most of the induction was done by their Cuban colleagues and/or by the sisters in charge.

It is a fact that South Africa’s epidemiology differs from that of Cuba’s, as do the policies of the two countries. It is obviously imperative for all foreign doctors – not only Cubans –to know the national guidelines and policies for priority public health programmes.

Policies and norms like National Control Programme of Tuberculosis, Sexually Transmitted Infections Control Programme, the Essential Drug List and Standard Treatment Guidelines were explained to the first groups, although superficially (through flyers), by the provincial and regional authorities, but not at all to the later groups.

One doctor said: “One thing that is happening here is that we have clinical sessions every Friday. Most of these things are explained in the clinical sessions, such as TB, HIV/AIDS, and this helped a lot.” However, most of the Cuban doctors referred to having learnt about these programmes and the specifics of South African treatment protocols by self-learning.

Some of the doctors view the efficacy of such courses with disdain. Said one:

I think that doctors should be given medical literature and health policies, with particular clinical and epidemiological aspects of the health problems of a given country or place, and learn from there. My experience is that there is more time wasted in courses, and the course I had on legal medicine for two days was very bad. I had to learn things on my own.

When asked about referral systems the doctors generally say they have learned by doing. All complain bitterly about the referral system.

This is not a compassionate system. Every time you need to refer a patient, you spend more than an hour literally pleading with colleagues to accept a patient whose life is at high risk; in Cuba this does not occur and could be considered a crime.

Most doctors interviewed did not see language as a major problem. One doctor at a clinic in Soweto remarked: "Here it is difficult because people speak many local languages. When I was in Orange Farm I learnt a lot because people there speak one local language, but here I know and understand a few words."

When asked if they feel respected as professionals, all of them answered positively. When asked if they were respected as Cuban doctors specifically, most said that they were respected simply because of their work as professionals. One explained: "There are many nurses who do not know where Cuba is on the map, so their respect towards me is not because I am a Cuban."

3. Scope of practice and perceptions of Cuban doctors regarding their role at district level

3.1. Clinics and community health centres

Thirteen Cuban doctors are allocated to clinics and community health centres. They visit an average of four institutions each. While some of them are allocated to one clinic or community health centre, others rotate through different facilities and services within the communities. One doctor visits 11 different institutions. In addition, most of them are dealing with social grants and medicolegal cases (rape, violence, etc.). One doctor performs terminations of pregnancy as her main duty, while another two perform abortions once a week.

According to the interviewees, their work at these clinics and community health centres has not been well defined or understood: there are no job descriptions, policies or any defined criteria. In some cases the Cuban doctors see 30-35 patients a day, while in other cases they see 70-75 a day. At the beginning they struggled to adjust due to this undefined role, but with time they have found common ground with the staff and, in most cases, they found a way to work together. (Some clinics in the Sedibeng District seem more resistant to this team approach, overloading doctors with patients and other duties. In some cases doctors have also to dispense drugs, a duty generally undertaken by nursing sisters.)

One experience was described as follows:

Generally I am the only doctor in the clinic. The nurses consult patients and when they have doubts, they ask me for help and then I explain to them the management of the case. At this moment, the work of the nurses is excellent because I have empowered them.

About half the Cuban doctors in Gauteng are involved in internal organisational meetings.

The bulk of their work is curative, although they approach patients in a holistic manner.

All Cuban doctors experience the dilemma of responding to a large patient load with limited time to implement their patient-centred approach, which requires more time. One states:

This is one of the things that shocks me here. At times patient are not given enough space to express themselves – for example, to explain that previously he or she had the same problem and Doctor X or Y treated him or her with one or two drugs. This history information is fundamental for correct management of the patient.

They also encounter misunderstandings with colleagues when they try to do things “their way”. One remarks:

I am not sure if it is because of lack of time or because they have learnt as a habit dedicating less time to the patient. They attend patients hurriedly because there is a long queue outside. We found it difficult in the beginning to face this situation because in Cuba we don't have such. In Cuba you dedicate all the time that is necessary to your patient. Sometimes we had comments that we were slow, but this disappeared with the time, in particular by nurses, and they end up adopting our style.

All Cuban doctors working in Gauteng feel under-utilised. All of them are specialists -- highly qualified professionals with expertise and experience in developing and implementing comprehensive PHC programmes, with particular emphasis on promotion and prevention as the most cost-effective component. Since, as described above, the demand at primary level is mostly curative, all of them are absorbed by these services. This leaves them unable to plan and implement preventive strategies, as they do in Cuba.

As one doctor put it: “I don't think that it was necessary to bring me all the way from Cuba to treat a simple flu or just dish out drugs, I do have specialised skills to offer instead.”

Some doctors have tried to introduce preventive programmes but the pressure of what one calls the “queue syndrome” has conspired against them. Several interviewees also mention that when they want to implement such programmes they are inhibited from doing so by a failure of staff to understand their intentions.

However, even though they are not satisfied with the results, the doctors' approach in the management of chronic diseases has made a very real difference, according to the sisters interviewed. One manager discusses this comprehensive method:

At the end of the day if you don't have this rapport you prescribe wrongly and the client will come back after two weeks or whatever because he isn't

satisfied with the service. This is why in South Africa we got used to overcrowded clinics, which was not a good approach. We were not used to implementing the preventive aspect of primary health care. We thought we were doing it, but we were not.

The Cuban doctors are critical of what they regard as static elements within South Africa's public health system. One remarks:

The Family Planning Programme (intended to enable women to make informed decisions about their sexual and reproductive lives) is a passive programme. They always think of human rights but also they should think of the persuasive forms of achieving a patient's good health, and the health of the child, and generally the health of the family. In general there are programmes such as counselling for high-risk cases, such as multiparae and hypertension, including those with HIV infection. But these things are not regularly done, so they remain in papers. What happens if you cannot be persuasive, because this is regarded as violation of human rights? For example, a woman who has two children has AIDS and she wants to have another child -- as a doctor you know the consequences. So it becomes very difficult to convince her not to have the third child because it is her right.

3.2. Hospitals

The two Cuban doctors permanently assigned to Gauteng hospitals function at a specialist level, conducting rounds through the wards, outpatient departments and performing casualty duties. They also play an important role in mentoring interns, junior doctors and other doctors. They are also involved in some internal organisational tasks, like preparing monthly schedules and reorganising the services with clear criteria and roles for nurses and doctors.

All doctors working at the clinics are doing casualty duty on average twice a week at district hospitals. This has been a challenge for some to learn procedures and local techniques, since it is not part of their responsibilities in Cuba.

An eight-hour shift is stipulated, but all the doctors stay as long as required, which sometimes means working overtime (with no remuneration for extra time worked). According to one doctor: "I am also on call at the hospital every two weeks for the whole week because we are only two Cuban doctors."

3.3 Other facilities

Some doctors have to visit old-age homes to update prescriptions and provide other assistance. One doctor described his job thus:

Including this one where I perform abortions, I work in 11 or 12 clinic and old-age homes. The old-age homes are mainly 'white'. At the beginning they were not happy with me, but with the years and because a black doctor is better than nothing, they have to accept me.

On request by the authorities, there are also prison visits.

3.4. Management

Two Cubans hold managerial responsibilities. One has been appointed Senior Medical Officer to resolve serious problems in a community health centre and has been successful in reorganising the services to bring them up to the required standards. Another Cuban doctor functions as an advisor to provincial health officials, helping the region with health information systems and using the information for management. He also performs managerial roles and coordinates all doctors in the region.

4. Beyond clinical work

4.1. Research

Most of the Cuban doctors are also doing operational research. According to one this was an initiative suggested by the Cubans to a provincial manager in 1998. He recalls:

I am the person who created primary health care research after convincing Dr X that there is no primary health without associated research. After convincing him, I formed part of the organising committee and I think that it is one of the biggest contributions I have made.

Since then, Cuban doctors have actively participated in the annual Prakash Vallabh Gauteng Research Conference, where they have regularly won prizes.

In addition to conducting their own research, they have also developed, in some instances, local skills, empowering nurses to perform research. As one sister in charge mentioned: “We were scared of doing research, then (a Cuban doctor) convinced us that we were capable, and we realised by ourselves how important it is to answer some questions for improving the quality of our services.”

4.2. Training

All the Cuban doctors, whether in clinics, community health centres or hospitals, spend time training staff, either formally or informally. In addition to the continuous onsite day-to-day training, they have, in some instances, scheduled weekly sessions to review clinical cases, themes, policies or to interpret statistics. One doctor explains:

Officially I do not have any responsibility of this nature, but as a habit from our medical school I do teach the nurses how to manage new cases, prevention of disease and difficult or strange cases that they are not familiar with.

Regional managers confirm this. Says one: “They are helping with clinical discussions, research, and statistics to be used for decision making and training. Please, put training there.”

4.3. Outreach

In the Meadowlands Clinic Cuban doctors used to run a successful community-based programme involving clinic staff and community members, but it came to a halt when the doctors had to return to their clinic duties because of the pressures of “the queue”. The sister in charge referred to this project as follows: “The community appreciate their presence greatly. Even now, the community is still asking about the project.” This programme was implemented in Tshwane region but was discontinued for the same reasons.

4.4. Voluntary work

One doctor mentioned that in his scarce free time, he takes part in some voluntary community work:

They invite me to come and present health topics because they know that I don't charge them anything. In the district they requested me to present on HIV/AIDS, a programme that I have started, so they want me to give them part of this programme and I am going to do it free of charge. I also belong to an association called Buzanani. We meet every month, in fact they meet every Sunday, but I can only attend once a month because of my work. I am their doctor.

5. Relationship with peers

5.1. Perceptions held by Cuban doctors

Most Cuban doctors interviewed emphasise that they have good relationships with their colleagues. They mentioned that despite some initially wary attitudes among their local colleagues, such suspicions have for the most part been overcome and solid professional relationships built. One quote illustrates this: “There were some who tried to know my level of knowledge, asking questions taking advantage of the fact that we did not understand English very well. We passed through all these things. Generally the majority gave us support.”

However, serious friction with their colleagues did develop in some cases as a result of the different attitudes the Cubans brought with them to their work in South Africa's severely strained public health system. One Cuban doctor offers a scathing assessment:

Clinically and technically I will not attempt to confirm anything because it would be unethical. But the attitude of (local) doctors towards work is completely different from ours. They do not have a sense of responsibility for work. It is not 100% of them who behave this way. But some do not care whether there is a patient in the queue with difficulty breathing who should not be the last to be attended to, or get out of their consulting rooms and see if there is a patient that needs urgent medical attention. They do not classify the patients. They do not give priority to the cases that deserve it and generally, their standard is not equal to that of ours.

There have been moments where we had to cut the relationships with our colleagues because there were situations that compromised the life of the patients.

One Cuban doctor recalls the transformation of the attitude of a senior South African colleague, who was very resistant to the Cuban presence at the outset.

He was negative towards us. One day he called me after he had rectified his negative opinions. He acknowledged the amount of work done by us, saying that we were the only doctors who had maintained the same behaviour since we came. Other doctors when they come for the first time they show discipline, but as the time passes they change. When they told me that I was going to be responsible for this clinic (Senior Medical Officer), he congratulated me and if he wants to do something, he ask for my opinion.

5.2. Perceptions held by South African and other doctors

Among the five interviewed peers of the Cuban doctors, three were South Africans and two from other countries; four worked full-time in the public sector. When asked how they viewed media reports in 1996 questioning the competence of the Cuban doctors, three said they did not believe the reports, one had doubts but did not know what to believe, and another did not remember. One South African said:

I didn't believe what media said, because it was sort of paradoxical situation, when Cuba has one of the best health systems in the world. I think it was a question of negative attitude from the local guys that said 'maybe these guys are going to take our jobs'.



Three of the peers interviewed were doing jobs similar to those of their Cuban colleagues, –one was reporting to a Cuban, and another was a junior doctor mentored by a Cuban.

Most of their peers do not feel that Cubans enjoy better conditions of employment. All peers interviewed referred to excellent relationships with Cuban colleagues. In two cases the academic role was highlighted, in one case by a senior and in the other by a junior peer who recognised the high level of knowledge of their Cuban colleagues, and commented that everyone asks them for second opinions. All in all, they think that the work of the Cubans is important for the public sector, and that the programme should definitely continue. Two of them bitterly complained about a Cuban colleague leaving without any replacement. One senior South African specialist said: “This (Cuban doctor) is good. I believe we are going to lose him, and I am very heartsick.”

6. Relationship with managers

6.1. Cubans' perceptions

Cuban doctors report to the sisters in charge of clinics directly and, administratively, to the regional Chief Medical Officer (CMO). In the hospital setting they report to the

heads of departments and the CEO of the hospital, in the same manner as other doctors.

With few exceptions Cuban doctors characterise their relationships with their direct managers as excellent; with CMOs as relatively satisfactory.

6.2. South African managers' perceptions

Five managers were interviewed during this research: three sisters in charge of clinics where Cuban doctors work fulltime, one hospital CEO and one regional CMO. All are South African citizens, all have worked with foreign doctors of various nationalities before and all have worked with Cuban doctors for more than four years.

When asked about rumours of Cuban medical incompetence spread by the media in 1996, three said they did not believe such reports, two were doubtful and one did not know. They had no previous knowledge of the Cuban health system.

The three nurses in charge say the Cubans are hard workers, always prepared to sacrifice, and that the communities are very fond of them. Said one nurse: "They are prepared a lot for sacrifices. They never say no, they never watch the clock, and sometimes they are abused by other colleagues because of this generous attitude."

The nurse-managers appreciate the attitude of Cuban doctors compared to any other doctors because of their dedication and approach to work. On the other hand, one doctor-manager says he assumes that the community would prefer South African doctors instead. The other doctor-manager is of the opinion that Cubans are like any other doctors.

Nurse-managers also comment that the Cubans' English is quite good, although they recognise that at the beginning some struggled a bit. They also acknowledged their attempts to learn local languages to communicate directly with patients. "Yes," said one nurse manager, "language was a problem at the beginning, but not for long. They (Cuban doctors) were even prepared to learn the local language." Interestingly, the other two managers say the Cubans still have communication problems. One remarked that "in meetings people are struggling to understand them."

Nurse managers confirmed that they had taught the Cuban doctors some things, such as budgeting and administration, and that the Cubans were receptive to their advice. The doctors strongly emphasised their willingness to share and the attitude to teach constantly.

The three nurse-managers characterised their relationship with the Cuban doctors as excellent, while the other managers referred to it as "the same as with other doctors". The nurse managers emphasised that they would like the Cubans' contracts to be extended.

Nurse managers socialise more with Cuban doctors than they do with other doctors. Some peers and nurses working directly with Cuban doctors have described their approach to patients as very caring and holistic. One peer puts it this way:

Compared with my school the approach of the Cuban doctors to the patients is a bit different. In my personal opinion, they tend to be more thorough, they are not like us, they go deeper. They tend not just to deal with what the patients are just telling them, but they tend to go far deeper.

One manager says of patients' attitude to a Cuban doctor: "They hold him in high esteem. Everyone asks for him." In this regard, another manager says:

With the caring they are also different, because they would follow up with their patients. They want to see what happened to the patients. They are actually interested in the feedback even when the patient is referred to the hospital."

Another manager says "The community knows them. Chronic patients in particular will request to be seen by so and so, calling them by name." Another sister says: "I have learnt a lot from them, their humbleness. When they go into the consultation room the client will not feel inferior, they feel that they are at the same level".

One manager referred to difficulties of handling some contractual situations since the Cubans work under a state-to-state agreement:

There is a lack of communication between the national office and the provinces and down to us. Because often a situation will arise and you don't have the policies or the contract. It's a government-to-government thing done at national level and things don't very easily fall down to local levels. Sometimes there is an issue and you want to deal with it. And then they might say 'our contract says this'. And you haven't got that, you try to find out, and the provincial head office doesn't know what's happening.

Another doctor manager was reluctant to differentiate the Cubans from other doctors because he openly disagrees with the entire programme. He would instead contract general practitioners to provide public services under special conditions in their consultation rooms, which according to him are closer to the people.

7. Adaptation to the country and society

The 11 doctors who have been in South Africa longer have managed to settle down with their families. Although six of them referred to accommodation problems at the beginning, they are now living comfortably. Most have bought their own transport. Half of them belong to a medical aid scheme that is used mainly for dentistry and/or specialised services. They rarely socialise with non-Cuban peers or colleagues. Without exception the Cuban doctors are of the view that if they fall severely ill they would definitely choose to be referred to Cuba - a normal practice in such cases in any Cuban programme. They know that Cuba will be responsible for the logistics and cost of such cases.

Little has been done by South African organisations to help integrate the Cuban doctors into local communities. For example, only three Cuban doctors were

contacted by political parties when they arrived, one was asked to come to a church to be introduced to its constituency, and nine were invited to community gatherings. In general such initiatives seem to have tapered off.

When asked if they feel integrated into the South African health system, seven said yes, two feel partially integrated, and seven said no. With regard to feeling integrated into the medical community, three responded affirmatively, three said partially and nine do not feel integrated. In terms of feeling part of South African society in general, one feels integrated, two partially and 12 do not feel that they are part of society.

Asked why they are willing to stay in South Africa, those whose contracts allow them to stay indefinitely gave a range of reasons: four feel useful in South Africa, five indicated they stayed for purely economic reasons and two to contribute to social programmes in Cuba with their financial contribution.

One doctor related her initial experiences here as follows:

On the first day I told one of my colleagues that I wanted to go back to Cuba. On the second day they took us to Johannesburg. We met friends and sympathisers and I started feeling better; this was eight years ago.

Asked why she stayed, the doctor remarked:

There are different motives: one is because of economic reasons, the other is that I feel that I am contributing more here than in Cuba. In Cuba I was one of the many specialists in family medicine apart from the fact that I was also part of the administration staff of my polyclinic. But Cuba did not need me as they do here.

The Cuban doctors cite a range of positive experiences since coming here, including “speaking in Parliament”; “greeting Mandela”; “acknowledgement of my work”; “receiving a visit from and being greeted by Adelaide Tambo at my clinic”; “one child’s life that I saved when I thought he was gone”; “to be welcomed by nurses when I won the third prize at the research conference”; and “to be recognised by some colleagues who at the beginning were sceptical of our work”.

What makes me happy is when I come across a child whose life I saved, who calls me by name then gives me a hug and a kiss. That is what makes a doctor proud, not money. For instance in casualty during morning hours around 7am, most of the doctors have not yet arrived. In that time many critical patients attend the hospital and in most cases because there are no doctors so early in the morning, they call me. This way I have saved many lives. This makes me feel proud of myself.

When asked about negative experiences they mentioned unethical commercial attitudes in medicine; passivity of some staff in the face of disease; deaths; racism; trauma; poverty; lack of education; AIDS; the death of a Cuban colleague; patients passing away in the waiting queue; seeing a child die; violence; and sexual abuse.

One doctor who worked in wartime Ethiopia and Angola says: “Here in a weekend there are more violence-related cases than in my professional war experience.” Says another:

I have received a lot of infants who passed away in the queue waiting to be attended by a doctor. This was very traumatic for me. One of the bad things I have come across is children who have suffered sexual abuse. Now I have learn legal medicine, which includes management of rape and violence. I see these cases frequently and I cannot stop doing this type of work because not all doctors have the capacity to do it.

8. Opinions of the programme

8.1. Cubans on the programme

The doctors interviewed feel that induction in Cuba was excellent for the initial groups, but has since declined in quality. In South Africa they deemed induction quite poor; some suggest the best practical way to understand the South African system is for one Cuban doctor to hand over to another.

They unanimously agree that it would be more cost effective for South Africa to review the character of the programme, envisaging a different role for them by looking at the potential contribution to improving the quality of comprehensive primary health care, emphasising preventive strategies and models. One doctor emphasises this point as follows: “I would recommend to the authorities to put more emphasis on the promotion and prevention of disease so that the pressure at work can be reduced. Take into consideration the epidemiological factors.” (Most Cuban doctors feel that there is a need to shift to a more epidemiologically orientated system that relies in part on increased community participation.)

Some of the Cuban doctors feel isolated, particularly those who do not have Cuban family members living with them, and feel that there is insufficient effort to keep them together as Cubans. They argue that they stay long distances from each other (a fact confirmed by the researcher during field work) and, due to workload, they visit each other only infrequently. Some suggest that the programme should cluster them in one district to keep them in contact with their medical and homeland community, and at the same time, enable them to provide more comprehensive services.

Salary was a concern expressed only when the researcher pressed the issue. The Cuban doctors say they know that the system in South Africa is based on money, and they have heard comments like: “If you are not getting specialist salary, maybe your qualifications are not compatible with ours.” They sometimes feel embarrassed to explain why they are not paid as specialists.

When asked about the advice that they would give their compatriots considering working in South Africa, they said they must be prepared to work hard (14) and not compare South Africa with Cuba (9). Other responses included the need to learn South African programmes; not be “contaminated” when they come here; to be

careful about AIDS; to uphold your values and never abandon them; and to be proud of being a Cuban.

8.2. South Africans on the Cuban doctors

The majority of South Africans managers and peers interviewed are grateful for this programme; they say it has made an impact and is still needed in Gauteng. They feel that the three-year contract offered the latest arrivals should be longer “like the other Cubans”, since it takes a while to understand the system.

One nurse remarked: “When relationships are consolidated and they are fully integrated, they have to leave. This is not fair to us.” During fieldwork, this view was voiced frequently, both by interviewees and by people who were not even being interviewed at the facilities visited. A farewell card collected recently for a doctor returning to Cuba reads: “We thank you out of our heart for your love and kindness you gave us these last years, we will never forget you. Nobody will ever be able to replace you”.

8.3. Cubans on the Cuban side of the collaboration

This research does not attempt to explore the views of the Cuban doctors about the quality of their own government’s collaboration in the programme. However, a few items should be noted in this regard.

In addition to their South African managers, Cuban doctors are also accountable to a parallel structure known as the Cuban Collaboration Office. This entity, subsidised by the national DoH, is intended to facilitate the programme’s functioning, communications between the two parties, and to administer and defend Cuban interests within the programme. It deals mainly with the Cuban financial component, logistics of leave, social problems and the like. Representatives of this office visit all Cuban doctors throughout South Africa once or twice a year. In Gauteng there is a bimonthly meeting with all the parties involved (Gauteng Health Department, Cuban Collaboration and doctors) where issues of concern are discussed. According to the doctors interviewed, the Cuban office will follow up the problems identified and try to resolve them for the doctors’ benefit.

There is anecdotal evidence suggesting that in some cases support to Cuban doctors has been poor, but the research does not attempt to include this within its scope nor to draw conclusions in this regard.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

1. Conclusions

The results of this assessment indicate that the Cuban doctors working in Gauteng are highly qualified and caring health professionals, and that the generally positive response to their presence mirrors that in other countries where Cuba conducts medical collaborations (Borrego, 2003; Gallo, 2003; Luis & Rojas, 2001; Napoles, 2001; Barnes, 2000; Hamata, 2001; Velazques, 1996; Aidi, 2001). Although there were some reservations at the beginning of the programme, the South Africans who have worked with Cuban doctors for eight years confirm the value of the programme.

It is also clear that the distribution of the Cuban doctors throughout Gauteng has helped to expand primary level health services (Bismilla, 1999; Gungubele, 1999; Gauteng DoH, 1999; Cuban Embassy, 1997 and 1998; National DoH, 1999).

The recruitment process undertaken by the Cuban authorities seems to have been open, transparent and fair. The recruitment of Cuban doctors followed procedures prescribed by the HPCSA, and responds to South African standards, both in terms of clinical qualifications and experience, as well as language proficiency (Kruger, 2001; Cohen, 1997). According to the Cuban doctors, the South African examination was difficult. Some also suggest that the type of questions asked were often inappropriate for the needs of this country.

The induction of the doctors in Cuba was quite good at the outset, with less attention having been paid to this aspect with the later groups. In Gauteng the same situation prevailed: the first groups received a better reception and induction, and were therefore more easily able to adapt than the later groups. This probably has to do with differences in approach and commitment to the programme among the different managers in the Gauteng Health Department, who changed over time. The top managers involved at the beginning had a strategic vision of the potential impact of expanding primary health care by bringing in Cuban doctors specialised in family medicine. The current decrease in the number of doctors might also be the result of the original developers of the programme no longer being involved, and those who followed not having the same vision.

Although some groups benefited to some extent from induction sessions and mini-courses, most Cuban doctors learnt South African policies and procedures, as well as the referral and other systems, on their own. Lately, induction has been, in practice, done mostly by Cuban colleagues who have been here for some time. Due to the fact that Cubans come from a completely different health system, this may well be the best approach to introducing new doctors to the South African system.

Most of the Cuban doctors in Gauteng are PHC oriented, and this came through clearly in the interviews. All their opinions and analysis are based on the principles and philosophy of comprehensive PHC. The KwaZulu-Natal study reinforces this view (Hammett, 2003). This was also confirmed by their South African colleagues, who acknowledged that they were impressed by the Cuban doctors' values, in particular their holistic, integrated approach, which is strongly patient-centred. In this regard, the Cubans' major dilemma is South Africa's heavy bias towards curative services, to the detriment of a preventive approach.

The Cuban doctors also feel that the time they are able to dedicate to their patients is insufficient, and this creates conflict between themselves and their colleagues because the Cuban doctors are used to spending more time talking to patients. They insisted that the problem is not only that of the "pressure of queues", but also a different approach to treating patients and providing services.

They also expressed concerns about the implementation of preventive strategies, specifically the gap between clearly defined policies and poor implementation. They have expertise in this field, coming from a country that has invested mainly in preventive strategies for more than 40 years and currently has the best health indicators in the developing world (IFCO, 1998; Feinsilver, 1997; Perez et al, 1991). However, they feel that their role has not been well defined and that they are under-utilised. In spite of this, there are some examples of good practice and lessons learnt in the implementation of preventive activities by Cuban doctors in Gauteng clinics.

An interesting finding of the study is that the South African doctors in managerial positions are not knowledgeable about the different aspects of the programme and show little interest in the performance of the Cubans working under them. This lack of interest is indicated by the variance between the views expressed by the doctors and nurses working daily with the Cubans. For example, the Cuban doctors have been very supportive in the training of health workers. This was emphatically recognised by all nurses interviewed, and demonstrated another important role for fulltime doctors at primary level. However, the doctor-managers were not aware of this.

The fact that the Cubans have been able to teach and introduce new approaches tends to confirm that language has not been a major barrier, as most of the Cubans' colleagues confirmed. Generally they have shown a positive attitude in this regard, even learning African languages to communicate with their patients.

However, there seems to be a serious communication problem between the different levels of management. This is reflected, for example, in a lack of proper explanation of the details of the Cuban doctors' contracts, which has sometimes resulted in managers taking inappropriate decisions due to a lack of information. This is an important issue that has resulted in the mismanagement of some cases of Cubans who decided unilaterally to terminate their contracts. Hammett also demonstrates a lack of communication between government departments.

In general, and despite some hiccups at the beginning, logistical support in Gauteng has been satisfactory. This helped the doctors to adapt more quickly and easily. However, the integration of the doctors in the communities where they are working

has not been facilitated by local members of the community, which contributes to a feeling of isolation among the doctors and their families. In the case of those without family, the sense of isolation is even more intense. This situation was blamed on a range of factors -- long distances, heavy workloads, and so on – but there is also a lack of community gatherings, such as sports activities, which the Cuban Collaboration Office used to organise in the past.

With regard to motivating factors, it is clear from the study that the Cuban doctors came to South Africa and have stayed primarily for two reasons: financial benefit and because they feel needed here. The Cubans' local colleagues also feel they are needed here, and complain that their replacements do not arrive soon enough.

While in most of the other provinces Cuban doctors are allocated mainly to hospitals, the Gauteng programme is unique since most of the Cuban doctors are working at primary level.

2. Recommendations

Based on the results of the study, this research offers a range of recommendations to the sponsoring authorities.

For the Gauteng Health Department:

- Recommit to the programme and engage with the Cuban authorities to replace the doctors that have left; fill vacant posts subject to areas of greatest need
- Design appropriate induction strategies for incoming foreign doctors
- Develop packages with national health policies and guidelines to facilitate adaptation to the health system
- Handover periods to be done by Cuban doctors
- Improve communication with Cuban doctors' managers in terms of contractual conditions
- Review the current role of the Cuban doctors, taking into consideration their willingness to provide training and expertise in promoting preventive interventions
- Explore and promote the Cuban approach to patient care, allocating medical students to work with them
- Promote the mentoring and supportive role of specialists at hospital level for community doctors and interns
- Learn and replicate good practices and models implemented by the Cuban doctors, especially in chronic diseases
- Share with other provinces the benefits of recruiting Cuban family practitioners for the expansion of primary health care
- Advise community and governance structures to engage more proactively with new Cuban doctors to optimise their utilisation at community level
- Review remuneration scales in relation to their experience, qualifications and positions
- Assist in the creation of a website on the Cuban collaboration in South Africa

For the Cuban authorities:

- Return to the good induction and preparation practices that were done for the first groups leaving Cuba
- Coordinate with South African authorities for a handover period between contracts of Cuban doctors
- Communicate more frequently with doctors to avoid the consequences of isolation
- Reactivate more frequent social gatherings of the Cuban community to ensure cohesion and commitment, as well as the preservation of culture and values
- In new contracts, review the advantages of families accompanying doctors

Areas that warrant further research include:

- Assessment of the Cuban Health Programme in other provinces
- Client satisfaction surveys on the treatment and management of the Cuban doctors at primary level
- Preventive intervention models implemented by Cuban doctors
- The continuous caring and patient-centred approach implemented by the Cuban doctors under the pressure of a curative-orientated health system

3. Summary

Conducting this assessment has been revealing for the researcher. Two fundamental elements have emerged. First, the unquestionable need for Cuban doctors in Gauteng to work as fulltime doctors at primary level; and second, the acknowledgment and appreciation of their professionalism and approach by most people with whom they work – an appreciation that contradicts prior perceptions.

The openness of participants was also surprising. All participants in the study were eager to discuss these issues – particularly the Cuban doctors themselves. They were not afraid of expressing their opinions and ideas despite the potential for retaliation. Their thoughtful comments and constructive criticism are one more sign of their willingness to maximise their contribution to the improvement of the South African health system.

REFERENCES

- Aidi, H. (2001.) *First Cuban doctors that work in the Agadez desert in Niger*. Revista Cubana de salud.[online] Available <http://www.afrocubaweb.com/infomed/havanahealing.htm>
- Arenstein, J. (1997) Report slates Cuban doctor. *Mail & Guardian*. July 1997. Available <http://www.mg.co.za>
- Báez, C. et al. (1993). *Induction of foreign doctors, Mozambique*. Chimoio, Mozambique. Unpublished article. Presentation at the Jornadas de Saúde. Maputo. 1993.
- Cliff, J. & Báez, C. (1993) *Induction of foreign doctors*. Unpublished paper. Paper presented National meeting Mozambique 1993.
- Barnes, C. (2000) *Cuban doctors in Jamaica*. Latinoamerica noticias, July 2000. [online] Available <http://www.globalexchange.org>
- Beberley, S. (2000). Health statistics to compare with the best in the industrialised nations. *The Guardian*, Dec 2000. Available journalism.berkeley.edu/projects/safrica/adapting/cuban.html+WHO+Cuban+doctors&hl=en&ie=UTF-8
- Bismilla, R. (1999) *Cuban doctors Programme. Evaluation of impact in Gauteng Province*. Department of Health. District health services. Accompanying letter to full report to NDoH.
- Caller, H. (2001). *Health care for all: British doctors are learning from Cuba*. The Green Left Weekly Home Page. [online] Available www.ratb.org.uk/frfi/158_healthcare.html
- Castro, F. (1999). *Speech to representatives of Brazil's National's Students Union*. Belo Horizonte, Brazil, July 1, 1999. Available www.cuba.cu/gobierno/discursos/1999/ing/f010799i.html
- Cherian, M. (2003). *Agradecen municipios venezolanos colaboración médica* Granma. Agencia de Información Nacional. Available www.redboliviana.com/comun/foros/topic.asp?TOPIC_ID=16820
- Cohen, T. (2001). Corrupt medics to be punished. *Dispatch on line*, 9-2-2001, E. London.
- Cohen, R. (1996). *Brain-Drain Migration*. Background research paper prepared for the Green Paper on International Migration. South African Commission on International Migration, 1996-Available www.queensu.ca/samp/transform/Cohen1.htm

- Couper, I. (2003). *The Cuban health System*. Unpublished letter. Held by HPCSA
- Corzo, C. & Markowitz, A. Nicaragua rejects aid from Cuban doctors. Medical supplies will be accepted. *The Miami Herald*, November 4, 1998.
- Castaneda, M. (2003). *Living accounts. Historical research that reads like a novel*. Eight novels to date on the work of Cuban doctors in Latin America and Africa. Pablo de la Torriente Brau publishing house. Granma. Havana. August 8, 2001
- Cuban Embassy (2003). Personal communication. July 2003 by anonymous.
- Cornish, J. (1999). Hostility to hospitality for Cubans. Critics to Cuban doctors are now swallowing their words. *Business Day*, Nov 10 1999.
- Davis Wright, J. (1998). *South Africa's need for doctors: Why turn to Cuba?*. The RDP Series. Unisa Centre for Latin American Studies: Public Lecture. Pretoria, 12 February.
- Davis Wright, J.(2003). Personal communication. 2003, held by a FOCUS member
- Delgado, F.(1996). *Cuban medical cooperation. First evaluation*. Febr-June 1996, Pretoria. National Department of Health. 19/07/96
- Department of Health- South Africa. (1998). *Health care for all: Department of Health achievements and highlight of 1997*. Pretoria, 22 January 1998.
- Department of Health-South Africa. (1995). *Agreement between the Government of the Republic of Cuba and the Government of the Republic of South Africa regarding the recruitment of medical doctors*. Cuba, Havana 1995.
- Dixon, N. (1998). *Cubans in Klerksdorp*. African perspective Magazine. African perspective.com.[online] Issue #47 Saturday 09/02/2000
- Feinsilver, J.M. & Apter, D.E.(1993). *Healing the Masses: Cuban Health politics at home and abroad*. University of California Press; Feinsilver J M, Apter D E. Paperback—328 pages, 1993 Nov.
- Friends of Cuba Society. (1999). *Annual report of the Friends of Cuba Society*. FOCUS archives, 1999
- Gaither, C. (2000). *Cuban help stem brain but face complaints of preferential treatment*. Adapting to change. [online] Available journalism.berkeley.edu/projects/safrica/adapting/cuban.html
- Gallo, P. (2003). *Latinoamerica en foco*. Revista de salud. August 1998. Available www.latinoamerica-online.it/temi2/scienza4.html

- Hernández, G. (1997). *Las médicas cubanas del desierto*. Vida, edición digital sobre la cooperación médica cubana. Agencia de Información Nacional (AIN). [online] Available www.ain.cubaweb.cu/vida/niger/médicas.htm
- Gauteng, DoH. (1999). *Cuban doctors Programme: Evaluation of impact*. Gauteng Health Department. Archives.1999.
- Gauteng Health Department (1999). *Cuban doctors programme evaluation, Vaal Region*. Gauteng Health Department. Archives.1999.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Aldine publishers. Chicago 1967.
- Gleijeses, P.(2002). *Conflicting missions. Havana, Washington y Africa, 1959-1976*, Ciencias Sociales press, Washington.2002.
- Gungubele, M.(1999). *MEC speech to the Cuban Doctors for appreciation of health services rendered in the Gauteng Health Department*, Gauteng Health Department. Archives.14/06/99
- Hamata, P.(2001). Cuban doctors arriving soon . *The Namibian* .12/12/2000
- Hammett, D. 2003. *From Havana with love*. A case study of south to south development cooperation operating between Cuba and South Africa in the health care sector Centre of African Studies, University of Edinburgh. Available www.era.lib.ed.ac.uk/retrieve/1185/DanHCuba.pdf
- Hatton, P.(2000). *South Africans have some of the best medical treatment available in the world*. Stellenbosch University magazine. Nov, 2000.
- Interreligious Foundation for Community Organization (IFCO)/Pastors for Peace(1991). *Health Care in Cuba: A health care system dedicated to health and healing in Cuba and in the world*. Update—Cuba: on the road to a family medicine nation. *Journal of Public Health Policy*. 12(1):83-103, 1991 Spring.
- Koppel, M (1998). *Proposed 2000 doctors for Central America* The Militant, Vol.62,no. 45.[online] www.ratb.org.uk/trti/158_healthcare.html
- Kruger, H. (2002). Doctors in the Rural areas. *Dispatch on line* . E. London, 10-1-2000.
- Luz, B. M. (2003). Departamento de Caaguazú-Paraguay. *Granma*. Havana. Diciembre 2002.[online] Available www.radioreloj.cu/otrasnoti/otras6-4-01.htm
- Mc Bride, R & Schostak, J. (1990). *Qualitative Method*. On-line Chapter 4. Action research. Retrieved January 23, 2004. Available <http://www.uea.ac.uk/care/elu/Issues/ResearchRes1Ch4.html#Ch4H>

- Ministry of Health, Cuba.(1996). *Pensamiento del Comandante en Jefe Fidel Castro Ruz como doctrina de la salud pública cubana*. First Report to the Government on the Evaluation of Cuban Public Health Strategies: Havana, 12 September.
- Nápoles, M.(2002) *Agradecen Municipios venezolanos colaboración médica*. Vida,edición digital sobre la cooperacion médica cubana. Agencia de Informacion Nacional (AIN).[online] Available <http://www.ain.cubaweb.cu>
- Nápoles, M. (2001). *Cuba: Cuban doctors praised*. African perspective staff, African perspective. Caribbean this week. Issue 47.9/02/2000.[online] Available (www.africaonline.com/site/Articles/1,3,31691.jsp)
- National Department of Health.(1999). *National report of the Cuban Collaboration Programme*. Pretoria. National Department of Health,1999.
- Nzimande, B.(2002) Internationalism contributed to victory, *Umsebenzi*, SACP newspaper, Johannesburg, February 2002.
- Parr Lemkau, J.(2002) *He Heals Without Pills — Portrait of a Cuban Family Doctor*. Agencia de Información Nacional (AIN).[online] Available (www.med.wright.edu/arch/lemkau/sansol.html - 30/02/02)
- Perez, J. T., Von Braunmuhl, J., Valencia, J. J.& Marquez, M. (1991) *Cuba's family doctor programme*. House of Commons - Health - Appendices to the Minutes of Evidence. Available www.parliament.the-stationery-office.co.uk/pa/cm200001/cmselect/cmhealth/30/30ap91.htm
- Patton, M.Q.(2002). *An introduction to qualitative methods. How to Use Qualitative Methods in Evaluation*, Beverly Hills, Cal, Sage, 1987, págs. 7-22.
- Pietoni, P. (2000) *Cuban health care systems and its implications for the NHS plan*. Memorandum to Parliament of Profesor Patrick Pietoni. (PH, 97, appendix 60)
- Republic of Cuba & Republic of South Africa: *Agreement regarding the recruitment of medical doctors*, 1995, Havana.
- Richards, R. (2000). *Being a good doctor*. Institute of Medicine in Nepal writing in Innovative Schools for Health Personnel. Institute of Medicine in Nepal. Available http://www.network.unimaas.nl/publications/books/adressing_needs.htm
- Riera, L. (2002). Lawsuit against U.S. for human and economic damages. *Granma*, Havana.
- Rodriguez, R (2000). *When I am sick, I look for the Cuban doctors, traditional healer*. Keta District, Ghana . Agencia de Información Nacional (AIN).[online] Available <http://www.ain.cubaweb.cu>

- Rosenberg, G.(1996). *Cuban doctors lend a hand in rural South Africa*. The Militant [on line] Vol.60/no.25, June, 1996. Available http://www.themilitant.com/1996/6025/6025_21.html
- Reid, S.(2001) *Crisis in staffing of rural hospitals*. Position paper of Rural Doctors Association of Southern Africa. Available www.rudasa.org.za/download/crises_staffing.doc
- Santana, A. (1998). *Impacto en el reino de Volta*. Vida, Edición digital sobre la cooperación médica cubana. Agencia de información Nacional (AIN). [online] Available <http://www.ain.cubaweb.cu>
- Smith, S.(1995). South Africans indebted to the Cuban people, *The Mail & Guardian*. 24 October 1995.
- Van Niekerk, R. & Sanders, D. (1999). *National Audit of Health Human Resources. NDoH, 1997*. South African Health Review 1997. Health Systems Trust and the Kaiser Family Foundation. Durban 1997.
- Van Rensburg, L.(1997). *Views on an Afrikaner homeland*. Afrikaner Forum discussion magazine. [online] Available southafrica.com/forums/showthread.php3?threaded)
- Waitzkin, H., Wald, K., Kee,R., Danielson, R, & Robinson L (1997). *Primary health care in Cuba: Low and high technology developments pertinent to family medicine*. Division of Community Medicine, University of New Mexico, Family Practice Center. *Journal of Family Practice*. 45(3):250-8, 1999 Sep.
- Wilson, P.(1999). Cuban doctors limitations. *Business Day*, 20 Nov.1999
- Velázquez, A. (2001). *The lack of doctors in Mozambique*. Agencia de información Nacional (AIM)16/6/96. Available www.geocities.com/Paris/1661/aim20.html
- Velázquez, A. (1999) *El presidente de Gambia Yanya Jammeh recibió a médicos cubanos*. Vida, edición digital sobre la cooperación médica cubana. Agencia de información Nacional (AIM). Available <http://www.ain.cubaweb.cu>

APPENDIX 1:

Semi-structured interview guide: Cuban doctors

Explain purpose and confidentiality of interview

Interviewee details:

Group (1st, 2nd, 3rd, 4th):

How long have you been in SA?

How many institutions have you worked since you come to SA? Describe.

How many positions have you held since at each facility?

Besides your clinical work, have you execute other responsibilities?(managerial, academic, research, etc.)

What exactly is your speciality, post and job description currently?

Please describe your overall role, functions and responsibilities

Clinical (clinic, CHC, outreach, old age home, medico legal/court, prison)

Teaching/Academic

Managerial

Others)



RECRUITMENT IN CUBA

What was your rank, position and job in Cuba?

How did you hear about the recruitment of Doctors for South Africa?

How did you apply? Describe process

Were you examined by Cuban Provincial Authorities?

Were you examined by Cuban National Authorities?

Were you interviewed by the SAMDC/HPCSA in Cuba?

Describe your examination experience.

Where/how did you learn English? Classify your knowledge at that time.

How were you informed on the results, how long it took?

Did you sign a contract in Cuba?

When you signed the contract in Cuba, did you agree with the contractual conditions?

How long it took for you to come to SA after the examination?

Did you come on your own, without the family?

INDUCTION

Have you received any type of induction in Cuba on the South African history, society and health systems?

Describe your arrival at JHB Airport.

How was the induction at provincial level?. Describe.

How was your induction at district level. Describe

Have you got a place to stay right from the beginning? Describe

If yes, have you got the essentials in the house to live decently?
If not, describe.

Have you got transport to go to work and come back from home?
Was transport efficient?

How were you doing your personal activities (e.g. shopping)

Describe your arrival at your clinic/hospital.

Were you introduced to the District Health System in your area?

Were you officially explained on referral systems (e.g. how the system works, referral letters, phoning to referral points,etc.)

Were you introduced to relevant stakeholders that your work will depend in one way of another?

Were you introduced to South African health policies?

Essential Drug List and SGT Guidelines?

If yes, were you explained that most were new policies?

And, why the implementation of these policies were important in the South African context?

Were you introduced to the TB Control policies guidelines?

Were you introduced to the STI control Programme policy?

And others?

Who played an important role in this period of induction? Why?

Have you always been in the same facility?

If not, explain why.

How many different facilities have you been?

Describe the process of induction at each facility

If you have been at different facilities, was it good or not for you? Explain.

How about the assistance from the Cuban part? Were they supportive to facilitate to resolve your problems?

Could they have done better?

Were you happy in that time (induction)?

If not, explain.

PEERS

Do you work with another doctors?

When you started, were you working with other doctors in the same facility?

How many?

Which nationalities?

Were they working at the same level/same responsibilities?

How was the relationship with these doctors, describe

Did you have clinical sessions or some type of meeting to discuss clinical cases?
Describe

If not, did you have any opportunity to raise your doubts?

If not, were you having working relationship with other Cuban doctors from other districts?

Was language a problem to communicate with your peers?

Did you feel respected by your peers at the beginning?

How is your relationship currently with your peers?

Do they respect you now?

Have you learn something from your peers?

Have you touch something to your peers?

Do you socialise with your colleagues?

Can you tell me one good thing from your peers?

Can you tell me one bad thing from your peers?

Did you feel that you were treated differently by your peers because you are a Cuban doctor? Describe

NURSING STAFF

How was the relationship with the nursing staff at the beginning?

Did you feel welcome by them?

Did they assist in your integration?

Did they assist with the language?

Were they resistant to your presence?

Were they resistant to your treatments?

Were they resistant to your approach (people's centred)?

Were they open to you or they went to the superiors?

Did you feel that you were treated differently by the nursing staff because you are a Cuban doctor? Describe

MANAGERS

Is and were your manager(s) a doctor or a nurse?

If it was a doctor, which nationality?

For how long was he/she heading the facility?

If is a nurse, for how long was she heading the facility?

Was he/she supportive?

Was she/he helping in your adaptation?

How often did you meet he/she?

Did you have special mechanisms to meet your manager or it happened haphazardly?

Were you collecting stats at your work monthly?

For which purpose?

Were you sharing the stats with your manager?

Was she/he aware/interested? Was she/her signing it?

How was the evolution of your relationship?

Are you socialising with your managers?

Was your manager resolving or helping to resolve your personal/individual problems?

OTHERS

Why did you come to South Africa?

Why are you still in South Africa?

Is it your family with you? Espouse, children, others

Are you leaving comfortably?

Do you have your own car?

Are your children at school?

Who pays for it?

Do you have health assurance? Describe

Have you been sick to use it?

If not, do you know other Cuban colleague that has benefit from it?

Were you or your colleague assisted at a public or private facility?
How was the service?

If you are severely sick do you prefer to stay here or go to Cuba?

Who pays for that?

If you or your family member pass away in SA, who pays for the return of the body?

Have you lost your job in Cuba?

Are you worried about your family in Cuba while you are here(e.g. education, health care, etc.)?



Do you smoke? Did you smoke before you come to SA?

Do you have contact with other Cuban colleagues in SA?

How will you describe the difference of working in other provinces?

Are you aware of the impact of your presence in SA? Describe.

Have you felt supported by community, churches, political parties members?

Have you assisted to any social event at a South African family (e.g. wedding)
How frequent?

Have you visited any home at the township where you work as a guest?

Do you feel integrated into the SA Health System?

Do you feel integrated into the medical community in SA?

Do you feel integrated in the South African Society?

Tell me one good thing that happened to you in your practice as a Dr in SA.

Tell me one bad thing that happened to you in your practice as a Dr in SA

What are the main criticisms that you have on the SA –Cuban collaboration Programme?

Give me three recommendations to improve the programme.

What advise will you give to Cubans that will be coming to SA to work as Drs?



APPENDIX 2:

Semi-structured interview guide: Cuban doctors' peers

Explain purpose and confidentiality of interview

Interviewee details:

Years of experience:

Work only for the public sector and private sector.

Please describe your overall role, functions and responsibilities in the public sector

Are you South African?

If not, how long have you been in SA?

Was it difficult to adapt your school of Medicine in SA?

Have you worked with doctors of other nationalities?
Describe your experiences.



How long have you been working with a Cuban Dr.?

Did you have some knowledge of the Cuban Health System before?

Can you describe your perceptions of Cuban Drs before you met them?

Did you feel that Cubans had better employment conditions than you?

Do you think that language was/is a limiting factor for Cuban Drs ?
If yes: in relation to patients or for communicating with the rest of the system?

Have you noticed differences in the management of conditions?

Have you noticed differences in the management of patients?

Did you found them easy to adapt to the South African situation?

In your opinion, what is your view on what patients think of the Cuban Drs?

Have you taught them something?
If yes, were they receptive to your input?

Have u learnt something from them?

Did you have clinical sessions or some type of meeting to discuss clinical cases?

Are you aware that Cubans are gathering stats?

Do you discuss stats with them?

How will you describe your relationship with the Cuban (s)?

Are you socialising with them?

Do you think that Cubans are doing a good job?

Do you know how many Cubans are in the country?

Do you think that the presence of Cubans in SA have shown good results in the health system?

Do you think that SA will depend of Cubans for many years? Can SA stop the Cuban programme now?



APPENDIX 3:

Questionario para los medicos cubanos que trabajaron en Gauteng

Este estudio es para la Tesis de la Maestria en Salud Publica de la Dra Carmen Baez y es una evaluacion del Programa de Colaboracion Cubana en Sudafrica, Provincia de Gauteng. Es un compromiso profesional e etico resguardar TODOS la confidencialidad posible dentro de las limitaciones logicas que este medio es expuesto(que son ajenas a la autora)

Fecha de graduacion: _____

Grupo de medicos al que UD pertenecio (1st, 2nd, 3rd, 4th):

Cuanto tiempo estuvo en Sudafrica? _____ anos

En cuantas instituciones trabajo durante su estadia en Sudafrica? Describa.

Describa su especialidad y cargo

Ocupo algun cargo aparte de sus funciones clinicas? Si -No

Si positivo, describa que cargo ocupo.

Aparte de sus tareas clinica en su institucion, tuvo que ejercer otras funciones?
Clinica (clinic, how many clinics, CHC, outreach, old age home, medico legal/court,
prison) _____

___ Un
policlinico _____

Dos o mas policlinico.Describa.

Otra (outreach, old age home, medico legal/court, prison)_____

Ensenanza/Docencia_____

Gestion _____

Investigacion_____

Otras _____

SELECCION EN CUBA

Cual era su posicion, jerarquia y /o trabajo en Cuba antes de ir para Sudafrica?

Como se entero de que se estaban buscando medicos para Sudafrica?



Como Ud se presento? Describa.

Fue examinado por las autoridades provinciales?

Fue examinado por las autoridades nacionales?

Fue examinado en Cuba por las autoridades del Consejo Medico Sudafricano?

Describe su experiencia.
Donde aprendió inglés?

Como clasificaria su nivel de inglés en aquellos momentos? Excelente-bueno-regular-malo?

Cuanto tiempo llevo para recibir la respuesta?

Firmo Ud un contrato antes de salir?

Estaba Ud de acuerdo con las condiciones en su contrato?



Cuanto tiempo le llevo para salir para Sudafrica despues del examen?

Fue a Sudafrica solo/a, sin su familia?Did you come on your own, without the family?

INDUCCION

Recibio algun tipo de preparacion en Cuba sobre la historia, sociedad y sistema de salud sudafricanos?

Como fue su llegada a Sudafrica? Tenia mucha gente esperandolo en el aeropuerto?

Otros _____

Quien fue que jugo un papel importante en estse periodo de adaptacion?

En relacion a la colaboracion cubana, en este periodo, jugaron un papel importante?
—

Podrian haberlo hecho mejor?

Como UD se sentia en este periodo al inicio en Sudafrica?

PEERS



Trabajo con otros medicos?
—

Cuantos?

—

De que nacionalidades?

Tenia ellos las mismas tareas/responsibilidades que UD?

Tenis Ud con ellos una buena relacion?
—

Tenian sesiones/reunions clinicas para discutirs casos? Con que frecuencia?

—

Fue el idioma una barrera para comunicarse con sus colegas?

Se sintio respetado desde el principio por sus colegas?

Como evoluciono su relacion con ellos?

Lo respetaban cuando deajo Sudafrica?

Aprendio algo de ellos?

Cree que ellos aprendieron algo de UD?



Socialiso con sus colegas?

Mencione un elemento positivo y un negative sobre sus colegas.

Positivo__

Negativo:_____

ENFERMERAS

Describa su relacion con las enfermeras desde al principio.

___ Se sintio bienvenida por ellas?

Lo/a ayudaron para integrarse?

Lo/a ayudaron con el idioma?

Noto algun tipo de resistencia?

Se resistieron a sus conductas /tratamientos?

Y a su abordaje con los pacientes? Pensaban que Ud se atrasaba mucho con cada paciente? Si positivo, explique como lo resolvió.



Si hubo problemas lo discutieron con Ud.. o se dirigieron directamente a sus superiores?

Piensa que lo trataban diferente porque es cubano/a?

JEFES/DIRECTORES

Is and were your manager(s) a doctor or a nurse?

If it was a doctor, which nationality?

For how long was he/she heading the facility?

If is a nurse, for how long was she heading the facility?

Was he/she supportive?

Was she/he helping in your adaptation?

How often did you meet he/she?

Did you have special mechanisms to meet your manager or it happened haphazardly?

Were you collecting stats at your work monthly?

For which purpose?

Were you sharing the stats with your manager?

Was she/he aware/interested? Was she/her signing it?

How was the evolution of your relationship?

Are you socialising with your managers?

Was your manager resolving or helping to resolve your personal/individual problems?



OTHERS

Why did you come to South Africa?

Why are you still in South Africa?

Is it your family with you? Espouse, children,others

Are you leaving comfortably?

Do you have your own car?

Are your children at school?

Who pays for it?

Do you have health assurance? Describe

Have you been sick to use it?

If not, do you know other Cuban colleague that has benefit from it?

Were you or your colleague assisted at a public or private facility?
How was the service?

If you are severely sick do you prefer to stay here or go to Cuba?

Who pays for that?

If you or your family member pass away in SA, who pays for the return of the body?

Have you lost your job in Cuba?

Are you worried about your family in Cuba while you are here(e.g. education, health care, etc.)?

Do you smoke? Did you smoke before you come to SA?

Do you have contact with other Cuban colleagues in SA?

How will you describe the difference of working in other provinces?

Are you aware of the impact of your presence in SA? Describe.

Have you felt supported by community, churches, political parties members?

Have you assisted to any social event at a South African family (e.g. wedding)
How frequent?

Have you visited any home at the township where you work as a guest?

Do you feel integrated into the SA Health System?

Do you feel integrated into the medical community in SA?

Do you feel integrated in the South African Society?

Tell me one good thing that happened to you in your practice as a Dr in SA.

Tell me one bad thing that happened to you in your practice as a Dr in SA

What are the main criticisms that you have on the SA –Cuban collaboration Programme?

Give me three recommendations to improve the programme.

What advise will you give to Cubans that will be coming to SA to work as Drs?

APPENDIX 4:

Semi-structured interview guide: Cuban doctors' managers

Explain purpose and confidentiality of interview

Interviewee details:

Do you work only for the public sector?

Since when are you managing this facility/hospital:

Please describe your overall role, functions and responsibilities.

Are you South African?

If not, how long have you been in SA?

Have you worked with doctors of other nationalities before?

Describe your experiences.

How many Drs are reporting to you?



Do you have mechanisms to discuss issues with the Drs under you? How frequent?

How long have you been the manager of a Cuban Dr.?

Did you have some knowledge of the Cuban Health System before?

Can you describe your perceptions of Cuban Drs before you met them?

Do you find them difficult or easy to work with/manage?

Do you find them disciplined?

Have Cubans help you to fill gaps that otherwise would have made it difficult to deliver services?

Do you find them dedicated, prepared for “sacrifices”?

Did you feel that Cubans had better employment conditions than other Drs?

Do you think that language was/is a limiting factor for Cuban Drs ?

If yes: in relation to patients or for communicating with the rest of the system?

Do you find them professional in their work?

Have you noticed differences in the management of conditions?

Have you noticed differences in the management of patients?

Did you find them easy to adapt to the South African situation?

What is your view on what patients think of the Cuban Drs?

Have you taught them something?

If yes, were they receptive to your input?

Have you learnt something from them?

Did you have clinical sessions or some type of meeting to discuss clinical cases?

Are you aware that Cubans are gathering stats?

Do you discuss/sign their stats?

How will you describe your relationship with the Cuban (s)?

Are you socialising with them?

Do you know how many Cubans are in the country?

Do you think that Cubans are doing a good job?

Do you think that the presence of Cubans in SA have shown good results in the health system?

Do you think that SA will depend on Cubans for many years? Can SA stop the Cuban programme now?



**APPENDIX 5:
Deployment of Cuban doctors in Gauteng**

Doctor	Speciality	Metro/Region	Clinic/CHC	Old age home	Other	Emergency
1	Family Medicine	Johannesburg	Hillbrow CHC			Hillbrow CHC
2	Family Medicine	Johannesburg	Shiawelo			Lilian Ngoyi CHC
3	Family Medicine	Tshwane	Pyramid Littleton clinic	2	Out reach HBC	
4	Family Medicine	Ekhuruleni	Tsakane Nokhutele clinic Calcot clinic A. Raditselane cl. Kingsway clinic			Nokuthela Ngweya
5	Family Medicine	Ekhuruleni	Khwathema cl. Thembelische cl. Sanel Geduld cl. Sanel Dagafontein cl. Vitanova Center	2		Nokuthela Ngweya
6	Family Medicine	Ekhuruleni	Jabulani Demai Vooslorus			Pholosong
7	Family Medicine	West Rand	Khutsong			Cartonville
8	Family Medicine	West Rand	Mohlakeng Ext 12 Toekomrus cl.			Leratong
9	Family Medicine	Wes Rand	Maki Legkete Ext 12			Leratong
10	Family Medicine	Vaal	Johan Heynes		Regional Office	Johan Heynes
11	Family Medicine	Vaal	Heidelberg cl. Ratanda cl. Devon cl.			Heidelberg
12	Family Medicine	Vaal	Nevai Mbatha			Johan Heynes
13	Family Medicine	Vaal	Empilisweni Zone 7			Johan Heynes
14	Surgeon	Vaal				Sebokeng
15	Physician	Vaal				Sebokeng

APPENDIX 6: Letter to Gauteng Health Department

190 Frances Street
Observatory
Johannesburg
2198

30 May 2004

Dr L. Rispel
Head of Department
of Health
Gauteng

Re: Request for authorisation to assess the Cuban Health Collaboration Programme
in Gauteng

Dear Dr Rispel,

I am currently finalising my Masters in Public Health at UWC and I have chosen as the topic for my mini-thesis an assessment of the Cuban Health Collaboration in Gauteng.

The intention is that my contribution with this piece of research will be to pilot a set of instruments and a methodology for a future national study, about which we have had a preliminary discussion with the National Department of Health and the Cuban Collaboration authorities in South Africa.

The aims and objectives of the study are as follows:

AIMS

- To identify the limitations and constraints, as well as examples of good practice, of the Cuban Health Programme in Gauteng
- To give feedback and recommendations for action to the National and Gauteng Provincial Departments of Health, as well as to other relevant stakeholders, based on the findings of the study, to inform the development of collaborative strategies to optimise the management and impact of the Programme.

OBJECTIVES

- To describe the recruitment process and criteria for selection of Cuban doctors by the Cuban health authorities and Health Professions Council of South Africa.
- To describe and evaluate the induction, conditions of work and introduction to stakeholders of Cuban doctors.
- To document the experiences of Cuban doctors working in the peri-urban and urban areas of the Gauteng province, at different levels of care, with a specific focus on both constraints to as well as good practice in health care.
- To assess the views of peers and health managers who have worked with the Cuban doctors from both the professional and the human relationship points of view.
- To generate recommendations for actions to improve and optimise the programme in South Africa in order to be maximally beneficial to all parties involved.

I view of the fact that my research will contribute to the assessment of the Cuban Collaboration Programme in your province, I would like your approval and support for the project.

Yours sincerely,

Carmen Baez



Dr Carmen Báez

Note: Please receive a copy of the study's protocol.

cc: Dr Likibi
Dr Jorge Delgado Bustillo