COALITION FORMED IN THE NORTH-EAST U.S.A. TO SUPPORT FIGHT AGAINST APARTHEID

The North-east Coalition for the Liberation of Southern Africa (NECLSA) was formed on December 10,1977 after a demonstration opposing Amherst colleges *financial* support of apartheid.At the meeting, representatives of thirteen schools and six national organizations decided to call for a North-east regional conference on Southern Africa.A steering committee was formed representing each campus,and national anti-apartheid organisations.Other supportive political groups also have one membership and voting rights in the coalition. The purpose of the conference was to bring together the many different groups working against apartheid in order to share experience, and plan for coordinated activities.

A weekend long conference was organised at Yale (from March 31-April 2,1978).Over 400 registered participants representing 48 schools from as far away as UCLA*(African Activist Association representative)*; and large number of local and national organisations.The conference plenary session voted to continue the steering committee on the same basis and adopted *a statement of purpose and an analysis of foreign policy*. UFAHAMU will bring you more details of NECLSA and other anti-apartheid groups in the US in the forthcoming issue (Vol 8 No 3) dedicated to Steve Biko and the *political prisoners* who have died or are still in the jails of Southern Africa.

On the dav the conference was ending,*The New York Times* April 2,1978 had an Editorial appropriately titled HEADING FOR THE EXIT IN SOUTH AFRICA where they finally admitted:

> *The campuses are astir again and the issue is South Africa.Students and teachers want to attack the nation's racist policies through the power of American corporations doing business there.The protestors are asking universities to use their influence as stock-holders to force the corporations to reduce or abandon operations in South Africa.That failing,they want the universities to sell the stock.Similar demands have come from church groups, foundations and major pension funds whose portfolios include the shares of the many of the 350 corporations with investments in South Africa worth $1.7 billion.....*

THE ROLE OF HEALTH CARE IN SOCIALIST REVOLUTIONS: MOZAMBIQUE AND CUBA

by

Phyllis Safiya Gabriel and Susan M. Stuart

> . . . *For ourselves and for humanity, we must turn over a new leaf, we must work out new concepts and try to set a foot a new man (sic).* (F. Fanon, *The Wretched of the Earth*, 1967.)
>
> *Comrades, either the lice destroy socialism, or socialism destroys the lice* (Lenin, 1917).

In the existing literature on the political economy of health care, there is a significant lack of information and analysis on socialist health care systems. The focus of this paper will be on the nature and dynamics of health care under socialism as well as its revolutionary role in a society undergoing a socialist transformation. First, a theoretical framework of the dynamics of health care under socialism will be presented. This will be followed by an examination of the health care sectors of two socialist Third World countries: Mozambique and Cuba. The purpose of the case studies is to illustrate how a society undergoing socialist change practically incorporates the ideology of a socialist health care system.

I. THEORETICAL FRAMEWORK

In order to completely understand the dynamics of any health care system, it is important to analyze it in relation to the larger political, economic and social dimensions of a country. The health care system generates its own dynamics which make it unique and distinct from other institutions within society. However, there is a symbiotic as well as a dialectical relationship between a health care system and the overall forces that determine a society. Vicente Navarro, in his book, *Medicine under Capitalism*, and in other publications, is one of the few individuals who has written extensively on the relationship between the health care system and the society. Throughout his analysis, Navarro maintains that medicine is not autonomous from society. He views the overall system of health care to be the dialectical result of forces that

exist both outside and within medicine.[1]

Because of this relationship between health care and the society, it is clear that the nature and dynamics of health care systems in socialist countries are different from those in capitalist countries. Unfortunately, the recent popular literature in the medical field has generally failed to understand these distinctions. Consequently, the social-democratic reforms in the health care sectors of Western Europe and Canada are often wrongly identified as socialist.

Non-Neutrality of the State and the Health Sector

The state is not an ideologically neutral entity.[2] In capitalist societies it represents the bourgeois' class priority for private property and capital accumulation, and the attending norms and values. The health care sector mirrors this particular ideology. Frantz Fanon, writing about the role of psychiatry in Algeria, rejected the notion of "neutral" psychiatry. He emphasized the role the psychiatrist plays in disseminating the norms and values of society.[3] In a larger perspective, the ideology of the capitalist state is manifested in the health sector through the following: the emphasis on curative versus preventive medicine; the individual blame for sickness and disease; the financing patterns; the importance of the private sector; the priorities given in research and the allocation of resources; and the class, racial and sexual hierarchy of the health labor force.

The notion of the non-neutrality of the health sector is usually not recognized by capitalist ideologues. Health care is seen as a social institution only there to provide a service for the population. On the other hand, the non-neutrality of the health sector is immediately acknowledged by socialist societies. This is evidenced in the importance the socialist countries have given to the health labor force in disseminating political ideology. In China, for example, an important criterion in the selection of barefoot doctors and candidates for medical school has been the prospective candidate's ideological strengths. One sees throughout socialist societies the importance of ideology in the medical school curriculum. Courses on political economy and the conditions of the working classes and the peasants are an integral aspect of their studies. In socialist revolutions, the health sector has often been considered the major sector of society that will gain support for the revolution. The re-organization of the health care system has also been used as a strategy to break old class hierarchical structures not only inside but outside the health sector.

In a socialist transformation the ideological premises are such that the society must re-examine the forces that have traditionally determined the hierarchical structures of the health labor force, the accessibility to health care, the admissions to medical school, and the authoritarian nature of medical education and services. This re-examination and ultimate re-organization of all levels of the health system is a dialectical process influenced by outside events and then by those events generated from within. For example, after reviewing the literature on the development of the present day health care system in a select number of socialist countries, it became clear that each country underwent ideological struggles within their own ranks on how to most effectively meet the health needs of their populations. These conflicts also reflect the events occurring in the larger society. The ideological conflicts in the larger society were manifested in the course of action the government pursued in re-organizing the health system. In China, the struggle between the importance of technology versus political ideology in the training and supervision of health personnel is well-known in the international health field. In the Soviet Union, the hub of ideological struggle has revolved around a centralized versus a more decentralized pyramidal health care structure. In recent years, the Soviet Union has sought to decentralize this structure and actively extend more services to the rural areas.

Class, Racial and Sexual Characteristics of the Health Sector

In a socialist society, the reassessment of the political, social and economic forces that determine the functioning and organizational structure of the health care system is manifested in the high priority given to the elimination of class, racial and sexual barriers. In capitalist societies these barriers are manifested in a number of ways. Depending on the country's economic development and the extent of social legislation, these barriers are more acute in some social settings than in others. However, in all capitalist societies, the distribution of functions and responsibilities within the health labor force follows class, sex, racial and ethnic lines.[4]* For example, in the United States, physicians tend to be white upper-middle class males. Nurses are usually from the working and middle classes and are almost all females. Within the nursing structure a large percentage of licensed vocational nurses

* Racial and ethnic barriers have become more pronounced in recent years in several Western European countries where immigrants from Turkey, Greece, Italy and the Middle East are now altering the former ethnic homogeneity of these countries.

(LVNs) are black females while the more skilled registered nurses (RNs) are predominantly white. Auxiliary and service personnel are primarily females, often black, from the lower and working classes.[5] These barriers are also manifested in the rigid professional restraints that exist between all the various levels of health care personnel. There is a minimum amount of mobility and egalitarian interaction between the different categories of health workers. For example, rarely do nurses become physicians, or serve in the higher levels of hospital administration or boards of insurance corporations. The Scandinavian countries are the noted exceptions, where nurses are given priority in medical school admissions. In addition to the above, the availability of good medical services usually follows class, racial, and to a certain extent, sexual lines. This is particularly graphic in the non-socialist Third World countries where health facilities and personnel serve primarily the elite of the population and where social welfare legislation is often non-existent.

Examination of socialist health care systems reveals that medical education is no longer a privilege for the few. In addition, socialist countries have actively pursued a policy that will eventually eradicate the professional restraints between the different levels of health care personnel. For example, in the Soviet Union all health workers are in one trade union rather than individual unions each representing their own professional interest. This has been coupled with a non-authoritarian approach to medical education as well as the dispensing of medical services.

The process of eradicating professional hierarchical barriers is difficult. Physicians, in particular, are often still the highest paid health workers and are given special amenities in terms of housing and other commodities. They often have a dominating role in the decision-making processes of the health system because of their technical and highly necessary expertise. This overconcentration of their input has helped to maintain traditional elite attitudes regarding physicians. Special preferences given to the physician were often deliberate in order to encourage more and more individuals to go to medical school. The historical reality of all socialist countries has been one of a shortage and maldistribution of physicians. Furthermore, as previously noted, physicians served primarily the upper-classes. So, in part, this policy attempted to break the old class barriers to medical education, encourage more people to become physicians, and have a larger force of physicians providing care to the entire country.

Today, in most socialist countries women are visible in all levels of the health care system. In the Soviet Union, for

example, it is well known that 75 percent of all physicians are females. They participate in the highest decision-making bodies of the health system, as well as hold the more prestigious positions in the universities and research institutes.[6] Women in socialist countries are no longer primarily relegated to a paraprofessional or auxilery level of health work as in most developing and advanced capitalist countries. This is not to say that women do not participate in the paraprofessional modes of health services, only that they are now more fully integrated in all sectors of the health labor force. Nor are health services, whether they are provided by a physician, dentist or paraprofessional, viewed as women's work. The socialist nations today are not all at the same stage of development in terms of eradicating these barriers in the health care system. As their societies progress, the forces that cause racial and ethnic discrimination, sexism and class hierarchy will be eliminated.

Planning and Organization of Services, and Delivery of Care

The ideology which validates and perpetuates the way in which health care is delivered and organized under capitalism places the burden of responsibility for health on the individual rather than on the society at large. This can be seen most clearly in the non-socialist countries of the developing world and in the United States. However, even in advanced capitalist nations, where private practice has been limited greatly by national health insurance or by a national health service, the ideology of capitalism permeates the education of the personnel, the modes of treatment, the areas of research, and the organization of services.

Some of the characteristics of health care in capitalist societies are the following: a lack of centralized planning, which results in fragmentation and duplication of services; an over-emphasis on curative medicine and the neglect of preventive medicine; an over-concentration of health care delivery in hospitals to the detriment of neighborhood clinics; the neglect of environmental and occupational causes of illnesses; an increasing emphasis on specialties in medicine; the irrational use of technology; poor personnal distribution; a shortage of middle-level health workers and general practice physicians; an absence of team approaches to health delivery; low levels of consumer or community participation in planning; and the growth of intermediate, profit-making industries such as insurance, drug, medical equipment and building-supply companies. Again, in the more advanced capitalist nations with strong social welfare systems some of these characteristics have been attenuated. In the developing world, on the other hand, the situation is the

most extreme, and for this reason is much less contradictory.

The major health problems of the non-industrialized world are the result of poor sanitation and malnutrition; in other words, they are environmentally induced. The disease picture is much like that of the industrialized nations prior to the early part of this century. Infectious diseases rather than chronic illness claim most of the lives, resulting in very high infant mortality rates and short life spans. The difference between the developing nations in the 1970s and the industrialized nations in the early part of this century is that the latter experienced sufficient economic growth to solve much of the problems of sanitation and malnutrition. The developing world has not historically experienced the same type of economic growth due to colonialism and imperialism.

Considering the disease patterns of the developing world, the curative, hospital-based model of health delivery which has been adopted throughout these regions appears even more irrational than in the industrialized nations from which it has been exported. There are several reasons why developing nations have an over-concentrated capital in curative and hospital services while neglecting environmental and preventive services. First of all, the elite of these countries have been greatly influenced by the technology and ideology of the Western capitalist nations. Secondly, this model of health delivery is better suited to treating the illnesses of the more affluent urban-dwelling population. And finally, this type of health care is more profitable than preventive and ambulatory care which are less easily commodified, and, by definition, are usually much more decentralized.

A preventive approach to health problems is commonly discussed among public health circles as if it were the panacea to the world's health problems; however, the definition of prevention stops short of discussing socioeconomic problems. It is fine and good to talk of the necessity of instituting preventive measures such as sewage treatment, health and nutrition education, and vaccination campaigns; however, any attempt to set up such programs on a systematic basis requires a unified, and equitable health care system and an ideological approach which focuses on collective actions to improve health rather than individual ones. And finally, a real prevention cannot occur unless the root causes of malnutrition and poor environmental conditions are attacked. For example, nutrition education does little good if a society is dependent on a market economy and the people have no money. This is why even basic public health measures which by themselves do not appear socialist or radical cannot be carried out in the Third World unless the society undergoes basic structural changes. It should not be surprising that one of the first shifts in

emphasis in new socialist nations is away from the urban-based, curative pattern toward the decentralized preventive and ambulatory care model.

Before such a shift can take place in the delivery of health care, however, socialist societies must centralize planning and reorganize and consolidate their health services. Once a national planning mechanism and a centralized administrative structure is established the redistribution of resources can begin. An aspect of the consolidation of services into one national organization is the elimination of private, profit-making institutions, including hospitals, clinics, individual private practices, and insurance, drug, and medical equipment companies. Because health care is no longer seen as a commodity, but as the social responsibility of the society, all services will eventually be provided without charge, and all health personnel will be salaried employees of the ministry of health.

Once the health care system has undergone reorganization and centralization, it must begin a new process of decentralization of services in order to correct the problems of maldistribution. Throughout the developing world the most glaring health care shortages are in the rural areas. The attempts to rectify this situation are predictably difficult because of the need to relocate personnel in the countryside. Various types of moral and economic incentives and disincentives are commonly applied in socialist countries. The relocation of medical personnel is made difficult not only because of the resistance to moving away from the cultural and social life of the cities, but also because the medical profession will have been educated to practice curative, hospital-based medicine. The greatest amount of prestige has been traditionally accrued in the specialties and in the teaching hospitals of the cities.

Probably the most dramatic and well-known example of a socialist government's attempts to correct the problems of urban-rural health distribution is that of China. In 1965, the situation was still so bad that Mao Tse Tung reprimanded the ministry of health with the following words:

> *Tell the Ministry of Public Health that it only works for 15 percent of the entire population... The broad ranks of the peasants cannot obtain medical treatment... The Public Health Ministry is not a people's ministry. It should be called the Urban Public Health Ministry or, the Public Health Ministry of the privileged or even, the Urban Public Health Ministry of the privileged... A vast amount of manpower (sic) and materials have*

> *been diverted from mass work and are being expended in carrying our research on the high-level, complex, and difficult diseases, the so-called pinnacles of medicine. As for the frequently occurring illnesses, we pay no heed or very slight heed to their prevention or to finding improved methods of treatment. It is not that we should ignore the pinnacles. It is only that we should devote less men (sic) and materials in that direction...*[7]

Although Mao's directive was followed by massive transfers of urban medical personnel and by revisions of the medical school curriculum which combined theoretical study with practice in the communes, the major innovation was the training of a totally new type of personnel -- the "barefoot doctor."

Most socialist countries in the developing world rely heavily on paramedical personnel in their efforts to bring about urban-rural equalization. However, the degree to which this type of approach is followed depends on the size of the rural population and the amount of resources available to the Ministry of Public Health. It also depends on the degree to which highly specialized and capital intensive medicine is equated with superior health care. It is understandable that the employment of paramedical personnel and simple technology is automatically seen as inferior medicine by many in the Third World since it is also predominant in the ideology of the industrialized nations. What may be the best solution to a problem for medical, as well as social, cultural and economic reasons, may also be considered inferior care simply because it is not the care that has traditionally been associated with the upper classes.

Since by definition all developing countries face great economic difficulties, two of the most complicated and contradictory decisions facing the new socialist ministries of health will be those of how many paramedical personnel and how much tchnology to utilize. As class lines begin to dissolve and as the imbalance between urban and rural services begins to be rectified, these questions will be dealt with in an increasingly objective way because economic variables will be less important and the decision can be based on the most appropriate personnel and technology for the situation. In the early stages, however, the decisions are more problematic because a certain type of care continues to be associated with a higher class position because of the legacy of capitalism.

As was mentioned above, a key part of the decentraliza-

tion of services is the establishment of a network of neighborhood, ambulatory care clinics. These clinics provide sick care for illnesses which do not require hospitalization or complex diagnoses as well as preventive care for the population of the surrounding area. Neighborhood health centers are not only a logical way to treat most illnesses; they also allow for more community participation in decision-making because of their accessibility. The exact form that these clinics take are again determined by the needs of individual countries. In some socialist countries a series of new clinics is also set up in factories, as well as in neighborhoods, as part of a new emphasis on occupational health.

Another concept which is central to most socialist health care systems is that of the health team. The health team replaces the rigid hierarchical organization of personnel by shifting the responsibility for the patient's health to a team of persons which may include a general practitioner, a public health nurse, a dentist, a sanitation expert, a nutritionist, as well as other types of health workers. Members of the health team share information with one another in order to eliminate fragmentation and duplication. The particular make-up of the health team (e.g., the number of specialists it includes) will vary depending on the situation.

Another area which is undergoing drastic change in socialist societies is medical research. It is common to find that socialist countries put money into applied research that helps to solve their most immediate health problems. Research that benefits only a small percentage of the population is discouraged since it represents a misallocation of valuable resources. This reduction of highly specialized, esoteric research, also contributes to the elimination of hierarchical boundaries between health workers as well as to the demystification of the role of the medical scientists.

II. CASE STUDIES

Mozambique and Cuba have been selected to illustrate the dynamics of health sectors under socialism as well as to provide examples of the revolutionary potential of health care delivery in the transformation of societies. Each country represents a different phase in the development of a Third World socialist society. In each case the dialectical forces existing outside the health sector has enormous impact within this sector. As each society consolidates and strengthens its socialist structures, the dialectical processes within the health sectir become more pronounced. Cuba illustrates a socialist society which inherited a relatively developed health care sys-

tem at the time of its revolution. Therefore, a discussion of Cuban health care necessitates focusing heavily on the internal dynamics of the system. Nearly 20 years have passed since the victory of the 26th of July Movement in Cuba, while in Mozambique FRELIMO forces have only been in power for three years on June 25, 1978. Because each country is at a different stage in the revolutionary process, we are able to focus on the role of health care during very different phases of the transformation to socialism. This is not to say that each country goes through exactly the same dialectical process; the stages that a society undergoes will be determined not only by the ideology of the leadership but also by the historical and cultural conditions and the intervention of outside forces. In the case of Mozambique the emphasis will be on the role that health care plays during the time of the actual physical struggle, while in Cuba we will examine the role that health care plays once the fighting has ceased and the buildings of the new society has begun.

The revolutionary struggle in Mozambique which brought FRELIMO to power was twofold in nature: it was a national independence struggle against direct colonial domination by the Portuguese, and a struggle for a socialist restructuring of the society. Samora Machel, FRELIMO leader and President of present-day Mozambique, has said: "There is no real independence without revolution and no revolution with socialism."[8] Although the leadership of Cuba undoubtedly shares these sentiments today, the revolution was not fought in the name of socialism.

In Cuba, the national independence had been won from Spain in 1895. The revolution of 1959 was fought in the name of overthrowing the corrupt Batista regime which was dominated by U.S. corporate interests. Although the July 26th movement which spearheaded the revolt was committed to democratic and anti-imperialist principles and a program of revolutionary change which included land reform, universal free education and diversification of the economy, it did not call itself socialist or communist. Not until 1961 did Fidel Castro make the public pronouncement that he was a Marxist-Leninist and that Cuba was on a road to socialism.

The guerilla struggles in Cuba and Mozambique both owed their success to an ability to gain the support of the rural peasantry. While the actual fighting lasted for only about two years in Cuba, a more protracted struggle was waged in Mozambique. FRELIMO was created in 1962 and the war for independence continued until the victory in 1975. Because Mozambique experienced such a long period of armed struggle in comparison to Cuba, the social and economic structure of the society was much more uprooted. At the same time, Mozambique had been much less developed economically. This meant that in relation to Cuba,

Mozambique's health infrastructure was virtually non-existent. For example, at the time of independence, Mozambique had 83 physicians for a population of 10 million, whereas Cuba had approxiamtely 6,500 physicians for a population of 6,500,000.[9] Although this ratio did not mean that there was an equal distribution of one physician for every 1,000 persons in Cuba, in comparison to Mozambique it is an indication of a vast difference in existing health personnel and facilities. Due to this underdevelopment of the health sector and to geographical factors, the health conditions as reflected in the patterns and types of diseases were much worse in Mozambique. Finally, a factor that these two countries have in common and that has made their struggles to build a new society more difficult, has been the aggression of hostile neighbors: the U.S. in the case of Cuba, and South Africa and the NATO powers who supplied armaments to Portugal in the case of Mozambique.

Mozambique

> *On the health front it is our medical personnel who are our operational forces. They are vanguard forces in our movement in our Revolution.* (Samora Machel. *Mozambique Revolution*, no.58, 1974, p.16.)

There has been abundant empirical evidence to support the concept that the health care sector has an active role in a country's struggle for social change. All revolutionary leaders from Lenin, Mao, Fidel Castro, Amilcar Cabral to Samora Machel have acknowledged the crucial role that this sector provides in not only the transforming of a society but in the actual struggle for socialist change and gaining support from the population.

Robert C. Hsu, in his insightful article, "The Political Economy of Rural Health Care in China," stated:

> *. . . In terms of its impact on the peasants, the new health care system has probably touched more souls, minds, as well as bodies, in the rural area than other institutional changes and thus affected most favorably the attitudes of the peasants toward the socialist leadership.*[10]

The following discussion will analyze how health care services and their providers became an important instrument for politicizing the population and gaining support for the national liberation movement in Mozambique. During this period of socialist transformation, the non-neutrality of the health sector will

be graphically illustrated. In addition, examples will be given of how Mozambique, through FRELIMO, sought to break with traditional class, racial and sexual barriers in the health sector.

A brief historical description of health care during the colonial era in Mozambique is necessary. Historically, the delivery of all types of health care, from sanitation and immunization campaigns to specific dental, maternal and child health services, was extremely inadequate. Furthermore, the level of development of the existing health care infrastructure was low and characterized by disorganization, fragmentation of services, and overconcentration of facilities and personnel in the urban areas. Modern health care services in the rural areas were virtually non-existent. For example, a year before independence there were approximately 550 Portuguese doctors in Mozambique, almost all working in private practice in the capital city of Lourenco Marques (now Maputo). The major hospital in Lourenco Marques received one-third of the government's total health budget and half the budget for pharmaceuticals.[11] As may be expected, the system functioned well for the Portuguese colonialists and a few African and Asian elites. In a revealing speech made in late 1975 to the World Health Organization delegates at the United Nations, the Mozambique Minister of Health described these conditions:

> *The existing health structure was divided into a larger number of small services and organizations, each with a greater or a lesser degree of autonomy, but each rivalling the other in a state of disarray.... Even in the three main cities there was a great imbalance between one government department and another... the city of Lourenco Marques where we have a neurosurgery centre with equipment that would be the envy of many an international centre, but where in a maternity ward women give birth on the cold and bare floor, where newly born children lie heaped up higgledy piggledy, where the rain leaks through, where three beds must make do for five parturients, and so on and so on...*[12]

Compounded by Portuguese colonial policy and 10 years of armed struggle, the state of the country at the time of independence in terms of health resources (e.g., personnel, facilities, equipment, drugs, etc.) and morbidity and morality patterns was deplorable. For example, there was only one radiologist in the entire country, and by May 1976 the number of doctors for the entire population had decreased to twenty.[13] In spite of the scarcity of recorded data on disease rates and patterns, it is generally recognized that the major health problems prior to independence were malaria, tuberculosis, bacterial and amebic

dysentary, bilharziosis, leprosy, measles and malnutrition.* These conditions were also exacerbated during the 10-year struggle by war wounds and their after-effects. However, during these 10 years a strong political commitment to the people had developed. In the liberated regions of the country, FRELIMO formed and organized cadres of health workers whose task was not only to provide care to the wounded and ill, but to heighten the political and social consciousness of the people. The healing of the "mind" as well as the body was emphasized. This was carried out almost entirely in the rural areas where over 95 per cent of the Mozambican people resided.

The development of a health care strategy designed to simultaneously politicize and deliver health care was a difficult process. It was hindered not only by a shortage of resources and the effects of enemy bombings, but also by ideological conflicts among the people. When the armed struggle was launched on September 25, 1964, the immediate concern of FRELIMO was maintaining the health of its fighters. As FRELIMO acquired control of territories, primarily in the north (Niassa and Cabo Delgado Provinces), a program to meet the most urgent health care needs of the population was designed. FRELIMO realized that the ultimate improvement of people's health existed in the larger society with the institutions that are integrated into the complex social, economic and political network. They initially established health centers for the training of paramedical personnel, e.g., public health promoters and auxiliary nurses.

Tanzania and Zambia had a crucial role in this development and implementation of health services in the liberated regions. In Tanzania, for example, centers were established for the training of FRELIMO health workers. In addition, a central hospital was founded in Tanzania which assisted the smaller, more modest health centers in the liberated zones.[14] In spite of outside assistance, FRELIMO was forced for three years (1968-1971) to suspend the training of new health care workers in the liberated zones.[15] It was during this period in particular that FRELIMO's forces and their supporters suffered great losses. Samora Machel has noted that during these years FRELIMO was not able to provide even a bare minimum of medical services.[16] It was also during this period that the "non-neutrality" of health care became most evident. For example, Machel attributes the lack of a socialist perspective on the part of many health workers for the collapse of health care to the people.[17] This situation was compounded by a depletion of already

*These conditions are still prevalent today in Mozambique. However, the government since independence has concentrated a large portion of its resources on eliminating these public health problems.

scarce medical resources and heavy artillery losses. The external dialectic forces in the overall society had tremendous impact even on delivering a minimum amount of health care. What emerged from these years, though, was a more concrete understanding of how health care (i.e., providers and services) are integrally related to the ideological perspective of the larger society. FRELIMO developed a clear recognition of the "politics of health."[18]

This was manifested in the following ways in the liberated regions of the country. Hospitals became the centers of actively incorporating the ideological perspective necessary for a socialist transformation. The FRELIMO hospital became the center of "national unity... revolutionary and organizational propaganda and a combat unit." As stated by Samora Machel, "In a FRELIMO hospital there are no tribes, no regions, no religious beliefs -- there is nothing to divide us."[19]

Elitism and authoritarianism in the health work force were actively discouraged. The workers formed "workers' councils" for every basic service in the hospital, e.g., pharmaceutical, laundry, and nurses. This was to ensure workers' input in problem solving and decision-making. Since independence, the formation of "workers' councils" is officially integrated into the labor policies of the country.[20] Access now to larger urban-based hospitals and technical assistance and supplies from various countries has made this policy crucial for eliminating traditional hierarchical and elitist barriers, because services and division of labor are more complex than in the FRELIMO hospitals of the liberated regions. As expected, the hospitals in the liberated regions were rudimentary and often merely thatched huts. Yet, this is an example of how the ideological transformation of the society began at a very simple level and is expanding to the entire country now that independence has been achieved. This is not to say that the transformation of a society or any one of its sectors takes place in a monolithic fashion or at the same rate.

Regarding specific providers in the health labor force, the position of doctors during this period is not clear. However, it can be speculated that the few physicians in the liberated regions were in favor of FRELIMO and its health strategy. In time of war traditional authoritarian patterns usually associated with the medical profession are often incompatible with the reality of the struggle; but, due to lack of data, an analysis of how physicians interacted with other levels of health workers and their role in the decision processes cannot be made.

Patients also became a part of this ideological process. Educating patients on health as well as political issues was

given high priority. Convalescing patients were encouraged to actively participate in some aspect of maintaining the hospital center, or were given training in order to become health education agents in their communities. This stems directly from the health education campaign carried out in all the liberated regions. Patients and all other FRELIMO organs--military bases, village committees, schools--participated in this campaign. All FRELIMO cadres became health educators. For example, school teachers accompanied by children would go into a village and instruct the people on prevention of infectious diseases.[21]

The training of health workers reflected FRELIMO's understanding of the "politics of health". Emphasis was placed on ideological perspective during the training period.[22] Awareness of class issues, the social and economic effects of capitalism, and the many traditional social and economic restrictions placed on women were brought to the fore. The role of women in the struggle and ultimately their role in a new society became important issues. During this time women integrated in the military struggle and participated in the various political, education and health campaigns.[23] However, an analysis of the power structure of FRELIMO and its decision-making bodies in terms of women's representation in this process, as well as an analysis of all the numerous issues that confront women daily is a subject for a future article.

Since all medical supplies and technology were scarce or non-existent in the liberated areas, it was not difficult to place importance on "ideological correctness" over technical expertise. This is not to say that the technical aspect of health training or care was ignored, but due to the effects of war and of colonial policy, technology was given a lower priority than ideology. Moreover, as witnessed earlier, an ideological perspective in line with FRELIMO's from the health workers was essential in order that they could be utilized as a means of gaining support for the struggle. Clearly, such support is crucial for the success of any cause and cannot be achieved only through material means. As in all socialist change, a combination of social and political education, concomitant with the improvement of economic conditions, have been important factors for a successful struggle.

The type of health worker trained during this period also illustrates the impact that ideology and lack of technology has on the development of health services. FRELIMO hospitals and health centers relied almost entirely on paramedical personnel. Meeting the basic needs of the people was essential, and, could be done by this level of health provider. There are a number of health care measures, both preventive and curative, that do not require a high level of medical expertise, i.e., immunization campaigns, education about simple sanitation, dress-

ing of wounds, and treatment of common ailments. As indicated, FRELIMO did not have the necessary resources to train a higher level of medical worker, such as physicians, radiologists, medical technologists and pharmacists. Consequently, the paramedical personnel who were trained became the primary providers of health care and transmitters of political ideology.

The experience gained by FRELIMO in providing health services in the liberated regions of Mozambique through the auxiliary health workers led to the creation after independence of a community health promoter.[24] The role of the community health promoter is similar to that of the "barefoot doctors" of China and to some degree the "feldshers" of the Soviet Union. The community health promoter is recruited from rural areas and receives four to six months of training to recognize and treat three or four of the most common diseases in Mozambique as well as provide information to the people about sanitation, nutrition and other health education issues. Once trained they are integrated back into their specific community.[25] These workers today are the key links between the rural areas and the larger health network of the country.

The FRELIMO government's health strategy since independence does include the training of all types of health personnel from the community health promoter to the public health nurse, medical technician, dental assistant and physician. Yet, priority is placed on the training of community health promoters. As Mozambique consolidates its socialist transformation and improves the social and economic conditions of the people, one can speculate that the role of the community health promoter will not be as essential and will evolve into a higher level of health provider in terms of training and expertise.

The major purpose of this discussion was not to analyze the current state of health services in Mozambique. However, a brief reference to the present situation is necessary in order to recognize the full impact that the health sector has on shaping and influencing the socialist transformation, not only during times of active war but in subsequent periods. In the first year of independence the health budget was increased by approximately 40 percent, private practice was abolished, and all health services and facilities were socialized.[26] Most medical care is now free, with the exception of a nominal fee (less than 25 U.S. cents) for out-patient consultations. This fee, however, is often reduced in regions where the majority of the population are subsistence farmers. The experiences gained in the struggle are evident in the curriculum now being designed for the training of health workers, and on the emphasis for preventive measures that is integrally related to an overall socialist perspective. The priority given to the creation of a centralized health system today is directly related

to the structure designed in FRELIMO's liberated zones. Furthermore, it reflects Mozambique's need to have a tightly organized health care structure in this period of its development so that planning of its health services and utilization of resources can be properly allocated to the most impoverished areas of the country. Socialist transformations in other countries have shown that the health sector must experience various phases of development as do all other sectors within society. Mozambique is still in the phase of consolidation where external forces have a predominant influence upon the internal dynamics of the health sector. As stated previously, as a society consolidates and strengthens the socialist structures the forces within the health sector become more pronounced.

Mozambique is receiving assistance primarily from the Soviet Union and the World Health Organization and, to a lesser extent, from a few Eastern and Western European nations.[27] This undoubtedly will have an influence on the course of action the health sector pursues. On the other hand, experience has also shown that each country can draw upon the lessons of other nations but will ultimately design a health care system suited to its particular needs. The theoretical concepts that characterize health care remain essentially similar in the socialist countries. Health care strategies may vary depending upon the historical and social realities of the country (i.e., urban emphasis, de-centralization, greater usage of auxiliaries, small renumeration for services as in rural China, etc.) but basic theoretical foundations remain the same.

Cuba

> *When the extraordinary thing becomes*
> *the daily thing a revolution exists.*
> (From a Cuban wall poster.)

One of the most celebrated achievements of the Cuban revolution has been the vast improvement in the health status of the population. This has been acknowledged not only by the Cuban government and its supporters but also be the bourgeois press of the capitalist nations. Articles written on Cuban society often mention such things as the incredible advances in the redistribution of medical services and personnel and cite statistics which reveal the eradication of diseases such as malaria and polio. However, because these articles usually focus solely on the change in the health status of the Cuban people and ignore the structural and ideological changes which the health sector itself has undergone, they tend to reinforce the notion that the health sector is a neutral sphere. The purpose of this case study is to emphasize the process which this sector has undergone rather than the outcomes, in order to illus-

trate how health--like any other sector within a new socialist economy--experiences an arduous process of restructuring and re-education.

Role of Health in the Cuban Revolution

Ths high priority assigned to health care in Cuba dates back to the earliest stages of the revolution. The first field hospitals established in the Sierra Maestra to serve wounded guerrilleros provided health care for campesino families who had never before received treatment from modern practitioners. The experiences in the rural area--where the Rebel Army received its strongest support--later influenced the setting of priorities in spending. Despite the fact that the country was experiencing a severe capital shortage exacerbated greatly by the U.S. trade embargo, the decision was made that health and other social benefits could not wait until the country had further developed. Although the percentage of the national budget allotted to health is not known, it is generally agreed to be quite high. In a speech given in 1970, Fidel stated that the expenditures for public health had increased from 22.7 million pesos in 1958, to 236.1 million in 1969.[28] The Cuban leaders no doubt perceived the relationship of a healthy populace to economic growth as well as to continued support of the revolution. It can be speculated, however, that the intensity of their dedication to the improvement of health conditions arose from their experiences in the most impoverished areas of the country during the armed struggle.

Redistribution and Reorganization in the Health Sector

Attempts were made to begin the process of redistribution of health services in 1959 by giving special attention to the needs of the rural area. The strong commitment of the revolution to the countryside was revealed by the fact that the first significant changes in the health sector were directed toward the rural-urban imbalance. As in other developing countries, there were virtually no health services available to the rural population before the revolution. The hospitals and clinics which did exist were located in the major cities, and agricultural workers were not covered by the social security law which gave some protection to urban workers. The first measure adopted to help relieve the situation in the rural area was the establishment of the Rural Social Medical Service in 1960. The law which created the rural service required that all graduates of medical school serve for one year (later increased to two years) in a rural post.

The changes which were initiated in relation to the rural area in these first two years were not part of a larger

centralized structure or plan. As in the rest of Cuban society, the first two years within the health sector of the new government reflected a program of reform which did not include basic structural changes. The actual consolidation of the health structure--the first step in creating an organization capable of mobilizing and distributing health resources--did not occur until 1961 when a new Ministry of Health (MINSAP) was given authority over the previously autonomous health directorates and all health activities in the private sector. It is no coincidence that this consolidation process paralleled the move toward socialism in the larger society.

As the socialist goals of the Cuban leadership evolved, true structural and ideological changes became feasible within the various sectors of the society. At the same time, the internal dynamics of the different sectors no doubt created conditions which helped to reinforce and promote the socialist ideology of the leadership. Within the health sector, for example, the fulfillment of the promise of health care for the entire population demanded that a restructuring along socialist lines occur. This was made even more evident when one-half of Cuba's physicians and ninety per cent of the only medical faculty in the country were lost through emigration in the first three years.

When one visits Cuba today he or she sees a strong emphasis on primary and preventive care with most of the services being delivered in a decentralized fashion in what are known as polyclinics. In order to arrive at the point where health care could be delivered in this fashion several important stages had to be undergone.

One of the basic principles of reorganization seems to be that centralization must precede decentralization; this occurred in Cuba in planning and administration as well as in the organization and delivery of services. After the consolidation of health services under MINSAP had taken place, a process of regionalization of services was initiated. The new structure was divided into seven health provinces which were subdivided into regions and areas and finally into sectors. The polyclinic is the administrative unit of health areas which serve a population of approximately 25-30,000. By 1970, the area polyclinic* was considered to be the central focus of the health care system. Despite this emphasis on highly independent and decentralized delivery of care, problems continued to exist a-

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* The polyclinic provides primary and preventive services as well as social services to the health area. It also tends to function as a meeting place for all sorts of other community activities.

round the issue of an over-concentration of power and prestige in hospitals. These issues are now being dealt with in Cuba and will be discussed in a later section.

A centralization of hospital and clinic services in the urban areas also preceded the construction of new hospitals and clinics in the rural areas. This had to be done because there were many small urban hospitals and clinics which were inefficient and duplicated valuable resources and services. Although they decreased in number, the average size of hospitals increased in the urban areas. In the rural areas new hospitals were built, thereby distributing the number of hospital beds away from Havana and toward the countryside and the small provincial cities.

> *In 1959, for example, the city of Havana, with only 22 per cent of the population, had 54.17 per cent of all beds, whereas the province of Oriente (one of the poorest provinces in Cuba), with 35 per cent of the population, had only 15.5 per cent of all beds. However, as a result of the attempt to equalize the distribution of resources, 10 years later, the proportion in Havana had been decreased to 40 per cent of all beds, whereas in Oriente it had increased to 23 per cent.*[29]

It is interesting that the organization of health service seems to have developed more smoothly than other economic sectors in the society. In the mid-1960's, Cuba had opted for a highly centralized model of economic organization and planning which had been proposed by Che Guevara (and had been hotly debated by other Marxist economists). This model had proved to be overly bureaucratic and inefficient and was abandoned in the early 1970's in favor of a more decentralized system.[30] Guttmacher and Danielson have suggested several reasons for the relatively even transition that took place within the health sectors:

> *It is also probable that, in comparison to the economic sector, the components of health administration were better understood..., less seriously disrupted by setbacks (such as massive medical emigration and the blockade), and more amenable to centralized planning and decentralized administration.*[31]

Although this analysis is correct in that more technical expertise and infrastructure seem to have been available to the

health sector than to other sectors such as agriculture and industry,[32] however, it may not give enough credit to the struggles which took place within the health sector. In fact, the authors' separation of health from "the economic sector" suggests that they may view health as somehow separate from other areas of production. This type of division creates the illusion that the service sectors are somehow immune to the contradictions that occur in other sectors of the economy.

Mass Mobilizations in Health Care

The decentralization which took place within the health sector was given strength by the fact that since the early 1960's mass mobilizations had been educating and preparing the people to take part in the decision-making process. Although Cuba never utilized mass lay involvement to the extent that it was employed in countries like China which were technologically less developed, it did mobilize great numbers of people for specific campaigns. The Committee for the Defense of the Revolution (CDR), the Federation of Cuban Women (FMC), the Central Organization of Trade Unions (CTC), the Association of Small Farmers (ANAP), and the Young Communists' League (UJC), all participated in organizing the population for prevention campains against diseases such as measles, tetanus, and polio.

> *It is the task of the CDR to secure the registration of the entire population at their respective polyclinics. The CTC guarantees the regular medical examination of workers in the food service industries, health centers and hospitals, and also assists in the preparation and enforcement of sanitary work norms. ANAP collaborates in the control of animal brucelosis and tuberculosis. And the FMC organizes examinations for early detection of cancer in women and is responsible to MINSAP for major aspects of the operation of public day-care centers. Health education is undertaken with initiative by all community organizations.*[33]

The participation of the mass organizations in prevention campaigns was undoubtedly a crucial factor in bringing down the incidence of infectious diseases in Cuba. The leading causes of death in prerevolutionary Cuba were diseases which were easily preventable once resources were made available for their eradication. Health education, vaccinations, and construction of sewage facilities--all procedures which can be carried out most effectively through mass work--have significant impact on these diseases.

The mass organizations which were responsible for so much of the grass-roots work in health care in the 1960's now represent lay people in a more institutionalized fashion on the public health commissions of the area polyclinics and represent the concerns of the community to the polyclinic staff. Representatives of these organizations also participate in similar health commissions at the regional, provincial, and national levels; the most active commissions are at the local level, however, since they concern themselves with more immediate issues.

One might expect to find that participation by lay people on health commissions would essentially be a symbolic gesture with professionals dominating the decision-making process, however, due to the mass mobilization around health issues that occurred in the 1960's, and to the fact that mass organizations were able to take credit for much of the accomplishments, community leaders now wield a great deal of real influence in health planning. In fact, mass lay involvement probably helped to counter-balance the power of the medical profession which had been given an enormous role in all levels of decision-making. Danielson has observed that:

> *When the health commission is assembled, it is the most widely representative body of its kind in Cuba. Other ministries assemble similar, but less broadly representative commissions to gain cooperation and participation in other 'fronts' of the revolution.*[34]

Medical Personnel and Education

The question of the power of the medical profession and the breaking down of hierarchy and the old class relations within the health sector requires discussion. A special set of circumstances, and the decisions that were made to cope with them, may have reinforced to some extent the class position of physicians vis a vis other health workers and their patients. When the country lost one-half of its physicians, crucial decisions had to be made concerning the education and training of new personnel. Instead of opting for the training of paramedical personnel to fill the void, it was decided that the ratio of physicians would be restored to prerevolutionary levels. This commitment was an admirable one since it appears to have stemmed from the belief that the substitution of lesser trained personnel for physicians would be opting for inferior health care. However, in retrospect, it can be seen that this decision may have contributed to problems of over-specialization and fragmentation in some areas of health delivery and also

helped to produce shortages of crucial auxiliary and paramedical personnel who were greatly needed in the delivery of care.

In order to attract large numbers of students into medical education various incentives were created. These included the granting of special privileges and the incorporation of physicians into the planning and decision-making processes at all levels of the health sector; doctors who wished were also allowed to retain their private practices.[35]

It should not be assumed that the decision to grant material incentives to those becoming physicians was arrived at easily. Throughout this period, a major ideological debate was taking place at the highest levels of the Cuban leadership around the issue of material versus moral incentives, and the outcome was that the strategy of moral incentives had been much more highly emphasized in most areas of production. Although providing material incentives to doctors while stressing moral incentives in other areas of labor was clearly contradictory, it was a contradiction that was undoubtedly recognized and accepted as necessary by the Cuban leadership. The government felt that it could not demand constant sacrifice from the people without providing certain social benefits such as health care. Therefore, compromises were made within the health sector in order that socialist emulation could work in other sectors of the economy, i.e. moral incentives were made more effective because certain material needs were being met. As one observer has put it, "...the very process of creating abundance began to create the incentives that would eventually become internalized as the motivations of the 'New Person'."[36]

One can only speculate as to the extent of the debate which went on around the issue of the training of huge numbers of doctors and the decision to grant material incentives. It must be remembered that within the health sector the decision-makers were nearly all physicians in the period when this decision was made. It would be interesting to know what the positions of various planners were within the health sector and if there were any controversy over this decision, or any tension between positions of the health planners and of the economic planners at higher levels. Since health care was seen as a service to be distributed as rapidly as possible to formerly deprived areas of the population, it may have been felt that there was less time to deal with ideological issues than in other sectors of the economy.

The elitest attitudes which tend to be predominant in highly skilled professionals were probably much less severe among the ranks of those pysicians who remained in Cuba after the massive emigrations. Guttmacher and Danielson contend that even before the revolution the Cuban Medical Federation was

controlled by "progressive, leftist, and communist leadership."[37] The top leadership of the Minstry of Health was also dominated by those who had strongly supported the revolution. Roemer has pointed out that the first ministers of health since 1959 have been chosen because of their participation in the revolutionary struggle and that two of the first four ministers actually fought in the Sierra Maestra with the guerrilleros.[38] The ideological perspective of the leadership of the Ministry of Health and the massive lay involvement in the health sector in the early years, probably healped to mediate a situation which could have been much more problematic because of the power assigned to one highly-skilled class of personnel. The revolutionary spirit of the larger society no doubt also had a significant impact on the new classes of medical students.*

The push to create a supply of new physicians is evident in the percentage of university students who were enrolled in medical school. As late as 1971, thirty per cent of students were in medical schools, however, by 1972, the planners had reduced the quota to twenty per cent--anticipating that the goals of restoring previous numbers of personnel were being reached.[40]

As was mentioned earlier, one of the results of this decision to place a high priority on educating physicians is that other types of medical personnel were in short supply. In more recent years attention has been paid to educating new types of personnel such as auxiliary technical sanitarians, auxiliary nurses, x-ray tachnicians, lab technicians, and dental assistants.[41] The interesting thing is that despite the feelings concerning the utilization of paramedical personnel which appeared to have predominated in the early years following the revolution, in recent years their roles have been expanding in the delivery of care. According to Navarro, nurses have more clinical responsibilities than their counterparts in the United States and Great Britain.[42]

It is to the credit of the Cuban health system that it has been able to respond to problems as they have arisen with incredible flexibility. For example, the issue of specialization was addressed by two physicians from the Ministry of Health in a recent article on community health:

> *...the effect of medical specialization should be noted. Although it has had some positive effects, it has undermined the doctor-patient relationship, reducing*

* Danielson points out that, "In 1968,...a higher percentage of young communists was found among medical students than among other student categories except political science."[39]

> *it to a temporary, compartmentalized relationship between specialist and patient with a particular ailment. This has contributed to the loss of the comprehensive approach, the dispersion of responsibility in medical practice, an unnecessary increase in the number of referrals and the fact that the population regards specialization as 'superior' and demands it even when it is not the type of attention required ...although the health system has followed principles adapted to the policies of our socialist state and emphasized disease prevention, the promotion of public health and the importance of primary care, our medical students and specialists have gone on being trained in accordance with traditional conceptions with a basic emphasis on treatment.*[43]

The authors of this critique go on to describe changes which are taking place at this time in Cuba to make the system of medical education even more responsive to the needs of the community. These revisions also stress further integration of physicians into work teams. This type of self-critical analysis reveals the high level of consciousness present within the Ministry of Health, indicating that the system will not stagnate but continue to be refined along socialist lines.

Final Comments

An interesting characteristic of the changes which have taken place within the Cuban health sector is that they have proceeded at a gradual but constant pace. Although the health sector was very underdeveloped at the time of the revolution, the new leaders still inherited a system which carried with it all of the contradictions and inequities of capitalist medicine. Because the most important priority was not ideological purity but rather the amelioration of terrible health conditions, certain aspects of the old system were retained until they could be discarded without jeopardizing the health status of the people. For example, private practice was never officially abolished but tended to die a natural death as the result of the increasing strength of the public system and the changing ideological perspective of new classes of medical students.[44] The drug industry was nationalized over a period of seven years. Changes in the medical curriculum also evolved over a period of time; new principles such as an increased emphasis on prevention and the incorporation of manual labor into medical training

were officially adopted in 1965.[45] Direct costs for medical services have been eradicated, however, nomial fees are still charged for drugs (with reduced prices for persons with chronic conditions).[46]

Although certain problems in Cuban health care have been emphasized in this case study, it should be stressed that they are not major flaws in the system and that they fade in significance when compared with the tremendous advances of the entire sector. Many other progressive aspects of the system have not been dealt with here, such as the fact that fifty per cent of medical students are now women (as well as 31.5 per cent of the leadership of the health workforce)[47] and that a great deal of mobility exists between the various professions within the health workforce (e.g., a nurse can go on to become a doctor). That these changes continue to occur is the real test of the strength of the Cuban revolution.

III. SUMMARY

The aim of this study was two-fold in nature: to present a theoretical discussion of the major characteristics of health care in a socialist society and to illustrate these characteristics through two case studies.

Integral to our aim was understanding the dialectical processes occurring in the reorganization of the health sector in a society undergoing a socialist transformation. As stated previously, these processes mirror the larger society as well as generate their own dynamics within the health sector.

The selection of the case studies was based on the fact that each country represents a different phase in the construction of a socialist society. The Mozambique study illustrated the role of health during the period of armed struggle, while the Cuban study emphasized the subsequent phases of consolidation and reorganization of the health sector.

There are several significant parallels between the Mozambique and Cuban experiences. For example, each country experienced a mass exodus of all types of health workers. In one context, this exodus represented a "cleansing" process. In the situation of Mozambique, one physician who remained was quoted as saying, "Its better they have gone. Such doctors would only have hindered us in our new task."[48] In both countries, though, the loss of trained health workers exacerbated the enormous task of restructuring the health care sector.

In each case the health sector became an instrument for politicizing the population and consolidating the socialist

structures, and in both countries changes in the health sector were given very high priority in the development plans of the new governments. Both Mozambique and Cuba have pursued policies that were designed to confront and eliminate traditional hierarchical barriers in the health labor force. Each country was confronted with the issues of specialization technology in the training of health workers and dispensing of services. Based on their own historical and social realities, different strategies were followed. Both emphasized rural health development, mass mobilization techniques and prevention campaigns. Lastly, each was faced with the necessity for centralization and planning.

Political analysis have only begun to realize the strategic importance of the health sector in a socialist revolution. Because the health sector affects people's lives so directly and is often one of the most underdeveloped spheres in non-socialist Third World countries, it is perceived as critical in gaining support for revolutionary struggles. The ultimate purpose of this paper was to demonstrate the revolutionary potential that the health sector has in the non-industrialized regions of the world as well as to point out the forms which new socialist health systems will take and the special problems which they will encounter.

In conclusion, credit should be given to the role of international solidarity by countries such as the Soviet Union and China in the building of new socialist societies. At the present time, Cuba is continuing this process by aiding various African nations including Mozambique.

Footnotes:

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