Final Draft

EVALUATION OF THE HUMANITARIAN AID IN FAVOUR OF THE CUBAN POPULATION 1999 – 2000

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MAY 2000

ECHO/EVA/210/1999/01013

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ABBREVIATIONS

AAA	Agro Acción Alemana (DWH)
ACLFM	Asociación Cubana de personas con Limitaciones Físico-Motóricas
ACP	Assembly of States of Africa, Caribbean and Pacific.
ACPA	Asociación Cubana de Producción Animal
ACTAF	Asociación Cubana de Técnicos Agro Forestales
AIDS	Adquired Inmuno Deficiency Syndrome
ANAP	Asociación Nacional de Agricultores Pequeños
ANNF	Asociación Navarra Nuevo Futuro
ANSOC	Asociación Nacional de Sordos y Hipoacúsicos
APS	Associazione per la Partecipazione all Sviluppo
BOR	Bed Occupancy Rate
CIDEM	Centro de Investigación y Desarrollo de Medicamentos
CISP	Comitato Internazionale per lo Sviluppo
CISS	Cooperazione Internazionale Sud-Sud
Cuba RDA	Cuba República Democrática de Alemania (Orthopaedic Workshop)
DWH	Deutsche Welthungerhilfe (AAA)
EC	European Commission
ECHO	European Community Humanitarian Office
EMSUME	Empresa de Suministros Médicos
ENIMO	National Industry for Medical Material
ESCO	Empresa de Servicios a la Colaboración
EU	European Union
GDP	Gross Domestic Product
GHAP	Global Humanitarian Aid Plan
GVC	Gruppo Volontario Civile
I-C NGO	In-Country Non Governmental Organisation
IEC	Information, Education and Communication
IGO	International Government Organisation
IMEFA	Industria Médico Farmacéutica
IMF	International Monetary Fund
LRRD	Linking Relief, Rehabilitation and Development
MINCIN	Ministerio de Comercio Interior
MINVEC	Ministerio para la Inversion Extranjera y la Colaboración Económica
MINSAP	Ministerio de Salud Pública
MoH	Ministry of Health
MPDL	Movimiento por la Paz, el Desarme y la Libertad
PAHO	Pan-American Health Organization
OIKOS	Cooperaçao e Desenvolvimento
UBPC	Unión Básica de Producción Cooperativa
UNDP	United Nations Development Programme
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

SUMMARY FRAMEWORK (CANEVAS)

Subject of the evaluation: **The humanitarian aid in favour of the Cuban population over the last 2 years being 1999 and 2000.**

Name of partners: MoH (MINVEC-MINSAP) and NGOs: ACSUR, ANNF, Caritas-G., CISP, Erikshjälpen, GVC, MDM-E, MDM-F, MPDL, OIKOS, RCross-G., SCF & project with Handicap Int.
Operation contract n° PG: ECHO/CUB/210/I999/01000
Microprojects: ECHO/CUB/210/I999/03000
Decision 26/11/99
Dipecho: ECHO/TPS/219/1999/03000
Dates and duration of the operation PG: 1/4/99-30/11/99, amendment until 2/2000
Amount: total of 11.4 million Euro in 1999 and 2000
Sectors concerned: ECHO's support to Health and Social services through:

- Global Plan: mainly drugs (both raw materials and medicines) alimentary and cleaning products, fabrics and basic medico-surgical material
- Microprojects: as a complement to the Global Plan to reach the most vulnerable and to resolve deficiencies in infrastructure and equipment.
- Dipecho: to reduce the harmful effects of natural disasters by IEC campaign and strengthening selected infrastructures.

Description of the evaluation:

Dates: from 10 April to 26May 2000
Report n°:
Name of the consultants: Dr. Carlos Artundo & Dr. Maurice Coenegrachts, Quest consult
Purpose: Appraise and evaluate 1999's and current ECHO's aid to Cuba; to specifically assess the relevance and coherence of such intervention in the light of the humanitarian situation and needs; and eventually to recommend an exit strategy according to the LRRD policy.

Methodology: A mix of quantitative data of EC Cuba's programme management and epidemiological data with national economic indicators of the Cuban government on the one side.
On the other side semi-structured interviews with all stakeholders including health services users and beneficiaries (focused group interviews).
Visits to samples all types of health and social centres in the capital and the poorer remote provinces of the East.

Conclusions:

Relevance:

- ♦ Attempts have been made to identify vulnerable groups through the MoH institutions. More work need to be done to identify those not covered, especially elderly living alone.
- ♦ So far the aid has been useful for the health of the Cuban population. However dependency of vulnerable people on state institutions has been identified. Alternative strategies or community participation are lacking.
- ♦ The programmes show **good understanding** of the reverse effects of the Cuban double speed economy and the vulnerable groups created by this. The identification of the needs could benefit from more input by NGO and social beneficiaries.
- ♦ More time is needed to include needs assessment and evaluation of the projects by NGOs.
- ♦ Other *interventions* are food aid and security programme (phasing out), co-financing of NGO projects (increasing) and economic co-operation (supporting economic reforms)
- ♦ Participation in the Cuban *disaster* preparedness at Caribbean level.

Co-ordination, coherence and complementarity:

- ♦ Co-ordination between NGO's has to be improved with the active participation of ECHO. The authorities have the instruments to co-operate with ECHO but make it unnecessarily complicated. Therefore ECHO should take a harder line of negotiation with the government to facilitate the work of NGOs.
- ♦ The complementarity between NGO and authorities is potentially there.

- The ECHO representative is in the acting position. Communication with NGOs and IGO needs improvement.
- The NGOs have the linking role with the beneficiaries.
- Between the 4 EC instruments[(*)] there is lack of co-ordination. Co-operation between the instruments must be strengthened.

Effectiveness:

- Distribution and consumption of the aid are **effective**. However, the potential effect of aid is too diluted in a health system that is over-sizing, high-tech based and constrained by ideology.
- The NGO-ECHO consortium has performed a **fair repartition of activities.**
- Part of the vulnerable population is reached through and with the government instruments but some do not benefit because of the emphasis on institutionalisation instead of on community orientation.
- As the project focused on supporting the most vulnerable, project costs were justified so far. However there is no long-term strategy of improving the most vulnerable.

Key solutions are: community oriented services for elderly; support to the MoH in developing strategic thinking on health and social system reform; hard-line negotiation on improvement of customs and transport; and acceptance of real re-dimensioning and common-sense technology in the impoverished health and social system.

Efficiency of aid:

The NGO consortium has a poor output for following reasons:

- Centralised purchase and distribution of goods, without effective feedback instruments.
- Weak strategic plans, no standardised monitoring, lack of established communication lines. Operational and budget management are fair. There is technical competence for execution but needs assessment and monitoring are weak. However, monitoring is not standardised and needs the decentralised counterpart (province) to be more implicated.
- The government does not always facilitate monitoring but in some places they learn and apply own monitoring.
- The quality of products has improved. Because of known problems there is still oversupply of raw material for drugs.

Impact and strategic implications:

- The programme has **direct impact on the basic needs of institutionalised vulnerable population.** Some people are still excluded.
- Dependency of the beneficiary on the “Unique Cuban Health System” does not allow coping mechanisms of the individuals to emerge and develop outside of the institutions. Secondly the state remains dependent on ECHO products (delivered without strong conditions).
- The microprojects are too varied to allow focused impact and to support in a comprehensive way.
- There is no focused gender nor local capacity building. But they are difficult to put in place (all NGOs are ± governmental!).

Visibility:

Ranks from excellent to nearly absent dependent on the NGO.
Because Cuba is highly literate, public information through leaflets is advisable

Horizontal issues:

- Men and women are considered equal in legal terms, but machismo is still strong. Many directors in health sector are women.
- LRRD: timid attempts are used through large variety of microprojects tackling rehabilitation and development. Some projects are still an extension of the GP.
- Security is not an issue in Cuba.

[(*)] Food Aid & Food Security Programme, Co-financing with NGOS, Economic Co-operation and ECHO

Recommendations:

1. To maintain temporarily ECHO's aid to Cuba
2. To establish a clear exit strategy, co-ordinated with the other EC services (LRRD)
3. To undertake a prudent and progressive phasing-out (2000 and 2001)
4. To produce an strategic inflexion in ECHO's intervention for the last period, as an important element of the exit strategy
5. To approve a last package of ECHO's aid reducing by half the 1999 pattern and to be directed towards the most vulnerable people
6. To include a last direct supply transition component directed to the prioritised social centres of MINSAP
7. To include an integrated social programme focused towards the most vulnerable persons both interned in social institutions and living on their own
8. The latter to be community oriented (preventing institutionalisation and promoting coping mechanisms), decentralised, locally based and participatory
9. To reconsider the selection of NGOs according to suggested criteria
10. To sign longer contracts with NGOs: one year
11. To change the structure, profile and functions of ECHO office in la Havana
12. To improve the visibility and communication policy
13. To firmly renegotiate the working conditions of NGOs
14. EC together with European Member States to negotiate NGOs status and role
15. To develop an European Commission common strategy
16. To set up a Cuban Task Force, including the different EC Services present in Cuba
17. To organise a working session of all consultants involved at present in missions to Cuba
18. To assess ECHO's eventual last programme in one year time
19. To reassess ECHO's withdrawal if situation and/or scenario changes

EXECUTIVE SUMMARY

The present evaluation by two independent consultants was requested by ECHO with the purpose to appraise and evaluate 1999's and current ECHO's aid to Cuba; to specifically assess the pertinence and coherence of such intervention in the light of the humanitarian situation and needs; and eventually, to recommend an exit strategy according to the LRRD policy.

After a briefing in Brussels with all relevant staff members (from ECHO-3, ECHO-5 and DG DEV), the field work was undertaken in April and early May (approximately, four weeks).

Taking into account the large scope of objectives of the evaluation main emphasis was put on meeting stakeholders at all levels in different geographic settings. Visits to samples of institutions, projects, provinces and meetings with key people, were combined with focused groups interviews and qualitative techniques to have a crosscut and comprehensive information feeding mechanism.

Due to the well known historical and political circumstances, Cuba was highly **dependent** upon the former URRS / East block. The latter represented 85% of Cuba's trades and subsidies were a common pattern. After the disintegration of the COMECON and asphyxiated by the US embargo, the economy of Cuba started to decline at the end of last decade; from 1989 to 1993 Cuba's GDP declined to 35% while the generous subsidies disappeared. This led to the **"Special period"** during which survival was the only objective for most Cubans.

Since that time and after the peak of the crisis in the first part of present decade, and partly due to timid concessions to the market like development of the dollar market and tourism, Cuban economy at macro level is **slowly recovering**. At the same time social contrasts become dramatically tangible: those having and not having access to the dollar market.

Moreover the coping mechanisms of the Cuban population have been weakened by the "feeding bottle" policy, induced by both the URRS and the Cuban State.

"Health for all", together with education, has been and still is a cornerstone and political priority for the Cuban regime. The **health status** of the population is comparatively talking acceptable. The **Health System** though, has deteriorated over the last years due to the lack of investments and maintenance; and overall, is oversized and overstaffed. Efficiency is clearly its main weakness and the management poor.

In this context, **ECHO's intervention in Cuba** over the last seven years has **assisted** the country to maintain a certain level of basic health and social services. And it has also **supported** an important number among the most vulnerable people to be assisted by the health and social public services. Indeed, such intervention (mainly through the Global Plans) has been very peculiar compared to other ECHO programmes, and might be understood as an indirect support to the MINSAP budget. However, the rigidity of Cuba's centralised policy and the exceptional situation, Cuba is confronted with, made that the intervention of ECHO was a feasible alternative to provide humanitarian aid to the population.

In relation to **the 1999 Global Plan**, the **stated objectives have been reasonable achieved**. Nevertheless, some operational problems identified in previous evaluations have not been solved (delays in transport and in the production of drugs). The excessive centralised approach, and the lack of a firm dialogue with local counterparts are in our opinion key weaknesses of the program.

Concerning the **microprojects,** in general they **have improved** significantly the situation of the health and social institutions covered through small-scale interventions. However, the variety of projects in terms of geographical location and fields of intervention, may have reduced their global impact.

Criticisms on the comprehensive intervention would be: the **"humanitarian dependence"**, **lack of innovation** over the time, **questionable sustainability** and the lack of a clear and negotiated **strategy**. Although it must be admitted that the Cuban authorities **did not facilitate** the dialogue up to now and were reluctant to innovations.

In any case, it is advisable to take advantage of the above-mentioned dependency for future negotiations.

Concerning the other EC services: their presence in Cuba is modest compared with ECHO's program. International actors in the field observe a lack of co-ordination, even in some cases coherence, among them.

On the other hand, the consulted European Member States follow a general tendency to decrease their humanitarian assistance and to increase their rehabilitation/development programmes. The other international Organisations and Donors share the same pattern.

Therefore and in the light of the above considerations, it is possible to summarise that there is a consensus about the idea that **Cuba is not anymore in an emergency situation**. However, the situation remains very **fragile** and can **reverse quickly** due to natural disasters (such as cyclones, hurricanes and the "silent drought" in the poorer East of the island), and political and economic unpredictable changes both internal and external.

There is also a **wide consensus** about the evidence that in Cuba currently exist important **pockets of humanitarian needs** and the **most vulnerable people** (basically those excluded from the dollar circuit), suffer an extremely **precarious** situation in humanitarian perspective.

An **abrupt withdrawal of ECHO** can seriously **affect** the vulnerable in the health and social sectors, and cause an additional stress for the health system as long as alternative solutions are not prepared. Besides, an important part of the positive impact of the past EC intervention by ECHO could be wasted.

Although at present ECHO is probably not the most adequate instrument for a needed sustainable co-operation with Cuba, it is the only one that can support right now the most vulnerable people. Once it is decided to use other EC instruments for the co-operation with Cuba and taking into account the differences in timing, procedures and flexibility, this type of co-operation will not be in place nor functional in the near future.

It is also worth to consider that ECHO's aid accounted for about 80% of the total EC co-operation with Cuba in 1999 and approximately 65% for the period 1993-99.

Consequently, the first general recommendation is to **maintain temporarily ECHO's aid to Cuba** but establishing a **clear exit strategy** coherent and co-ordinated with the other EC Services (LRRD): a **prudent and progressive phasing-out** is recommended.

Secondly, to undertake a **strategic inflexion in ECHO's** intervention for this –in principle- last period, as an important element of the exit strategy.

In this sense, it is recommended to approve a **last ECHO aid package** (reduced to **half** of the previous) in a two year implementation period during the years 2000 and 2001.

It has to be focused towards the most vulnerable both interned in social institutions and the ones living in the community. This programme would have two components:

1. A *last direct supply transition* project could cover the prioritised and identified needs for approximately one year and the current pattern should be in our view reduced by half. This last donation should be directed to the social institutions of MINSAP and the total amount should not exceed 4 MEURO. Some criteria are suggested for the prioritisation of items to minimise dependency and a stronger application of vulnerability criteria.
2. An *integrated programme* aiming to assist and support the extremely vulnerable people. The rational behind this relates to the relevance of performing urgent rehabilitation by improvement of the quality of live of the most vulnerable and by facilitating the transition towards a medium and long term development strategy. In this way, the experience of some previous microprojects is used but frame them in an operational strategy and comprehensive approach.
   This programme would include a short term and small scale rehabilitation (in the context of the humanitarian Council Regulation), basic equipment and furniture for the prioritised social institutions (elderly homes and houses, institutions for mentally and physically disabled people, collective centres); as well as the support to home care services for the most vulnerable living on their own. And the total amount might be around 6 MEURO
   The *key concepts* of this programme are: community orientation (preventing institutionalisation, promotion of coping mechanisms) and decentralisation. The whole should be locally and participation based (including participation in-kind by the institutional beneficiaries).

The **new strategy and approach recommended** to ECHO **requires changes at all levels**: in the *relation with the Authorities* (a more firm position is suggested), the *type and role of the implementing partners (NGOs)* (several criteria are suggested); for the *duration of the contracts* (longer contracts of one year are suggested); and the *structure, profile and functions of the ECHO office in La Havana.*

In terms of timing, it is recommended to approve the last direct supply transition package in June 2000 on the one side and on the other side the integrated social programme in September 2000, after the needs have been identified and prioritised (see further details in proposed methodology).

Moreover, some suggestions are made to improve the visibility of the intervention and a general communication policy.

For the **NGOs** and because of identified problems they face in their daily work, it is recommended to firmly **renegotiate** the TOR for ECHO (20.04.94), applying the same recognised conditions for ECHO to the partners working with the EC.

At a higher level, a common agreed position between the EC and the European Member States is recommended to negotiate the NGOs status and role.

The above mentioned **phasing-out of ECHO** implies the phasing-in of other EC instruments in key areas to optimise past intervention, minimise the negative impact of ECHO's withdrawal and achieve the greatest global impact. Based on this and LRRD logic, **a European Commission global strategy** is recommended in the frame of the EC available instruments present in Cuba.

Besides that, the different actors should develop operational strategies and action plans in a coherent and co-ordinated way.

Preliminary suggestions for other EC Services are: to add a close and medium/long term Technical Assistance (TA) to MINSAP (Economic Co-operation); to include water supply for remote and vulnerable communities (new strategy of co-operation with civil society; Co-financing of NGOs projects); and a decentralised programme to support the production of basic food for the population (Food Aid and Food Security).

A **Cuban Task Force** both in Brussels and at field level is suggested in order to make the common strategy operational. This Task Force can prepare and propose a global and coherent EC operational strategy for Cuba and discuss and agree upon the different instruments' interventions. So it will accomplish complementarity, synergies and long term maximum impact.

A joint working session with all the consultants involved in on-going missions to Cuba at present is also suggested in order to feed technically the work of the CTF.

Finally, a **reassessment** of ECHO's withdrawal is recommended in the case that the situation changes significantly or the scenario recommended in this report would loose its sense.

1. INTRODUCTION

Purpose of the consultancy
To appraise and evaluate 1999's and current ECHO's aid to Cuba; to specifically assess the relevance and coherence of such intervention in the light of the humanitarian situation and needs; and eventually, to recommend an exit strategy according to the LRRD policy.

Scope of the report
The main objective of the report is that of most Global Plan evaluations. In addition, the scope of objectives for this report was the following: if appropriate an exit strategy and transition measures had to be designed and Cuba's dependency on EC aid to be reduced.
ECHO requested the report but the other EC Services also participated, as they are interested parties in the exit strategy.

Limiting factors
The time of 25 days provided for an ambitious appraisal and the pre-condition that the consultants should not be familiar with the region and thus not prejudiced.
Also, the informal co-ordination and the blurred areas of responsibility of the different instruments of the EC render the analysis and especially the implementation of the recommendations more complex.
An analysis of logistic data of ECHO-NGO and combined with the MoH epidemiological data gives approximate information on relevance, adequacy and efficiency of the programme and the benefits for the MoH. However it blurs the analysis of the accessibility and of the pockets of exclusion of the vulnerable population. To perform the latter analysis a different approach was designed in the plan of action, to collect extra qualitative information.

Problems to be considered
Premise: The main goal of the GHAP and individual decisions is to meet the most pressing needs of the vulnerable population groups.
Criteria: If the needs are met, are they met in an efficient and effective way? Are the needs well identified and by whom? What is the accessibility and how can it be sustained?
Which strategy has been designed to reach this objective?
What is now the strategy and methodology of investigation to be applied to answer these questions in the most comprehensive way?

Methodology
a) To collect quantitative and qualitative data by semi-structured interviews applied to selected stakeholders at national, provincial and municipality level. To meet the NGOs collectively[1] and individually.
b) To be transparent about the purpose of the evaluation and to generate active participation of all the stakeholders of the programme.
c) To meet beneficiaries in the field as they have best knowledge of social and political challenges, of daily needs and of practical problems.
d) To visit centres of all types ranging from referral teaching hospitals to first level curative and social centres, even the most disadvantaged.
e) To travel to the disadvantaged East of Cuba as it is more affected by natural disasters. The inland of 3 of its 5 provinces was visited in order to evaluate the accessibility to Health and Social services.
f) To interview the users of these centres. Focused Groups interviews were hold with the users of the social services in Santiago and with a group of para-medical beneficiaries of the ECHO aid[2].
g) Several feedback meetings were held with selected stakeholders: ECHO office, NGOs and MINVEC and MINSAP.

Data collection:
Quantitative and qualitative data.
Literature on economical and political background.
Documents and evaluations of EC and MoH.
Epidemiological and statistical data of the MoH (MINSAP) and MINVEC.
Interview of key informants: ECHO, partners, other NGO's, EC instruments, counterparts, IGO, and beneficiaries.
Focused group interview of partners and beneficiaries of the health and social system.
Visual inspection of premises and remote areas.

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[1] Annexe 8 and 9
[2] Annexe 10

2. BACKGROUND CONTEXT AND SITUATION ANALYSIS

History

After[3] the disintegration of the COMECON (1998) and the economy of Cuba starting to fade away, the Revolution's most renowned achievements, health and education began to slip.
The Cuban Democracy Act (Torricelli) of 1992 gives the US president the power to sanction countries co-operating or trading with Cuba.
Many Cubans did turn to the black market functioning on US dollars. The government legalised the use of dollars in 1993 but no backtrack is permitted on the revolutionary ideals fought for 40 years ago (e.g. to the market economy).
In March 1996 Clinton signs the restrictive Helms-Burton Act, increasing the gravity of the embargo against Cuba and thus aggravating the "Special Period"[4].

Political scene:

In the Common Position[5], the EU links in no coercive way its economic co-operation with Cuba to Cuba's opening process towards pluralist democracy.
Cuba requested to enter unconditionally in the ACP group and was given an observer status at the negotiations of the 5th **Lomé Convention**.
Cuba was condemned for its human rights record in Geneva mid April 2000 by the Human Rights Commission of the UNO Member States. So Cuba had its request withdrawn and the visit of the Community Troika of the EC was unilaterally cancelled.

Within the EC and also among officials of other countries there is a strong tendency to a pragmatic approach on the **Common Position**. They stress on increasing development co-operation to improve the development of a human civil society and at the same time they propose to maintain pressure on the respect of human rights. The lesson has been learned that the embargo was not effective. It only has helped Castro to be seated stronger in his saddle and to limit the influence of the opposition. Logistical and other assistance offered by exile organisations undermines the opposition group's credibility within Cuba.
The Elian issue has reinforced this impression.
The fact of Cuba not entering the Lomé convention affects the type of aid to be given to Cuba.

Economical context:

With a population of 11 million and 99.3 inhabitants per km², Cuba counts 14 provinces.
In the last 20 years the Cuban economy was in hibernation partly due to inefficient central planning based on quantitative targets. Diversification of production was not considered and energy and technological dependency was extreme (feeding-bottle effect).
Since 1962 the economical embargo of Cuba became an USA priority.
In 1963 Mr. Fidel declared sugar as the centrepiece of Cuba's economy which subsequently would be sold to Moscow at a subsidised price. Education and health became a tool for the government and a priority.
In 1980 the USSR agreed delay of debt by Cuba and increased the subsidies. Gasoline was nearly free. In that period, because of the opening arising around Cuba, thousands (128.000) of dissidents were permitted to leave Cuba.
The feeding bottle policy of the USSR was briskly followed by the disintegration of the communist block and thus reducing to zero the aid from this side. This lead to the Special Period of 1990.
The former Socialist Sphere represented 85% of Cuba's trade. After the COMECON[6] collapsed Cuba's GDP declined at least by 35% from 1989 to 1993 and the export by 75%.
Since 1994 Cuba has begun a process of economic recovery that is still fragile and subject to multiple factors. After the levelling in 1994, the rate growth of the Cuban economy has increased by 2.5% in 1995 and to 7.8% in 1996. It has slowed down and dropped to 2.5% in 1997 due to the low result of the sugar

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[3] Coe A. p. 36-46.
[4] The name Special Period is used in Cuba to describe the consequences of the collapse of the economical system after 1990.
[5] The Common Position took effect in Dec. 1996.
[6] Bataller M. et al. p. 13 & 26, WHO p.211

harvest, the reduction of international market prices for sugar and nickel, and the effect of climatic disturbances on agriculture and fisheries.
Appraising the Cuban economy several factors must be taken into account:

1. Few trading options due to the US embargo and no access to the international credit mechanisms, WB, IMF.
2. Low performance of the Cuban economy compared to the rest of Latin America in terms of long-term growth rates[7].
3. High degree of *equity expressed by the universal access to education and health services* as well as similar income levels throughout the population.
4. The State is the dominant economic factor in the country.
5. *Agriculture* has not attained the level demanded and it affects the nutrition level s of the population and the funds assigned to foreign trade, by intending to redress the food security imbalances.
6. The GPD growth over 1999 was 6.2%, which suggests a slow recuperation of the Cuban economy.

In 1997 the creation of a two-tier banking system was a major financial reform. The central Cuban bank was left to operate as a commercial bank[8].
The recent improvement in Gross Domestic Product (GDP) is due to increase in productivity of key sectors: tourism, sugar and nickel production and energy industry. This year the banks granted 17% more short term credits to productive organisations.
For the last six years the annual average growth was 3.4% against a 9% loss between 1989 and 1993.
Some main measures taken by the government to improve the financial balance were:

-Timid opening towards foreign investment.
-Public services reform with reduction of human resources.
-Cutting subventions to loss making state production units.
-Timid commercialisation of agricultural alimentary products in the so-called agro-markets.

But each growth of the Cuban economy is cancelled out by uncertain international economic conjuncture and the yet negative commercial balance, due this year to the fall of the sugar price and the increased fuel prices. But more than that the growth is impeded by the absence of foreign investment for the known reasons.
Thus the notified growth of 1999 was only visible in a light improvement of the living standard of a part of the population. Still there is a scarcity of food items. The average salary is 223 Pesos monthly or $12[9].
Anyway the circuit of hard currency market and the access of Cuba to capital markets is still insufficient to permit capacity of handling to economy politics. The foreign debt of Cuba was 11.200 million dollars in 1998.

The following table shows the evolution of GDP over the last years:

	1996	1997	1998
GDP in million pesos	22.815	22.952	23.900
per capita in pesos	2.071	2.074	2.150

The relative opening to the economy after 1989 caused a gradually increasing *unequal redistribution of income* with increase and diversification of consumption[10]. Most Cubans have a low standard of living while officially 62% of the population has *access to the dollar*[11]. But according to other sources and direct observation[12] more than half has no access to the dollar market and thus no access to basic hygiene and rehabilitation items (for house repair).
Mostly the access to dollars is provided by tourism, informal trade and by relatives sending dollars from the States. Presently Cuba's revolution is trapped in a double block: the impossibility to go back to the early days and the regime not being inclined to progress.

[7] According UNDP Cuba GDP for 1997 was the second lowest of the Caribbean with $ 1.198 before Haiti with $250 per capita.
[8] Bataller M. et al.p.25.
[9] The official rate of USD: Pesos 20 = $1
[10] Dossier Nb.68, 40 years of revolution in Cuba, Irela May 1999: p.24
[11] 20% according Irela! P.30 §86.
[12] In the country side is closed to tourism and market economy, partly because of transportation problems. Now most people are in these remote areas and in the cities only a happy few have substantial relation with tourism, another few have casual or illegal income from tourism.

Transition to the market economy is not possible and the government is unwilling to consider massive privatisation. Private ownership of land and productive capital by Cuban citizens is limited to farming and self-employment.

Social development and challenges:

From its start in 1959 the Revolution was based upon two principles: restoration of national sovereignty and social development of equity. Political participation in Cuba was obtained by individual and voluntary participation in mass organisations. These were consolidated in the first decade as the Committee for Defence of the Revolution, the Federation of Cuban Women and the Union of Communist Youth. At that time the interests of the individuals and those social representations seemed convergent. But in the last decade other values emerged, such as *personal dignity, independence of opinion and action and distinction from the others*. These priorities collide with the top-down structure of the comprehensive state institutions.
At the cost of great budgetary efforts and at the expense of a drastic reduction in the quality of life of the population (being access to energy and to decent hygiene), Cuba has been able to maintain at a high level its main social indicators (e.g. frequency of utilisation of health services). On the other hand, the country's *infrastructure and services have deteriorated and demand resources*, which significantly exceed current availability.[13]
Political and economical threats have *undermined the social equity* and the capacity of the Cuban Government to provide for the Social Welfare.
In the actual political context and because of the time limits of the mission we are limited in the investigation for pockets of vulnerability and assessment of the precariousness. This issue should be further explored.
Because little is objectively known on the magnitude of vulnerability, here follow some indications.

Indications of precariousness:

1. The double-speed *dollar economy*: University professionals earn ± 250 pesos, much less than any employee in contact with the dollar economy. Beside the salary, 40% extra income is required only to reach the basic basket.
   On the one side tourism brings the necessary hard currency, at the other side food for international tourist consumption is deducted from the food available for Apparent Consumption of the Cubans. This is only one of the many signs how Cubans are *discriminated against tourists*. It is not wrong to say that beside health and education, tourism has become a top priority.
2. The *minimum salary* ranges between 100 to 130 pesos. The minimum budget to cover housing and food costs is 700 pesos/month
3. From observations and discussions: Professionals have a *borderline income* e.g. an engineer with 2 chronically ill children cannot afford specialised food beside the drugs (which also have to be paid and are more expensive if the drugs are not available in normal pharmacies)[14].
4. It is not clear how many people live below the poverty line (BPL). Interviews with beneficiaries and random population confirm that in Cuba people still survive. In spite of the *institutionalisation of all vulnerable categories* still not all individuals are covered.
5. *Food tickets* cover the basic necessities for 10 days: only coffee, sugar and rice, no oil.
6. Typically people who have no access to productivity and have no or *less coping mechanisms* are: children, elderly and disabled people.

Where are the pockets of vulnerable people living in precarious situation:

1. **Elderly** people: 13 % of the Cuban population are elderly. From them 9% are living without family support. It is assumed that at present only 20% of the elderly without relatives would benefit from social services, which would leave *100.000* elderly without assistance. This statement should be verified.
2. The prisoners and families of prisoners

[13] UNDP.org: Cuba_appeal. htm: Emergency situation in the republic of Cuba; Consolidated appeal from the UN, Recovery and Rehabilitation Programme, Dec. 1998.
[14] See Annexe IX on vulnerability as viewed by present NGO's

3. Other **social-economically excluded**: single mothers, street children, alcoholic and disabled people.
4. Medically vulnerable: the **chronically ill**: insulin-dependent (around *35.400*), asthma, TB and hypertension. AIDS patients and sero-positives are often admitted in sanatorium. Besides in sanatorium where HIV positive and AIDS patients are treated (there is rarely treatment with antiviral drugs available), the *terminology used* is still of “protecting the rest of the population” and “deviation of normal conduct” which leads to social inequity.
   Moreover there is no access at all time to drugs and disinfectants nor hygiene products.
5. **Racial inequity:** 40% of the Cuban population is from *black origin* (imported slaves or refugees from Dominican and Haitian wars). In spite of the legal equality of races and of prohibition of racism, little black and few mulattos ascend to governing posts. The highest concentration of black population is found in the Orient, in the rural area. Amongst Caucasian population the black man is socially accepted but still mistrusted. They used to benefit from social reforms but in a difficult economic context they are the first to be sacrificed.
6. The island has a **geographic inequity** for climatic and racial reasons. *The East* is in the lead for *natural disasters*[15]. The last occurred last year.
   Also most of the Negroid population lives in the capital and in the East.
   Access to health and communication is more difficult because of the many mountains.
7. *Women have equal rights* at all levels and 47% of the hospital executive are women. As in other Latin American countries the society is of a «machismo» and intolerant to any deviation. This problem is reflected on all types of minorities. Prostitution has also increased with tourism as a way to generate hard currency.
   The Special Period saw the creation of Pregnant Mother homes. Healthy pregnant are still advised to join the *pregnant mother homes* in order to receive their share of vitamins and proteins. At the same time they are isolated from family life and concentrated in structures with lack of resources.
8. Therefore and as long as the Cuban government is desperately fighting to keep its marginal groups and ill in over-sized centres with obsolete infrastructure and borderline hygienic conditions, all the **institutionalised people** are vulnerable and especially in some of the elderly homes.

Conclusion:

There is a strong tendency within the Cuban State to provide everything for the citizen. Cuba applied the same feeding-bottle policy applied by the USSR to Cuba’s citizen. This is a double-edged sword:
Given the difficult economic context the state can no longer provide institutionalised coverage of good quality for all its ‘vulnerable’ citizens.
But because of the long-term history of over-institutionalising of vulnerable people, especially during the Special Period, individual coping mechanisms no longer exist. This **institutionalisation** is done with the best intention but creates a difficult situation for many people.
On the other side it is difficult to guarantee full coverage of all vulnerable citizens in a comprehensive programme, e.g. the elderly, family of prisoners etc.
The social and health system is also put in danger by the desperate efforts to keep the institutions in the same grandeur and size as induced during the USSR influence period. The quantity of institutions is a direct threat to quality of care when financial and trade resources are low.

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[15] See Annexe XII, table 7: Humanitarian aid by ECHO in Cuba: note the disasters mostly occurring in the Oriente.

Health and social sector:

Demographic features and Health status

The population of Cuba in 1998 was 11.1 million inhabitants; with a total of 151.080 new alive born, a crude birth rate of 13.6 per 1000 inhabitants, an average annual growth of population of 4.5 per 1000 inhabitants, a global fecundity rate of 49.4 (per 1000 women between 15 and 49) and a total fecundity rate of 1.58 (children per woman). The life expectancy at birth (1995-2000) is 75.48, 73.5 for men and 77.5 for women.
12.7% of the people were over 60 years old in 1996, 14.6% are nowadays and 18% are expected to be in the year 2015. In this respect, Cuba is at the moment the third country in Latin America (in ageing population) and is expected to be the first in the years to come. This implicates the threat of an ageing population and a social security and social services with high expenses.

Thirty years ago, infectious and parasitic diseases were a main cause of mortality of the Cuban population. Nowadays, there is a clear predominance of the chronic diseases, degenerative diseases and accidents. The first causes of death at all ages are the heart diseases, malign tumours, cerebrum-vascular diseases and accidents and they account for 65% of all deaths.

The estimated mortality rates (adjusted rates per 100000 inhabitants) for 1999 are 142.0 (heart diseases), 114.0 (cancer), 56.2 (cerebrum-vascular diseases), accidents (38.7), suicides (16.0) and diabetes mellitus (11.0).
It is worth to mention that in 1998, the addition of “external” causes (accidents, suicides and homicides) accounts for 8127 deaths and would be the third cause of death, behind the cerebrum-vascular diseases.

Again in 1998, the main mortality rates were 7.0 (general mortality per 1000 inhabitants), 7.1 (infant mortality rate, per 1000 live birth), 12.8 (perinatal mortality rate), 47.7 (maternal, per 100.000 live birth).

In relation to the morbidity, the incidence of mandatory reported diseases in 1998 shows a rather similar picture related to previous years. In the first place there is acute respiratory disease (44178, rate per 100.000 inhabitants) followed by acute diarrhoea (8703, rate per 100.000), blenorragia (266, rate per 100000), chickenpox (196, rate per 100000), viral hepatitis (153, rate per 100.000) and food poisoning outbreaks (92, rate per 100.000).
Concerning the classic transmissible diseases, the situation is really good due to the optimal vaccination coverage (in 1999 and in children less than 2 years; it was for example 99.2 for BCG and 91.1 for DPT less than one year).

In general, the epidemiological pattern tends to be rather similar to our northern societies. However, the water and food related diseases together with the ones related to the extremely poor housing and hygienic conditions, constitute an increasing and serious public health threat.
Following the opinion of the national director of epidemiological surveillance, the water-transmitted diseases (acute diarrhoeas, typhoid fever, hepatitis A), are a public health priority and are linked to the water supply problems and control.
Other public health priorities in his respect are the fight against dengue, the AIDS epidemics and diabetes mellitus.

The Health System

Basis, policy and organisation

Health has been in the past and still is a cornerstone and a political priority for the Cuban government. The Cuban **Health policy** aims to improve the health of the Cuban population and prioritises **strategies** related to the reorientation of the health system towards primary health care (family doctor and nurse); the improvement of hospital care; the stimulation of high tech programmes and research institutes; the development of drug programmes and natural/traditional medicine; and to give attention to stomatology, ophthalmology and health transport.
The Health strategy emphasises equity, health education and promotion, disease prevention, decentralisation, multi-sectoral approach and community participation.
The four priority programmes are mother & child, chronic diseases, communicable diseases, and care for elderly.

The Cuban National Health System is financed and ruled by the State through the Ministry of Public Health (MINSAP) and by the law is defined as unique, integral and decentralised. Its main characteristics are:

- Financed by the state budget
- The organisation and provision of the services is completely public
- Universal coverage
- Free of charge at all levels (except small/symbolic contributions for medicines, spectacles)
- Constitutional freedom of access to any level
- Run by civil servants paid by salary

The **organisation** of the system is based on the Public Health Law (1983), and establishes three levels in coincidence with the administrative division of the country: national, provincial and municipal.
The Ministry of Public Health (MINSAP) at central level, has the regulatory/normative and methodological functions, as well as the co-ordination and control roles.
It also manages directly the university centres, the research and highly specialised institutes, the pharmaceutical industry (IMEFA) with its production laboratories, the company distributing medical/surgical material and equipment (EMSUME) and an import-export company for medicines and medical equipment.
The provincial level is represented by the Provincial Direction of Public health, depending administratively and financially of the provincial governments. They manage directly the provincial hospitals, blood banks, the provincial centres of epidemiology and hygiene, the educational centres (for health technicians) and a network of pharmacies.
The municipal level is represented by the Municipal Direction of Public health, depending administratively and financially of the municipal governments. And the units attached to them are the policlinics, municipal and rural hospitals, municipal centres of epidemiology and hygiene, stomatology clinics, elderly homes and centres, centres for physically and mentally disabled people and mother homes.
The financial flow between the three levels is not very transparent.

Annex II shows the organisation of MINSAP at central level.

Physical resources (infrastructure)

In annexe XII, Table 1 shows the physical and human resources (total numbers) over the last decade and *table 2* the physical resources by type of institution over the last decade. Finally*, table 3* shows the number of beds per type of institution in the period 1992-1998.
In 1998 MoH counted a total of 67.282 medical beds, out of them 60.215 in hospitals and 5870 in other units such as policlinics, mother homes and others. The beds for social assistance were 13.499, out of them 10.847 in elderly homes and 2652 for physically and mentally handicapped persons. In total, there were 139 beds per inhabitant.
In 1999 the estimated number of medical beds were 61.110 and for the year 2000 it is expected to reduce to 58.550. So far a tendency to decrease the number of installed beds.

Human resources

As above mentioned, *table 1* shows the human resources of the system over the last decade.
In 1998, there were a total number of 63.483 doctors (29.924 family doctors), 9873 dentists, 1825 pharmacists, 82.527 nurses and 56.637 technicians. The increase in the number of health professionals has been tremendous over the last years. For instance, the number of doctors in 1998 is 3.5 times that of 1980 and almost two times more than in 1990. The family doctors in 1998 were 2,5 times more than in 1990. In the case of dentists, the increase between 1990 and 1998 was 30% and for nurses 16%.
The preliminary budget for the year 2000 foresees an increase of 25% in the salary budget line due to the incorporation of 2367 new doctors, 162 dentists, 1919 nurses and 3230 technicians.
Generally speaking, the technical level of the health professionals is very good compared with other countries in the region.

The personnel management of the health institutions is counterproductive. Official policy is to leave people in jobs until alternative employment can be found.
The salary however is not a major cost as the highest is 450 P/month for a specialist doctor and 300 for the Provincial Delegate of the MINSAP.

Financial resources

The following table shows the preliminary budget for the year 2000 in relation to the previous years:

CUBA: MINISTRY OF PUBLIC HEALTH, PRELIMINARY BUDGET FOR THE YEAR 2000 (in million pesos)

	REAL	BUDGET	ESTIMATION	PRELIMINARY
CONCEPT	1998	1999	1999	2000
TOTAL	1344,9	1410,0	1600,2	1732,0
SALARIES	771,8	820,5	987,7	1027,6
OTHER EXPENSES	573,1	589,5	612,5	704,4
of which				
- Food	67,8	63,0	71,0	74,2
- Medicaments	195,9	211,0	183,8	211,0
- Repairs and Constant Maintenance	21,2	20,0	42,9	44,8

In 1999 the composition of the budget was 62% of the total for salaries, 12% for medicines, 4.4% for food and 3% devoted to maintenance. Besides that, 127 million .USD is expected to be the total amount for medical equipment and material for the year 2000 (to be bought abroad in hard currency).

The following table shows the public health expenses over the last decade and the expenses as percentages of the GDP:

YEARS	EXPENSES IN PUBLIC HEALTH	EXPENSES AS % OF GNP	EXPENSES AS % OF THE TOTAL CONSTANT EXPENSE
1990	937.4	4.8	6.6
1991	924.9	5.7	6.3
1992	938.3	6.3	6.6
1993	1076.6	7.1	7.4
1994	1061.1	5.5	7.5
1995	1108.3	5.1	8.0
1996	1190.3	5.2	9.3
1997	1265.2	5.5	10.0
1998	1344.9	5.6	10.3
1999	1410.0	5.9	10.7

The above tables show a constant increase of the public health expenses over the last decade. Even during the worst years of the “special period”, the country managed to maintain and even increase the level of expenses in public health.

Performance and perspectives

The hospital network has reduced its activity over the last decade at the same time that the activity in the primary health care settings increased.

	1990	1995	1998
Admissions per 100 inhabitants:	15.2	13.1	12.5
Length of stay:	10.0	10.1	9.3
Bed occupancy rate (BOR):	78.5	73.3	69.6

Comparison between 1997 and 1998 learns that the admissions to hospitals have decreased by 4%, consultations in emergency rooms have decreased by 12.5% and external consultations in hospitals decreased by 20%.
Direct observation in the health facilities visited, gives the impression that bed occupancy is low and in some cases less than 50%.

In general, the health infrastructure is very generous but exceeds by large the needs and the comparative international standards. Moreover, its situation has deteriorated during the past years due to the lack of maintenance and inversions. Buildings are in bad shape and often oversized and infrastructure and medical equipment are obsolete. Most equipment dates from the seventies and spare parts that should have come from the previous East block are recuperated from defective machines.
The health facilities are overstaffed and paradoxically, more professionals are incorporated into the system. The management of the system is poor. Efficiency is the main weakness.

In 1996 and related to the crisis of the "special period" a new policy of improvement of the health system was defined. The key aspects are improvement of quality, efficiency and client satisfaction.
And in 1998 a policy of redefinition ("redimensionamiento") is defined and starts timidly to be developed in the hospital sector reducing the number of installed beds.
However, the reduction of installed beds in itself is not diminishing the running costs. On the contrary, can reduce efficiency. Mainly because it is not accompanied by the reduction of personnel (as pointed out before, for the year 2000 is expected a significant increase in personnel).

At present, certain health services are not available for most Cubans meanwhile top technology is available in highly specialised centres. In other words, a "two speed " system is running: there is no food or hygienic products to clean the hospital and at the same time, high tech equipment is prioritised (e.g.nephrology and cardiology equipment**)**

In brief, the Cuban health system has many positive features and achievements: in particular, the human resources. However, as it is at the moment is clearly not sustainable. In our opinion, the need for a deep "re-dimensioning" and reform is an urgent priority.

Other departments dealing with the social assistance programmes

The Ministry of Work and Social Security

Within the Ministry there is one General Direction in charge of social assistance and social programmes. This department is responsible for social assistance, community oriented social programmes; and associations for disabled.
As it was the case for the MINSAP, the central level assumes the regulatory and methodological function and the co-ordination and control roles.

- The social assistance is managed and funded by the Municipal Direction of Work and Social Assistance; and includes assistance in cash, in services (paying the bill of water, electricity, and the food for children at school and in kind (supplementary food, cleaning products or clothing). The social worker evaluates the need according to given scales.
- Community oriented social programmes care for elderly, disabled, single mothers and children in social disadvantage. In the case of the elderly it can include the classical home care services such as cleaning, cooking or washing. These programmes are also managed and funded by the municipality.
- Associations for disabled: there are three national associations: "Asociación de Limitados Físicos Motores" (ACLFM) with 46000 members, "Asociación Nacional de Ciegos de Cuba" (ANCC) with 19000 members, and the "Asociación Nacional de Sordos e hipoacúsicos" (ANSOC) with 14000 members. The three of them have provincial and municipal branches and are mainly subsidised by the State.

In the past there has been a comprehensive institutionalisation of the elderly. Presently because of waiting lists and the increasing ageing of the Cuban population there is a new wave of des-institutionalisation. Two ministries are dealing with the attention and care of elderly people: the primary health care team of MINSAP (family doctor, nurse, social worker and gerontologist), and the social workers of the Municipal Direction of work and social assistance in charge of home care programmes.

The Ministry of Internal Commerce

The *gastronomy* department belonging to this ministry is in charge of the so called "restaurantes de la familia y mercaditos comunitarios" (family restaurants and community markets).
The family restaurants provide meals to the vulnerable elderly (earning less than 50 pesos per month) with symbolic payment of 1 peso.
In the community markets any person with an income of less than 50 pesos, can benefit of a daily meal.

The Ministry of Housing

The Provincial Direction of Housing has a specific department dealing with people without home, named "Unidad Provincial de Atención a las Comunidades de Tránsito" (UPAAC) These units take care of the persons affected by collapsed homes[16] and social cases (persons migrated from other provinces, alcoholics, ex-prisoners, new couples without home).
The above mentioned persons are re-allocated in collective centres/buildings for a transitory period. The problem is that in many cases and due to the lack of new houses, the persons can stay for several years [17].
The living conditions in those buildings are extreme from a humanitarian perspective: a "normal" standard maybe one room per family ("cuartito") without water, one bed for adults and child and lack of hygienic conditions.
It is worth mentioning that presently and only in La Havana around 125.000 people live in these centres.
In brief, the social programmes suffer an excessive institutionalisation. However, presently there is an increasing openness towards community oriented approaches. This fact together with the existence of basic infrastructure and human resources (both within the health care system and the municipal social services) creates the conditions for supporting community based home care services for the vulnerable elderly people.

[16] very common; in the district of Centro Habana there is an average of almost two buildings per day
[17] we interviewed persons leaving in such centres for more than ten years

3. EVALUATION OF ECHO INTERVENTION IN CUBA

Introduction

ECHO's intervention in Cuba started in 1993 with the intervention in favour of the population affected by the cyclone in the eastern provinces (decision CE 31.03.93). The disaster occurred in the midst of the economical backtracking of the special period and triggered by the US embargo and the collapse of the COMECON, thus severely affecting the Cuban public health system.

The humanitarian aid of the EC to Cuba is based on two principles:
- The needs of the most vulnerable population in the middle of the economic crisis
- The political criteria established by the Common Position and defining the scope of interventions.

After a needs assessment in 1994, a first **Global Humanitarian Aid Plan** was started, to be followed by 5 more until 1999 (see Table 7 for all projects).
The support went mainly to the area of health. The beneficiaries are the population *most vulnerable to the critical situation* and who need *special medical and social attention*. They are kids, elderly, pregnant women, mentally and physically disabled and the chronically ill.
The global plans basically cover food, drugs (both raw materials and medicines), hygiene products, linen, medical and dental material to be distributed in all the medical and welfare centres throughout the country. These include hospitals, policlinics, dental surgeries, rest homes, sanatorium for Aids patients and blood banks.
The first and second plan supported national orthopaedic programmes and also drinking water programmes with the National Institute of Water Resources.
The partners of ECHO in the global plans were sixteen European NGOs with as counterpart the Cuban MINVEC and MINSAP. They actively participated in the *needs identification*.
ECHO co-ordinates and facilitates the work of the NGOs which includes *implementing and supervising the aid* together with their local counterpart, supposed to be Cuban NGOs or decentralised government.
In the first plan each NGO was responsible for the distribution of the purchased product all over Cuba. Comparative tendering effects purchases. Because of logistic constraints and efficiency, from the second plan onwards each NGO remained responsible for the purchase of specific items and each NGO was assigned one province.
Monitoring of the distribution became more feasible and it was more transparent how the target population was reached.

The **Microprojects**[18] were approved to complement the global plan of humanitarian aid in 1996, with 2 objectives:
- To reach the vulnerable group of the population not covered by the Cuban public services (or not accessed by the Global Plan).
- To resolve the bottlenecks caused by deficiencies in infrastructure and equipment in the beneficiary institutions and which are impeding the reception of humanitarian aid.
- A third objective is added more silently: reinforce the role of the Cuban civil society, generating collaboration with local NGO's as Caritas Cuba.

In 1998 and 1999 the **Dipecho** projects were added to reduce the harmful effect of natural disasters on the economy and to protect the vulnerability of the population, by training and information of the most vulnerable population and reinforcing the essential infrastructures.

The European Union still is the main donor especially through ECHO, with a support to the sanitary and social system worth more than 76 million Euro from 1993 to May 2000 (see **table 7** Humanitarian aid by ECHO in Cuba)

Previous evaluations

The evaluation of April 1998 was carried out after the Fourth Global Plan. In its analysis the appropriateness of aid reaching the vulnerable population was considered to be fair. However some groups of vulnerable people were considered excluded of the group of beneficiaries. They comprise elderly without family support, single mothers and children less than 7 years in homes and interns between 7 and 13 years old.

[18] see Annexe VII

The relevance of the aid was evaluated as being high and all the elements of the aid were essential. The institutional capacity of the MINSAP increases the relevance.

Practical recommendations were:

-For Microprojects: to define the strategy lines for identification of future projects.
-The Global Plan:
Improve the transport.
To reduce oil and double the milk donation, which has been done.
Avoid accumulation of drugs in the laboratories.
Improve visibility of aid and distribution with the logo "European Union donation":[19]
Increase the proportion of Insulin Actrapid to Insulatard to resolve better the diabetic crises: from 11% Actrapid in 1997 it became 16% in 1999.
To decrease the number of raw materials: from 17 to the 14 presently.

GHAP 1998:

The following table shows the proportion of Aid in the 5th Global Plan, 1998

ITEMS	Euro	%
Drugs (finished product)	1.200.000	16,8
Drugs (Raw material)	1.100.000	16
Food	1.550.000	22
Hygiene products	700.000	10
Clean linen	700.000	10
Medical & Surgical material	1.050.000	15
Stomatology products	600.000	8,6
Reserve	100.000	1,4
Grand TOTAL	**7.000.000**	**100**

Global Plan for Humanitarian Aid 1999:

The design:

1. Evaluation by independent consultants about needs and priorities.
2. Echo prepares action plans with a distribution plan, in accordance with MINSAP and MINVEC
3. Each selected NGO buys a product (food, hygiene etc.)
4. The NGO in co-ordination with ECHO organise the transport to Cuba
5. The state company ESCO (Empresa de Servicios para la Colaboracion) in Havana receives the goods and performs the custom formalities
6. ESCO organises transport from the harbour or airport to the main warehouses of Havana or seldom directly to the provinces.
7. Each *NGO is responsible for the distribution, control, monitoring and evaluation of the humanitarian operation in its assigned geographic zone*. But the transport is done by ESCO
8. The aid is distributed to the whole country through centres of social attention or by the pharmacy network.

The BENEFICIARIES of the humanitarian aid are reached through the health and social system, being hospitals, polyclinics, dental clinics, elderly homes and houses, maternity houses and pharmacies. They are all the people admitted or assisted in these units including chronically ill receiving drugs from the pharmacies. The total is estimated to cover 16% of the Cuban population.

Planning and identification of needs

[19] when the company forgot to mention the logo the product was sold in the pharmacies instead of being free of charge.

The strategy tries to comply with the objective of reaching the most vulnerable but has to be conform to the MoH system. Notwithstanding the ECHO needs assessment and because of a MoH using its own needs identification system the ultimate decision taken after long negotiations is deviant from the primary needs identification.
Rather than a strategy there are criteria of distribution.

Practically:
Largely the needs are identified at the Central level, MINSAP (at EMSUME for the medical material).
The needs for alimentary, cleaning products and fabrics should be calculated on the number of real, occupied beds for adults. For paediatric beds an extra factor for milk is included.[20]
NGOs participate in needs and priority identification within the limits of ECHO's and MoH priority list.

Intervention strategy:

The MoH defines the intervention methodology. All aid is canalised through the MoH distribution system and means and to its institutions.

The objectives:

1. Guarantee treatment for patients with chronic high-risk diseases.
2. Ensure surgery for patients with serious acute diseases.
3. Support the dental-oral health programme, targeting pregnant women and children.
4. Provide extra proteins, vitamins and fats for patients in long-stay care centres with priority given to Pregnant Women houses and to hospitalised children.
5. Guarantee hygiene in hospital and social centres, policlinics, dental clinics and blood banks.
6. Maintain minimum hygiene conditions for patients during surgery and convalescence in the hospital.

The means:

1. Provide 14 raw materials for local drug production and short and long acting insulin (see Annexe III).
2. Supply small clinical and surgical equipment.
3. Supply and distribute dental and oral care products.
4. Supply and distribute food in hospitals and mother houses: powder milk, vegetable oil and canned meat.
5. Supply and distribute hygiene products
6. Supply and distribute fabrics, green for surgery and white for sheets in the hospitals.

The process:

Of both 1999 Plan and microprojects are:
The selected NGO purchases the product in Europe and contracts the transport to Cuba. In general, each NGO is in charge of buying a given item although there are some exceptions in order to balance different budgets. The transport is by sea in the case of the non-perishable products (Coral line, Nirint Shipping, Melbridge line and Keneker companies), and by air in the case of raw materials, medicines and one part of medical material (Cubana de aviación, Iberia and Air Europe).

Once the product arrives in Cuba, the state company "ESCO" (depending to MINVEC) takes care of the customs procedures and the transport to the "ad hoc" central warehouses in Havana. This process is closely followed up and "pushed " by the persons in charge within the ECHO-Cuba's office. Note that ESCO does not have its own trucks, so it has to subcontract the service.

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[20] Factor 1 (being bag, box or drum) is used for distribution of meat, soya and milk to the Centres of Social Assistance per bed and ½ for the places and the other hospital institutions. Factor 1 also to calculate the milk for Paediatric beds, Psychiatric, Gynaeco-Obstetric and Oncological hospitals but ½ for the places.
The day centres calculate the places, being the number of daily visits to establish the needs.
For the policlinics and the dentistry the number of seats and the number of consults are considered.
White linen goes to the Centres of Social Assistance and hospitals and green linen to Surgical Units of the hospitals.
Toilet soap is distributed to hospitals, Centres for Social Assistance, polyclinics, dental practices and blood banks. Industrial detergent goes to city hospitals and homes with over 100 beds.
Domestic detergent is issued to Centres of Social Assistance, hospitals, policlinics, dental practices and blood banks.
All items, food included, are distributed according standards of consumption established by the MINSAP: e.g. x Gram of milk per bed or Y gram per place of day visitors of homes or X Litre of detergent or disinfectant per bed and/or per place.

Last year, five central warehouses were involved in this process (Cangrejeras, Fábrica, calle Monte, EMSUME warehouse and National Base of Transport).
Food, hygiene products and linen are stocked in the warehouse of Cangrejeras at 25 km of Havana.

In some cases (when the quantity assigned to the province corresponds with one or more containers), the content is sent directly through ESCO to the province where the NGO and provincial MINSAP supervise the reception. In the other case, transport starts from the central warehouses and the products are sent directly through the MINSAP transport company to the provincial warehouses belonging to MINSAP. From there, goods are distributed to the final beneficiaries (health and social institutions belonging to MINSAP).
ESCO is very bureaucratic and not efficient. They cause important delay when goods must go through the customs. Often they send documents back because they are judged incomplete or insufficient [21].

In the case of raw materials, they are transported from the central warehouse to the different pharmaceutical laboratories (7 in 1999). And after production, these drugs as well as the insulin are transported to the National Base of Transports. From here they are distributed to the provincial warehouses for further distribution to the pharmacies and the health institutions. Some provinces come to Havana in order to pick up their share of medicines.

In brief, the bureaucratic procedures are extremely heavy and slow and the management of the whole process is poor. Although some improvement has been noticed over the years, in 1999 a worsening of the situation related to customs procedures and central storage has been identified. According to our information, the key problem is the transport. As pointed out before, ESCO has to subcontract the services of transport to another state enterprise.

Conclusions according the Logical Framework of the Global Plan

Relevance

Needs assessment:

- Serious attempts have been made to identify vulnerable groups through the MoH institutions. More work needs to be done to identify the excluded especially the elderly living alone.
- Now the NGO's role is merely restricted to a logistic executor. However, their knowledge of the province, the institutions and the needs of the population can be used more properly with a technical support of ECHO for needs identification and priority setting.
- Where even the **community movements are institutionalised** it will need time and innovation to have the *grassroots participating in the needs and programme assessment*. The advantage however of a government linked NGO is the *absence of private and political wing interests* which is sometimes typical for NGOs in other countries.
- The objective of reaching the vulnerable covers almost the entire health and social system (see previous objectives). Apparently the concept of 'pockets of vulnerable people' is still politically a sensitive issue.
- Presently priorities cover almost the entire health and social system, especially when the microprojects are added. It is not evident in which degree NGOs did participate in needs assessments previously.

Context:

- There is a **good understanding** of the adverse effects of the Cuban double speed economy and the vulnerable groups created by this. But to really identify the criteria of vulnerability social instruments are needed together with time and participatory consultation of NGO and beneficiaries. In emergency projects sufficient time is not provided
- In order to be more effective partner NGOs should be empowered and their legal entity obtained through negotiation with the authority. This is the only way to make use of their thorough experience. The same empowerment is needed for involving community and local NGOs.
- Microprojects and individual decisions reinforce the global plan.

Other interventions:

- ECHO is also financing actions to prevent the impact of catastrophes on the vulnerable population: schools, health and social facilities.
- Other EC *interventions* are food aid and security programme (phasing out), co-financing of European NGO projects (increasing) and economic co-operation (supporting economic reforms)

Co-ordination, coherence and complementarity:

[21] Mission report F.Galera & M.Nieuwkerk, Dec.1996, p.17

Co-ordination between NGOs has to be improved with participation of ECHO. The NGOs would appreciate more feed back on project planning and a clearer insight in the plans of ECHO Brussels.

- ♦ Co-ordination seems fluent and more professional with NGOs implementing other programmes beside ECHO's. Those NGOs don't have to leave because jobless during bridging periods.
- ♦ The authorities have instruments to co-operate but make it unnecessarily complicated. The complementarity between NGO and authorities is potentially there. Therefore ECHO should take a harder line of negotiation with the government to facilitate the work of NGO's.
- ♦ *Action on information received from the periphery (NGOs and recipient centres) should improve*. ECHO passes the information to the MINSAP but without consequence: e.g. too many long needles and lubricant oil for endoscopy is not used but remains in the racks. Communication lines and feed back from the recipient centres should be top priority.
- ♦ The ECHO representative is in acting position. The communication with NGOs and IGOs needs improvement. Many issues are too diplomatic to be neglected (NGO legality, ECHO's image e.g.).
- ♦ The NGOs play the essential linking role between ECHO and the beneficiaries. But between the 4 EC instruments there is lack of co-ordination. Co-operation between the instruments and the expected complementarity could be strengthened and be less competitive.

Effectiveness:

- ♦ Distribution and consumption of the aid is effective but distribution is slow. However, over-dimensioning and top technology of the Cuban health services as well as the health management based on ideology create a bottomless pit were the aid could be dissipated.
- ♦ The NGO-ECHO consortium has performed a **fair** distribution of activities.
- ♦ Part of the vulnerable population is reached through and with the government instruments but the rest does not benefit because of the emphasis on institutionalisation of vulnerable people instead of on community orientation.
- ♦ As the project focused on supporting the most vulnerable, project costs were justified so far. However there is no long-term strategy of improving the most vulnerable.
- ♦ Key solutions are: community oriented services for elderly; support to the MoH in developing strategic thinking on health and social system reform. Hard-line negotiation on improvement of customs and transport; and acceptance of real re-dimensioning and common sense technology in the impoverished health and social system.
- ♦ **Participatory needs assessment** and **re-scaling of the health and social system** are not taboo but neither easy to negotiate. They indeed require a process of substantial health reform.
  As participatory needs assessment is weak, the target of the aid is not sufficiently focused and cost benefit of the intervention weakened.
- ♦ After consulting the stakeholders some products must be rethought in a future planning.

Monitoring of the global plan by the NGO's lead to following *conclusions for future implementation*:

- **Priority** in the food items is oil and then milk. The national milk production needs to be boosted with other EC instruments.
- Cloth has been given enough. Supervision of these items must be left to the hospitals. Textile production to be stimulated.
- Dentist and surgical material are no priority except devices for dialysis devices.
- Insulin is important and of the raw materials those treating chronic diseases as hypertension, asthma and epilepsy should be kept. The products processed with delay must be discarded.

Conclusion:
Because of *lack of strategy and lack of insight in the public health approach*[22] it is not possible for ECHO to perform proper needs assessment. Nor is it possible to monitor whether *efficacy of the aid* is pursued.

[22] See Chapter 6

Technical assistance is needed in order to advise how resources can be used in the most effective way and which investments have the greatest return (equipment, rehabilitation).

Efficiency of aid:

Partner and logistics:

The output of the NGO consortium is constrained for following reasons:

- State *bureaucracy* and not functioning of feedback communication because of *centralisation* affect the purchase and distribution of items. Apparently most information and feedback of the provincial MINSAP gets lost on its way to Havana. Needs identification together with the province is *gradually improving*, learning from the past.
- The reason seems not to be the communication at Provincial level. As far as observed in the 4 visited provinces communication between the provincial MINSAP, the provincial and municipal offices of ESCO and the NGO happens in *better harmony*.

Lack of established communication lines and effective co-ordination makes the programme overall vulnerable. Too many relations seem informal. However negotiation with the Cuban government is said to function best this way.
The yearly identification and adaptation of needs is supposed to be done by the NGO co-operating with ECHO in each of the provinces and by the responsible of the recipient centres together with the Provincial Offices of the MINSAP. In reality little effect was given to the recommendations. The result is that in some cases, inapt items are brought in or items are piling up on top of the already available items.
An example for the first was the delivery of washing machines in homes for elderly (microproject, July 1998). The last machine has just been installed last month because no previous study was done by the MINSAP on the feasibility of the project. Electricity or water system was deficient. Both deficiencies are typical in the Cuban system because of obsolete equipment and the difficulty to find spare parts from previous COMECON countries.

Efficiency in distribution and transport (managed by ESCO) leaves a lot to be desired. The transport[23] and the distribution cause a lot of **bureaucratic headaches with no lessons learned**.
Delay in processing may affect the **bioactivity of a product** e.g. nystatin [24]looses 1%/month even if kept in the best condition. These products need to be suspended or technical advice from the pharmaceutical industry has to resolve the problem if transport and processing don't improve.
In general, the distribution within the province is much faster than the primary. As a general rule, the more peripheral the quicker the distribution system operates.

Monitoring:

By the NGO's:
There is no *standardisation of the monitoring of aid* established between the NGO and ECHO consortium. The variety of forms and techniques are as many as the NGOs. The result is that not the same accuracy is obtained for the follow-up of storing condition, visibility and distribution.

By the MoH:
Several provincial MoH have adopted the system, which is a good sign. As there is a variation of NGOs and no frame for supervision, other NGOs do not interfere in the MoH internal affairs and consider the aid as accessed when received by the province. The government does not always facilitate monitoring.
Of course when the monitoring is too thorough there is little space for the provincial health administration to organise a proper monitoring system.
Operational and budget management is fair. There is good technical competence for execution of the programmes.
Quality of products has improved. Because of previous problems there is piling up of raw material for drugs and medical items.

[23] See chapter of implementation
[24] See table 6

Quantitative results:

The following table shows the quantity and state of reception of items by the date.

Global Plan 1999			
PRODUCT	**NGO**	**PLANNED**	**% received by 4/2000**
Milk	CISP	304 Ton	99.8
Milk	MDM E	138 Ton	99,96
Cooking oil	MDM E	279.095 Litre	99,7
Canned meat	ACSUR	317 Ton	99,5
Hygiene products	MPDL		
Industrial detergent		266 Ton	99,6
Domestic detergent		165 Ton	99,4
Toilet soap		538.400 Units	96
Ammoniac soap		90.750 Litre	98,7
Clean linen, white	ANNF	118.000 m	Received Dec. 99
Green linen		88.500 m	
Decision 12/1999			
White linen		89.922	Received April 2000
Green linen		49.680	

For percentages of ECHO's provided items in relation to the estimated annual consumption in the country See Annexe III

For insulin the situation in dec. 1999 was:

DRUG	N° of registered patients	%
Actrapid insulin	1.944	13
NPH insulin	33.422	44

Conclusion:

Except for the raw material all the items **are distributed and consumed.**

Impact and strategic implications:

In most reports the *n° of beneficiaries* are considered the total number of visitors of the health system. This is of course an *overestimation*. Moreover, if statistical information is not reliable qualitative information may give a more realistic picture than quantitative information.
An example:
The pregnant mother houses are presented by the government as a success story. Such a success that some of them are by 25% overcrowded, with the same obsolete kitchen and laundry equipment as in most institutions.
The same is true for the elderly homes. Fit elderly without relatives are admitted in crumbling buildings (improved with ECHO aid) with poor washrooms. The homes are congested; there is little privacy and space for occupation. Also here ECHO supports with occupational aid and infrastructure equipment (see in the beginning of this chapter on ECHO strategy).
For sure it is not the aim of an ECHO programme to change the cultural pattern like for example the *collectivist socialist state approach*. But on the other hand it is questionable whether EU funds should be used to maintain an *inefficient system*.
The aid is **highly appreciated** by the MoH, as it is 100% **responsive to their needs definition**. The aid permits the MoH to redirect financial resources (hard currency) to one of their many other priorities.

Reduction of human suffering: The NGOs together with their local partners *feel motivated by the gratitude and relief* generated by the aid to the institutions. But part of the vulnerable are still excluded because only state mechanisms are used.

Health is indeed a government priority but not in terms of long term planning, but rather in terms of direct political visibility: e.g. unwillingness to close wards and to close inefficient wings of hospitals. The priority definition is keeping the "*Unique Health System of Cuba" running.* The issue is being raised on **oversizing and re-dimensioning** of the Public Health System, but the solutions still have to be worked on.

Dependency of the state on the unconditionally delivered goods and services and the dependency of the beneficiaries on the so called unique comprehensive health system reinforce the absence of the coping mechanisms of state and individual.
So far the aid has been useful for the health of the Cuban population but dependency is maintained in a yet over-dependent and over-institutionalised vulnerable population.

Perspectives and viability:
Cuba is not anymore in an emergency situation. However, the situation remains very **fragile** and can **reverse quickly** due to natural disasters and political and economic unpredictable changes both internal and external.
There is also a **wide consensus** that in Cuba currently **pockets of humanitarian needs** do exist.
An abrupt withdrawal of ECHO can seriously affect the vulnerable in the health and social sectors, and cause an additional stress for the system as long as alternative solutions are not prepared.
Besides, an important part of the positive impact of the past EC intervention by ECHO could be wasted.
Technical support is advisable to organise community programmes away from and complementary to the institutions and thus assure sustainability.

Visibility:
The visibility issue in general has improved over time. However, significant differences can be observed between NGOs and between projects.
It ranks from excellent to nearly absent according to which NGO.
Because Cuba is highly literate, public information through leaflets is advisable

Horizontal issues:
- Men and women are considered equal in legal terms, but machismo is still strong. Many directors in health sector are women.
- LRRD: The microprojects are too varied to have ideal impact and to prepare long term rehabilitation and development. Half of the microprojects are in fact an extension of the GHAP.
- Security is not an issue in Cuba with a policeman at every corner. Traffic is the major threat to safety.

Microprojects

Since they started in 1997 some of the projects respond to emergency situations. Others are complementary to the Global Plan as in the cases of insulin or linen donations.
The name micro is maybe not appropriate: worth 250.000 Euro and more they are full projects.
Next tables are an attempt to group the varied type of activities under the denomination of microprojects, which are meant to complement the aid to the more vulnerable.
The projects are grouped per type as far as possible because some projects are combined e.g. rehabilitation of homes, the kitchen and the garden for occupational therapy. The budgets are approximate for the same reason.
A full list of projects is provided in Annexe VII.

The main groups over 3 years and 5 decisions are:

TYPE of project	Euro
Kitchen equipment	2 million
Infrastr. laundry, steam, electr	1 m
Surgery, nefrology, laboratory	1 m
Drinkable water	900.000 E
Prosthesis	700.000
Cold chain	200.000
Clothes & linen	1.500.000
Shelter	500.000
Insulin	300.000

The logical framework is not repeated for the microprojects: most remarks are the same as on the Global Plan.

Some specific conclusions:
The above list of projects raises a question on the coherence of the scope of aid provided.
Diversification of action complicates the intervention strategy, the implementation, sustainability, criteria and instruments for monitoring:
Microprojects **are relevant as far as** they seek to implicate more the needs identification by the NGO and peripheral counterpart. If so, local actors tend to co-operate more. But co-ordination can be tiresome.
With respect to the ***technical quality*** the **interventions are adequate**.
The impact and efficacy are high when infrastructure of the health system has been improved (e.g. laundry). It is however questionable if the aim of reaching the most vulnerable is achieved.

The needs for surgical and medical material are also determined at central level in EMSUME (Undertaking for Medical Supplies). They intervene especially in the identification of needs of the Microprojects and the bridge decisions, backed by the specialist hospitals. By the decision of 1999 following products were purchased: Dialysis item M-15 and M-23, Vein and artery lines, subclavia and Tenckoff catheters, small surgical material, theatre and laboratory equipment (microscopes), ophthalmology, nefrology, cardiovascular intensive care material. Beside this and in previous plans orthopaedic (hip prosthesis, plates and screws) and stomatology equipment was purchased.
These kind of projects might fall under above-mentioned objectives but do not respond to the priority of needs of the most vulnerable. It seems more an attempt to keep up with the international high tech standards.
The *rehabilitation projects are not targeted*. As explained previously a public health specialist and a hospital manager would enable the NGO and ECHO team to direct the aid to sustainable structures.
Support to over-dimensioned hospitals is not a priority in relief aid and *far from sustainable*. There is no doubt that the actions are **lifesaving and improve the quality of life**. But again, technical support could help deciding which actions have the greatest return

Logical framework for separate activities

Evaluation criteria	Food security	Raw material for drugs	Microprojects
Relevance	useful so far but limited to MoH channels	meets the needs of the chronically ill	have improved by better needs assessment, but still long way to go
Co-ord/ co-op	needs improvement with GOs	too centralised	NGO-ECHO communication is better but co-ordination needs more decentralisation
Effectiveness	needs better targeting with community involvement	lack of strategic health system reform to make the drug supply effective	diluted targeting leads to low programme result concerning. Reaching the vulnerable
Efficiency	bureaucracy and poor transport by MoH and lack of standardised monitoring	poor: no oversupply of drugs can be tolerated, lack of technical monitoring	technically, implementation is good but transport and inter-NGO co-ordination is poor
Impact	good if direct impact is considered but capacity building and coping mechanisms do not benefit of the programme	partly good but poor efficacy in production and transport, also poor co-ordination within MoH instruments	good within the range of individual activity, less if considering an overall health and social strategy

ECHO's office in Cuba: Structure and functions

The ECHO's office in Cuba shares the physical space (premises) and personnel with the Food Security Programme (DG DEV) managed by Ms. Mireia Pita.
The personnel included in ECHO's budget are:

- 1 logistician/driver
- 1 security guard
- 1 secretary, sociologist, assisting both the acting co-ordinator of the office and the other expatriate staff member
- 1 Accountant, economist, in charge of the accountability and administration of the office (50% in ECHO's budget and 50% in FSP budget)
- 1 operations assistant, chemical engineer, in charge of the reception and customs procedures follow-up and paper work (both, the global plan and microprojects); nowadays, she is also assisting MBV in microprojects
- 1 operations assistant, pharmaceutical technician, in charge of the logistic follow-up and distribution of row materials, drugs and medical/surgical material
- 1 operations assistant, with pre-university studies, in charge of the warehouse and logistic follow-up and distribution of non-medical materials (food and cleaning/hygienic products)

In addition, the office has two ECHO experts: 1 primary education teacher with extensive humanitarian background in charge of the global plan and 1 economic statistician with generalist background, in charge of the microprojects and DIPECHO.
Although it is not clear from a formal and administrative viewpoint, the first expert assumes in practice to a certain extend the role of "ad interim co-ordinator"

The personnel included in the Food Security Programme -FSP are:

- 1 logistician/driver
- 1 security guard
- 1 cleaning lady
- 1 gardener
- 1 receptionist
- 1 secretary

Taking into consideration that ECHO and FSP services share the same premises, the human resources included in the FSP budget provide services also for ECHO except in the case of the secretary.

Finally, the office has 3 car (2x4), 6 computer PC, 4 printers, 1 photocopy machines, and 2 GSM mobile phones.

4. OTHER EUROPEAN UNION CO-OPERATION WITH CUBA

The other European Commission Services

Food aid and food security programme

The programme initiated its activities in Cuba in 1992. For the period 1993-99, a total amount of 22.6 MEURO has been invested.
The programme has had two main components, the direct assistance to the primary and secondary education centres through the provision of food aid and inputs ("insumos") for the school kitchen gardens. And the second component is related to the stimulation of the agriculture production through the support of private co-operatives and farmers by providing imported inputs.
In 1999 an evaluation was carried out and the major identified weakness was the sustainability of the intervention.
Recently, the main area of interest is the support of poor families in vulnerable areas in the production of vegetables and proteins in order to guarantee the self-consumption.

The current on-going project with a total value of 0.5 MEURO, started in January 2000 and is expected to be finalised in June 2002. It is being implemented by "Agroacción alemana" in the oriental provinces of Santiago, Guantánamo and Holguín.
According to the expert in the field, the perspective is to close the office in La Havana and to manage the remaining activities either from Central America office or from Brussels directly.

Co-financing of NGOs projects

From 1993, an aprox. Number of 106 projects have been financed with a total value of 21.7 MEURO; being the contribution from the EC 10.5 MEURO (48%).
At present, there are 10 projects in the pipeline (some of them from 1998) with a total value of 4.2 MEURO.
The main fields of intervention have been education, health, agriculture and alternative energies.
Since June 1999, the Commission has established a dialogue with the European NGOs on Cuba (Meso-dialogue), aiming to define a common approach to Cuba main problems and the way to address them in the frame of the Common Position.
At present a new strategic frame is under discussion with emphasis on the empowerment of Cuban civil society and improvement of living conditions for the most vulnerable individuals and communities.

Economic co-operation

According to a recent background note on "EC co-operation with Cuba"[25], this type of co-operation has two objectives: to support the undergoing economic reforms and to encourage the emergence of the private sector.
The Commission has consequently provided support to the reforms that have taken place at state level in the area of modernisation of the economy through technical assistance programmes. For example the support to the creation of a fiscal and budgetary system and the creation of a legal framework for the regulation of the energy sector.
The Commission has also funded projects aiming to promote the emergence of the private sector, such as the training of middle managers and professors on business administration ("DEADE", currently on its 3rd year), and the promotion in the setting up of small enterprises ("PYMES", the second year has just started).

[25] "EC co-operation with Cuba". Mimeo, May 2000

In the area of promoting European values, the EC is currently undertaking two projects: the spring European cinema festival in La Havana and the second phase of the TV program "Space Europe". Moreover, the EU pavilion in the Havana fair and the Santiago fair has been funded regularly over the past years.

Under the 1999 budget, the financial support for the EU participation in the Havana and Santiago fair has been renewed and also the TA program on fiscal and budgetary system support (second phase).

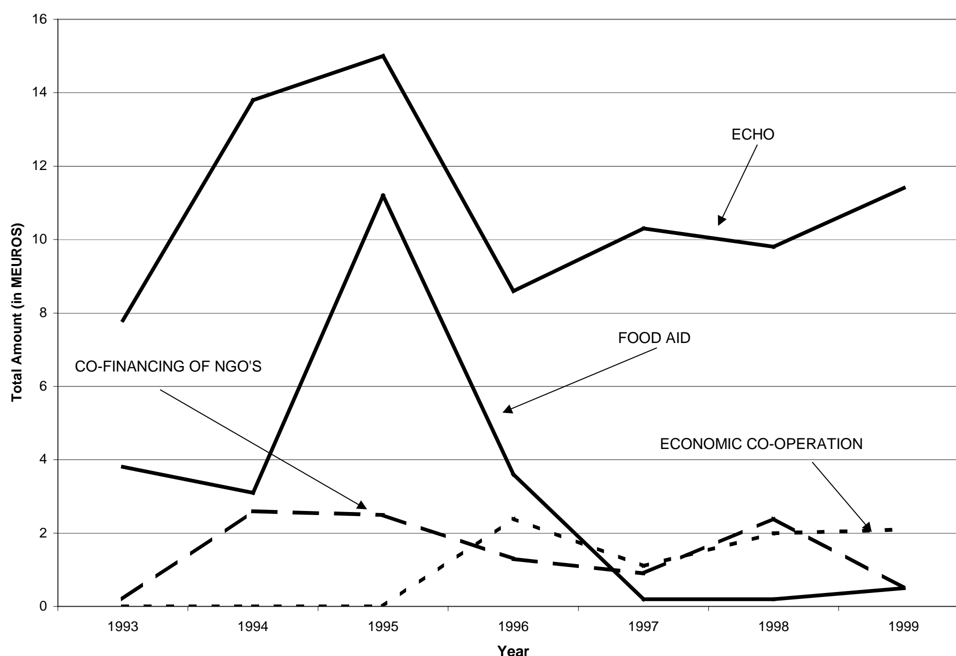
Finally, an identification mission on the support to economic reforms was undertaken in April (currently under preparation), and an evaluation /identification mission on the area of private sector has just finalised.

The following table summarises the EC Co-operation with Cuba in the period 1993-99:

EC CO-OPERATION WITH CUBA 1993-1999
(approximate figures in MEURO)

	1993	1994	1995	1996	1997	1998	1999	TOTAL	% OVER THE TOTAL
B7-210 & 219 ECHO (*)	7.8	13.8	15.0	8.6	10.3	9.8	11.4	76.7	65%
B7-20 FOOD AID AND FOOD SECURITY (Including T.A.) (**)	3.8	3.1	11.2	3.6	0.2	0.2	0.5	22.6	20%
B7-6000 CO-FINANCING OF NGO'S PROJECTS (***)	0.2	2.6	2.5	1.3	0.9	2.4	0.5	10.4	9%
B7-311 ECONOMIC COOPERATION WITH THE PVD-ALA. SUPPORT TO ECONOMIC REFORMS (****)	-	-	-	2.4	1.1	2.0	2.1	7.6	6%
TOTAL	11.8	19.5	28.7	15.9	12.5	14.4	14.5	117.3	100%

(*) Info checked with Mr. Santiago Vallejo, desk Cuba, ECHO 2
(**) Info checked with Ms. Mireia Pita, Food Aid and Food Security, La Havana
(***) Info checked with Ms. Ginevra Letizia, DG DEV
(****) Info checked with Ms. Belén Martínez-Carbonell, DG DEV



European Member States [(*)]

Spain

The Spanish co-operation is obviously important and is framed through regular joint commission meetings (every three years, the last in July 1998) and channelled by the Spanish International Co-operation Agency (AECI).
According to the Spanish sources, the total value of co-operation was (in million US$) around 11.6 in 1996, 6.0 in 1997 and 8.9 in 1998.
For the year 2000, it is expected to be around 10.7 MEURO from the Spanish Government and at least the same amount from the civil society and the different Autonomous Communities, provincial and municipal bodies (very difficult to estimate).

The main areas of intervention are: humanitarian aid, modernisation of economy and infrastructures, health and social sector, human resources education and training and cultural activities.
Currently, some significant projects are the “Acueducto Albear” (water supply system for 17% of the population of La Havana ant total value of 1.5 MEURO); and the rehabilitation of historical buildings in the old town. Moreover, the projects related to the education and updating of Cuban professionals, students and professors are also relevant.
The AECI is also supporting projects in relation to agriculture (credit co-operatives), water supply interventions, housing and the ones related to genre.

Concerning the more specific health and social projects, there are focused on primary health care (PHC), rehabilitation of hospital services and the support of elderly homes. These projects as well as the ones related to agriculture, housing and genre are implemented by Spanish NGOs. At present, around 12 of them are funded by the AECI.

In relation to the humanitarian aid, in 1998 was around 0.9 MEURO (oil and milk), 0.6 MEURO in 1999 (milk) and expected 0.6 for the year 2000.

France

The French co-operation has been relatively modest over the last years, and includes the named normal co-operation (0.6 MEURO for the year 2000) and the co-operation through the French NGOs (around 0.2 MEURO per year).
However, it is expected a significant increase in the coming years coming from the “Fond de Solidarité Prioritaire” (priority solidarity fund) (to be formally approved in June 2000). This would mean to increase by 375% the current budget dedicated to the so-called normal co-operation.

At present, the French co-operation is focused on the cultural field and the education/updating of Cuban professionals (mainly in health and agriculture).
Concerning the co-operation through NGOs, is implemented by around twelve French NGOS in partnership with local NGOS.

Belgium

There is no bilateral co-operation between Belgium and Cuba.
However, there are some collaboration programmes developed by universities in Belgium in the farming field (genetic research).
Moreover, the Belgium Co-operation (BTC) finances some projects of OXFAM-B in the field of farming and agricultural education and training.

[(*)] The information that follows has been provided by the different European Member States official representatives in La Havana

Italy

The Italian Co-operation with Cuba initiated in 1994. The bulk of Italian intervention is related to emergency programmes implemented by Italian NGOs or by UN Agencies like WHO and UNDP/UNOPS.
It is worth to mention that their emergency projects are based in an emergency logic but creating a sustainable basis for development.
Globally, there is a significant increase of the Italian Co-operation over the past years. For 1999, a total amount of 7.5 MEURO was foreseen, with an important increase in the co-operation through NGOs component.

In 1999 there were approved the following emergency projects:

- The “Havana vieja” project (0.5 MEURO; prevention of fall downs and rehabilitation)
- Mental health and reproductive health in Cienfuegos (0.3 MEURO)
- Assistance to the drought in Granma (0.5 MEURO; through UNOPS)
- Direct food aid (1 MEURO; and it was 5 MEURO in 1998)

On the other hand, the other main on-going projects are the following:

- “Programa de Desarrollo Humano a nivel Local” (PDHL) (Locally based human development program); with a total value of 1.5 MEURO and implemented by UNDP/UNOPS. According to Italian and UNDP sources, this program is being successfully implemented. Its key points are the decentralised (based locally) and multisectoral approach and the involvement of local communities and leaders.
- “La Havana Ecopolis”; project of recuperation of deprived areas and community-based sustainable development in the city of La Havana, with a total value of 1.4 MEURO and implemented by the ONG CRIC.
- Santiago water supply project; with a value of 1 MEURO and implemented by the NGO CISS
- Rehabilitation of the historical buildings in Santiago; implemented by the NGO APS and total cost of 1.4 MEURO

Germany

Germany has not bilateral co-operation with Cuba; only through the German NGOs.
However, and following the change of Government in Sep’98, it was decided to start the official co-operation from government to government. In Sep’99 an identification mission identified the Environment as the cornerstone for the future co-operation; including the empowerment of the Cuban environmental policy and TA for environmental issues such as fight against contamination, air pollution and erosion. The budget foreseen for this new co-operation could raise 1.7 MEURO for a period of 3-4 years.
A field visit of the German Minister of Co-operation was expected for the third week of May.
In relation to the past and present co-operation, around 1 MEURO was devoted to fund the NGOs and approximately a similar amount for the scientific co-operation.

Portugal

Portugal has an insignificant co-operation with Cuba. Perhaps in the future, they might approve triangle programmes (co-operation with third countries, such as in the case of Cuban doctors working in other developing countries).
The First Secretary of the Portugal Embassy underlined the need of a new legal frame and concrete guarantees to facilitate the work of the NGOs and suggested negotiating the issue with the Cuban Authorities.

5. OTHER DONORS AND INTERNATIONAL ORGANISATIONS

United Nations Development Programme (UNDP/UNOPS)

The UNDP does not manage the projects; UNOPS is the implementing agency for UNDP.
UNDP has a yearly budget for Cuba of around 10 million US$ and its main fields of intervention are the environment and the support to the productive activities.
In the environmental field, they are undertaking a project of forestall recuperation in Camaguei and Pinar del Río, and an important project related to the production of energy from sugar cane (financed by France, Germany and Switzerland).
Related to the second are the assistance to the banking system and the training in management for Cuban enterprises.

The most important project of UNOPS is the "Programa de Desarrollo Humano Local" (PDHL) (locally based human development programme).
It started in Sep'98 with a budget of 2.5 million US$ (aprox. half from the Italian Co-operation and the rest from the Italian Committee integrated by 220 NGOs and regional/municipal bodies). The Cuban entities contribute with 4.5 million pesos in kind.
The geographical location is Granma (6 municipalities), Pinar del Río (6 municipalities) and Habana vieja (1 municipality); and is based in the creation of provincial multisectoral working groups depending on the provincial governments and in the fields of health, education, environment, territorial planning and local economy (support to the small local business).
The above mentioned groups identified the key local problems and propose the projects to be funded. The range of projects might include: sustainable agriculture in given area, solid wastes, rural tourism, rehabilitation and equipment of primary health structures, communication equipment for medical emergencies.
A renewed budget of 3.0 million US$ has been recently approved for the coming 16 months.

The UNOPS/UNDP representatives underlined the lack of co-ordination and coherent approach among the different EC services

World Food Programme (WFP)

In the past 35 years, the WFP invested in Cuba a total of 209 million US$: 17 in emergencies and 192 in development.
During the last years, the Program has been particularly active in the five oriental provinces. At present, they are undertaking a food vulnerability study in such provinces and it will be available at the end of May.
Related to development, the WFP has implemented a food security program in Las Tunas (milk production; around 50 million US$) and last year they started a project in Granma aiming to develop the production of basic food products (17000 individual farmers and 18 million US$ for 4 years).
Also in the field of development and with a total value of 18 million US$ for 4 years, the WFP is providing credits for productive activities; and equipment, inputs and consumables for farming.

Concerning the emergency projects, the most important is the named "emergency project for the drought". And it is a direct food aid project covering daily 257000 persons (217000 in education, 15000 in health and 25000 pregnant women). The items provided are oil, rice, peas, powered milk and wheat flour.

Nowadays, the tendency is to decrease the food aid; being the maximum 5600 Tons per year (around 3 million US$).

However, and according to the WFP representative's view point, the economic system does not make feasible the national food production. This fact together with the single crop of sugar cane and the "past culture of dependence", creates a precarious situation in which the country is not able to produce the basic food products.
Although recognising that at the moment Cuba is not in a food emergency situation, the representative underlines that there are cyclic emergency situations due first of all to the "silent drought" in the oriental provinces; and second, to the cyclones and hurricanes. The above mentioned provoke food vulnerability and food emergency situations.

Finally and in relation to the EC intervention in Cuba, they underline the lack of co-ordination and coherence among the different instruments.

Pan-American Health Organization (PAHO/WHO)

The Pan-American Health Organisation is at present developing two projects in Cuba:

- Strengthening of the Cuban National Health System (0.3 million US$; 30% of regular funds).
  This project includes the support to the epidemiological surveillance system, research, hospital accreditation and the regulatory/normative issues.
- Municipal development project (0.6 million US$ and 60% of regular funds). In the last four years, the project reached 44 municipalities and the counterpart is the municipal government. In brief, the content of the project is the identification of problems and its prioritisation; the promotion of a "culture of project"; and the facilitation of one PC, photocopy machine, small library and a room for educational activities.

PAHO's office yearly budget is around 1 million US$ from regular funds and around 4 million US$ from out-of-budget funds.

Canadian Co-operation

The Canadian co-operation through CIDA started in Cuba in 1994. During the first two years it was a small program mainly related to Canadian universities linkages.
CIDA has three ways of co-operation with Cuba:

- *Bilateral:* from government to government (around 2 million US$ per year). And includes the support to the economic reform (training for civil servants and diploma in public administration); and human rights/good government practices (still under discussion)
- *Multilateral:* it depends of the emergency situations (cyclones, hurricanes). The last donation was in 1998 and included oil and school paper for a value of 5 million US$.
- *Partnership branch:* it is channelled through Canadian NGOs, universities and unions (3 million US$).

On the other hand, it is worth to mention the named Medical Assistance Programme (MAP). Through this program, the Canadian pharmaceutical companies donate medicines to the NGOs to be distributed in Cuba. From 1995, a total amount of 4 million US$ has been donated to Cuba.

USA Interest Office

As well known, the official co-operation does not exist.
According to the information provided by a representative of the office, there is two ways of private co-operation:

- *Cuban persons living in USA*: they are allowed to send a packet of products (food, medicines, batteries) to their relatives in Cuba for a total value of 200 US$ per month and per person resident in USA.
  The system works as follows: the named consolidators companies (and with approval and permission from the government; the Treasury department in the case of money and Commerce for food), crowd together the packets and send them to Cuba. Once in Cuba, the "Cuba packs" company distributes the packets.
  This system started in 1992 and for the period 1992-99, they estimated a total amount of 2.5 billion US$

- *American NGOs:* The American NGOs are allowed to send relief items to Cuba and they channelled the aid through Caritas Cuba, the Cuban Council of Churches (related to the American Council of Churches, protestants), and the Cuban Evangelic Churches.

The NGO "Disarm" send medicines directly to the paediatric hospitals.

Recently, the "Order of Malta" sent a donation of 6 million US$ in medicines.

Other American NGOs send financial resources to local counterparts to undertake development projects.
The tendency of this type of NGO collaboration is to increase in the future.

6. CONCLUSIONS AND RECOMMENDATIONS

General

There is a consensus about the idea that Cuba is not anymore in an emergency situation[26]. However, the situation remains very fragile and can reverse quickly due to natural disasters (very common in the area, such as cyclones, hurricanes and the "silent drought" in the poorer East of the island), and political and economic unpredictable changes; the latter related to internal or external causes.

But there is also a wide consensus about the evidence that in Cuba at present, there exist important pockets of humanitarian needs; and the most vulnerable people (basically those excluded from the dollar market), suffer an extremely precarious situation in a humanitarian perspective. This is particularly true for the elderly without family protection and resources, physically and mentally disabled people, single mothers without resources, people living in social institutions, drug-dependent persons and children without family protection.

The ECHO's intervention in Cuba over the last seven years has assisted the Country to maintain a certain level of basic health and social services available in well known very difficult circumstances. And it has also supported an important number among the most vulnerable people to be assisted by the health and social public services. An abrupt withdrawal of ECHO can seriously affect these people in the health and social sectors and cause an additional stress for the health system as long as alternative solutions are not prepared.
Besides that an important part of the positive impact of the past EC intervention by ECHO could potentially be wasted.

Moreover, although at present ECHO is probably not the most adequate instrument for a needed sustainable co-operation with Cuba, it is the only one that can support right now the most vulnerable people. Even if it is decided to use other EC instruments for the co-operation with Cuba and taking into account differences in terms of timing, procedures and flexibility, this type of co-operation will not be in place nor functional in a near future.
It is also worth to consider that ECHO's aid accounted for around 80% of the total EC co-operation with Cuba in 1999 and approximately 65% of the total aid for the period 1993-99.

Recommendation:

To maintain temporarily ECHO's aid to Cuba but establishing a clear exit strategy, coherent and co-ordinated with the other European Commission Services (LRRD). A Progressive and prudent phasing-out is recommended

Strategy

The intervention of ECHO in Cuba (mainly through the Global Plans) has been very peculiar compared to other ECHO programmes, and may be understood as an indirect support to the MINSAP budget.
However, the rigidity of Cuba's centralised policy and the exceptional situation, Cuba is confronted with, made that ECHO's intervention was a feasible alternative to provide humanitarian aid to the population.
Moreover, ECHO's presence has given to the European NGOs the opportunity to work in Cuba and assist the Cuban population.

However, some negative aspects can be identified like the *humanitarian dependence, lack of innovation over the time, questionable sustainability and lack of a clear and negotiated strategy.* Although it must be admitted that the Cuban authorities did not facilitate the dialogue up to now and were reluctant to innovations.
In any case, it is advisable to take advantage of the above-mentioned dependency for future involvement and negotiations.

[26] In need of "urgent short term humanitarian assistance to save and preserve lives of people facing serious difficulties resulting from natural or manmade disasters". Communication from the Commission on LRRD of 30.04.96

Recommendation:

To undertake a strategic inflexion in ECHO's intervention for this –in principle- last period, as an important element of the exit strategy.
In this sense, it is recommended to approve a last ECHO aid package to be implemented in the year 2000 and 2001, reduced to half of the previous, for around 10 MEURO.
The program has to be focused towards the most vulnerable, should prevent (minimise) dependency and facilitate the transition towards a medium and long-term development strategy.

The programme

In relation to the 1999 Global Plan, the stated objectives have been reasonable achieved. Nevertheless, some operational problems identified in previous evaluations have not been solved. This is the case for the delays in the process of customs procedures and transport of the products to the central warehouses and even more relevant, in the delays in the production of medicines from the raw materials provided by ECHO. The centralised approach and the lack of firm dialogue with local counterparts are key weaknesses of the Plan.

The so-called microprojects have significantly improved the situation of the health and social institutions covered by them through small-scale interventions (basic rehabilitation and equipment of kitchen, laundry or general services).
However, the variety of the projects in terms of geographical location and fields of intervention, may have *reduced their global impact*.
Generally speaking, because of lack of strategy and lack of insight in the public health approach it is not possible for ECHO nor for the NGOs to perform proper needs assessment.
Finally, the social institutions belonging to MINSAP are in worse conditions than the medical ones. And in the social scene, the community-oriented approach needs to be reinforced and developed.

Operational Recommendations for ECHO:

1 **To approve an exit strategy in the frame of a European Commission global strategy.**
2 **To be shared formally with all relevant actors and in particular with the Cuban authorities.**
3 **There is a need to narrow the strategy of aid**
4 **To approve a last ECHO aid package with the following specifications:**

- **To finalise the so-called Global Plans after finalising the on-going activities**
- **To approve a last direct supply transition project to cover the identified needs for one year.**

  The **criteria** suggested are:

  - Priorities suggested by the Health and Social authorities (both, at central and peripheral levels), managers of the recipient institutions, NGOs and IGOs and ECHO-Cuba
  - Supplies which create less dependency
  - To minimise the problems of withdraw (in particular, for the most vulnerable)
  - To strongly apply the criteria of vulnerability (for the beneficiary persons as well as for the recipient centres) and thus increasing effectiveness of the plan.
  - Situation of the production of drugs in the country and performance in previous years of the laboratories

    In the light of these criteria, we recommend a drastic reduction of the number of supplies for this proposed last period and to be focused very specifically on the most vulnerable persons living in social institutions. The total amount of resources for this programme should not exceed 4 MEURO.

- **To prepare an integrated programme aiming to assist and support the extremely vulnerable people; both the institutionalised and those living in the community.**

The rational behind this relates to the relevance of performing urgent rehabilitation by improvement of the quality of live of the most vulnerable and by facilitating the transition towards a medium and long term development programmes. In this way, the experience of some previous microprojects is used but frame them in a strategy and comprehensive approach.
This programme would include a component of urgent/ short term rehabilitation[27], basic equipment and furniture for the prioritised social institutions (elderly homes and houses, institutions for mentally and physically disabled people, collective centres); as well as the support to home care services for the most vulnerable living on their own.
The key concepts of this programme are: community orientation (preventing institutionalisation, promotion of coping mechanisms), and decentralisation. The whole programme should be locally and participatory based (including participation in-kind by institutional beneficiaries).
A geographical prioritisation is also recommended taking into consideration previous interventions (by any donor) and the need situation (the five oriental provinces are clearly in disadvantage)

We recommend the following approach and methodology:

- ✓ The strategic frame proposed by ECHO (in light of the more global EC strategy), discussed and agreed upon by the NGOs and central authorities.
- ✓ Although MINSAP would continue to be the natural counterpart (in charge of health and social services, traditional field of intervention for ECHO), it is recommended to open the view to other possible counterparts like the Municipal departments of social assistance (in charge of home care for the most vulnerable), and the provincial units of attention to the transit communities (in charge of the extremely vulnerable people without house). Even in the case of MINSAP, to move the focus from the central level to the local one is recommended
- ✓ Need identification at local level by the selected NGO, local counterparts and with ECHO expertise
- ✓ Preliminary approval of the global programme at central level (ECHO plus central level authorities)
- ✓ Approval by ECHO Brussels
- ✓ Implementation by the NGO together with the local counterparts (co-financing, in all cases, the beneficiary centre/community/families should contribute partially)

This new programme could be ready for approval by the end of summer (after the needs identification process), and the implementation phase could be extended until the end of the year 2001. The total amount of resources could raise around 6 MEURO.

<u>The new strategy requires some changes and adaptations at all levels, such as:</u>

- **The relationship with Authorities and local counterparts**
- **The type and role of the implementing partners (NGOs)**
- **The contracts with the implementing partners**
- **The structure and functions of the ECHO office in La Havana**

The first requires a common approach and needs to be addressed together with the other EC instruments and services. In general, a more clear and firm position is recommended.

In the case of NGOs, it is recommendable to move the current frame in the light of the following criteria:

- ✓ **To reduce its number**
- ✓ **To work with those having other sources of funding, including their own funds and have decided to co-operate in Cuba in the future without ECHO**
- ✓ **To prioritise the ones with more experience in rehabilitation processes**

[27] In the frame of the Council Regulation Nb.1257/96 of 20 June 1996 concerning humanitarian aid (article 2.d), and the Communication of the Commission to the Council and the European Parliament on Linking Relief, Rehabilitation and Development (LRRD) of 30 June 1999 (point II).

- ✓ **To re-elaborate the geographic specialisation, including in the eventual new contracts (for the transition programme) apart from the monitoring role and over all, the needs identification role**
- ✓ **To promote the work in partnership with local NGOs (although in the current reality, it is not easy to identified "real" Cuban NGOs)**

In relation to the contracts, duration of approximately one year is recommended taking into consideration the type of work to be undertaken.

Concerning the structure and functions of ECHO's office in La Havana, in our opinion it should be adapted to the new phase. That means to be less devoted to the logistics and to be able to input operational strategic thinking, technical expertise in the health and social fields and communication/public relations skills; as well as to play a more significant role in terms of co-ordination.

In general, a decentralisation and empowerment of the field is highly recommended: From ECHO Brussels to ECHO-Cuba and From ECHO-Cuba to the partners.

Proposed Timing

June'2000: Approval last transition direct supply package (4 MEURO)
Sep'2000: Approval Integrated social program (6MEURO)
June'2001: ECHO assessment mission to Cuba
Sept'2001: Finalisation first programmes
Dec'2001: Eventual ECHO withdrawal

Visibility

Ranks from excellent to nearly absent.
Because Cuba is highly literate, public information through leaflets is advisable

Recommendation:

For an eventual last direct supply programme, the products bought in Europe should be labelled in origin, even the small units (whenever possible)
Concerning the drugs produced with the raw materials, the labelling of the units (even the blisters) should be addressed.
In the case of small-scale interventions in a given centre or institution, a permanent plaque has to be installed in the main entrance. In general, a standardisation of issues related to visibility from ECHO side is recommended.
Besides that, a communication policy and activities should be promoted.

Non Governmental Organisations

The European NGOs working in Cuba undertake a work and role of paramount importance for the future development of the Cuban society.

However, the NGOs working in Cuba agree that they face important difficulties in their daily work. The first basic problem is the lack of legal status for the NGOs. But this problem can uniquely be solved at legal level. Other problems are related to the administrative inscription, the use of their houses as offices (they cannot open offices), the appointment of local personnel (they are not allowed to), the access to international lines and internet and other administrative and bureaucratic constraints. In practice, their activities are "tolerate" (they use their apartments as offices, they appoint local personnel etc.), but without legal basis creating an insecurity and discretionary situation.
This problem has been identified by the Member States consulted.

Recommendation:

The European Commission should present together with the European Member States a common position and negotiate with top level Authorities on a legal solution in order to guarantee and facilitate the work of the NGOs.
In the meantime, we recommend to firmly renegotiating the Terms of Reference for ECHO (20.04.94), applying the same conditions recognised for ECHO to the partners working with the European Commission.

The other European Commission Services

ECHO has played in the past seven years a major role in the European Commission co-operation with Cuba (around 65% of the total aid for the period 1993-99). However, for the times to come it is probably *not the most adequate instrument for a sustainable co-operation*. Therefore, the establishment of an exit strategy is suggested and developed in the previous points, The above mentioned progressive and prudent phasing-out, implies the phasing-in of other European Commission instruments in key areas in order to optimise past intervention, minimise the negative impact of ECHO's withdrawal (mainly for the most vulnerable) and achieve the greatest global impact.

On the other hand, It has been observed a lack of co-ordination between the different European Commission Services and instruments acting in Cuba. Even in some cases, contradictions and lack of coherence among them. Different international key actors have translated this observation to the consultants.

Recommendation:

Based on the above mentioned and in light of the LRRD policy, a European Commission global strategy is recommended implying its different Services and instruments present in Cuba. Besides that, the different actors should develop operational strategies and plan of actions in a coherent way.

Preliminary suggestions:

ECHO: Already mentioned above

ECONOMIC CO-OPERATION (B7-311): Taking into consideration the important EC involvement through ECHO in the Health and Social sector (MINSAP) over the past seven years, and in particular, in the pharmaceutical sector; and in light of a LRRD logic, a **close technical assistance to MINSAP** is recommended with the following components:

- Health System Reform ("Redimensionamiento")
- Health financing; financial mechanisms; programming and budget control
- Health services organisation and management
- Pharmaceutical sector: Support to the national production of essential medicines and medical material (prosthesis), quality control of drugs and rational use of drugs

We recommend a "close" and medium/long term technical assistance in order to be able to be effective and useful for the country. In particular, the assistance and support to the "Redimensionamiento" process is highly recommended.
These components might be added to the programme of support to institutional reforms (currently under preparation)

CO-FINANCING OF NGOs PROJECTS (B7-6000, B7-6430): Taking into account the epidemiological current pattern in Cuba (as mentioned in point 2), it is observed that the water transmitted diseases is a key public health problem and priority. This is particularly true in the case of rural and remote areas and communities. Therefore, and according to the stated objectives ("to improve the living conditions of the most vulnerable sectors of the Cuban population"), we recommend to include a **programme related to water supply systems for remote and vulnerable communities** as one of the key parts within the new strategy of co-operation with civil society. Eventually, these projects might be implemented together in partnership between the European NGO and the given local community.

FOOD AID AND FOOD SECURITY (B7-20): The programme has assisted the country over the past years, providing an important amount of direct food aid to the educational facilities. Moreover, it has been supporting the production through the assistance to the small private agricultural co-operatives. At present, only a small project is envisaged. On the other hand, ECHO from the very beginning, has been providing food items to the vulnerable people assisted in the health and social institutions. Taking into account the above mentioned and the fact that the country is not able to produce some basic food items, and despite the difficulties encountered in the past related to the implementation of the agricultural projects, it might make sense to support the national production of basic goods.
Furthermore, it is worth to mention that this sector is the only one together with the tourism, where the private initiative is working, although with many contradictions.
Therefore, a structural and **decentralised program of support to the food production for the population** is recommended. And according to the view of the expert in the field, the individual farmers and the co-operatives might be the target beneficiaries.

Operational recommendation:

To set up a **Cuban task force** both in Brussels and in the field, to be able to produce and implement a coherent strategy and plans of action
At Brussels level, the task force might be integrated by the different Cuba-desks and chaired by the Commissioner Cabinet. The same logic maybe applied at the field level, but in this case chaired by one of the expatriate correspondents assuming the co-ordination role.
Although obvious, the task force should develop a close and regular exchange and co-ordination with the European Member States, both in Brussels and at field level.
The task force should prepare and propose a global and coherent EC LRRD operational strategy for Cuba (in the frame of possible EC instruments available in Cuba), and discuss and agree upon the different instruments' interventions searching complementarity, synergies and long-term greatest impact.

Taking into consideration that several evaluation/identification different missions to Cuba are running at present in parallel, it might be advisable to organise a joint working meeting (through a consensus building approach), and to use their technical inputs for the preparation of a common strategy.

Final recommendation:

The above-mentioned scenario, might not work for several reasons. In this hypothesis, we recommend to reconsider ECHO's withdrawal and reassess the situation.

Finally, we recommended to the EC (ECHO) to undertake an assessment mission to Cuba in June 2001 in order to reassess the situation from an humanitarian perspective focusing on the impact of ECHO's withdrawal, as well as concerning the "state of the art" of the meanwhile reinforced other EC Services.

List of recommendations

1. To maintain temporarily ECHO's aid to Cuba
2. To establish a clear exit strategy, co-ordinated with the other EC services (LRRD)
3. To undertake a prudent and progressive phasing-out (2000 and 2001)
4. To produce an strategic inflexion in ECHO's intervention for the last period, as an important element of the exit strategy
5. To approve a last package of ECHO's aid reducing by half the 1999 pattern and to be directed towards the most vulnerable people
6. To include a last direct supply transition component directed to the prioritised social centres of MINSAP
7. To include an integrated social programme focused towards the most vulnerable persons both interned in social institutions and living on their own
8. The latter to be community oriented (preventing institutionalisation and promoting coping mechanisms), decentralised, locally based and participatory
9. To reconsider the selection of NGOs according to suggested criteria
10. To sign longer contracts with NGOs: one year
11. To change the structure, profile and functions of ECHO office in la Havana
12. To improve the visibility and communication policy
13. To firmly renegotiate the working conditions of NGOs
14. EC together with European Member States to negotiate NGOs status and role
15. To develop an European Commission common strategy
16. To set up a Cuban Task Force, including the different EC Services present in Cuba
17. To organise a working session of all consultants involved at present in missions to Cuba
18. To assess ECHO's eventual last programme in one year time
19. To reassess ECHO's withdrawal if situation and/or scenario changes

Bibliography

- “Anuario Estadístico de Cuba 1998, edición 1999”, Oficina Nacional de estadísticas (ONE), La Habana 1999
- Bataller M. et al., Economic mission report to cuba, internal, EC 5/98.
- Campa Homero, Proliferan en Cuba las ONG, Proceso 1072, Internacional No.24, 5/97
- Coe Andrew, Cuba, the Odyssey illustrated guide, Twin age ltd.1995
- Colaboración cubana a otros paises 1960-1999”, MINVEC, March 2000
- Evaluation reports, Hegoa 1997 and 1998.
- Galera F. & Nieuwkerk M., Mission report: Identification et suivi de projets mis en oeuvre par les ONG et confinancés par la CE à Cuba; Euronet Consulting, Dec.1996
- Instituto de Relaciones Europeo-Latinoamericanas:, 40 años de revolucion en Cuba: Transicion hacia donde?, Irela Dossier N°68: May 1999
- MINSAP, El papel de la Ayuda Humanitaria Europea en Apoyo al SNS en Cuba, 8/97.
- OMS, Report on Health in the Americas 1997, Cuba p.211-225.
- Portocarero Herman, Cubaanse nachten 1995-1999, Van Halewyck 2000.
- “Superar la pobreza humana”, UNDP report, New York, USA, 2000
- The Economist Intelligence Unit, EIU Country Profile 1999-2000: Cuba,
- UNDP.org: Cuba_appeal.htm: Emergency situation in the republic of Cuba; Consolidated appeal from the UN, Recovery and Rehabilitation Programme, Dec. 1998.

ANNEXES

Annexe I: List of interviewees and visited institutions

ABAD Jorge, Mr.; MD, Director, Paediatric Hospital North, Santiago de Cuba
ALEOTTI Attilio, Mr.; Emergency Projects Co-ordinator, Italian Co-operation
ALFONSO Angela, Ms.; MD, Deputy Director of quality control and register of drugs
ALVAREZ María Tomás, Ms.; MINVEC Representative, province of Santiago de Cuba
AREVALO Leonor, Ms.; Administrator, Mother House, Municipality of Palma, Santiago de Cuba
AVILA Mr. Troadys; Director, Orthesis and Prosthesis workshop, Las Tunas
BEAUCHAMP Sandrine, Ms.; Co-operation Assistant, Embassy of France
BELLON Ramón, Mr.; MD, Director, Elderly House “Mtz Villena”, 10 Octubre District
BONNET Philippe, Mr.; Head of Service, Co-operation and cultural action, Embassy of France
BORREGO Roberto, Mr.; Administrator, Provincial General Hospital, Las Tunas
BUCHARA Sergio, Mr.; Consultant, PDHL, UNOPS-UNDP
CABRERA Jesús, Mr.; MD, General Director, IMEFA, MINSAP
CAMBRAS Rodrigo, Mr.; Prof. MD, Director of the Orthopaedic Hospital of Frank Pais
CAMILLERI Giovanni, Mr.; Responsible PDHL, UNOPS-UNDP
CAMPELLO Mr.; MD, Director, MINSAP, Province of Guantánamo
CAPPIELLO Severine, Ms.; NGOs Researcher, Embassy of France
CASTRO Mr.; MD, Director of Planning and Finances, MINSAP (¿?)
COMENDEIRO Enrique, Mr.; Director, International Affairs, MINSAP
CONTRERAS José Manuel, Mr.; MD, Director of MINSAP, Province of Las Tunas
CRUZ Osvaldo, Mr.; Deputy Director of MINSAP, Municipality of Palma, Santiago de Cuba
CUESTA Pilar, Ms.; MD, Deputy Director, South Mother and Child Hospital, Santiago de Cuba
DE BEYTER Patrick, Mr.; Ambassador, Embassy of Belgium
DIAZ Graciela, Ms.; Deputy Director of MINSAP, Province of Santiago de Cuba
DIAZ-MARQUINA Esteban, Mr.; acting Head of Unit, ECHO-5
DOMENECH Irelis, Ms.; Principal Specialist, Developed Countries Department, MINVEC
DOMINGUEZ Juan Rafael,Mr.; MINVEC Specialist, Province of Santiago de Cuba
DOMINGUEZ Nilo Abel, Mr.; Deputy director of International Affairs of CIDEM
ESTEVEZ Sixto, Mr.; MD, Epidemiology and Hygiene Deputy Minister assistant, MINSAP
FACHADA Orlando, Mr.; Food security, DG DEV, European Commission
FELICES Andrés, Mr.; ECHO-5
FERNANDEZ DEL RIO Raimundo, Mr.; MD, Director, Elderly House “24 de Febrero”, 10 Octubre district
FERNANDEZ Gralia, Ms.; MINSAP, Province of Santiago de Cuba
FERNANDEZ RUBIO Pablo, Mr.; Representative, Cuban Red Cross, Guantánamo
GOMEZ MORANDO Manuel, Mr.; MD, Director, South Mother and Child Hospital, Santiago de Cuba
GOMEZ Rinaldo MD; Deputy Director, Paediatric Hospital “Centre Havana”.
GONZALEZ Dagmar, Ms.; Director, Developed Countries Department, MINVEC
GONZALEZ Daysi, Ms.; MD, Director, Policlinic “Nguyen Van Troi”, Centro Habana District
INFANTE Daniel, Mr.; MD, Head of Social Assistance Department, MINSAP, Las Tunas
KRUG Wilfried, Mr.; Counsellor, Embassy of Germany
LANGART Raul, Mr.; ESPO Representative, Province of Guantánamo
LAUSIN José Manuel, Mr.; General Co-ordinator, Co-operation Technical Office, AECI
LEON Raul, Mr.; Assistant General Director, IMEFA, MINSAP
LESCANO Alexis, Mr.; Director of Drugs Company, MINSAP, Las Tunas
LETIZIA Ginevra, Ms.; DG DEV, European Commission
LLORENTE Sinuel, Mr.; MD, Projects and Research Responsible, MINSAP, Province of Guantánamo
MARIEN Karel, Mr.; Second Secretary of the Embassy of Belgium
MARRERO Mario, Mr.; Director of Services and Insurance, MINSAP
MARTINEZ-CARBONELL Belén, Ms; DG DEV, European Commission
MILANES Nora, Ms.; MD, Stomatologist, AIDS Sanatorium, Santiago de Cuba
MOLINA Mario Luis, Mr.; MD, Deputy Director of Drugs, MINSAP, Las Tunas
MILLAN. Enrique, Mr.; MD, Deputy Director, Provincial General Hospital, Las Tunas
ALBUQUERQUE Ruth, Ms,; Acting Head of Unit; ECHO-3, European Commission
MUÑIZ Inés, Ms.; MD, Medical Director, Mother House, Municipality of Palma, Santiago de Cuba
MURILLO Angel, Mr.; Director, International Affairs, MINVEC

OTERO Enrique, Mr.; specialist in orthopaedics, vice director of production, La Habana
PADRO Angel, Mr.; Administrator, Psychiatric Hospital “El Viso”, Santiago de Cuba
PALMA FRAGOSA Luisa, Ms.; First Secretary, Embassy of Portugal
PICHARDO Mariano, Mr.; MD, Consultant, PAHO/WHO
PITA Mireia, Ms.; Programme manager in Cuba, Food Security Programme, DG DEV, European Commission
PORTO Marlene, Ms.; Director, Quality control and register of drugs Centre
PRIETO Santos, Mr.; Director of Social Assistance, Ministry of Labour and Social Security
PUGA Rinaldo, Mr.; specialist in paediatrics, department of immuno-reumatology, Hospital (??)
RAMIREZ Abelardo, Mr.; MD, First Deputy Minister, MINSAP
REY Eloy, Mr.; MD, Director, Psychiatric Hospital “El Viso”, Santiago de Cuba
RICARDO Eddy, Mr.; Financial Deputy Director, MINSAP, Las Tunas
RIVERA Olgadelia, Ms.; Psychologist, AIDS Sanatorium, Santiago de Cuba
RIVERO Enrique, Mr.; Consultant, PAHO/WHO
RIVERO José, Mr.; Director, EMSUME, MINSAP
ROBER Georgina, Ms.; MINVEC, Las Tunas
ROCA José, Mr.; acting Head of office, ECHO-Cuba
RODRIGUEZ FONSECA Pedro, Mr.; MD, Donations Responsible, MINSAP
RODRIGUEZ Alfredo, Mr.; Director of MINSAP, Municipality of Palma, Santiago de Cuba
RODRIGUEZ Guillermo, Mr.; General Director of Ortopedia Tecnica Reabil
RODRIGUEZ Raul, Mr.; MINVEC Specialist , Province of Guantánamo
RODRIGUEZ Romilio, Mr.; Deputy Director, “10 de Octubre” Hospital, Centro Habana District
SAN MARTIN José Luis, Mr.; MD, Director of Epidemiological Surveillance, MINSAP
SANCHEZ Noemi, Ms.; Social Worker, AIDS Sanatorium, Santiago de Cuba
SANCHOYERTO Ramiro, Mr.; MD, Director, “10 de Octubre” Hospital, Centro Habana District
SCOGNAMIGLIO Giuseppe, Mr.; Second Secretary, Embassy of Italy
SERRA Enrique, Mr.; Deputy Director, South Mother and Child Hospital, Santiago de Cuba
TAMAYO Mirelis, Ms.; International Affairs, Provincial Government, Las Tunas
TEOPEZ Isolina, Ms.; Council President, Bayate Community, Municipality of El Salvador
TORRES Angel, Mr.; head of equipment and medical/surgical material unit, EMSUME
VALDES Elías, Mr.; MD, Director of Hospital Services, MINSAP
VALDIVIA Germán, Mr.; Representative, UNWFP
VALDIVIA Nelly Cristina, Ms.; MD, Director of Primary Health Care and Family Medicine, MINSAP
VALLEJO Santiago, Mr.; desk Cuba, ECHO-3, European Commission
VAZQUEZ Enrique, Mr.; MD, Director, AIDS Sanatorium, Santiago de Cuba
VEGA Enrique, Mr.; MD, Director of Adult care and Social Assistance, MINSAP
VEGA Pedro, Mr.; Director, Health Services, MINSAP, Las Tunas
VERA Oscar, Mr.; MD, Deputy Director, IMEFA, MINSAP
VILLAFRUELA Isabel, Ms.; MD, Director, Policlinic of Puerto Boniato, Santiago de Cuba
VINCI Maria Beatrice, Ms.; expert, ECHO-Cuba
VOCKERODT Victor, Mr.; United States of America Interests Section, Embassy of Switzerland
WISHART Linda, Ms.; First Secretary (Co-operation), Embassy of Canada

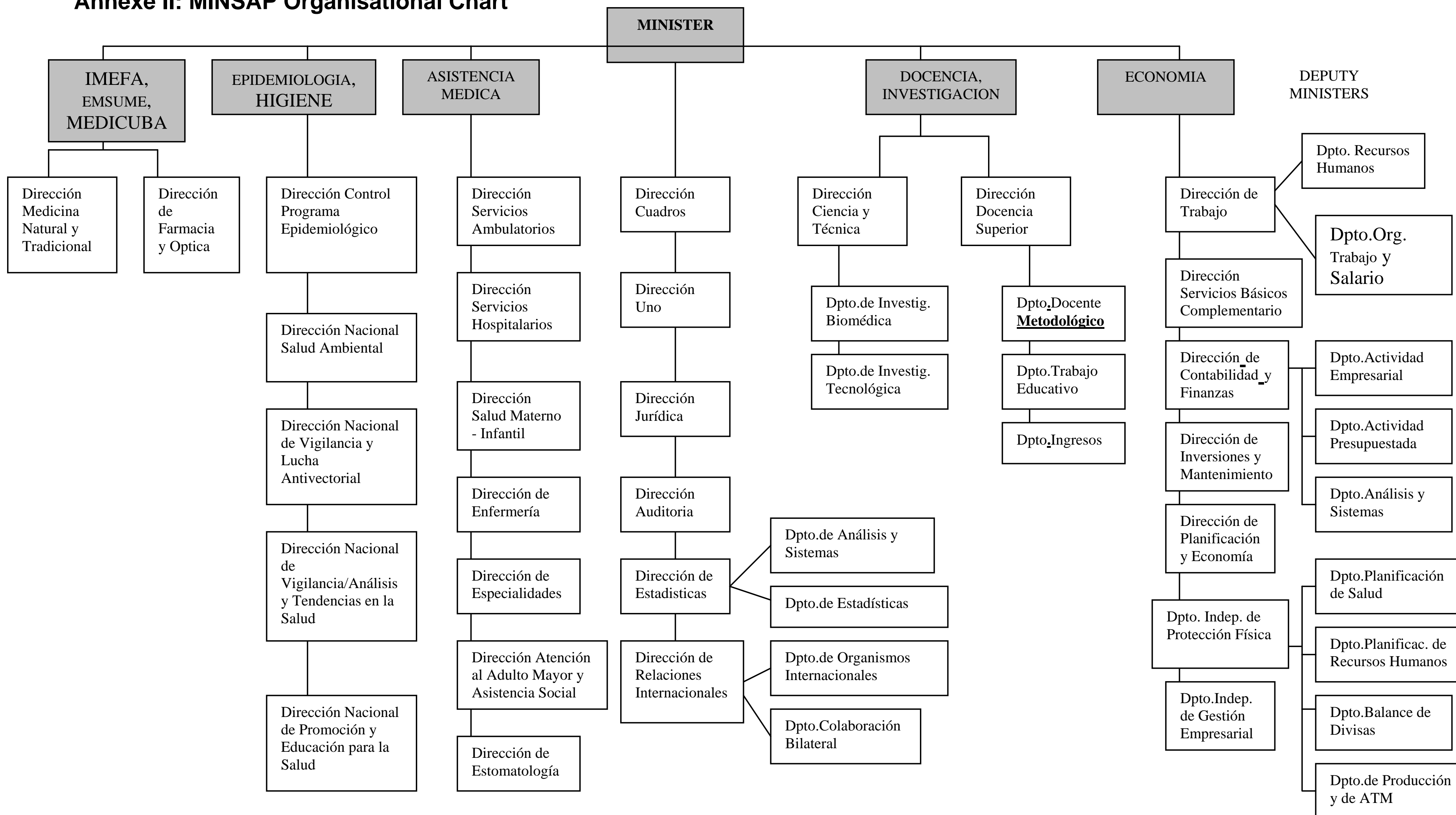
Health and Social Institutions visited:

Casa de abuelos “Eterna juventud”, Centro Habana district, La Habana
Centro de investigación y desarrollo de medicamentos, La Habana
Complejo científico ortopédico int. Frank Pais
Complejo gerontológico “Alfredo Gómez Endra”, Centro Habana district, La Habana
Cuba RDA, orthopaedic workshop and rehabilitation, La Havana.
Hogar de ancianos “24 de febrero”, 10 de octubre district, La Habana
Hogar de ancianos “Rubén Mtz. Villena”, 10 de octubre district, La Habana
Hogar de ancianos “Santvenia”, La Havana.
Hogar de ancianos “La Salud”, Prov. de Havana.
Hogar de ancianos de San Vicente de Paolo, Vejical.
Hospital clínico-quirúrgico “10 de octubre”, Centro Habana district, La Habana
Hospital docente pediatrico Centro Habana
Hospital pediátrico El Cerro
Policlínico docente “Nguyen Van Troi”, Centro Habana district, La Habana
Psycho-medical care centre of Arroyo Arena, La Lisa.

Almacén material médico-quirúrgico, Santiago de Cuba
Farmacia Palma Soriano, Palma Soriano, Santiago de Cuba
Hogar de ancianos “Mario Muñoz”, Santiago de Cuba
Hogar materno “Mariana Grajales”, Palma Soriano, Santiago de Cuba
Hospital materno-infantil sur, Santiago de Cuba
Hospital pediátrico norte, Santiago de Cuba
Hospital psiquiátrico “El viso”, El Carey, Santiago de Cuba
Policlínico Puerto Boniato, Santiago de Cuba
Sanatorio SIDA, Santiago de Cuba
Albergues (“Comunidades de tránsito”) de Guanabacoa, Lawdo y Cerro

NGO’s:
AZNAR Victor, co-operator MPDL
CARDONA José Maria, MD, Regional co-ordinator for MDM-E, C-A, Mexico and Caribbean.
GILBERT Steve, co-ordinator CARE
GONNE Loreolana, project co-ordinator CIES
GUALTIERI Osvaldo, co-operator APS-CISS
GUILLAMON Alex, project co-ordinator Entrepueblos
LAMBIASE Calo, co-ordinator CISP
MARINELLO Lilli, Project director GVC
MATIAS Pilar, co-ordinator ANNF
MIR Jorge, logistic CISP
MURILLO Pepe, co-ordinator PTTI, ACSUR
NINO Concha, co-ordinator MDM-E
PRESSACO Maria Grazia, co-ordinator GVC
REIS Arlindo, director OIKOS
RIGALDIES Pascal, dirctor Handicap International
ROUEST Luciano, co-ordinator Entrepueblos
RUIZ Sara co-operator MPDL
SAENZ Eva, co-ordinator Medicus Mundi
SANCHEZ Maritza, Lic., programme co-ordinator Caritas G.
SASSE Peter, project co-ordinator Deutsche Welthungerhilfe (AAA)
SPETS Weine, Ing. regional director for Erikshjälpen,
SUAREZ Rolando, M.D., director Red Cross, La Habana
WOODING Bridget, consultant SCF
i

Annexe II: MINSAP Organisational Chart



Annexe III: Percentages[28] of ECHO's provided items in relation to the estimated annual consumption in the country[29]

1.- Actrapid insulin

Nb of registered patients (Dec'99): 1.994
Average consumption units per month and per patient: 3.84
Consumption per month: 7.665
Consumption per year: 92.000
Provided by ECHO/NGOs in 1999: 12.000
Percentage: 13%

2.- NPH insulin

Nb of registered patients (Dec'99): 33.422
Average consumption units per month and per patient: 1.26
Consumption per month: 42.000
Consumption per year: 504.000
Provided by ECHO/NGOs in 1999: 219.682
Percentage: 44%

3.- Raw materials

Raw material	*Medicines*	*Days of consumption*[30]	*%*
Benzeracide clorhidrate	Levodopa & Venceracide	75	**21%**
Cefalexine Monohidratade	Cefalexine susp. Oral 125	99	**27%**
Clortalidone	Clortalidone 25 mg.	233	**64%**
Digoxin	Digoxine 0.25 mg.	235	**64%**
Diphenilhidantoine base	Fenitoine 100 mg. Tabletas	211	**58%**
Ethyllbiscoumoacetate	Ethylbiscoumoacetato 0.3 Gr.	305	**84%**
Glibenclamide	Glibenclamide 5 mg.	250	**68%**
Isosorbide 40% lactose	Dinitrate of isosorbide 10 mg.	244	**67%**
Methyldopa alfa	Alfa methyldopa 250 x 1000	168	**46%**
Nistatin	Nistatin cream 25 Gr.	274	**75%**
Nistatin	Nistatin powder susp.	235	**64%**
Nistatin	Nistatin vaginal 15 tabs	278	**76%**
Nistatin	Nistatin oral 12 Gr.	283	**78%**
Oxaciline sódium	Oxaciline sódica cap. 250 mg.	158	**43%**
Pilocarpine	Pilocarpine 2% col. 10 mg.	169	**46%**
Pilocarpine	Pilocarpine 4% col. 10 mg.	162	**44%**
Propiltiuracil	Propiltiuracil 50 mg. x 20	286	**78%**
Quinidine sulfate	Quinidine sulfate	34	**9%**
Verapamil	Verapamil 80 mg. x 60	102	**28%**

[28] These figures come from MINSAP sources + ECHO-Cuba office plus own estimations, crossing data and info received

[29] Take into account that data provided by IMEFA are not accurate. In fact, concerning the registered patients for Actrapid Insulin in 1999 e.g. there is a difference of 26% between IMEFA data and the ECHO data.
Moreover there is an impression that about other donations there is lack of transparency. For example, the Order of Malta USA, donated recently 6 million USD in medicines and Canada 6 million CAN $ from 1995 until now. This apart from other hundreds of small donations impossible to control.
It is also surprising that in the list of priorities provided by IMEFA, none of the items is similar to the 1999 plan.

[30] Estimated days of consumption per year with the raw materials provided by ECHO/NGOs in 99

4.- Food aid

4.1. Soya oil

(Estimation based on 1 litter per month per hospital bed and beds in elderly centres & houses, mother houses and centres for physically and mentally handicapped persons)

Provided by ECHO/NGOs in 1999: 279.095 litters
Estimated coverage: 8 months
Percentage: 67%

4.2. Powdered milk

Estimation based on 55-gr./ day and per bed (2 glasses) for vulnerable patients in paediatric & gynaecology/obstetric hospitals, elderly centres and houses, institutions for physically and mentally disabled persons, and pregnant mother houses.
And 28 gr./ day and per bed (1glass) in the rest of hospitals and social centres.

Provided by ECHO/NGOs in 1999: 441 Ton
Estimated coverage: 5 months
Percentage: 41%

4.3. Tinned meat

Estimation based on 60 gr. Per time for all beds in hospitals, elderly centres & houses, mother houses, and centres for physically and mentally handicapped persons.

Provided by ECHO/NGOs in 1999: 316 Ton
Covering: 60 times
Percentage: impossible to assess

5.- Cleaning products plus white & green drapery

5.1. White cloth

MINSAP planning for 1999: 803.872 meter.
Provided by ECHO/NGOs in 1999 (2 decisions): 207.922 m.
Approx. percentage: 26%

5.2. Green cloth

MINSAP planning for 1999: 612.128 m.
Provided by ECHO/NGOs in 1999 (2 decisions): 138.180 m.
Approx. percentage: 23%

5.3. Toilet soap

MINSAP planning for 1999: 1.101.300 units
Provided by ECHO/NGOs in 1999: 517.536 units
Approx. percentage: 47%

5.4 Industrial detergent

MINSAP planning for 1999: 593 Ton
Provided by ECHO/NGOs in 1999: 265 Ton
Approx. percentage: 45%

5.5. Domestic detergent

MINSAP planning for 1999: 318 Ton
Provided by ECHO/NGOs in 1999: 164 Ton
Approx. percentage: 52%

In relation to the **medical/surgical material**, it is impossible even to estimate the percentage because there are no data related to consumption.

Annexe IV: Projects grouped according specialisation:

Rehabilitation and kitchen equipment:

PROJECT (combined)[31]	**NGO**	**Decision**	**BUDGET**
20 rest homes	ACSUR	12/97	15.800
province hosp./incl. rehab. of homes	Erikshjalpen		47.000
3 maternal hosp.	MDM E		133.000
paediatric hosp	SCF		19.000
rest homes	CISP	7/98	160.000
rest homes and gardens	CISP	6/99	210.000
health centres together with air cond. and occupational therapy	MPDL		220.000
3 paediatric hosp. And steam circuit, garden	ANNF		220.000
prov. hospitals with air condition and garden	GVC		250.000
rest homes and hospitals	OIKOS		130.000
restaurants for elderly	Caritas Germ.		100.000
support to sanitary structures, incl. sanitation	MDM E	11/99	175.000
gen. support to hospitals & social centres	ANNF		375.000
TOTAL			2.054.800

Programs of infrastructure rehabilitation:

hydraulic and electric system of health units	CISP	12/97	15.800
laundry machines, 18 houses for elderly	MPDL	12/97	108.000
rehabilitation. of steam gen. in health units	ACSUR	7/98	80.000
laundry equipm. for disabled and elderly	MPDL	7/98	105.000
rehabilitation of steam systems	ACSUR	6/99	230.000
support hosp. & centre of social attention	ANNF	11/99	375.000
TOTAL			913.800

Equipment of specialist services:

air cond. surgery and equipment lab.	MDM-F	6/99	140.000
equipm.& surg. & nefrolog. material	MPDL	11/99	370.000
equipm. nefrology	OIKOS	11/99	380.000
equipm. surgery	Solidaridad	11/99	200.000
TOTAL			1.090.000

Provision of Insulin: SCF 11/99: 300.000

Insure drinkable water: GVC 12/97: 382.000
GVC 7/98: 350.000
Qual. water after hurricane: MDM E 98:200.000

Shelter:
Temporary shelter for Hav.: Paz y Tercer Mundo‘98: 80.000

[31] Some of the budgets include other activities which are mentioned.

Rehab. of roofs after hurricane: German RC 11/98: 200.000
6/99: 200.000

Orthopaedic material:
Leprosy clinic: German Red Cross ‘97: 16.000
Knee & feet for disabled: Handicap Int. ’98: 300.000
Knees & prosthesis material: Hand. Int.‘6/99:200.000
Ass. to disabled: Handicap Int. 11/99: 200.000

Cold chain:
and AIDS prevention: MDM-F ‘97: 93.000
in health units: MDM-E ’98: 100.000

Fabrics:
Distribution of clothes for elderly: Caritas Germany ’97.: 860.000
White linen provision, complement to Global Plan: ANNF ’97: 98.000
Clothes and linen for disadvantaged mothers: Oxfam-B ’98: 325.000
Distrib. of clothes and training soc. ass. for minor: SCF ’98: 400.000

Annexe V: Beneficiaries of drugs made from raw material provided by ECHO.

PACIENTES CRONICOS INSCRIPTOS
- (DATOS MARZO DEL 2000)

	PRODUCTOS (Plan 99 y/o 98)	INSCRIPTOS	PORCENTAJE	BENEFICIARIOS
(*)	Clortalidona 25 mg. tabletas	246.204	63,8	157.078
(*)	Digoxina 0.25 mg. tabletas	2.690	64,4	1.732
a	Fenitoina 100 mg. tabletas	16.388	57,8	9.472
(*)	Dinitrato Isosorbide tabs.	66.659	66,8	44.528
(*)	Etilbiscoumacetato tabletas	753	83,6	630
(*)	Glibenclamida 5 mg. tabletas	84.927	68,5	58.175
(*)	Insulina NPH 100 U. bulbo	33.422	54,7	18.282
(*)	Insulina Atrapid 100 U. bulbo	1.994	13,0	259
(*)	Levodopa y Benseracida tabletas	4.706	20,5	965
(*)	Metildopa 250 mg. tabletas	50.400	46,0	23.184
(*)	Propiltiuracilo tabletas	3.917	78,4	3.071
(1)	Pentaeritritol 10 mg. tabletas	19.872	64,4	12.798
(1)	Pentaeritritol 20 mg. tabletas	71.998	56,6	40.751
(*)	Pilocarpina 2% colirio	23.921	58,9	14.089
(*)	Pilocarpina 4% colirio	2.271	67,9	1.542
(1)	Sulfato Quinidina tabletas	2.557	47,9	1.225
(*)	Verapamilo 80 mg. tabletas	13.680	27,9	3.817
	TOTAL	**646.359**	**60,5**	**391.598**

(1) Plan Global 98

(*) Plan Global 98 y 99

Annexe VI: Criteria for the distribution of food, linen and hygiene products.

Annexe VII: Humanitarian micro-projects by NGO:

The micro-projects were implemented as a complement to the Global Plan of 1994 and started in. The objective is dual:
To reach individuals living in a situation of extreme vulnerability and who are not assisted by the Cuban public services and thus not included in the Global Plan.
To alleviate deficiencies in the equipment of support receiving centres by the means of short-term activities of rehabilitation.

Types of micro projects and executing agencies

GVC
I. Drinking water: 2 stages, provinces 7: 1997 and 98
Project for drinkable water in urban and rural area, finalised in 8/1999 in all the Provinces. It concerned the donation of essential equipment to the laboratories for water control

II.ECHO 210/1999/2007/GVC: Support to improvement of the health system of Pinar del Rio province and to vulnerable groups and hospital assistance 6/99: 250.000 Euro
Pilot project 6 months + 3 months amendment until 4/2000:
Organic vegetable growing gardens for auto consumption and as occupational therapy with ACTAF (Cuban Association for Agro- forestation techniques)
Area: health centres for elderly, homeless and pregnant
Equipment for cooking and for conservation of food as well as armchairs by GVC 2000. In a rest home in San Luis, 1 centre for homeless and a house for elderly in Pinar del Rio and the polyclinic of Sandino with irrigation system and/or rehabilitation of tanks and wells.
Beneficiaries: 1950. Budget 105.000 Euros
Attention to seriously ill, intensive cares and intermediate care
Air conditioning: 36 in 19 institutions of the province, lab surgery, XRay and 100 elements in 8 inst. in PdR:
Improve surgical attention: equipment with air conditioning of all the hospital theatres, ICU, delivery rooms and dialysis units in the province, a total of 100 AC units, by GVC 2000. Beneficiaries: 47.544./ Budget 95.000 Euros.

Remarks:
beneficiaries 1274 + 705 ambulatory elderly, Pregnant: admission in 97 5083 BOR of 90.8% or 18% of stay
Difficulty bank account (3 months), local shopping esp Copextel and Cimex, and lack of co-ordination of cy with institution
Lack of co-operation in gardening projects between MoH and Agriculture, and water problem in 1center
Monitoring: periodic visits to the centres
Visibility: poster + materials, photo
Shared manual for the garden project of the 5 NGOs
Problems:
-Very short term contracts. The time frame does not consider the time needed to open a bank account in Cuba, the time needed to import European products and hence to get the ware out of customs on the road to the provinces and the time lost for installation of the materials by the ministry because of lack of materials.
-The needs of emergencies do not get proper diagnostics and are not actualised. The ONG is not involved in the diagnosis whereas the ONG has to assume the implementation.
-Restrictive framework of the ECHO contracts, moreover with a civil society which is basically not existing.

ACSUR: ECHO/CUB/210/1999/02003: 230.000 Euro
1. Rehabilitation of Boilers and steam systems in hospital centres of Granma(5) and Las Tunas (7), 2nd stage, continuation of GP 98 and finalised last week!
until: 2000 with amendment, problems with ESCO, ALASTOR (Empresa nacional de calderas, initial low commitment) and the shipping cy
2. Unforeseen project of mother houses with reserve of GP 99
Visibility: radio, logos, folios

MDME:
-ECHO/TPS/219/1999/03008:START OF project 15/4/2000 DIPECHO
-ECHO/CUB/210/1999/03004: 175.000 Euro
Amendment of 2 months requested for problems with ESCO

Sterilisation , sanitation
Visibility: folio, poster, manual for sterilisation and workshop.

CARITAS
210/1999/02010
Improve the state network of public kitchens to vulnerable population, not institutionalised, with voluntaries and problem solving for food provision (garden, etc.)
Installation of kitchens: ovens wood and gas, tables and seats, cooking pots,
with central distribution point and distrib to the provinces
with the Provincial Directories of Gastronomy
Difficulties: MINCIN impeding possibilities, commercial register needed to buy ovens with EMSUNA (major part of MINCIN)
Beneficiaries: Granma 3320/ Guantanamo 1276/ Santa Clara 103 / Total 4696
Visibility: posters, stickers, folders with lists of beneficiaries
Budget: 100.000

ANNF
210/1999/02006 amendment for 1 month
1 Nutritional support to paediatric hospitals in Havana City: 3
Infrastructure for food preparation
start 9/99 to finish march2000
Hosp Ped Docente de Centro Habana, 1997 10.800 admissions
Total beneficiaries in 1 year 14.616
Remarks:
Delay of preparatory in hosp Juan Manuel Marquez up to 2/2000 date of planned ending
Workshop and inauguration by MINSAP and MINVEC on 25/2, with nutrition manual
Budget: 6/99 of 220.000 and 11/99 of 375.000 Euro
Occupational therapy ECHO-MINSAP-ACTAF-ANNF
initiated 8/99
1 hospital and 2 medico-psycho-pedagogic centres
86 psy from 18-60 , 60% without family/ 200 pt, 107 can work/ 150 places (90) intern
Irrigation system from Spain
Washing area
Rest homes and handicapped, 1st (17) and 2nd project (11)
deficiencies in infrastructure in the centres, water and electricity

OIKOS
rehabilitation of kitchen and refectories in houses for elderly and homes and conditioning of hospitals: 210/02009: BUDGET: 130.000 Euro
Pilot project for gardens
Problem of provider/ co-responsibility of Provincial Directory of health (boiler with Alastor)
Visibility: inauguration

HANDICAP international:
210/1999/03001:200.000 Euro on 11/99 and 200.000 on 6/99
visit to 10 orthopaedic workshops
REABIL, production of prosthesis, production of feet
ENIMO, new components, SIME
discussion with MINSAP over possibility of rehabilitation project of disabled
Visibility: posters, celebration of 35 years lab Cuba RDA

OIKOS:
Rehabilitation and equipment of rest homes and houses for elderly: cooking materials and boilers.
2 vegetable gardens with water pump in a house for elderly and a psychiatric clinic.
Distribution of disposable articles for dialysis.
Critics:
Institutionalisation of dependence.
Development needs a revolution in the mentality as all is planned by the state.
Proposition for ECHO: rehabilitation of boilers and stream circuit in 5 hospitals.

In June 99 stomatology material of the GP 98 was still not distributed. The same happened with medico-surgical material remained in the stores, the destination being a single hospital
Minvec is repeating the same errors causing delay over and over again, while the procedures should be identical and blocking projects over more then a year (from mid 1998 to June 1999 for a cold chain project).

CARITAS Guantanamo
Distribution of clothes to elderly in the 5 Oriental provinces, the centre and the province of Habana for an amount of 860.000 Euros in 1997. SCF distributed to children
System of family attention food services to elderly with low income. Caritas has 72 restaurant projects in total. The 7 in Guantanamo supply to more then 2000 people.

CRA:
99/02008: Budget: 200.000
Rehabilitation of the roofs of the houses hit by hurricane George
The Red Cross in Guantanamo:
has a serious problem and irreparable delay with the identification of excluded vulnerable population and of the needs of supporting services. The circuit of information starts from the German Red Cross to the Red Cross Society of Guantanamo and after this the circuit is interrupted at the Red Cross of La Havana. No project was introduced except for cyclone intervention.

MDM-F
99/02004: Budget: 140.000 Euro
Reactivation of the Laboratory for Hygiene and Epidemiology in the province of Camagüey Microscopes, diagnostic products and scales.

MPDL
99/02005: Budget: 220.000:Refrigeration, air conditioning/ occupational therapy
Refrigeration in 19 rest homes
Air condition in 25 mother houses and maternity with equipment
Gardening project in 2 rest homes and 1 psychiatric clinic
99/03002: Budget:370.000: Equipment, nefrological and surgical material
New propositions:
Air conditioning in 3 centres for burns
Disposable material for 5 maternity's
Ophthalmology project according national plan (also OIKOS)
Problems:
lack of participation in laundry (1997) and gardening projects, especially at the start
Obtain supplies and provisions for the garden project, especially inside Cuba idem GVC!).
The impact of the aid is dependent of the seriousness of previous lack!!

CISP
99/02001: Budget 210.000 Euro
Attention to the elderly in 2 provinces, equipment and gardening (occupational therapy and autoconsumption)
Extension of 3 months because of problems of delivery of supplies.

Erikshjälpen:
1997! :Hospital clin chir Camilo Cienfuegos in Sancti Spiritus: 700 beds, occupation 75%
-renovation and rehabilitation of 4 cold rooms
-rehabilitation of drug store with condensation machine
st I buying equipment/ st II renovation of areas
Problems: duration 1 year for 6 months both in stage I and II, bank transference, production of equipment, calendar of technicians of COPEXTEL

The ONG consortium gardening project, included in their 1999 budget:
Centres for mentally and physically handicapped (5), rest homes (8), one sanatorium for AIDS, hospitals (2 + 1 psychiatric). Budget 250.000 Euro for 47.544 beneficiaries.
in 4 centres by GVC in PdR, 3/2000.
ANNF 4 and MPDL 3 in Ciudad Havana
CISP 4 in Matanzas and 1 en Villa Clara
OIKOS 3 in Prov. Havana

Annexe VIII: Meeting with NGO's

Meeting with the NGO's on 14/4/2000: participatory technique concerning the co-operation of NGO in Cuba with ECHO in the GHAP and projects

Weakness
In order of priority given by the assembly.
Beneficiaries do not participate in the needs and impact analysis.
Centralisation, hierarchisation and bureaucracy.
Excessive wastage of energy and difficulty to function for NGO's.
Precarious stay of the NGO is problem both for local personal and for ECHO.
Narrow space for the NGO in identification of projects (logistic role).
Difficulties of dialogue and exchange with local counterparts (lack of decisional capacity of the provincial governments and not assumed responsibilities).
Absence of civil society (if present it is institutionalised) and no autonomy of in-country NGOs.
The projects are focused on health without attention on other fields.
Difficulty for the NGO to work and function.
Lack of legal personality.
Short contracts.
Sustainability: the GHAP affects the national quota by substitution and not complementing it.
The counterparts confuse between co-operation and solidarity aid.
Lack of transparency (exaltation in statistics and accomplishments in social issues.
There is no culture of learned lessons.
Dependency is a characteristic of the GHAP.

Strengths

Partnership with ECHO, umbrella function.
Impact of NGO interventions with ECHO
Effect of multiplication
Effective reaching the beneficiaries
Existing human resources (in the Cuban society)
Structured relation with the government in a legal frame
Coherence of the interventions, co-ordination and specialisation.
Reaching the vulnerable population through the microprojects and relieving the Special Period.
Counterparts don't meddle with private interests.
National health system.
Visibility
The co-ordination facilitates feedback.

Annexe IX: Work session with ECHO partners & other NGO's 2/5/2000.

Other NGO's are AAA, Care Canada, PTTI, GVC-EntrePueblos, CIES, Medicus Mundi:
The relation with ECHO.
The future of ECHO's intervention and intervention in general in Cuba. Relief aid has to be abandoned in Cuba, when and how?
How to improve impact on the vulnerable?

Proposed improvements in the collaboration with ECHO and MoH:
Participation of NGO:
More activity of NGO side in identification of needs XXXXXX[32]
More time to elaborate projects (or buy the products before the time frame). XX
More freedom for the shopping, outside Europe and co-ordinate local shopping XX
Facilitate the Transport to the provinces by support of NGO and ECHO.XX
NGO should enter in areas also outside the responsibility of MoH
Positive aspect of the Frame Contract. Possibility to change and adapt it and ECHO more proactive to defend the NGO legality. XXXXX
Improve communication with Brussels (good access to ECHO Cuba XXX) XX
Improve information between NGO's through ECHO (also for joined shopping). XXXX
Formalise meetings on strategy, not only log.
ECHO should facilitate not substitute the NGO-counterpart logistics.

Future of ECHO:
Leave the emergency because there is no real emergency situation. XXXXXX

When
Immediately, give 1 year to MINSAP to organise itself .XXXX
Reduce progressively because of the created dependency XXXX

How
Projects with impact on the infrastructure XXX
Open up the lines of rehabilitation (vulnerable). More development than microprojects. XX
Start more structural projects and with technical assistance to the pharmaceutical industry and for the production of orthopaedic components, for 3-4 years.
Promote the participation of the beneficiaries.
Sectors of housing water schools and health centres.
Co-ordinate actions NGO-local partners.

Vulnerability:
Who are they?
In Cuba it is rare to find vulnerable without any type of attention. Neglected groups do exist living in extreme precarious situation: elderly, single mothers, prisoners and relatives, disabled, chronic and mentally ill. XX
The rural and mountainous population in the East has less access to the services and has scarce possibilities of social-economical development. XXXXX
Population with no access to dollar. XX
People without house, water. Insalubrious neighbourhood. XXX
The not institutionalised population.

Who is covering them?
Through the existing services in theory, but not always practically. XXXXX
Associations for disabled (Aclifim, ANCI, ANSOC)
Family

How to reach them?
It is difficult to trace the most vulnerable. NGO is bound by contract to government institutions. XX

[32] XX: for the number of NGO statements.

Through existing structures having good coverage but scarce (precarious) resources. Need of rehabilitation and new and more adapted approach! XXX
The identification must happen in the territory and by the NGO's. The I-C NGO needs participating proactively in the identification of community projects. XXX
Through negotiation with the state.
Working with UBPC, co-operatives to increase production and income.

Annexe X: Users of the health and social services

Focused group interview I:
Not all the invitees arrived. 4 women and 2 men participated.

A young epileptic women married with 2 children with congenital skin disease.
Her husband, a university trained professional.
A single old mother, of 75, having lost her only son. Has hypertension and cataract.
Single mother of 45 years with 6 children, 3 still dependent from her.
A chronic ill adult man with 6 months in a sanatorium.

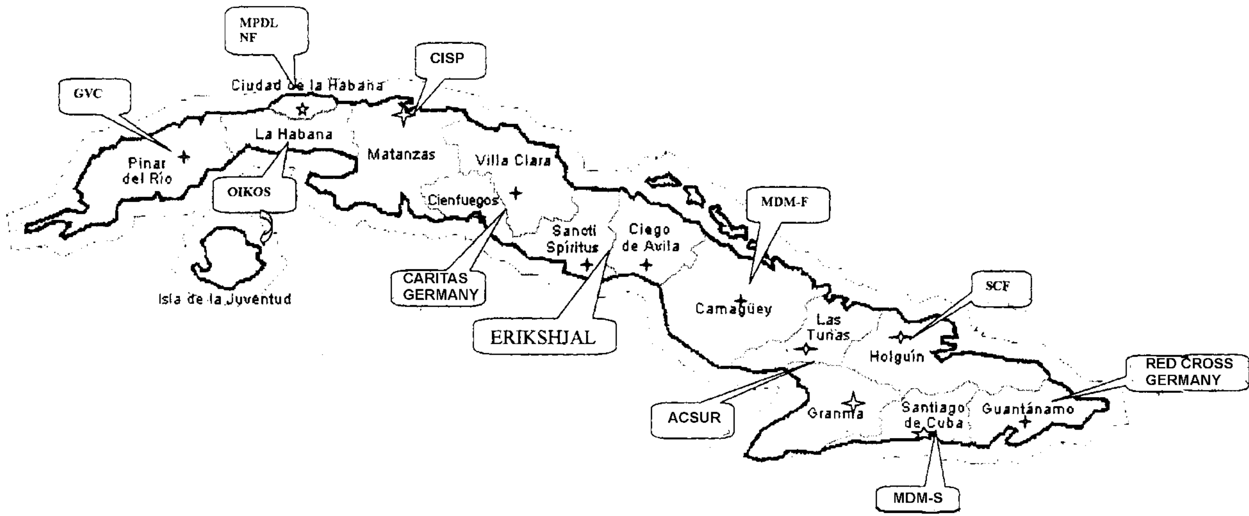
Conclusion:
In spite of the social worker network the accessibility is low: long waiting times, easier through relations, lack of information.
Their resources are even lower. So once contacted the support is irregular and only for some days
It more feasible to have assistance with zero income than with an average income and additional problems of housing or chronic health problems in the family.

Focused group interview II:
10 participants, all functioning in Health and Social Work institutions:
Policlinic doctor
PHC stomatologist
MD of home for mentally disabled
Social worker of mother house
Dipl. Hospital nurse
Geriatrist
Epidemiologist
Chief dietician of prov. Hospital
Pharmacist, pilot ph.
Social worker of Min of Work

Issues discussed in focused and free dialogue:
Impact and efficacy of ECHO humanitarian aid.
Priorities for the future.
Sustainability of the programmes
Vulnerability and identification.

Conclusion:
The participants use casuistic information to analyse.
Priorities are purely own-demand driven.
Unanimity on the extreme working conditions: poor salary, obsolete material, and lack of basic products.

Annexe XI: Map of Cuba



Annexe XII: Tables and figures.

TABLE 1: CUBA PHYSICAL AND HUMAN RESOURCES OVER THE LAST DECADE

INDICADORES SELECCIONADOS 1991-2000 SALUD PÚBLICA								
				HABITANTES POR				
AÑOS	MÉDICOS	ESTOMATÓLOGOS	MÉDICOS DE LA FAMÍLIA	MÉDICO	ESTOMATÓLOGO	HOSPITALES	POLICLÍNICOS	CAMAS EXISTENTES
1991	42634	7515	15141	251	1423	267	421	64347
1992	46860	8057	18503	231	1343	270	423	65190
1993	51045	8531	22021	214	1280	277	427	65392
1994	54065	8834	25055	203	1241	278	435	65703
1995	56836	9148	27169	193	1200	281	440	66116
1996	60129	9600	28350	183	1146	281	442	66263
1997	62624	9816	28855	176	1124	283	440	66948
1998	63483	9873	29934	175	1126	283	440	66261
1999	65474	10012	30596	170	1113	283	440	62000
2000	66227	9933	30540	168	1123	283	440	58550

TABLE 2: MINSAP; resources by type of institutions (1992–1998)

UNIDADES	1992	1993	1994	1995	1996	1997	1998
Total	1910	1931	1953	1988	2000	2027	2042
Asistencia médica	1715	1732	1747	1780	1783	1804	1816
Hospitales	272	279	280	281	281	283	283
Generales	79	80	82	82	83	85	83
Clínico-quirúrgicos	30	30	30	31	31	32	34
Rurales	63	64	64	64	64	64	64
De maternidad	20	20	19	19	18	18	18
Materno-infantiles	15	16	16	16	16	16	16
Infantiles	29	28	26	26	26	26	26
Especializados	31	36	38	40	41	42	42
Otros hospitales	5	5	5	3	2	-	-
Institutos de investigación	11	11	11	11	11	12	12
Otras unidades de asistencia médica	1432	1442	1456	1488	1491	1509	1521
Policlínicos	423	427	435	440	442	440	440
Puestos médicos rurales y urbanos	175	169	165	165	164	161	161
Hogares maternos	164	176	183	208	209	220	231
Balnearios minero-medicinales	3	3	3	4	4	4	4
Clínicas estomatológicas	166	166	167	168	168	166	166
Bancos de sangre	24	25	25	25	26	26	27
Otras unidades	477	476	478	478	478	492	492
Asistencia social	195	199	206	208	217	223	226
Hogares de ancianos	170	174	179	182	190	196	197
Hogares de impedidos físicos y mentales	25	25	27	26	27	27	29

TABLE 3: MINSAP; number of beds per type of institution (Cuba 1992-1998)

UNIDADES	1992	1993	1994	1995	1996	1997	1998
Total de camas	80684	80695	81907	81364	81549	82037	80781
Asistencia médica	66348	66494	67353	67137	67284	67969	67282
Hospitales	59635	59765	60142	60078	60020	60645	60215
Generales	16563	16735	17455	17418	17668	17976	17822
Clínico-quirúrgicos	16632	16375	16317	16492	16372	16637	16688
Rurales	1668	1714	1698	1698	1698	1698	1671
De maternidad	4482	4482	4350	4350	4198	4198	4147
Materno-infantiles	1020	1136	1121	1135	1135	1150	1150
Infantiles	7830	7730	7286	7286	7286	7286	7208
Especializados	10632	10779	10820	11077	11107	11260	11089
Otros hospitales	808	814	1095	622	556	440	440
Institutos de investigación	1157	1157	1207	1207	1349	1349	1197
Otras unidades de asistencia médica	5556	5572	6004	5852	5915	5975	5870
Policlínicos	381	375	358	372	379	263	249
Puestos médicos rurales	41	47	47	47	47	47	47
Hogares maternos	2718	2941	3146	3369	3350	3526	3687
Balnearios minero-medicinales	64	64	64	64	64	64	64
Otras unidades	2352	2145	2389	2000	2075	2075	1823
Asistencia social	14336	14201	14554	14227	14265	14068	13499
Hogares de ancianos	11736	11638	11666	11581	11639	11438	10847
Hogares de impedidos físicos y mentales	2600	2563	2888	2646	2626	2630	2652

Table 4: GPHA 1999; Proprotion of aid and budget structure

STRUCTURE DES DEPENSES DU Ivéme PLAN GLOBAL D' AIDE HUMANITAIRE A LA POPULATION CUBAINE		
COMPOSANTS	**BUDGET**	
	ECU	**%**
ACHAT DE PRODUITS	5.316.279	75'95
TRANSPORT INTERNATIONAL	295.388	4'22
TRANSPORT LOCAL (Véhicules ONG)	133.050	1'94
PERSONNEL (Expatrié et National)	634.250	9'23
VISIBILITE	53.991	0'8
AUTRES (Communic., Cont, Qualité, Assurances)	101.316	1'44
FRAIS DIRECTS ET D' ADMINISTRATION	429.770	6'14
RESERVE (ECHO et ONG)	35.956	0'5
TOTAL PLAN GLOBAL	**7.000.000**	**100'0**

COMPOSANTS DU Ivéme PLAN GLOBAL D'AIDE A LA POPULATION CUBAINE		
	BUDGET	
COMPOSANT	**ECU**	**%**
MEDICAMENTS	1.956.134	37'45
Matiére premiére pour médicaments	908.628	17'40
Médicaments élaborés	1.047.506	20'06
ALIMENTS	1.253.564	24'00
MATERIEL CLINIQUE ET CHIRURGICAL	759.115	14'53
MATERIEL TEXTILE	431.201	8'26
PRODUITS DE STOMATOLOGIE	448.755	8'59
PRODUITS D'ENTRETIEN D'HYGIENE	374.275	7'17
TOTAL	**5.223.044**	**100'0**

Table 5: Quantities of drugs received as raw material and the % of it produced and distributed by the 7 laboratories to the provinces.

And Insulin received as finished product and distributed.

DRUG	Quantity of received raw material, Kg.	Date of Reception	Planned Production	% Produced	Quantity in Kg.distributed	% of raw material processed and distributed
Lab: Ocho de Marzo						
Cefalexine oral suspension	325	4/10/99	164.500	0	0	0
Oxaciline 250 mg	660	4/10/99	183.333	93	170.499	93
Lab: Medsol (Planta 1)						
Chlortalidone 25 mg	1050	29/9 & 4/10/99	38.888.900	69	26.171.760	69
Digoxine 0,25 mg	7	29/09/99	25.925.900	66	17.055.080	66
Fenitoine 100 mg	950	4/10/99	8.796.300	29	2.534.310	29
Glimenclamide 5 mg	450	29/9/99	83.333.300	15	12.685.390	15
Dinitrate isosorbide 10 mg	800	4/10/99	29.629.600	72	21.456.520	72
Lab: Julio Trigo						
Pilocarpine 2% colirium	51	29/09/99	229.755	62	141.572	62
Lab: Roberto Escudero						
Nystatin creme	1000 box	19/06/99	343.285	60	205.971 box	60
Lab: Reinaldo Gutierrez						
Levadopa & Benceracide	50	29/09/99	833.333	149	1.243.200	149[33]
Ethylbiscoumacetate 0,3 mg	120	29/09/99	381.000	0	0	0
Methyldopa 250 mg	4150		15.660.400	112	17.606.600	112
Nystatin oral tabs	150 box	19/06/99	283.000	61	173.964 box	61
Nystatin vag tabs	850 box	19/06/99	7.727.300	20	1.525.980 box	20
Propyltiuracil 50 mg	150		2.884.600	80	1.044.800	36
Verapamil 80 mg	225		2.678.600	105	2.651.730	99
Lab: Juan R. Franco						
Nystatin powder suspens.	2.200	8/7/99	254.600	100	247.482	97
Lab: Ensufarma, finished products						
Insulin NPH 100U amp		7/4 to 12/8/99	219.287 amp received	100	219.436	100
Insulin Actrapid 100U			12.000	100	11.960	100

[33] The exceeding percentage must be explained by processing rest stock of previous PGHA. This illustrates also the lack of accuracy in the provided data of IMEFA.

Table 6: GPHA 1999; Description of medical and surgical material

RELACIÓN DE PRODUCTOS DE NEFROLOGÍA,OFTALMOLOGÍA Y MEDICAMENTO DE LA DECISIÓN 99

OIKOS	Contrato 99/03003			
PRODUCTO	Cantidad propuesta	Cantidad recibida	Pendiente a recibir	OBSERVACIONES
Dializador M-15	12.000	1.500	10.500	Se esta distribuyendo lo recibido
Dializador M-23	12.000	6.000	6.000	Se esta distribuyendo lo recibido
Linea Venosa	22.000		22.000	
Linea Arterial	22.000		22.000	
Catéteres Tenckoff	1.000		1.000	
Catéteres Subclavia	1.000		1.000	
Tabletas p/ clorar el agua para 20 litros	72 cajas x 14.000 Tabs.			
Tabletas p/ clorar el agua para 100 litros	23 cajas x 43.000 Tabs.			

MPDL	Contrato 99/03002			
PRODUCTO	Cantidad propuesta	Cantidad recibida	Pendiente a recibir	OBSERVACIONES
Lámparas halógenas 24 V. 50 W.		3.050		Esta mercancia esta en el aeropuerto
Lámparas halógenas 120 V. 150 W.		225		Idem. al anterior
Lámparas halógenas 220 V. 50 W.		225		Idem. al anterior
Bisturí Crescent		200		Idem. al anterior
DK Line de 5 ml.		30		Idem. al anterior
Cja. de acero inox. con almohadilla Silic.		18		Idem. al anterior
Edge Ahead Knife recto		100		Idem. al anterior
Pinzas Bipolares		18		Idem. al anterior
Cables para Pinzas Bipolares		18		Idem. al anterior
Bisturís Phaco 3,2		200		Idem. al anterior
Cánulas infusión 2,5 mm.		20		Idem. al anterior
Cánulas infusión 4 mm.		28		Idem. al anterior
Tijeras Vannas Rectas		14		Idem. al anterior
Tijeras Vannas Curvas		14		Idem. al anterior
Espátulas Wecker		10		Idem. al anterior
Ganchos Sinskey		19		Idem. al anterior
Cánulas Sincoe		14		Idem. al anterior
Cánulas aspiración irrigación		18		Idem. al anterior
Tijera cuerpo vitreo Recta		1		Idem. al anterior

SCF	Contrato 99/03007			
PRODUCTO	Cantidad propuesta	Cantidad recibida	Pendiente a recibir	OBSERVACIONES
Insulina NPH (Insulatar) 100 U.	55.820	55.820		Ya fue distribuida nacionalmente

Table 6: GPHA 1999; Description of medical and surgical material

RELACIÓN PRODUCTOS PLAN GLOBAL 99

MATERIAL CLINICO QUIRURGICO	
PRODUCTO	Cantidad
CIRUGIA OFTALMICA	**MDM-F**
Seda 8/0	717x12
Nylón 10/0	560x12
Sutura de poliester Trezado 4/0	54x12
Lente intra-ocular p/cámara posterior	731
Material viscoelástico	400+637 (?)
CIRUGIA CARDIOVASCULAR	**MDM-F**
Hemofiltro pediátrico de 0,16 m^2	144
Hemofiltro p/adulto de 0,7 m^2	176
NEFROLOGÍA	**MDM-F**
Catéter p/ dialisis peritoneal 5 mm x 42 cm	89
Catéter p/ hemod. subclavia CH 12 x 15 cm	110
Dializador capilar, aclaramiento de Urea 166-175ml/minuto factor Ultrafiltración 4,0-5,5	2.112
Linea arterial p/dializ.comp.Riñon art. FA-153	74x36=2.664
Linea arterial p/dializ.comp.Riñon art. FA-501	38x30=1.140
Linea venosa p/dializ.comp.Riñon art. FV-169	85x36=3.060
CUIDADOS INTENSIVOS ADULTO	**Erikshjälpen**
Trócar E.V. c/cánula plástica 14 G.	4.700
Trócar E.V. c/cánula plástica 16 G.	13.850
Trócar E.V. c/cánula plástica 18 G.	20.875
Catéter E.V. yugular 16 G.x 45 cm aguja 14	11.200
Urinómetro, capacidad 500 ml.	1.080
Sistema drenaje torácico tricameral	680
CUIDADOS INTENSIVOS PEDIÁTRICO	**MDM-F**
Catéter E.V. pecutanes 18 Gx 30 aguja 16 G	1.875
Catéter E.V. pecutanes 17 Gx 30 aguja 15 G	1.875
Cánula p/traqueatomía 15 mm. X 3,0 mm	38x10=380
Cánula p/traqueatomía 15 mm. X 3,5 mm	38x10=380
Cánula p/traqueatomía 15 mm. X 4,0 mm	38x10=380
Cánula p/traqueatomía 15 mm. X 4,5 mm	38x10=380
Cánula p/traqueatomía 15 mm. X 5,0 mm	30x10=300
Cánula p/traqueatomía 15 mm. X 6,0 mm	30x10=300
Trócar E.V. cánula plástica 20 G.	15.900
Trócar E.V. cánula plástica 22 G.	2.400

PRODUCTO TERMINADO	CANTIDAD
Insulina NPH 100U. (GVC)	92.000+1.000
Insulina NPH 100U. (SCF)	103.500+1.000
Insulina NPH 100U. (MDM-F)	22.182
Insulina Actrapid (GVC)	11000+1.000
Bolsas para medicamentos	770.000

NOTA: Total Insulina NPH a recibir=218.287
1.000 (V Plan)
219.287 Total

ONG´s	Nº. de contrato
C.R.A.	210/1999/01010
MDM-F	210/1999/01005
Erikshjälpen	210/1999/01004
OIKOS	210/1999/01011
Caritas Alemana	210/1999/01012
G.V.C.	210/1999/01008
S.C.F.	210/1999/01009

CIRUGIA ORTOPEDICA	Erikshjälpen
PRODUCTO	CANTIDAD
Protesis cadera titanio 41 mm	288
Protesis cadera titanio 43 mm	533
Protesis cadera titanio 45 mm	533
Protesis cadera titanio 47 mm	205
Placa cadera acero 70 mm, 4 perf.	1.372
Placa cadera acero 80 mm, 4 perf.	1.580
Placa cadera acero 90 mm, 4 perf.	1.595
Placa cadera acero 70 mm, 6 perf.	330
Placa cadera acero 80 mm, 6 perf.	500
Placa cadera acero 90 mm, 6 perf.	452
Tornillo 4,5 dia. Cab. exagonal 30 mm	3.000
" " " " " 32 mm	3.000
" " " " " 34 mm	3.000
" " " " " 36 mm	3.000
" " " " " 38 mm	3.000
" " " " " 40 mm	3.000
" " " " " 42 mm	3.000
" " " " " 44 mm	3.000

ESTOMATOLOGIA	Cruz Roja (A)
PRODUCTO	CANTIDAD
Fresas 0,08 mm	35.000
Fresas 0,10 mm	35.000
Fresas 0,12 mm	35.000
Resina Autopolimerizable (Kits)	2.396
Agujas largas cap.x 100	4.200
Agujas cortas cap.x 100	4.200
Piezas de mano	1.338
Aceite Sprey x 500 ml.	4.020

PRODUCTO	CANTIDAD	
MATERIAS PRIMAS	Kg.	
Benceracida Clohidrato	50	O
Cefalexina Monohidrato	325	CA
Clortalidona	550	O
Clortalidona	500	CA
Difenilhidantoina base	950	CA
Digoxina	7	O
Etilbiscoumacetato	120	O
Glibenclamida	450	O
Isosorbide Dinitrato 40%	800	CA
Metildopa	4.150	CA
Nistatina	4.200 bous	CA
Oxacilina Sódica (Adicional 120)	540+120	O
Pilocarpina Clohidrato	50	O
Propiltiouracilo	150	CA
Verapamilo Clorhidrato	225	CA
Quinidina Sulfato (Adicional)	25	O

Lectura a quien corresponde traer cada Materia Prima
O=OIKOS CA=Caritas Alemana

Table 7: Humanitarian aid by ECHO in Cuba

DATE	Motivation of the Decision	EURO
03/93	Storm of the Century	500.000
07/93	Ophthalmic Neuropathy	5.500.000
11/93	infectious diseases	495.000
11/93	medical aid against asthma	480.000
11/93	products for hospitals	500.000
12/93	Inundation	330.000
Subtotal aid of 1993	7.805.000	
02/94	Raw material for drugs and hygiene products	3.510.000
07/94	Ist Global Plan of Humanit. Aid to the Cuban Pop.	9.994.500
12/94	Cyclone Gordon	350.000
Subtotal aid of 1994	13.854.500	
07/95	II nd GP of Humanitarian Aid to the Cuban Pop.	15.000.00 0
Subtotal aid of 1995	15.000.000	
10/96	Hurricane Lilly	600.000
10/96	III rd GP of Humanitarian Aid to the Cuban Pop.	8.000.000
Subtotal aid of 1996	8.600.000	
8/97	Dengue epidemy	350.000
11/97	IVth GP of Humanitarian Aid to the Cuban Pop.	8.000.000
12/97	Microprojects	2.000.000
Subtotal aid of 1997	10.350.000	
06/98	Vth GP of Humanitarian Aid to the Cuban Pop.	7.000.000
07/98	Microprojects	2.000.000
11/98	Hurricane Georges	500.000
	DIPECHO projects 1998	350.000
Subtotal aid of 1998	9.850.000	
04/99	VIth GP of Humanitarian Aid to the Cuban Pop.	7.000.000
06/99	Projects in favour of the Cuban population	2.000.000
11/99	Proj. in favour of the Cuban pop. (bridge decision)	2.000.000
	DIPECHO projects 1999	410.000
Subtotal aid of 1999	11.410.000	
GRAND TOTAL 1993-1999	76.869.500	

Annexe XIII: Terms of Reference

TERMES DE RÉFÉRENCE

POUR L'ÉVALUATION DE L'AIDE HUMANITAIRE EN FAVEUR DE LA POPULATION CUBAINE

ECHO/EVA/210/1999/01013

Nom de la société : Consultant indépendant
Nom du consultant : Artundo Carlos

Plan Global à evaluaer

- Région et pays : CUBA.
- Période couverte : 1999 et début 2000.
- Secteurs à évaluer : ceux du plan global et des micro-projets.
- Décision(s) :
  - ECHO/CUB/210/1999/01000.pour un montant de 7 Mio.€(Plan global)
  - ECHO/CUB/210/1999/03000 pour un montant de 2 Mio €(Micro-projets)

Introduction

Depuis 1989, suite à l'effondrement du camp socialiste, Cuba traverse une profonde crise économique qui est source de graves problèmes notamment dans les domaines de l'alimentation et de la santé.

Cuba est le seul pays d'Amérique latine avec lequel l'Union Européenne n'a pas conclu d'accord de coopération. Toutefois, l'aide de l'U.E. est présente depuis plus de 7 ans, notamment, par le biais de l'aide humanitaire en faveur de la population cubaine.

L'aide communautaire en faveur de Cuba s'effectue conformément au point 3 e) de la position commune de l'U.E. adoptée en décembre 1996 et est canalisée via les quatre types d'instruments suivants : aide humanitaire par le biais de ECHO ; opérations de sécurité et d'aide alimentaire via la DG Développement (DEV) ; cofinancement d'opérations par le biais d'ONGs européennes via la DG DEV et programmes de coopération dans les domaines économique, commercial, culturel et social via la DG DEV.

L'Office humanitaire souhaite faire le point sur ses interventions passées et réorienter, si nécessaire, les aides futures en faveur de la population cubaine. A ce titre, il a été décidé d'évaluer l'aide humanitaire fournie par ECHO en 1999.

Rôle du consultant

L'évaluation de l'aide humanitaire constitue une tâche très importante pour la Commission européenne non seulement en raison des sommes considérables consacrées à cette activité, mais également en raison du souci constant d'améliorer le travail humanitaire et d'utiliser au mieux les crédits qui lui sont consacrés.

Pendant le déroulement de la mission, tant sur le terrain que lors de la rédaction du rapport, le consultant devra faire preuve de bon sens et d'indépendance de jugement. Il fournira des réponses précises et directes à tous les points des termes de référence en évitant d'utiliser un langage théorique et académique.

Buts de l'évaluation

Les buts poursuivis par la présente évaluation sont les suivants :

Analyse de l'opportunité et du degré de réalisation du plan global humanitaire et des micro-projets en faveur de la population cubaine dans les secteurs mentionnés au point 1 ;

Analyse du degré d'accomplissement des objectifs poursuivis et de l'efficacité des moyens mis en œuvre ;

Analyse et quantification de l'impact de l'aide ;

Analyse du rôle joué par ECHO dans le processus décisionnel ainsi que des autres activités dont les services de la Commission sont responsables ;

Vérification de la visibilité de ECHO tant dans les régions bénéficiaires de l'aide que parmi les autorités et partenaires locaux ;

Etablissement de recommandations précises et concrètes sur le futur des financements de ECHO. Ces recommandations seront basées sur les besoins à caractère humanitaire dans le cadre du mandat de ECHO et de la Position Commune définie par le Conseil le 2 décembre 1996, point 3-e) ;

Identification d'éventuels nouveaux canaux de distribution de l'aide humanitaire ;

Dans l'hypothèse où l'évaluation concluait que ECHO devrait abandonner le type d'aide octroyé actuellement, établissement d'une « stratégie de sortie »;

Examen du lien entre urgence-réhabilitation-développement: quels types d'aides pourraient se substituer ou prendre le relais de l'aide humanitaire ?

Objectifs spécifiques de l'évaluation

Les objectifs spécifiques suivants s'appliquent à tous les secteurs évalués :

Brève description du plan global et analyse de son contexte **: la situation politique et socio-économique, les besoins humanitaires et les capacités locales pour y répondre.**

L'analyse de la situation actuelle du pays, en termes politiques et socio-économiques, devra inclure une vue d'ensemble permettant d'y situer l'aide financée par ECHO. Cette analyse devra être tant quantitative que qualitative et contenir des informations sur différents secteurs de l'économie telles les politiques sociales et économiques en vigueur, les niveaux de revenus et leur répartition au sein de la population, politiques sanitaire et médicale, l'accès à la nourriture, etc.

La deuxième partie de l'analyse du contexte devra être consacrée à l'identification des groupes vulnérables et leur répartition dans le pays ainsi qu'à l'estimation des besoins par catégorie.

L'analyse devra aussi permettre d'apprécier la capacité des pouvoirs publics et de la population à faire face aux problèmes mis en évidence.

Analyse de la pertinence **des objectifs de l'aide, du choix des bénéficiaires et de la stratégie utilisée par rapport aux besoins identifiés.**

Examen de la coordination **et de la** cohérence **pour chacun des secteurs considérés avec :**

- les autres donateurs, les opérateurs sur le terrain ainsi que les autorités locales ;
- les interventions éventuelles d'autres services de la Commission dans la zone avec des projets similaires ou en relation avec le plan global évalué. Les projets identifiés seront décrits avec leur montant et les éléments de l'aide ;

Analyse de l'efficacité **en termes quantitatifs et qualitatifs pour chacun des secteurs.**

Le rapport coût-efficacité **doit être mis en évidence sur base, notamment, des éléments quantitatifs tels que définis au point 5.4.**

Analyse de l'efficience **de la mise en œuvre de l'aide portant sur :**

- la planification et la mobilisation de l'aide ;
- la capacité opérationnelle des partenaires ;
- la stratégie déployée ;
- les éléments principaux de la mise en œuvre de l'aide tels que : personnel, logistique, comptabilité, respect des habitudes locales, choix des bénéficiaires, etc. ;
- la gestion de l'entreposage des marchandises et des installations ;
- la qualité et les quantités de marchandises et de services mis en œuvre et leur correspondance avec les spécifications contractuelles (y compris les conditions d'emballage, l'origine des marchandises et le prix) ;
- les systèmes de contrôle et d'auto-évaluation mis en place par les partenaires.

Analyse de l'impact **de l'aide. Cette analyse devrait inclure, notamment, les éléments suivants :**

- contribution à la réduction des souffrances humaines ;
- création de dépendance vis-à-vis de l'aide humanitaire ;
- effets de l'aide humanitaire sur l'économie locale ;

- effets sur les revenus de la population locale ;
- effets sur la santé et les habitudes nutritionnelles ;
- effets sur l'environnement ;
- conséquences des programmes humanitaires sur les « capacity-building » locales.

Analyse de la visibilité **de ECHO.**

Examen de la viabilité **de l'aide et notamment de l'opportunité de mettre en place des politiques de développement et/ou de coopération pouvant se substituer à l'aide humanitaire.**

Sur base des résultats obtenus lors de la réalisation de la présente évaluation, le consultant formulera des recommandations **opérationnelles sur les besoins de type humanitaire qui pourraient faire l'objet d'un financement communautaire. Ces recommandations peuvent couvrir, si nécessaire, des domaines autres que celui de l'humanitaire, tels le développement ou la coopération.**

Analyse de la méthode de programmation utilisée par ECHO dans l'élaboration du plan global en faveur de la population cubaine à faire figurer dans le rapport de synthèse.

Formulation des « leçons apprises **» dans le cadre de cette évaluation. Les "leçons apprises" devront également porter sur le rôle joué par ECHO et les autres services de la Commission dans le processus décisionnel et de mise en œuvre de l'aide.**

Méthode de travail

Pour l'accomplissement de sa tâche, le consultant utilisera l'information disponible à ECHO, auprès de ses correspondants sur le terrain, dans les autres services de la Commission, auprès des partenaires de ECHO au siège et sur le terrain, auprès des bénéficiaires de l'aide ainsi qu'auprès des autorités locales et des représentants des Etats membres sur place.

Le consultant analysera l'information récoltée et la synthétisera dans un rapport cohérent répondant aux objectifs de l'évaluation.

Etapes de la mise en oeuvre

Briefing à ECHO **avec le personnel concerné de la Commission pendant 3 jours maximum et mise à disposition de l'ensemble des documents nécessaires à l'évaluation ;**

Mission sur place **: le consultant travaillera en étroite collaboration avec les correspondants de ECHO, avec les partenaires de ECHO, les autorités locales, les organisations internationales et d'autres donateurs ;**

Le consultant consacrera le premier jour de sa mission **sur place à des discussions préliminaires et préparatoires avec le correspondant de ECHO et les partenaires de ECHO sur place;**

Le dernier jour de la mission **sera consacré à une discussion avec le correspondant et les partenaires d'ECHO sur les observations découlant de l'évaluation, et l'équipe se réunira pour établir les lignes directrices du rapport de synthèse qui sera rédigé sous la responsabilité finale du chef d'équipe ;**

Le projet de rapport **(en 10 exemplaires) sera envoyé à l'unité « Evaluation » de ECHO à Bruxelles 8 jours avant sa présentation et sa discussion lors du debriefing ;**

Debriefing **à ECHO de 2 jours maximum ;**

Remise du rapport final **qui prendra en compte les remarques éventuelles soulevées lors du debriefing.**

Une **visite au siège des partenaires** pourra être effectuée selon les besoins avant ou après la mission sur le terrain.

Consultants

La présente évaluation sera réalisée par deux experts possédant une bonne expérience dans le domaine humanitaire et de son évaluation. Une solide expérience dans les domaines spécifiques de l'évaluation qui leur ont été confiés et de la zone géographique où elle se déroule est également requise. La très bonne connaissance de la langue espagnole est obligatoire.

Les membres de cette équipe d'experts sont:

Mr Artundo Carlos

chef d'équipe, responsable de la coordination de l'évaluation et de la rédaction des rapports, et

Mr. Coenegrachts Maurice

Les deux consultants rédigeront conjointement deux rapports.
Un rapport couvrira l'évaluation du programme d'aide de ECHO conformément aux points 4 et 5 des présents termes de référence. L'autre rapport développera plus spécifiquement les points 4.6 à 4.9 et 5.10 des termes de référence.

Calendrier

L'évaluation aura une durée de 42 jours, répartis entre la date de signature du contrat et la fin le 15 juin 2000 avec la remise des rapports finaux.

Rapport

L'évaluation donnera lieu à l'établissement de deux rapports, rédigés en français ou en anglais, d'une longueur maximum de 18 pages y compris le résumé de l'évaluation qui devra figurer en tête du rapport.

Le rapport d'évaluation est un outil de travail extrêmement important pour ECHO. Le format de rapport, mentionné ci-dessous, sera donc strictement respecté.

Page de couverture

- titre du rapport de l'évaluation :
  - « Pays, *plan global,secteur - partenaires - 1999* » ;
- période de l'évaluation ;
- noms des évaluateurs ;
- mention indiquant que le rapport a été établi à la demande de la Commission européenne, financé par celle-ci et que les commentaires s'y trouvant reflètent uniquement l'avis des consultants.

Table des matières

Résumé **(voir formulaire en annexe).**

plan global evalue (5 LIGNES MAX.)
dates de l'évaluation:
RAPPORT N°:
Noms des consultants:
BUT ET METHODOLOGIE DE L'ÉVALUATION (5 lignes max.) :
PRINCIPALES CONCLUSIONS (+/- 25 lignes)
- *Pertinence*
- *Efficacité*
- *Efficience*
- *Coordination, cohérence et complémentarité*
- *Impact & implications stratégiques*
- *Visibilité*
- *Questions transversales*

RECOMMANDATIONS (+/- 20 lignes)
LEÇONS APPRISES (+/- 10 lignes)

Le corps principal **du rapport débutera par un point relatif à la méthodologie utilisée et sera structuré conformément aux objectifs spécifiques formulés au point 5 ci-dessus (maximum de 12 pages).**

Annexes

- liste des personnes interviewées et des sites visités ;
- termes de référence ;
- abréviations ;
- carte géographique des lieux des opérations.

Si le rapport contient des informations confidentielles émanant de parties autres que les services de la Commission, celles-ci figureront dans une annexe séparée.

Le rapport doit être écrit dans un langage non-académique et direct.

Chaque rapport sera établi en 20 exemplaires et remis à ECHO.

Le rapport devra être accompagné de son support informatique (sur disquette) sous le format Word 7.0 ou d'une version plus récente.

Canevas de résumé pour l'évaluation d'une opération ou d'un plan global

Le résumé doit fournir une information synthétique et directe sur les points clés de l'évaluation concernée. Il suit une structure type à partir des critères principaux de l'évaluation et du management des interventions d'aide.
Tous les points doivent être traités. Dans le cas où un point n'est pas traité, il faut expliquer pourquoi.
L'annexe fournit des détails destinés à vous aider à compléter ce document.

Opération évaluée (*plan global evalue*) : Pays de l'opération (*pays ou région*) :……………. Nom du partenaire (*noms des partenaires principaux*) : ……………. N° du contrat d'opération (*décision*) : …….. Dates & durée de l'opération (*période couverte*) : Montant : ………………..…EURO Secteur(s) concerné(s) et description (5 lignes max.) : ………..
DESCRIPTION DE L'ÉVALUATION Dates de l'évaluation (début - fin): Rapport n° (remplir par ECHO) : nom du consultant: But & méthodologie (5 lignes max.)
CONCLUSIONS (+/- 25 lignes) *Pertinence* - Evaluation des besoins, identification des bénéficiaires, analyse des problèmes, méthodes d'évaluation des besoins suivies. - Connaissance et analyse du contexte et de la situation humanitaire. - Pertinence et faisabilité de la stratégie d'intervention : objectif général, objectif spécifique, résultats, activités et moyens, calendrier, prise en compte des facteurs externes au projet, participation de la communauté, systèmes de protection ….
Efficacité - Analyse des résultats obtenus et degré de réalisation de l'objectif spécifique ; prise en compte de l'évolution de la situation. - Coût-efficacité.
Efficience - Gestion opérationnelle par le partenaire, déroulement de la mise en œuvre (compétence technique, personnel, efficacité du suivi, de la coordination), qualité des produits. - Gestion administrative (coûts, gestion du budget).
Coordination, cohérence et complémentarité - Cohérence et complémentarité avec les interventions d'autres bailleurs de fonds et services de la Commission. - Coordination mise en place sur le terrain (autres agences humanitaires, autorités locales, E.M. et autres, coopération avec ECHO).
Impact & implications stratégiques - Analyse de l'impact de l'opération (mesures utilisées) - Analyse d'autres effets et de la viabilité (dépendance, environnement, genre, …). - Perspectives, lien entre urgence, réhabilitation, développement.
Visibilité - Visibilité (bénéficiaires, les partenaires, les autorités locales) - Moyens utilisés et effets.
Questions transversales - LRRD ; droits de l'homme.
RECOMMANDATIONS (+/- 20 lignes)
LEÇONS APPRISES (+/- 10 lignes)

Annexe au canevas de résumé

Pertinence *(Appréciation des objectifs de l'intervention. Justification des objectifs par rapport aux problèmes et aux besoins)*
Evaluation des besoins Identification des bénéficiaires (type, nombre, localisation, informations socio-économiques., …) ? Description des problèmes des bénéficiaires ? Analyse des besoins ? Identification des besoins prioritaires (en rapport avec le contexte politique et humanitaire, et la stratégie d'intervention de ECHO) ? Méthodes utilisées pour évaluer les besoins (consultations participatives, normes utilisées pour identifier l'urgence humanitaire, évaluation technique, …) ?
Contexte et situation humanitaire Connaissance de la situation de base du pays (politique, sociale, économique et sécuritaire) et des contraintes ? Connaissance et analyse de la situation humanitaire ? Connaissance des stratégies des autorités nationales (notamment en matière de préparation aux catastrophes) ? Expérience du partenaire ? Connaissance de la capacité locale de réponse à la situation humanitaire ? Description des autres types d'intervention en réponse à la situation humanitaire ?
Stratégie d'intervention (Référence : le cadre logique de l'intervention) Objectif général (en relation avec le mandat de ECHO / la Déclaration de Madrid) ? Ciblage adéquat des bénéficiaires par rapport aux besoins identifiés ? Moyens & critères utilisés? Objectif spécifique défini en termes d'avantages pour les bénéficiaires, et quantifiable ? Cohérence entre l'objectif spécifique du projet et les besoins humanitaires prioritaires ? Cohérence entre les résultats et la demande des bénéficiaires ? Justification des activités ? Des moyens prévus ? Caractère approprié et faisable de la stratégie prévue (calendrier, plan de travail, système d'intervention, participation de la communauté, logistique …) ? Identification des autres parties impliquées ? Identification et prise en compte des facteurs externes au projet, des contraintes ? Prise en compte, dès le départ, des aspects de viabilité (technologie, environnement, structure de soutien local, aspect de genre, …) ? Systèmes de protection prévus ?

Coordination, cohérence et complémentarité *(Prise en compte efficace des interventions connexes)*
Cohérence et complémentarité avec les interventions, présentes et futures, d'autres bailleurs de fonds ? D'autres services de la Commission ?
Organisation mise en place pour la coordination sur le terrain :ministères et autorités locales, autres agence humanitaires (NU, ONGs), contact direct avec les bénéficiaires, coopération avec le correspondant ECHO, la délégation, … ?
Efficacité *(Degré de réalisation des objectifs de l'intervention)*
Résultats Résultats réalisés (qualitatifs et quantitatifs) ? Contribution des résultats à l'objectif spécifique pour les bénéficiaires (qui en bénéficie ? Moyens de mesure, …) ? Prise en compte de l'évolution de la situation ? Efficacité des modifications ? Coût du projet en rapport avec le degré de réalisation de l'objectif ?
Suivi Systèmes de mesure mis en place ?
Facteurs de succès/ d'échec Descriptions des stratégies de réussite ? Analyses des faiblesses et recommandations ?
Efficience *(Qualité économique de la transformation des moyens en résultats et réalisations)*
Gestion opérationnelle par le partenaire, déroulement de la mise en œuvre Compétence technique : Planification de la mise en œuvre (respect du calendrier, système de gestion, …), capacité de mobilisation ? Gestion de la logistique ? Adéquation qualité, quantité des produits livrés ? Systèmes de transport, de distribution, de stockage … ? Respect des habitudes locales ? Aspects techniques spécifiques propres à chaque secteur ? Personnel : Compétence du personnel utilisé ? Organisation sur le terrain ? Mesures de sécurité du personnel ? Communication ? … Suivi : qualité du suivi ? Auto-contrôle ? contrôle de la qualité ? Qualité du reporting ? … Coordination : qualité de la coordination ?
Gestion administrative Coûts ? Gestion du budget ? Politique d'approvisionnement ? …

Impact & implications stratégiques *(Effets qui peuvent être attribués à l'intervention. Modification de la situation par rapport à celle existant avant l'intervention)*
<u>Impact</u> Analyse de l'impact ? Mesures utilisées ? Contribution à la réduction des souffrances humaines ? Création de dépendance vis-à-vis de l'aide humanitaire ? Effets sur les revenus de la population locale ? Effets sur les aspects de genre ? l'environnement ? le renforcement des capacités locales ? Autres effets ?
<u>Perspectives & viabilité</u> Perspectives futures ? Urgence, crise prolongée, réhabilitation ? Opportunité de mettre en place des opérations de développement ? **Respect des principes énoncés dans la Déclaration de Madrid ?**
Visibilité *(Moyens qui contribuent à faire connaître l'action de ECHO)*
Moyens utilisés ? Visibilité » obtenue ?
Questions transversales *(…)*
LRRD :
Droits de l'homme :
RECOMMANDATIONS (+/- 20 lignes)
LEÇONS APPRISES & RÉTROACTION (+/- 10 lignes)