

APPENDIX

Zaire's health policy and Belgian overseas development support

1. 1974-1984: Zaire defines its health policy and strategies

In 1975 the Commissioner of State for Public Health convened two committees to define the new unit of health care in Zaire, that is the rural or urban *health zone* (*zone de santé*), the main goal of which was to make health care accessible to the entire population.

The health zone is financially independent. It is run by the zone's medical officer (*médecin chef de zone*) and encompasses all the services, whether run by the government, by private companies or by religious missions. The urban zones contain an average of ten health centres (1 per 10,000 inhabitants) and a hospital centre per 100,000 inhabitants. The rural health zone comprises an average of 20 health centres (1 per 5,000 inhabitants) and a general reference hospital per 10,000 inhabitants.

The staff of the health centre is responsible for health promotion among the population it serves. It consists of a nurse, two auxiliaries, and a receptionist, who offer all the curative and preventive care and all the promotional and rehabilitation services that can reasonably be set up at this level, given the epidemiological profile and available and useable resources. The health centre's team runs the centre through the health committee, made up of representatives from the population. The health team teaches the people what measures to take in order to improve family health, using the media of curative and preventive consultations, health committee meetings, village and neighbourhood gatherings, health education in schools and the action of community workers. The latter are expected to transmit information to their neighbours and to report to the centre any events, important in terms of health, that occur in the village or local community.

The zone's medical officer coordinates these activities so as to offer effective and accessible care to the population he covers. He submits his programmes to the local health committee (*conseil local de la santé*) and keeps them informed about the implementation of his programmes. The committee brings together all the parties contributing resources to the health zone.

A number of key ideas have emerged from the meetings of the regional commissions, which are composed of the heads of the health services of each region (former provinces):

- the health services of all the networks (missionaries, companies, and State) have been integrated into a functional whole, while retaining their separate legal statuses;

- the various groups forming the health zone have been allowed to use the revenue that were generated (self-financing);

- within each health zone priority has been given to developing health centres rather than to village health workers.

The commissions work out the detailed principles of health policy, but they have been silent as to how the envisaged structures should function. The relationship between the zone's medical officer and the medical director of the reference hospital is not clearly established, which has resulted in many conflicts.

In October 1975 the *Bureau des Oeuvres médicales catholiques* (Bureau of Catholic Medical Charities) or BOM took over from the regional commissions and held a national colloquium on community medicine at Manresa. The responsible authorities of Church and State medical services looked to the future, when planning the primary health care services.

Then between 1976 and 1979 BOM went on to organize a colloquium in each region. The commissions' conclusions could thus be circulated with the Health Department's backing and field experiments were not hampered by overly rigid official texts.

Field experiments had already started in the early seventies at Bwamanda, Kisantu, Kasongo, and Vanga. This is where the first health zones took shape, with each zone making its particular contribution to the implementation of the national health strategy. Bwamanda integrated the health zone with the other sectors of development, Kisantu proved to the capital's authorities the validity of primary health care (PHC), especially of community involvement, Kasongo provided the theoretical framework, while Vanga served as a starting-point for the support that US AID gave to the health zones from 1982 onwards. Also hundreds of doctors and nursing auxiliaries came for practical training and discovered here their new responsibilities in the zones.

In 1980 the officials of WHO's Expanded Programme of Immunization (EPI) realized that the goal of vaccinating 80% of the country's children would be unattainable if the programme continued to rely on mobile units. The vaccination work had to become part of the existing health zones' activities, while



Map 17 — The 306 health zones of Zaire, 1984
 (Source: Department of Public Health, Republic of Zaire)

health zones had to be promoted where they did not exist. With this in mind, the EPI began offering a national course on PHC planning and management including vaccination, for the medical officers of the zones.

The course is unique in that it combines the planning of the health zone's overall health care system with the conducting of programmes such as the EPI.

One of the stumbling-blocks of Primary Health Care is the inadequate preparation of personnel. At university the young medical officer is prepared neither to practice alone in the bush nor to manage a hospital as a whole, and still less to promote a dialogue with the community in order to secure its participation.

Therefore a complementary training seminar for medical officers has been held yearly since 1981, to enable these doctors to plan the coverage of their zones by their health centres and schedule the inclusion of EPI, diarrhoeal disease control and antimalarial activities in these centres.

This seminar teaches planning rather than management. Once the doctor returns to his area and must tackle the problems of implementing his plans, he feels the need to become familiar with the management tasks traditionally neglected by the medical profession. Such management training is all the more necessary as the health zone is given an independent legal status. The first management course, with a strong financial bias, was offered in late 1985.

The Health Department's Action Plan of 1982-1986 made it possible to harmonize the assistance given to the health zones by multilateral development agencies such as WHO and UNICEF, bilateral agencies such as *Belgian Cooperation* AGCD, US AID, etc., NGOs such as OXFAM and religious organizations.

The health zone also gained the legal status of a corporate entity.

Gradually the health zones covered the country. By June 1985 100, out of the 306 in existence were operational, and served 30% of the population (see map 17).

In his inaugural speech of December 5, 1984, the founding president of the MPR and President of the Republic of Zaire placed his third seven-year term in the category of *social development*. He announced that the entire health plan would be covered by rural and urban health zones designed to make health care accessible to all Zaireans. The programme outlined in this speech is the culmination of ten years of efforts to define a national policy and strategies to provide all Zaireans with the best possible means to withstand the onslaughts of disease.

2. The strengths of the health strategy

Zaire's main advantage is certainly the fact that it devoted ten years to drawing up the reform of its health care system. In addition, it made wise strategic choices, often against the tide.

These strategic choices were the following three:

1° *Prevention is not always better than the cure.*

It is important to solve health problems, but not to apply principles. Calculating the cost/benefit ratios of curative and preventive treatments often reveals that curative care should receive priority. Although it provides only short-term solutions to the acute problems raised by the disease, the immediate results it offers enable auxiliary nurses and doctors to win the population's confidence. They can then encourage the people to support preventive action, whose less certain results appear only in the longer term and are often difficult to assess.

For example, much of the time set aside for health education about malaria is devoted to telling women how to administer chloroquine to their children at home. In this case curative home care is preferable to preventive measures, because it will be a more effective and cheaper means of avoiding child deaths due to malaria.

2° *The health centre is the pillar of the national primary health care system.*

This choice is founded on the following factors:

- the existence in Zaire of an extensive network of former dispensaries;
- the nationwide training of enough qualified personnel to staff the health centres;
- the Kazumba pilot project in West Kasai, where village health workers (VHWs) set up in competition to the rural dispensary nurse-aids; and the fear (later justified) that the VHWs would turn into substandard nurse-aids.
- the refusal of some communities to entrust the village's entire medical supplies to a single person responsible for handing these resources out to the whole community (family medicine rather than a village pharmacy);

Zaire's refusal to link the global PHC strategy to the village health worker does not mean that appeals for volunteers are to be ruled out. A VHW is used when a small community is too far from its health centre. Moreover, volunteer community workers are available in every community, where they are mainly responsible for circulating health information.

3° *The role of the national programmes.*

Zaire has created national bodies to train and supervise health zone personnel for specific interventions,

to assess the zones' actions, and if necessary to provide specific logistical support, such as vaccines, contraceptives, etc. However, the health zones remain responsible for the implementation of their programmes.

The national agencies do not replace the health zone by setting up field intervention teams. They do not impose their goals of coverage or achievements on the zones' medical officer, for it is he who, together with the community involved and bearing in mind the available resources, can best decide what share of the resources should be allocated to a given programme in order to get better results. If specific objectives were imposed by the national agencies, there would be the risk of resources being channelled away from the health zones to achieve these sole objectives, to the detriment of activities more profitable in terms of health.

3. The uncertainties of the national health strategy

The principle of the health zone's self-financing is accepted. Other problems subsist, led by the ability of training activities to finance themselves and by the difficulties of government control, particularly since the Government may collect part of the population's tax contributions to cover the cost of national services.

Unresolved problems are:

1° Equitable subsidizing or self-determination

According to the principle of national solidarity, a proportion of the State's tax revenue should serve,

through health zone subsidies, to make health care accessible to all the people, and particularly the least-privileged, that is the inhabitants of scantily populated and remote rural areas and the urban poor. The criteria for allocating these subsidies have yet to be defined.

Subsidizing the health zones would make them more vulnerable, since they would depend on annual national budget decisions. Subsidies would also enable the State to continue coordinating resources and ensuring the quality of health care.

2° Level of care and local financing possibilities

Only the oldest research method in the world, that of trial and error, can provide the answer to this question. Service utilization studies will reveal whether the services, as planned correspond to what patients can pay and to State subsidies. Indicators are needed that will allow continuous assessment of service utilization in relation to socio-economic level.

3° Balance of power between the providers and the users of services

Everyone in Zaire agrees that the people are involved in the health activities, but do they simply contribute material and financial resources or are they actually taking part in the management of services?

There is not yet a consensus in Zaire on the balance of responsibilities between the providers and the beneficiaries, nor is there a consensus on the ways to achieve this balance. Ongoing experiences should help to provide an answer.