Als ideale kandidaten voor deze prijs worden personen of werkgroepen aangezien die door hun werk, in moeilijke omstandigheden uitgevoerd, op belangrijke wijze hebben bijgedragen tot het formuleren en/of implementeren en verspreiden van een innoverend waardevol concept op het gebied van de gezondheidszorg Zo uit artikel 9 van het Bijzonder Reglement blijkt dat, bij de rangschikking van twee of meerdere werken waarvan de waarde als vergelijkbaar wordt aangezien, de voorkeur dient gegeven aan een werk dat in een ontwikkelingsland werd verwezenlijkt, betekent dit geenszins dat waardevolle werken uit ontwikkelde landen, bv de recente formulering en implementering van het concept der palliatieve zorgen, voor de prijs niet ontvankelijk zouden zijn

Even duidelijk zal bij de beoordeling van de voorgelegde werken blijken dat deze werken niet alleen vanuit zuiver wetenschappelijk oogpunt dienen geevalueerd, maar dat naast wetenschappelijk verantwoorde concepten en werkwijzen, persoonlijke inzet, groepsgeest, altruistische bewogenheid en sociaal belang evenzeer in aanmerking dienen te worden genomen"

Tot zover de beweegredenen van onze confrater André De Schaepdryver en zijn echtgenote Theresia Caenepeel om deze prachtige prijs te stichten

De ***eerste Prijs De Schaepdryver-Caenepeel***, voor de periode 1994-1997, wordt verleend aan ***Dr. Michel Jancloes***, *"Director, Division of Strategic Support to Countries in greatest need, of the World Health Organization" Vanwege Ambassadeur J M Noirfalisse, permanent vertegenwoordiger van Belgie bij het secretariaat van de Verenigde Naties, werd het volgend bericht ontvangen*

Monsieur le Secrétaire Permanent,

Je vous serais reconnaissant de bien vouloir remettre le message suivant, de la part du Ministre de la Santé, Monsieur M. Colla, au Docteur M Jancloes:

"Cher Docteur,

J'ai appris lors de mon passage à Genève, que vous aviez reçu le prix De Schaepdryver-Caenepeel 1995-1997.

Je tiens à vous en féliciter sincèrement

Colla".

De bekroonde kandidatuur luidde "Report of development work realized with poor populations from developing countries aiming at their autonomous development in health"

Kennis van het gemotiveerde voorstel van de betrokken jury wordt door de heer ***S. Pattyn*** *gegeven in volgend verslag*

Een toepasselijke lijfspreuk voor Michel Jancloes zou kunnen zijn "Help uzelf, zo helpt U Jancloes, of de organisaties die hij heeft opgezet".

Inderdaad heeft de arts Jancloes van bij het begin van zijn activiteit in ontwikkelingslanden ingezien dat het niet opgaat op een paternalistische manier hulp te sprenkelen over degenen waarvoor ze bedoeld is, waardoor de ontvangers deze passief in ontvangst nemen en even berooid als voorheen achterblijven wanneer de hulp van buitenaf opdroogt Dat het beter is de mensen te leren vissen dan ze de vis te geven Dit solidariteitsprincipe heeft Dr Jancloes toegepast in de gezondheidszorg in ontwikkelingslanden

Geboren in 1943 in Verviers, behaalde hij in 1968 het diploma van doctor in genees-, heel-en verloskunde aan de Université catholique de Louvain en in 1977 het doctoraat in Volksgezondheid Gedurende vijf jaar, van 1969 tot 1975, organiseerde hij de rurale medische infrastructuur in de zone Kisantu in Bas-Congo, waarbij hij de bevolking motiveerde met spectaculaire ontwormingscampagnes, om hun drinkwatervoorziening ter harte te nemen, zelf iets te doen aan hun voedselvoorzieningen waarbij hij steun verleende aan de allerarmsten

De grote uitdaging ontmoette Jancloes in de Pikine, een voorstad-slaapstad van Dakar, de hoofdstad van Senegal, waar hij van 1975 tot 1981 werkte Geconfronteerd met die schier onverzadigbare medisch-sociale nood in deze megalopolis, vatte hij het plan op, dat later een lichtend voorbeeld op wereldschaal zou worden, de bevolking te leren zelf een lokaal ziekteverzekeringssysteem op te zetten, gezondheidscentra in te richten en uit te rusten met aangepaste middelen Uit het Pikine-model is een hele methodologie gegroeid om aan vragen van de bevolking te voldoen Het lag ook aan de basis van het latere zogenaamde Bamako-initiatief Dit project was zo indrukwekkend dat Michel Jancloes werd weggeplukt door de Wereldbank om zijn inbreng te leveren bij de ge-

zondheidsontwikkeling in Oost-Azie (Indonesie en Zuid-Korea) en West-Afrika, waarbij telkens gepoogd werd de investeringen te laten verschuiven weg van de gesofisticeerde ziekenhuizen in de grote steden naar gezondheidscentra in de periferie en met integratie van familieplanning.

Vanaf 1986 werkt Michel Jancloes in het hoofdkwartier van de Wereldgezondheidsorganisatie te Genève in de afdeling "Cooperation with countries and people in greatest need", waarvan de bedoeling opnieuw is de uitbouw van haalbare en duurzame basisgezondheidszorg (Primary Health Care – Soins de Santé Primaires) voor de armsten Let op de uitdrukking cooperation **with** people in greatest need.

De jury voor de Prijs De Schaepdrijver-Caenepeel, bestaande uit de HH A Kint (voorzitter), P G Janssens, J V Joossens, G. De Backer van de K A G B en ikzelf, secretaris, Mevr Y Verhasselt, Vast Secretaris van de Koninklijke Academie voor Overzeese Wetenschappen en de H. H.W Van Lerberghe van het Instituut voor Tropische Geneeskunde, rekening houdend met de doelstellingen van de Prijs, nl. "Als ideale kandidaten voor de prijs worden personen of werkgroepen aangezien, die door hun werk, in moeilijke omstandigheden uitgevoerd, op belangrijke wijze hebben bijgedragen tot het formuleren en/of implementeren en verspreiden van een innoverend waardevol concept op het gebied van de gezondheidszorg Naast wetenschappelijk verantwoorde concepten en werkwijzen dienen persoonlijke inzet, groepsgeest, altruistische bewogenheid en sociaal belang in aanmerking te worden genomen" stelde op 10 juni 1997 unaniem voor de prijs De Schaepdryver-Caenepeel toe te kennen aan Dr Michel Jancloes voor zijn werk "Report of development work realized with poor populations from developing countries, aiming at their autonomous development in health"

De Koninklijke Academie voor Geneeskunde van Belgie sloot zich bij dit advies bij geheime stemming aan op 28 juni 1997.

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De Voorzitter dankt de verslaggevers van de onderscheiden jury's en geeft het woord aan ***Dr. Michel Jancloes*** *die een voordracht houdt over* ***"New Deals for Community health in developing countries"***.

Twenty years afo, we were talkıng about barefoot doctors and today we speak of consultatıons wıth vırtual doctors on the Internet We are wıtnessın the most advanced medıcal technology sıde by sıde wıth an ıncrease ın the number of people who have no access to the most elementary basıc health servıces At a perıod when poverty grows quıetly ın the shadow of wealth, thıs Prıze ıs tımely To gıve credıt to autonomous development ın health, ıncludıng carıng, ıs rıght and more relevant than ever.

I am very honoured for thıs award and want to express my gratıtude to and Mr and Mrs De Schaepdryver-Caenepeel Through me, ıt belongs to Belgıan ınstıtutıons and ındıvıduals who have played and contınue to play an ınfluentıal role ın Internatıonal Health. In partıcular, I want to mentıon the General Admınıstratıon for Development Cooperatıon, the Instıtute of Tropıcal Medıcıne of Antwerpen, the Publıc Health School of Louvaın and Medıcus Mundı My gratıtude also goes to Mr Kıvıts, Professor Janssens, Professor Lechat and Professor Vandepıtte and my day-to-day 'comrade-ın-arms', my wıfe.

In addressıng you today, I would lıke to gıve a brıef hıstorıcal revıew, tracıng the evolutıon of thınkıng on communıty health and ınternatıonal cooperatıon ın developıng countrıes over the last four decades and presentıng the maın lessons learnt from case settıngs ın my personal experıence. I shall then look at the future and ıts new opportunıtıes for communıtıes to ımprove theır own health and lıvıng condıtıons.

I shall feature the decades as follows 'Self-relıance Movements' of the sıxtıes, followed by the "Prımary Health Care Great Awakenıng", "Cost-recovery to the rescue", and last a "Market for Essentıal Packages".

Between 1960 and 1975, health polıcy makers and managers ın developıng countrıes were confronted wıth ımpossıble polıtıcal pressures sprınging frost post-ındependence expectatıons, and from people's aspıratıons to self-determınatıon and self-relıance. In a very short tıme they had to ensure access for all to hospıtals

under state welfare policies. But also, under the pressure of radical popular leaders defending community rights for endogenous development, they had to expand the coverage of public health services Consequently, governments made arrangements for accelerated training to increase the number of health professionals and for investments in hospitals networks. At the same time, many community-based comprehensive development projects were initiated. Most investments were made without prior feasibility studies on incremental recurrent costs.

During this period, with bi-polar policy directions great achievements were made especially in the training of manpower and in the development of health districts/zones, including community participation. It was during my first assignment with the Belgian Development Cooperation Agency (AGCD) in the zone of Kisantu (Zaire), that I received my basic education in community health (1) During a visit 20 years later I was able to identify a few ingredients of successes in terms of sustainability which I will summarize:

— most paramedical staff locally trained in community health were still practicing (2);
— activities launched on the basis of popular preference were sustained, for example, local production of fish (easy to farm and sell) and wells,
— compliance with medical services, especially, on the part of the poorest depended on trust: i.e. the attitude of their personnel and visible results. For example, a campaign on protected wells and deworming involved requesting villagers to collect the ascariasis worms which were expulsed and to put them on display at a public meeting area in the village. This resulted, indirectly, in improved tuberculosis control because relationships between the villagers and the workers at the health post were established (3, 4)

In the mid-1970s government economic restrictions generally started leading to an increased proportion of the health budget being spent on staff salaries, which made less available to spend on logistic support, drugs and maintenance This imbalance led to an under-utilization of human resources and a drop in productivity It also became clear that health care providers alone cannot improve health status Evidence accumulated showed that communities themselves can produce health. Not surprisingly, it is at this period

that the famous declaration of Alma Ata and Health for All by the Year 2000 based on the strategy of Primary Health Care (PHC) was adopted

Hundreds of thousands of voluntary village health workers were trained, but in many countries, the drop-out rate was extremely high due to lack of supervision and more importantly, due to confusion about their social responsibilities many governments interpreted PHC as merely training of community health workers who were then expected to become local civil servants The complexity of primary health care development in a period of economic stringency led to health budgeting and programme planning which was in contradiction to the declared principles of community-based decision-making The international community continued, and even intensified support to juxtaposed series of campaigns targeted by disease. The logic of sypply-driven "programmes" prevailed against the logic of demand-driven "services" The support for programmes conceived and organized by disease, by age and too often by technology has weakened the fragile capacity of local institutions instead of strengthening it International agencies, financially all-powerful, especially, in the poorest countries, imposed their priorities, often in a disorganized manner Village health workers were assumed to undertake a multitude of tasks prescribed by many special programmes, and medical officers received incentives to leave their duty posts to attend a multitude of training seminars on single subjects. As I used to say, many organizations were "playing with the feet of barefoot doctors instead of giving them shoes" (5)

A great deal was published and much publicity on "this PHC great awakening" was given to the interface between populations and front-line health workers Reviews of project appraisals revealed interesting systemic issues, with high concern for sustainability of successful stories Fortunately, the need to strengthen district management capacity in order to back up Primary Health Care outreach activities was recognized and gradually developed in many countries Schools of Public Health, such as the Institute of Tropical Medicine in Antwerpen and several nongovernmental organizations played influential roles in this direction

At this time I was assigned by AGCD to work with the peri-urban populations in Pikine (Senegal) to develop a network of

health posts What I learnt there is very simple when a system does not work (in this case, free services meant expensive drug bills for the majority) new solidarity mechanisms based on a cost and risk sharing system have to be introduced (6) If they legally infringe established administrative and fiscal rules, initiatives controlled by local communities, especially the poor ones, need political protection It is important to ensure publicity through public debate and involvement of all local leaders and politicians upstream in order to socially legitimize changes and avoid long-term isolation and marginalization (7)

I would call the next period "Cost Recovery to the Rescue", awaking from social dreams to the economic realities Cost-recovery was generated as a by-product of structural adjustment policies The inadequacy of government resources to cover expenditure of the various levels of the health system, including salaries, has led to substitution financing such as user fees, privatization or community co-management initiatives such as the Bamako Initiative with many facets sometimes reviving local traditions of solidarity (8) Different health markets have blossomed side by side, without regulations, their importance fluctuating in accordance with the laws of supply and demand traditional leaders, liberal practitioners, humanitarian associations, state or municipal services (providing private and/or public services, whether profit-making or otherwise) health insurance, several types of pharmaceutical networks and community initiatives The international community jumped into this setting, bristling with agendas for reform and has settled down at the bedside of sick ministries of public health (9) A key feature of reform has been decentralization, but models introduced were often imported and neglected the necessity of providing economic incentives for people working in the government sector

Some of the most interesting developments relate to initiatives for the poor such as those providing access to small credits, and functional literacy programmes. The Belgian Survival Fund Initiative is among these They are worthy of mention despite their indirect links with health, for they surely provide a long-term potential for sustaining social activities

From my experience with the World Bank in support of the health reform process, it is impossible to draw general conclusions on the impact of such reforms on people's health, given the hete-

rogenicity of the decentralization context and process It was expected that from increased financial and administrative autonomy, an improvement in the coverage, the efficiency, the continuity and the quality of services would follow and would generate self-disciplinary cost-containment measures In macroeconomic terms, shifts in redistribution of resources to PHC with pro-poor fiscal adjustments has not happened Also, the issue of local governance, including adequate funding for public health services coverage has remained.

In the current decade International Health is at a critical crossroads Radical opposite ideologies confront one another – on one side, a donor-driven approach exists, directed towards selected cost-effective interventions – "value for money" with the promotion of Essential Packages. On the other side we see a community-centered approach supported by nongovernmental organizations and directed towards integrated services delivery "value for people" with the promotion of the social infrastructure (cooperatives, women's groups, associative organizations). We see also the expansion of the health industry market (through increased transfer of health-care technologies), while information and education about social responsibilities in public health and reduction of health inequities do not keep pace.

Development strategies have undergone upheavals in recent years because of ideological changes, globalization and macroeconomic policies and diminishing solidarity Centralized planning under State control has given way to movements of comprehensive liberalism Total privatization has been promoted to counter the inefficiency and incompetence of budget-consuming administration However, the need to maintain or restore the civil service to its rightful role is obvious

Everywhere, including in the developed countries, the role and interaction between society bodies, especially between government authorities – including policy-makers and civil administration and civil society groups are being changed. New means for community health development exist and need to be strongly supported by all parties. This is the main challenge of my current assignment in WHO (10, 11) I will mention three of these means which seem to be critical in a context of increasing social disintegration and welfare disparities between and within countries.

1. Investments from multilateral and bilateral funds and the private sector are being expanded to geographical areas where people live in very poor conditions. In these investments, negotiations have to be made to include social components as a compromise, to market efficiency. The income-generating projects (e.g. in agro-industry, tourism, fishing, manufacturing, banking, industry) should be linked with capability-generating projects such as female functional literacy and preventive health programmes It is the time now for socially-minded entrepreneurs to provide a booster to public health.

2. Society's own indigenous organizations are being increasingly recognized, and are in a better position than ever to negotiate and contract public health activities which they are ready and able to manage More and more development agencies, with government endorsement, provide direct support to these local nongovernmental organizations. New channels of resource allocations for public health work are opening up. Equity concerns should be properly treated upstream in the initial design of contracts, to be sure that they will not be limited so as to satisfy only a part of the community The poorest must be encouraged for participating in project formulation and public health debate because later they will resist joining in They do not have self-confidence about their rights nor about their usefulness to their societies. Production of safe-water, immunization and communicable disease control are good examples for the involvement of all

3. Last – but the one most closely linked to the purpose of this Prize concerns autonomous development in health for poor populations We have to consider the informal sector which has continued to grow in most parts of the developing world. This is a sector where any "deal" with the formal sector does not make sense by its very nature. How can we facilitate rather than combat the informal organizations which regulate the informal health sector? These organizations have unfamiliar denominations such as small republics or the smuggler unions, the vigilance fronts, as they are called? These organizations deal with the sale of water, drugs and any health-related materials. Sometimes they manage remittances from workers, as informal health insurance. They have their own rules, and control the application of those rules; they ensure secu-

rity and defence of rights Self-help and survival govern their internal functioning

The value of the Prize awarded to me will be used to increase our knowledge of these self-help initiatives and a book of stories about poor communities as reported by local journalists will be produced and published

A new era in community health is dawning Very complex – it is linked with the behavour of global leaders but it is also close to our own door – our own children. More than ever, community involvement is critical This prize is right – new lessons will be learnt and will receive due publicity thanks to it

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De Voorzitter dankt Dr M Jancloes voor zijn interessante uiteenzetting en geeft het woord aan Dr R Moreels, Staatssecretaris voor Ontwikkelingssamenwerking, die de gelegenheidsrede houdt

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* *

De Voorzitter richt zich tot slot in volgende bewoordingen tot de vergadering

In naam van de Academie dank ik U hartelijk, Mijnheer de Staatssecretaris, voor deze merkwaardige rede en laat mij toe U mijn waardering te betuigen voor het enthousiasme waarmee U uw boeiende, doch moeilijke taak vervult.

Met deze plechtigheid heeft de Koninklijke Academie voor Geneeskunde het wetenschappelijk werk van verscheidene onderzoekers luisterrijk willen bekronen en heeft ze aldus de kwaliteit van hun werk in het licht gesteld. Wanneer men echter na een operaproductie voor de tenoren applaudisseert, weet men dat hun prestaties slechts mogelijk werden dank zij de gezamenlijke inspanningen van de dirigent en het orkest enerzijds en van de talrijke technici en medewerkers, die voor het belangrijke werk achter de schermen instonden, anderzijds Mutatis mutandis geldt hetzelfde voor de wetenschappers Daarom wil ik bij deze hulde hun echtgenoten en familieleden betrekken, die vaak in stilte en met geduld en toewijding voor de nodige steun instaan, alsook hun team en hun coordinatoren, die voor de infrastructuur en de werkomgeving van de onderzoekers hebben gezorgd

Tevens wens ik nogmaals de Staatssecretaris Dr R Moreels voor zijn voordracht en zijn komst naar de Academie te danken, alsook de mecenassen (inzonderheid vandaag de familie Daels, de H K Verleysen, de H en Mevr. De Schaepdryver-Caenepeel) die het mogelijk maakten dat de Academie prijzen kan stichten en

uitreiken De laureaten wens ik een verdere schitterende wetenschappelijke loopbaan toe en U allen, Dames en Heren, die aan deze plechtigheid hebt willen deelnemen, dank ik voor uw interesse en uw steun aan het wetenschappelijk onderzoek in Vlaanderen