

# THE RURAL PRACTITIONER: TRAINING AND SUPPORT IN CONGO-ZAIRE

Africa is always presented through images that shock people and we are known only for failures and inefficiency. But Africa, for all its problems, has almost unlimited potential. In my experience, MFamMed, as promoted by MEDUNSA and continuing medical education, as promoted by Doctors on Call for Service, are the most appropriate medical teaching systems that could help Africa produce the best total health entrepreneurs for its third millennium.

I have four important points to make about the model of the rural practitioner. Firstly, this model will vary according to the basic medical infrastructure of the country. In first-world countries, at whatever the level in the hierarchy of medical services, there is always a specialist available.

Areas of speciality are clearly and severely demarcated. A doctor steps over the lines at his own risk, even if he thinks he is acting in the best interests of the patient.

Secondly, the expectations of a doctor also change according to the country in question.

In the USA an ENT specialist will be one of a large team and would never be called upon to enter another medical domain. In Congo-Zaire, a doctor may be alone in a hospital and will be expected to assist in any emergency.

Thirdly, areas of specialisation have developed because the domain of medical knowledge has expanded beyond belief. Yet no doctor can plead ignorance as an excuse for errors. Doctors with little or no opportunity for referral to specialists need specialist training to know how to intervene well in areas with minimal resources.

Finally and most importantly, health care personnel cannot afford to specialise in the pathology without reference to the social and economic context of the person who comes to them with a problem. In our African rural context, the practitioner cannot afford to ignore the total needs of the person; he must find ways to meet them.

## Family practice residency programme in Congo-Zaire

In Congo-Zaire, in 1985 at the beginning of our programme, we were not immediately aware of all four of these dimensions. The issues as we saw them then included newly-qualified doctors alone in rural areas with no experienced support; doctors overstretched, having to assume administrative responsibilities; doctors with no access to continuing education and little or no contact

with colleagues. Inadequate salaries often meant that doctors undertook income-generating work and eventually drifted back into urban practice.

Our Family Practice Residency programme has developed over the past 10 years to meet our needs. Similar programmes are taking root in Kenya, Uganda and Angola. The training hospitals have to correspond to certain criteria and the programme covers all the areas of medicine.

After two years, trainees who pass the examination receive a certificate. However, four basic weaknesses remain to be addressed:

- Lack of recognition of the student status of doctors on the programme;
- No official paper accrediting the training;
- No training in pedagogy for doctors in charge of the training programme and a heavy work load; and
- Certain specialities not represented.

## Distance learning masters degree in family medicine

During 1993 I met two groups of people who have become key players in our current programme. The first is Dr Groen of DOCS, an organisation whose mission is to assist medical professionals to lend their services in needy countries throughout the world. These services involve mentoring, encouragement, sharing insight and practical skills in a two-way process.

The second is Dr Jannie Hugo and Professor Sam Fehrsen of MEDUNSA, whose MFamMed programme could be a solution to the accreditation problem. At a meeting in Nairobi in 1994, representatives from Zaire, Uganda, Angola, Kenya, MEDUNSA and DOCS, as well as information technology experts from HealthNet and Mission Aviation Fellowship, mapped out a feasible masters degree by distance learning, with personal supervision from tutors at the university. Two separate programmes evolved, one in Kenya based on the three main church hospitals and one in Congo-Zaire.

In Congo-Zaire, the learner-centred Masters in Family Medicine meets the learning needs of the rural doctor. The doctor chooses topics relevant to his daily problems from 12 broad categories. The programme is patient-centred, nothing is learned in the abstract and the candidate's management of the patient-doctor relationship is the key to his success in the programme.

Our eight students work in isolated rural hospitals and we meet once a month in Goma, a central location. We discuss current epidemiology and how we are managing to function in a war situation. We share our assigned readings from the MEDUNSA modules and experienced doctors help others with approaches to difficult cases. We communicate with MEDUNSA by satellite E-mail and as programme co-ordinator, I channel communications and medical information to other groups in Congo-Zaire.

This programme has, in our view, been crucial to the survival of medical services in rural areas during the recent war. Many doctors left, but those who had done the residency training all stayed. The way forward must be a system that can be self-sustaining, producing affordable doctors for the rural population on the eve of the third millennium.

## Challenges for rural medicine in Congo-Zaire

In my country we inherited a fine medical infrastructure from missionaries. We have just come through a terrible war. The country is divided into 325 health zones for our 45 million people. The challenge is to find enough doctors to go to the rural health zones, to prepare them adequately for the challenges they will meet and to support them with continuing medical education.

We intend to link the seven referral teaching hospitals to MEDUNSA by satellite and hope to establish our own College of Family Medicine in the foreseeable future. Good rural health care is not just a dream, it is a possibility. ●

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