Hands-on training in health district management

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In Zaire it has been shown that a practice-based course can prepare trainee doctors for health district management in a reasonably short time at low cost.

Health districts in which primary care plays a vital role need good management, and proper training for this role, covering all the tasks of the district doctor, has to be provided within a reasonably short period of time. Doctors in rural areas should be able to:

- maintain the quality of primary care provided by personnel less qualified than themselves;
- provide medical, surgical and obstetric care of a technical level worthy of a district hospital;
- rationalize the distribution of tasks between the different levels of care;
- manage, or assist in managing, material and human resources;
- maintain a dialogue with individuals and groups in order to obtain community participation in running the health system.

District health system – Kasongo style

Kasongo, a rural district in eastern Zaire, covers approximately 15 000 km^2 and has a population of some 200 000 people. At the end of the 1980s its district health system, based on primary care, comprised a 180-bed general hospital and about 20 health centres run by nurses. The system has the following managerial features.

- The service section is managed with resources raised by a stable rural health district.
- The health district is run by a management committee including all the district doctors, the administrator and the head of nursing.
- Each doctor has secondary-level clinical functions, being responsible for a hospital department or a referral outpatient clinic.
- Each doctor has supervisory duties in four or five health centres.
- Each doctor has logistical, administrative and/or teaching duties; one, for example, is the hospital director and another is in charge of fuel and drug supplies.
- All the doctors have managerial responsibilities for specific programmes at district level, for instance that covering the control and prevention of tuberculosis.
- Coordination is ensured by holding weekly team meetings and by providing free access for staff to systematically filed documents relating to all activities.

Learning by seeing and doing

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possible results, only one new trainee was accepted every four weeks so that at maximum capacity there were three students, separately completing weeks 1–4, 5–8 and 9–12 of the course.

A course coordinator welcomed the trainees, set objectives for each phase of the course, arranged weekly follow-up meetings, and promoted the course report. Although standard formats were laid down for the different phases of the programme, adequate scope was allowed for initiatives taken by students on the basis of their knowledge of public health and any special interest they had in particular aspects of the system. This would not have been possible without the support of all the doctors in the team, who took turns at supervising the students in the departments or programmes they headed.

During the first week each trainee observed the work of a referral outpatient clinic and thus gained an insight into the links between the primary and secondary levels of care. This took only two to three hours a day and so the student had time to settle in and read documents explaining the system.

The trainees spent the second week at an urban health centre in the city of Kasongo, where they observed the staff doing curative and preventive work and maintaining contact with the population. They had the opportunity to familiarize themselves with strategies for diagnosis and treatment in curative consultations and with instructions for follow-up in high-risk groups.

For the third week the trainees, now with an improved understanding of the complex task of evaluating referral cases, returned to the referral clinic, where, under the supervision of the resident doctor, they practised interviewing patients. During the fourth week they studied the work of a rural health centre and observed preventive consultations held in remote villages.

The second four-week period was spent in a hospital department of the trainee's choice with a view to learning how to use files and evaluate the quality of care. Visits were made once or twice a week to health centres in order to compare the supervisory techniques of different resident doctors.

During the third four-week period the trainees functioned as members of the health team. Under a resident doctor they assumed responsibility for a hospital department and attended management committee meetings dealing with the quality of care in the hospital, staff management, and feedback from the health centre supervisions. They also supervised health centres under the guidance of the resident doctors and took an interest in the development or evaluation of a health programme or research in progress. In effect the students acted as staff members, doing a share of the routine work involved in running the health district and thus making a useful contribution in return for the training given during the first two months.

The cost of the course, including accommodation, transport in the district, meals and

documents, but not transportation into Kasongo or the time spent by doctors on training, was US$ 1000 per trainee. The rather long duration of the course was considered necessary so that the trainees could gain a good understanding of all aspects of the health system.

Of the 18 doctors trained between mid-1985 and mid-1988, 12 are working in Zairian health districts. Most of the trainees acquired the requisite skills and know-how, and a limited follow-up survey in 1995 indicated that these were being applied. In order to maintain or improve on the progress made, the training should be backed up by further supervision or by self-training, involving, for example, team analysis of problems and possible solutions.

The following factors possibly contributed to the success of the course.

- The health system was integrated in character and was run by a team.
- The team was large enough to tackle student training yet small enough to maintain satisfactory communication.
- The teaching method allowed the trainees to play an active part in the course.

The course provided an unexpected bonus in that the students helped to expose weak points in the system, suggested solutions, identified previously unrecognized areas of potential development, and, most importantly, put pressure on doctors in local teams to devise adequately structured approaches to management.

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Coherent training was provided at extremely low cost within a system operating on a routine basis. When trainee doctors were placed in real situations they were able to acquire the skills and know-how necessary for health district management. The approach to training outlined above is relevant to the participants' careers and should be regarded as an alternative to that based on seminars and workshops run by central authorities. The key to success appears to lie in starting with a model of a coherent health system. ■
