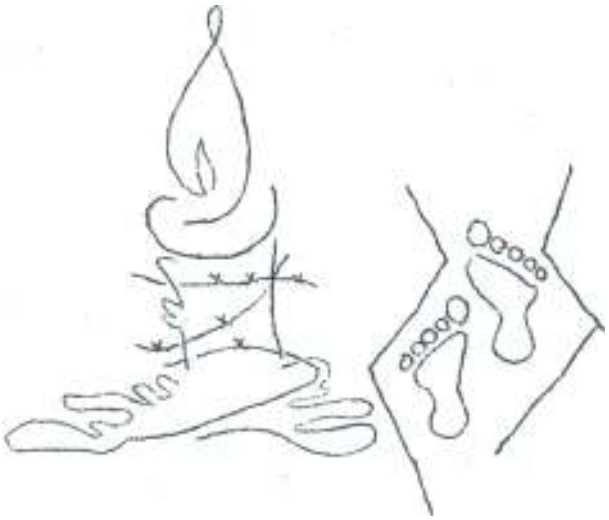
CHC II

Notes on a year of Travel and reflection - 1982



Community Health Cell
Centre for Non-formal & Continuing Education
“Ashirvad" 30 St Marks Road: Bangalore 1

Back ground

1. Both of us had been members of staff of a department of Preventive and Social Medicine of a medical college in South India, since we graduated in 1971 and, 1977 respectively. Both had decided to join the department following the experience of participating in disaster relief camps during our internship (Bangladesh refugee relief camps, 1971 and Andhra Cyclone relief camps 1977-78). The experience brought us in close touch with communities in acute need and we became interested **in** the challenges of health care delivery in the conditions of poverty.

2. During the years 1973 - 1981, the department of Preventive and Social Medicine of this college passed through a rapid phase of growth in response to the institution's, renewed commitment to the rural reorientation of medical education. During this phase seven rural field practice areas were initiated and an urban network of health and development efforts around the college, organised. A unit of occupational Health geared to training and research programmes in the plantations of South India was also established. A comprehensive rural internship programme as well as a rural orientation camp for pre-clinical students was evolved. A wide range of informal, basic and continuing education efforts for community health workers, doctors and nurses from rural health projects and small hospitals, plantation medical officers and other plantation health staff were also developed during this phase.

3. The work was most interesting and the field experience rich and varied. The leadership of the department and the institution was farsighted and progressive and most of us in this phase got experience that was not only relevant but very comprehensive too. Few institutions in this country can boast of the phenomenal range of programmes that were built up systematically during this phase.

4. However over the years we began to sense a growing alienation which we soon realised was both conceptual as well as process related.

   The conceptual alienation was, with the focus and setting of Preventive and Social Medicine as a subject in the context of medical care and education. The teaching of the subject was academic and examination orientated. Numerous compartmentalized subjects had been put together under its banner. In the absence of integral links with the teaching hospital and adequate institutional commitment to effective, community field practice areas, the subject did not succeed in making any impact on the attitudes of students or faculties of other departments and was

gradually becoming just another subject speciality rather than the means to a more comprehensive preventive and social orientation of medicine

5. The process-oriented alienation was linked to the mechanism of the growth of the department. It seemed to us that there was a quantitative growth of staff, facilities, courses and field practice areas without a qualitative growth in planning, research, staff enrichment and programme monitoring and evaluation. New and pilot programmes soon became routinised and due to a constantly changing staff pattern, the working of the department often became adhoc and one of crisis intervention. Programmes initiated as means to an attitudinal change, gradually, became ends by themselves.
6. we soon realised that some of these problems arose from the inability of most medical college managements to understand and plan effectively for rural/ social reorientation of medical education

   Firstly, this reorientation process was most often misunderstood as the effort of a single department rather than a concerted efforts of the entire faculty of a medical ·college. The stress was, therefore, on programmes by PSI1 department rather than innovative modifications in the teaching, service and research efforts of clinical and all other departments

   Secondly, there was always a dichotomy between the investment and inputs into a clinical ward and those planned for, in a community field practice area or community ward. This was not only in terms of available senior faculty but also in terms of supportive staff, facilities and budgetary sanctions

   Thirdly there seemed to be insurmountable obstacles in linking the community field practice area with the teaching hospital in an effective referral services complex as envisaged by the Government of India report on Medical Education and Support Manpower (Shrivastava, 1975)

   Fourthly the needs and exigencies of transportation by a community medicine department team was an area of much misunderstanding.

   Fifthly, in the absence of a perspective plan to commit adequate resources to a field practice area, to enable a team of staff to live in the area and evolve an effective community programme to be used for teaching purposes, much of the staff involvement in the community was remote control, tending towards 'armchair community medicine

   In spite of the fact that the thrust in these years was very much towards a process of rural reorientation all these factors continued to play their part in the evolving situation even in this college.

7. Of all the programmes mentioned earlier, it was the informal training of community health workers, alumni doctors from rural hospitals, nurses from rural dispensaries and plantation medical officers, that gave us maximum job satisfaction and a sense of fulfillment. These training programmes gave us adequate scope for experimenting with non-formal and innovative training methodologies using a group dynamic, problem solving approach. Supporting such groups, who would actually be undertaking work in the community, seemed more fulfilling than preparing medical students or nurses for an examination. This informal, alternative experience also helped us in becoming critically aware of the inadequacies of our didactic, rather compartmentalized medical education system

8. Over the years we also gradually moved in our understanding of health from its historic medical connotation of sickness caret to the broader, positive definition of physical, mental and social well being. We became more aware of the socio-cultural and political determinants of a health system and its close links and interactions with the development process. It seemed to us that whereas the medical profession would continue to map the overflow of preventable illnesses through curative measures, serious health professionals and workers should and could initiate processes to turn of the tap of disease and ill health at its very origins in the individual's life style, attitudes, family life, community life and environment

   As these ideas began to dominate our thinking we began to get more interested in a wide range of areas and issues not covered by orthodox medical education, viz., alternative approaches to health care; issues related to development and socio-political change; team building and group dynamics; informal and non-formal pedagogy, non-drug positive health therapies; Don-allopathic systems of medicine including folk medicine; cross cultural conflicts in medicine; holistic health and so on

   All this supported a paradigm shift within our own perspectives from 'sickness care: to 'health'

9. Inevitably an active involvement with the field realities of urban and rural field practice confronted us with social issues of poverty, inequality and injustice. This confrontation of value systems, life styles, attitudes and modes of team functioning and decision making was at both a team level and a personal level. Swinging between the mat-level simplicity of the rural centers and the ivory towered affluence of the college and hospital was a constant tension. Working with and among rural people also heightened our sensitivity to the impersonal and dehumanising medical culture of our large, highly westernised model of college and teaching hospital. It also made us more than aware of the cross cultural conflicts that the poor patient experiences when he visits the hospital from a rural areas or urban slum.

10. Over the years our interest in the newer dimensions of health brought us in contact with a large number' of groups and agencies like the medico-friend circle, Voluntary health association of India, SEARCH, Indian Social Institute, Society of Young Scientists, Science for the villages, CREST and Family Welfare Centre, ASTRA of Indian Institute of Science, Oxfam, Lokayan, Catholic Hospital Association of India, CMAI and Asian Community Health Action Network. We participated as members or resource persons in meetings and networking sessions. The awareness of the large numbers of people committed to health work outside the formal governmental or university network was a great support.

11. In 1981, some arbitrary decisions by the University affecting the student community led to a crisis in the college. During this period we had opportunity to organise a solidarity movement to raise public opinion and the general consciousness of the campus residents on such arbitrariness of authorities. Apart from gaining some experience of the dynamics of organising such a collective action, it also gave us an understanding of the types of motivation of staff and students on the campus. At a deeper level we understood even a greater evolving crisis that the institution was running into-- in which the dimensions of lack of communication and motivation; lack of continuity in processes of planning and decision making; lack of participatory decision making; lack of inculturation and value formation; and pursuit of excellence out of context of the pursuit of social relevance were going to play an increasing part.

12. All the above factors led to a certain degree of work related personal frustration and an increasing desire to rethink our role in medical education and health care. We therefore decided to 'drop out' of the college for a year and spend ,it visiting health and development projects in the country, meeting friends, colleagues, and community health workers, as a process of reflection and evaluation of, our own personal work experiences and perspectives since graduation.

Overview of 1982

13. The year 1982 with all its component activities was a rich and meaningful experience for both of us at a personal level and well served its main purpose. We visited a whole range of field projects and met committed people from different ideological backgrounds which helped to widen our horizons. The contact with a wide circle of people actively searching for ways and means by which health and development could be more meaningful for people especially the rural and urban poor was inspiring.

    We met alumnus of our college working in small rural mission hospitals and reflected together on some of the inadequacies of the medical education in our alma mater

with specific reference to challenges of rural hospital practice.

We met community health workers in their own project setting and observed the successes and failures of our training programmes. We identified pressures that where pushing individual CHWs beyond their capacity. We also become aware of the deviations from our training as well as its overall limitations especially when individuals were working out of context of a supportive infrastructure.

We met medico-friend-circle colleagues and a whole range of health and development activists who were involved with evolving a wide range of alternative projects and processes with the people. In our discussions with them, we focused on understanding their work in a process sense as it evolved through positive and negative experiences. The interactions gave us a rich feed back of the imperatives of health and development work in our social reality.

We read and reflected on many issues concerning our vocation in greater depth than had been possible in the earlier years. We searched for answers to many technical and social questions facing us and though we did not always arrive at a definite conclusion, we discovered points of contact with the experience of others and identified processes through which more meaningful answers could be obtained.

14. Being a personal quest, the effects of which we hoped would be reflected in our future work, we did not plan to write a formal report for the institution as such. However, we list out here some broad perspectives which evolved as learning experiences from the year. It is impossible to share the whole experience just in a few paragraphs but the following perspectives highlight the salient conclusions of the search.

Some perspectives

15. The positive physical, mental and social dimensions of health, both at an individual and community level have failed to capture the imagination of the medical professionals and medical educationists because of their historical pre-occupation with Sickness care.

    Years of a floor mopping' attitude to the overflow of disease has resulted in what has been described as 'highly sophisticated curative practices along with all the paraphernalia of mystification, professionalisation and total submission to the dictates of the drug industry

    The new 'tap turning off' attitudes in response to the people's needs as well as potential available knowledge consisting of such ideas as

- # Primary health care;
- # Health education;
- # Demystification of medicine;
- # Popularization of health producing activities and attitudes;
- # Strengthening of people1s traditions of self care;
- # Community organization and participation in health care

and so on therefore continue to be viewed with suspicion, resentment and intellectual opposition

The ethos of medical care and education, in rurally oriented medical colleges like ours and others we visited during the 1982 trip as well as in most of the health services under non-governmental voluntary agency auspices continue to reflect this myopic medical view

16. Ill health in the ultimate analysis is a direct product of an unjust socio-economic political system which results in poverty and in equity of resources and opportunities. A health Team/ heath project health institution, if it's clear in its health objective should inevitably become a part of development process which seek solutions for issues of social justice Of which illness or disease are but a symptom. Health work should therefore become a development of alternatives by which this process of democratization is extended to the grass roots enabling people to shape and run their own structure as a pre requisite. Hospitals dispensaries, medical colleges and academic health departments which are products of existing structures need much internal change before they can participate in such process. For a start they need to become less hierarchical, less elitist and more sensitive to the people, especially the poor and more participatory.

17. Those of us who function at technological levels in our professional capacities need to respond creatively to people's needs and evolve alternative and appropriate frameworks of technology, manpower, processes and communication, within the constraints in which our people live. Mobile clinics, rural camps, hospital outreach programmers and other such ideas which get doctors/nurses out 'of institutions into the realities of rural village and urban slum life are therefore only means. The ends being the adaptation of specialized knowledge and technical skills to the situation of people's lives

18. Especially in medical colleges when such ideas are experimented with as part of a rural reorientation process, it is crucial to ensure that they are evolved through a flexible process which stimulates voluntarism and creativity. Otherwise what has happened in most situations is the thrusting of frustrated, resentful faculty into a

situation outside a hospital setting where they dish out limited st0ck of pills to a curious general public. Each department needs to understand the levels of care in the health pyramids, the types of workers available and adequately reorient their own teaching to "the best possible use of these resources under each circumstance" rather than "the pursuit of an ideal un-related social reality".

As examples of this flexible, creativity one may suggest initiatives such as:-

- # Pre-clinical department faculty organizing human biology teaching in village schools;
- # An OBG Department organizing learning sessions for dais and ANMs;
- # An anesthesia department experimenting with simple procedures for field anesthesia including acupuncture;
- # A plastic surgery department organizing a burns prevention education programme in a village school;

A mobile clinic programme would then become a means to such creative reorientation and as and when each department identifies a more concrete, more socially relevant role in the community. Only if such creative interactions and freedom of innovation is made possible; can medical college faculty ever grow out of their ivory towered isolation. It must be kept in mind that social community orientations is a first step towards the preventive and promotive reorientation of medical roles.

19. It is common place for professional institutions to talk of social relevance, rural reorientation and so on. However, more often than not these have been attempted by a whole series of adhoc, un-integrated activities representing ideas of individuals rather than a thoughtfully analysed, planned process of change involving collective discussions of faculty.

    Changes in attitudes, 0bjectives and even professional direction can be brought about only if the institutional management or team leaders are sensitive to process. This is as true of rural projects, small peripheral hospitals, large specialist hospitals or even a medical college. A' social reorientation of its activities and objectives can evolve gradually through the acceptance of a need for:

    - # an understanding of the historical process and growth of an institution/profession/ activity;
    - # the overall social context in which it operates and the new values or vision it wants to move towards,
    - # a setting of clearly defined, measurable objectives;
    - # a participatory planning process which involves formal and informal feedback and evaluation as an integral component;

- # a team building approach in decision-making; a stress en the development 0f the human resources of the team rather than material resources and structures
- # a shared value system which shapes attitudes and evolves practice of individuals within the institution/project

During the year of travel we come across some institutions and projects who were going about this social reorientation in a serious systematic way and it was through an interaction with them that we understood .all the components of such a process

20. Team work, professional, or social in any endeavor decides ultimately its success or failure. This was an important learning experiences Many programmes though committed to health in community had not internalised "healthy team" functioning within their structure and the effects of this incongruence were obvious. Highly individualised efforts pushed in a non-participatory set up were not uncommon where of orientation to achievement, overshadowed team development, ultimately sensitive to this dimension, having arrived at its need not always without a crisis in the project/team. However, by realigning the objectives and methodology so that team members were enabled, enriched and actively encouraged to participate, they were beginning to move towards more integrated: efforts. This dimension was as true of the interaction between team members the interaction between the team and villages or the community. A partnership in development if it has to be truly in a spirit of dialogue must go beyond divisions of professional/non- professional expert/lay, educated/illiterate, medical/non-medical, provider/beneficiary and so on. That this was happening at least in some projects was a good experience to observe.

Some aspects of this team work that we collected from various experiences was;

- # an evolution of mutually shared common objectives. and roles through group work;
- # a concentration on strengths of individuals rather than weaknesses
- # an increasing opportunity for sharing of ideas, feelings, hopes and experiences
- # a constant effort to internalise a shared value system ego in community health oriented efforts this may include healthy life styles and attitudes, community feeling, simplicity, non-hierarchical functioning, learning from the people, adapting technology etc
- # an informality and openness in inter-personal relationships
- # a commitment to learning from field experiences of the entire team rather than just "theory". This would automatically mean a commitment to constant experience analysis, critical reflection and review
- # an inculcation of participatory management in planning and decision making

Though much of this may seem unrealistic at first, in our present highly institutionalised set up we discovered through interactions with, even institutionally based people that institutions or structures by themselves were not stifling or limiting of such a process.

The major block was the formality of ideas with which individuals and decision makers choose to function with-in them. It was thus an attitudinal constraint not a structural one.

21. **One of greatest dangers to any social change, reorientation relevance seeking endeavor is a rapid setting in of institutionalization include:**

    # Routinisation of activities; ,
    # Formalisation of functions/relationships;
    # Increased red-tape;
    # Fixity of roles;
    # Fear of precedence;
    # Discouragement of disregard for informal and formal feed back;
    # Lack of adequate communications;
    # Inability of leadership to encourage, enrich and support team members

    What was surprising was that many people saw team work' as a genetic attribute of individuals not an environmentally stimulated response However, many others had discovered that "good teamwork" does not Just happen. It needs to be planned for and worked for. We even met teams who were moving from a phase of hierarchical functioning to a phase of participatory functioning patiently relearning attitudes and seriously questioning past modes of functioning. ***That this was possible was heartening.***

22. Having been part of a phase rural re-orientation of medical college before we embarked on this year travel and reflection, we could not help but critically review and reflect on the process we had been part of. Some overall perspectives that that emerged were

    a. Rural reorientation of medical education is a term that needs to be changed since the need is not just to focus on a geographical setting as an end in itself but to focus on social-economic and cultural functions on socio economic and cultural factors and issues relevant to health care these are important in the context of context of the community interaction outside the hospitals but are equally important factors within the context of hospital functioning. The effort thus becomes a social and community orientation of all aspects of an institution's efforts

b. The focus of efforts must not be to get Staff and students to just physically move into rural areas as an educational or service effort but to challenge and change attitudes within the profession and institution Stimulated by the perceptions from the community experience. These attitudes would include **:-**

    # desire to humanise hospital environment by humanising medical team-patient relationships,. and improving medical team-patient communications;
    # encouraging demystification of medical knowledge and health education;
    # increasing sensitivity of hospital staff to conditions of poor patients, the socio-economic factors under which they operate and the cultural realities of their lives;
    # making our technology subservient to people's needs - not making people subservient to professional; technical, institutional needs. The latter is possible only through a continuing system of social audit of institutional services.

c. Such attitudinal changes which is the crux of all our efforts can seldom be brought about by orders, bonding, pressures, monetary incentives, or indirect coercion or disincentives even though each of this may have a temporary effect.

    The change can be brought about only by

    # increasing role models in the institution by better staff selection;
    # open discussion and democratic decision making; ,
    # a constant and continued exposure of faculty and students to all those already involved in such work
    # ana1ysing of positive and negative field experiences through a problem solving approach;
    # a creative and flexible encouragement to all suggested initiatives by faculty

d. An attitudinal change is a sensitive process and is one area where the counter-productivity of hastily applied, impractical, irrelevant often super-imposed methods should be constantly kept in mind and avoided, eg., inadequately prepared or unsupervised field exposure, planning insensitive to the communities' feelings and needs, publicity consciousness in efforts and so on. Such efforts often result in a growing cynicism which is more difficult to tackle in the long run

23. It is important to record here that these perspectives were gained visiting people

working both "within formal and informal institutions, projects and networks in health, development and' education. In all of them there healthy dialogue of whether existing team/institutions can really internalise some of these newer perspectives and processes within the existing constraints and established relationships and modes of functioning. In other words, can a medical college, a department of an existing institution a technology or specialist oriented hospital, a curative oriented peripheral hospital even bureaucratized health project, actually change their attitudes to support and build people's health,' and people's initiatives to gain greater autonomy over the structures/processes in society that can promote their health?

Can existing ethos and frames of references of medical institutions change so that rather than continuing as "providers of medicine" they could, become “enablers of health”.

Ravi Narayan
Thelma Narayan