REGIONAL SEMINAR ON DEVELOPMENT OF FIELD TRAINING AREAS, THEIR NEEDS AND ADVANTAGES FOR THE TEACHING OF MCH AND FAMILY PLANNING TO HEALTH PERSONNEL

DR/4

29 May 1975

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DAILY REPORT FOR FOURTH DAY
(28 May 1975)

The subject of Support to and Utilization of Field Training Areas was covered in a whole morning session which became longer than originally scheduled, because of the lively involvement, enthusiastic discussions and the generally expressed wishes of the participants to provide more time. The session was also different from the previous plenaries in the fact that it was held in a seminar room with participants around a large table instead of the auditorium, and was characterized by the replacing of formal presentations by raising a list of organized questions and inviting answers from the entire group. The proceedings are therefore summarized below in the form of the questions raised and the answers elicited.

I Student Perspectives

Q.1 What is the best staging of FTA programmes to meet objectives?

A.1 The basic principle is that student time in the FTA is extremely precious teaching time, therefore, it should be used only for activities that cannot be carried out elsewhere. Anything that can be done in the hospital or classrooms should not take up time in the FTA.

A.2 Start contact with FTA early in the students professional education, from the first year if possible, and extend it right through until the internship training. This should be done by using field visits early in medical training to begin to introduce attitude change by getting over the cultural shock of first exposure to villages while students are still idealistic. It is also the best time for learning basic skills. Then toward the end of the medical course an in depth, prolonged residential experience in the FTA is essential to get real understanding and field practice.

Q.2 How can functional analysis and role definition be related to FTA use?

A. No progress can be made in proper team relationships until the roles of each member are clearly defined. There are now good and simple scientific techniques for carrying out functional analysis. The job analysis then leads to direct application in educational planning. The balance of time in the FTA should be directly derived from this job analysis and clearly stated objectives.

The following grid was developed to relate a set of objectives to definition of emphasis (ranging from + to ++++) required for orientation of the various members of the health team, in accordance with their expected and actually observed roles. This method will permit semi quantitative determination of the extent of teaching/learning experience needed. The example was taken from the Iran sub-groups statement of objectives.

Grid
FIA Use

Objectives	Behvar	Behyar	Nurse	Med. Doctors
1. Understand problem of community	+	+	Imp. ++	V. Important Objective ++++
2. Provide for fertility regulation	++++	+	++	++++

Q.3 The concern is frequently expressed. will students learn wrong information and techniques from auxiliaries?

A. If job descriptions are properly prepared before-hand for all levels of workers including the auxiliaries, and brought up to date on the basis of actual performance, the relationships will be established in an organized manner and any apprehensions will be seen to be ill-founded.

Q.4 What is meant by: "Doctor is leader of health team"?

A. A leader should be humble and gentle and well aware of the roles of all team members, and the problems they face. Such awareness will bring recognition of the fact that routine activities can be done better by specially trained auxiliaries than by the doctor. This includes routine primary care and screening of cases for referal.

Q.5 What is the definition of good quality?

A. Good quality care in community terms means the best possible care for all rather thar excellent care for the few or the elite. This is totally contrary to usual medical thinking, especially in medical schools where excellence tends to become the enemy of the good. The community doctor must learn to make difficult decisions in allocating resources in accord with principles of social equity.

Q.6 What is the right balance of supervision?

A.1 Supervisors should all have had adequate previous field experience.

A.2 Supervisors should be available in the field when help is needed by students.

During early exposure to the FTA more supervision will be needed than later when students are taking more responsibilities.

A.3 Supervisors should be gentle in welcoming requests for help, but this does not mean spoon-feeding since students should also be given independence.

A.4 Supervisory support should never mean taking away the special role and responsibility from any category of student, unless expressly requested or considered expedient for some emergency need; therefore, supervisors should devote special effort to developing these qualities.

A.5 Good supervision is always primarily an educational effort.

Q.7 What are appropriate facilities for an FTA?

A.1 For residences for students and faculty, village housing can be improved quite cheaply, to be quite adequate and acceptable. New urban type of structures should be avoided at all costs, as they set the FTA personnel apart from the community and tend to unduly bind the teaching institution to an area which later may become unpracticable.

A.2 Drugs and equipment should be simple and of direct relevance. This should not become an area of money-saving. The list of such drugs and equipment should be prepared in the FTA by persons with field experience and not initially at faculty campus/hospital.

II Faculty Perspectives

Q.1 How much field experience should faculty members have?

A.1 Clinicians drawn into field should be given opportunity for developing in-depth understanding of community problems. Even more important is a process by which those working in the field already who are particularly effective will be drawn into faculties.

A.2 Screen for people who genuinely like people and therefore can understand problems of people, specially rural.

A.3 Field experience specially means understanding of health team relationships.

A.4 Community health departments should make use of part-time people.

Q.2 What inter-disciplinary balance?

A.1 It is essential to have a coordinating department such as the community health department which stimulates the involvement of other departments.

A.2 Other departments can also be sometimes prime-movers (e.g. paediatrics).

Q.3 How much participation in living and working?

A. If faculty members, especially department chairmen, are unwilling to live and work in the village, the whole activity will continue to be unpopular and low status. It is essential that faculty provide leadership in the sense of going first to show that the problems can be solved.

Q.4 How can the faculty ensure enthusiasm?

A.1 Example setting by key faculty members is essential.

A.2 Good team work provides a good learning experience.

Q.5 How can large groups be handled most efficiently?

A.1 Using student leaders in an appropriate ratio with other students represents a tremendous unused resource.

A.2 Self-directed learning should be promoted, programmed teaching.

A.3 More precise objective-setting so students and faculty know precisely what they should be doing.

A.4 Using some leadership from the community since it has been clearly shown that in some FTAs community leaders take great pride in participating in teaching on a continuing basis.

A.5 Using of paramedical and auxiliary health workers to teach medical students as well as students in any of the health professions.

III Community Perspectives

Q.1 How can community saturation and fatigue be minimized?

A.1 Involvement of community in all stages of the work so that they become proud of their role.

A.2 Having periodic meetings with village elders and give them credit, specially when government officials come from outside.

A.3 Even after an FTA has progressed substantially it can continue to be used and an average area nearby can be used for extension/field visits.

A.4 Be careful to handle crises of any kind, specially guard against and be alert for rumours.

Q.2 What can community contribute?

A.1 Almost everything within its capability as long as its acceptance, satisfaction and sometimes even its sense of pride in hosting the FTA can be maintained. A particular contribution that is often easily arranged is to have them provide the buildings and residences for staff.

IV Data Base

Q.1 What are the uses of field data?

A.1 All kinds specially micro-planning.

A.2 This information regarding the community is like temperature and pulse etc. of a patient.

Q.2 What sources and kinds of data?

A.1 Data should be streamlined.

A.2 Routine community data-vital statistics.

A.3 Clinical data.

A.4 Data should be identifiable and cross-referrable.

A.5 Special survey data collection should be self-limited and not go on and on.

A.6 Well planned longitudinal studies data can be collected for planned long periods, if monitored and used.

Q.3 What constraints?

A.1 Good ideas and initiative.

A.2 Infecting others with good ideas.

A.3 Funds.

Q.4 What controls?

A.1 Do not do unnecessary data collection which does not have precise use objectives.

A.2 Exchange of ideas with colleagues.

Q.5 How can provision be made for data for special research?

A. A general data base makes for a very efficient arrangement for special studies, especially in epidemiologic studies and health services research.

Q.6 How do you provide for teaching and evaluation?

A. These activities should be built into the routine collection of information.

V Attitude Change

Q.1 How do attitudes change? (of health personnel)

A.1 Role models are most important (e.g. medical students follow their professors).

A.2 Some supervision to provide a minimum discipline.

A.3 Gratification response from performance of good work which is appreciated.

A.4 Intellectual process of understanding and explaining (knowledge).

A.5 Social pressure - peer - effect, i.e. group behaviour.

A.6 Community pressures, especially the response of grateful patients.

A.7 Administrative regulatory pressures: and administrative recognition and appreciation and rewards.

A.8 Use frustration among students carefully, since this gets directly effective value change, otherwise you might be teaching at the cognitive levels only which have less lasting effect.

Q.2 What is wrong with present values of health personnel?

A. Already brought out in other preceding discussions.

Q.3 What are the most useful practical means?

A. The FTA provides an ideal opportunity for graded doses of exposure to situations which will in themselves produce attitude change. The opportunity is to set up a whole environment in which the proper values underlying community care can be demonstrated and encouraged rather than expecting students to pick these up on their own.

A.4 How much frustration can students stand?

A. Someone has to be always present and sensitive to the common occurrence of frustration among students exposed to the extreme needs of rural communities. They should be able to provide moral support at the right time. Although some feeling of frustration is frequently useful as it involves the effective level of learning if suitably channelled and utilized.