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

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OBJECTIVES AND CRITERIA FOR DEVELOPMENT OF FIELD TRAINING AREAS IN SUPPORT OF HEALTH TRAINING INSTITUTIONS

by

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INTRODUCTION

It is the need of the time to develop FTAs in developing countries. In view of the demand of the population for providing Health Care Services in the far flung rural areas and realisation of the authorities of the 'Need' of such services, it has become imperative for the health authorities in the Government to train medical personnel in such appropriate numbers as would be able to cater the needs of the ever growing population and deliver the Health Care Services at their door step.

With this concept of health delivery, the Government has increased the number of seats in existing Medical Colleges and has opened new Medical Institutions. So much so that more than 3 000 medical men and women of MBBS category are being trained in the 13 existing institutions of Pakistan in the year 1975.

Though this increase in number of medical trainees is in conjunction with the needs of other categories of health personnel for providing Health Care, but by no means sufficient, as this projected increase in number in manpower is regulated by the resources of the country and the practical possibilities of employing the output within the country, both in public and private sectors. It is a hard pressed struggle to achieve self-sufficiency within the meagre resources of funds, equipment, teaching staff and premises for the medical and other training institutions.

Granted that some headway could be made by increasing the number of medical manpower, but the quality of training has to be such as would be able to deliver the health "goods" to the people at their door step.

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The training (in these 13 odd institutions) of about 3 000 doctors is hospital-oriented where the sophisticated equipment and modern facilities are available; this hospital-oriented training is such that the communities in rural areas are not able to drive any or adequate benefit. Reasons are many, predominantly the socio-culturo-economic ones. Our medical education perhaps emancipates the medico from traditionalism but isolates him from the rural people. The result is that there is an unwillingness to work with pleasure or reluctance to serve effectively with working populations in rural areas.

On reciprocal basis, the rustic villagers do not enjoy the intrusions of people with "superior wisdom" from cities descending upon them, even though they are the beneficiary of such a thing as the "health delivery" at their door step. In short, the hospital trained doctor from a large or fair-size city does not like to work in rural areas. Rural people do not so well accept the city-trained doctor.

Our medical education frequently revolves round ideals, divorced from the harsh realities of life. The result is that our medical men find it hard to adjust in a society which is predominantly rural and uneducated. Some medicos feel that their future is all the more uncertain if they cherish moral values or follow the dictates of religion, service to humanity, etc., other medicos opine that they experience the transition from complete dependence to independence in rural areas, which is responsible for feeling of uncertainty and stress; these medicos are in search of an appropriate course of action which may be instrumental in their self-fulfilment. They fail because there is little guidance available to them.

There appears to be a great need to minimize the feeling of imposition of city doctors on village people and this could be achieved by bringing the trainee medicos in contact with villagers at an earlier stage of medical training.

The guidance is to be provided to the trainee medico to reduce frustration as well as stress on one hand and the villagers could hopefully be conditioned to accept the city hospital-oriented medico through the agency of "Field Training Areas".

With this background in mind, the FTAs are to be established, for which the following objectives are considered helpful

OBJECTIVES

1. To study the result of Family Health Care Service when such service is provided to a semi-urban community;

2. To develop a community base for training manpower - medical as well as para-medical - who can adjust themselves with the traditions and culture of the semi-urban and rural areas;

3. To assist the semi-urban-rural community to obtain Maternal and Child Health and Family Planning Services in particular and preventive services in general;

4. To provide guidance to the health authorities of the developing countries to train their medical manpower in FTAs specially when the facilities and community orientation in the training institutions are meagre; and

5. To provide further guidance for implementation of the recommendations of Shiraz Conference of 1963 where it was suggested to establish rural health infrastructure for training of medicos but due to socio-culturo-economic handicaps or difficulties the health centres in sufficient numbers for training of medicos could not be established.

EXISTING AREA

There is an existing semi-urban low income area of about 76 000 population, situated about 20 miles from Karachi which is being used as an operational unit for a Health and Family Welfare Project. This locality is divided into two units comprising 5 400 and 6 600 houses respectively. Each house accommodates an average of 6.3 members of a family.

Primarily this area is being used by the National Research Institute of Fertility Control. A preliminary progress report is attached herewith along with the forms, charts, etc. used in this project. A rough survey indicates that municipal services such as water supply, sewage disposal, roads and transport facilities are rather inadequate but recently electricity, buses, local train services have been provided. About 70% of the population is literate and composition of population by profession is about 20% labourers, 45% clerks, 15% office peons and messengers, 8% unemployed and 12% small business owners or employees. Other information is not available. Two clinics staffed by doctors and lady health visitors are functioning to gain people's confidence by providing services to meet the current interests and health needs.

PRESENT METHODOLOGY

At present about 300 students of MBBS class are given theoretical lectures on different subjects of Community Medicine further supported by audio-visual aids, e.g. slides, films, charts and models over a period of two years, starting in third year of MBBS and continuing through fourth year MBBS. Total of theoretical teaching is 85 hours.

Armed with theoretical knowledge, students are taken to various community organizations in the city for their practical work, which is mostly observation by the students and writing their reports on their field visit. This field visit programme is of 80 hours, as per time-tables submitted, and is given due consideration in the assessment of the University examination at the end of the fourth year in the subject of Preventive and Social Medicine. Fair amount of stress is laid on MCH, School Health and Family Planning as will be seen in the recording of journals prepared by students which will be presented during the seminar. This responsibility of teaching solely rests with the Department of Preventive Medicine. The guiding force of this methodology was the recommendation of Pakistan Medical Council which is as follows:

"The hospitals in further growth should extend their activities from out-patients into the community.'

This teaching of community medicine although hospital and disease oriented, yet extends into the community, but is not problem solving and remains isolated in one compartment of Preventive Medicine. The clinical departments are not involved and the students remain poorly orientated to the social aspects of diseases in the community. They learn to treat the diseases rather than the person.

PROPOSED METHODOLOGY

Therefore, it is proposed to allot each student two household units in which there are about 12 family members. The student would provide health care services to the 12 family members, for a period of two years. Environmental sanitation, water supplies, immunizations, nutrition, family planning, maternal care, minor ailments, health education, etc. receive due consideration of the student. A complete history of each member of the family is maintained in the journal which is periodically reviewed and assessed by the staff members of the Department of Preventive Medicine. The records of the services provided to the family members are given due consideration in the University examination of the student as at present. The 300 students would thus look after and follow as many as 3 600 members of a community for a period of 2 years.

This is a fairly revolutionary step and departure from the traditional method of teaching community medicine, and, therefore, it has to be translated into practicability in phases. Slow, gradual persuasive attitude towards the students and other faculty members is required for this transition.

From the didactic classroom teaching, the students have been brought out in the community as shown by the time-tables. They can be taken further into semi-urban FTA for training in Community Medicine.

To start with, during the afternoons, a batch of 15 students could be taken to this existing area once a week or every fifteen days. In collaboration with the staff of National Research Institute of Fertility Control (NRIFC) the 15 students acquaint themselves with the family members of 30 houses under the supervision of the doctors of the Department of Preventive Medicine. In other words the members living in 30 houses are registered with the students. The history of each member is recorded in the journal.

At 15 days intervals, students visit their allotted families and provide required services. Minor ailments are attended through the clinics which exist, while in case of necessity those requiring treatment of specialists are referred or brought to the hospitals. The main stress would remain on preventive services while records and forms of NRIFC would be completed and given to that organization for their information and use.

In order to involve the clinical departments, the Professors of Gynaecology, Paediatrics Medicine, would be invited to accompany the Professor of Preventive Medicine at two months intervals to teach the students in this FTA for which purpose a suggestion/guidance/request/recommendation may have to be made by WHO to the National Medical Council which is the standardizing organization on medical education. In this respect some progress has already been made and the clinical departments have been given guidance. A couple of times, a Professor of Gynaecology has gone out with the students in the field not in the existing FTA but in other rural areas along with a Professor of Surgery and the Secretary of Health, Government of Sind, who is incidentally an Orthopaedic Surgeon. This step is only an educative measure for other clinical departments but further and more vigorous measures are needed to elicit support and participation of clinical departments.

Gradually by rotation, as mentioned in the time-table, all the remaining 285 students are involved in the provision of these health care services.

For the training of para-medical staff such as Health Guards, Health Assistants, Sanitation Officers, Nurse-aids, locally recruited persons may be attached to the groups of students. After two years, these para-medicals will stand trained in such procedures as purification of water, food hygiene, sewage and refuse disposal, dispensing of medicines, sterilization, etc.

On paper, the above proposal appears to be good, but the practical difficulties are many. To enumerate a few, the following need priority:

(a) Transport - availability and maintenance is of extreme importance. Day to day expenses for a fleet of 30 micro-buses cannot be borne by the institution. To start with three micro-buses have to be obtained and the cost of maintaining them is to be borne by an aid giving agency. Afterwards, as this proposal gets going, the number of conveyances could be increased.

(b) The other difficulty will be the acceptance of this method of teaching by the Faculty Members who are very influential and will resist the change. Old traditions and patterns are hard to be shaken and discarded; any change is considered an infringement on their authoritative opinions. Here, persuasion guidance, directive, suggestions, recommendations from various national and international sources, preferably trough National Medical Council should be able to overcome this difficulty.

Persuasion has resulted in accepting the movement of students from the college premises into the community organizations. It is expected that through WHO advice and assistance, other difficulties will also be solved.

(c) The parents and the 40% women medical trainees might also be hesitant to accept the 'Health Care' responsibilities of families in a field training area which is not so well controlled administratively as the patients in a hospital.

Because of socio-cultural patterns, the religious and moral considerations, women trainees will be under the risk of unknown apprehensions in an FTA. This could be overcome by:

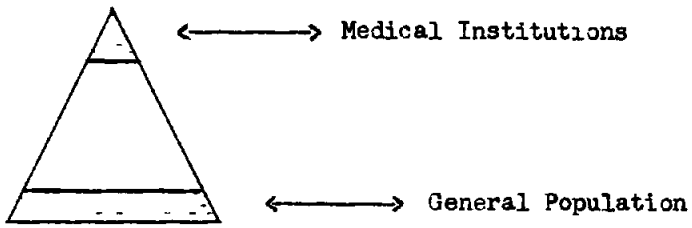
i) keeping two women trainees together;
ii) registering literate, educated and refined families with these students;
iii) maintaining a close supervision of the trainees by the doctors;
iv) volunteers from the Local Social Organization who will keep a watch and provide guidance.

(d) Selection, recruitment and payment of stipend to the para-medical staff during training period will pose anotner problem. This has to be solved by:

i) local Government administration with adequate financial support;
ii) selecting the boys and girls of matric or below matric level and ensuring their absorption in basic health units which are being established in the new health policy to be announced shortly.

CONCLUSION

The concentration of our efforts up till now was at the top of the pyramid, i.e. Medical Institutions.



out little attempt was made to improve the lot of general population as there was a huge gap. With the help of FTAs this gap could be reduced for the benefit of the people through large efforts at alleviating the clinico-social pathologies that exist in the masses of developing countries, and for the benefit of health personnel, both at teaching and operational levels through contacts with realities in live communities, and therefore some reorientation of their human as well as professional attitudes and behaviours.

DEPARTMENT OF PREVENTIVE MEDICINE
DOW MEDICAL COLLEGE, KARACHI
9 November 1974

FIELD VISIT PROGRAMME FOR FOURTH YEAR MBBS
(1973-1974)

The above-mentioned students are required to attend according to the batches mentioned below in connection with their field visits as provided in the College time-table.

Time: From 9.30 a.m. onwards

Days & Dates	COD Hills KDA Water Supplies	Mahmood-abad KMC T. Plant.	Public Health School	Epidemic Diseases Hospital	T.B. Centre	Lions Club CHK	Leprosy Centre Sadar	School Health Serv.	Rehabi-litation & Voca-tional Centres	Skin Unit CHK
Monday 18.11.74	A	B	C	D	E	F	G	H	I	J
Tuesday 26.11.74	B	C	D	E	F	G	H	I	J	A
Wednesday 4.12.74	C	D	E	F	G	H	I	J	A	B
Thursday 12.12.74	D	E	F	G	H	I	J	A	B	C
Friday 20.12.74	E	F	G	H	I	J	A	B	C	D
Saturday 28.12.74	F	G	H	I	J	A	B	C	D	E
Monday 6.1.75	G	H	I	J	A	B	C	D	E	F
Tuesday 14.1.75	H	I	J	A	B	C	D	E	F	G
Wednesday 22.1.75	I	J	A	B	C	D	E	F	G	H
Thursday 30.1.75	J	A	B	C	D	E	F	G	H	I

Batches

Batch A 1-30	Batch B 31-60	Batch C 61-90
Batch D 91-120	Batch E 121-150	Batch F 151-180
Batch G 181-210	Batch H 211-240	Batch I 241-270
Batch J 271 onwards		

Note

(a) Students visiting COD Hills, Mahmoodabad Treatment Plant and Leprosy Centre will be provided college buses for both sides. Other students will reach themselves at their visiting institutions.

(b) All students are required to submit their field reports written in their journals on the next day of the visit, before 1.00 p.m.

(Prof. M.A. Ansari)

DEPARTMENT OF PREVENTIVE MEDICINE
DOW MEDICAL COLLEGE, KARACHI
4 March 1975

FIELD VISIT PROGRAMME FOR FOURTH YEAR MBBS
(1973-1975)

Time: 2.30 p.m. to 4.30 p.m.

Dates	Water Carriage or Health Admn at Centre & Province	CHK ODD	Anti-rabic Section	Sugar Cane Vendor	Hotel or Infec-tious Disease Ward	Public Urinal	Steam Disin-fection	Barber Shop	Beggar	Food Ven-dor	Already Performed in 10 wks. 1 whole day spent for each of these
	1	2	3	4	5	6	7	8	9	10	
12.3.75	A-1	A-2	A-3	A-4	A-5	A-6	A-7	B-8	A-9	A-10	
13.3.75	B-1	B-2	B-3	B-4	B-5	B-6	B-7	B-8	B-9	B-10	1.COD Hills KDA Water Supplies
19.3.75	A-2	A-3	A-4	A-5	A-6	A-7	A-8	A-9	A-10	A-1	
20.3.75	B-2	B-3	B-4	B-5	B-6	B-7	B-8	B-9	B-10	B-1	2.KMC Treat-ment Plant
26.3.75	A-3	A-4	A-5	A-6	A-7	A-8	A-9	A-10	A-1	A-2	3.Public Health
27.3.75	B-3	B-4	B-5	B-6	B-7	B-8	B-9	B-10	B-1	B-2	School
2.4.75	A-4	A-5	A-6	A-7	A-8	A-9	A-10	A-1	A-2	A-3	4.Epidemic Diseases
3.4.75	B-4	B-5	B-6	B-7	B-8	B-9	B-10	B-1	B-2	B-3	Hospital
9.4.75	A-5	A-6	A-7	A-8	A-9	A-10	A-1	A-2	A-3	A-4	5.TB Centre
10.4.75	B-5	B-6	B-7	B-8	B-9	B-10	B-1	B-2	B-3	B-4	6.Lions Club
16.4.75	A-6	A-7	A-8	A-9	A-10	A-1	A-2	A-3	A-4	A-5	7.Leprosy Centre
17.4.75	B-6	B-7	B-8	B-9	B-10	B-1	B-2	B-3	B-4	B-5	
23.4.75	A-7	A-8	A-9	A-10	A-1	A-2	A-3	A-4	A-5	A-6	8.School Health Services
24.4.75	B-7	B-8	B-9	B-10	B-1	B-2	B-3	B-4	B-5	B-6	
30.4.75	A-8	A-9	A-10	A-1	A-2	A-3	A-4	A-5	A-6	A-7	9.Vocational & Rehabi-litation
1.5.75	B-8	B-9	B-10	B-1	B-2	B-3	B-4	B-5	B-6	B-7	Centres
7.5.75	A-9	A-10	A-1	A-2	A-3	A-4	A-5	A-6	A-7	A-8	10.Skin Unit CHK
8.5.75	B-9	B-10	B-1	B-2	B-3	B-4	B-5	B-6	B-7	B-8	
14.5.75	A-10	A-1	A-2	A-3	A-4	A-5	A-6	A-7	A-8	A-9	
15.5.75	B-10	B-1	B-2	B-3	B-4	B-5	B-6	B-7	B-8	B-9	

Batches

A-1	1 - 15	B-1	136 - 150
A-2	16 - 30	B-2	151 - 165
A-3	31 - 45	B-3	166 - 180
A-4	46 - 60	B-4	181 - 195
A-5	61 - 75	B-5	196 - 210
A-6	76 - 90	B-6	211 - 225
A-7	91 - 102	B-7	226 - 240
A-8	103 - 115	B-8	241 - 255
A-9	116 - 127	B-9	256 - 270
A-10	128 - 135	B-10	271 onwards

For No. 5 visit - when the Infectious Disease ward is established

Whoever is present in the Infectious Disease Ward will teach the practical application of such principles as notification, isolation, disinfection (concurrent/terminal), immunization etc. along with the five levels of prevention in the admitted cases.