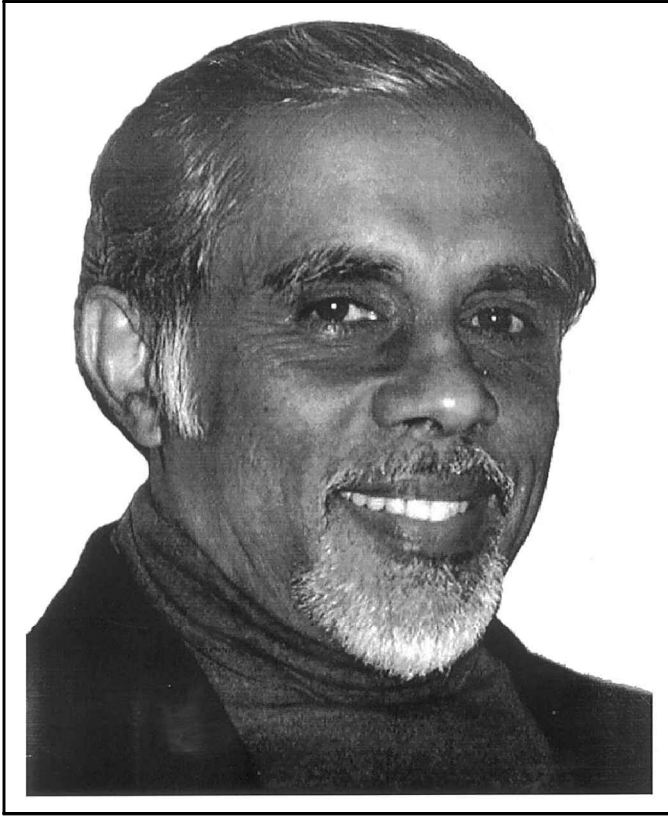




MAKING A DIFFERENCE

An Interview of Abraham Joseph



Abraham Joseph, MBBS, MD, DCH, MS (Epidemiology) is Past Chairman of The Network. He is Professor and Head of the Department of Community Health, Christian Medical College, Vellore, India. Twenty-five years ago he helped create a community-based educational program that is still thriving. The program has resulted in positive changes in some of the health beliefs and practices of villagers with whom students work. I interviewed Dr. Joseph in person at The Network meeting in Linköping in October 1999, and subsequently had multiple e-mail exchanges with him through June 2000.

Jane Westberg, PhD
Associate Editor, *Education for Health*

What drew you into medicine?

I was actually interested in engineering. While I was applying to several colleges, my father said, “Why don’t you also apply to Christian Medical College (CMC), Vellore for medicine?” I agreed. It so happened that I was selected for medicine and not for engineering.

How was your experience in medical school?

I enjoyed my studies in CMC. It is one of the leading schools in India and Asia. In those days students only spent time in the community during their third and fourth year. One afternoon a week, we visited families in a local farming community. We inquired about their health problems and advised preventive measures. This educational program itself was good, but the community acceptance of students was not good because we made our visits when the family was trying to rest after having worked all morning.

What was your specialty in your residency?

I did community health after doing a two-year diploma course in pediatrics. I did pediatrics because I feel that community health specialists should also be good clinicians.

How did you get involved in medical education?

After my postgraduate training in community health, I started getting involved in the activities of the Department of Community Health. We needed to improve the quality and variety of services that we provided to the community. We also wanted to make medical education more interesting and challenging.

The proposal, which was accepted, was to have a three-week long community-based program for first-year students. We (the staff) and the students lived in a village and worked there from 6 am until 7 at night. This enabled students to visit homes at a time that was convenient for the community. On some occasions students even had to visit the families after dinner. The students worked in pairs because only half of them knew the local language, Tamil. There was a girl and a boy in every pair so that women in the village would not feel shy talking with the students.

Each pair of students had about 15 families. They did a general profile of the family, including their educational status, and they inspected the cleanliness of the environment. To assess the families’ socioeconomic status, the students looked at some of the families’ possessions and their land. The students also looked at their health-seeking behaviors, child rearing practices, and the health beliefs of each family. For example, students learned that colostrum is not usually given to babies. It is thrown on the mud wall, not on the ground, because

some villagers believe that trampling on colostrum can negatively affect the secretion of milk.

We wanted the students to do something that they would enjoy, so we had them assess the nutritional status of children by weighing them. In an effort to link some of the students' activities to their studies in physiology and anatomy, we had some of them draw blood to assess factors such as the hemoglobin level or the presence of microfilaria.

The first year that we tried this new program we were anxious about what would happen. The students actively participated, and the reaction from the community was very good.

That's terrific. What did the people like about having students in their community?

The students went into the homes and sat with the families on a mat on the floor. The families liked it because here were students from the city who were willing to sit and talk with them in their homes. The families would always offer the students something, maybe some peanuts or corn.

The community was happy because we were taking care of their immediate, medical needs. If the family had a health problem, in the evening the students would bring them to a faculty-run clinic. The students accompanied the families when we cared for them. That gave us an opportunity to teach the first-year students how to look at minor health problems.

We insisted that the students would do something that the community regarded as a felt need. In Tamil, we call it "*sharmadan*," which means working along with the community. Before going to a village we met with the leaders and asked, "What do you want done in your village?" They might say, "When it rains our roads are waterlogged. Can you do something about that?" The students then helped with making a soakage pit. This created a bond between the community and the students.

We also told the leaders, "You, the entire community, are the teachers. The students will be learning, not from books but from seeing what you do and learning from what you say."

About a month of groundwork has to be done before we take students to a community.

How did the students react?

Very well! Much better than we had anticipated. Every year each batch of students has evaluated the program. Since beginning the program in 1975, we have made some minor changes based on their feedback. The basic structure of the program, however, hasn't changed. Some of the graduates are now on our faculty as specialists.

Does the information that students collect about health beliefs and practices lead to their doing any health education?

Students use the information that they collect to create posters for exhibitions. They also do street plays and folk media. Twenty-five years ago it was common for families to brand newborns and give them castor oil. Now these unhealthy practices have stopped. Neonatal tetanus, which was a complication of branding, is no longer a problem.

What kind of supervision do faculty members give students in the villages?

Usually one senior and one junior faculty will supervise a group of 12–15 students. In the first year we provide fairly intensive, close supervision. Later in the students' curriculum there are three other block postings when the supervision is less intense because the students know how to interview and how to get the cooperation of the village.

The second block posting is in the students' third year of medical school. The third program is in their fourth year. Both are two weeks long. In the third year, some students return to the village they went to in their first year. Others go elsewhere, depending on the projects that they undertake. During their internship, students spend three months with us.

How do you select the villages that you and the students work in?

We select villages that have health care needs. The villages have to have about 2000 people and 350–400 families. There need to be places where students can stay and a place where we can establish a kitchen. The water has to be reasonably adequate. The living conditions are typical of villages, but we don't want to make it too uncomfortable or difficult.

We return to the same village every 10 years. We don't want to use the same village too often. Each year the students document their findings, so when the next batch of students comes 10 years later, they can see some change in perhaps the demographic structure or the beliefs and practices. We've now had three rounds in some villages.

Don't you now have interdisciplinary teams working in villages?

Yes. We started by taking just medical students, but in 1980 we decided that this was a good opportunity for interdisciplinary teaching. So today 60 of the students are medical, 10 are occupational therapy, and 10 are physiotherapy. We also have dietary students, pastoral-counseling students, students doing masters in statistics and students doing epidemiology. Since 1997 all of the students are in the first year of their course.

Who are the teachers who go to the community with the students?

Predominantly they are teachers in community health, occupational health and physiotherapy. We also involve some clinicians for specific activities.

How do the students learn and work together?

They do all of the activities together. In the afternoon, we have “clinico-social” discussions during which students of the various disciplines present a medical problem and have the clinicians of that discipline comment and serve as discussants. We also focus on the cultural, social, environmental, and economic aspects of the cases.

Do the students have any other classes or clinical experiences together?

No, they hardly have any other classes together.

When you introduced the community-based program in 1975, were there objections from faculty members or others?

Time was borrowed from anatomy, physiology and biochemistry, so the faculty members in these departments were unhappy. Some of the clinicians, especially the sub-specialists, thought it was a waste of time to be with people in the community. We, however, had a very strong Principal [Dean] who was very enthusiastic about our program. Also, once we showed that the program worked, more faculty accepted it. Now most of them accept it. It's hard for people to criticize something that has worked for 25 years and is well regarded by students.

Are there other schools in India that are doing community-based education?

Yes, this has been a positive outcome of our program. When the new health science university was formed in our State, the Vice Chancellor said that all colleges must have community-based education starting in the first year. She invited us to help with this. We had a WHO-sponsored workshop for all of the teachers.

Our program has also influenced the Medical Council of India, the national body that decides the curriculum. Three years ago, they decided that community health must begin in the first year and continue throughout medical school. Now several institutions in India are using the model.

What lessons have you learned during your quarter of a century of work in community-based learning?

1. If you want communities to accept your students, the medical school must have responsibility for health services for a defined community and must address the communities' felt needs. We provide primary, secondary, and tertiary care to a population of 250,000 people who live in about 150 villages. These services continue, regardless of whether the students are present in the community.
2. Don't expect students to do anything that the staff are not willing to do. If you expect students to move freely, visit their homes and understand their lifestyles, you must do likewise. We have to be role models and set the example.
3. There must be adequate supervision in the first year. If first-year students get good supervision, they will be confident to go to the community on their own in the subsequent programs.
4. Students shouldn't collect data for the sake of collecting data. They should analyze it and learn from it. Also, the information they collect and their "community diagnosis" and intervention plan must be fed back to the community. We do this with a health exhibition that the students organize and also at a public meeting. Our department also uses this information in ongoing discussions with the community regarding ways to continually improve primary care activities.

Are there any lessons that you've learned from your interdisciplinary teaching?

Interdisciplinary teaching is best done in the community with common learning objectives. It's easy to teach occupational, physical therapy, and medical students using a problem in which the person has a disability because the students can all learn from each other.

The teachers need to accept the principles of community-based learning and be willing to work in the community. All of our physical and occupational therapy teachers went through our course when they were students, so they know its value.

Do you recommend rotating communities every 10 years or so?

It takes five to seven years to see any change in a community. The students see this change through the data that they collect and the data collected by previous students. Students realize then that even though things might look dim at the moment, change is taking place over time, and most of that change is positive.

What changes would you like to see at your school in this new century?

No program is complete or perfect, so we need to see how we can improve it further. I would like to see more horizontal integration, modular teaching interactive teaching, and interdisciplinary teaching. Due to the restrictions of the university, we are unable to do problem-based learning.

Is there anything you'd like to see happen with The Network?

More sharing and helping. Giving to others and graciously accepting new ideas from others are important aspects of The Network. The Network has played an important role in promoting problem-based learning and community-based learning. Now The Network needs to play a leading role in new areas and in tackling such challenges as finding more reliable and effective methods for student assessment.