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Chapter

Community Oriented Graduate Medical Education - A Gandhian Approach

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Abstract

In the last century, the fields of Health Care System and Academics, there have been significant progress. The experience of implementing community oriented medical education for more than last five decades at Mahatma Gandhi Institute of Medical Sciences (MGIMS) Sewagram based on Gandhian Ideology has helped us to develop a mutually beneficial partnership with local health system & Community and discharge our social responsibility. The institute has made several innovations in its academics & health care to raise the social consciousness of medical students as well as to equip them to work in rural areas. We are sharing the innovations along with our experience of working in partnership with Public Health System & Community for their further replication elsewhere.

Keywords: MGIMS, DCM, CBOs, Gandhian Approach, community oriented medical education

1. Introduction

> *"All other pleasures and possessions pale into nothingness before service, which is rendered in a spirit of joy."*
>
> *- Mahatma Gandhi.*

In the last century there have been significant changes in the field of Health Care Delivery (both in Private and Public) System and in the functioning of academic institutions. On one hand there have been rapid progress in the both fields but at the same time new challenges have also emerged. With the advent of market economy and globalization both demographic transition and epidemiological transition have led to widening health disparities between rich and poor segments of the society and also poor access of health care to marginalized segment of population and also at times to the rural area. It is expected from the academic institutes to bring a change in the health status of the community, they serve as well as to create a demand to provide high quality and cost -effective health system. Thus, the social responsiveness, social responsibility and social accountability has posed a significant challenge to academic health institutions [1, 2].

There is a substantial inequity in terms of health and development progress among the rural population in India. Among the states those are doing well, there also remain pockets where not much has changed since independence in 1947. This inequity further worsens with every passing year, resultant health being has become

one of the major determinants for worsening inequity. In India paying for health care has become a major source of impoverishment for the poor and even for the middle class. In this situation the Gandhian Philosophy of serving the underserved & reaching the unreached has become more important. The Medical Institutes can make, the Gandhian Dream- "people's health in people's hand", a reality.

1.1 Gandhian concept of Village Development

Mahatma Gandhi was always for "Swaraj" meaning by self – rule where villagers would be able to exercise authority/control on the happenings around them in the field of social, culture, education, health and agriculture etc. Thus, it is clear that Gandhiji's "Swaraj" was to empower the village community in order to ensure that, they have controlled on the happenings around them. Gandhian vision of ideal village or village Swaraj is that it is a complete republic, independent of its neighbours for its own wants and yet interdependent for many others in which dependence is necessary. (3, 4)

Gandhiji said on ideal village – "An ideal Indian village will be so constructed as to lend itself to perfect sanitation. The cottages will have courtyards enabling householders to plant vegetables for domestic use and to house their cattle. It will have wells according to its needs and accessible to all. It will have houses of worship for all, also a common meeting place, a village common for grazing its cattle, a co-operative dairy, primary and secondary schools in which industrial education will be the central fact. It will produce its own grains, vegetables and fruit, and its own Khadi. This is roughly my idea of a model village...I am convinced that the villagers can, under intelligent guidance, double the village income as distinguished from individual income. My ideal village will contain intelligent human beings. They will not live in dirt and darkness as animals. Men and women will be free and able to hold their own against anyone in the world." (3, 5)

At Mahatma Gandhi Institute of Medical Sciences, we have strived hard to improve the quality, equity, relevance, and cost -effectiveness in the health care delivery in order to discharge our social responsibility. The medical institutes capacity is judged on the basis of their response and interaction with constantly evolving health systems and the community in order to produce medical graduate who has sense of social responsibility. The big question is if our medical institutes are prepared for this? Are they ready and willing to shoulder the responsibility so as to contribute to the development of healthier society? (6).

The experts believe that incorporating this fundamental issue in the institute mission may be a stepping stone towards ensuring that thee medical institutes discharge their Socially Accountability that is deeply nested at MGIMS in all its activities related to health care both at institution level and at community level. The medical students both, under-graduates and post-graduates experience the social responsibility while working both at institute level & with the community and at times they also participate actively. (7)

"Community-based education is not only learning in the community but also learning with and from the community. As the communities actively participate in CBE, they not only contribute but also benefit from the CBE process. The ultimate goal of CBE is to help the students understand social dynamics of health promotion and disease prevention and to impart a sense of social justice and cultural humility in the health professions through the education process." (8)

Under "social responsibility" the medical education program focuses on producing a "good "practitioner, leaving the onus on respective medical institute to define which competences are the most appropriate to meet health needs of patients. Under "social responsiveness", the medical education program focuses on attaining the clearly defined competences that are defined from an objective analysis of people's health needs. Under "social accountability", the medical education program

aims to produce health system change agents that would have a greater impact on health system performance and ultimately on people's health status, implying a quest for innovative practice modalities combining individual and population based services. (9, 10)

The available evidence suggests that implementing such a social accountability framework is feasible and yields the desired results of producing socially responsive competent medical physicians. (11). We therefore share the experience of implementing community based medical education for more than five decades at Mahatma Gandhi Institute of Medical Sciences (MGIMS) Sewagram. Our humble submission is that the attempt at MGIMS is not the most perfect model and may have its own limitations and flaws.

2. Methodology

The literature search on community oriented medical education, Gandhian Philosophy & Social accountability was conducted. Further, qualitative methodology was adopted to draw inferences based on personal interaction & interviews and discussion with faculty & supportive staff at Mahatma Gandhi Institute of Medical Sciences, Sewagram, with health care providers, with public health system, with community members representing various community based organizations, local panchayat members and with village level health functionaries like Accredited Social Health Activist (ASHA) and Anganwadi Workers (AWW). Wherever required available secondary information was also utilized. It also includes personal experience of the Author over last 27 years at MGIMS.

3. The Institute

The Mahatma Gandhi Institute of Medical Sciences, is India's first rural medical college. Nestled in the karmbhoomi (work place) of Mahatma Gandhi, at Sewagram. The institute was stated in Gandhi Centenary Year 1969.

3.1 VISION & MISSION

The vision of the institute is to develop a replicable model of community oriented medical education which is responsive to the changing needs and is rooted in an ethos of professional excellence. The Mahatma Gandhi Institute of Medical Sciences, Sewagram is committed to develop high standard of medical education, research and health care by adopting holistic approach, integrating modern medicines with traditional Indian system of medicine. The institute in committed to provide the affordable health care to the marginalized & underserved community especially underprivileged segment of society from the rural area.

3.2 HISTORY

When Mahatma Gandhi left Sabarmati Ashram and set up his ashram at Sewagram in 1936, the epicenter of India's independence struggle shifted to this obscure village in Maharashtra. In 1944, when Gandhiji returned from his last imprisonment at Aga Khan Palace, Sewagram was experiencing a number of epidemics. In this situation, Bapu had no use of the guest house built for his guests. He got it converted into a dispensary, and later, into a 15 bedded hospital for women and children. It was christened "Kasturba Hospital" in memory of Kasturba

Gandhi, who had passed away in 1942. Kasturba Hospital has the distinction of being the only hospital in the country started by the Father of the Nation himself.

Dr. Sushila Nayar, who joined Mahatma Gandhi in the year 1939 as his personal physician and in independent India she joined as Union Health Minister with then Prime Minister of India Pandit Jawaharlal Nehru in 1962. When Shri. Lal Bahadur Shastri, who had a rural background, became Prime Minister he desired to start a medical college in the rural area which can deliver the rural oriented medical education. Dr. Sushila Nayar took this as a challenge and in the process Mahatma Gandhi Institute of Medical Sciences was started in 1969 in the Gandhi Centenary year as experimentation in the medical education to create a rural bias amongst the medical students.

MGIMS is 50-years-old now. From a 15 bedded hospital in 1944, the Kasturba hospital has gradually grown into a 934-bedded hospital. The institute also runs a 50-bedded Dr. Sushila Nayar Hospital, in the tribal areas, in Melghat 250 kms away from Sewagram.

4. INNOVATIONS IN COMMUNITY-ORIENTED LEARNING AT SEVAGRAM

The various innovations have been developed at MGIMS to create the social consciousness among the medical students- **Figure 1**.

The few important innovations are:

4.1 ORIENTATION CAMP

At MGIMS, Students are admitted in undergraduate medical course (MBBS) from all over the country and are selected on the basis of a common eligibility examination at National Level. Soon after admission to the Institute, students attend a 15-day orientation course in Gandhi Ashram (Where Gandhiji lived from

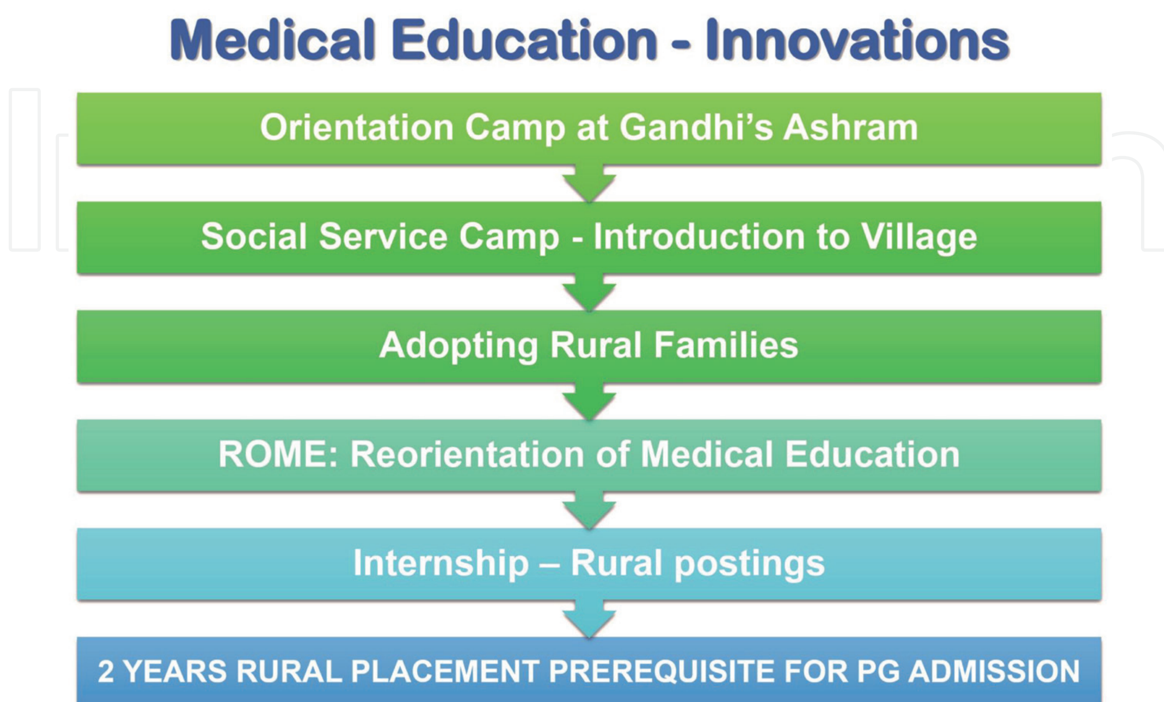

Figure 1.
Medical education - innovations.

DOI: http://dx.doi.org/10.5772/intechopen.93302

1934 to 1946) to learn about a value system based on Gandhian ideology. The students during the Orientation Camp live in Gandhi's Ashram and have to follow all routine of the Ashram, viz. – participation in morning and evening all religion prayer, participation in Sharamdan and community activities like spinning yarn which is popularly known as Khadi. The students are oriented towards value of dignity of labor (Sharamdan), religious tolerance and simple living and high thinking. The students are also taught relevance of Gandhian Thoughts/Philosophy in medical education with special context to personal hygiene, balance diet & nutrition and environmental health with the help of renown Gandhians who are specially invited and shares their experiences and interact with the students. The students are also exposed to the importance of Yoga, meditation and nature care as well as on spiritual health which was near & dear to Gandhiji.

During the camp students are also provided an orientation towards institute's Code of Conducts which are:

1. Wearing Khadi (hand woven) clothes
2. Eschewing Non- Vegetarian food, smoking, alcoholic drinks, intoxicating drugs
3. Participation in all religion prayer and Sharamdan
4. Non-observance of untouchability
5. Equal respects to all religion

4.2 VILLAGE ADOPTION SCHEME (SOCIAL SERVICE CAMP)

4.2.1 The context

The medical graduates in India are trained mainly in tertiary care hospitals where they become completely dependent on technology. The villages of India need the doctors who have to rely on their own knowledge, skill with sound community orientation, clinical competence and good communication skills. The Social Service Camp is an attempt to achieve the objective of the Institute and to expose the students how to provide value based and cost- effective medical education especially in rural and resource constrained setting.

4.2.2 The Practice

The camp is organized as a two weeks residential camp during the first year of M.B.B.S. course. Every year a new village is selected for organizing the camp. The criteria for the selection of the village includes:

- **Demand from the village for holding the Camp**: The villagers pass a resolution in the Gram Panchayat (local self-government at village level) meeting and request the MGIMS to adopt their village.
- **Population:** During Social Service Camp each student is allotted 3–4 families consisting of 15–20 individuals for the Family study. Hence preferably the population of the village should be around 1500 to 2000, considering the number of 100 students.

- **Distance:** The distance of the village should be preferably less than 30 kilometers from MGIMS.

- **Infrastructure and space:** As the camp is residential, the villagers are expected to provide space for making lodging arrangements for boys and girls separately, and for the staff staying at the camp site during the camp. They are also expected to provide space for cooking the food and for dining. They should also provide space for camp activities and space for arranging Health Exhibition. Usually the village school building is used for accommodating the students. The permission to use the school is obtained from District Education Officer by MGIMS. However, the alternative arrangement for school students' classes is made by MGIMS in tents.

- **Water and electricity**: The villagers should be ready to make provision for water as well as electricity for the camp purpose. The actual charges of electricity are paid by the MGIMS.

- **Active participation and support**: The villagers are expected to give assurance to participate actively in the camp activities and extend their support during the camp.

So far 51 villages have been covered. Each student is allotted 3–5 families consisting of 15 to 20 individuals. The students make a detailed study in the allotted families with the help of a journal of Community Medicine Practice under the guidance of faculty, Post Graduate students and Para Medical staff of the DCM.

The students visit the allotted families in the morning as well as in the evening to collect the information related to their socio-economic status, environmental and housing conditions, dietary pattern, immunization status of the children, addictions, personal habits and health status of every individual of the family etc. They also learn about the customs, ethnic groups. Community based organizations working at the village level and facilities available in the village level. During the camp, the demonstration of chlorination of wells, construction of soakage pits and smokeless chulah (furnace) etc. are also given.

During these camps, the students get so much acquainted with the families as if they are the members of the adopted families. During the social Service Camp all residents of the village are examined and are subjected to blood, urine and stool investigations. Wherever it is required, they are provided advice or treatment, in the general outpatient clinic in the village itself. Those who require specialist attention are referred to the specialist clinics which are organized in the camp daily in the afternoon. Again, specialist provide their advice or treatment, if it is so required, patient is referred to Kasturba Hospital, Sewagram for admission/special investigations. The health care is totally free of cost during the camp period.

The students also carry out the diet survey in the family and calculate the calorie and nutrients intake of individuals under the supervision of the teachers.

The students are trained on how to communicate with the villagers and are given briefing about the various models, charts, exhibits placed in the exhibition hall. Later they bring the family members to the exhibition hall and educate them with the help of the charts and models under the guidance of the Health Educator.

4.2.3 Monthly Follow up of the Allotted Families

After the Social Service Camp, for the next three years, the students visit their adopted village every month on a fixed Saturday. In the first year of their visits, the

students study personal hygiene, basic sanitation, housing, immunization, diet, nutrition, growth and development.

During the subsequent period, the students are given exercised related to maternal, newborn & child health, growth & development, breast & complimentary feeding, antenatal & postnatal care and Nutrition education. Consideration is given to health education involving teaching aids developed by the students themselves and to fertility control.

In the final year of their visits, the students perform exercises pertaining to local endemic diseases and their association with environmental sanitation, housing, vectors, personal hygiene, safe drinking water and develop IEC material on preventive measures. The role of village level health providers & VHNSC are also studied by the students. (11)

4.2.4 Qualitative Methods and PLA techniques

The students are introduced to Qualitative methods and PLA tools during Social Service Camp. They are explained the qualitative techniques and also demonstrated how to apply those techniques in the villages to understand the views, perceptions, expressions and opinions of the villagers about a topic. The students are exposed to the PLA tools such as Social Mapping, transect walk, Venn diagram, Seasonal Calendar, Force Field Analysis and Focus Group Discussion.

4.2.5 Developing Communication and leadership skill

Family visits are the mainstay of Social Service Camp. The morning and evening hours are allotted for family visits where they interview family members regarding nutrition, hygiene adolescent health geriatric health and other related issues. This help them in developing rapport with the family, empathy and communication skills. They are prepared for these visits through having sessions on communications skills - active listening, reflecting, importance of asking open ended question, appreciation, empathy and not being judgmental through role plays. They are also taught about age specific communication; i.e. how to communicate with different age group. During the camp duration the students convince and mobilize the families allotted to them to avail the benefit of screening and curative services provided in the camp. This helps them to practice persuasive communication and negotiation skill. The students also get opportunity to negotiate behavior change with the family member in their subsequent monthly village visits.

During the social service camp, formal interactive sessions are also arranged on topics related **to** leadership skills, viz. activism, working as a change agent, problem solving, team building and assertiveness etc. Group exercises during the field work and classroom teaching also helps them to learn the team building, negotiation and conflict resolution. In group exercises students also identify their own strengths and weaknesses for the leadership skills and prepare a personal improvement plan.

4.2.6 Impact of the Practice

- **Orientation of the medical students to Rural life**: Staying in the village for 2 weeks the students observe the real characteristics of rural area like simplicity, poverty and illiteracy. They also observe the social and health problems of the villagers. This help in creating rural bias among the medical students and to bring a change in their attitude.

- **Orientation to Qualitative Methods and techniques**: The students are also exposed to various techniques of qualitative methods such as focus group discussion, social mapping, Venn diagram, seasonal calendar, etc....
- **Understand the role of family in health and disease:** They realize the importance of family study and role of the family in child rearing, socialization, personality formation, care of dependent adult, seek and injured, care of women in pregnancy and the child birth and care of aged and handicapped.
- **Management of patients with limited resources:** During camp the students observe how the patients are treated at village level and with limited resources.
- **Development of communication skills among the students**: Through interaction with the families and villagers and educating the family members in the exhibition arranged in the village they learn how to convey health messages in simple and understandable languages.
- **Learning of Basic research methodology:** In the Social Service Camp the medical students appreciate the health problems and undertake a small research project. The students are trained in how to conduct small research through Essential National Health Research (ENHR) workshop.
- **understanding the health and health related behaviour by the villagers:** The reflection of the villagers in focus group discussion has revealed that:
    - The villagers understand the importance of environmental sanitation as the villagers have been trained for how to chlorinate the well water, how to dispose waste water, garbage and refuse. They are motivated to construct soak pits, sanitary latrines and smokeless chulah etc.
    - Villagers realize the importance and practice of proper hand washing before cooking and before eating.
    - The health seeking behaviour of the family is changed. During illness they seek medical help as early as possible from the nearest health facility.
    - They understand how to take care during pregnancy, postnatal period and care of children.
    - The home delivery has been almost abolished.
    - The villagers do not allow their daughters to marry before reaching the age of 18 years.
    - The adolescent girls and women have been educated for the gender specific hygiene practice.
    - Breastfeeding practices and immunization coverage have improved.
    - The villagers become aware of various communicable and non-communicable diseases, diet and nutrition and immunization etc.

4.3 REORIENTATION OF MEDICAL EDUCATION CAMP (ROME CAMP)

The ROME camp for two weeks is organized for students, after 2nd Professional examination. This time students stay at one of the Rural Health Training Centres of MGIMS, Sewagram. The camp is organized with the objectives:

1. to expose students to the organization & functioning of health care delivery system and implementation of national health programs at PHC level

2. to make students understand the role of family and social environment in the disease causation and health care seeking practice

3. to expose students to community health need assessment methods

During this camp, the visits are arranged for students to different levels of health care facilities and to interact with health care providers. Over the years we started involving the district level Programme Officers/Managers including District Health Officer and Civil Surgeon, Wardha for providing practical teaching to the medical students during the camp. They also share their experiences related to various facilitation factors, barriers and challenges in the implementation of health programme. Usually the clinical case presentation for undergraduate students are taken place in the premises of the hospital but taking the advantage of ROME camp, community based clinical case presentation at family level are organized under the supervision of the faculty members from the clinical specialties. Thus, students understand the role of social and environmental factors in health and diseases. They are also exposed to the various socio-cultural factors and established community practices in the village which have strong bearing on health and diseases as well as with the health seeking behaviors of the community. The students are also given opportunity to plan, collect the data, analyze it and write the report on small community-based surveys on various priority health issues related to community health needs.

4.4 Essential National Health Research

While working with the students in the field, in 1995 few students approached me requesting that they have to understand the reason & ways to handle certain issues related to allotted families in the adopted villages. Consequently, using participative approach, we decided to introduce an exercise on Essential National Health Research" with the undergraduate medical students. Accordingly, a two days' workshop on Research Methodology was organized to give an overview on Research Methodology. At the same time, the students in the group (3 to 5 students) were asked to find out the health problems in the allotted families in the villages. In the second stage, students prioritized the health problems and reached to consensus about the priority health problem to be addressed. In group, the students were taught how to convert the health problem to researchable question followed by developing a research protocol including literature search, objective of research and detail methodology and then the students conduct research projects in the groups under the guidance of faculty members of the department of Community Medicine.

Initially, a few students were interested to conduct research in hospital setup. However, they were motivated to take up the research topic in the field. The emphasis was given to undertake simple intervention which may sometime require behavioural change process so that the family members get full advantage of research. It has been highly satisfying both for students & for the community. Thus, in true sense a prototype of action research in the field has been developed

the undergraduate students which has been refined during last 20 years and the process of undertaking research project is continuing in the adopted villages on voluntary basis.

4.5 Internship in Rural area

Interns are posted for three months at both rural health training centre & urban health training centre out of their twelve months internship training programme. The interns are exposed to primary health care delivery & Kiran clinics so that they can sharpen their clinical competence with limited diagnostic facilities. They also interact with CBOs & VHNSC to appreciate their role in health promotion and disease prevention.

4.6 Community Oriented Education to Nursing Graduates and Post-Graduate students

For last 8 years we are providing rural orientation to the undergraduate and postgraduate nursing students on rotation basis at our Rural Health Training Center, Anji and Urban Health Center, Wardha.

During their posting at RHTC they work very closely with Primary Health Center staff in the delivery of RMNCH programme. They also assist PHC staff in conducting deliveries. They visit to rural community and interact with CBOs & VHNSC. The faculty posted at Rural Health Training Center supervises their activities and conduct academical sessions in the afternoon. During the posting they are also given a small project either in School or in the community on priority health issues.

Similarly, during their posting at Urban Health Training Center, they are allotted few families in the field. Under guidance of faculty and social workers they conduct family study and present their brief report in the end of posting. The students are also posted at OPD of the Center for clinical exposure in rotation.

4.7 Rural Placement Programme for Post- Graduation Admission

In 1994 Mahatma Gandhi Institute of Medical Sciences, Sewagram decided that those who desired to do Postgraduate Programme at MGIMS will have to serve for two years at a designated rural site. At MGIMS we selected nearly about 100 rural sites which were managed mainly by NGOs on “No Profit No Loss” basis and serving the marginalized community in the underserved rural area. We could able to identify these sites in every part of country. The students are posted at these sites on voluntary basis and while the doctors are working in the rural area, they are closely monitored by the faculty members of MGIMS on quarterly basis and sometime the visits are paid to the NGOs sites to ensure the proper utilization of manpower.

On successful completion of two years’ programme, the students were given admission to various PG programmes. At MGIMS presently we have PG programmes in all basic medical disciplines However the Government has come out with the National Entrance Examination for admission to PG programmes and we have to keep this Scheme in abeyance while our request to continue with the Scheme is pending with the appropriate authority.

5. Partnering with Public Health System & Community

In order to discharge the social responsibility of an academic institution, we have developed an interface between Mahatma Gandhi Institute of Medical

Sciences, Sewagram with District Health System and Community. This interface is being utilized to have an integrated approach in the health care and research programme in the field. Over the years we have taken confidence building measures with the health system and have developed mutually beneficial partnership and in the process, we are working very closely with Primary Health Centres, Sub-Centres and Community Health Centres in the field. MGIMS play an important role in capacity building of health care providers on various health and health related issues and the District Health System in return has contributed significantly by supporting the community-based health care delivery and research as well as in teaching and training including during the Social Service Camp and ROME Camp. In the process, Institute has developed two Rural Health Training Centres at Anji and Bhidi and Urban Health Training Centre at Gandhi Memorial Leprosy Foundation, Wardha. These Centres act as a bridge between MGIMS and District Health System in discharging social responsibilities of MGIMS in providing health care to the marginalized rural population and promoting community-based research by the faculty members of MGIMS, Sewagram. All clinical faculties of MGIMS, Sewagram are regularly visiting these Centres on periodic basis to extend specialist health care at Primary Health Centres. Consequently, the MGIMS has signed a Memorandum of Understanding with the District Health System to manage two Primary Health Centres at Anji and Talegaon in rural area and two Primary Health Centres in the city of Wardha in urban area two years back which has further strengthened the partnership.

6. Community Mobilization

The DCM is involved in providing services to 100 villages in Wardha Block since 1985. Based on the experience over the years we promoted various community-based organizations (CBOs) and built up their capacity for promoting health action in the community. Initially we interacted mainly with the Village Panchayats (Local Bodies) and once we developed a good understanding with the Panchayat, we started promoting CBOs. Over the years two important CBOs which have been promoted are –.

6.1 Self Help Groups of Women

In the initial years we used to visit the villages while delivering the health education in the community. We noticed that every time we visited the community, a different set of people gathered. Hence, we decided to develop Women Self Help Groups on the guidelines of National Agriculture Bank for Rural Development (NABARD). These groups are informal groups and don't require any formal registration, however, number has to be restricted to 20 members. In the initial years, we spent a considerable time using SHG only for economic empowerment of women and to provide them relief from the moneylenders. These Self-Help Groups collect token monthly subscription from the members and utilized the collected amount for internal lending. Once the groups have a certain amount of money, then bank provide them a formal linkage by which they are eligible for the bank loan to undertake small income generation activities. Over the years these SHGs have been proved as good example of micro financing at community level. Once these groups' financially stabilized, we started introducing health agenda in their activities by providing them relevant information in a phased manner. At present the DCM has nearly 300 Self Help Groups in the field practice area and promoting health action on various health and health related issues in the community.

6.2 Adolescent Girls Group (Kishori Panchayat)

The members of Self-Help Groups prompted to help adolescent girls who don't have proper information related to menstrual hygiene and suffering rampantly with anemia. Accordingly, we started organizing community based Adolescent Girls Groups known as Kishori Panchayat. These groups are mainly involved in adolescent to Adolescent health programme. They have been oriented towards various adolescent health issues, maternal health, child survivals, environmental health and family life education as well as on RTI/STD/HIV control. These girls in turn also trained their peers and younger adolescent girls in the villages.

Later on, we have developed these girls' groups on the bases of activities of the Rashtriya Kishor Swastha Karyakram (National Adolescent Health Programme). At present we are linking these community based adolescent activities with the school based adolescent health programme to ensure sustainability. Additionally, two Adolescent Health Resource Centers have been developed at our Rural Health Training Centers at Anji and Bhidi which acts as reference centers for both for community based and school based adolescent health programmes.

7. COMMUNITY OWNED HEALTH CLICS (KIRAN CLINICS)

Mahatma Gandhi Institute of Medical Sciences, Sewagram is committed to provide accessible and affordable health care, primarily to underprivileged rural communities. In the community health needs assessment (using both quantitative, qualitative and participatory methods) in 60 villages, the findings emerged that the delivery of Primary Health Care was available at Primary Health Centre (PHC) or Sub-centre level but not at the village level. Villagers had to travel a long distance for seeking primary health care even for the basic ailments and it costed them a lot. Apart from the direct health expenditure on consultation, medicines or investigations, patients had to forego their daily wages and spend on transportation. The VHNSCs of respective village recommended to establish a village-based clinic, to cater to the unmet need of providing primary health care at the village level especially directed towards marginalized, poor and vulnerable section of the society-women, children and elders.

The Kiran clinics were started in selected villages under the CLICS (Community Led Initiative for Child Survival) program in 2004 to meet the health needs as defined above. The pre-condition set by Department of Community Medicine (DCM) for partnering with the VHNSC to establish a clinic was that at least 60% of the population of the village should contribute to the Village health fund. This was done to ensure financial sustainability of the clinic in the long run. Apart from providing curative services, preventive and promotive services are also provided through the clinic. It is an attempt to overcome constraints that affect access to care like distance, transport and availability of services of basic health care facility.

Usually services given under any research-project stop after project ends, Kiran clinics have sustained through community-ownership for a period of more than 15-years, which, is a testimony to simple but robust and transparent management and reflects the '*Value*' community gives to clinics. One key learning is that community doesn't really expect free healthcare delivery but are willing to pay minimal cost provided services are of desired quality and are able to cater to their needs.

Quality health services are provided in the Kiran clinic. One diabetic patient showed his satisfaction saying "Doctors and sister give psychological support along with quality treatment. I am 100% satisfied with services given at very low cost." (12)

In our field practice area, 23 such clinics have been established. The cost comparison in terms of doctor's fee, cost of drugs, transport, and lost wages has been strongly in favor of the Kiran Clinic (approximately 64 rupees at the Kiran Clinic versus 390 rupees for treatment outside the village which is a savings of almost 350 rupees.)"

In the Kiran clinic only, generic drugs are being purchased and made available to the patients at no-profit, no-loss basis to ensure affordability Apart from organizing clinic, the VHNSCs also ensure the quality of services at the clinic. Again, the DCM supplied them with a tool in the form of a QA checklist which covers a number of quality parameters from the presence of health care providers to adequate infrastructure and logistics, including drugs. The charges and the cost of treatment for the patient are also under scrutiny, as is the client satisfaction based on simple exit interviews. To top it all, it also looks into equity issues - whether the clinic manages to reach out to the disadvantaged and marginalized in the community, including the women and children.

The Kiran Clinics also act as hub for Health promotion by providing Growth monitoring, Antenatal care, Screening for Hypertension and Diabetes and also provide support in organization of VHND (Village Health Nutrition Day) at Village level. Thus, it offers a promise for new and innovative health initiatives.

The community is engaged at every stage (planning, implementation and evaluation) in the functioning of Kiran clinics and has been able to successfully run the clinics for the last 15 years. The committee has flexibility and authority to make necessary changes in functioning of the clinic, e.g. addition of new services, registration fees, drug price and incentive to village volunteer etc. Over the years, the committees have taken several decisions to improve the services through these clinics as per demand of the community; e.g. addition of new services like treatment of non-communicable diseases and other health promotion activities.

Community dialogue, voluntary participation, empowerment of people and involving them in decision making have been crucial for ensuring ownership. One member of VHNSC expressed her gratitude saying - *"It's my pleasure to work for community. It gives nice feeling to me. Even if I am not doctor, I am able to contribute for improving health of my village."*

8. Strengthening the Panchayati Raj Institutions (PRI) and Village Health Nutrition and Sanitation Committee (VHNSC)

DCM continuously engages with PRI members in all villages in its field practice area. Orientation sessions are organized through the Rural and Urban Health Training Centres to empower the PRI and VHNSC members for health action at the community level. Due to its continuous engagement with VHNSC, in most of the villages in the field practice area, monthly meetings of VHNSC members are ensured.

VHNSC has a vital role in decentralized health planning and monitoring. NHM envisaged VHNSC to function adequately with involvement of community members and promote people's participation in the planning process. However, there should be a tool which facilitates in planning, implementation according to village specific health plan, and community monitoring of health services at the village level. (13)

Mahatma Gandhi Institute of Medical Sciences (MGIMS) has developed a community-led approach and ensures the provision of high quality and affordable health care with emphasis on maternal and child health, in partnership with local community and health system. The strategy is to empower the communities to

manage and own village-based primary health care. The DCM has initiated various community-based organizations in the villages – self-help groups of women, adolescents groups (more than 60 in numbers) and empowered Village Health, Nutrition & Sanitation Committees (VHNSC) in every village in a systematic manner.

The programme uses the Integrated Model of Communication for Social Change (IMCFSC) to guide its BCC activities. IMCFSC uses an iterative process where 'community dialogue' and 'collective action' work together to produce social change as shown in **Figure 2**. (14) The VHNSC have been empowered for health planning, organization of Immunization Day, monitoring of the health functionaries, and they work in close collaboration with the local health system and democratic body. There is an effort to link health and developmental activities at the village level.

Formal interaction of medical and nursing students with community-based organizations is arranged during their village visit; they witness the activities of community-based organizations. This helps aspiring doctors understand the role of individuals, families and communities in preventing diseases, maintaining and promoting health, and improving health-seeking behaviour.

Based on our experience of working with VHNSC it can be inferred that most VHNSCs are moving in right direction by addressing social determinants of health for which they have been empowered to recognized the social determinants of health being important in improving the health of the community as a whole, however it require continuous support, hand holding and monitoring from both public health system and other stakeholders. (15)

Community based organization will be the key to bring about the overall development of the villages. Most importantly, communities need to control the process. The ultimate goal is for communities to have the confidence and competence to make informed choices from a range of appropriate options for sustainable and equitable development. The need of the hour is to bring about a holistic change in the lives of beneficiaries among the villagers by uplifting their socioeconomic and health status through effective linkages through community,

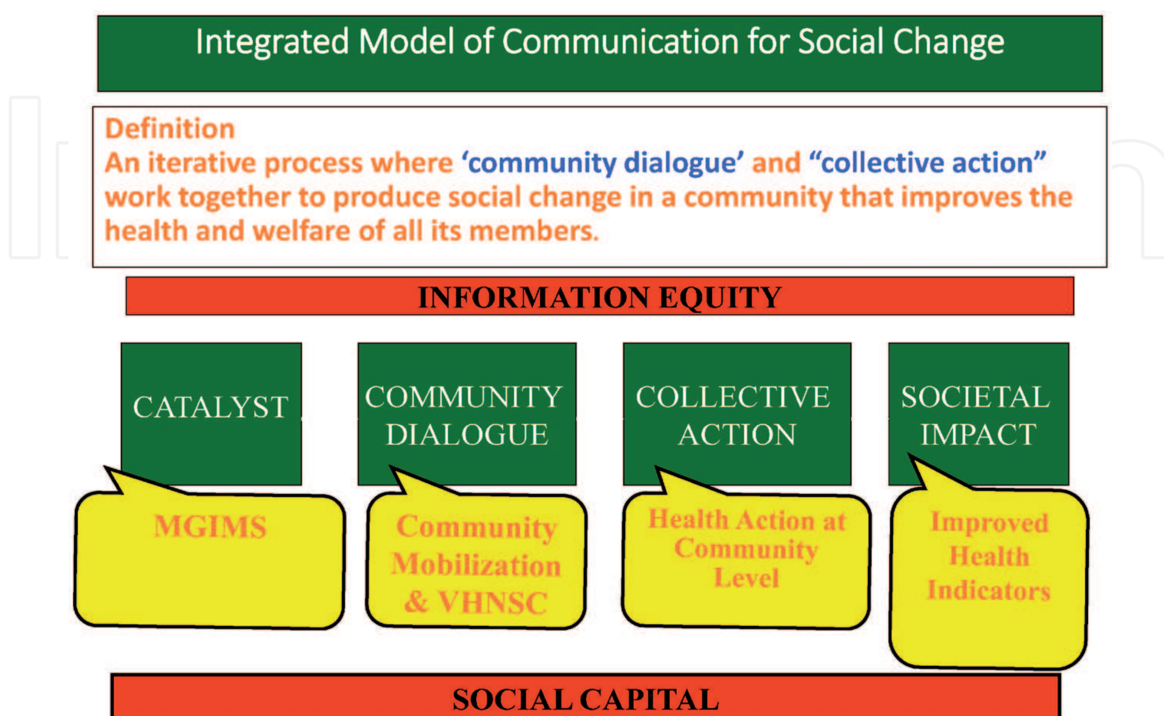

Figure 2.
Integrated model of communication for social change.

governmental and other developmental agencies. The VHNSC should be able to prepare an Integrated Village Development Plan with technical guidance from local organizations/agencies. (16)

As a part of their social responsibility, medical colleges needs to play the role of catalyst to bring all the stakeholders (Villages level committees, PRI members, Health functionaries – ASHA, AWW, ANM, MPWs, School students and teachers, NGOs etc..) on one platform and make an integrated plan for development of villages in their community development block area. Capacity building of the community and household will be pivotal if sustainable development is to be ensured and the Gandhian dream of Gram Swaraj is to be realized.

9. Conclusion

At present we have developed an interface between community, health system & MGIMS, which requires further nurturing in a manner that all three stakeholders sustain their commitment. The MGIMS has discharging its role to nurture & further develop this partnership in order to discharge its social responsibility in short term & social accountability in long term.

"Gram-Swaraj, the economy of small scale: in the past 12 years, from the recession of 2008 to the economic crisis of 2020, we have seen that a globalised economy is too fragile. It crumbles in the face of local tremors like the real estate scam in the USA or the emergence of a new virus in Wuhan. Gandhi would remind us of the humaneness and stability of local production, local consumption, and local community of relationships. He called it Gram-Swaraj. Such change in economy would invariably be accompanied by the decentralisation of political power. Globalisation has produced authoritarian political leaders everywhere. For Gandhi, the true democracy, responsibility, and relationship can be better practised locally." (17)

Acknowledgements

Author is thankful to all his collogues in the department of Community Medicine At MGIMS, Sewagram for their direct or indirect contribution.

Conflict of interest

"The author declares no conflict of interest."

Acronyms and Abbreviations

ANC	Ante-natal care
ANMs	Auxiliary Nurse Midwives
CBE	Community Based Education
CBOs	Community Based Organization
CLICS	Community Led Initiative for Child Survival
DCM	Department of Community Medicine
IMCFSC	Integrated Model of Communication for Social Change
MCH	Maternal and Child health
MGIMS	Mahatma Gandhi Institute of Medical Sciences
NHM	National Health Mission

OPD	Out Patient Department
PHCs	Primary Health Centres
PLA	Participatory Learning & Action
PNC	Post-natal care
RHTC	Rural Health & Training Centre
ROME	Reorientation of Medical Education
SDG	Social Determinants of Health
SHGs	Self Help Groups
UHC	Urban Health Centre
VHNSC	Village Health Nutrition and Sanitation Committee
VHND	Village Health and Nutrition Day
WHO	World Health Organization

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References

[1] Flexner Abraham. Medical Education in the United Sates and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. Bulletin No. 4. New York; 1910 [cited 2016 Sep 11]. Available from: http://archive.carnegiefoundation.org/pdfs/elibrary/Carnegie_Flexner_Report.pdf

[2] International Reference Group (IRG) members on Medical education. Global Consensus for Social Accountability of Medical Schools. East London, South Africa; 2010 [cited 2016 Sep 11]. Available from: http://healthsocialaccountability.sites.olt.ubc.ca/files/2011/06/11-06-07-GCSA-English-pdf-style.pdf

[3] Village Swaraj. Written by: M. K. Gandhi. Compiled by: H. M. Vyas. Published by: Navajivan Publishing House, Ahmedabad, India. Available online from: http://www.mkgandhi.org/ebks/village_swaraj.pdf

[4] Gandhiji on Villages. Compiled by: Divya Joshi. Published by: Mani Bhavan Gandhi Sangrahalaya Mumbai. Available online from: http://www.mkgandhi.org/ebks/Gandhionvillages.pdf

[5] Garg BS, Raut AV. Adarsh gram: A Gandhian dream of Gram Swaraj. Indian Journal of Community Medicine. 2015;**40**:1-4

[6] Social BC. Accountability: Medical Education's Boldest Challenge. MEDICC Review. 2008 Oct [cited 2016 Sep 12];**10**(4):52. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21483336

[7] Boelen C, Heck JE. Defining and measuring the social accountability of medical schools [Internet]. Geneva; 1995 [cited 2016 Sep 11]. Available from: http://apps.who.int/iris/bitstream/10665/59441/1/WHO_HRH_95.7.pdf

[8] Choulagi BP. Community-based education in the Institute of Medicine, Tribhuvan University, Nepal: a qualitative assessment. Advances in Medical Education and Practice. 2019;**2019**(10):469-478

[9] Murray RB, Larkins S, Russell H, Ewen S, Prideaux D. Medical schools as agents of change: socially accountable medical education. The Medical Journal of Australia. 2012 Jun 4 [cited 2016 Sep 11];**196**(10):653. Available from: https://www.mja.com.au/journal/2012/196/10/medical-schools-agents-change-socially-accountable-medical-education

[10] Elsanousi S, Elsanousi M, Khalafallah O, Habour A. Assessment of the Social ccountabilityof the faculty of medicine at University of Gezira, Sudan. Eastern Mediterranean Health Journal. 2016;**12**(4):258-266

[11] Garg BS, Nayar S. Doctors for Rural Poor. World Health Forum. 1996;**17**:268-270

[12] Bhagat VA. Kiran Clinic: Community Owned Primary Health Care - A Case Study. Indian Journal of Community & Family Medicine. Jul-Dec, 2017;**3**(02):61-64

[13] Kamble RU, Garg BS, Raut AV, Bharambe MS. Assessment of functioning of village health nutrition and sanitation committees in a District in Maharashtra. Indian Journal of Community Medicine. 2018;**43**:148-152

[14] Figueroa ME, Lawrence Kincaid D, Rani M, Lewis G. Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes. 420 Fifth Avenue, New York, New York 10018-2702: The Rockefeller Foundation; 2002. p. 7

[15] Kamble RU, Garg BS, Raut AV, Bharambe MS. Assessment of

involvement of Village Health Nutrition and Sanitation Committees (VHNSC) on Social determinants of health (SDH) in a District in Maharashtra. A Cross sectional study. Indian J Comm Health. 2019;**31**(3):401-406

[16] Garg BS. Village First-Community Empowerment on Health & Development Based on Gandhian Approach – An Experience of Working in few Villages of Wardha District, Maharashtra. The Indian Journal of Medical Research. January 2019;**149**(Supplement):63-67

[17] Abhay B. Faced with today's crisis, what would Gandhi do? Lancet, www.thelancet.com Published online June 18, 2020, doi: 10.1016/S0140-6736(20)31413-6

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