We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,900
Open access books available

186,000
International authors and editors

200M
Downloads

Our authors are among the

154
Countries delivered to

TOP 1%
most cited scientists

12.2%
Contributors from top 500 universities

WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com

Chapter

Community-Oriented Graduate Medical Education: A Gandhian Approach

Bishan Swarup Garg

Abstract

In the last century, there have been significant progress in the fields of health-care system and academics. The experience of implementing community-oriented medical education for more than last 5 decades at the 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 and community and to discharge our social responsibility. The institute has made several innovations in its academics and health care to raise the social consciousness of medical students as well as equip them to work in rural areas. We are sharing the innovations along with our experience of working in partnership with public health system and 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 the one hand, there have been rapid progress in 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 the rich and poor segments of the society and also poor access of health care to a 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, and they serve as well as to create a demand to provide a high-quality and cost-effective health system. Thus, the social responsiveness, social responsibility, and social accountability have posed a significant challenge to the 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 that 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 one of the

IntechOpen

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 and 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 self-rule, where villagers would be able to exercise authority/control on the happenings around them in the field of social, culture, education, health, agriculture, etc. Thus, it is clear that Gandhiji's "Swaraj" was to empower the village community in order to ensure that they have the control on the happenings around them. The Gandhian vision of ideal village or village Swaraj is that it is a complete republic, independent of its neighbors 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 the 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 the constantly evolving health systems and community in order to produce a medical graduate who has a sense of social responsibility. The big question is whether our medical institutes are prepared for this. Are they ready and willing to shoulder the responsibility so as to contribute to the development of a healthier society? [6].

The experts believe that incorporating this fundamental issue in the institute mission may be a stepping-stone toward ensuring that these medical institutes discharge their social accountability that is deeply nested at the MGIMS in all its activities related to health care, both at the institution level and at the community level. The medical students, both undergraduates and postgraduates (PGs), experience their social responsibility while working both at the institute level and the community level, 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 the 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 the health system performance and ultimately on people's health status, implying a quest for innovative practice modalities combining the 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 5 decades at the Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram. Our humble submission is that the attempt at the 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, and social accountability was conducted. Further, a qualitative methodology was adopted to draw inferences based on personal interaction and interviews and discussion with the faculty and supportive staff at the Mahatma Gandhi Institute of Medical Sciences, Sewagram, with the health-care providers, with the public health system, and with community members representing various community-based organizations (CBOs), local panchayat members, and with village-level health functionaries like accredited social health activists (ASHAs) and anganwadi workers (AWWs). Wherever required, available secondary information was also utilized. It also includes the personal experience of the author over the last 27 years at the MGIMS.

3. The institute

The Mahatma Gandhi Institute of Medical Sciences is India's first rural medical college. It is nestled in the karmbhoomi (workplace) of Mahatma Gandhi at Sewagram. The institute was stated in the Gandhi centenary year, 1969.

3.1 Vision and mission

The vision of the institute is to develop a replicable model of community-oriented medical education that 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 a high standard of medical education, research, and health care by adopting a holistic approach, integrating modern medicines with the traditional Indian system of medicine. The institute in committed to provide affordable health care to the marginalized and underserved community, especially the underprivileged segment of the society from the rural area.

3.2 History

When Mahatma Gandhi left the 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 the Aga Khan Palace, Sewagram was experiencing a number of epidemics. In this situation, Bapu had no use of the guesthouse 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 as "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 joined Mahatma Gandhi in the year 1939 as his personal physician and, in independent India, she joined as Union Health Minister with the then Prime Minister of India, Pandit Jawaharlal Nehru, in 1962. When Shri. Lal Bahadur Shastri, who had a rural background, became the 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, the Mahatma Gandhi Institute of Medical Sciences was started in 1969 in the Gandhi centenary year as an experimentation in the medical education to create a rural bias among 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 km away from Sewagram.

4. Innovations in community-oriented learning at Sevagram

Various innovations have been developed at the MGIMS to create social consciousness among the medical students (**Figure 1**).

Few important innovations are described in the following sections.

4.1 Orientation camp

At MGIMS, Students are admitted in an 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 the Gandhi Ashram (where Gandhiji lived from 1934 to 1946) to learn about a value system based on Gandhian ideology. The students

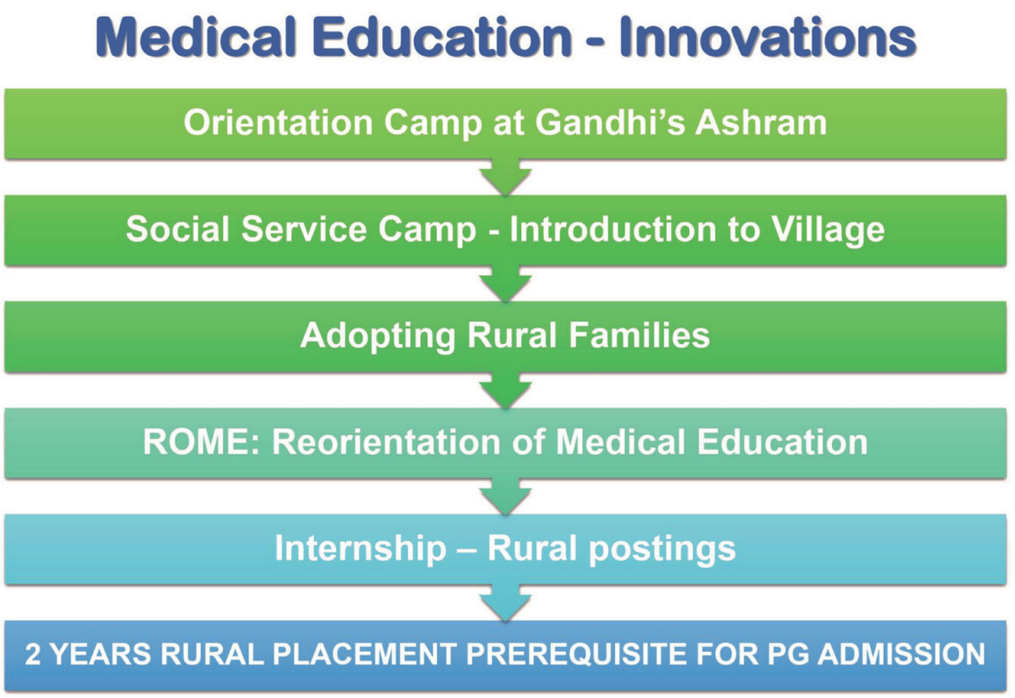

Figure 1.
Medical education—innovations.

during the orientation camp have to live in the Gandhi Ashram and have to follow all routines of the ashram, viz. participating in morning and evening all-religion prayers and participating in Sharamdan and community activities like spinning yarn which is popularly known as Khadi. The students are oriented toward value of dignity of labor (Sharamdan), religious tolerance, and simple living and high thinking. The students are also taught the relevance of Gandhian thoughts/philosophy in medical education with special context to personal hygiene, balanced diet and nutrition, and environmental health with the help of renowned Gandhians who are specially invited, and they share their experiences and interact with the students. The students are also exposed to the importance of yoga, meditation, and nature care as well as spiritual health, which was near and dear to Gandhiji.

During the camp, students are also provided an orientation toward the institute's code of conducts which are listed below:

1. Wearing Khadi (hand-woven) clothes

2. Eschewing nonvegetarian food, smoking, alcoholic drinks, and intoxicating drugs

3. Participation in all-religion prayer and Sharamdan

4. Nonobservance 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 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 settings.

4.2.2 The practice

The camp is organized as a 2-week residential camp during the first year of the MBBS course. Every year a new village is selected for organizing the camp. The criteria for the selection of the village include the following:

- **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 the 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 1500–2000, considering the number of 100 students.

- **Distance**: The distance of the village should be preferably less than 30 km from the 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 campsite during the camp. They are also expected to provide space for cooking the food and for dining. They should also provide space for the camp's activities and for arranging the 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 the MGIMS. However, the alternative arrangement for the school students' classes is made by the MGIMS in tents.

- **Water and electricity**: The villagers should be ready to make provision for water as well as electricity for the camp's 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's activities and extend their support during the camp.

So far, 51 villages have been covered. Each student is allotted 3–5 families consisting of 15–20 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 the faculty, postgraduate students, and the paramedical staff of the Department of Community Medicine (DCM).

The students visit the allotted families in the morning as well as in the evening to collect the information related to their socioeconomic status, environmental and housing conditions, dietary pattern, immunization status of the children, addictions, personal habits, 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 the facilities available in the village level. During the camp, the demonstration of the chlorination of wells, construction of soakage pits, 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, specialists provide their advice or treatment; if it is so required, the patient is referred to the 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, and 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 3 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 exercise related to maternal, newborn, and child health; growth and development; breast and complimentary feeding; antenatal and postnatal care (PNC); 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, and safe drinking water and develop IEC material on preventive measures. The role of the village-level health providers and Village Health Nutrition and Sanitation Committee (VHNSC) are also studied by the students [11].

4.2.4 Qualitative methods and participatory learning and action (PLA) techniques

The students are introduced to qualitative methods and PLA tools during the social service camp. They are explained about the qualitative techniques and are also demonstrated on 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 the 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 helps 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, that is, how to communicate with different age groups. During the camp's 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 an 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, assertiveness, etc. Group exercises during the field work and classroom teaching also help them to learn 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 the rural area such as simplicity, poverty, and illiteracy. They also observe the social and health problems of the villagers. This helps 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.

- **Understanding the role of the 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 adults, sick and injured, care of women in pregnancy and childbirth, and care of the aged and handicapped.

- **Management of patients with limited resources**: During camp, the students observe how the patients are treated at the village level and with limited resources.

- **Development of communication skills among the students**: Through interaction with the families and villagers and by 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 the essential national health research (ENHR) workshop.

- **Understanding health and health-related behavior by the villagers**: The reflection of the villagers in the 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 wastewater, garbage, and refuse. They are motivated to construct soak pits, sanitary latrines, smokeless chulah, etc.

    - Villagers realize the importance and practice of proper handwashing before cooking and before eating.

    - The health-seeking behavior 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 to care for 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 noncommunicable diseases, diet and nutrition, immunization, etc.

4.3 Reorientation of Medical Education camp (ROME camp)

The ROME camp is organized for students for 2 weeks, after the second professional examination. This time, students stay at one of the rural health and training centers of the MGIMS, Sewagram. The camp is organized with the following objectives:

1. To expose students to the organization and functioning of health-care delivery system and implementation of national health programs at the primary health center (PHC) level.

2. To make students understand the role of family and social environments in the disease causation and health-care-seeking practice.

3. To expose students to community health needs assessment methods.

During this camp, 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 program 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 the health program. Usually, the clinical case presentation for undergraduate students takes place in the premises of the hospital, but taking the advantage of ROME camp, community-based clinical case presentation at the family level is 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 sociocultural factors and established community practices in the village, which have a 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 and ways to handle certain issues related to allotted families in the adopted villages. Consequently, using the participative approach, we decided to introduce an exercise on essential national health research with the undergraduate medical students. Accordingly, a 2-day workshop on research methodology was organized to give an overview on research methodology. At the same time, the students in the group (3–5 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 a consensus about the priority health problem to be addressed. In the group, the students were taught how to convert the health problem to a researchable question followed by developing a research protocol including literature search, objective of research, and detail methodology, and then the students conducted research projects in the groups under the guidance of the faculty members of the Department of Community Medicine.

Initially, a few students were interested to conduct research in a hospital setup. However, they were motivated to take up the research topic in the field. The emphasis was given to undertake simple interventions which may sometime require

a behavioral change process so that the family members get full advantage of the research. It has been highly satisfying both for students and for the community. Thus, in true sense, a prototype of action research in the field has been developed for the undergraduate students, which has been refined during last 20 years, and the process of undertaking a research project is continuing in the adopted villages on a voluntary basis.

4.5 Internship in rural area

Interns are posted for 3 months at both the rural health and training center and the urban health training center out of their 12-month internship training program. The interns are exposed to primary health-care delivery and Kiran clinics so that they can sharpen their clinical competence with limited diagnostic facilities. They also interact with CBOs and VHNSC to appreciate their role in health promotion and disease prevention.

4.6 Community-oriented education to nursing graduates and postgraduate students

For last 8 years, we are providing rural orientation to the undergraduate and postgraduate nursing students on rotation basis at our rural health and training center, Anji and urban health center, Wardha.

During their posting at the Rural Health and Training Center (RHTC), they work very closely with the primary health center staff in the delivery of the RMNCH program. They also assist the PHC staff in conducting deliveries. They visit the rural community and interact with the CBOs and VHNSC. The faculty posted at the rural health and training center supervises their activities and conduct academic sessions in the afternoon. During the posting, they are also given a small project either in the school or in the community on priority health issues.

Similarly, during their posting at the urban health training center, they are allotted few families in the field. Under the 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 the outpatient department (OPD) of the center for clinical exposure in rotation.

4.7 Rural placement program for postgraduation admission

In 1994, the Mahatma Gandhi Institute of Medical Sciences, Sewagram, decided that those who desired to do a postgraduate program at the MGIMS will have to serve for 2 years at a designated rural site. At the MGIMS, we selected nearly about 100 rural sites that were managed mainly by nongovernmental organizations (NGOs) on a "No Profit No Loss" basis and were serving the marginalized community in the underserved rural area. We were able to identify these sites in every part of the country. The students are posted at these sites on a voluntary basis and while the doctors are working in the rural area, they are closely monitored by the faculty members of the MGIMS on a quarterly basis and sometimes the visits are paid to the NGO sites to ensure the proper utilization of manpower.

On successful completion of the 2-year program, the students were given admission to various PG programs. At the MGIMS, presently we have PG programs in all basic medical disciplines. However, the government has come out with the national entrance examination for admission to PG programs, 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 and community

In order to discharge the social responsibility of an academic institution, we have developed an interface between the Mahatma Gandhi Institute of Medical Sciences, Sewagram, and the district health system and community. This interface is being utilized to have an integrated approach in the health care and research program 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 centers, sub-centers, and community health centers in the field. The MGIMS plays an important role in the 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 during the social service camp and ROME camp. In the process, the institute has developed two rural health and training centers at Anji and Bhidi and an urban health training center at the Gandhi Memorial Leprosy Foundation, Wardha. These centers act as a bridge between the MGIMS and district health system in discharging social responsibilities of the MGIMS in providing health care to the marginalized rural population and promoting community-based research by the faculty members of the MGIMS, Sewagram. All clinical faculties of the MGIMS, Sewagram, are regularly visiting these centers on a periodic basis to extend specialist health care at the primary health centers. Consequently, the MGIMS has signed a memorandum of understanding with the district health system to manage two primary health centers at Anji and Talegaon in the rural area and two primary health centers in the city of Wardha in the urban area 2 years back, which has further strengthened the partnership.

6. Community mobilization

The DCM is involved in providing services to 100 villages in the 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 the CBOs. Over the years, two important CBOs have been promoted and they are described in the following sections.

6.1 Self-help groups (SHGs) 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 the National Agriculture Bank for Rural Development (NABARD). These groups are informal groups and do not require any formal registration, however, number has to be restricted to 20 members. In the initial years, we spent a considerable time using SHGs only for economic empowerment of women and to provide them relief from the moneylenders. These self-help groups collect token monthly subscriptions from the members and utilize the collected amount for internal lending. Once the groups have a certain amount of money, then banks provide them a formal linkage by which they are eligible for bank loans to undertake small income-generation activities. Over the years, these SHGs have been proved as a good example of microfinancing at the community level. Once these groups were

financially stabilized, we started introducing health agenda in their activities by providing them with relevant information in a phased manner. At present, the DCM has nearly 300 self-help groups in the field practice area and they are promoting health actions 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 do not have proper information related to menstrual hygiene and are 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 program. They have been oriented toward various adolescent health issues, maternal health, child survival, environmental health, and family life education as well as on reproductive tract infection (RTI)/sexually transmitted infection (STD)/human immunodeficiency virus (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 basis of activities of the Rashtriya Kishor Swastha Karyakram (national adolescent health program). At present, we are linking these community-based adolescent activities with the school-based adolescent health programs to ensure sustainability. Additionally, two adolescent health resource centers have been developed at our rural health and training centers at Anji and Bhidi, which act as reference centers for both the community-based and school-based adolescent health programs.

7. Community-owned health clinics (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 quantitative, qualitative, and participatory methods) in 60 villages, the findings emerged that the delivery of primary health care was available at the Primary Health Centre (PHC) or sub-center 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 the 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 toward the marginalized, poor, and vulnerable section of the society—women, children, and elders.

The Kiran clinics were started in selected villages under the Community-Led Initiative for Child Survival (CLICS) program in 2004 to meet the health needs as defined above. The precondition set by the 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 the 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 the distance, transport, and availability of services of the basic health-care facility.

Usually, services given under any research project will stop after the project ends. Kiran clinics have sustained through community ownership for a period of more than 15 years, which is a testimony to the simple but robust and transparent

management and reflects the "Value" the community gives to the clinics. One key learning is that the community does not really expect free health-care 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 the 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 vs. 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 a no-profit, no-loss basis to ensure affordability. Apart from organizing the 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 quality assurance (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, and screening for hypertension and diabetes and also provide support in the organization of the Village Health and Nutrition Day (VHND) 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 the functioning of the clinic, for example, 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 the demand of the community; for example, addition of new services like treatment of noncommunicable diseases and other health promotion activities.

Community dialog, voluntary participation, empowerment of people, and involving them in decision-making have been crucial for ensuring ownership. One member of the 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 (PRIs) 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 centers to empower the PRI and VHNSC members for health action at the community level. Due to its continuous engagement with the 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. National Health Mission (NHM) envisaged VHNSC to function adequately with the 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 (MCH), in partnership with local the 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 and sanitation committees (VHNSCs) in every village in a systematic manner.

The program uses the Integrated Model of Communication for Social Change (IMCFSC) to guide its BCC activities. IMCFSC uses an iterative process where "community dialog" and "collective action" work together to produce social change as shown in **Figure 2** [14]. The VHNSCs have been empowered for health planning, organization of Immunization Day, and 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 behavior.

Based on our experience of working with VHNSC, it can be inferred that most VHNSCs are moving in the right direction by addressing the social determinants

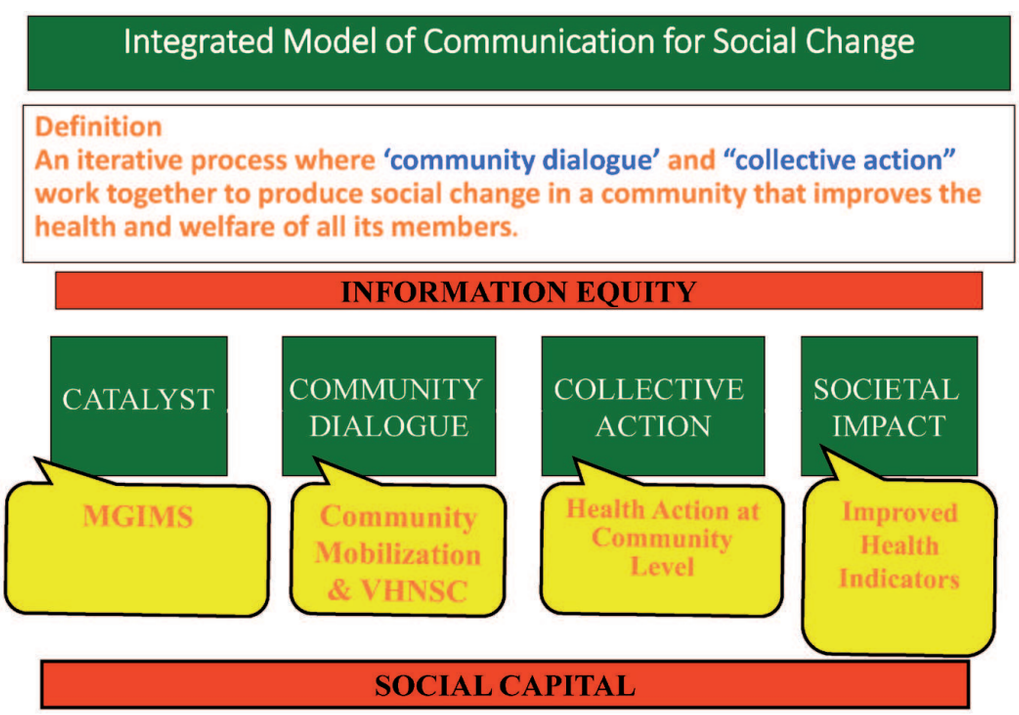

Figure 2.
Integrated model of communication for social change.

of health (SDGs) for which they have been empowered to recognize the social determinants of health being important in improving the health of the community as a whole; however, it requires 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, 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 need to play the role of catalyst to bring all the stakeholders (village-level committees, PRI members, health functionaries—ASHAs, AWWs, auxiliary nurse midwives (ANMs), MPWs, school students and teachers, NGOs, etc.) on one platform and make an integrated plan for the 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, and MGIMS, which requires further nurturing in a manner that all three stakeholders sustain their commitment. The MGIMS has been discharging its role to nurture and further develop this partnership in order to discharge its social responsibility in the short term and its social accountability in the 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

The author is thankful to all his colleagues in the Department of Community Medicine at the MGIMS, Sewagram, for their direct or indirect contribution.

Conflict of interest

The author declares no conflict of interest.

Acronyms and abbreviations

ANC	antenatal 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	outpatient department
PHCs	primary health centers
PLA	participatory learning and action
PNC	postnatal care
RHTC	Rural Health and Training Center
ROME	Reorientation of Medical Education
SDG	social determinants of health
SHGs	self-help groups
UHC	Urban Health Center
VHNSC	Village Health Nutrition and Sanitation Committee
VHND	Village Health and Nutrition Day
WHO	World Health Organization

Author details

Bishan Swarup Garg
Dr. Sushila Nayar School of Public Health, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha, Maharashtra, India

*Address all correspondence to: gargbs@gmail.com

IntechOpen

© 2020 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/3.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. CC BY

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. Available from: http://archive.carnegiefoundation.org/pdfs/elibrary/Carnegie_Flexner_Report.pdf [Accessed: 11 September 2016]

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

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

[4] Joshi D. Gandhiji on Villages. Mani Bhavan Gandhi Sangrahalaya Mumbai. Available 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;**10**(4):52

[7] Boelen C, Heck JE. Defining and Measuring the Social Accountability of Medical Schools. Geneva; 1995. Available from: http://apps.who.int/iris/bitstream/10665/59441/1/WHO_HRH_95.7.pdf [Accessed: 11 September 2016]

[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;**196**(10):653

[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. 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 Journal of Community 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. 2019;**149**(Supplement):63-67

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

IntechOpen

IntechOpen