

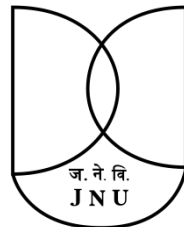
**UNDERSTANDING OF PRIMARY HEALTH CARE AMONG FACULTY OF  
COMMUNITY MEDICINE IN INDIA: A STUDY OF KNOWLEDGE, PERCEPTIONS  
AND PEDAGOGY**

*Thesis submitted to Jawaharlal Nehru University*

*for award of the degree of*

**DOCTOR OF PHILOSOPHY**

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Date: 31<sup>st</sup> December 2020

**DECLARATION**

I declare that the thesis entitled “Understanding Of Primary Health Care Among Faculty Of Community Medicine In India: A Study Of Knowledge, Perceptions And Pedagogy” submitted by me for the award of the degree of **Doctor of Philosophy** of Jawaharlal Nehru University is my own work. The thesis has not been submitted for any other degree of this University or any other university.



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**CERTIFICATE**

We recommend that this thesis be placed before the examiners for evaluation.



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And I thank the Almighty who gave me this task and made me complete it.

A handwritten signature in blue ink that reads "Mohit P. Gandhi". The signature is written in a cursive style with a horizontal line underneath the name.

Jaipur

Date: 31<sup>st</sup> December 2020

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Mohit P. Gandhi

*Dear nenamapamu,*

*Here's a small compensation for last six years...*

*...for everything that I should have done for you, but didn't.*

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# List of Abbreviations

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ANM	Auxilliary Nurse Midwife
ASHA	Accredited Social Health Activist
CM	Community Medicine
DoCH	Department of Community Health, St. John's Medical College, Bengaluru
DoCM	Department of Community Medicine
DoCM-SPH	Department of Community Medicine and School of Public Health, PGI Chandigarh
DoCM-TSI	Department of Community Medicine, The Second Institute
FGD	Focus Group Discussion
MBBS	Bachelor of Medicine and Bachelor of Surgery
MC	Medical College
MCH	Maternal and Child Health
MCI	Medical Council of India
MD	Doctor of Medicine
ME	Medical Education
MGIMS	Mahatma Gandhi Institute of Medical Sciences, Sevagram
MPH	Master in Public Health
NCD	Non-communicable Diseases
NGO	Non-governmental Organization
OPD	Out-patient Department
PG	Post-graduate/Post-graduation
PGI	Post-graduate Institute of Medical Education and Research, Chandigarh
PH	Public Health
PHC	Primary Health Care
PhD	Doctor of Philosophy
RHTC	Rural Health Training Centre
SNSPH-DoCM	Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sevagram
St. John's	St. John's Medical College, Bengaluru
TSI	The Second Institute
UG	Under-graduate/Under-graduation
UHTC	Urban Health Training Centre

# Introduction

---

*sarve bhavantu sukhinah sarve santu nirāmayāḥ |*

*sarve bhadrāṇi paśyantū mā kaścidduḥkhabhāg bhavet | |*

[An ancient Sanskrit *Shloka* that means: ‘May all be happy; May all be free from infirmities; May all see good; May none partake suffering’]

The concern for health of the people has been as old as humankind. One key event in the 20<sup>th</sup> Century, when the governments from across the world came together to share the concern for ‘Health for All’, was the Alma-Ata Conference held in 1978. The participants of the Conference declared Primary Health Care (PHC) as the strategy to attain this goal by the year 2000 AD. They defined PHC as ‘essential healthcare’ which is ‘based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination’. So, PHC was not a synonym for ‘essential healthcare’, but a specific approach towards it.

While PHC approach was lauded as a noble idea, a section of global health experts were concerned about its feasibility in the economic and health services context of those times. The poor state of economies of newly independent countries was used as an alibi to promote technological interventions targeted against a set of diseases and health conditions selected by the experts. Despite failure of a similar technology-intensive and vertically implemented approach for malaria control in 1950-60s, it was assumed that such selective interventions would work universally, irrespective of the context. This concern for ‘manageability’ was compounded by the concern for ‘efficiency’ expressed by international financial institutions in 1980-90s. And so the national governments were asked to cut-back expenditure on sectors like health and open-up to private providers. The adverse effects of such policies on the parameter of equity were soon visible, and the discourse once again shifted to comprehensive approaches in the first decade of 21<sup>st</sup> Century. However, the juggernaut of private sector and the underlying ideology brought-in what is known as

‘Universal Health Coverage’ which focuses on making medical care accessible and affordable to the end-user. Though, PHC approach is still considered relevant and desirable, as is evident from declaration of the Astana Conference held in 2018.

Health policies in India have reflected the abovementioned shifts in international discourse on health systems development. The country began with a comprehensive and integrated, though doctor-dominated, plan proposed by Bhole Committee in 1946 which led to establishment of a network of Primary Health Centres. However, due to inadequate budgetary allocations and a focus on tertiary-level institutions, the progress was slow. Vertical programs were instituted for disease control and for family planning which only got integrated in the decade of the 1970s. The first Health Policy (1983) was influenced by the Alma-Ata Declaration, and led to massive expansion in PHC infrastructure. The second policy (2001), in the backdrop of Health Sector Reforms, talked about introducing fee in government health facilities and piloting social health insurance schemes that later took the shape of *Rashtriya Swasthya Bima Yojana*. National Rural Health Mission (2005) brought new energy into the public health system by addressing issues cutting across programs, and by establishing mechanisms for community participation. The third policy (2017), in order to ensure Universal Health Coverage, proposes free primary care by public sector, and ‘strategic purchasing’ of secondary and tertiary care from public and private sector. This prescription has manifested in the form of *Ayushman Bharat*. While this may improve the utilization of medical services, it has marginalized the ethos of making communities self-reliant and self-determining, and of co-ordinating with other sectors for health.

As can be seen, the adoption of PHC approach has only been patchy (Labonté et al., 2014, Ramani et al. 2019). One of the foremost requirements for this, or any, approach, to influence the health systems is that the system actors understand and believe in the underlying concept. Doctors, being omnipresent in the system, need such moulding the most. And to ingrain this approach in their psyche, catching them young, when they are still in their formative years in the Medical College (MC) and yet to enter narrow specializations, provide a good window of opportunity.

Several policy documents have suggested reforms in Medical Education so as to align it with principles of PHC and produce doctors which are more relevant to the country’s context.

Bhore Committee (1946) proposed establishing Departments of Preventive and Social Medicine in each MC, and merged the curriculum of Diploma in Public Health with the undergraduate medical curriculum. Srivastava Committee (1975) formed the base for the Re-orientation of Medical Education (ROME) scheme that focused on giving rural orientation to the students and the faculty. All three National Health Policies (1983, 2001, 2017) have expressed concerns about urban orientation and specialization among the medical students, and have proposed remedies to change the scenario in favour of the underserved. The undergraduate curriculum proposed by the Medical Council of India mentions ability to 'recognize "health for all" as a national goal and health right of all citizens...' as its first objective. The minimum standard requirement prescribed for a MC makes it mandatory to have a rural and an urban health training centre to expose the students to the community.

However, the reality is what it is. While vacancies at Primary and Community Health Centres are a continuing concern, doctors who are in the system are found to be alienated from the communities and bring bio-medical bias in Public Health planning.

Orienting students in PHC is a shared responsibility of all the departments of the MC. However, the Departments of Community Medicine (DoCMs) were supposed to take a lead in this regard. To what extent they are able to do that depends, among other factors, on how the faculty of Community Medicine (CM) themselves understand this approach. That is what this study attempts to explore.

The thesis is organized into six chapters. Chapter 1 traces the changing contexts and approaches towards health systems designing and development from mid-20<sup>th</sup> century till present times. It has three broad sections. The first section explains the PHC approach as adopted at the Alma-Ata Conference in 1978. It starts with the context that made this conference possible in the first place, and goes in the details what PHC approach is, and more importantly, what it is not. The section then traces the political and economic developments that led to adoption of Selective PHC approaches and its extension under the rubric of Universal Health Coverage. The second section traces the reflection of PHC approach in the national health policy and planning in India, starting from Bhore Committee

(1946) till the latest National Health Policy (2017). The third section, similarly, traces the reflection of PHC approach in the country's policies regarding Medical Education.

The study uses a predominantly qualitative approach to explore the research question. Most of the data has been collected through in-depth face-to-face interviews with faculty at four departments of CM. The second chapter presents the conceptual framework and the different methods used in the study. All stages of research, from conceptualization to selection of research approach, from selection of institutes and respondents to the processes of data collection, compilation and analysis have been explained in detail. In addition, the Researcher's experiences and reflections have been included under each section. Towards the end of the chapter, a brief bio of the Researcher has been shared so as to make explicit the possible biases and limitations that he might have unconsciously brought into the research.

The Researcher spent a month each in DoCMs at PGI-Chandigarh, The Second Institute, MGIMS-Sevagram, and St. John's-Bengaluru. Chapter 3 describes these four DoCMs in terms of their historical development, their activities (teaching-training, service and research) and their interactions (with other departments in the MC, other CM departments, government health department, other government department and others).

The understanding of the faculty has been assessed across eleven themes. These include 'Understanding of Health', 'Community Participation', 'Intersectoral Coordination', 'AYUSH-Folk' and 'Private Sector' among others. The responses of the faculty to each theme were first free listed. Based on the Researcher's interpretation of 'Primary Health Care' from Alma-Ata Report and its subsequent analyses, the responses for each theme were arranged in an order. The responses found closest and farthest to the interpretation were taken as the two 'poles'. These polar responses were respectively assigned a score of 5 and 1. Other responses were assigned a score of 4, 3 or 2 depending on their quality with reference to the two poles. The fourth chapter presents the understanding of the faculty about PHC. The larger section of the chapter contains the qualitative analysis of faculty responses. The responses to each theme have been presented as five sets, numbered from 1 to 5. There is a smaller section in the end which presents a quantitative analysis of the scores assigned to the faculty on various themes. While the qualitative part gives an in-depth sense regarding

the variations in understanding of PHC at individual and department level, the quantitative part conveys the same in a nut shell.

The analysis shows an overall gap in the understanding of PHC among the given set of faculty. It also brings out variations in the understanding across departments, and even among the faculty of the same department. Chapter 5 details the factors and processes that shape this understanding and influence the extent to which the CM faculty are able to adopt PHC approach in their work. The factors and process are seen to be operating at three levels: structural, milieu and individual. Structural factors are those distal factors which may not be readily perceived, may be difficult to act upon but are real, omnipresent and powerful {like 'Structure of Medical Knowledge and Education' and 'Professional Character of (Community) Medicine'}. Milieu-level factors surround the individuals more proximally and are themselves shaped under the weight of the structural factors {like 'Understanding of the Discipline' and 'Pedagogy'}. Individual-level factors refer to the aspirations, motivations and experiences of individual faculty (including those during early life and those outside professional domain). These factors and processes are intricately linked, with each one interacting and influencing the rest.

The last chapter compiles the suggestions given by the faculty regarding how the students and faculty can be better oriented about comprehensive PHC approach. These apply at the level of Central and State Government, Directorate of Medical Education and of Health Services, the Regulatory Body, the MC and its various departments, the DoCM and at the level of individual faculty. Some of the suggestions are novel in the sense that they have not often been found in the literature. This includes the stress on increasing the focus Social Sciences and Humanities, and including faculty from other disciplines in DoCMs. However, many of the suggestions are not new and have been made countless number of times since 1950s. The fact that these have not been acted upon so far prompts one to think why. The Researcher asserts a lack of organized effort on the part of CM fraternity and a general aversion for 'politics' among doctors as the reason.

The CM fraternity, thus, needs to 'open-up' to better understand the PHC approach; it needs to 'get organized' to be able to reflect this approach in its work; and it needs to 'reach-out' so as to infuse the approach in the health system. To move beyond the hospital



and the disease-frame was the first leap. To move beyond the community and the conventional health frame is the second leap that needs to be taken now.

# Chapter 1: Primary Health Care and its Place in Policies on Health and Medical Education in India

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This chapter traces the changing contexts and approaches towards health systems designing and development from mid-20<sup>th</sup> century till present times. It has three broad sections. The first section explains the Primary Health Care (PHC) approach as adopted at the Alma-Ata Conference in 1978. It starts with the context that made this conference possible in the first place, and goes in the details of what PHC approach is, and more importantly, what it is not. The section then traces the political and economic developments that led to adoption of Selective PHC approach and its extension under the rubric of Universal Health Coverage. The second section traces the reflection of PHC approach in the national health policy and planning in India, starting from Bhore Committee (1946) till the latest National Health Policy (2017). The third section, similarly, traces the reflection of PHC approach in the country's policies regarding Medical Education (ME).

## I. The Primary Health Care Approach

### I.1 The Context of Alma Ata Conference

#### I.1.1 What was happening in the different countries of the World?

Post World War II, several countries, especially in Asia and Africa, got decolonized. Newly independent countries, naturally, wanted to focus on the most immediate needs of their people, including health (Venediktov 1998, Cueto 2004, Banerji 2008). The approach most of them adopted was of building referral hospitals and medical schools. These would be based in urban areas and would consume the majority share of health budget. For rural areas, rudimentary structures were created which focused on vertical programs supported by international agencies and donor organizations (Frenk et al. 1990, Bisht 2013). They also bore the push for population control programs from the developed countries (Chakravarthi 2008). This model did not give the results that the population of these countries had aspired for.

During the same time, many less developed countries realized that the root cause of their poverty trap was the prevalent Capitalist World Order (Navarro 1984). This led to several nationalist, anti-imperialist and leftist movements (Cueto 2004). The Cold War was going on between the Capitalist (United States of America) and Socialist (United Soviet Socialist Republic) ideology. Though, 2/3<sup>rd</sup> of the United Nations member countries, comprising of 55% of World's population, had decided to remain non-aligned (Banerji 2008). This scenario made the developed World to re-think their strategy in order to safeguard their position, and was the prelude to the call for 'New International Economic Order' (Navarro 1984).

Even in the developed world, inequities were on the rise. The hospital-based modern medical services were becoming unaffordable (Venediktov 1998). And, there was a 'crisis of faith' in medicine because the rising costs were not translating into meaningful improvements of health (Bisht 2013).

In parallel, some Asian, African and Latin American countries were developing alternative models of health systems with limited financial, technological and human resources that questioned the top-down vertical approach and the role of medical profession in health care provisioning (Tejada 2003, Bisht 2013). For instance, Cuba had extended existing doctor-led healthcare system to rural areas; China and Africa had developed non-medical grass-root level people into health agencies ('Barefoot Doctors') (Frenk et al. 1990, Cueto 2004, Chakravathi 2008). Such models came out of the socio-political contexts of these countries in those times.

### **I.1.2 What was happening in Non-Government Sector?**

Like some of the developing countries mentioned above, several non-government organizations were experimenting with smaller-scale models of low-cost, effective, comprehensive, context-specific healthcare in remote and underprivileged parts of the World. For instance, a project in Central Java promoted chicken and goat farming to increase the income of the poor; Chimaltenango project in Guatemala trained locally recommended people as community health promoters; a project in Jamkhed forayed into several issues of rural development (terrace farming, check dams, social forestry) together with health (Arole and Arole 1994, Litsios 2004).

In 1960s, the World Council of Churches realized the flaws in its focus on curative services: the hospitals were simply a 'factory for repair' where humans were reduced to bodies (Litsios 2004). Also, the cost of running hospitals was increasing. And so, in 1968, Christian Medical Commission (CMC) came into existence. CMC supported several community health projects, like the ones mentioned above. Leading WHO officials, including Halfdan Mahler, were close to CMC, and were influenced by its work (Cueto 2004). Moreover, a wide range of NGOs had joined forces to form NGO Committee on PHC that helped 'keep WHO on track' (Litsios 2004).

The decades of 1960s-70s were also the time for several social movements in, both, the developed and the developing Worlds: radical science movement, anti-war movement, women's health movements (Chakravathi 2008). Existing dogmas, and the authorities backing them, were questioned, and no taboo was left untouched (Navarro 2008).

### **I.1.3 What was happening in Academic Circles?**

A series of writing came out during this period that: questioned the dominance of biomedicine {Ivan Illich's 'Medical Nemesis: the Expropriation of Health' (1975)}; highlighted the role of other social factors {the Canadian Lalonde Report (1974); Thomas Mckeown's 'Modern Rise of Population' (1976)}; and challenged the specialist driven healthcare system by bringing to light the various ground level experiments happening around the world {John Byrant's 'Health and the Developing World' (1969), Kenneth Newell's 'Health by the People' (1975), Carl Taylor's 'Doctors for the Villages' (1976) and serial issues of CMC's *Contact*} (Cueto 2004; Litsios 2004). These publications criticized the assumption that western medical system would meet the needs of the common people in developing countries, and called for alternatives (Chakravarthi 2008; Navarro 2008).

### **I.1.4 What was happening in UN and WHO?**

In 1937, the League of Nations' Health Organization held a conference on Rural Hygiene in Bandung (Indonesia). Besides talking about 'intersectoral and interagency collaboration', 'health education and broader education reforms' and 'utilization of nonmedical health personnel', the conference also talked about 'rural reconstruction', 'land reform', 'honouring indigenous languages, cultures and traditions', 'populace's "free will" in adopting plans for "betterment", 'primacy of nutrition', 'recognition that some

technological innovations may actually encourage the spread of diseases such as malaria', 'insistence on government responsibility for providing direct treatment for the sick' and saw 'public health work as the "entering wedge" for economic development and self-governance' (Brown and Fee 2008).

After the World War II, the League of Nations' Health Organization gave way to World Health Organization (WHO). The latter strayed from the 'insights and principles' articulated by the former at the Bandung Conference and turned to 'technology-based approaches and vertical programs' (Brown and Fee 2008). It concurred with the approach of seeing 'scientific and technological assistance as instrument to resolve world poverty' (Chakravarthi 2008). It pushed universal technological solutions for all countries which did not allow grounded context-relevant solutions and systems to emerge (Priya 2018).

In 1960s, the failure of this 'silver bullets' approach became clear, most evidently in the field of malaria control (Tejada 2003, Cueto 2004, Banerji 2008, Chakravarthi 2008). It was realized that countries with different historical experiences can't be expected to respond to similar interventions in similar ways (Rifkin and Walt 1986), and that a basic health infrastructure was a necessary pre-requisite for the success of any program (Litsios 2004). This led to a shift in approach towards establishing Basic Health Services (Newell 1988, Cueto 2004, Yesudian n.d.).

In 1973, Halfdan Mahler who had worked extensively in third world countries on, not Malaria, but Tuberculosis, and for whom 'social justice' was a 'holy word', became the Director General of WHO (Cueto 2004). In the same year, WHO released 'Organizational Study on Methods of Promoting the Development of Basic Health Services' which highlighted the need to engage people in decisions regarding their health and health services. It suggested that the health sciences were responsible to describe possible interventions, their implications and cost, but not to choose (Newell 1988, Cueto 2004). This report was followed by WHO-UNICEF joint study on 'Alternative Approaches to Meeting Basic Health Services in Developing Countries' in 1975 which saw 'poverty, squalor and ignorance' as the root cause for disease and ill health and proposed principles like 'equity' (Newell 1988, Cueto 2004).

In parallel, UN General Assembly, in 1974, resolved to establish a New International Economic Order (Cueto 2004). Rifkin and Walt (1986) writes, 'The influence of the development debates which focused on the nature of poverty and the need to confront the necessity for structural changes and the interaction of all the UN agencies in attacking these problems brought added dimensions to the thinking of international health planners.' Subsequently, in 1976, the slogan of "Health for All" was given at the World Health Assembly (Cueto 2004, Chakravarthi 2008).

So, a gradual increase of forces of democratization among the masses of people in Third World countries and a dynamic leadership at WHO, besides several other factors, made the International Conference on Primary Health Care at Alma-Ata possible (Yesudian n.d.).

## **I.2 The Alma-Ata Conference**

In the year 1978, delegations from 134 governments and representatives of sixty-seven United Nations organizations, specialized agencies and non-governmental organizations signed a historic declaration on health at Alma-Ata (WHO-UNICEF 1978: 13). The declaration proposed PHC as the approach to achieve the goal of Health for All. PHC, as stated in the declaration, is 'essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination' (WHO-UNICEF 1978: 3). It called for a health system which undertakes, 'at least', the following at its primary level: (1) education concerning prevailing health problems and the methods of preventing and controlling them, (2) promotion of food supply and proper nutrition, (3) an adequate supply of safe water and basic sanitation, (4) maternal and child health care, including family planning, (5) immunization against the major infectious diseases, (6) prevention and control of locally endemic diseases, (7) appropriate treatment for common diseases and injuries, and (8) provision of essential drugs (WHO-UNICEF 1978: 4).

Narayan (2008) sees the declaration as a paradigm shift in WHO's approach towards health and healthcare from its earlier bio-medically driven disease control strategies implemented through vertical programs. Chan (2008) acknowledges that 'the Declaration broadened the

medical model to include social and economic factors'. Koivusalo and Baru (2008) assert that it has provided 'a basis for the mobilization of people's health movements that have been actively contesting the growing inequalities in health'.

### **I.3 What is Primary Health Care Approach?**

Meaning of the word 'primary', as per Merriam-Webster Dictionary, when used as an adjective, is: most important (like, 'economy was the *primary* focus of policy debate'); most basic or essential (like, 'security is a *primary* need'); or, happening or coming first (like, '*primary* stage of civilization', '*primary* school', '*primary* stage of a disease'). So, PHC is the first point of contact to the larger healthcare system. It takes care of the most basic and essential healthcare needs. It is the most important component of a healthcare system as it can take care of a large majority of health issues. Bitton et al. (2016) says 'Strong PHC is the foundation of efficient, equitable, and resilient health systems, and can address the majority of care needs for the majority of people, regardless of where they live'.

The philosophy of PHC goes much beyond the dictionary meanings, or any definition. It's an approach that considers 'protection of health as the most important basis for free development of human personality and as a guarantee of happiness and capacity for creative work' (Venediktov 1981). It positions health as a fundamental human right that governments must uphold for the present and future generations (WHO-UNICEF 1978; Venediktov 1998, Bisht 2013). It sees attainment of health as an issue of development in the spirit of social justice (WHO-UNICEF 1978: 3; Narayan 2008). Mahler (1981) says, "Health for All" means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it'. Mahler (1986) quotes a Minister of planning from a developing country in Africa as saying: 'For us, the strategy for Health for All through primary health care is not merely a health matter: it is an exciting new model for human development.' While considering it as a byproduct of overall development, the approach also sees health as an instrument for the same (Cueto 2004). So, PHC appreciates a two-way relationship between health and development.

PHC is not just a strategy for health service improvements. Going beyond the 'technical biomedical intervention paradigm', it is based on an understanding that improvements in a range of social, political and economic factors are required to ultimately influence the

health status (Rifkin and Walt 1986; Bhatia and Rifkin 2010). Health problems, like social problems, are 'complex and ill defined', and PHC acknowledges this nature of health issues (Tejada 1981). It recognizes attainment of health as a part of the struggle for a more egalitarian society (Singh and Singh 2004). PHC, thus, is a 'statement of values as much as a strategy for health care' (Bhatia and Rifkin 2010).

The PHC approach envisions a health system which caters to preventive, curative and rehabilitative ('comprehensive') needs of all ('universal') (Bisht 2013). It proposes distribution of health resources and provisioning of services based on the need rather than considerations like the ability to pay (Taylor 1981, Koivusalo and Baru 2008, Bisht 2013). 'Equity is one pillar on which PHC rests' (Rifkin and Walt 1986).

'Health is not merely a disease problem but a development problem' (Rifkin and Walt 1986). 'The health of the poor is largely the result of a combination of unemployment (and underemployment), poverty, a low level of education, poor housing, poor sanitation, malnutrition and lack of will and initiatives to make changes for the better' (Mahler 1981). The determinants of health can't be 'neatly separated from other social and economic determinants'. And so, the responsibility to achieve such 'health' can't be assigned solely to 'one bureaucratic-administrative sector of the state' (Tejada 2003). In fact, 'Action taken outside the health sector can have health effects much greater than those obtained within it' (Mahler 1981). Based on this understanding, the PHC approach calls for a coordinated effort across sectors which can, directly or indirectly, influence health instead of limiting to health sector alone (Taylor 1981, Tejada 1981, Venediktov 1981, Banerji 1990, Cueto 2004, Chan 2008, Narayan 2008, Bhatia and Rifkin 2010). Mahler (1986) says, 'People do not think in terms of sectors. They think of food as a means of nutrition and enjoyment, of water and sanitation as necessities of life, of cleanliness and access to health care as part of the quality of life. But to ensure the availability of all of these, other sectors in addition to the health sector have to play their part. That is the intersectoral aspect of primary health care'. Yesudian n.d. quotes a study done by Caldwell (1986) in two Nigerian villages which found a gain of 20% in life expectancy at birth when sole objective of health care was easy access to health facilities for illiterate mothers, 33% when it was education without health facilities, but 87% when it was both. So, inter-sectoral action also brings in the benefit of synergy. This principle later got enshrined in the phrase 'Health in all policies' (Labonte et al. 2014).



The PHC approach promotes technologies that empower people and not make them dependent (Priya 2013). It considers technology to be appropriate if it is relevant to the need of masses, and not just classes (Cueto 2004). The approach discourages overspecialization of health personnel and favors training of lay health personnel. It also advocates for inclusion of traditional healers and birth attendants in the healthcare system. Stressing on the role of communities in ensuring appropriateness of technology, Mahler (1986) says '(I)n all societies, having an informed public would make it easier to select health technology wisely, so that the technology used would be not only scientifically sound, but also acceptable to people as well as to those who apply it; by implication that means that it can be afforded too.' Newell (1988) adds, 'Any selection is essentially a value judgement. Only the society should have the right to make this choice. PHC offers this choice to its rightful recipients'. People's participation leads to demystification of medical technology, and this further increase their participation; that was what happened in case of oral rehydration solution (Mahler 1981).

The approach urges health systems to stop doing for people what they are capable of doing for themselves and making communities self-reliant (Taylor 1981). It stresses the same even at country level rather than only seeking technical assistance for some disease control programs from external experts (Venediktov 1998). Mahler (1981) says, 'The spirit of self-reliance - at the individual level, the family level, the community level, and the national level - will be fundamental to any strategy for achieving health for all. Self-reliance sets people free to develop their own destiny. It is the essence of primary health care'. Labonte et al. (2014) prefer the term 'self-determination' as it may not always be possible to be self-reliant in terms of financial and technical resources. But the ability and space to negotiate and decide should still be with the community and the country (Narayan 2008).

The PHC approach proposes a health system which is 'integrated' and not fragmented by programs and services. Taylor (1981), in the spirit of PHC, calls for moving away from narrow project-based approach. Tejada (1981) underscores the need for a constant interaction between different levels of health-care. This interaction includes two-way assisted referrals, but also includes technical and other forms of cooperation. Arole and Arole (1994) call 'integration', along with equity and empowerment, as central to a sustainable PHC movement.

The PHC approach advocates for taking health planning and health care services as close to people as possible instead of keeping these centralized and basing them in communities rather than only in institutions (Newell 1988). Mahler (1986) pushes for decentralization to district-level as districts are close enough to sense the ground, and large enough to have all levels of care. Frenk et al. (1990) add that decentralization has to be accompanied by enhancing the authority of people. In fact, they stress on the importance of 'knowledge, skills, values, status and authority'.

Community participation is another fundamental principle of PHC approach, and a lot has been said about it.

### **I.3.1 Community Participation and PHC**

The PHC approach calls communities and individuals to take responsibility for their health and to contribute labour and/or financial and other resources, to the extent possible (Priya 2018). At the same time, it also talks about empowering the community to participate at every stage of planning and implementation (Priya 2018). 'Primary health care starts with people and their health problems, and since they have a major role in solving these problems, they have to be actively involved in doing just that...It is that active involvement that most distinguishes primary health care from the kind of basic health services that were so much looked forward to in the past...' (Mahler 1986). Banerji (1984) seconds this when he says 'Primary health care is based on people, rather than on a predetermined system'. Chan (2008) says, 'With an emphasis on local ownership, primary health care honoured the resilience and ingenuity of the human spirit and made space for solutions created by communities, owned by them, and sustained by them.'

### **I.3.2 Why to involve communities?**

Communities have to be involved because 'Health is not a commodity that is given. It must be generated from within'; health action has to be, similarly, generated from within the community (Mahler 1981). Health priorities, and activities to address these priorities, have to be decided keeping in centre those who are to be served (Tejada 1981). 'Health for All is possible only if All are mobilised for Health'; and this essentially include the people themselves (Singh and Singh 2004).

When communities and individuals share the responsibility for their own health or contribute resources, it makes things more economical. But their involvement also makes things better as the solutions arrived in consultation are more practical and acceptable (AKF-WHO 1981), and sustainable (Arole and Arole 1994, Bhatia and Rifkin 2010). Bhutta et al. (2008) reports that community support groups affect household and family practices, care seeking and survival.

Community participation also leads to a demand for accountability (Yesudian n.d.). 'Active involvement of people raises their self-esteem, mobilizes their social energies and helps them to shape their own social and economic destiny' (Mahler 1986). An aware and organized community can remedy, no matter how alarming the situation may be (Singh and Singh 2004).

### **I.3.3 What is Community Participation?**

Yesudian n.d. shares four levels of community participation: 1) community utilizes the services of the provider, 2) community contributes resources, 3) community is consulted while planning services, and 4) community is involved at all stages of decision making. The PHC approach vouches for the fourth level. 'It emphasizes social control over health service development, namely problem identification, programme formulation, and programme implementation and evaluation' (Banerji 1984).

Often external agencies (individuals and organizations) go with preconceived notions about what are community's needs, and with ready-made solutions for these imagined needs. They interact with the community to convince them about these solutions so that they can be smoothly implemented. This may be done out of genuine concern for the people, or as a part of 'civilizing mission', or to satisfy vested interests. But, irrespective of the intentions of the external agency, this is not the form of community participation that PHC approach envisions (Mahler 1981, 1986).

The essence of community participation in PHC is to 'go to the people and learn from them' (AKF-WHO 1981). Mahler (1981) goes a step further and says that health action 'must be a response of *the community* to the problems that people in that community perceive, carried out in a way that is acceptable to them and properly supported by an adequate infrastructure' (emphasis added).

Bhatia and Rifkin (2010) differentiate between ‘community mobilization’ (having community people accept professionals’ assessment and activities for health improvements) and ‘community empowerment’ (transforming attitudes and behaviours that enable community/individuals take decisions about their own lives). Banerji (1981) says, ‘If health services have to become meaningful, they need to be subordinated to the communities’. Community Health Workers, as per this view, are community’s representative in the health system and not the other way round (Labonte et al. 2014).

### **I.3.4 How should Community Participation be attempted?**

The area of overlap between epidemiological needs and felt needs should be the initial focus of action (AKF-WHO 1981). If this overlap is satisfactorily handled, the size of overlap will increase over time on its own. In case the health service infrastructure is able to handle this increased overlap and is still left with more capacity, the tool of health education may be used to increase the size of overlap still further. At the same time, communities need to be empowered to hold their local healthcare system accountable, both for services and for the finances (Bhatia and Rifkin 2010). Patience and a continuous dialogue are needed to engage the communities. One can’t set a time-limit for community participation (Arole and Arole 1994).

### **I.3.5 What are the barriers to Community Participation?**

With reference to barriers to community participation, Yesudian n.d. cites the four fallacies enumerated in an analysis by Polgar (1963): Fallacy of the empty vessel (assuming that people have no prior perception about health and illness); Fallacy of the separate capsule (assuming that health is unconnected with other aspects of people’s lives); Fallacy of the single pyramid (assuming that communities are organized along a single hierarchical structure, and that engaging with ‘the one’ leader would be enough); and, Fallacy of interchangeable faces (assuming that all communities are similar).

AKF-WHO (1981) shares professional dominance, public apathy and political expediency as the three barriers to community participation. The professional tend to disregard opinions of those outside the profession (Bhatia and Rifkin 2010). Tejada (2003) see the root of this superiority complex in the narrow bio-medical understanding of health. This makes the professionals consider communities as passive recipient of their services. Even the

community sees participation in terms of co-operating and contributing resources rather than becoming aware of their strengths (Yesudian n.d.). And then, there are economic and political interests in making/keeping people dependent (Banerji 1981).

#### **I.4 What Primary Health Care Approach is not?**

PHC is 'a set of guiding values for health development, a set of principles for the organization of health services, and a range of approaches for addressing priority health needs and the fundamental determinants of health' (Chan 2008). However, 'The concept (of PHC) has been repeatedly misinterpreted and distorted. It has fallen victim to oversimplification and vogueishly facile interpretations' (Tejada 2003). Tejada (2003) shares, 'Repeatedly, while I was deputy director general of WHO, I was forced to keep a prudent silence when high-level officials from a given government would tell me with pride that they had a specific "office" or a "national program" for primary care, or that they had primary care activities only in the most peripheral health centres.'

Tarimo and Webster (1994) lists many such misinterpretations: a) PHC is only community-based health care, b) PHC is the first level of contact between individuals/communities and health system, c) PHC is only for poor people in developing countries who can't afford real doctors, d) PHC is a core set of health services – the 'eight elements', e) PHC is concerned with rural areas, simple, 'low-tech' ('primitive') interventions, and health workers with limited knowledge and training and is opposed to doctors, hospitals, and modern technology, and f) PHC is cheap.

While PHC keeps communities at its centre, it calls for far-reaching changes at all levels of health systems (including the highly specialized hospitals). It is not 'a mechanism to expand the existing disease-oriented, curative health services pre-decided by the providers', or 'a parallel system for rural areas and poor people which is 'independent' of the conventional and expensive system serving the urban elite' (Tejada 1981).

Though PHC encompasses the first level of contact, it is not just that (Frenk et al. 1990, Priya 2018). This sense of the word is an 'anachronism' (Tarimo and Webster 1994). After World War I, Lord Bertrand Dawson proposed to the British Government a 3-tier structure for health care services (primary, secondary and tertiary). 'He and the commission first identified primary care as the most basic level of a structured health system (akin to primary

or elementary education), concerned with caring for simple common problems in outpatient settings' (Bitton et al. 2016). 'This has been, until now, the prevailing concept of PHC in most developed countries' (Frenk et al. 1990).

Referring to the special eight paper series of Lancet titled 'Alma-Ata: Rebirth and Revision' published in 2008 on the occasion of 30 years of Alma-Ata conference, Bhatia and Rifkin (2010) say that the concept of 'primary care' is often used interchangeably with 'Primary Health Care' approach. Labonte et al. (2014) similarly shares a persisting confusion regarding whether PHC should be seen 'as a first point-of-contact for ill individuals with the formal health system in which integration across care levels is emphasized, or as the locus through which the health systems engage with communities and other sectors on broadly defined health concerns, including SDH'. Lewin et al. (2008) refer to these views as 'narrower views of primary health care, often (coming) from high-income settings'.

The report of WHO's Commission on Social Determinants of Health clarifies that PHC is 'not simply health services at the primary care level (though it is important), but rather a health system model that acts also on the underlying social, economic and political causes of poor health' (CSDH 2008, p33). Chan (2008) recalls that 'primary health care offered a way to organize the full range of health care, from households to hospitals, with prevention equally important as cure...' Frenk et al. (1990) urge that instead of viewing PHC as a particular level of care, and trying to sub-ordinate it, it has to be seen as a new paradigm of medical practice. The approach actually brings a unity of purpose across different levels of healthcare (Venediktov 1981).

The PHC approach arose out of the experience of a number of countries which were relatively poorer in the 1950s-70s, like China. But the rising demand for health care in view of the Non-communicable diseases and re-emerging of communicable diseases, and the high cost of healthcare, makes PHC principles like community empowerment, appropriate technology and intersectoral coordination applicable across the World. 'It provides a road map for developing health services for all the countries in the world, from the richest to the poorest' (Banerji 2008). Though, the level of sophistication of services provided at 'primary-level of care' may vary from country to country. The Alma-Ata Declaration did give a minimum range of essential health services that any health system ('at least') needs to

pursue. The number of such services could vary with time and across countries. While such a list of services is a part of the PHC approach, it is not *the* approach (Tarimo and Webster 1994).

The PHC approach is centrally and seriously concerned about equity. If outrageously high proportions of resources are allocated to urban hospitals where specialists provide high-technology treatment that benefits a minority of population, while cost-effective solutions for the common problems of the majority are left starving, PHC approach calls for redressing such 'imbalances'. It is not *per se* against any type of personnel, institution or technology (Tarimo and Webster 1994).

The root of this misunderstanding is related to the lack of clarity regarding the concept of 'health', and to 'our mental and behavioural conditioning to an obsolete world model that continues to confuse the concepts of health and integral care with curative medical treatment focused almost entirely on disease' (Tejada 2003). Mahler (1981) says, "Health for All" implies the removal of obstacles to health - that is to say, the elimination of malnutrition, ignorance, contaminated drinking-water, and unhygienic housing - quite as much as it does solution of purely medical problems such as a lack of doctors, hospital beds, drugs and vaccines'. While PHC approach stresses on the need to address other determinants of health, it also underscores the importance of ensuring medical care (Priya 2018). It recognizes the role of hospitals and other specialized referral and support services. For instance, research into issues like which radiotherapy in fact prolongs life, or to develop a simple test to predict which patients would benefit from intensive coronary care – these may appear to be bio-medical issues but are critical parts of PHC (AKF-WHO 1981).

PHC approach calls for 'appropriate' technology, which is different from 'primitive' technology (Frenk et al. 1990). Tejada (2003) traces the roots of this problem to the diverse and even contradictory meaning of the term 'primary'. It may mean 'primitive and uncivilized' or 'principal or first in order or degree'. 'As a result of the simplistic and biased perception of the experiences on which the concept was based<sup>1</sup>, it was easier, more comfortable and safer to accept the former meaning while the spirit of Alma-Ata clearly

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<sup>1</sup> Like the Barefoot Doctors of China

embraced the latter' (Tejada 2003). In fact, PHC approach expects health system to use this principle of 'appropriateness' at all levels: primary, secondary and tertiary (Priya 2018).

PHC approach is not 'cheap'. It talks about cost-effective solutions for all the genuine needs of the majority of population. While the per-capita investment may appear small, when multiplied with the number of people to be reached, the expenditure may in fact seem to be unaffordable for the governments.

In a nutshell, 'There is a fundamental difference between integral health care for everyone and by everyone - care that is multisectoral and multidisciplinary, health promoting and preventive, participatory and decentralized - *and* low-cost (and lower quality) curative treatment that is aimed at the poorest and most marginalized segments of the population and, what is worse, provided through programs that are parallel to the rest of the health-care system without the direct, active and effective participation of the population' (Tejada 2003).

PHC is not a technical solution which can be implemented in a bureaucratic programmatic mode. It is an approach that needs to become the default way of thinking and acting; that needs to become a culture; that needs to be embodied in the entire health care system.

## **I.5 Selective Primary Health Care**

According to Litsios (2002, quoted in Chakravarthi 2008) there was 'tension between advocates of a community-centred and a health-services-centred vision of PHC, which continued into and beyond the Alma-Ata'. The idea was not fully embraced by capitalist countries and there was an immediate backlash from medical establishments (Bisht 2013). Within a few months of Alma-Ata Declaration, the Rockefeller Foundation sponsored a small conference entitled 'Health and Population in Development'. It was attended by, among others, the then President of World Bank, administrator of United States Agency for International Development and Vice President of Ford Foundation. UNICEF was also one of the participating organizations (Cueto 2004). The conference was based on a published paper entitled 'Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries' (Walsh and Warren, 1979). This paper challenged the Alma-Ata's PHC approach (Yesudian n.d.).



### I.5.1 What is Selective Primary Health Care?

Walsh and Warren (1979) lauded the goals set by Alma-Ata Declaration, but considered them unattainable in view of the resource constraints faced by the poor countries. They suggested prioritizing ‘diseases’ for control as ‘not all ills can be attacked now’. They based prioritization on the prevalence, morbidity, mortality and feasibility of controlling the disease. So, the diseases which were highly prevalent in the population, were responsible for large morbidity and mortality and could be effectively prevented or treated by efficient interventions were to be selectively targeted. The authors found this vertically implemented selective disease control approach as ‘least wasteful’ and most promising. However, they stressed Selective PHC as an ‘interim’ strategy, till comprehensive care may be made available to all (Walsh and Warren 1979).

**Table 1: Difference between Selective and (Comprehensive) Primary Health Care as per Rifkin and Walt (1986)**

	<b>Selective PHC</b>	<b>(Comprehensive) PHC</b>
The difference in definition of ‘health’	‘absence of disease’; ‘(under) control of those trained to deal with disease’	‘physical, mental and social well being of the individual’; ‘removed “health” from the sole responsibility of the medical professional’
The importance of equity	‘success evaluated on the principle of effective disease control for the least amount of money’	‘One of the measures of success for achieving PHC is the equitable provision of healthcare to all people’
The need for a multi-sectoral approach to health problems	‘focuses on mobilizing health services’	‘include not only the management of health services but also the management of agriculture, schooling, irrigation and markets for produce’
The importance of Community Involvement	‘only significant in terms of getting large groups of people to accept the medical interventions the professionals have selected to use’	‘core to eventual community self-reliance’

Rifkin and Walt (1986) contrasts Selective PHC with Alma-Ata’s Comprehensive PHC saying that while the former focuses on ‘programme’, the latter focuses on ‘process’ (Table 1).

While PHC considers social justice as a requisite for health and believes in empowerment and social transformation, Selective PHC accepts the powerlessness of the weak and offers a 'safety net' through technology (Wisner 1988). While as per PHC, 'diseases in less-developed nations were socially and economically sustained and needed a political response', Selective PHC assumed that 'diseases in poor countries were a natural reality that needed adequate technological solutions' (Cueto 2004). Given the wide differences, Yesudian (n.d.) calls 'Selective PHC' as an oxymoron.

In 1980, James Grant, an economist and lawyer by training, became the Executive Director of UNICEF. Under his leadership, the organization started promoting low-cost interventions based on the Selective PHC approach. These included growth monitoring, oral rehydration, breast feeding and immunization (GOBI), to which food supplementation, family planning and female literacy were later added (FFF). Largely though, it was limited to immunization and oral rehydration (Cueto 2004).

### **1.5.2 What are the problems with Selective PHC?**

Selective PHC views each disease as distinct, with its own separate mix of epidemiological, ecological and social factors. Walsh and Warren (1979) listed 'malnutrition' as an issue of moderate priority because it was too complex to control. Acute Respiratory Infections (ARIs) were left out because they would require administration of antibiotics that non-medical practitioners were not allowed to do in many countries (Cueto 2004). By selectively targeting a few diseases, the prevalence, morbidity and mortality from those diseases may fall. But that still leaves the individuals vulnerable to host of other diseases/health conditions which are not targeted (Yesudian n.d.).

Secondly, it concentrates on initiatives aimed at only certain sections of the population (Yesudian n.d.). For instance, oral rehydration and immunization are largely meant for under-5 children. If the system does not also provide for the health of the adults, the child may still not get avenues for reasonable growth and development in the family. The various ills of children resulting from poverty, ignorance, disease, malnutrition and the breakdown of family life are inter-related (Rao 1967). 'A child's death is the ultimate consequence of a cumulative series of biological insults rather than the outcome of a single biological event' (Mosley and Chen 1984, quoted in Rifkin and Walt 1986).

Thirdly, the selective approach oversimplifies the relation between an intervention and its benefits (Frenk et al. 1990). Disease control is multi-factorial. Unless basics like nutrition and water are tackled, the epidemiological impact of selective interventions may be much less than estimated (Yesudian n.d.). They may act only as a 'band-aid' (Cueto 2004). But Selective PHC does not recognize contributions and cooperation by those outside the health profession (Rifkin and Walt 1986).

Fourthly, even selective interventions would require a strong and reliable implementation machinery, a strong general health system. '...powerful interventions and the money to purchase them will not buy better health outcomes in the absence of efficient systems for delivery' (Chan 2008). Challenges in implementing selective interventions in areas having a weak health system have been experienced in the past (Yesudian n.d.). On the contrary, a Selective PHC approach may divert attention and resources away from basic health and socio-economic development (Cueto 2004).

Fifthly, choosing Selective PHC for its promise of short-term success may endanger the slow and long process that leads to sustained improvements in people's lives and health (Rifkin and Walt 1986). Progress in disease-specific indicators may make the governments complacent, and they may forget about other issues that also need attention. Thus, the approach, which is presented as 'interim', tend to become permanent (Yesudian n.d.).

Lastly, while it may become necessary to prioritize or select to start the process, 'who' makes the selection is an important question. In Selective PHC, these decisions are made by 'experts' and not by the community for whom they are meant (Newell 1988, Frenk et al. 1990, Bisht 2013). This approach finds people's cultural habits complex and difficult to handle (Walsh and Warren 1979), without realizing that people living in abject social and economic conditions may simply not use the effective and efficient solutions (Rifkin and Walt 1986). It seeks community involvement only for better acceptance of pre-selected interventions which makes the communities more dependent instead of self-reliant (Werner 1995). Wisner (1988) calls this an 'instrumental' view of community involvement as opposed to 'transformative' view taken by Alma-Ata's PHC. Banerji (1984) considers this to be an 'authoritarian' and 'paternalistic' approach, Newell (1988) sees it as a form of 'health service feudalism', and Mahler (1986) calls it 'nothing short of misguided neo-colonialism'.

The critics in 1980s called Selective PHC as a strategy with short-term goals which was 'dangerously counter-productive', 'destructive', a 'counter revolution', and something that needed to be rejected (Banerji 1984, Newell 1988, Cueto 2004).

Even the originators of the idea, Julia Walsh and Kenneth S. Warren, accepted that technology, in isolation, can't be expected to succeed (Walsh 1988); and that it was an 'art' to make what appears to be possible, possible (Warren 1988). Rockefeller Foundation held another conference in 1985 titled 'Good Health at Low Cost' in which case studies from China, Cost Rica, Sri Lanka and Kerala were presented. 'In his summary in the conference proceedings Warren concludes that improvement in health status in those relatively poor countries had occurred over time, and had to be attributed to a complex mix of social policies guaranteeing adequate nutrition, widespread education and equitable delivery of health services within a political framework which allowed those policies (Rifkin and Walt 1986).

Still, Selective PHC was the approach that prevailed, thwarting the dream of a comprehensive PHC system. Selective interventions were projected as the 'leading edge' of Comprehensive PHC, something that would prepare the ground for more radical changes (Wisner 1988). That not only didn't happen, 'selectivism' {that is, 'prioritization of health based on largely "technical" (as opposed to social or democratically set) grounds'} became one of the themes for the reforms in 1990s and beyond (Green 2008).

### **I.5.3 What went in favour of Selective PHC?**

As against (Comprehensive) PHC, Selective PHC was projected as a cost-effective approach (Banerji 1984, Bisht 2013)<sup>2</sup>. It was also projected as a politically neutral approach when compared to (Comprehensive) PHC which would question the status quo (Newell 1988). Unlike (Comprehensive) PHC, it had a component of technology which was external to (not embedded in) the communities, like vaccines. It had short-term and tangible outputs in terms of reduction in prevalence, morbidity and mortality instead of the long-term and abstract ideals like self-reliance enshrined in Comprehensive PHC (Cueto 2004). It was to be implemented vertically as opposed to (Comprehensive) PHC which required the 'magic of integration' (Frenk et al. 1990).

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<sup>2</sup> The authors, however, inform that this claim was not based on sound evidence

This approach was pushed by the Physicians who saw (Comprehensive) PHC as ‘anti-intellectual’ and did not have trust in the capacities of communities and in the lesser qualified health volunteers (Cueto 2004). By doing so, they could retain their supremacy and resist reforms (Frenk et al. 1990). It was pushed by the industry which had stakes in the business of technology. It was pushed by the international donor agencies and financial institutions. And it was pushed by the new conservative neo-liberal regimens that were emerging in the main industrialized countries in that period<sup>3</sup> (Cueto 2004). Halfdan Mahler was left almost alone within WHO to forward the agenda of (Comprehensive) PHC (Cueto 2004). UNICEF, under James Grant, had already back-tracked and launched GOBI-FFF (Yesudian n.d.).

The demonstration models of PHC had been developed by NGOs working on a smaller scale led by charismatic leaders. On a national scale, evidence was more restricted (Bhatia and Rifkin 2010). On the other hand, the international success of Smallpox program was a moral boost for the Selective approach (Cueto 2004).

At the same time, economies of the low income countries were further hit by the Oil Crises of 1980s (Labonte et al. 2014). They not only had to cut expenditure on health, but also had to seek external funds for basic sustenance.

The balance of power was heavily tilted towards Selective PHC.

## **I.6 The Years of 1980s and 1990s**

### **I.6.1 Dominance of International Financial Institutions**

With the backdrop of global recession following the Oil Crises, the influence of International Monetary Fund and World Bank over national policies increased. In 1989, a standard package of economic reforms was drafted by these financial institutions and the United States Department of Treasury (‘Washington Consensus’). It advocated reduced government and called for privatization, liberalization, de-regulation (‘free-trade’) (Bisht 2013). Loans to developing countries were now coming with these conditionalities under the rubric of Structural Adjustment Programs (SAP). Besides other things, SAP called for a cut in social sector spending, and for adoption of ‘efficient’ mechanisms (Werner 1995).

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<sup>3</sup> Ronald Regan became the President of United States of America in 1981 (till 1989) and Margaret Thatcher became the Prime Minister of United Kingdom in 1979 (till 1990).

The prescriptions for health were given by the World Bank's World Development Report of 1993 (titled 'Investing in Health'). It proposed a three-pronged approach: a) foster an economic environment that enables households to improve their own health; b) redirect government spending on health to more cost-effective programs (i.e. shift from specialized tertiary care services to packages of public health interventions and essential clinical services at primary level); and c) promote greater diversity and competition in the financing and delivery of health services (World Bank, 1993). The 'Health Sector Reforms' (HSR) practically consisted of new health financing mechanisms, like user fee and health insurance; and new service delivery mechanisms, like contracting and Public-Private Partnerships (PPPs) (Green 2008, Labonte et al. 2014). They limited State's responsibility to 'essential' health care, thus, in-effect, leaving out secondary and tertiary care to market mechanisms (Bisht 2013). For Public Health (PH), they promoted prioritization of problems and selection of interventions based on Disability Adjusted Life Years (DALYs) which decontextualised the health problems and reinforced the hegemony of the international technocrats (Duggal 2001, Priya 2001). The reforms had scant regard for the role of other sectors in health (Bisht 2013).

The view of health as a 'means' of economic growth, rather than a worthy 'end' in itself, gained dominance (Narayan 2008, Bisht 2013). Support to low-income countries was now more prominently seen by the developed world as a 'self-interest' rather than a 'responsibility' (Bisht 2013). 'Equity' was forsaken for efficiency (Bhatia and Rifkin 2010).

### **I.6.2 Formation of International PPPs**

The emergence of HIV-AIDS and resurgence of TB and Malaria once again moved the focus away from broad based comprehensive measures to fighting the fire (Chan 2008). At international level, Global PPPs like the Global Fund for AIDS, TB and Malaria (GFATM) and Global Alliance for Vaccines and Immunization (GAVI) got formed. These partnerships (which had private multi-national corporations) became more significant policy actors than an inter-governmental organization like WHO (Green 2008). They reinforced vertical interventions instead of strengthening of health systems (Bhatia and Rifkin 2010, Labonte et al. 2014). The national governments, let alone communities, had little space for involvement (Green 2008).

### **I.6.3 A Conformist WHO**

In 1988, Mahler ended his term at WHO, and his successors could not fill the vacuum left by him (Cueto 2004, Green 2008). Echoing the sentiments of development banks, the World Health Report (1999) made a plea to recognize the limits of the State. It put forth the concept of 'new universalism' where everyone would be covered, but only for certain essential healthcare services prioritized on the basis of their cost-effectiveness and the economic realities of the country. The services would be provided by public as well as private providers, though nobody would have to pay at the time of using the service (WHO 1999). This was when, just an year before, a similar report mentioned that '(t)he quest for cost-containment and more efficiency...frequently take precedence over the health-for-all principles and values. Consequently, from the patient's point of view, often what is referred to as "reform" does not contain any element of improvement' (WHO, 1998). This was further reinforced by WHO's Commission on Macroeconomics and Health in 2001 which proposed: a 'Close-to-Client' system for delivery of specific interventions; and a mix of state and non-state health service providers (with financing guaranteed by the state), as it would promote competition (Sachs, 2001). Over the same period, rich private foundations got a formal entry in this inter-governmental organization.

In the year 2000, the year by which the comprehensive goal of 'Health for All' was to be attained and which couldn't happen, instead of prompting introspection and reinvigorating the call, 'Safe Blood Starts With Me' was kept as the theme of World Health Day! (Narayan 2008).

### **I.6.4 Millennium Development Goals**

In the year 2000, 189 countries endorsed the Millennium Declaration at the United Nations. The Declaration had set eight Millennium Development Goals (MDGs) to be achieved by the year 2015. These included: i) eradicate extreme poverty and hunger; ii) achieve universal primary education; iii) promote gender equality and empower women; iv) reduce child mortality; v) improve maternal health; vi) combat HIV/AIDS, malaria and other diseases; vii) ensure environmental sustainability; and viii) global partnership for development<sup>4</sup>. On ground, this only reinforced the vertical approaches for the 'killer' diseases, 'swinging the pendulum away from health system issues' (Green 2008, Bisht 2013). Bitton et al. (2016)

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<sup>4</sup> <https://www.un.org/millenniumgoals/>

writes, 'The Millennium Development Goals' vertical approach toward healthcare has, in many countries, created fragmented, inefficient, often parallel health systems focused on treating specific diseases rather than promoting holistic health and well-being'.

So, the disregard for the PHC approach worsened with the oil crisis, global recession and structural adjustments introduced by the development banks. These factors diminished the resources for social sector and thus made selective approaches the preferred option (Chan 2008). 'The key themes of Alma Ata were largely lost in this: equity seemed to be overtaken by pursuit of efficiency; the focus on health care structures left little space for consideration of the wider determinants of health; and while decentralization of health care governance was a common policy agenda item, participation of communities in decision-making was not seen as a key component of this (in economic parlance, it was a supply-side, rather than demand-side, driven agenda)' (Green 2008).

## **I.7 Beginning of 21st Century**

The HSR failed to bring substantial improvements in the health systems. On the contrary, they increased health inequities, reduced healthcare access (Lewin et al. 2008). Reappearance of communicable diseases once again proved the futility of standalone technological solutions. 'Primary health care increasingly looks like a smart way to get health development back on track' (Chan 2008).

Rise of non-communicable diseases (NCDs), whose risk factors were largely beyond the control of health sector, brought the need for inter-sectoral co-ordination back into focus (Chan 2008). Moreover, individual patients, their families and peripheral workers had a very important role in NCD management. This would require a decentralized healthcare delivery, building capacities of primary-level staff and empower members of the community. The physicians and non-physician clinicians would have to work as a team and the primary level would have to be linked with higher levels of care for information support and referrals. Thus, rising chronic diseases made yet another case for strengthening of PHC (Beaglehole et al. 2008).

In parallel, pressure was also being built by NGO coalitions and social movements. They came together and organized a People's Health Assembly in the year 2000 as an alternative to the annual World Health Assembly. The purpose was to highlight the neglect of 'Health



for All' goal by WHO, and to place this goal and Comprehensive PHC back on the global, national and local agenda (Narayan 2008). The assembly, constituted by the 1500 participants from 92 countries, adopted a People's Charter for Health. The Charter reclaimed health, and not just medical care, as a human right irrespective of the economic and political concerns. It demanded rights to: work, freedom of expression, political participation, religious choice, education, and freedom from violence - equally for all men and women. It criticized unsustainable exploitation of natural resources, profit maximizing behaviours and needless consumption by a few capitalists from a few countries. It urged the 'People of the World' to demand from governments, to promote, finance and provide comprehensive PHC, and to regulate the private medical sector (PHM 2000b)<sup>5</sup>. Three similar assemblies have been held since in years 2005, 2012, 2018. Besides, a Global Health Watch has been instituted as an alternative World Health Report.<sup>6</sup>

A Commission on Social Determinants of Health was set-up by WHO which, in its 2008 report, stated that 'Health Systems should be based on the PHC model, combining locally organized action on the social determinants of health as well as a strengthened primary level of care, and focusing at least as much on prevention and promotion as on treatment' (CSDH 2008). The commission gave following overarching recommendations: a) improve daily living conditions; b) tackle the inequitable distribution of power, money and resources; and c) measure and understand the problem and assess the impact of action. It was critical of 'reforms' which split the provisioning and purchasing, which prioritize cost-effective medical intervention over those that address social determinants, and which makes the private sector stronger.

In the same year, WHO released its World Health Report titled 'Primary Health Care - Now More Than Ever' (WHO 2008). It highlighted three worrisome trends in health systems development: disproportionate focus on specialized curative care, fragmentation of service delivery by vertical programs, and unregulated commercialization. The report recommended reforms in the domain of universal coverage, service delivery, public policy and leadership. The recommendations in the domain of universal coverage got selectively amplified as Universal Health Coverage (UHC).

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<sup>5</sup> phmovement.org

<sup>6</sup> ghwatch.org

## I.8 Universal Health Coverage

Mahler, in 1981, wrote, ‘We often refer to “coverage” by the health services, and with obvious pride, we say that such and such facility has been established in such and such an area where so many thousands of people live...The reality is that, of the people to whom the facility is said to be available, only the minority who live the closest to it actually use it. The majority are excluded’. The Alma-Ata document talked about ‘accessibility’, ‘affordability’ and ‘acceptability’ of health and health-related services, besides laying out several other principles for designing health systems (WHO-UNICEF 1978).

In 2008, WHO proposed ‘Universal Health Coverage’ in the name of PHC (WHO 2008). It gave three directions in which health systems need to move to achieve UHC: a) expand progressively to bring more and more people under health protection; b) expand the range of committed services (the ‘essential package’); and c) expand the proportion of expenses covered through pooling or pre-payment mechanism as against the out-of-pocket expenditure (WHO 2008).

As can be inferred, this concept of UHC is restricted to curative care. While curative care is a necessary ingredient for attainment of health, it is far from being sufficient. Social determinants, which were integral to and meshed with the concept of Health in the Alma-Ata Declaration, have been delegated a supplementary role in the UHC approach. This is detrimental to the comprehensiveness, and thus, universality, as espoused in PHC approach (Bisht 2013). By referring to an ‘essential package’, the approach harks back to Selective PHC. It isolates the health problems of the people from the context in which they live.

UHC largely focuses on ‘accessibility’ and ‘affordability’ of medical services which is evident from the way the Director General of WHO defined the theme of World Health Day 2018. The theme was ‘Universal Health Coverage: everyone, everywhere’, and he explained it as ‘ensuring people can get quality health service where and when they need them without suffering financial hardships’<sup>7</sup>. It promotes pre-pooling of resources through insurance so as to insure that people do not have to face problems at the time of, and after availing, medical services. The term ‘coverage’ is, thus, more about covering people with medical insurance and less about covering them with health care.

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<sup>7</sup> <https://www.youtube.com/watch?v=2u9qZ3waZbw>

It justifies multiple providers and calls for making the system plural. World health Report-2010 ('Health Systems Financing: Path to Universal Coverage') endorses a reduced role of State. It even criticizes earlier attempts at implementing PHC through 'government-funded and delivered services as a centralized top-down management' (Bisht 2013). While Selective PHC compromised on comprehensiveness, it 'still retained the possibility of state-run public health programs and equity for that set of interventions where cost-effectiveness was demonstrated' (Bisht 2013). By calling for a mix, UHC has made the medical care system more complex, both for the user and the administrator. Moreover, the profit maximization intent inherent to most of the private sector compromises equity and makes space for unethical and irrational practices. While there has been a lot of research on how to finance the costly modern medical care, little has been talked about why the costs are high in the first place (Priya 2018).

In 2015, seventeen Sustainable Development Goals (SDGs) were adopted by 193 UN member States for the next 15 years<sup>8</sup>. These are as follows: i) no poverty; ii) zero hunger; iii) good health and well being; iv) quality education; v) gender equality; vi) clean water and sanitation; vii) affordable and clean energy; viii) decent work and economic growth; ix) industry, innovation and infrastructure; x) reduced inequalities; xi) sustainable cities and communities; xii) responsible consumption and production; xiii) climate action; xiv) life below water; xv) life on land; xvi) peace, justice and strong institutions; and xvii) partnerships. The third goal ('good health and well being') has nine targets covering maternal and child health, communicable and non-communicable diseases, substance abuse and road traffic accidents, sexual and reproductive health and family planning and the illness and deaths due to pollution. The 8<sup>th</sup> target is to 'achieve Universal Health Coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and essential medicines and vaccines for all'. That shows how UHC is being viewed internationally.

Bisht (2013) writes, 'The Alma-Ata Declaration represented a great intellectual and moral leap forward for humankind...The current concept of universal health coverage has only a notional allusion to Alma-Ata'. But still, all this is happening in the name of PHC. As Narayan (2008) says, 'In neoliberal world, terminologies get co-opted'.

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<sup>8</sup> <https://www.un.org/sustainabledevelopment/development-agenda/>

## **I.9 Why did PHC fail to take roots?**

As has been explained in preceding sections, the change in global political and economic context has played a decisive role in promoting selective approaches and not letting Alma-Ata's PHC approach take roots. But apart from the context, there have been several critiques of the Alma-Ata document itself that are said to have limited its acceptance.

Shukla (2008) writes, 'Like great works of literature, the Alma Ata Declaration has more than one layer of meaning, and has been interpreted in different ways by different persons'. 'In its more radical version, primary health care was an adjunct to social revolution'; 'In its mildest version, primary health care was an addition to pre-existing medical services' (Cueto 2004). 'The approach was almost immediately misunderstood' (Chan 2008). These different meanings undermined the power of the concept (Cueto 2004).

Though the Declaration was a radical document in its times, it was after all a 'consensus document' among WHO's member States (Shukla 2008). Such documents are unable to criticize anyone. The report mentioned categories of power (the 'haves' and 'have nots'), but it did not question their power (Priya et al. 2019). It suggested changes in mind-set with regards to the level of care to be prioritized and type of technology to be preferred, but was silent on the super-structures that lead to specific mind-sets (Navarro 1984). It appealed to the powerful, by offering 'large untapped markets' for appropriate technology, rather than mobilizing the powerless (Navarro 1984, Shukla 2008). It gave remedies without naming the maladies (Shukla 2008).

PHC is an approach and not a program. Instead of understanding why existing strategies were failing, and why alternative thinking was needed, the participants at Alma-Ata jumped on finding solutions. They made to-do 'lists', when actually they were expected to understand and internalize the alternate approach (Newell 1988). Those who tried to understand were sympathetic to the arguments of social justice and equity, but still, they focused mainly on service provision (Bhatia and Rifkin 2010). Green (2008) identifies that while the principles of Alma-Ata declaration are universal, both in time and space, they are based on a particular set of values that are not universally shared.

Though the document detailed how different sectors could contribute towards Health, it still gave disproportionate emphasis on healthcare services (Navarro 1984). Even here, the

focus was on primary-level, and it only scantily mentioned the need for the secondary and tertiary-level to be realigned as per the principles of PHC (Priya 2018, Priya et al. 2019). The document viewed 'communities' as a single pyramidal structure and neglected the complexities within the communities (Cueto 2004, Priya et al. 2019).

Priya (2018) supplements these liberal-democratic and neo-liberal critiques with a 'politics of knowledge' perspective. She says that while Alma-Ata documents realized the importance of traditional practitioners, it saw them as a popular resource which could be trained in modern methods to help the community. The document did not recognize that these practitioners, and the community in general, also had a knowledge base that was contextual and could be a more appropriate alternative in addition to the modern solutions. 'Unless the knowledge and choices of lay people are valued, there is little possibility of "community participation", especially in decision-making, which is essential for "empowerment"' (Priya 2018).

When it came to implementation, 'It was not clear just after the Alma-Ata meeting how primary health care was going to be financed' (Cueto 2004). PHC had 'the utopian goal of "Health for All" and an unspecific methodology' (Cueto 2004). The lesson to be learnt is that 'a holistic approach, idealism, technical expertise, and finance should - must- go together' (Cueto 2004).

## **I.10 Is PHC relevant now?**

Green (2008) shares some of the unmet challenges to the health system: a) inequity remains endemic; b) health systems remain professionally dominated (minimal role of communities); and c) health (service) systems still struggle to look upstream towards the root causes of ill-health. Koivusalo and Baru (2008) add that rampant commercialization and health sector reforms have adversely affected the principles of equity and universality. So, there is a need to go back to Alma-Ata (Walley et al. 2008, Bisht 2013, Bitton et al. 2016).

While the Comprehensive and Selective PHC approaches were seen as 'irreconcilable' earlier (Rifkin and Walt 1986), a section of PH professionals now feel that this duality needs to be rejected (Bhatia and Rifkin 2010). However, 'achieving quality universal health coverage in a sustainable way will require moving beyond vertical programming toward

integrated health systems, in large part by prioritizing primary health care' (Bitton et al 2016).

In 2018, WHO and UNICEF organized a global conference on PHC with the theme 'From Alma-Ata towards Universal Health Coverage and Sustainable Development Goals' at Astana. Through the Declaration made at the conference, the member States committed to: a) making bold political choices for health across all sectors; b) building sustainable primary health care; c) empowering individuals and communities; and d) aligning stakeholder support to national policies, strategies and plans. The declaration called knowledge and capacity building, human resources for health, technology and financing as the drivers of success of PHC (WHO-UNICEF 2018).

The Alma-Ata Declaration has remained a reference point to hark back on, irrespective of the politico-economic context (Venediktov 1998). It remains a vital element of health systems activism in many low and middle income countries (Labonte et al. 2014). Major academic Journals run series of articles dedicated to the conference and the approach to mark anniversaries of the historical event that took place in 1978. Banerji (2008) calls it a 'ritual', because this discourse seldom leads to any policy change. For this to happen, Labonte et al. (2014) say that leadership and courage within government and civil society are needed. Navarro (2008) urges the poor across the world (not 'poor countries', because there is nothing like that) to form an alliance to make alternatives like Alma-Ata possible.

Alma-Ata's call for genuine PHC is a necessity 'not only for health but also for the future of countries that aspire to remain sovereign nation states in an increasingly unjust world' (Tejada 2003).

## **II. Primary Health Care and the Health Policies in India**

### **II.1 Pre-independence**

The health care system developed by British was for the military, European staff, their families, and to some extent, for the natives (Banerji 1973). Given the size of British population in India, and their healthcare demand, the British found it wiser to establish Medical Colleges (MCs) within India to train assistants for British Doctors. The concern for the healthcare needs of indigenous population increased a bit after the 1857 mutiny. Apart

from the Sanitary Commissions established in provinces, the little PH interventions taken were limited to port cities as a part of quarantine measures under International pressure that could have otherwise hampered movement of British troops and goods. Civilian's health was literally in private hands. The medical care service was through a few scattered philanthropic medical dispensaries and the so-called District Board Dispensaries; government hospitals were only at the district and sub-divisional level (Seal 1978). Majority of doctors were in private practice (73%) and in urban areas (70%); of these, 63% were licentiates (Priya 2018). Very little was available for rural areas except vaccination against smallpox (Seal 1966). The indigenous systems and folk medicines were not given any space, except briefly when integrated medical teaching was started in Calcutta. The indigenous practitioners formed associations, organized conferences, petitioned government and also adopted 'modern' forms of mass drug production and institutional structure for training (Priya 2018).

## **II.2 First two decades (1950s and 60s)**

### **II.2.1 Bhore Committee (1946)**

Health Survey and Development Committee, or, Bhore Committee (1946) laid the foundation for PHC in India more than 30 years before Alma Ata Conference (1978) (Yesudian n.d.). Its basic premises were public provisioning of free health services to all, and viewing health services as one among several other dimensions to be planned for (Priya 2018). The committee made the villager ('the tiller of the soil') as the chief beneficiary.

Bhore Committee gave a 3-tier structure for healthcare services within each district with a primary unit, a secondary unit and a district health unit. Each of these levels would have clinical staff (Doctors, Nurses, Pharmacists) and PH staff (PH Nurse, Midwives, Health Assistants, Sanitary Inspectors). In addition, the committee made provisions for Social Workers at all three levels of hospitals. There would be a District Health Organization responsible for the overall supervision of healthcare activities at various levels in the District. Whole-time salaried Doctors were to be employed in PH services who would combine curative and preventive functions. The committee also acknowledged doctors in private sector as a resource which could be used wherever necessary (Gol 1946).

The Committee recommended only the 'fully trained' doctors and called for banning the licentiates<sup>9</sup>. In order to meet the huge demand for doctors, the committee placed a target of producing 4,000 to 4,500 doctors per year. Medical Schools, that were so far offering Licentiate Courses, were to be converted to MCs; existing MCs were to be strengthened and their intake increased; and new MCs were to be opened. It recommended setting-up an All India Medical Institute to begin producing high quality teachers. Besides, around 200 carefully selected persons would be sent for overseas training to occupy teaching positions in the country (GoI 1946).

The committee advocated the training of dais as an interim measure until adequate number of midwives become available. The committee was largely convinced that Indian Systems of Medicine didn't fully address the contemporary health needs and were 'static'. It was left up to the provinces to decide on inclusion of these systems (GoI 1946).

### **II.2.2 Sokhey Committee (1948)**

The National Health Planning Committee was appointed in 1938 under the chairpersonship of Col. S S Sokhey, and it submitted its report in 1948 (NPC 1948). It acknowledged the simplicity of rural culture and advocated for utilizing local talent so as to facilitate penetration of relatively alien medical technologies in traditional Indian society. Given the limited training capacity in the face of huge requirement of medical personnel, the Committee opined that the organization would have to begin with partially trained people for simpler works. The base of proposed organization was the Health Worker (HW) who was to be a literate man/woman selected by the village for a population of 1000, and who will be progressively trained by the State. The Committee recommended establishing one MC in every District. Teaching faculty could be built with the help of experienced doctors already present in the district (including those practicing privately), and by sending additional ones from among those concentrated in the cities.

Keeping with the elitist and internationalist model of modernization of the first Prime Minister of India, as against the bottom-up Gandhian vision, the doctor-led model of PHC

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<sup>9</sup> The Bhore Committee followed the Goodenough Committee of UK in recommending abolishment of Licentiates. Though, it called for reserving seats in Medical Colleges for existing Licentiates to take an 18 to 24 months course and obtain the degree of MBBS.



recommended by the Bhore Committee was accepted (Banerji 2008, Priya 2018). While England started with Apothecaries, Russia with Feldshars and China with Bare Foot Doctors, India chose to go for the one and the only 'fully trained' doctor (Seal 1981).

However, even the 'irreducible minimum' budget asked by the Bhore Committee was not heeded to (Duggal 2001). And much of it was invested in building MCs in urban areas to train doctors while little was done to develop primary and secondary levels of care in the periphery (Duggal 2001, Priya 2018). Establishment of Primary Health Centres was made a part of the 'Community Development Program' with a target of having one Centre per development block (Duggal 2001). Given the socio-political pressures, other systems of knowledge got some token share in the health budget despite the silence of Bhore Committee (Priya 2018). Folk medicine, however, got further marginalized.

While the number of Allopathy doctors increased through this approach, the capacity of the system to absorb them was not built. As a result, they went into private sector. Over the years, this sector became an organized interest lobby that acquired power to influence policy. And this became the state of affairs much before the liberalization-privatization-globalization of 1990s (Priya 2018).

### **II.2.3 Mudaliar Committee (1961)**

The Health Survey and Planning Committee, or Mudaliar Committee was appointed in 1959 to review the progress made in the health system over the past decade (GoI 1961). While the Committee appreciated the idea of Primary Health Centres, it found these to be of little use without adequate resources as recommended by the Bhore Committee. So, instead of expanding the network further, it recommended strengthening of existing Centres. Further, the Committee opined that, with improved communication facilities in rural areas, a well provided district-level facility would be sufficient to cater to the needs of the entire district. Moreover, the committee proposed mobile medical units going from District/Taluk hospitals as an interim measure till resources become adequately available to establish the ideal Primary Health Centres.

The committee saw huge potential in the existing private sector (both health facilities and personnel) that could be purchased for public use. It urged that services of private practitioners should be availed 'wherever possible', on a part-time basis – in hospitals as

well as teaching institutes. And such services, even in times of epidemics, should be availed 'under conditions that are acceptable to them'. To institutionalize these ideas, the committee suggested an insurance model inspired by the one followed in United Kingdom and Scandinavian Countries (GoI 1961).

The Committee acknowledged that health human resource, except doctors, was not increasing. It also accepted that doctors were not going to rural areas. Even then, it insisted on expansion of ME (Duggal 2001).

### **II.3 The Decades of 1970s and 80s**

The hospital-centric urban-based healthcare model and the technology-intensive vertically implemented disease control programs had come under criticism internationally, and also in India (Yesudian n.d.). There were different uni-purpose workers moving in the same communities for different vertical programs. Kartar Singh committee was appointed in 1972 to look into this issue. It proposed a framework to integrate staffs from different programs and develop a single cadre of Multi-purpose Workers. The 5<sup>th</sup> Five Year Plan (1975-79) brought the Minimum Needs Program so as to increase accessibility of health services in rural areas, besides elementary education, rural water supply, rural roads, house-sites for landless, slum improvements, rural electrification etcetera (Duggal 2001, Deodhar 2003).

The country was also host to isolated community health experiments, like the one in Jamkhed. A doctor-couple went into an underserved part of Western India with a limited set of ideas, but with an open mind. Their main objectives were to reduce infant and maternal morbidity and mortality, to control chronic diseases like leprosy and TB and provide basic curative care. They started with the last objective through a base hospital and mobile clinics, but slowly, started organizing people in the form of farmers' clubs. With time a network of Village Health Workers and Women's Groups (*Mahila Vikas Mandals*) got established. These organizations forayed into sanitation (soak-pits), water supply (check-dams, bore-wells), agriculture (terrace farming), nutrition (community kitchens), social forestry, income generation (poultry, tents on rent) etcetera. In the process, caste and gender-based issues and questions like stigma associated with leprosy were also tackled. Not much of these activities or efforts were initiated by the project. They came from the people, and the project tried to facilitate wherever needed and to the extent possible. Even geographically,

the project expanded much beyond what was initially planned. It was because of the community which started 'seeing' the ill-health, insanitary conditions and social misery prevalent in other villages, and wanted to share the change that they had experienced (Arole and Arole 1994). Such efforts have been internationally acknowledged to have contributed to the understanding of PHC (Perry n.d.). Several such projects were presented at the National Symposium on Alternate Health Care Delivery System (1976) and at National Conference on Evaluation of PHC Programs (1980) organized by Indian Council of Medical Research (ICMR) (Deodhar 2003).

### **II.3.1 Srivastav Committee (1975)**

The report titled 'Health Services and Medical Education: A Program for Immediate Action', also known as the Srivastava Committee Report, was published by ICSSR in 1975 (MoHFW 1975). The Committee was of the opinion that without making a direct, sustained and vigorous attack on the problem of mass poverty, no program of health services could succeed. It stressed that 'development' meant development of humans, not of things. And for this, education and health should receive adequate resources.

The committee found the western model of health services not only unaffordable, but also inherently inappropriate for the country. It proposed that health education should form an essential part of all forms of formal and informal education. In addition, one must be helped to develop proper attitudes towards health, disease, pain, ageing and death.

The Committee was concerned that the health professionals failed to connect with the community, and were costly for the system. It saw no need to increase the number of MCs or medical seats. Instead, it proposed developing part-time semi-professional workers from within the community, and supplementing them with a professional staff within a well-knit referral network.

The Committee was worried that majority of resources were, so far, focused on urban areas and in tertiary hospitals. While it advised against increasing the number of Primary Health Centres, it recommended strengthening of existing centres by adding human and other resources. It proposed a supervisory cadre of Health Assistants. The committee was not in favour of posting fresh graduates at these Centres as they lacked experience. Instead they

may be posted at hospitals to relieve experienced doctors for short service at Primary Health Centres.

The Committee called for integration of isolated programs, including the Family Planning program. It also proposed setting up of a national health system by integrating the traditional and modern systems of medicine. The Committee urged for a comprehensive effort to deal with hunger and improve nutritional status of population (MoHFW 1975).

The Union government formed in 1977, post-Emergency, expressed concern about the inadequate allocations made in education and health sector. The then Health Minister positioned health something which people have to attain for themselves, and government has to support them in doing so (Narain 1978). In order to entrust 'people's health in people's hands', and based on the recommendations of Srivastava Committee, it introduced the cadre of Community Health Workers, encouraged training of *Dais* and promoted indigenous systems of medicine.

### **II.3.2 ICSSR-ICMR Report (1980)**

In 1980, a report titled 'Health For All: An Alternative Strategy', jointly prepared by Indian Council of Social Science Research (ICSSR) and ICMR, was released. It took a comprehensive view of health and craftfully integrated it with overall development. It saw development of health services as necessary, but not sufficient and claimed that good health and good societies go together. It deemed it necessary that the country re-dedicate itself to the task of creating a new social order based on equality, freedom, justice and dignity, and to eliminate poverty, inequality, ignorance and ill-health.

To achieve 'Health for All', the report advocated following three programs to be pursued side-by-side: integrated overall development; improvement in nutrition, environment and health education; and provision of adequate healthcare services for all, especially for poor and underprivileged. Integrated development, as per this report, would entail work guarantee at reasonable wages with equitable opportunities for women; improvement in the status of women which should show as improvement in sex-ratio; adult education with emphasis on health education and vocational skills; universal elementary education for all children (6-14 yrs); welfare of SC/ST; creation of democratic, decentralized and participatory

form of government; rural electrification and improved housing with provision of houses for landless and slum clearance.

It had a similar comprehensive view on other two programs as well. For instance, the report started its recommendation for improving the nutritional status of the population from the need to grow adequate food, reducing post-harvest losses, creating adequate system of storage and distribution and increasing the purchasing power of people through employment and food-for-work programs. Only then did it recommend special programs for specific nutritional deficiencies and supplementary feeding programs for carefully identified groups.

It called for an increase in the investment in health, and for prioritization of promotive and preventive activities in rural areas to improve nutrition, sanitation, water supply, education and healthcare services. It favoured developing capabilities for high-level indigenous research with a view to attain self-reliance. PHC, common diseases, environment and drugs should be priorities for research. To improve administration, the report called for delegation of responsibilities, authorities and resources from Centre and State to Local bodies at district level and below. The success of this approach, the report said, would depend on the capacity to create a mass movement by organizing the poor and underprivileged.

Highly influenced by Alma-Ata Declaration and ICSSR/ICMR Report, the 6<sup>th</sup> Five Year Plan (1981-85) gave priority to rural areas, talked about large-scale training of first-level health workers, recommended against expansion of curative facilities in urban areas and highlighted need for linkages between programs and sectors (Duggal 2001). It reduced population norms for Primary Health Centers (from 80,000-1,20,000 to 20,000-30,000) and Sub-centers (10,000 to 3,000-5,000) (Deodhar 2003). Though, it also opened-up for privatization in the name of efficiency and quality (Duggal 2001).

One of commitments at Alma-Ata Conference was that each Member State would frame a National Health Policy (Singh and Singh 2004). In 1981, Ministry of Health and Family Welfare, Government of India, constituted a 'Working Group on Health For All by 2000 AD' which accepted PHC approach as the strategy to be followed (MoHFW 1981). And in 1983, the first National Health Policy was framed.

### **II.3.3 National Health Policy (1983)**

The first National Health Policy (1983) was framed on the principles of PHC. It acknowledged that hospital-based, disease and cure oriented approach followed by the country so far had benefitted only the 'classes' living in urban areas and had deprived the rural and urban masses. This curative approach had also led to neglect of preventive, promotive, PH and rehabilitative aspects of health care. The policy committed to universal provision of comprehensive PHC through reorientation of health education and reorganization of healthcare services. It called for integration of all plans of health and human development with overall national socio-economic development process through co-ordination between sectors like agriculture and food production, water supply and sanitation, housing, education and social welfare, rural development etc. The policy was sensitive to call for organized effort to improve purchasing power of people so that they can get enough to eat, and imparting nutrition-related education so that they could better utilize locally available food products. It also proposed supplementary feeding programs for severely malnourished communities. The policy promoted self-reliance for production of drugs, diagnostics, vaccines, and bio-medical equipments.

However, with a view to save public resources, the policy proposed that government should encourage private medical professionals (in establishing their practice) and NGOs (in establishing curative centers). For similar considerations, the policy proposed that government should encourage private investments in specialty and super-specialty services. In order to mobilize additional resources and to ensure community shared the cost of services as per its ability to pay, it suggested States to design health insurance policies.

Massive expansion of PHC infrastructure took place during 6th and 7th Five Year Plans (1981-90). However, it remained underutilized because of lack of human resource, facilities, management and logistics (Duggal 2001).

### **II.4 The Decade of 1990s**

The Structural Adjustment Program and Health Sector Reforms were pushed by the Bretton Woods Institutions in 1980s and 90s in several countries of the world. This increased the pace of commercialization, privatization and corporatization of health care and worsened the disparity in access to health care (Priya 2018). Gill (1993), however, welcomed the

leadership role of World Bank in Health. Following the massive economic crisis, the 8<sup>th</sup> Five Year Plan (1992-97) shifted the focus from 'Health for All' to 'Health for the Underprivileged', and increased the emphasis on privatization (Duggal 2001). The 9<sup>th</sup> Five Year Plan suggested offering space at Primary and Community Health Centres to local qualified private practitioners for after office hours practice against a rent so as to tide over the difficulty of finding doctors for rural areas (Duggal 2001).

#### **II.4.1 National Health Policy (2002)**

The second National Health Policy (2002) was framed in the backdrop of SAP and HSR imposed on the country in the early 1990s. The policy acknowledged rural-urban and interstate inequities in terms of health indicators and infrastructure, and highlighted social inequities. It highlighted that fall in PH expenditure was leading to rise in out-of-pocket expenditure. It proposed an increase in Government's Healthcare expenditure to 2% of GDP, and focus on PHC services.

At the same time, the policy proposed user fee for certain secondary and tertiary services in public healthcare system for those who could pay. It also proposed to enhance the role of private sector in providing health services at all levels - primary, secondary and tertiary. 'In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category.' So, the policy proposed to pilot social health insurance scheme and encouraged setting of private health insurance. It even encouraged handing over of public service outlets at different levels for management by NGOs. The policy encouraged provision of medical tourism by extending fiscal incentives, including the status of 'deemed exports' to such services. The underlying intent was to earn revenue by capitalizing on the comparative cost advantage (Sengupta 2002).

For increasing flexibility, creativity and community participation in delivery of national programs, the policy proposed increased role of civil society and local self government institutions. So far, PHC was deemed appropriate for rural areas only. Urban areas were considered as a homogenous mass – an over-served elite absorbing far too much of national health budget (Yesudian n.d.). The policy proposed an organized two-tier urban primary care structure for urban areas. Though the policy criticized vertical programs as expensive, it

had no plans for their integration. It wished to be measured on the parameter of equity. However, its sole prescription for bringing equity was increasing the proportion of allocation for primary health sector.

## **II.5 Post the Year 2000**

The adverse impacts of SAP and HSRs were becoming evident and the international discourse was now shifting back to strengthening public systems. In India, two important events took place over the next decade. First was launch of National Rural Health Mission and second was setting of a High Level Expert Group on Universal Health Coverage. Both these initiatives involved civil society and health movement groups (Priya 2018).

### **II.5.1 NRHM**

In 2005, Government of India launched the National Rural Health Mission with an explicit aim to strengthen the general PH health system which would benefit all individual health programs (MoHFW 2005). It had five main approaches: institutionalized mechanisms for involving the community ('communitization'), flexible financing; improved management capacity; monitoring of progress against standards (like Indian Public Health Standards); and, human resource management.

The mission instituted formal mechanisms to involve communities. This included Village Health and Sanitation Committees (VHSCs), *Rogi Kalyan Samiti* (RKS) at Primary Health Centres and other Hospitals, and representation of civil society members in District, State Health Societies. It empowered the VHSCs and RKS by providing them with untied funds. It introduced the ASHA, who was to be a community health volunteer to be selected by the community which she had to serve. It made space for community in the annual planning process through the mechanisms of Village Health Action Plans that would progressively feed into Block, District and State Health Action Plans. The Mission also proposed mechanisms of community-based monitoring of health services and *Jan Sunavi/Samvad* so to maintain a community pressure on the health system.

In order to ensure equity between States, the Mission devised differential Centre-State share in financing its activities. At local levels, it stressed on proportionate representation from all hamlets and from disadvantaged categories in VHSCs. ASHAs would prioritize



hamlets inhabited by the vulnerable. Data for all programs would be generated in a way so as to enable monitoring of services to special categories.

For convergent action across sectors at local level, the Mission relied on VHSCs. Convergence was also envisaged in the Mission Steering Group and at State-level. At the level of the Ministry, a Departmental Committee on Convergence was to be formed. It committed to work with the Ministry of Education to make health promotion and preventive health an integral part of general education; and with the Ministry of Labour for occupational health.

It proposed an additional ANM at Sub-Centres, additional Staff Nurses at Primary Health Centres and CHCs and additional specialists at CHCs. For mainstreaming of AYUSH, the Mission created posts for such practitioners at Primary Health Centres and CHCs. The mission proposed skill up-gradation trainings to tide over the shortage of different categories of staff in the field and to improve the services (like Skilled Birth Attendant training and 6-months Anaesthesia course for Medical Officers). To encourage staff to join PH services and to retain them, the Mission proposed several human resource innovations like incentives and improved career progression. Besides, a cadre of management professionals was to be inducted in the system.

However, the Mission proposed 'risk pooling' through social health insurance to reduce out-of-pocket expenditure. Though, there was a realization that such systems would not be cost-effective in absence of a strong preventive health system and curative PH infrastructure. It promoted contractual appointments, thinking that new cadres would justify their needs over time prompting States to consider their regularization. It allowed the RKs to decide on the issue of charging user-fee, to generate local funds. While it proposed skill up-gradation for peripheral staff, it left little for the traditional birth attendants.

### **II.5.2 High Level Expert Group on UHC**

In 2011, High Level Expert Group instituted by the Planning Commission of India submitted its report on Universal Health Coverage for India (PCI 2011). The report defined UHC as 'Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative

and rehabilitative) as well as PH services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services'. It based its recommendations on ten principles which included non-exclusion and non-discrimination, protection of patients' rights and putting health in people's hands. Among its several recommendations, it called for increase in PH spending, especially on PHC services. It advised against using insurance companies or any other independent agents to purchase health care services on behalf of the government. Instead it recommended direct purchasing from contracted-in private networks providing integrated primary, secondary and tertiary care. It saw communities as not just recipients of care but as having the capacities to create and promote health, and its participation in health care as representing deepening of democracy.

### **II.5.3 National Health Policy (2017)**

The third National Health Policy (2017) was framed in the backdrop of a strong international push for Universal Health Coverage which was overwhelmingly concerned about access and affordability of medical care. The policy justified its need on four grounds: growing burden of non-communicable and some communicable diseases, growing incidences of catastrophic health expenditure, a rapidly growing healthcare industry and country's enhanced fiscal capacity. The policy states following as its goal: 'attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence'. Though, it largely focuses on health care services rather than on orienting other sectors towards health. The policy puts forth ten principles that includes professionalism, integrity and ethics; equity; affordability; universality; patient centred and quality of care; accountability; inclusive partnerships (including those with healthcare industry), pluralism (of medical systems); decentralization; dynamism and adaptiveness.

The policy calls for an increase in public spending on health to 2.5% of GDP. It proposes free primary care by public sector, and 'strategic purchasing' of secondary and tertiary care from public and private sector. It states that the order of preference for strategic purchasing would be public sector hospitals followed by not-for profit private sector and then

commercial private sector. It sees medical tourism as a form of resource mobilization for health sector (MoHFW 2017a).

While supporting a rights-based approach to healthcare, the policy expresses inability to commit to Health as a justiciable right because of conceptual complexities and operational inadequacies.

#### **II.5.4 Ayushman Bharat**

In 2018, the Government launched *Ayushman Bharat* which has two broad components: *Prime Minister's Jan Arogya Yojna* (PMJAY or National Health Protection Scheme) and Health and Wellness Centre. PMJAY extends an annual cover of INR 5 lakhs for accessing secondary and tertiary medical care services as per identified packages at empanelled public and private hospitals. The scheme covers 10 Crore families identified as poor and vulnerable as per Socio-Economic Caste Census. For PHC services, 1.5 lakh existing Sub-Centres and Primary Health Centres are to be up-graded to Health and Wellness Centres in terms of infrastructure, equipment and human resource. A new cadre of Community Health Officers will lead the HWCs and will ensure provision of 12 identified services including primary-level mental health, ENT, oral and palliative care (MoHFW 2018). However, the social determinants of health have still been kept at the fringes, and the capacity of households and communities has still been left unrecognized.

In a nutshell, Priya (2018) writes, 'the Indian State has viewed provision of Universal health care as its responsibility, but the model of Health Service Development it adopted created a "logic" such that the system veered towards provisioning by the private sector through a doctor and institution-centred system, to the detriment of the objectives of PHC (Primary Health Care).' No matter how much importance PH receives in words, if that does not translate in financial commitment, it remains an aspiration. Successive Five Year Plans kept the allocation for Health sector way below the requirement (Duggal 2001, Singh and Singh 2004). The CHV scheme launched in 1977 could not flourish after the change in Union Government three years later; though, this initiative was re-launched under NRHM. In early 90s, *Panchayati Raj Institutions* were given greater powers over primary-level health services. But due to lack of focus on capacity building of these institutions, this initiative did not yield desired results, especially in North India. NRHM brought the idea of community-

based monitoring, but it largely remained at the pilot stage (Priya 2018). All the three National Health Policies failed to confer to Health the status of a right.

In parallel, there has been a civil society that has resisted such trends through discourses and campaigns about strengthening of public services, accountability, rational and generic drug use, right to health care and generating evidence in support of the same. These have not been able to shape the direction of health service development, but have certainly acted as brakes to slow down the pace of commercialization (Priya 2018).

### **III. Primary Health Care and the Medical Education Policies in India**

One of the important requirements for bringing comprehensive PHC plans into practice is to make people, in general, believe in the underlying concept. Making the required resources available alone will not help unless the entire health system is re-oriented towards PHC (Tejada, 1981, Yesudian n.d.). AKF-WHO (1981) gave the corollary of a car factory. If you want to change the model of the car, you have to completely restructure the assembly lines. On priority, the functionaries who would run the system need to internalize the basic approach (Ramalingaswami and Shyam 1980, Seal 1981, Venediktov 1981, Choudhury 1986, Frenk et al. 1990). Doctors, who are at the top of the hierarchy, are organized and are close to the decision makers, need such moulding the most (AKF-WHO 1981, Yesudian n.d.).

Education is one of the most important tools to change, and sustain, the belief systems. In 1981, a conference on role of hospitals in PHC was organized jointly by Aga Khan Foundation and WHO (AKF-WHO 1981). Speaking at the conference, Mahler said, 'our movement for health for all will stand or fall with the success or failure of our efforts to prepare the future generations of health development workers for community oriented team-work in the spirit of the primary health care approach'. The conference traced back the reason why hospitals were not able to inculcate PHC approach in their trainings and services, and why state/national authorities were not able to go full-steam with PHC, to the failure of traditional ME to train and orient students in the concept of PHC. It found that the critical disjunction between the needs of a health service system and the medical training institutes made modern medical graduates unsuited for PHC. The conference found an

urgent need for MCs to be permeated with the challenging philosophy of PHC. It urged MCs, given the special status they enjoy in the society, to endorse and accept PHC approach.

In reference to the reluctance of medical graduates to work in rural areas, Seal (1981) opine that the solution has to be found in their training; 'It is too late after medical education has been completed according to a set pattern...' The same logic holds for understanding of PHC. Frenk et al. (1990) says, '...no reform can be sustained if it is not firmly rooted in a re-orientation of medical education where a change of paradigm is produced and reproduced'. What has come to be the 'fact of life' has been a result of formal and informal training and interactions over several years (Tejada 1981). If that has to be reversed, 'it is necessary to introduce fundamental changes in the way medical education is conceived and organized' (Frenk et al. 1990). 'The goal necessarily require(s) restructuring of medical education and health care delivery systems' (Kapur 1985).

Several committee reports have suggested reforms in ME so as to align it with principles of PHC and produce doctors which are more relevant to the country's context.

### **III.1 Bhore Committee (1946)**

Bhore Committee (GoI 1946) recommended linking MCs to multi-disciplinary Universities. It cites the Inter-Departmental Committee of Great Britain as saying, 'We are certain that it is as full participants in the life of Universities, having close associations with those following other branches of learning, that teachers of medical students will receive the strongest stimulus to give their best, and medical students will be encouraged to develop those qualities of mind and character that make a good doctor.'

Though the Committee left selection of students to the individual MCs, it said, 'any test which does not provide for assessing a candidate's personality, initiative, powers of observation and independent thinking, will have largely failed in its object.' It suggested that 1/3<sup>rd</sup> of admissions in any MC would be done by pure merit, and the remaining may be divided among different communities. And overall, a quarter to a third of the admissions should be reserved for women candidates. Moreover, it asked for reservation for students from provinces which were not in a position to open a MC in near future. In order to circumvent economic barriers for ME, the committee proposed not only free ME but also

stipend to the students who were willing to enter public service after completing the course.

The Committee was clear that the objective of professional education was to provide Doctors suitably trained to undertake the health work required for the masses. Thus, the training of the 'basic doctor' had to combine the curative and preventive components. The Committee saw three objectives of PH administration: maintenance of health, prevention of sickness and early diagnosis and cure of disease. It said that during ME, the responsibility to train students in these objectives lay with different departments. It expressed displeasure that despite pronouncements by the Medical Council of India (MCI), that students should be directed by their teachers to the importance of promotive and preventive measures, little had been achieved. The Committee recommended setting-up of Departments of Preventive and Social Medicine in every MC with facilities for teaching, research and field work (rural and urban) (GoI 1946, Vol II, page 357, point 11). The role of DoPSM was to demonstrate the utilization of the instructions received in other departments in the (rural and urban) community. It also called for merging of the content taught in Diploma in Public Health (DipPH) course with that of UG medical curriculum (GoI 1946, Vol II, page 383, point 84). Besides, the Committee called for setting of a hospital social service so as to organize the teaching of social medicine.

The Committee had a comprehensive view regarding health. It included factors ranging from nutrition to housing, from environment to working conditions in industries while conceptualizing health interventions. It proposed remedies like physical and health education in schools and PH engineering. But this comprehensive view was not adequately reflected in its prescription for ME.

Sokhey Committee (1948) proposed training on social and economic implication of medical science as an essential part of medical curriculum. It urged medical teachers to be 'fully alive to their social function' (NPC 1948).

### **III.2 Medical Education Conference (1955)**

A ME Conference was held under the auspices of the Ministry of Health, Government of India in 1955. It was resolved at the Conference that there should be a Department of Preventive and Social Medicine with full time staff in every MC (MoH 1955). Recognizing the

emphasis on curative principles and practices in the existing medical teaching, the Conference said that PSM 'should be so taught to the students...that its philosophy, with its emphasis on the preventive aspect of medical care, may become an integral part of their way of thinking...' (MoH 1955). The Conference acknowledged the innate spirit of idealism and social service with which students enter the MC. 'These altruistic impulses continue to survive and thrive under condition which facilitate contact with his fellow men, their physical and social environment and their daily life of joys and sorrow...'. It urged the DoPSM to preserve these ideals and develop them into an abiding force (MoH 1955).

The Conference resolved that teaching in PSM would start with first year and run through all years, including internship. In pre-clinical phase, student would be taught about Human Ecology, Biostatistics, Field Survey and would attend Clinical Conference. In clinical phase, Environmental Hygiene, Epidemiology ('the diagnostic discipline of Public Health') and Community Organization and Public Health Administration would be taught. The students would be oriented in various levels of prevention: prevention of complications and rehabilitation, prevention of mass spread by early treatment of source, prevention of disease by modification of human host and environment, and through health promotion. 'The idea of levels of prevention should become reflexive in their thinking' (MoH 1955).

Rural and urban health centre should be associated with the DoPSM. They form the 'laboratories' in which practical experience can be acquired by the student. Field Experience would be given through Family adviser or Family doctor plan with rural work projects, and through co-ordinated OPD services. Under the former, the student would visit his/her allotted family every week for 2 hours for 2-3 years. 'This can be considered his laboratory session...' The first responsibility of the student would be to establish friendly relations with all members of the family. S/he should try to be helpful to them in general, and should accompany them to health centre or hospital whenever required. Gradually, the student should go into other aspects of family life, discover the major health issues and try to remedy them. The Conference proposed training pairs of students as class specialists in various lines, like building smokeless *chullah* or soakage pits, and they would be called on when any family needed a specific help. Every week, students would share their experiences in the class. The Conference suggested that it would be possible to develop a specific sociological lesson from each family (MoH 1955). Within the MC campus, a co-ordinated

outpatient service would be developed in which students would be posted for one or two days every week. Accompanied by Medical Social Workers (MSWs), they would follow the patient to his home and would be helped to study the social environmental and other factors related to illness. Such a study would be followed by a seminar in which all the concerned departments would participate.

The teaching would essentially be integrated with that of other departments. 'An important part of the work of the department of PSM is to stimulate the teaching of all departments in this field. The preventive approach should not be separated from the totality of medical education'; 'The ultimate goal is for every teacher in the medical college to be a teacher of preventive and social medicine.' It also mandated personnel from DoPSM to routinely participate in clinical-pathological conferences. Besides giving the students a comprehensive picture and enabling them to get into the habit of thinking in terms of multiple causation, such conferences would also educate other members of faculty in preventive medicine.

Anticipating a fundamental problem, the Conference said, 'The Department of PSM should provide some service which other departments will respect.' This could be expertise in communicable disease, or parasitology, or social sciences, or biostatistics. 'In any event, there should be some specialised service which will make the department clinically respected if the desired result of bridging the present gap between preventive and curative medicine is going to be achieved.' This concern, regarding ensuring a status to PSM/CM departments at par with other clinical departments, has been frequently raised (Editorial 1958, Dasgupta 1958, Mahajan 1972).

Banerji (1973) summarizes the intended roles of DoPSMs as: a) giving a social perspectives to health problems and health practices in the country, b) interacting with teachers of other disciplines to provide a social dimension to their teaching, and c) knitting together concepts and methods of the conventional 'hygiene and public health' with those from other related medical disciplines to impart teaching of comprehensive health services.

A symposium on "Teaching of Preventive and Social Medicine in the Undergraduate Colleges of India" was held at the second Annual Conference of the Indian Public Health Association in 1958. That hygiene and sanitation were no more sufficient was asserted, and preventive and social aspects were projected as the 'modern trends' in medicine (Vishwanathan 1958).



The conference passed resolutions pertaining to training of teachers of PSM, development of practice fields for the UGs, inter-departmental collaborations and participation of the DoPSM and students in hospital OPD and home-care services.

### **III.3 Mudaliar Committee (1961)**

Mudaliar Committee (Gol 1961) found that medical training had failed to impart the rural-bias among medical students, and had made them over-reliant on mechanical means of diagnosis and treatment. Even if some of them did occupy a rural posting, they would just be waiting to shift to an urban posting. In parallel, the committee found a lack of orientation of Medical Officer and other staffs in PH methods, which affected the integrated design of healthcare delivery.

The Committee recommended norm of one MC for every 50 lakh population and set a target of one doctor per 3500 population. To address the shortage of doctors in rural areas, it proposed: a) compulsory, and rotatory, rural postings for doctors who wish to join Government services, b) commitment of specified years of rural services from undergraduate and post-graduate medical students at the time of admission, c) offering rural services to retired doctors, d) incentivizing rural services by offering reservation in selection for post-graduate studies, e) offering non-practice allowance or PH allowance. Enablers in the form of residential quarters were also recommended.

In order to address the shortage of doctors in rural areas, the 3<sup>rd</sup> Five Year Plan (1961-66) suggested a short-term course to prepare medical assistants, which was opposed by the Medical Council and Doctors (Duggal 2001).

Deodhar (2003) opines that lack of leadership and direction, mediocrity, lack of interest and support from the MC and State authorities have been chronic problems faced by DoPSMs. For instance, only 8 out of 43 MCs by 1958, and 18 out of 60 MCs by 1961, had established DoPSM (Editorial 1961). Even these departments suffered from shortage of HR, infrastructure (museums, field practice areas) and logistics. Elsewhere, part-time lecturers were continuing, and touching upon some elements of Hygiene. Such lecturers had no interest in reaching out to other departments and remained in a 'self-imposed' isolation (Vengsarkar 1958). While there were several discussions on PSM curriculum, there was none standardized from the side of MCI (Editorial 1961). As a result, one or two Universities

had done away with examination in PSM as, they felt, PSM related questions could be asked in question papers of other subjects (Editorial 1958b).<sup>10</sup> Some even felt that a separate department was not necessary as PSM topics could be taught by faculties of different departments, and that this would widen the divide between curative and preventive fields (Vine 1958). Till 1966, a State like West Bengal did not find it necessary to give PSM a full departmental status and had appointed only one professor for three MCs (Seal 1966). Niyogi (1973) raises similar issues.

### **III.4 Medical Education Committee Report (1969)**

The Committee expressed concerns about absolute shortage of qualified physicians in the country and a heavy urban skew in their distribution (GoI 1969). Many positions at Primary health Centres were vacant and those posted there were on a constant look-out for transfer to cities because of lack of basic amenities. In contrast, there were too many PG seats along with a handsome stipend which was fuelling the trend towards specialization. The Committee criticized continuing with the ME of developed countries<sup>11,12</sup> and called for contextualizing it to the needs of the country.

The Committee urged that curriculum should be designed with the aim of producing a basic doctor. The students must be trained in an environment as close as possible to that in which he would eventually be going to work. They should be thorough with diseases prevalent in the region and should be able to diagnose most of them clinically, without an elaborate lab set-up. They should be able to perform minor surgical procedures and undertake life-saving measures.

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<sup>10</sup> Vengsarkar (1958) opined that the idea of having an isolated examination for PSM denotes 'schizophrenia', given that the basic philosophy of the subject is to assimilate with the entire medical curriculum.

<sup>11</sup> Health care, as per western notions, is equal to medical care (Deodhar 2003). Those governments have ensured basic amenities (water, nutrition) and have built necessary safeguards (workplace safety, norms for pollution etc.). They can afford to have a restrictive meaning of the term.

<sup>12</sup> Frenk et al. (1990) writes, 'While in Western medical care, the physician acts in an independent and highly specialized fashion to address each patient's complaint, in the poor countries - it was argued - he or she should become more concerned with training and supervising health auxiliaries, designing cost-effective systems, and a practice mode limited to what can actually be provided to the population instead of being defined by the population's demands for care. The doctor should be motivated by a different set of moral norms, where the good of the community and the fair apportionment of existing resources is valued above the needs of the individual. Unfortunately, this "medicine of developing areas" failed to address how the new model of health care should be incorporated into existing medical systems.'

The Committee proposed that teachers of PSM should preferably have clinical experience. The teaching may be enriched by participation of General Practitioners in seminars and group discussions. It stressed on integrated teaching across departments and participation in Clinico-pathological conferences. 'To teach preventive aspects of disease in one department, and the clinical and curative aspects in another, does not alter the present-day outlook of the medical student, who doesn't attach much importance to preventive work, however long the course in PSM may be.'

The Committee proposed Internship at District Hospitals and rural health centres provided that it is adequately supervised by the facility in-charge as well as by the faculty. 'The intern...must not learn bad habits'.

The Committee, way back in 1969, discouraged Capitation Fee charged by private MCs. It suggested following measures to encourage doctors to go to rural areas: adequate non-practicing and rural allowance, residential accommodation and transport, compulsory rural postings for Medical Officers on rotation, preference in PG for those who serve in rural areas. It recommended posting to rural areas only after 1-2 years of service in a hospital, or under supervision of another MO.

The reports contains a note by the then DG-WHO, Dr. MC Candau. He urges the newly independent countries to free themselves from technical colonialism, and says, 'We must not delude ourselves that by concentrating our resources on obvious immediate needs we are necessarily doing the best thing for the country in the long run'.

### **III.5 Srivastava Committee (1975)**

The Committee expressed concerns about urban tertiary-care oriented ME which relied heavily on curative methods and sophisticated diagnostics tests with little emphasis on the preventive and promotional aspects of community health. It found the training irrelevant to the health needs of the community. It was critical of the trend towards specialization. 'Medical Education continues to postpone, rather than prepare, a doctor for the practice of medicine in the community' (MoHFW 1975). While there was lack of incentives and adequate recognition for work within rural communities, there were attractive opportunities for medical human resource in foreign countries.

The Committee acknowledged the reforms already suggested by others. For instance, the entire internship period should be spent at district/sub-divisional/taluka hospitals with occasional forays in community through Primary Health Centres; principles of educational science should find increasing application in teaching and training; and attitude for continued life-long learning has to be developed during UG ME. The Committee saw no need to increase number of MCs or medical seats. Such decisions should be based on a regular review of the health needs and available resources.

The Committee opined that setting-up DoPSM had not met with significant success as it lacked scholarly foundation, and field practice areas were not adequately prepared. Moreover, the department had not able to escape the stranglehold of inherited system of ME. It urged that DoPSMs would have to be broadened in concept and extended in operational aspects. They would have to be provided with rural and urban field practice areas. And teaching of community medicine needed to be a joint endeavor of all departments, not just of DoPSM.

The Committee said there were three ingredients for any educational change: content, structure and process. It opined that enough had been said about the content but little attention had been paid over the structure and process. It thus proposed a 'Medical and Health Education Commission', full with authority and resources, as the structure to bring about the needed change (MoHFW 1975).

Similar to the criticisms of Srivastava Committee, Banerji (1973) says that doctors who laid foundation of the DoPSM in the country had received their education and experience under colonial rule. For the colonial regime, and effectively for these 'Brown Englishmen', PH meant sanitation and hygiene for cantonments and civil-lines. Post-Independence, instead of building on the limited indigenous training capacity, they were sent to United States for advanced PH training on advice of 'international experts'.<sup>13</sup> As a result, they became even more disconnected to the local context. The distance from context was inherited, batch after batch, as an institutional legacy. The linkage between the department and the public

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<sup>13</sup> This strategy was, however, criticized even at that time for being temporary, expensive and de-contextualized (Editorial 1958a). Establishing AIHPPH-like institutes at Delhi, Bombay and Madras for PG training was suggested so as to prepare teaching cadre for DoPSMs (Editorial 1961). However, international experts suggested 'short cuts' (Allen 1958).

healthcare system was poor and facilities for field work were not adequately developed. As a result, students perceived the discipline as a set of concepts to be discussed but did not find it relevant in day-to-day practice (Panackle 1986). The faculties lacked first-hand ground-level experience (Lal 2004) which affected the quality of teaching, and research. Low monetary return was another factor that contributed to the unpopularity of PSM as a discipline.

### **III.5 Re-orientation of Medical Education (ROME) Scheme**

In the latter half of 1970s, a plan of action based on the recommendations of Srivastava Committee was adopted by the third joint meeting of Central Council of Health and Family Welfare and ratified by Conference of Deans and Principals of MCs in India. One of the mainstays of this plan was a scheme for Re-orientation of Medical Education (ROME). The objectives of the ROME scheme were a) to give rural orientation to the faculties, students and the interns, and b) to channelize the potential of MCs to improve health care services in rural areas (Panackle 1986). Each MC was expected to take administrative charge of three Primary Health Centers where medical students and interns would be posted. The students and interns were to accompany their faculties in conducting mobile health clinics in the villages falling in the area of the Primary Health Centre. In addition, the students were to collect baseline data of the area and actively participate in health promotion and specific protective activities. Faculties and interns were also to attend rotations at taluka/tehsil hospital, Sub-divisional and district hospitals. To a certain extent, the scheme did offer an opportunity to develop a comprehensive understanding of health as envisaged by PHC approach.

However, the ROME scheme was designed only around a few weeks out of the 5.5 years MBBS course. It didn't have any recommendations for rest of the course/curriculum. The scheme didn't have provision to first re-orient the urban-biased and cure-minded medical faculties before expecting them to re-orient the medical students. It was largely concerned about delivery of specialized medical and surgical services in rural areas through mobile teams of MCs, and there was no regard for the socio-economic conditions of the community. The scheme had little concern for the status of health service delivery at Primary Health Centres and other facilities where the students were supposed to work and learn. The scheme itself defied the basic principles of PHC. It didn't stress for co-ordination

between key stakeholders (for instance, MC faculties and the staff of Primary Health Centres). Non-cooperation from other departments of MC was also an issue (Panackle and Ramalingaswami 1990, Deodhar 2003). It prescribed inappropriate technologies like the giant Mobile Vans (the 'white elephants') which were not suited to Indian roads and were difficult to maintain. It didn't integrate preventive and promotive services with the curative services. It didn't provide for community participation; even the Community Health Volunteers were out of the design. Besides, there was lack of clear directives and oversight from the Medical Council of India, and monitoring of the scheme by directorates was limited to quarterly reports. And there were numerous operational issues like staff shortages and poor fund flow that marred the scheme. The lack of interest among faculties and students was, both, an outcome of and a contributor to the recipe that went sour (Panackle 1986).

### **III.6 ICSSR-ICMR Report (1980)**

The Report expressed concern that Medicine was dominated by technology, and doctors were inebriated with their notion of science. Most of them served in urban areas. ME was being imparted in teaching hospitals, and specialization was held in high regards. Moreover, there was little interaction between the ME system and the healthcare delivery system. The doctors produced by this system were of little use in view of the needs of the society.

The Report found re-orientation of ME as essential to create doctors who can work based on community needs. It proposed that candidates, who socially and culturally resemble the majority of population to be served, should be recruited as medical students. The curriculum should focus on common health conditions, and should develop skills required for routine community-level practice. The curriculum should include issues of management, personnel, accounts, medical audit etcetera, which will be essential for working. The students should be able to recognize their role in the health team, and also that of other members. They should identify themselves as one of the members of the team. The training should be delivered largely in PH facilities close to the level at which the candidate is going to work after completion of the course. ME should not alienate students from their own people.

Specialty and Super-specialty training should be open to candidates with prior work experiences. The branches and number of seats in such branches should be as per the needs

of healthcare system. The training should largely happen in PH facilities by recognizing the senior specialists/super-specialists working there as faculties.

All key positions in healthcare systems should be acquired by doctors holding PG in PH. PG in clinical branches may acquire these positions after a diploma in PH.

### **III.7 AIIHPH-ICMR Workshop (1980)**

A workshop on Utilization of Primary Health Centres for Training of Medical Students in Community Medicine was jointly organized by All India Institute of Hygiene and Public Health and Indian Council of Medical Research in 1980 (AIIHPH 1980). The participants found the proposition very desirable as it would prepare the students for their future job and would also involve MCs in delivery of PHC services in the district.

The participants recommended that management of such Primary Health Centres should be transferred from District Administration to the Dean/Principal of the MC along with proportionate supervisory and clerical staff. The planning, implementation and evaluation of the programs should be done by a committee headed by Dean. Heads of concerned departments and PH Officials (District/State) would be the members, and HoD-PSM should be the member-secretary of this committee. Modest accommodation should be provided for students, residential staff and visiting faculty at these Centres. A teaching block consisting of classroom/seminar room, library and a meeting hall should be present. Such Centres should be given additional staff, especially for the hostels (cook, sweeper, *chowkidar*). Even DoPSMs should get additional staff over the existing MCI norms. All positions in various MC departments should get filled. Two mini-buses (15-seater) and two covered jeeps (all diesel-operated), should be provided along with adequate POL. Similarly, mobile vans should be provided at the concerned Primary Health Centres.

The participants recommended that teachers from all disciplines should be involved in training, services, planning and problem-solving at these Primary Health Centres or rural units. All activities happening at the Centre, its Sub-centres, and in community should be utilized in training of medical students and interns. One PSM faculty should continuously stay at the PHC with the students. Faculty from other departments should also stay, for shorter duration though. All concerned health officers at local, district, regional and state levels should be involved in teaching community medicine to UG medical students. In order

to strengthen the referral system, specialists from MCs should regularly visit intermediate level hospitals (DH/CHC). Students should also be trained at these levels.

In the year 1988, the Conference of the World Federation of Medical Education adopted what came to known as 'Edinburgh Declaration' (WFME 1989). In order to reorient ME towards the goal of 'Health for All', it urged MCs to: a) enlarge the range of settings in which educational programs are conducted, to include all health resources of the community, not hospitals alone; b) ensure continuity of learning throughout life by shifting emphasis from the didactic methods so widespread now to self-directed and independent study as well as tutorial methods; c) build both curriculum and examination systems to ensure the achievement of professional competence and social values, not merely the retention and recall of information; d) ensure that curriculum content reflects national health priorities and the availability of affordable resources; e) train teachers as educators, not content experts alone, and reward excellence in this field as fully as excellence in biomedical research or clinical practice; f) complement instruction about the management of patients with increased emphasis about promotion of health and prevention of disease; g) integrate education in science and education in practice using problem solving in clinical and community settings as a base for learning; and, h) in the selection of medical students, employ methods that go beyond intellectual ability and academic achievement, to include measures of personal qualities. The declaration also mentioned other improvements that would require wider involvement: a) encourage and facilitate co-operation between the Ministries of Health, Ministries of Education, community health services and other relevant bodies in joint policy development, programme planning, implementation and review; b) ensure admission policies that match the numbers of students trained with national needs for doctors; and c) increase the opportunity for joint learning, research and service with other health and health related professions. The declaration was subsequently endorsed by the 42<sup>nd</sup> World Health Assembly.

A 'Regional Conference on Public Health in South East Asia in 21<sup>st</sup> Century' was held in the year 1999 (Deodhar 2003). It came out with what is called 'Calcutta Declaration' which urged that PH should also address issues related to poverty, equity, ethics, quality, social justice, environment, community development and globalization; has to involve communities, and increase the allocations of human and financial resources. At the same



time, PH needs to be strengthened by creating career structure and establish policies to mandate competent background and relevant expertise for persons responsible for health, and by reforming PH education, training and research. Following this, Indian Public Health Association, Indian Association of Epidemiologists and Indian Society of Malaria and other Communicable Diseases, in their joint conference in the year 2000, came up with what is called 'Agra Resolution'. It called for establishment of Indian Public Health Services, making PH qualification and experience mandatory for all PH positions, and developing a network of training & research institutions (Deodhar 2003).

### **III.8 Medical Education in National Health Policies**

The first NHP (1983) acknowledged a cultural gap between the providers and receivers of healthcare and called for a separate Medical and Health Education Policy so as to produce human resource which is more relevant to the country's context in terms of quantity, distribution and orientation. However, 7th Five Year Plan (1986-90) pushed for specialization and super-specialization (Duggal 2001).

The second NHP (2002) expressed need for reforms in ME so that graduates join peripheral services with adequate skill sets. It proposed a progressive increase in share of PG seats for PH and for Family Medicine. The policy also opened specialization in PH to non-medical graduates from allied field. On the issue of shortage of doctors in rural areas, the policy proposed the States to appoint licenciates or Indian System of Medicine (ISM) practitioners; to transfer skills to para-medics; and to simplify procedure for recruitment of doctors. At the same time, it asked the States to consider making two-year rural posting mandatory before awarding of the graduate degree.

NRHM (2005) recognized that the curriculum gives undue emphasis on tertiary care and specialization which strengthens the urban bias of medical students and fails to orient them to the needs of rural areas. It calls for re-orientation of ME so that doctors are geared to rural needs. It also calls for compulsory and incentivised rural service, and HR measures to retain doctors in PH services.

The latest NHP (2017) recognizes the need to revise the under graduate and post graduate medical curriculum keeping in view the changing needs, technology and the newer emerging disease trends (MoHFW 2017a). In order to attract and retain doctors in remote

areas, it proposes to give preference to students from under-served areas; establishing MCs in rural areas; realigning pedagogy and curriculum to suit rural health needs; mandatory rural postings dovetailed with clear and transparent career progression; financial and non-financial incentives etcetera.

Mahler (1981) asks a few searching questions in reference to PHC and ME. 'Do graduates think and behave in terms of:

- ...“health” rather than of “disease”? That is to say, do they apply techniques of prevention and health promotion and not only those of cure and rehabilitation?
- ...the family and community rather than in terms of individual sick patient?
- ...membership of a health team consisting of doctors, nurses, and other health workers as well as social scientists?<sup>14</sup>
- ...making the best and most effective use of the financial and material resources available?
- ... their country's pattern of health and disease and its relevant priorities?

He says, 'If...the answers are not an unequivocal “yes”, there is urgent need to re-examine the whole philosophy and program of the (medical) school concerned' (Mahler 1981). The focus of most of the policies and committees mentioned above has been limited to preparing medical students, technically and mentally, to be able to provide primary-level medical care and preventive medicine in rural and remote areas. This is very much desirable to improve access to primary-level medical care. This also offers a potential opportunity to the graduates to understand PHC approach better and reflect it in their work. But to expect this potential to get automatically realized just by physically locating the graduate in periphery may be an over-expectation.

Despite concerns expressed and recommendations made by different Committees and Policies, ME has remained unresponsive to the needs of the country, and urban orientation and bias for curative care continues to be the mainstay. There hasn't been a significant

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<sup>14</sup> 'If we want a system...in which major decisions concerning health are taken and implemented by the community, the doctor will have to become only one component of a team...' (Mahler 1981).

change in the nature of knowledge, attitude or practice of medical graduates/post-graduates. Graduates are more suited to work in hospitals than in communities (Rangan and Uplekar 1993, Yesudian n.d.). There is a social alienation of the modern health service structure and providers from the community (Priya 2018). There is a predilection for specialization (Lal *et al.* 2007, Kumar and Dhaliwal 2011, Bhat *et al.* 2012), and for urban practice. Twenty-four percent (8286/33968) sanctioned positions of Medical Officers at Primary Health Centers are vacant (MoHFW 2017b), despite more than sixty thousand medical-seats in the country (MCI 2017). The statistics for specialist cadre are worse, with 68% sanctioned positions at CHCs lying vacant (MoHFW 2017b). At the same time, we have thousands of doctors migrating to developed countries each year (VHAI 1997 as cited in Rao 2009). Doctors, in general, are seen to be bringing medical bias in PH planning (Milton 1985, Bajaj 1998a). Research topics selected by the Community Medicine faculty and their post-graduation (PG) students are not found to be innovative/locally relevant (Lal 2004, Pandav 2010). Often, they are found to be influenced by international funding (Qadeer and Nayar 2005). With due regards to exceptions, doctors continue to remain techno-centric, give priority to curative care, have poor understanding of social dimensions of health and disease, can barely conceive the role of community in health planning and have scant regard for indigenous systems of medicines and traditional healing practices. The issues of hegemony of doctors/experts, highlighted by women's movement and expressed in Gandhian perspectives, are still marginal in PH discourse (Priya 2018). All of this lies diametrically opposite to the position of PHC.

Rangan and Uplekar (1993) administered a structured questionnaire to 342 interns from three MCs in Bombay. It had some basic questions related to community health. They found that around one-third of the interns equated 'Health for All' with achievement of Family Planning and immunization targets. The authors say that 'Health for All' and PHC receive little attention from most of the faculties, except 'perhaps' those from CM. Nath (1987) says, 'I have seen place after place that neither the student nor the rest of the faculty of many medical colleges is clear about this (PHC) concept'.

The issue actually goes beyond a lack of adequate understanding about PHC approach among doctors. Cueto (2004) and Narayan (2008) mention that physicians had actually resisted PHC approach. They considered it as 'anti-intellectual, promoting non-scientific

solutions and demanding too many self-sacrifices' and feared losing 'privileges, prestige and power' (Cueto 2004). Even those who embraced the concept distrusted medical auxiliaries. Mahler (1981) says that the health professionals are rarely willing to accept that people have the capacity to make the decisions regarding their own health. Mahler, in a 1980 speech, had complained about the 'medical emperors' and their negativism towards PHC because of false 'pompous grandeur' (Cueto 2004). This was partly because of the class character of the people who entered this profession, and partly because there was 'no steady efforts to reorganize medical education around primary health care' (Cueto 2004).

PHC approach is as relevant today as it ever was, if not more. If it has to be adopted by the larger health system, it has to be first understood, in its most comprehensive form, by the medical fraternity. ME at undergraduate level, which every future doctor has to pass through irrespective of his/her final career pathway, offers an ideal opportunity to start developing this understanding. While this endeavor has to be collectively owned by all the departments of MC, CM departments are 'advantageously placed' to shoulder a substantial share of this responsibility (Ko Ko 1987). It is, thus, worthwhile to explore how the faculty of CM themselves understand PHC.

## **Summary**

This chapter traced the changing contexts and approaches towards health systems designing and development from mid-20<sup>th</sup> century till present times. It explained Comprehensive PHC approach and contrasted it with Selective PHC and Universal Health Coverage. The chapter then looked at how successive national health policies have reflected PHC approach, in general, and with respect to ME. The next chapter presents the conceptual framework and details the methodology used for this study.

# **Chapter 2: Exploring the Current Status of Primary Health Care Approach in Community Medicine: Conceptualization, Design and Methodology of this Study**

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This chapter presents the conceptual framework, design and methods used in the study. All stages of research, from conceptualization to selection of research approach, from selection of institutions and respondents to the processes of data collection, compilation and analysis have been explained in detail. In addition, the Researcher's experiences and reflections have been included under each section so as to make the qualitative research processes transparent, and to share the challenges faced and how they were met. Towards the end of the chapter, a brief biographical sketch of the Researcher has been shared so as to make explicit the possible biases and limitations that he might have unconsciously brought into the research.

## **I. Conceptual Framework**

### **I.1 Locating the Study**

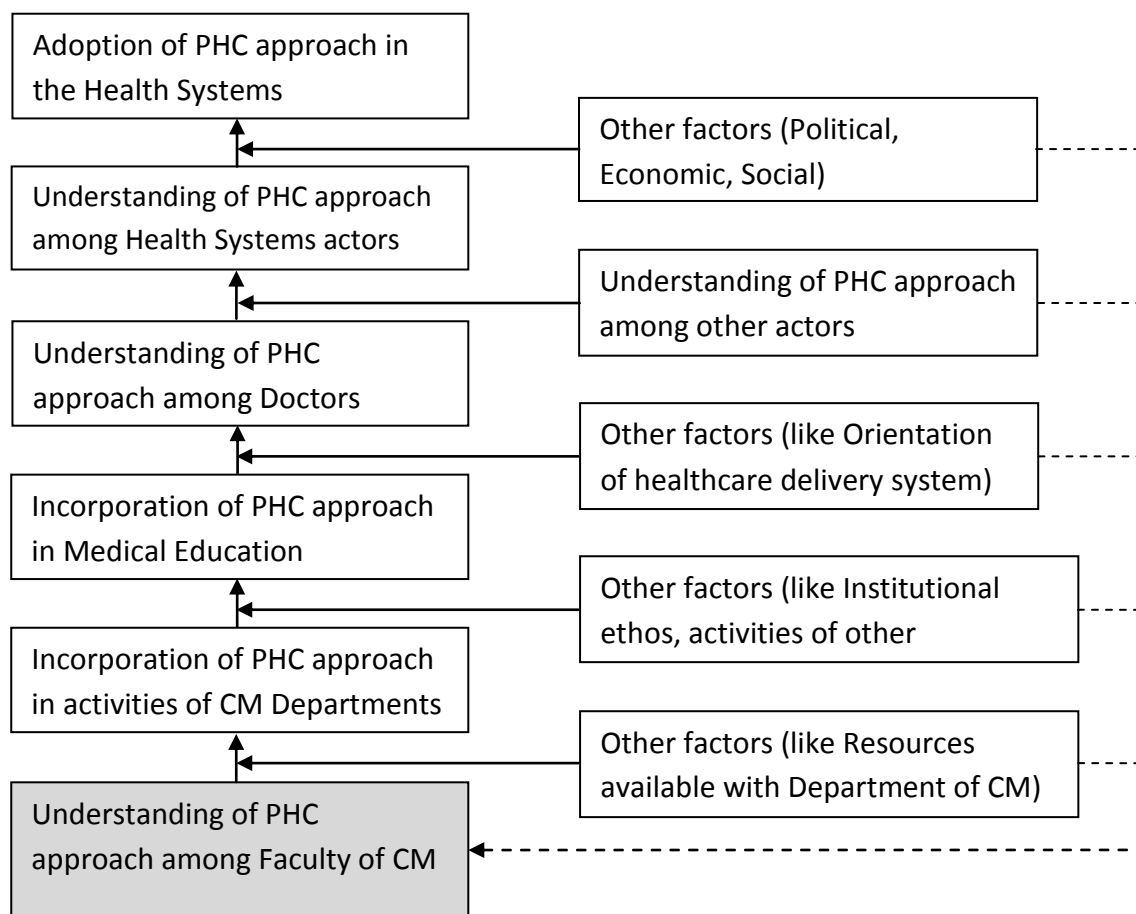
As detailed in Chapter 1, there are several political, economic and social reasons behind the limited adoption of Primary Health Care (PHC) approach in the health systems. One of these is the limited understanding of the approach among the key health systems actors ([Figure 1](#)). Doctors have a direct involvement at all levels and in all stages of the planning cycle in the health system. If this system has to be based on PHC, it is crucial for the doctors, besides others, to understand and believe in this approach.

Developing the understanding about PHC, as is true for any concept, is a lifelong endeavor. It is aided (or obstructed) by several influences, like the context one works in ([Figure 1](#)). However, the formative years of medical education (ME) is the time when the future doctors are first introduced to the idea of PHC. The understandings they develop during this period is a strong reference for the future. Different factors, like the ethos of the Medical College (MC), have an effect on how comprehensively the students are exposed to PHC

approach. Though the responsibility of sensitizing the medical students in this regards needs to be shared by all departments of the MC, the department of Community Medicine (DoCM) has to be at the forefront. The manner and extent to which this department is able to orient the future doctors about PHC approach depends on factors like resources that it has at its disposal. But a more important issue is how the faculty serving in the DoCM themselves understand the approach.

The way the Community Medicine (CM) faculty understand PHC approach is, thus, an important determinant of the way in which their students comprehend it (Figure 1). These students will become the doctors who will manage the health systems in future, and will influence the extent to which it is aligned to principles of PHC. Some of them will become faculty in the MCs, including in the DoCM, and will influence the understanding of their students about this approach.

**Figure 1: Location of the Present Study in the Wider Frame**



[PHC: Primary Health Care; CM: Community Medicine]

## **I.2 Objective of the Study**

To know how faculty of Community Medicine, who are mandated to shape the public health mindsets of medical students, understand 'Primary Health Care' and reflect it in their work.

## **I.3 Research Questions**

1. What do the faculty of CM understand by the concept of PHC?
2. To what extent do the faculty of CM consider the concept of PHC relevant, and reflect it in their teaching, research and field action?
3. What are the factors and processes that shape CM faculty's contemporary understanding and their extent of application of the concept of PHC?

## **I.4 Conceptualization of the Factors and Processes**

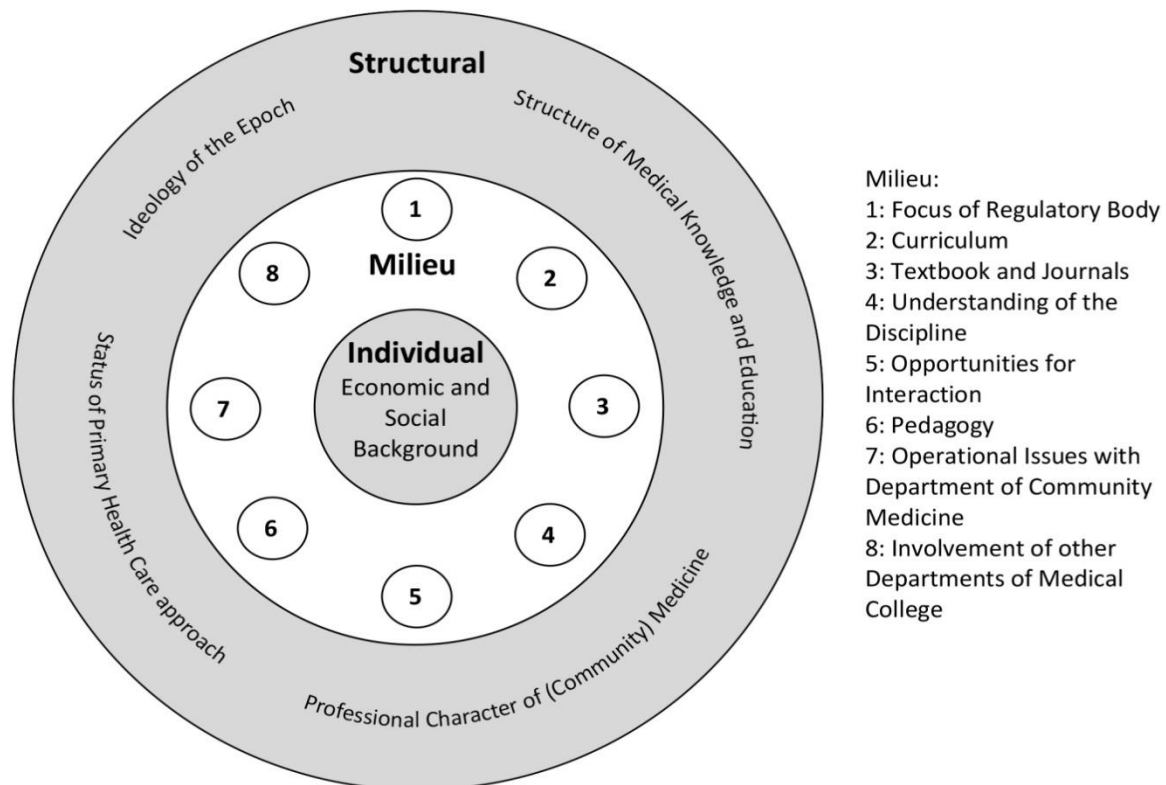
As shown in [Figure 1](#) (dotted lines on the right side), several factors may affect the way the CM faculty understand the PHC approach. Medicine/CM, like any other profession, is as much shaped by the social, cultural, political and economic factors as by the scientific advancements, if not more (Qadeer and Nayar 2005). They affect how the profession sees itself today and in future, and thus, how it wants to reproduce itself through education, research and practice. This decides the kind of candidates who are allowed to enter the MC/DoCM, the curriculum they are exposed to, the pedagogy through which it is communicated, the textbooks and literature they are offered and the socialization they are taken through. The professionals so produced feed back into the professional aspirations through their formal (conferences and journals) and informal interactions. This also shapes how the profession and its members decide to deal with other professions/professionals, if at all.

Besides operating through the professional pathways, the larger societal factors mentioned above also operate directly to sanction the value framework at individual and institutional levels. They decide what is absolutely non-negotiable, what is desirable and what the individual/institution can comfortably get away with. This decides the way individuals make career choices, and the manner in which regulators of the profession behave.

To be adopted, the comprehensive PHC approach poses specific requirements from the profession of medicine and CM. Whether or not these requirements are met, and to what

extent, depends on a complex web of factors as introduced above. These factors are intricately linked to each other and are difficult to compartmentalize. However, for the purpose of simplicity, they may be grouped at the levels of structure, milieu and individual (Ratcliffe and Gonzalez-del-Valle 1988)(Figure 2)<sup>1</sup>.

**Figure 2: Conceptualization of Factors and Processes shaping the Understanding of Primary Health Care among the Faculty of Community Medicine**



### I.4.1 Structural-level

Structural factors are those distal factors that influence the extent to which the PHC approach can penetrate the individual and his/her milieu. These factors may not be readily perceived, and are difficult to act upon. However, they are real, omnipresent and powerful.

Ideology of the Epoch: The way the world thinks in an era influences individuals (the CM faculty and their students), groups (the CM associations) and institutions (the medical council, the MCs, the CM departments). If materialistic possessions and unrestrained consumption is what the society values, it accordingly influences: the individual aspirations; how the discipline wants to be seen; how the department wants to grow; what kind of

<sup>1</sup>Figure 2, and the accompanying description, presents the initial conceptualization for this study. A modified framework, based on the findings of the study, is presented in Figure 4 (Chapter 5).



healthcare and ME system develops. PHC approach, however, positions health as a fundamental human right and not as a commodity.

Structure of Medical Knowledge and Education: Medical Science believes in objective reality and looks for tangible evidence. It searches for physical causes of disease inside individual bodies, and attempts to cure the disease by ameliorating that specific cause. Most of the ME happens in a tertiary-level set-up where students witness highly specialized form of clinical care. The CM faculty and their peers have all been, and are, a part of this structure. And so are their students. PHC approach, however, goes beyond this bio-medical view.

Professional Character of (Community) Medicine: Professionalization is a process of setting boundary that defines what all constitutes a profession. It is instilled through the formal and the hidden curriculum in the MC, and sustained through the professional associations. This boundary-work is desirable, but may become problematic if it makes the profession rigid and inflexible. PHC thinking of engaging with the communities and seeking cooperation of other sector has to cross this boundary.

Status of Primary Health Care Approach: Though the PHC approach has been widely acclaimed and periodically reclaimed as an idea, it has also been criticized as being primitive and cheap healthcare for the poor (Venediktov 1981); anti-intellectual and non-scientific (Cueto 2004); ambitious and vague, and so, un-realistic (Wisner 1988). So, it is easy for the faculty to discard it without understanding.

#### **I.4.2 Milieu-level**

These are the proximal factors that surround the individual and influence his/her understanding of, and receptivity for, PHC approach. These factors are themselves shaped under the weight of the structural factors discussed above, and in turn, shape the conditions under which the CM faculty are trained and expected to work.

Focus of Regulatory Body: ME in India is regulated by Medical Council of India (MCI). MCI is responsible for setting the minimum standards for MCs and ensuring that the same are followed (IMC Act, 1956). It is also responsible for preparing the curricular guidelines, develop mechanism for faculty development and ensure that standards of ME are maintained. And, going downstream, the Council is also mandated to uphold ethics in the

practice of medicine. The Council, thus, sets the immediate context in which the CM faculty and the students understand and reflect the PHC approach.

Curriculum: The curriculum set forth by the MCI gives the scope and direction for CM teaching and training at UG, Intern and PG level. It prescribes the hours and the level at which the teaching and training will take place; it gives a broad list of topics to be covered; and it prescribes the assessment methods. How and how much the curriculum stresses on PHC will directly influence how and how much the faculty, of CM and of other subjects, will focus on this approach.

Journals and Textbooks: Journals are a way of sharing ideas and perspectives. If they publish articles that incorporate PHC approach, and the faculty and their students read them, these may influence their understanding about the approach. They way commonly used textbooks explain the PHC approach, and the way they use the approach while explaining other concept of the subject, similarly influence how the students and faculty understand it.

Understanding of the Discipline: The department is called Community 'Medicine' in most of the MCs. As per the PHC approach, medicine is one of the ways to restore health. It considers 'medicine' as necessary, but not sufficient. If the name of the discipline is being taken literally by the general pool of faculty of CM, this may restrict an individual faculty's understanding of the PHC approach.

Opportunities for Interaction: Interacting with the community, with the local healthcare system, with officials of government departments other than health and with other organizations gives an opportunity to CM faculty to get different perspectives on health. Same purpose is expected to be served through peer interactions at PH conferences. Such interactions may deepen faculty's understanding about PHC approach, provided these forums provide space for it.

Pedagogy: As per MCI regulations, each MC is supposed to have a ME Unit which should facilitate training of faculty in ME methods and technology. Advanced trainings are conducted at designated nodal centers. These centers also encourage experimentation with new pedagogical methods and tools. How appropriate are these methods to orient the students on PHC approach will influence how effectively the MC faculty are able to do that.

Operational Issues with Department of Community Medicine: Each MC is supposed to have one Rural and one Urban Health Training Centre, and DoCMs are expected to utilize these for teaching and training of UG and PG students. The functioning of these centers is very important to further the understanding of the PHC approach, not only of the students but also of the faculty. Besides, human resource and logistics are basic for running any department. Adequacy of these resources is critical for orienting the students on PHC approach.

Involvement of Other Departments of Medical College: PHC approach applies to practice of medicine in general. So, to orient the students on this approach is a collective responsibility of all departments of the MC. While DoCM may take a lead, how effectively it is able to do so will depend on the extent to which other departments are involved in this endeavour. This again, would also depend on the levels of interaction of DoCM and others, and the importance other departments give to PHC.

### **I.4.3 Individual-level**

The possibility for the PHC approach to develop roots in the minds of faculties and students also depends on their economic and social backgrounds. Medical students, at UG as well as PG level, are selected through a highly competitive MCQ-based national-level entrance examination. To prepare for these exams, one needs to have financial and geographical access to private coaching institutes. Individuals who are able to clear this process are the ones whom the faculty then may try to orient on PHC.

So, there may be several factors working at structural, milieu and individual level that have a role in shaping the understanding of faculty about PHC and deciding the extent to which they reflect it in their work.

## **I.5 The Research Approach**

As mentioned above, understanding of the concept of PHC among faculty of CM and its application may be influenced by a number of structural, milieu and individual level factors. These factors interact with each other and across levels. It was not possible to address the issue by only focusing on a limited set of factors, or on any one particular level. Moreover, the understanding of the PHC concept feeds into its application and the application of the concept feeds into its understanding. It's a complex issue, and so, a systems approach was

employed to explore it. As it was the understanding and perceptions that had to be captured, and there was little literature on the subject, the study adopted an exploratory research design, and used predominantly a qualitative approach for data collection and analysis.

Departments of CM in four purposively selected MCs have been studied using in-depth face-to-face interview with present and past faculty and focus group discussions with students. The extent of application of the concept of PHC was assessed by observation of classroom and field activities and analysis of departmental research. A historical narrative was framed by tracing events and personalities in each of the DoCM to understand how it had engaged with PHC approach overtime. These narratives helped in contextualizing what faculties said regarding PHC, its relevance and its application. A synthesis of historical narratives, contemporary influences and the empirical findings was done to verify and modify the conceptual framework outlined in the previous section.

## **II. Selection of Departments**

### **II.1 Why four Departments?**

When the study began, there were 479 MCs in the country (MCI 2017). As the present inquiry was of qualitative nature, working with a numerically representative sample was not necessary. Given the resources limitations, even working with a sample which was representative on non-numerical criteria was also difficult.

Of the 479 MCs, 265 were under non-governmental management (MCI 2017). Many of these were capitation fee colleges where students of only a particular class could enter. The focus of Departments of CM (DoCM) and the receptivity of students for PHC approach in such effectively 'private' institutes need to be explored. But none of these were included in the study plan.

There were certain MCs/institutions which could have informed the study in their own ways. For instance, All India Institute of Hygiene and Public Health, Kolkata, established in 1932, is the first stand-alone Public Health Institute in South-East Asia and it started offering PG courses much before Departments of Preventive and Social Medicine (PSM) or DoCMs were established anywhere in the country. The experiments conducted at its Rural Health

Unit and Training Centre at Singur have influenced the recommendations of Bhore Committee (Deodhar 1989). Another could have been Institute of Medical Sciences, Banaras which is physically located within a multidisciplinary University. The effect of being close to departments of social sciences and humanities is worth exploring. There could be several other MCs, or DoCMs, whose specificities have been missed by the Researcher and which could have uniquely informed this research. But these didn't form a part of the present study.

The sample size of four departments was ascertained based on feasibility.

## **II.2 Why these four Departments?**

DoCMs of four purposively selected MCs were considered for collection of primary data (Table 2). All four MCs were established before 1978, the year in which Alma-Ata Declaration was made. This purposive selection was opted so as to explore the issue in the best case scenario<sup>2</sup>. One of the institutions allowed the study but wanted the findings to be anonymised, therefore its name and location has not been revealed in the thesis or any public documentation. It has instead been referred to as 'The Second Institute' (TSI) since it was the second institution studied.

- Post-graduate Institute of Medical Education and Research (PGI), Chandigarh: Established in 1962, it is an autonomous institute, and one of National Importance. Its DoCM was formally founded in 1977 and was upgraded to a School of Public Health during 2002-2006. The School offers only Postgraduate (PG) course in CM. Besides, the School also runs a Master of Public Health (MPH) program.
- The Second Institute (TSI): This is an old Government MC located in a state which has a separate Directorate of Public Health (DirPH) managed by a professional Public Health Cadre. The State posts personnel from its DirPH as faculty in DoCMs. This arrangement, and its implications on PHC orientation of students and other DoCM faculty, was worth studying. Being located in the State's capital, it also offered an opportunity to explore its role in the State's health planning process.

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<sup>2</sup> Two of the institutions, whose DoCM have acquired some leadership role within CM fraternity in the country and internationally, did not give permission for the study.

- Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sevagram: Established in 1969, MGIMS has been rooted in Gandhian philosophy which is so close to the concept of PHC. It is one of the few MCs in the country which runs offsite residential camps for its Undergraduates (UGs) as a part of Re-orientation of Medical Education (ROME).
- St. John's Medical College (St. John's), Bengaluru: Established in 1963, St. John's is an institute that is known for its social service orientation. Its department of Community Health is one of the older departments in the country, and it operates in a milieu where Bio-ethics and Humanities have been integrated with ME since long.

**Table 2: Ownership and Courses Offered by the Four Departments included in the Study**

S.No.	Institute	Ownership	Name of the Department	UG Course	PG Courses
1	PGI, Chandigarh	Government (Central)	Department of Community Medicine and School of Public Health	None	MD, MPH, PhD
2	The Second Institute	Government (State)	Department of Community Medicine	MBBS	MD, DipPH
3	MGIMS, Sevagram	Trust	Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine	MBBS	MD
4	St. Johns Medical College, Bengaluru	Trust	Department of Community Health	MBBS	MD

PGI: Postgraduate Institute of Medical Education and Research; MD: Doctor of Medicine; MPH: Master of Public Health; DipPH: Diploma in Public Health; MBBS: Bachelor of Medicine and Bachelor of Surgery; MGIMS: Mahatma Gandhi Institute of Medical Sciences

## II.3 Approaching the Departments

### II.3.1 Method

The Researcher approached a total of six DoCMs. In each case, a two-page brief on the study protocol was shared with the Heads of respective departments over a detailed e-mail along with other relevant documents [the Letter confirming admission to Doctoral program and the Certificate issued by Institutional Ethics Review Board of Jawaharlal Nehru University, New Delhi (JNU)]. This was done in phases. Department of Community Medicine

and School of Public Health (DoCM-SPH) at PGI and one more department (D1) were the first ones to be contacted. After finishing field work at DoCM-SPH, the Researcher got in touch with the DoCM at The Second Institute (DoCM-TSI) and one more department (D2). The field work at DoCM-TSI began only after a presentation to their Institutional Ethics Committee. In the middle of this field work, the Researcher contacted Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine (SNSPH-DoCM) at MGIMS. Finally, after completing field work at SNSPH-DoCM, Department of Community Health (DoCH) at St. John's was approached. A formal institutional consent was sought at each site (Annexure 1 and Annexure 2). The reasons why D1 and D2 did not permit the Researcher were not explored.

The methods and tools to be used for data collection were pilot tested at the DoCM of one of the Government MCs in New Delhi. This was done over five working days in the month of June 2018. Following changes were made based on this experience:

- Questions in the interview schedule, which would yield obvious responses, were removed; multiple questions, which could potentially lead to similar responses, were re-sequenced or merged; and questions which now appeared to be somewhat distant to the research objective were removed. This process was, however, repeated after every round of field work.
- The audio-recording of the pilot interview was not transcribed verbatim, but 'close-to-verbatim'. However, the Researcher realized that, going this way, it was sometimes difficult to keep his own interpretations out of the transcription process. At some places, things said more than once were not repeated in the transcript, and at others, the 'meaning' of a long response was typed as 'the' response. So, it was decided to henceforth transcribe word-by-word.
- The audio quality of the recorded Focus Group Discussion (FGD) was found to be poor. This was because a) the recording was done using an average smart phone (Moto G2), and b) the smart phone was placed near the Researcher and not in the centre of the group. It was decided to henceforth use a special recording device, and to place it carefully, especially during FGDs.

- Only two of the twelve PG students had filled the survey questionnaire. It was decided to henceforth take the contact details of the participants so that they may be followed-up in this regards.

The field work started in July 2018 and finished in September 2019. A period of one month was spent in each of the four departments (Table 3). During the month, following methods were used to collect the data: a) In-depth Interviews with Faculty; b) Questionnaire-based Survey with PG students and Interns; c) Focus-group Discussions (FGD) with PG students and Interns; d) Observations in classroom and field; e) Compiling list of PG dissertation and Faculty publications.

**Table 3: Schedule of Field Work for the present Study**

S.No.	Department	Start Date	End Date
1	DoCM-SPH	16th July 2018	18th August 2018
2	DoCM-TSI	10th December 2018	24th December 2018
		2nd January 2019	11th January 2019
3	SNSPH-DoCM	25th December 2018	29th December 2018
		11th Feb 2019	4th March 2019
4	DoCH	31st August 2019	25th September 2019

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

## II.3.2 Experiences

### DoCM-SPH (PGI, Chandigarh)

Being the first department, the Researcher was anxious and made multiple closely-spaced follow-ups regarding the request for field work. The institutional permission came around in a month's time.

The Head of the Department linked the Researcher with the faculty who was co-ordinating the PhD program in the Department. She helped the Researcher get contact details of other faculty and students, and introduced him to the PhD students in reference to the FGD.



## **DoCM-TSI (The Second Institute)**

Initially, there was some confusion whether the Dean of the Institute would decide on the request for field work or the officials in the State's Directorate of Medical Education. The permission was finally granted by the Dean after a presentation to the Institute's Ethics Committee. This had to be done despite the research proposal having been certified by the Institutional Ethics Review Board of JNU.

One of the young Assistant Professors in the Department was quite helpful with the process of getting institutional permission, and also in the first week of the field work. The faculty who consented for the interview were very respectful and open. Some of them were even concerned if the sound of the air-conditioner would interfere with audio-recording (I.F.2.1, I.F.2.4). Some PG students were also helpful. And, the attendants in the department were very friendly.

The overall experience in this department, however, was not a pleasant one. There were issues right from the beginning. Despite prior intimation, only two people in the department knew anything about this study till the field work actually began. For some reason not known to the Researcher, the protocol, or even the news that somebody was coming in the department for a month, was not shared with anybody else. Even after joining, the Researcher didn't get a platform to introduce himself, or the study protocol, to the department as a whole. So, to begin with, most of the people didn't have any idea who this person was, and what was he doing in their department.

The Researcher started meeting the faculty one by one with a 2-page brief on the study protocol. Many of them were welcoming and were prompt to give appointments for the interview. But some of them were not happy that while an Assistant Professor (AP) knew about this study, they were kept aloof. At least some of the junior faculty dilly-dallied for the interview on this account.

This got compounded by the fact that the Researcher was from JNU, a University known for promoting critical and independent thinking, and questioning of the establishment and its policies. DoCM-TSI was under State Government and at least some of the faculty were 'bureaucratic'. For instance, a junior faculty said, 'we should not show government in a bad light...we shouldn't oppose them'. Though this faculty gave the interview, but was hesitant

in putting his signature on the consent form. Even the Head of the Department found signing the institutional consent form as 'unnecessary'.

Moreover, JNU is located in New Delhi. 'What if he is from MCI?' So, despite having submitted relevant documents while seeking institutional permission, and despite having secured permission from their own Institutional Ethics Committee, the Researcher was asked to prove his identity.

Finally, the study involved 'observation' of classroom and field activities as one of its methods. Either the body language of the Researcher was not appropriate enough, or the department was probably not mature enough. These 'observations', whatever little of it that could be done, were perceived as 'surveillance'.

Because of all these reasons, there was little enthusiasm in the department for this study. In fact, even basic information like faculty's contact details was not shared. Given their multiple responsibilities and unpredictable work schedules, the only way left with the Researcher to contact the faculty was to visit their chambers every now and then, day after day. Despite the Researcher having met several PG students on a one-to-one basis, the FGD could not be conducted. With Interns, even an introductory meeting could not be held. Only once could the Researcher accompany the departmental team in field.

After about fifteen days, it was verbally communicated to the Researcher that the department was not comfortable with his presence, and that he should wrap things-up as soon as possible. The Researcher took a week-long break to attend the UG students' residential camp at MGIMS Sevagram. Having invested so many resources in this field work, he reluctantly returned and could conduct a few more interviews. On the last day of the month-long field-work, replying to an email in which transcript of his 13-minute interview was shared, the Head asked if there was a way to withdraw from the study!

All this happened despite a prior assurance by the Researcher that the departmental write-up would be shared before being finally put in the thesis, and same process would be followed before any publication involving data from the department. It is for these reasons that the department has been presented here anonymously.

### **SNSPH-DoCM (MGIMS, Sevagram)**

The department was very welcoming. There was a scheduled residential camp for UG students around the time when the Researcher first contacted them. Pending all formalities, they asked the Researcher if he could join the camp as it would next happen only after a year.

The Researcher presented the study protocol to the department in one of their scheduled seminars, and then approached the faculty individually. One of the faculty asked if the interview schedule could be shared in advance so that the respondent could gather his/her thoughts. The Researcher politely submitted that this would compromise the spontaneity of the interview, to which the faculty agreed.

Neither during the UG camp, nor later, did the Researcher was made to feel as an 'outsider'. The faculty realized that the purpose of the study was to 'understand' and not to 'investigate'. And so, they 'explained' and did not hide.

### **DoCH (St. John's Medical College, Bengaluru)**

The department was very prompt and courteous in communicating how the Researcher's request for field work was getting processed. It took little more than a month to get the institutional permission. They purposively asked the Researcher to visit in the month of September so that he could attend one of their annual UG field activity.

The department was very friendly and supportive. The first thing that happened when the Researcher reached the department was coffee with a group of faculty. And this must have happened half a dozen times over the month. The Researcher was linked to one of the faculty for day to day support, and she was very helpful throughout. On the second day, the Head called the entire faculty to the Seminar Room for an introduction to the Researcher and the study protocol. The Head also introduced the Researcher to the Dean of the Institute.

There was a pinch of apprehension about the study even here. Whether or not the Researcher could use the name of the Department/Institute was to be decided after looking at the draft findings. The write-up specific to the department was shared with the department and the changes suggested by the faculty were incorporated.

## **Other Departments**

- The Head of the Department where the methods and tools were piloted was very approachable and supportive.
- Two more Departments were visited so as to interview the past faculty. The faculty there were very welcoming and gave adequate time.
- The Head of D-1 accepted the request for field-work over e-mail. But when the Researcher reached the department, after travelling more than 2000 Kilometers, he very politely apologized for the inconvenience.
- The Head of D-2 agreed for the field work in-principle in an informal meeting with the Researcher. However, when the formal process was initiated, the request was turned down.

## **III. Research Methods**

### **III.1 In-depth Interviews**

#### **III.1.1 Purpose**

Interviews were conducted with the faculty so as to explore their perceptions about PHC. The rationale for using in-depth face-to-face interviews was that the topic required self-reflection and thought-gathering on the part of respondent to be able to communicate what one perceived, and why. It involved personal and sensitive issues which the individual might not have liked to share in a group. Given the apparent obviousness<sup>3</sup> of the topic, a need for probing was evident. Moreover, given their high stature, and the status differential between the potential respondents and the Researcher, any other method of data collection was less likely to work.

#### **III.1.2 Selection of Participants**

No sampling was done. All MD-CM faculty available in the department were approached for interview. The number of such faculty per department ranged from 10 to 15 (Table 4).

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<sup>3</sup> With regards to the topic of this study, a faculty said, 'Studying the understanding of PHC among faculty of Community Medicine is like studying the understanding of Surgery among Surgeons' (I.F.3.9).

Though their individual characteristics varied, the small numbers in each category per institute did not justify sampling.

**Table 4: Type and Distribution of Faculty interviewed for the Study**

S.No.	Department	Present Faculty		Past Faculty	Total
		MD-CM	Others		
1	DoCM-SPH	10 (10)	3 (4)	1+1* (2)	15 (16)
2	DoCM-TSI	10 (15)	NA	2 (2)	12 (17)
3	SNSPH-DoCM	9 (10)	2 (2)	2 (2)	13 (14)
4	DoCH	11 (11)	0 (0)	2+2** (4)	15 (15)
	Total	40 (46)	5 (6)	10 (10)	55 (62)

MD-CM: Faculty who are Postgraduate in Community Medicine; DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru; Numbers in ( ) denotes total number of persons approached; NA: Not Applicable; \*One very senior faculty, though not from PGI, was interviewed; \*\*Two present faculties, though not from Department of Community Medicine, were interviewed

Apart from those qualified as MD in CM, teaching faculty in the CM department having backgrounds other than in medicine were also interviewed, if available. Two past faculty per department were selected using convenience sampling. Two purposively selected faculty from Departments other than CM were also interviewed at St. John's. The purpose of interviewing all these faculty was to know more about the department rather than assessing their understanding about PHC.

### III.1.3 Method

The faculty were approached with a 2-page brief on the study protocol. An appointment was sought for the interview. At the given time and place, in-depth interviews were conducted after taking a written consent ([Annexure 3](#) and [Annexure 4](#)). All interviews were conducted by the Researcher himself in English or Hindi using an interview schedule ([Annexure 5](#) and [Annexure 6](#)). For some senior respondents having time constraints, the interview schedule was customised. The interviews were audio-recorded, and then transcribed verbatim. The transcripts were shared with the respective respondents, and their feedback incorporated before subjecting the data for analysis.

Out of sixty-two (62) faculty approached, the Researcher could interview fifty-five (55). Five (5) out of the seven (7) faculties who refused/avoided interviews belonged to DoCM-TSI ([Table 4](#)). The reasons for refusal/avoidance were not explored. The interviews happened in one to three sittings, depending on how much a faculty had to share and how much time they could spare at one go. When there was more than one sitting, the audio recorded in previous sitting was listened to so as to customize the questions for the next round.

At the end of these interviews, the MD-CM faculty were requested to fill-out a Personal Information Sheet ([Annexure 7](#)). Thirty-seven (37) out of forty (40) such faculty filled the sheet.

**Table 5: Number of Interviews Conducted, Recorded and Transcribed**

S.No.	Name of Department	Interviews Conducted	Interviews Recorded	Interviews Transcribed
1	DoCM-SPH	15	15	15
2	DoCM-TSI	12	11	10
3	SNSPH-DpCM	13	13	13
4	DoCH	15	14	14
	Total	55	53	52

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

Of the fifty-five (55) interviews, fifty-three (53) were recorded, using a digital voice-recorder (Sony ICD-PX370) ([Table 5](#)). In two cases, where the respondent didn't consent for audio-recording, hand-written notes were taken and were expanded soon after into a coherent narrative. For other cases, the audio-files were transferred from the Recorder to a dedicated folder in the Laptop. One audio-file of an interview with a past faculty of DoCM-TSI was unfortunately lost (I.PF.4).

### III.1.4 Respondent Profile

Almost a third of the respondents were above 50 years in age ([Table 6](#)). Though, half of the respondents at SNSPH-DoCM were below 35 years in age. The respondent pool had more males than females. However, this skew was reverse at DoCM-TSI and DoCH. Almost three out four respondents belonged to general category, and there were none from Scheduled

Caste/Tribe. Majority of respondents have had private English medium schooling in urban areas and had at least one graduate parent.

**Table 6: Demographic Profile of Present Faculty (MD-CM) Interviewed for the Study**

Variable	DoCM-SPH	DoCM-TSI	SNSPH-DoCM	DoCH	Total
<b>Age (in years)</b>					
> 50	3	3	2	3	11
35 - 50	4	4	2	8	18
< 35	1	2	4	0	7
Not mentioned	1	0	0	0	1
<b>Sex</b>					
Female	2	6	1	6	15
Male	7	3	7	5	22
<b>Caste</b>					
SC	0	0	0	0	0
ST	0	0	0	0	0
OBC	0	5	1	2	8
General	8	3	7	9	27
Not mentioned	1	1	0	0	2
<b>Type of School</b>					
Government	3	0	2	0	5
Government-aided	2	1	1	2	6
Private	4	8	5	9	26
<b>Medium of Instruction in School</b>					
Hindi	3	0	1	0	4
Other Regional Language	1	0	2	0	3
English	5	9	5	11	30
<b>Location of School</b>					
Rural	2	1	3	0	6
Urban	7	8	5	11	31
<b>Highest Qualification of Either Parent</b>					
Less than Graduate	3	2	0	1	6
Graduate	4	3	3	6	16
Postgraduate and above	2	4	5	4	15

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

**Table 7: Source of Medical Education and Teaching Experience of Present Faculty (MD-CM) Interviewed for the Study**

Variable	DoCM-SPH	DoCM-TSI	SNSPH-DoCM	DoCH	Total
<b>Graduation College</b>					
Government	9	8	4	1	22
Trust	0	1	4	10	15
Private	0	0	0	0	0
<b>Postgraduation College</b>					
Government	9	9	3	1	22
Trust	0	0	5	10	15
Private	0	0	0	0	0
<b>Number of CM Departments attended (total)</b>					
1	0	0	4	2	6
2	3	2	2	5	12
3	4	3	2	3	12
4	2	2	0	1	5
5	0	2	0	0	2
<b>Number of CM Departments attended (after MD-CM)</b>					
1	5	1	7	10	23
2	2	4	1	1	8
3	2	2	0	0	4
4	0	2	0	0	2
<b>Teaching Experience in CM Department (total)</b>					
> 15 years	3	1	3	5	12
5 - 15 years	5	5	1	6	17
< 5 years	1	3	4	0	8
<b>Teaching Experience in the present Department</b>					
> 15 years	3	0	3	5	11
5 - 15 years	5	1	1	6	13
< 5 years	1	8	4	0	13

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

None of the respondents had received UG/PG ME from a private MC (Table 7). There were six respondents who had done their UG and PG, and were now working as faculty, in the same department. Twenty-three respondents had served as faculty in no other department than the present one. The faculty of DoCM-TSI had the most diverse experience on this account. Almost a third of the respondent had a teaching experience of more than 15 years (ranging up to 35 years). All of these, except one had been in the same department for this



long. The average duration of stay in the same department was lowest in case of DoCM-TSI (a State Government MC).

More than half of the respondents had attained post-MD qualification(s) (Table 8). This included Doctorate in Philosophy, Diplomate in National Board, Master of Science, Master in International Health, MPH, Master of Business Administration, Postgraduate Diploma and Fellowships. Only one in four respondents had worked at a Primary Health Centre as a Medical Officer, and most of these belonged to DoCM-TSI. However, many more faculty had worked in some way at primary-level during their PG in CM. Besides, one in three respondents had worked in some public health agency other than a Primary Health Centre. This ranged from serving in a charitable hospital as a part of the rural service bond to being on deputation to international agencies.

**Table 8: Higher Education and Other Work Experiences of Present Faculty (MD-CM) Interviewed for the Study**

Variable	DoCM-SPH	DoCM-TSI	SNSPH-DoCM	DoCH	Total
<b>Qualification after MD-CM</b>					
From Foreign Institution	3	1	2	1	7
From Indian Institution	3	1	3	6	13
None	3	7	3	4	17
<b>Work Experience in Primary Health Centre (One year or more)</b>					
Yes	0	7	1	1	9
No	9	2	7	10	28
<b>Work Experience in other Public Health Agencies (One year or more)</b>					
Yes	4	3	2	3	12
No	5	6	6	8	25

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

### III.1.5 Experiences

Experience of interacting with faculty of CM was very educative and enriching. Initially, the Researcher was apprehensive about many things: would the faculty be ready to talk; would they spare so much time; would they allow the Researcher to record the conversation; would they open-up on personal issues; would they comment on policy matters; and would they give the minimum respect that a researcher deserves. Most of the faculties proved all these apprehensions wrong.

## **Organizing and Conducting the Interview**

Most of the faculty were very friendly and approachable, and were interested in the topic of this study. Almost all of them gave adequate time for interviews despite their busy schedules. Some of them went out of the way to help the Researcher. For instance, one faculty got his chamber locked from outside so that nobody could disturb during the interview (I.F.1.3). Another faculty, who was finding it difficult to give an appointment, suggested having the interview on the way while travelling to the field area (I.F.4.10). This interview happened on the backseat of the vehicle! Yet another faculty continued the interview while walking back from the visit to an urban under-privileged area near the college (I.F.4.11). Rarely, there would be a faculty who would hurry and say 'Any other question? Because I have given you enough time...I don't give so much time to anybody for interview.' At times, the interviews had to be rescheduled. Most of the faculty would inform in advance about the need for rescheduling, or, they would proactively call back later. But some were simply indifferent which used to throw the Researcher in self-doubt...'Was my way of approaching the faculty correct?'

## **The Interaction**

During the interviews, some faculty were very brief; some responded within the scope of the question in adequate details; and some went beyond the scope of the question, which was very much necessary for this study. But there were some who would mix-up several issues in quick succession, or would go tangential to what the question was. These interviews were difficult to follow. And then, some faculty would repeat the same stuff again and again. A few interviews went almost like a monologue, either because the responses were so enriching that the Researcher did not feel like interrupting, or because the faculty would not easily allow the Researcher to speak. The faculty were very open, even on personal questions like 'Did you join CM by choice'. And, except some from DoCM-TSI, they expressed their opinion on policy matters without any hesitation.

The Researcher, being very attached to the issues being explored in the study, would sometimes overstep the role of an interviewer, and instead, become a discussant for a while.

### **Immediate feedback from the Faculty**

Some of the faculty expressed that they enjoyed the interviews (I.F.1.3; I.F.4.2). Many felt that the interviews made them reflect on their own thought process and their work (I.F.1.1; I.F.1.2; I.F.3.1, I.F.4.2). One of them appreciated the Researcher for being a good listener. 'Because you listen, people tell you more than they intended to tell you' (I.F.4.6). Another faculty said 'I am happy that at least one person is curious to know about all these things' (I.PF.3). However, some faculty found the interview to be 'general' (I.F.4.7). They were expecting something specific.

### **Experiences with Audio-recording**

All but two respondents consented for audio-recording. People who have themselves engaged in research involving recorded interviews saw it as an obvious thing to do (I.F.1.1). A faculty shared her personal experience. 'Mine was a qualitative and quantitative study for my PhD. So, every time I used a recorder, people used to get scared' (I.F.2.1). Even others didn't hesitate. May be, it was because the Participant Information Sheet clearly mentioned the purpose of recording ('This is to ensure that Researcher is able to engage with the participants in a better way, does not miss anything said by the participant and is able to interpret it without bias'). In addition, the Researcher would assure the respondent before starting the interview that they may: refuse answering any question; ask the Researcher to stop recording if they have to say something very sensitive; and, review the transcript and ask for changes at that stage as well.

In one of the early interviews, the Researcher forgot to switch-on the audio recorder in time, and so, lost a few minutes of voice data (I.F.1.2). Sometimes, it so happened that respondents started telling important things before the Researcher could start recording, or after he stopped it. And sometime, important things could not be recorded as they were told during informal interactions. At times the Researcher requested the respondent to hold till the recorder could be switched-on. At other times, the Researcher would simply try to remember the conversation and jot-down important points based on recall.

The audio recording captures the voice intonations, but it can't capture the facial and bodily expressions. This appeared as a limitation on one or two occasions when, while reading the

transcript later, it was not very clear what the respondent would have actually meant by that statement.

## III.2 Focus Group Discussion

### III.2.1 Purpose

The purpose of having FGDs with students (PG/Interns) was: a) to, broadly, know their understanding of PHC and use it as a sort-of proxy for how the faculty understand it; and b) to explore their experience with CM and with DoCM(s). The rationale for having FGDs instead of interviewing individual students was to get a gross idea about their views in a limited time.

### III.2.2 Selection of Participant

Participants for the FGD were selected using convenience sampling.

### III.2.3 Method

At the pre-scheduled time and place, FGDs were conducted after taking a written consent from each participant ([Annexure 8](#) and [Annexure 9](#)). All FGDs were conducted by the Researcher himself in English or Hindi using a FGD guide ([Annexure 10](#)).

**Table 9: Number of Focus Group Discussions and Type of Participants**

S.No.	Department	PG Students	Interns	Others
1	DoCM-SPH	1 {n=8}	NA	1 {n=6}*
2	DoCM-TSI	0	0	NA
3	SNSPH-DoCM	1 {n=6}	1 {n=9}	NA
4	DoCH	1 {n=7}	1 {n=5}	NA
	Total	3 {n=21}	2 {n=14}	1 {n=6}

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru; Numbers in {} denotes total number of participants; NA: Not Applicable; \*PhD Students

A total of six (6) FGDs in three departments were conducted ([Table 9](#)). No FGD could be conducted at DoCM-TSI. All FGDs were facilitated by the Researcher himself in English or Hindi after taking written consent from each participant. All FGDs were audio-recorded using a digital voice-recorder (Sony ICD-PX370) and a smart phone.

### **III.2.4 Experiences**

- Organizing FGDs with students was more difficult than organizing the interviews with the faculty. As students (Interns as well as PGs) used to be posted at different places, it was hard to contact them. Secondly, since this was a group activity, it was not easy to decide on a date and time convenient to all members. Thirdly, students, especially Interns, were relatively less interested in participating in the study. For these reasons, the Researcher had to seek help of the faculty to gather the students for the FGD. The Researcher is not clear what remains of 'consent' when a person in authority, i.e. the faculty, facilitates the process.
- The FGDs with Interns were very useful in exploring their experience with CM and with DoCM(s). But the Researcher can't say the same as far as their understanding about PHC is concerned. They wouldn't comprehend questions on PHC approach too well. Given their brief exposure and experience, this is understandable.
- Some PG students, like some Junior Faculty, were a bit arrogant. But most of those who participated in the discussions were very open and vocal.
- Following the experience during pilot study, it was decided to use a special recording device instead of a smart phone. But subsequently, it was found that the digital voice recorder used in this study was also not very effective in recording the FGDs. And so, a smart phone was used in addition to the recorder. The two devices used to be kept at two locations to supplement each other's audio quality. [For interviews, the recorder was only as good as the smart phone].
- The Researcher, again because of being attached to the issues, at times over-stepped the role of a facilitator/moderator to become a discussant himself.

### **III.3 Classroom Observations**

#### **III.3.1 Purpose**

The purpose of making classroom observations was to see how the faculty transmit their understanding about PHC to the students in classroom.

### III.3.2 Selection of Classroom Activity

The DoCMs had diverse classroom activities for UGs (Lectures, Seminars) and PGs (Journal Clubs, Clinico-social Case Presentations). Selection of activities was done purposively, in consultation with the faculty, so as to observe as much variety as possible.

### III.3.3 Method

A total of eighteen (18) classroom activities were observed across the four departments (Table 10). Of these, nine (9) were intended for UGs/Interns and another nine (9) were for PGs.

**Table 10: Classroom Activities Observed in the Four Departments**

S.No.	Department	UG/Intern	PG	Total
1	DoCM-SPH	NA	7	7
2	DoCM-TSI	2	1	3
3	SNSPH-DoCM	2	1	3
4	DoCH	5	0	5
	Total	9	9	18

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru; UG: Undergraduate; PG: Postgraduate; NA: Not applicable

The points from a checklist were kept in mind while scribbling notes during the classroom activity, and they were documented in detail later on the same day ([Annexure 11](#)).

### III.3.4 Experiences

Most of the faculty allowed the Researcher to attend their lecture. In fact, some of them proactively called the Researcher to their lecture (I.F.1.12, I.F.4.6). Once, a senior faculty forgot to take the Researcher along while going for the lecture. He sent a call as soon as he realized, and even apologized for this (I.F.3.5).

The Researcher could observe the process of a Model Practicum Examination of 7th semester UG students at DoCM-TSI. One component of this examination was taking clinico-social history at the patient's bed-side. The Researcher stood with a student for 15-20 minutes to observe the process. He did introduce himself to the student and had shared the

purpose he was there for. The Researcher's presence would have certainly accentuated his exam-anxiety, but the student was in no position to refuse. The Researcher admits that it was unethical on his part, and he wishes that this had not happened.

There were some unpleasant experiences with classroom observations. One faculty at DoCM-SPH communicated his displeasure that the Researcher was being allowed to attend department's academic sessions (I.F.1.7). A senior faculty at SNSPH-DoCM, due to communication gap, denied permission to attend his lecture in a not so respectful way. At DoCM-TSI, the Researcher could attend a few sessions in the initial days with consent of the concerned faculty. But later, the department stopped sharing any information about the scheduled classroom activities. Once it so happened that the session had already started by the time the Researcher came to know of it. So, there was no way he could have taken prior permission to attend it. At the insistence of a PG student, the Researcher entered the session. And he didn't wish the faculty, so as not to distract them in an ongoing session. While this is a common practice in JNU, it appeared to have offended some of the medical faculty.

### **III.4 Field Observations**

#### **III.4.1 Purpose**

The purpose of making field observations was to see how the faculty transmit their understanding about PHC to the students in field, and how does it reflect in their own field activities.

#### **III.4.2 Selection of Field Activities**

DoCM-SPH had more than ten sites/areas spread across rural and urban locales with varying modes of departmental engagement. Selection of sites was done using convenience sampling.

SNSPH-DoCM and DoCH had multiple activities in their rural field practice areas. The selection of sites was done purposively, in consultation with the faculty, so as to observe as much variety as possible across rural and urban areas.

The need to select did not arise at DoCM-TSI.

### III.4.3 Method

A total of eighteen (18) field visits were made across the four departments (Table 11). Of these, fourteen (14) were in rural areas. One or more faculty were present in fourteen (14) of the field visits.

**Table 11: Field Activities Observed in the Four Departments**

S.No.	Department	Rural	Urban	Total	Faculty Presence
1	DoCM-SPH	2	3	5	3
2	DoCM-TSI	1	0	1	1
3	SNSPH-DoCM	7	0	7	5
4	DoCH	4	1	5	5
	Total	14	4	18	14

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

Notes were scribbled during the visits, and they were documented in detail on the same day after returning from field.

### III.4.4 Experiences

- A checklist was prepared for making observations in the field (Annexure 12). But it was devised keeping in mind a specific type of field interaction. It worked during the pilot testing phase. But it didn't always help in other departments simply because of the diversity of activities that the departments were engaged in.
- At SNSPH-DoCM and DoCH, the faculty were very forthcoming to take the Researcher to the field. Once it so happened at SNSPH-DoCM that, after having travelled about 5 kilometers from the town, the faculty realized that the Researcher should see the activity that they were going to participate in. So, they came back to pick the Researcher (O.F.3.5).
- At DoCM-SPH (PGI), each faculty has his/her own facility/field. So, the Researcher approached them individually with request for the field visit. One faculty proactively asked the Researcher to accompany him in field, and another one linked the Researcher to concerned Senior Resident. But one faculty first wanted to know what exactly the



Researcher wanted to observe in the field. Though, he later allowed the visit. Another faculty asked for a separate permission from the Head in this regards, thus, in-effect, declining the request.

- At The Second Institute, for the reasons already explained, only one field visit could happen.

## **III.5 Questionnaire Survey**

### **III.5.1 Purpose**

The purpose of having an open-ended questionnaire based survey about understanding on PHC with students (Interns and PGs) was: a) to make them gather their thoughts before the FGD, and b) to give the introverts an opportunity to express themselves through writing. The end-purpose, like that of FGD, was to use the understanding of students as a sort-of proxy for how the faculty understand PHC.

### **III.5.2 Selection of Participants**

Participants for the questionnaire-based survey were selected using convenience sampling.

### **III.5.3 Method**

Blank questionnaire formats, carrying the contact detail of the Researcher, were delivered to the students with a request to fill and return them during the FGD ([Annexure 13](#)). The students were followed-up on phone.

### **III.5.4 Experiences**

The challenge in contacting the students, as already explained for FGDs, affected this survey as well. The Researcher tried to personally meet, introduce the study, explain the purpose, and then hand-over the questionnaire to the students. But this was not possible in most of the cases. Secondly, it was a four-page questionnaire, and the students were expected to write in a descriptive way rather than just tick/encircle options. The questionnaire was bit demanding. So, the response rate was not satisfactory. Even many of the filled formats had very brief responses, and had several questions left unanswered. Some of the students, however, filled the questionnaire very diligently. It seemed that they wanted to put it out!

The questions asked through the questionnaire were a subset of those drafted for the faculty interviews. It was too ambitious on the part of Researcher to expect that the Interns would be able to comprehend these.

## **III.6 Topic Analysis of Department's Research**

### **III.6.1 Purpose**

The purpose of doing topic analysis of MD thesis and faculty's research projects was to get a broad idea about the focus of the department's research.

### **III.6.2 Method**

A list of thesis topics of MD students was sought from the concerned person in the department. A compiled list was made available at DoCH. At DoCM-SPH, a consolidated list till the year 2014 was available in Department's booklet (SPH 2014). SNSPH-DoCM provided Annual Reports from 1996-2018, and a list of dissertation was prepared from these reports. DoCM-TSI gave a list of ten topics worked upon in last three years. It was augmented by a list given on Department's webpage.

The list of faculty projects/publications was sought from the faculty at the end of in-depth interviews, and many of them shared it. The list was augmented with information available in department's booklet, annual reports and/or webpage.

The analysis focused on the broad area of research (like Maternal and Child Health), type of Study (like a Knowledge, Attitude and Practice Survey) and the study subjects (like rural women). This analysis was not done for individual faculty and has been presented only as a description rather than actual count in Chapter 3.

### **III.6.3 Experiences**

Merely looking at the topics did not yield many insights. But going beyond, especially for a research-focussed department like DoCM-SPH, would have been a near impossible task in the given time, and would have demanded compromising on other methods used in this study.

## IV. Transcription, Coding and Analysis

### IV.1 Transcription

#### IV.1.1 Purpose

The purpose of transcribing was to convert the speech into text, which would be easier to code and analyze.

#### IV.1.2 Method

Transcription was done after returning from the field work in each department. The audio-recordings of in-depth interviews (n=52; 5296 minutes) and FGDs (n=6; 427 minutes) were transcribed verbatim, totalling to 6,26,309 words (Table 12). It was done using free version of transcription software called “InqScribe”<sup>4</sup>. This software gives audio-controls and typing space in the same window, thus saving the inconvenience of shuffling between two different windows.

**Table 12: Duration of Interviews and Focus Group Discussions and Word Count of Transcribed Text**

S.No.	Department	Interviews		FGDs		Total	
		Minutes	Words	Minutes	Words	Minutes	Words
1	DoCM-SPH	1607	184106	138	20311	1745	204417
2	DoCM-TSI	814	99840	0	0	814	99840
3	SNSPH-DoCM	1143	135073	143	22509	1286	157582
4	DoCH	1732	149168	146	15302	1878	164470
Total		5296	568187	427	58122	5723	626309

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

The transcription involved three phases. In the first phase, the audio was played at a convenient speed, and the words heard through the ear phones were typed. In this phase, acronyms for commonly spoken words were used (for example, ‘PHC’ for Primary Health Care, or, ‘CM’ for Community Medicine). Once the whole file was been typed-out, the script was copied on a MS Word document. MS Word highlights spelling mistakes with red

<sup>4</sup> <https://www.inqscribe.com/>

underlines. In the second phase, such mistakes were corrected by scrolling through the document. The acronyms were expanded using the 'Replace' function of MS Word. In the third phase, the transcript was read word-by-word with the audio, so as to fill-in the missing words or phrases, if any.

The non-English parts of the interviews were not translated at this stage. They were typed in the usual Roman script. Later, only the excerpts, that were to be used as quotes, were translated in English.

### **IV.1.3 Experiences**

This was a very exhaustive and frustrating activity. Though it depended on the speed of the respondent's speech and how clear s/he was in his/her mind while speaking, the Researcher generally took 5-6 minutes to type one minute of audio recording. This comes to around 572 hours of work. The Researcher did explore free Voice Typing applications, like the one available in Google Docs. But the results were very far from satisfactory. The option of outsourcing this tedious job was just not available because of financial limitations.

Interviews/FGDs which were in English were easier to transcribe in comparison to those which were, wholly or partly, in Hindi. This was because the Researcher was using Roman script irrespective of the language spoken. And so, he had to first figure out the correct spelling which would capture the word spoken in Hindi. These portions were also more difficult to check for spelling and grammar.

There were some circumstances where the Researcher exercised his discretion whether to type verbatim or otherwise. Filler words like 'you know', 'actually', 'basically', 'of course', which were repeated out of habit, but otherwise did not have any significance, were not typed. Sometimes, the spoken sentence had jumbled-up words or grammatical errors. So, the Researcher first had to mentally organize them into a coherent sentence. Then he had to decide whether to type them out in the original fashion, or in a coherent version without disturbing the essence of the response. The jumbled-up/grammatically incorrect sentences are easily understood when 'heard', but they can be confusing when 'read'. Transcripts were meant to be read, so these corrections were regarded as justified.

Despite taking due care to record clearly, sometimes there were a few words which were not audible. This was because, during recording, the respondent would have moved away from the microphone, just to recline on the chair, or to show something on his/her pin board, or desktop, or to pull some of his published work out of racks. Or, the respondent would have pronounced the word in an atypical way. Such gaps were mentioned in the transcript as '(some words inaudible)'.

When the words spoken in Hindi were translated, despite trying hard, the essence could not always be retained. For instance, following quote was regarding how the faculty of other departments see CM: “amused tolerance”...*matlab log muskaraate hai aur kethe hai...“theek hai”*. This was translated as: “amused tolerance” ...meaning, people smile, and say...“okay”. Anybody who knows Hindi will understand that here, “okay” doesn’t fully capture “*theek hai*”.

While listening to the audio-recordings, sometimes the Researcher wondered how he managed to ask those questions, because they were now appearing to be offensive. This was because the body language and facial expressions, that would have made those questions sound innocuous during the actual interview, were not available now to supplement the audio recording. The Researcher was only ‘hearing’ the interview, and not also ‘seeing’ it.

## **IV.2 Sharing of Transcripts**

### **IV.2.1 Purpose**

The purpose of sharing the Interview and FGD transcript was to a) gain participants’ confidence in the research process, and b) let the participants add to or modify their responses.

### **IV.2.2 Method**

The transcripts were shared on e-mail. Respondents were requested for feed-back, but were consciously not followed-up for the same. If received, the feedback was incorporated in the transcript, and this was communicated back to the concerned respondent.

Out the fifty-two (52) interview transcripts, forty-nine (49) were shared ([Table 13](#)). The sharing was done within 0 - 72 days of returning from the field work. All e-mail got delivered

as in no case was a delivery-failure notification received. In case of three past faculties, transcript could not be shared because of non-availability of their e-mail ID. Out of the six FGD transcripts, five (5) were shared. One (1) transcript could not be shared as e-mail ID of none of group members was available with the Researcher (FGD.Intern.3).

**Table 13: Number of Interview Transcripts Shared and Acknowledged**

S.No.	Department	Interviews Transcribed	Transcripts Shared	Transcripts Acknowledged	Suggested Changes
1	DoCM-SPH	15	13	4	1
2	DoCM-TSI	10	10	3	2
3	SNSPH-DoCM	13	13	3	0
4	DoCH	14	13	10	4
	Total	52	49	20	7

DoCM-SPH: Department of Community Medicine and School of Public Health, PGI Chandigarh; DoCM-TSI: Department of Community Medicine, The Second Institute; SNSPH-DoCM: Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS Sewagram; DoCH: Department of Community Health, St. John's Medical College, Bengaluru

In response to the fifty-four (54) transcripts shared [49 interviews and five FGDs], there were twenty-one (21) acknowledgments [20 from interview respondents]. Of these, seven (7) participants also suggested changes in the transcript [all interview respondents]. The maximum number of acknowledgements and feedbacks came from DoCH ([Table 13](#)).

### IV.2.3 Experiences

Many faculty appreciated the effort (I.PF.3, I.F.3.10, I.PF.5, I.F.4.2). One faculty replied, 'Through your text I was also introduced to my mindset (and) perspective' (I.F.1.2). Two faculty had asked for the audio-files, which were immediately shared (I.F.1.7, I.F.4.5).

## IV.3 Coding

### IV.3.1 Method

Coding was done using R-based Qualitative Data Analysis software (Version 0.3-1)<sup>5</sup>. The reason behind using a software was that it makes it convenient to go to the root of coded

<sup>5</sup> Huang, R. (2018). RQDA: R-based Qualitative Data Analysis. R package version 0.3-1. URL <http://rqda.r-forge.r-project.org>

excerpt. Not just the Interview and FGD transcripts, but expanded notes of observation in classroom (n=18) and field (n=18) were also coded.

First, the transcripts and notes of the DoCM-SPH were imported in the software. Next, a set of codes were identified while reading the initial few transcripts. The broad categories of codes were: Department (like Field teaching-training of UGs, Department's interaction with Government Health System), PHC (like Understanding of Health, Community Participation), Processes/Factors (like Faculty's motivation while joining CM, Challenges related to Curriculum).

The scope of each code was defined and documented using the 'Code Memo' function of the software. Once the coding of all transcripts and notes was done, the process of preparing a departmental narrative was started. All the 'codings', i.e. excerpts, linked to a code were exported, and using them, a write-up was prepared for that code. Such write-ups were prepared for each code, one by one. And finally, all such write-ups were knitted together to produce a coherent narrative for the department.

Before taking up the transcripts and notes of DoCH, the existing set of codes were reassessed. This was a crucial exercise which led to changes in the name and scope, or deletion, of existing codes, and addition of new codes. This new set of codes was used for DoCH. The way in which the files of the DoCM-SPH department were coded was largely kept unchanged, except that the excerpts, whose codes were about to be deleted, were re-coded.

This exercise was repeated before starting the task for the SNSPH-DoCM and DoCM-TSI also. So, there were some variations in the codes that were used for different department. But this did not affect the analysis because the broad categories of codes and the department-wise narratives almost followed a common framework.

### **IV.3.2 Experiences**

The Researcher, till the end, tried to identify mutually exclusive codes. But this was a futile effort. The overlap in the scope of codes remained. This made assigning codes to the text a challenging exercise. The same sentence would fit in the scope of more than one code. Or, there would be two consecutive sentences which fit in two different codes. But by

separating the two, the linkage which the respondent was trying to establish would get lost. Every time such things happened, one would struggle to decide which code to put, or should the sentence be assigned multiple codes. This was less of a challenge when the interviewee had given very light or superficial responses. Those containing deep insights took a lot of time. At times, the Researcher got casual in assigning codes which costed dearly during analysis.

## **IV.4 Analysis**

### **IV.4.1 Method**

The department-wise narratives had three broad section: a) About the Department: this section had information about the concerned Institute, department, it's activities (teaching, research, services) and it's interactions; b) About Faculty's understanding of PHC: this section had responses of faculty on a set of themes around PHC; and c) About the factors and process: this section had reflections on faculty about the discipline of CM, about their personal journeys, about the challenges that they saw in incorporating PHC approach in their work, and their suggestions. Sections on the Department and on the Factors and Processes were relatively straight forward to organize, and the finding are presented in Chapter 3 and Chapter 5 respectively. Section on Understanding of PHC, however, required further analysis.

The understanding about PHC was assessed only for the CM faculty presently working in the four departments. The faculty having backgrounds other than medicine and the past faculty were not included as interviews with them had a different purpose. There were forty such faculty (see [Table 4](#)), of which two were excluded from this analysis. The interview with these two faculty (one each from TSI and SNSPH-DoCM) had to be customized because of the limited time given by the faculty, during which the Researcher could not sufficiently cover the domain of PHC.

For the thirty-eight faculty, the understanding of PHC was assessed across eleven themes ([Table 14](#)). 'Understanding of Health' is fundamental to understanding PHC. 'About Primary Health Care' sought to capture what the faculty, *prima facie*, understood by the term 'PHC'. 'Terminology' covered if the faculty were able to discriminate 'PHC' from the other two approaches - Selective PHC and UHC.



**Table 14: Farthest and the Closest Responses ('poles') for Themes on which Faculty's Understanding of Primary Health Care was Assessed**

<b>Theme</b>	<b>Farthest Response</b>	<b>Closest Response</b>
Understanding of Health	They agreed with the definition, called it 'complete', but didn't have much to say.	They saw 'Health' as something beyond the 'physical', and talked about different dimensions and determinants.
About Primary Health Care	They saw Primary Health Care only as provision of primary-level medical care (curative and preventive).	They saw Primary Health Care as a 'concept', as an 'approach', as a 'set of principles'. While they did talk about the healthcare system at primary-level and its challenges in detail, they could distinguish this from 'Primary Health Care'.
Terminology	They saw Comprehensive PHC, Selective PHC and Universal Health Coverage as basically same.	They appreciated the differences between the three approaches and also contextualized the shifts.
Community Participation	They found Community Participation important because it improves acceptance of services.	They believed that community is capable to identify most of its problems, figure out their solutions and arrange resources to implement those solutions.
Inter-sectoral Coordination	They considered inter-sectoral coordination as desirable, but didn't have much to say.	They appreciated the role that sectors other than healthcare have in health
Decentralization	They found decentralization important, but didn't have much to say.	They believed that the staff working in the periphery know the local context better, and so, should be heard and allowed to take decisions
Integration	They saw integration as a better approach, but didn't have much to say.	They believed that reasonable integration between programs bring efficiency in the system and makes the services comprehensive for the beneficiary
Institutional Delivery	They didn't see any advantages of delivering at home by a <i>Dai</i> . They saw this as risky.	They appreciated the advantages of home as a place of delivery; and/or they appreciated the advantages of <i>Dai</i> as a birth attendant
AYUSH-Folk	They didn't believe in AYUSH-Folk system as these lacked strong scientific evidence	They valued AYUSH-Folk; could appreciate that these (may) have a scientific basis; and talked about integrated medicine
Ready to Use Food	They placed freshly cooked food and ready to use food on equal terms by listing their respective advantages and disadvantages.	They appreciated locally prepared freshly cooked food as culturally and environmentally appropriate, and sustainable. They found improving the kitchen by empowering the mother to be still better.
Private Sector	They saw private sector as a synonym for quality, and insurance as a mechanism to improve the access to that quality.	They appreciated the centrality of a strong public healthcare system

‘Community Participation’ and ‘Inter-sectoral Coordination’ have been widely recognized as some of the basic principles of PHC. ‘Decentralization’ and ‘Integration’ have been proposed as the *mantra* for designing health care systems in the Alma-Ata Declaration. ‘Institutional Delivery’, ‘AYUSH-Folk’ and ‘Ready to Use Food’ had been primarily included as proxies for ‘Appropriate Technology’, though they covered more than that. ‘Private Sector’ assessed the extent to which the faculty could appreciate that, as made explicit in Alma-Ata Declaration, health of the people was ultimately the responsibility of the government. Equity, Universality, Comprehensiveness, Self-reliance, Self-determination, Acceptability, Affordability, Accessibility are some of the other key concepts associated with PHC. These were not specifically named as themes. But, as could be seen later, all of these found a reflection in the faculty responses.

Faculty responses to each theme were free listed. Based on the Researcher’s interpretation of ‘Primary Health Care’ from Alma-Ata Report and its subsequent analyses, the responses for each theme were arranged in an order. The responses found closest and farthest to the interpretation were taken as the two ‘poles’ ([Table 14](#)). These polar responses were respectively assigned a score of 5 and 1. Other responses were assigned a score of 4, 3 or 2 depending on their quality with reference to the two poles.

The faculty responses to any theme generally varied in two ways: a) their opinion about a particular issue. For instance, while one set of faculty might see possibilities in AYUSH and Folk, another set might see these with suspicion; b) their breadth and depth of engagement with a particular issue. For example, while one set of faculty might stop after saying that inter-sectoral co-ordination was desirable, others might go on to talk about why it was desirable, what were the existing mechanisms for coordination, what were the challenges and how could they be addressed. For themes like ‘community participation’ or ‘decentralization’, the faculty would not have a difference in opinion, but would differ in the depth of engagement.

As the faculty and their departments varied in terms of ‘level’ of the healthcare system that they largely worked with, their illustrations while talking about various themes also varied. For instance, with regards to ‘Intersectoral Coordination’, while one set of faculty would have referred to Village Health Committees, another set would have talked about inter-

departmental committees chaired by State’s Chief Secretary. The assigning of scores was based on the reflections and insights of the faculty in relation to the themes, and not based on the ‘level’ at which they worked.

It is important to note that the Researcher’s interpretation was used only to order the responses. The two ‘poles’ for each theme were fixed from within the pool of responses given by the faculty. So, the analysis is a comparison across peers rather than against some gold standard. Secondly, besides their responses for a particular theme, the overall experience of the Researcher with the faculty (‘the feel’) also guided the process of assigning the scores.

**Table 15: Number of Missed Responses**

Count of missed responses	Number of Faculty	Number of missed responses
0	12	0
1	16	16
2	4	8
3	3	9
4	3	12
Total		45

Number of missed responses = Count of missed responses × Number of faculty

**Table 16: Number of Missed Responses across Themes**

Theme	Number of Missed Responses
Terminology	13
Decentralization	9
Ready to Use Food	7
Understanding of Health	3
Institutional Delivery	3
Integration	3
AYUSH-Folk	2
About PHC	2
Inter-sectoral Coordination	2
Community Participation	1
Private Sector	0
Total	45

Some themes did not come-up during the interviews with some faculty, and so there were missed responses ([Table 15](#)). This largely happened simply because the theme just didn't come-up in the flow of the interview. In case of 'Terminology', the responses of certain faculty to other general questions on PHC indicated that it would be of little use to ask them specifically about this theme ([Table 16](#)).

Average of the scores assigned to the faculty for themes where they did have a response was assigned to such missed responses. The results of qualitative and the quantitative analysis are presented in Chapter 4.

#### **IV.4.2 Experiences**

- To figure-out a structure for organizing the text was the most difficult part of the study. The Researcher would start with one particular scheme, and in the middle of it, another scheme would appear to be better. For instance, the three broad sections initially made were: department, discipline and PHC. The entire text was arranged under these sections. But then, it was realized that to comment on 'discipline', while important, was not the core of the study. Instead, the focus has to be on 'factors and processes' which lead to a particular understanding about PHC. So, the text had to be rearranged. While going back to the Research Questions was helpful, structuring the text remained a challenge till the very end.
- Especially for the section on Understanding of PHC, but not limited to it, was the cycle of 'make-break-make'. Initially, department-wise narratives were prepared for each theme using the excerpts of all the faculty from that department. It was quite a task to link and stitch the responses together. But later, it appeared better to prepare individual responses of the faculty to different themes, so that they could be free-listed. So, the excerpts of individual faculty on individual theme were linked and stitched together to form a brief response of each faculty for each theme. And after free-listing, ordering and assigning scores to each response, once again, the individual responses had to be linked and stitched together to form coherent narrative for each score-set under that theme. This was a hugely taxing thing to do.
- The problem of same part of transcript fitting more than one code continued during analysis as well. The same part of narration would seem to fit at more than one place in

the text. For instance, the historical development of a particular field activity would fit under the history of the department, as well as under the section detailing the field activities of the department. Or, excerpts referring to the need for action across multiple sectors for attainment of health would fit under 'Understanding of Health' as well as under 'Inter-sectoral Coordination'. It would have been crude to create a neat division. So, in order to reduce repetition, such excerpts were detailed in one section, and just mentioned in the other.

- During analysis, many times the Researcher felt that he should have probed this further, or he should have followed this response with this question, or he should have let the faculty speak more on this. And, sometimes, stark gaps or contradictory things would emerge in the responses of the same faculty, or across the faculty of the same department. This would ideally require going back to them for clarification, but it was not feasible to do that.
- Assigning scores to faculty for their understanding of different themes was another challenge. First, it took effort to get over the hesitation in 'evaluating' people most of whom were ahead of the Researcher in terms of age, experience and accomplishments. And most of them had been very nice to the Researcher. To rate their response on a scale of 1 to 5 initially appeared disrespectful. But then, the work had to be done. Second, the response would vary in different ways. At times, there would be different opinions, and at times, the responses would differ in their length, breadth and depth. To devise an 'objective' scoring system for such a response-set was perplexing. Finally, two poles were fixed for each theme depending on the farthest and the closest response. The Researcher admits that there has been a significant role of 'subjectivity' in assigning the intermediate scores. Though, the Researcher believes that Qualitative Research allows for subjectivity as long as the process is transparent.
- At several places in the section in Understanding of PHC, it appeared that the broad points made by the faculty of one score-set had also been made by those of another score-set. So then, how would the Researcher justify assigning different scores to these faculty? It was realized that: a) while the broad points would be same, the relative emphasis and detailing would vary; and b) while those broad points would have come as

a collective wisdom of, say, 15 faculty in one score-set, all of that would have come from just three faculty in another score-set. Qualitative research is, after all, about such nuances.

## **V. A Brief Bio of the Researcher**

The Researcher is a middle-aged married male having two children. He has been brought-up in Jaipur-Rajasthan, in a middle-class *Jain* family. His father is a postgraduate and has retired from a Central government job. His mother has studied till 8<sup>th</sup> standard and has been managing the home. He has been educated in private English medium schools. He faced the pre-medical entrance after 12<sup>th</sup> standard and could secure a seat in a Government Medical College in Ahmedabad, Gujarat.

Though he had been an 'intelligent' student in school, his experience with MBBS curriculum and pedagogy was not great. Preventive and Social Medicine was one of the few subjects he enjoyed. This was because this subject allowed scope to understand rather than only remembering information. Though, the contribution of the concerned department in this regard was little. Because of the general disinterest for studies that he had developed over those four and a half years, he decided not to pursue postgraduation in any medical branch. He instead joined a rural Primary Health Centre under the State Government of Gujarat.

His work at the Centre involved a daily morning OPD followed by field visits to surrounding villages in the afternoon. He would supervise his staff, visit *Anganwadi* Centres and interact with community members during these village visits. He would have to regularly send multiple reports under different programs and attend target-oriented district-level meetings. He would have to manage the routine administrative affairs at the Centre, and periodic campaigns like Pulse Polio Immunization rounds. This was also the time when NRHM was launched. So, he was directly involved in formation of VHNSCs and RKS. He enjoyed the three and half years of working at the Primary Health Centre and considers it as an immensely learning experience.

He went on to take a full time course in Health Administration from the School of Health Systems Studies at Tata Institute of Social Sciences, Mumbai-Maharashtra. The School had faculty and students from diverse backgrounds, including medicine. The course had modules

on 'Understanding Society', 'India's Development Experience', 'State, Democracy, Politics and Social Conflicts', 'Social Science Perspectives on Health', 'Health Policy and Administration', 'Comparative Health Systems, 'Gender, Health and Rights' besides others. In addition, there were four internships: two in an urban slum, one with a field NGO and one with a District Health Administration. He also took two block placements (one with Sewa Rural<sup>1</sup>, and another with a State Institute of Health and Family Welfare) and wrote a Dissertation on the 'Role of Motivator Incentives in Family Planning Program'.

He then joined a Technical Assistance Project which was collaboration between World Health Organization and Revised National Tuberculosis Control Program. This assignment took him to the State of Bihar and involved working closely with the State Tuberculosis Office and with similar Offices in several Districts of the State. Though the job was to provide 'technical assistance', practically, it was day-to-day program support. He used to visit TB Units and go to meet patients on treatment. Often, he would meet the Civil Surgeon to sort out issues related to logistics and human resource, and would occasionally escalate these issues to the District Collector. In parallel, he was also exposed to the national-level program review meetings attended by government officials as well as development partners.

After working for three and a half years in Bihar, he returned to his home State and joined another international agency rooted in a reputed public health institute. This job entailed facilitating divisional and district-level trainings of service providers in delivering Post-partum IUCD services, and supporting them at facility-level. The service providers included Obstetricians and Staff Nurses working at secondary and tertiary level government facilities. As the job was focused on a single intervention and its monitoring was target-based, he didn't like it much and left after a year.

The Researcher then joined Centre of Social Medicine and Community Health at Jawaharlal Nehru University, New Delhi as a PhD Student. This centre was established in 1971, and was consciously housed in the School of Social Sciences. It endeavours '*to understand how health problems are shaped by socio-economic factors and to examine the social structure itself, to delineate the structural constraints that contour the scope of technical health*

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<sup>1</sup> <https://sewarural.org/>

*knowledge and health interventions*'. So as to follow an interdisciplinary approach that such an endeavor demands, the Centre has had a mix of faculty with backgrounds in medicine and in social sciences (like Sociology, Anthropology and Psychology) since its inception. During the two semesters of Course Work, the Researcher underwent modules like 'Social Science Issues in Community Health' and 'Political Economy of Health', besides others. Apart from classroom activities, the Researcher got exposed to a culturally diverse, socially aware and politically active student population that would speak out loud and clear to the powers that be. Beyond the campus, the Researcher got exposed to forums like *Jan Swasthya Abhiyaan*, All India Drug Action Network, Alliance of Doctors for Ethical Healthcare and South Asian Dialogue of Ecological Democracy's *Swasthya Swaraj*, and got involved with Medico Friend Circle<sup>2</sup>.

Thereby, the researcher had an explicit interest in and inclination towards PHC and the PHC approach.

## **Summary**

This chapter presented the conceptual framework and methods used to conduct the study. For each method, the rationale, the operational details and the Researcher's experience were documented. The profile of the departments and of the faculty included in the study was also presented. Towards the end, a brief bio of the Researcher was shared to make explicit the possible biases and limitations that might have influenced the qualitative analysis. The next chapter lays out the structure and activities of the four departments included in the study.

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<sup>2</sup> <http://www.mfcindia.org/>



# Chapter 3: Community Medicine

## Departments in Four Institutions: History, Activities and Interactions

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This chapter describes the four Departments of Community Medicine (DoCM) included in this study: a) Department of Community Medicine and School of Public Health, PGI-Chandigarh (DoCM-SPH); b) Department of Community Medicine, The Second Institute (DoCM-TSI); c) Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS-Sevagram (SNSPH-DoCM); and Department of Community Health, St. John's-Bengaluru (DoCH). The description includes department's history, its activities (teaching-training, research and service), and its interactions (with other departments in the Medical College, other DoCMs, government health department, other government department and others).

### I. Department of Community Medicine and School of Public Health, PGI-Chandigarh (DoCM-SPH)

#### I.1 Department History

With the partition of India in 1947, the erstwhile province of Punjab got bifurcated. As its earlier capital, Lahore, now came to be in Pakistan, there arose a need for a new capital city for the Indian side of the province. The government tasked Euro-American planners and architects to design this new city, called 'Chandigarh'.<sup>1</sup> This was a dream city of India's first Prime Minister, and is one of the few planned cities in the country. It is beautiful and has some of the architecturally renowned buildings, and the famous Open Hand Monument that symbolizes "the hand to give and the hand to take; peace and prosperity, and the unity of mankind". The beauty, however, gets a bit tinged when one comes to know that it was created at the cost of around 50 *Paudhi* speaking villages.

The city was completed in 1960, and in the same year, the Postgraduate Institute of Medical Education and Research, Chandigarh (PGI) was conceived. Though the Institute was started

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<sup>1</sup> <https://en.wikipedia.org/wiki/Chandigarh>

by the Government of Punjab in 1962, it became an autonomous Institute of National Importance by an Act of Parliament in 1967. It was mandated to a) provide high quality patient care; b) attain self-sufficiency in postgraduate medical education and to meet the country's need for highly qualified medical teachers in all medical and surgical fields; c) provide educational facilities for the training of personnel in all important branches of health activity; and, d) undertake basic community based research.<sup>2</sup>

Over the years, the State of Haryana and the Union Territory of Chandigarh were carved out of the post-independence Punjab. The hilly area in its north got merged with the State of Himachal Pradesh. These three States (Haryana, Himachal Pradesh and present day Punjab) and the Union Territory of Chandigarh largely constitutes the area catered by PGI. The Institute was started as a hospital, and so, the clinical departments were the first ones to be set-up. The DoCM was established in 1977, fifteen year after the Institute began.

### **I.1.1 Phase-I (1977 to 1990)**

To begin with, an Associate Professor from the Department of Paediatrics was given the responsibility of DoCM. This person was a graduate from All India Institute of Medical Science (AIIMS), New Delhi and had done his residency at Denever, Colorado (USA). He had been managing the community unit of the Department of Paediatrics. This unit itself was established a few years back by the then Head of Paediatrics Department after returning from a course on 'Medical Care in Developing Countries' at the Institute of Child Health, London. The Associate Professor, along with a resident doctor, used to conduct a weekly outreach clinic in a Sub-centre village around 20 kilometers from PGI. To begin with, they used to run OPD and make necessary referrals to PGI. Gradually, they expanded the scope of work to include administration of common vaccines to antenatal women and children, and efforts at improving the record keeping by the government staff. Even the span increased from one Sub-centre to a PHC area.

The then Director of PGI was a member in a Central Government's committee looking into models of rural healthcare delivery. The influence of those discussions, and a visit by the Union Health minister in 1975, led to the decision to start a DoCM. The purpose was to develop health care delivery models in the rural areas, and to familiarise PGI's faculty and

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<sup>2</sup> [https://pgimer.edu.in/PGIMER\\_PORTAL/PGIMERPORTAL/home.jsp](https://pgimer.edu.in/PGIMER_PORTAL/PGIMERPORTAL/home.jsp)

resident doctors with the rural healthcare services (I.F.1.12). An agreement was signed with the Health Department of Haryana to start collaboration at a *tehsil* hospital in Narayangarh. Residential facilities were established there, and it was decided that a Senior Resident (SR) each from Paediatrics, Obstetrics and Internal Medicine would go and stay there for a period of three months out of their residency program by rotation. It is important to note that no exclusive academic course was entrusted to the DoCM.

In parallel, the department expanded its activities in entire Ambala district, focussing on vaccination, prevention and treatment of diarrhoea and pneumonia, nutrition, safe delivery and family planning, largely implementing Unicef's strategy of GOBI-FFF (I.PF.1). The department was also involved in the training of the health and ICDS staff, including *Dais* and the newly formed cadre of Community Health Workers. Besides, there was a significant focus on field research on the issues of maternal and child health. They did pioneering work related to the disposable delivery kits and the Maternal and Child Health (MCH) card. Together with Christian Medical College-Vellore, they devised strategies for mass administration of polio vaccine even in absence of cold storage facilities. Within a few years, the IMR of the district almost halved and child morbidity reduced significantly. The work '...moved from clinical medicine, slowly, towards Public Health, and then Public Health took over totally' (I.PF.1).

Impressed by their work, the Department was given the responsibility to enhance the capacity of the faculty of several Medical Colleges (MCs) of the country regarding prevention and treatment of diarrhoeal diseases. The then Head of DoCM was involved in drafting the WHO's first global protocol for management of pneumonia. Following this, the WHO established a collaborative centre in the Department for prevention and treatment of this disease. Even ICMR established an advanced MCH centre in the Department.

So far, the department consisted of faculty with background in Paediatrics, Community Medicine (CM), Anthropology and Nursing, a few SRs and project-based staff. The academic activities were limited to teaching of Masters-level nursing students and guiding a few PhD candidates who also, incidentally, were largely from nursing background (I.F.1.2). So, in the first decade or so, the department was in a practice mode, 'primarily working in the rural healthcare delivery system, how something can be improved in one village, one sub-centre

and then in a primary health centre and how it can be expanded to cover more villages, and may be cover one block with that innovation, and then may be taken to the district level and then eventually to the national level' (I.F.1.12).

### **I.1.2 Phase II (1990-2007)**

Around 1990, the leadership of the department changed. With a CM person now in-charge, the focus shifted to develop the department on academic front. The number of faculty of CM was increased so as to start an MD course. The initial effort was to start it in Family Medicine. But 'some other specialties in the Institute felt that they were already doing that kind of work which eventually a Family Medicine doctor would do' (I.F.1.12). Subsequently, a proposal was prepared for an MD in CM taking into account the ongoing program at AIIMS, New Delhi (I.F.1.2). It got accepted and the first postgraduate student joined in 1996.

This was also the time when thinking about a School of Public Health (SPH) began. The faculty in the department had exposure to the ground realities by virtue of their intensive field engagements. Some of them also got exposed to the international thought processes. For instance, the in-charge had been to London School of Hygiene and Tropical Medicine for a Masters course. Discussions within the department and interactions with peers working full time in field, increasingly led to the realization that 'Health is a developmental issue...It is not only health sector, but people from other areas as well - nutrition, environment, the social scientist...they are all very important. It is a multi-disciplinary (approach) which is required, which was not possible in the earlier (set-up)' (I.F.1.4).

Another realization was that, given the norms for teacher-student ratio, the department would be able to train only a few MD students in CM. This will not be sufficient to address the public health (PH) needs of the region in quantitative terms. Also, it was realized that a significant part of PH work didn't necessarily require a person with medical background (I.F.1.5). Similar ideas were being discussed at the National level during that time. There were efforts underway to develop a consortium of ICMR Schools of Public Health, something which didn't ultimately work out. PGI was a party, even a host, to these deliberations (I.F.1.3).

Probably, it was also the charm of making the department in-sync with internationally accepted nomenclature. 'Like Johns Hopkins School of "Public Health"...so, the famous ones have "Public Health" in their names' (I.F.1.7); and trying to be at par with the best in the world has been the culture of PGI (PGI 2013, p27). Another view is that it wasn't an in-house idea, but something pushed by international development agencies through the Ministry to which the department gave-in (I.F.1.2).

A proposal was prepared by the team of faculty taking into account the ongoing programs in institutes like Achutha Menon Centre for Health Science Studies (I.F.1.2). While the new course could have been started exclusively with CM faculty, it was decided to keep the new positions open for faculty with backgrounds other than Medicine and CM. Having non-CM faculty in a Department of 'Community Medicine' would be against the norms of Medical Council of India (though PGI is outside the purview of MCI). For the same reasons, it would not be possible to offer MD course in CM from a School of 'Public Health'. And so, as a middle path, it was decided to 'upgrade' the DoCM to SPH. The name of the Department, however, has since been a constant point of contention among the faculty (as shared by I.F.1.2 and I.F.1.7).

### **I.1.3 Phase III (2007-till date)**

The proposal to upgrade the DoCM to SPH got accepted by Government of India under the X<sup>th</sup> Five Year Plan. Faculty from six 'sub-specialties' (Epidemiology, Health Promotion, Health Management, Health Economics, Environmental Health and Nutrition) were recruited besides a number of Junior and Senior Demonstrators. The Masters of Public Health course (MPH) was inaugurated by the then Regional Director, WHO-SEARO in July 2007.

In-sync with the growth in number of courses, students and faculty, the number of field practice areas has also grown. The department started with a Rural Health and Training Centre at Narayangarh. At present, there are more than ten facilities/areas, spread over the Union Territory of Chandigarh and the States of Haryana and Punjab. While some of these facilities are managed by the department, at others they piggy back with the staff of State/UT.

At the time of this study (i.e. in 2018), the department was in the process of starting a Bachelor in Public Health and an MD in Family Medicine.

## **I.2 Department Infrastructure**

The DoCM-SPH is housed in a building which is separate from the other academic, research and clinical blocks of PGI, but is on the same campus. The DoCM-SPH occupies the ground floor of this structure, while the first floor houses the Department of Hospital Administration.

Each faculty has a separate room, though the size varies as per designation. Similarly, there are separate rooms for the groups of SRs, Senior Demonstrators, PhD Scholars, Junior Residents (JRs) and Junior Demonstrators. The department has two large lecture halls that have more than sufficient number of chairs and tables arranged in U-formation. There is a good sound system and facility for visual projection in both the lecture halls. Posters with graphics on key PH concepts, like Social Determinants of Health, can be seen on the walls. All rooms and lecture halls are fitted with air-conditioners.

The department has a board for PH news maintained under the guidance of a faculty with background in Sociology. Paper cuttings from local English dailies are being pinned on it. The news titles displayed cover diverse domains, including environment ('The Seeds of Sustainability'), governance ('Why we treasure Democracy?'), food production ('Will it rain good fortune'), disaster ('What caused Dec.1, 2015 Chennai downpour?'), child sexual abuse in schools ('Lessons in Shame'), mental health ('Overcoming the blues') and medicine ('New clue to Huntington's disease').

The Department has adequate number of well-maintained air-conditioned vehicles to ferry the faculty and students to field.

### **I.2.1 RHTC**

The RHTC is located around 60 kilometers from the Institute. It is housed in one big room of the Sub-divisional Hospital at Narayangarh (Haryana). There are separate desks for the faculty, SRs, JRs and the staff. The central area has a sofa and a table for visitors and for JRs of other departments for post-OPD discussions. The notice board displays the details about the population covered by the RHTC, and the monthly activity schedule of the staffs. There is an air-conditioned four wheeler available for field activities. The residential complex of PGI staff is a five minute walk from RHTC. It has several single-seat rooms. The kitchen, toilets and bathrooms are common. The dining space has a television. There is a small

garden in the compound where, the photographs from past show, the JRs and staff celebrate birthdays and festivals.

### **I.2.2 UHTC**

The UHTC is located around 10 kilometers from the Institute in a resettlement colony. It runs in a small community centre building that it shares with an *Anganwadi* Centre. Practically, the dispensary (including its immunization sessions, ANC Clinic, OPD, pharmacy, store room and meeting room) runs in two rooms. There are remnants of swings in the compound on which children might have played in the past. The building is old and not very well kept, which is a pain point for the staffs. A new space had been allotted for construction of a more spacious centre. But the construction work is waiting for long to begin despite faculty's efforts.

Besides the RHTC and UHTC, the department has regular outreach activities in several other facilities/areas in collaboration with concerned UT/State health department.

## **I.3 Department Activities**

CM, for the Department at PGI, consists of four domains: Health Promotion, Epidemiology, PH Management and Family Medicine. These domains are covered through research, policy advocacy, teaching and field engagements, more or less in that order. The faculty of CM (and the SRs posted under them), those of PH (and the Junior and Senior Demonstrators employed with them) and the students (MD, MPH, PhD) are all engaged in these activities.

### **I.3.1 Research**

PGI is an Institute of Medical Education and 'Research'. A former Director writes that at PGI 'we need to develop expertise and clinical skills at par with any world class Institute and be at the cutting edge of research in clinical as well as basic sciences' (PGI 2013, p26). The then Director informs that Institute's faculty had published 750 papers, and that the extra-mural grant received for faculty projects had touched Rupees 33 Crores in the year 2012 (PGI 2013, p27-28). The Institute was found to be second in India and fifth globally in terms of number of publications from any medical institute during the period 2005-2014 (Table 3, p7 in Ray et al. 2016).

The DoCM, since its inception, has lived up to these standards. A booklet published by the Department, updated till 2014, gives a list of completed research projects (n=214) and publications [Journal articles (n=365), Books (n=29), Chapters in Books (n=53)] (SPH 2014).

As shown in [Table 17](#), three out of every four projects completed by the DoCM has been funded by a government agency. This includes agencies at national as well as State level, and extends beyond the core health institutions to include Department of Women and Child Development, and Pollution Control Board.

**Table 17: Distribution of Projects completed by Department of Community Medicine and School of Public Health, PGI (during 1977-2014) as per Type of Funding Agency**

S.No.	Type of Funding Agency	Number of Projects	Remarks
1	Government	158 (74%)	61 – PGI; 56 - National-level (ICMR, CTC-ICDS, MoHFW, NHSRC); 41 - State-level (NRHM, DoHFW, DST, SACS, SPCB)
2	International	45 (21%)	28 – UN Agencies (WHO, Unicef, UNFPA)]; 17 – Others (like The Union, University of California)
3	Non-government	7 (3%)	Like India Clinical Epidemiological Network
4	Private	4 (2%)	A Bio-tech Company
	Total	214 (100%)	

Source: PGI 2014

PGI: Postgraduate Institute of Medical Education and Research, Chandigarh; ICMR: Indian Council of Medical Research; CTC-ICDS: Central Technical Committee-Integrated Child Development Scheme; MoHFW: Ministry of Health and Family Welfare; NHSRC: National Health System Resource Centre; NRHM: National Rural Health Mission; DoHFW: Department of Health and Family Welfare; DST: Department of Science and Technology; SACS: State AIDS Control Society; SPCB: State Pollution Control Board; WHO: World Health Organization; Unicef: United Nations Children's Fund; UNFPA: United Nations Population Fund)

In its first decade or so, the department worked on community health issues, like diarrhoea, birth asphyxia, low birth weight, malnutrition, high risk pregnancy and safe delivery. It was one of the pioneers in developing and implementing initiatives like the five cleans during delivery (*Dai* kits) and the mother-child link card. These interventions were then systematically transferred to government programs.

There used to be an Anthropologist in the department in those years. The difference between his approach towards PH and that of the Paediatrician heading the department then is obvious in [Table 18](#). Such studies, which give primacy to the beliefs, opinions and practices of people, have happened in much lesser numbers post 1990s.



**Table 18: Some of the research works of the Department of Community Medicine (PGI) in 1970s and 80s**

<b>Paediatrician</b>	<b>Anthropologist</b>
<i>PhD Thesis</i>	
Neonatal rearing practices in rural area, Haryana, India	People's Perception about childhood illness and their therapeutic practices and preferences in four selected villages of Raipur Rani Block (Haryana)
A study of health problems of LBW babies in a rural community and feasibility of intervention package likely to improve their health status	
<i>Some of the Projects</i>	
Developing Effective MCH services in rural areas of India to improve family planning effort - an effective replicable model	Background, Training and Role of Indigenous Medicine practitioners in a Development Block of Haryana
Evaluation of Home Based mother's cards-A Multi-centric study	A study of opinion leaders in Punjab
Effect of Protein Calorie malnutrition on growth and morbidity of rural children	A study of people's perception about malaria control programme and their views regarding community participation
Assessment of Effectiveness of ORT in the Treatment of diarrhoea in pre-school children	Women's perception of pregnancy related health problems in selected villages of Haryana
Multi-centric study of physical, psychosocial and sexual growth during adolescence in rural area	Contraceptive perception and method choice among working and nonworking women in an urban slum
Operational pilot project on acute respiratory infections in children	A Study of spirit mediums with special reference to their role in health especially in the mental health
The effects of health sector development activities on health and nutrition	A Study of Harijan's perception of etiology of illnesses and their therapeutic practices and factors influencing them
<i>Books</i>	
Danger Signals in Common Illnesses	Folk and Modern Medicine – A North Indian Case Study
	Dais - The Traditional Birth Attendants in village India
	Women and Family planning
	Primary Health Care and Traditional Medical Practitioners
	The Pill user – A study in an urban setting of Chandigarh
	Environment and Integrated Child Development Services

DoCM-SPH faculty have challenged official coverage data, and have analyzed the allocation and utilization of state health budgets. 'Unless you document that Primary Health Care in the country is in really bad shape, nothing will move...This is our duty' (I.F.1.4). A lot of research is now happening on issues of public healthcare delivery system (like cost-effectiveness and program evaluation). The faculty have written journal editorials/opinions on health system issues like privatization, and on the challenges faced by the discipline of CM. They have also written about ethical issues like plagiarism in reputed journals.

Research on community health issues is still happening, though the issues have changed. For instance, now it is more about Non-communicable Diseases (NCDs). Studies have been done to show how a part of the tertiary/secondary level care can be effectively delivered at primary level, like management of hypertension and diabetes through health workers. There has been work on verbal autopsy to ascertain causes of maternal and neonatal deaths, on respectful maternity care, and on male participation in MCH issues. Among communicable diseases, a lot of research has been done on HIV/AIDS. Tobacco-related issues have also received significant attention. For some reason, the pathological and microbiological aspects of Streptococcus have received a sustained focus.

One of the faculty, and also his students, has been consistently working towards demedicalization. They have established the effectiveness of non-medical interventions [exercises (like Kegel exercise), diet modifications and *Yoga*] in certain women's health issues, like urine leakage, uterine prolapse, Polycystic Ovary Syndrome (PCOS), infertility and osteoarthritis through Randomized Controlled Trials (RCTs). They have also disseminated these interventions in local language through booklets and videos<sup>3</sup>, thus demystifying research.

Operational research on local issues are also being undertaken, like if half of the ultrasounds happening at the RHTC are coming out normal, are the clinicians overprescribing. Some attempts at participatory action research have also been made, like the one looking at adherence to medication among people with hypertension. There are a couple of studies on the effectiveness of indigenous medicine and *Yoga*, and on indigenous medical practitioners. A part of the body of work is catering to the long-term global health agenda,

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<sup>3</sup> <https://www.youtube.com/watch?v=ww2vUFj0YXM>

like the Prospective Urban Rural Epidemiological (PURE) Study. And some vaccine trials, sponsored by industry, have also been taken up.

### **Choosing the research area/topic**

Going with the ethos of PGI, the Department of CM has also encouraged its faculty to develop their niche areas of research. Kumar (2005) gives a blueprint of this process. While the faculty under the SPH have been appointed against a specific domain of PH, even those under the DoCM have formally declared areas of interest for pursuing research work. The faculty feel that, by remaining focussed, one can reach the depths and also starts getting recognized in that area (I.F.1.7). However, these divisions are not restrictive. While more work is done in the declared areas, the interfaces with other PH domains are also worked upon. A faculty, whose niche area was Primary Health Care (PHC), said ‘When we talk of out-of-pocket expenditure for PHC, so my colleague in Health Economics and myself, we work together. You talk about interventions for NCDs and PHC, my colleague working in NCDs and me work together.’ (I.F.1.6)

A faculty shared that a large majority of the department projects do not originate in the department but are actually commissioned projects (I.F.1.2). The gaps in evidence have been identified by the program/policy people in State/Central Health Departments, and specific requests are made to the faculty researchers. The faculty then conceptualizes and designs projects keeping the expressed need in consideration. And then, there are some industry-supported vaccine trials also.

### **Dissemination of Research**

The faculty are extensively writing in journals of CM, PH and Social Medicine, and also those of other disciplines: medical (like Journal of Obstetrics and Gynaecology of India, and Indian Journal of Paediatrics) as well as social science (like Economic and Political Weekly, and South Asian Journal of Socio-Political Studies).

A young faculty informed that the published research is further disseminated using Social media like Facebook and WhatsApp (I.F.1.9). One faculty has been disseminating the research findings through books/booklets in local language, and in form of YouTube videos (I.F.1.2).

A lot of their research has been able to influence policy as ‘even at the time of conception of the research, there was a linkage between, coordination between, dialogue between the health system and the researcher or the policymaker and the researcher’ (I.F.1.3).

### **Relevance of research**

Most students feel that the departmental research is relevant to the need of the hour and is contributing to policy. There is a conscious effort in the department to ensure that nothing ‘fancy’ or ‘bookish’ gets picked up (FGD.PH.1).

However, the Researcher could sense an obsession for publishing among some faculty. Whether it is a skill building activity, or a monitoring and supervision exercise, or a rapid assessment survey, or a multi-stakeholder engagement attempt, or an outbreak investigation, or any other activity for that matter...it had to end with a publication. And they push their students for the same. ‘I make sure that at least one paper should come out, or more, from MPH, and more from PhD and MD students’ (I.F.1.8). A SR, posted at one of the urban health clinics, said ‘One systematic review, and two papers - that’s my target. These six months should not just pass like that’.

While some students use the number of publications/projects as the yardstick to judge a faculty’s worth, some students call this a ‘race for publications’ which is not making any impact on the ‘life of the people’, and is only adding to individual careers (FGD.PH.1). Even some faculty also shared this concern. ‘We usually do RCTs. RCTs get successfully completed, but then, we abandon the population. The intervention is not sustained’ (I.F.1.11). ‘The study is over, it gets published, I get the fame, I start another study. But what did the patient get’ (I.F.1.9). This was also the feeling of the government staff working at facilities managed by the Department that there is no follow-up once the projects are over. However, for the department’s staff working in the same facilities, publication was a logical endpoint to any study.

A past faculty recalled how some Paediatricians in 1970s were investing resources in finding better treatment protocols for Tetanus. Their vision was to somehow improve the survival rates from 20% to 25%, without realizing that it would still be of little meaning. ‘So, it’s a frame of mind...you are a different mind, I am a different mind, somebody else is a different mind.’ (I.PF.1)

## **Challenges in Research**

Projects commissioned by the State Health Departments, Ministry or other government agencies form a bulk of the project work in the department. This, in a way, limits the scope of research work done in the department. 'In fact, we are trying to resist it because too much work gets burdened, loaded on to us...I don't think in last five years I have done any project which was of pure academic interest'(I.F.1.6).

With regards to project proposals initiated by the faculty, one of them shared that whether or not they will get funded depends on the discretion of the committee that evaluates the proposal. If some members of that committee see the Principle Investigator as a competitor, or are not in good terms with him/her, the proposal may not get a sanction (I.F.1.2). Similarly, publication of research depends on the discretion of editorial board of the concerned Journal. A few faculty shared their personal experiences to convey that this process was not always transparent, and that, at times, delays and rejections had ulterior motives (I.F.1.2, I.F.1.9).

Doubts were also raised regarding pro-establishment bias of editorial boards in general. '...sometimes it is very difficult when politicians are involved. For example, I want to evaluate *Ayushman Bharat*. If I evaluate, and I get a negative finding...will I be able to publish it? No' (I.F.1.9). It was not just hesitancy to evaluate populist schemes. Given the general socio-political environment, there was fear as well. 'When the proper journalists are shot, for us there is no security' (I.F.1.9). And, 'There cannot be any academic growth in an environment of fear' (I.F.1.2).

## **I.3.2 Policy Advocacy**

A former Director writes that, at PGI, 'You also get an opportunity to influence decision making at the highest level in higher echelons of the Government, because it is from amongst the experts of the National Institute that the Government seeks advice for its policies and programmes' (PGI 2013, p21). While being housed in a National Institute has helped, the DoCM-SPH has also worked hard to be able to do policy advocacy.

The DoCM-SPH has been giving inputs to the States of Haryana and Punjab, and the UT of Chandigarh, especially with reference to cost-effectiveness, capacity building and availability of medicines. At national-level, faculty have been involved with policies and program

planning on Universal Health Coverage (with NITI Aayog), respectful maternity care [with Ministry of Health and Family Welfare (MoHFW)], technologies for PHC [with Department of Science and Technology (DST)] etcetera. They have participated in preparation of national guidelines like the ones related to Maternal Death Review and NCDs. They have also been part of teams that have prepared modules for ASHAs and the new mid-level health practitioners. Some faculty are members of national-level steering groups. One of them is part of the expert group of a National Institute of Yoga which is also a WHO collaborating centre. Stressing on the need for engaging with the health system, a faculty said, 'For clinicians, their patients are their clients. We also have clients. Our clients are the people who manage the health systems. And if we don't treat the problems of our clients, then we are not doing the service part' (I.F.1.3).

### **I.3.3 Teaching and Training**

The DoCM-SPH conducts three programs: MD-CM, MPH and Ph.D. There are no UG courses.

#### **Classroom Activities**

The department sees CM as composed of four domains: Health Promotion, Epidemiology, PH Management and Family Medicine. There is a daily afternoon class for MD students in the department. From Monday till Thursday, this time-slot is utilized for practicals on each of the four domains. For instance, under Family Medicine, a first year PG student presented a case of a normal ante-natal woman, and in the process, entire ante-natal care would get discussed (O.C.1.7). Under Health Promotion, a faculty gave the task of advocating for Respectful Maternity Care with the Government (I.F.1.5). She shared that, to begin with, the MD students found it difficult because there was no role of statistics in this topic. Slowly, they figured out what to argue, whom to approach and how to translate it into a program once the policy was there (I.F.1.5).

On every Friday, there is a basic lecture on one of these domains as per a fixed schedule. One of these lectures is specifically dedicated to PHC (I.F.1.1). Though, 'Primary Health Care will come in every topic...it will come automatically' (I.F.1.2). Besides, on every Saturday morning, there is a Seminar, a Journal Club or a Clinic-psycho-social case presentation. For the case presentation, the student would take clinico-psycho-social history of a real patient in the field. In the process, 'they see what could have been done at primary level, secondary

level or before that, at primordial level' (I.F.1.1). Often, research ethics would be brought in the discussions during these sessions.

Classes are also being conducted at the RHTC as students posted there do not come back to the department on daily basis. But this depends on the interest of Faculty in-charge. Presently, and may be historically, the junior-most faculty is (made) the in-charge. There is a fixed weekly schedule for post-lunch sessions that includes Epidemiology/Biostatistics, PH topics and orientation on PubMed Search and Reference Management. Friday slot is reserved for case presentation. In addition to CM, the RHTC also gets JRs from other specialties. It is attempted to include them in these academic activities, but they are usually not very enthusiastic (O.F.1.1). The Medical Officers of the Sub-divisional Hospital, which hosts the RHTC, are not a part of these endeavours.

MPH program focuses on three out of the four domains mentioned above, leaving out the Family Medicine part. It is classroom based for first three semesters, with a daily mix of theory and practicals, and some exposure visits in field. They have one full module on PHC (FGD.PH.1). Besides, along with the Junior and Senior Demonstrators, they have a PH Review once a week. Debates on PH topics of contemporary relevance are sometimes held. The fourth semester is reserved for full-time internship. For PhD students, there is an initial 45 days module on research methodology and ethics. Thereafter, there is a Departmental Research Forum once a week. The Department also invites noted PH personalities for delivering the annual lecture on the foundation day of the School of Public Health. The list of past speakers includes the likes of Dr. Abhay Bang (SEARCH) and Dr. H. Sudarshan (Karuna Trust).

There are no restrictions for students, or faculty, from attending any class or activity, even if they are not its primary participants. This offers a scope for interaction of different streams and cross learning. However, because of busy or overlapping schedules, or because of lack of insistence, this doesn't seem to be happening much (O.C.1.3), except, to an extent, in the Saturday morning sessions. PhD students shared that, many-a-times, clinical topics are discussed in the Journal Club sessions. 'People who are from other background, maybe they are clinically not that good. So, they tend to sit quiet, they are not able to express themselves...' (FGD.PH.1)

Faculty take efforts to make lectures interesting. This they do by bringing in real life examples based on their own or other's field experiences. 'Without telling a practical experience or practical relations, it will be very difficult for them (students) to catch the principle' (I.F.1.9). They relate the concept to a process which the students are already aware of (O.C.1.2), and show its current relevance. For instance, in a lecture on Health System Strengthening, the faculty tried to compare investing in insurance (like the one in *Ayushman Bharat*) versus providing funds for PHC (I.F.1.6). The faculty narrate short stories to make a point; and crack jokes to lighten the mood during the lectures. A faculty briefly talked about the movie *Motorcycle Diaries* in his lecture (I.F.1.12). Some faculty also take feedback from students to ascertain if their efforts are making sense to them (I.F.1.9).

One characteristic observed in all classroom sessions was their punctuality. They would start and finish on time, even if this meant cutting the discussion abruptly (O.C.1.5). While the presentations had to be made in English, the house was more liberal with the language during the discussions. The focus on socio-economic deprivations was, however, largely limited to whether or not the student has correctly classified the case as per the standard system (like the Modified Prasad's Scale). While in some lectures, faculties gave time to students to ask question (O.C.1.3; O.C.1.7), this was not the case always (O.C.1.6). More common was faculty's incessant questioning when a student was making a presentation (O.C.1.1, O.C.1.5). Secondly, the faculty expected the questions to be answered in brief (O.C.1.4). 'Muddling-through' was not allowed.

The academic activities are highly valued by the MD students as not many Departments in the country have it so structured. However, they also resent it for the same reason. While in other colleges, the MD students would be free to explore different avenues of learning, things were very straight-jacketed at DoCM-SPH. 'It is very difficult for the post-graduates from here to attend even trainings which are going on in the same Institute' (FGD.MD.1). Secondly, the MD students feel that they are not taught as intensively as the MPH students. Even the faculty acknowledge that the MD program is 'more on medical side' and doesn't include other aspects as much as MPH program does (I.F.1.4). Some opined that the MPH program has been treated like a 'pampered child', which has 'diluted' the MD program (I.F.1.2, I.F.1.7). But, with MCI being at the helm of curricular affairs, the faculty felt there was little that they could do (I.F.1.4).



## **Field Activities**

MD students spend a year each at rural health facilities (RHTC and others), urban health facilities (UHTC and others) and in the MC hospital. There are no postings with the health department at district/corporation level.

One of the rural postings, the one at RHTC, is residential. Apart from CM, JRs and SRs of Paediatrics, Obstetrics & Gynecology and Radiodiagnosis are also posted at the RHTC. Those from Psychiatry and Radiotherapy also come once a week. JRs and SRs of CM handle NCD OPD on every Tuesday and Thursday at the Sub-divisional Hospital. On Fridays, they run a general OPD at a nearby Subcentre. For rest of the days, they are engaged in field activities, research, reporting and assignments. Depending on the need, they refer patients to PGI, but there is no mechanism of fast-tracking and follow-up. The PGI staff (CM and others) manages more than half the OPD of this Sub-divisional Hospital as many of the state government's posts of doctors are lying vacant. So, practically, the PGI SRs-JRs are here more to fill the gaps in delivery of clinical services and less to get a direct orientation to rural community.

At other health facilities/areas (other than the RHTC), the students commute on the days of clinic, which may range from daily to weekly. The students run a primary-level OPD in the morning hours and return to the department by afternoon for the classroom activities. At times, there are special screening camps for conditions like NCDs. The OPD workload doesn't generally allow the students to go in the community (O.F.1.2). Though, they do venture out when required academically (like for giving health talks or taking clinic-psychosocial case history for presentation in the department), or contextually (like visiting 'problem families', conducting verbal autopsy, organizing health awareness campaigns or investigating outbreaks). Each posting is three months long, and the patients do not appreciate that their doctors change every three months.

The daily slot from 8 am to 3 pm, when the MD students are in field, has been designated for 'Community-based Teaching'. Though SRs oversee the JRs, direct engagement of faculty with field for this purpose seems to be less frequent due to their other formal engagements. 'Some faculty are very very interested to visit the fields. Some faculty are not. That is a problem here' (I.F.1.9). Faculty involvement in field-based postgraduate training used to be

better in the past. Some faculty, who had done their PG from the same department, recalled having been exposed to PRA techniques and village walks during their field-based training, but they do not see these being used any more. 'May be I was lucky enough to be in the initial few batches when everybody used to get proper attention, when the department was smaller...I was lucky. Now I don't know...' (I.F.1.10). Even when a faculty was out in field, he was busy finalizing a paper on his laptop instead of accompanying the SR to the primary school for a health talk (O.F.1.3). Unless the faculties engage in field-based training, the JRs will simply carry forward their UG experiences (I.F.1.10).

But then, there are other practical ways which the faculty use to train their students. A faculty shared that one his MD students had identified children with refractory errors while doing health check-ups in a school. As the number of such children was not high, it was well within his means to sponsor the spectacles. 'But what will you learn from this? We need to pull out the specs from the pocket of the one who is supposed to give it'. So, one after the other, he asked the student to contact the Medical Officer of concerned Primary Health Centre, the Program Officer managing School Health in the District and the Civil Surgeon of the District. When none of them could help, he drafted a letter and sent the student to bring this in the notice of the MD-NHM. 'So what happens with all this? My job is to give training to these people. How many levels the system has, how does it run, what are its strengths, what are the weaknesses...and if you want them to act, how to do so' (I.F.1.7). And the faculty would relate such experiences with theory. 'How to put forth one's agenda while satisfying other person's ego...how to use those principles of Transaction Analysis while seeking inter-sectoral co-ordination...this I try' (I.F.1.7).

The opportunity to see patients is a pleasant revelation for the newly joined MD students who otherwise come with a 'dry' image of the discipline. One such student, after a week of joining the department, said 'now, what I feel is that no, it is not a non-clinical completely, it is clinical only' (FGD.MD.1). However, for the in-service MD candidates who already have experience of handling primary-level OPD, this goes counter to their expectation from the course.

During the hospital posting, the MD students go for three months each in Internal Medicine, Obstetrics & Gynaecology and Paediatrics, for two months in General Surgery and for a

month in Microbiology or PH Laboratory. The purpose of these posting is to get the student trained enough to be able to independently manage a primary-level OPD, emergency and laboratory, and to make timely referrals (SPH 2014). This is somewhat similar to what a graduate is expected to learn during the internship.

As can be seen, a significant proportion of the MD students' time is spent in delivering, or learning, clinical care. SRs-JRs agree that their interaction with patients in field OPDs is no different than what a Medical Officer might be having at a Primary Health Centre (FGD.MD.1). The history doesn't extend into occupational, environmental and social domains (O.F.1.2, O.F.1.4, O.F.1.5), except if one has to present a clinic-psycho-social case. This focus on clinical training/work was limiting the opportunity of the JRs to get experiential PH insights from the faculty (FGD.MD.1). Unfortunately, even the social science faculty took this clinical bias for granted saying that 'these people will always be doing more of curative work'.

The way CM JRs behaved with the patients in the clinics varied widely, from being sensitive (O.F.1.5) to being indifferent, and at times, blunt (O.F.1.4). Similar variations were seen among the JRs at community level. A faculty, who otherwise avoided taking cold-drinks, readily accepted it in a house so as not to offend the family (O.F.1.2). A SR gave a health talk in a primary school with the desired informality, except keeping the stethoscope round his neck all the while (O.F.1.3). However, in another field visit, when the SR reached the home that had suffered death of a child a few days back, the mother was in the middle of cooking the lunch. Without any introduction, forget taking consent or asking if it was an appropriate time for the conversation, the SR started filling out the long Child Death Review format (O.F.1.4). In another area (O.F.1.1), a SR was following-up an outbreak of diarrhoea by filling out a format in affected households. A female patient informed that she had felt very weak and ill, but didn't get admitted because, then, who would have done the household work. This response didn't make the SR to pause and think. He simply jumped to next 'yes/no' question.

## Research

### ***Choosing the research area/topic***

The area and topic students choose for their research is significantly influenced by the interests of their research guides. Though, there may be slight variations across programs.

- PhD students have to first identify an area, figure out who can potentially guide in that area, check the availability and interest of that person and only then join the department. However, many of the PhD candidates at DoCM-SPH are former MPH students of the department. They tend to continue with their ex-guides, and choose a topic accordingly.
- The number of MPH students is more than the number of available guides. So, the students get an opportunity to propose what broad area they would like to work in. This is matched with the declared interest areas of the faculty, and guides are allotted accordingly. Thereafter, the topic is finalized, keeping the background<sup>4</sup> of student as an important consideration.
- The number of students who join MD in the department in a year is less than the number of available guides. So, not all faculty get a new student each time; it happens turn-wise. And so, the allotment of guide happens first, and any discussion on the research area/topic happens subsequently. As not many students have a well formed mindset regarding what to work on, they do not mind working on an allotted area/topic. And then, 'if it is an area which the faculty is good at, he would be able to supervise the student in a better way' (I.F.1.8). In case a student doesn't wish to work in the suggested area, there is a scope for change of guide. Leaving things entirely on students' interest might skew their distribution across faculty. Students might fabricate 'interests' so as to get a particular faculty as their guide. 'That is a sensitive issue' (I.F.1.3).

Irrespective of the mechanisms in place, practically, the topic selection is significantly influenced by the guide's interests at that point in time.

### ***The Research Areas/Topics***

SPH 2014 presents lists of theses completed by students under different programs [PhD (n=14), MD (n=30) and MPH (n=34)]. MD theses have covered a diverse range of topics:

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<sup>4</sup> MPH students come from diverse backgrounds, like Dentistry, AYUSH and Veterinary Science

Child Health, Adolescent Health, Elderly Care, Women's Health, Road Traffic Accidents and Injuries, NCDs, Substance abuse (tobacco), Mental Health (Stress, Depression), non-medical interventions (use of hot water bottles for dysmenorrhoea), Health Programs/Schemes (ARSH, RSBY), Environment (Indoor Air Pollution), treatment seeking behaviour and evaluation of specific research methods. The students have done evaluations, quality assessments, knowledge and skill assessments, costing studies, comparisons and RCTs. The studies have largely been community based.

The six PhD theses submitted between 1983 and 2003 were all community based. However, six out of eight theses submitted between 2006 and 2011 were laboratory based, apparently falling more in the domain of Microbiology/Pathology than PH. For instance, one of the topics was 'Role of Collagen Binding Proteins in the Pathogenesis of Actual Rheumatic Fever and Rheumatic Heart disease (ARF/RHD)'.

The topics of MPH dissertations are relatively more unconventional, like 'Socio-Economic differentials in health service utilization among HIV/AIDS cases'. Domains like out-of pocket expenditures, job satisfaction, hospital safety during disasters, Bio-medical Waste Management and Environment have also been covered besides NCDs, Reproductive Health, RNTCP and IDSP. Topics like 'Extent and determinants of housefly problem and its impact', and those on dental health and on nursing curriculum, reflect the disciplinary backgrounds of students in this course.

### ***Following the research findings***

Whether the research gets disseminated and followed depends on the interest levels of the students and their guides. How this is done depends on the research topic and the findings. Publishing paper(s) is the most common way to disseminate the research, and both student and faculty at DoCM-SPH are particularly keen on it. If the research findings have some program implications, they are shared with the concerned program officer. If the guide feels that some part of it needs further study, s/he may suggest the next student to explore that area further.

It is not generally expected that a student research would inform the policy or program. This may happen only coincidentally. Based on his/her engagement with the community or the healthcare delivery system, the guide may have picked up some evidence-gap which the

student then works on. For instance, when the people in his field practice area complained about the problem of flies because of a nearby poultry farm, the faculty asked a student to study this issue for his dissertation. Secondly, if the guide is well placed in the policy circles, s/he may have been asked by officials to give some specific evidence-based input just around the time when the student is finalizing his/her topic. Like, a faculty was asked by a State government to evaluate the impact their *Beti Bachao Beti Padhao* campaign on the child sex-ratio which he suggested as a potential topic to a student interested in doing some impact assessment. In such cases, the student research, if done with adequate rigor, could influence the policy. But otherwise, 'how to convert the research into policy, how to bring them into action...that part is very weak' (I.F.1.7).

Despite such an exhaustive PG program, it is counter-intuitive that not all seats at DoCM-SPH get taken. A faculty tried to explain this (I.F.1.3). Almost till the time of this study, PGI used to conduct its own PG entrance examination. Those who would be able to clear it would be relatively a brighter lot in comparison to those who cleared other State/All India PG entrance exams. And so, those who would get an offer to join CM at DoCM-SPH would get a clinical seat through other exams. The charm of 'clinical' would pull them towards other institutes rather than joining CM at PGI, and thus, the seats here would remain vacant.

### **Other Teaching/Training Activities**

The DoCM-SPH periodically conducts a Research Methodology course which is open to JRs from all department of PGI. Some of the faculty supports the MPH course at Punjab University. Some of the faculty also organize national and regional workshops for the MC faculty, JRs and PH professionals from different institutions.

### **I.3.4 Field Activities**

The nature and area of fieldwork varies from faculty to faculty. Those from SPH side engage with activities like supportive supervision, program monitoring and capacity building. Those from DoCM, in addition, may see patients. While some of them relish seeing patients, some feel that this is not their prerogative. Some of the faculty have formed health committees with community representatives and local officials in their areas, and they tend to attend its

meetings. Faculty also participate when some special 'days' are celebrated in the field area. Research projects are another major motivation for the faculty to go into the field.

One of the faculty, mostly the junior-most, is stationed at the RHTC. This faculty supervises and facilitates the learning of the SRs and JRs posted at RHTC; participates in NCD clinic at the hospital to which RHTC is linked; conducts outbreak investigations in surrounding villages; maintain liaison with district health officials. This faculty is also responsible for the maintenance of the office space and the residential complex at RHTC.

The department also has a few ANMs, Multi-purpose Male Health Workers, Public Health Nurses and Medical Social Workers (MSWs), on its payroll. They do periodic demographic and health surveys, provide health education and deliver services under the National Health Programs (mainly MCH) in the defined population along with the government staff. They are also engaged with specific activities undertaken by the department/faculty, like a rapid survey on NCDs (Asthma, Hypertension and Diabetes). The population catered to in this fashion consists of rural folks, or migrants living in urban slums/re-settlement colonies. The department has also employed a few Pharmacists and Lab Technicians to support clinical services at the field posts that it directly manages.

While the field areas have been used for research and for training students, it is unclear if there was an intention or effort, especially post 1990s, to bring comprehensive and sustained change in the lives of the people living in these areas. This is difficult in the current set-up where the efforts made by different faculty of the department in the field are geographically isolated. One faculty felt that the effort should instead be made in the same area so that there are synergies and a visible cumulative impact (I.F.1.7).

There are some logistic challenges in field. The construction of new building for UHTC has been pending for several years despite approvals. With respect to maintenance of RHTC complex, a faculty shared that 'PGI almost disowns this facility' (I.F.1.9).

## **I.4 Department Interactions**

### **I.4.1 With other Departments of the Institute**

#### **Research**

Collaboration seems to be an institute-wide culture in PGI. The faculty, depending on the needs of a project, collaborate with various departments of the Institute – Obstetrics and Gynaecology, Paediatrics, Microbiology, Psychiatry, Pulmonology, Hepatology, Orthopaedics, Dermatology etcetera. Similarly, the faculty from other departments also approach DoCM-SPH. This is because a) DoCM-SPH offers a base in community; and b) these departments value the research expertise of the faculty of DoCM-SPH, and their understanding in specific domains. The frequency and extent of these interactions may, however, vary across the faculty.

Even for student research in the DoCM-SPH, the faculty of other departments serve as co-guides, depending on the topic. And this happens the other way round as well. There have been occasions when the institutional research/ethics committee has suggested the students from clinical departments to take the faculty of DoCM-SPH as co-guides. In some cases, this goes overboard resulting in PhD students having up to seven guides! Many a times, students, on their own, approach the CM faculty just for help with sample size calculation and for data analysis. However, the experience of students of DoCM-SPH, who have gone to ‘collect data’ from other departments, has not been good.

#### **Teaching/Training**

JRs are posted in the major clinical and diagnostic department during their second year. The faculty are sometimes asked to conduct short training programs for the staff of other departments on topics like leadership and management. SPH 2014 mentions Clinico-pathological Conference as one of the Institute-level teaching activity. Several ex-Directors have fondly remembered the educative potential of these conferences which involve several departments (PGI 2013). For some reason, it wasn't mentioned by any DoCM-SPH faculty or student. It seems that the opportunity provided by these conferences, to add PH perspectives to the clinical and pathological discourse, is not being used.



## **Service**

SRs and JRs from other departments (Paediatrics, Obstetrics and Gynaecology, Radio-diagnosis, Psychiatry and Radiotherapy) attend clinical duties at the RHTC. Though, the senior faculty are busy with their responsibilities at the base hospital.

## **Participation in Institutional Activities**

The faculty, working in the area of health management, had served in administrative capacity in the Institute. The present Head of the Department is also the Dean (Academics) in the Institute. One of the faculty is a member of the Institutional Ethics Committee. Such placements give ample opportunities to interact, understand and build relations with other departments. However, the department is not presently represented on some of the other committees like the one on Collaborative Research.

## **Department Status**

The department has close collaborations with other departments through research projects and student thesis. Some faculty even feel that other departments feel 'privileged' if they get a chance to work with the faculty of CM (I.F.1.4).

### **I.4.2 With Department/Faculty of CM of other Medical Colleges**

The faculty interact with those from other departments if they happen to be part of some multi-site research project. At times, these projects are also planned in a collaborative fashion. They are also called as resource persons, or as examiners, by other CM departments. They may share space with faculty from other departments as a part of some high level expert group; during a meeting at the Ministry; or during some workshop. Email groups and social media platforms (like WhatApps and Facebook) are the new forums where interaction happens. The faculty also attend conferences specific to their area of work, and also the more generic ones.

The faculty generally prefer conferences specific to their areas of interest rather than the generic ones (I.F.1.3). Some faculty found the popular national conferences to be deliberating on relevant issues, including PHC (I.F.1.6, I.PF.2). Others, however, were critical of these conferences for giving little focus on the academic/professional content (I.F.1.7,

I.F.1.9). Instead, the focus is on 'eating, drinking and election' (I.F.1.7). Moreover, the discussions at such conferences don't lead to anything substantial (I.F.1.1, I.F.1.2, I.F.1.7). They do attend conferences, for social reasons (I.F.1.3), or under academic compulsions (I.F.1.7), or because they get invited. A faculty having background other than medicine found these conferences discriminatory, unlike the international ones (I.F.1.5). During student years, cost of attending conferences is also a concern (I.F.1.9).

### **I.4.3 With Government Health Department**

#### **Facility level**

The department has more than ten facilities/areas for its field practice. The nature of engagement varies across the facilities/areas. It may involve managing the OPD, monitoring national health programs, doing supportive supervision, holding different health campaigns or investigating outbreaks. At each of these, the faculty, students and staff of the department are expected to work in close co-ordination with the government staff. However, there is little interaction except for administrative reasons. The government health staffs do not seem to be happy working at facilities managed by the Department, because it brings more work and closer supervision (O.F.1.4; O.F.1.5).

#### **District/Corporation level**

The faculty submits reports and shares feedbacks from the respective facilities/areas with the concerned district/corporation health office. They are invited as trainers for training the government staff, and are called to investigate if there is an outbreak. In past, some faculty were engaged in preparation of annual Health Action Plans at different levels.

#### **State level**

The department has signed MoUs with the States of Haryana and Punjab and the Union Territory of Chandigarh to do collaborative work at some of the health facilities/areas. Very often, the faculty are asked to provide specific evidence-based inputs for policy, or to evaluate a State's health program. They collaborate with State-level Health Society, AIDS Control Society and the TB Office.

## National level

Some of the faculty members are, or have been, members of national-level steering committees and expert groups. They are called for inputs at the Ministry of Health and Family Welfare, the National Health Systems Resource Centre, the Medical Technology Assessment Board, NITI Aayog etcetera. The Department has historically been working closely and extensively with the Indian Council of Medical Research.

The faculty regard officials in government health services as 'equal partners'. 'Rather, I give more importance to these people, and I tell them that "you are the practitioners...we are learning many things from you"' (I.F.1.4). They proactively tell their students not to think 'that we are from PGI' when meeting these officials (I.F.1.7). This understanding among the faculty was visible in the field (O.F.1.3).

The faculty also face challenges in interacting with the government health departments. They do not have any 'authority' in the system so as to really push hard for change (I.F.1.10). The government counterparts see them as 'outsiders' and may not (always) co-operate (I.F.1.5). They can't be very overtly critical, because the other party may simply shun them away; they don't have any 'binding relationship' (I.F.1.13). Things get better as rapport develops, but then, the officials get transferred and the situation is back to square one (I.F.1.10).

### I.4.4 With other Government Departments

The department faculty have been closely working with the functionaries of Integrated Child Development Scheme at various levels. It starts with the workers at the *Anganwadi*, to the Child Development Project Officers and, in past, has extended up to the Central Technical Committee. The engagement of department has ranged from doing regular examination of the children at *Anganwadi* centres to giving training of their staff, and engaging them with research projects related to nutrition. In past, the department had also undertaken evaluation surveys of the scheme in several districts.

Besides ICDS, They have interactions with the Department of Education with regards to School Health Program. Sometimes, the faculty are approached for imparting training to teachers and students on some health issue, like first aid.

Some of the faculty have done research with support/collaboration of the State Pollution Control Board, and State Departments of Science and Technology.

‘Beyond that, we have not been able to go...that you are taking support from agriculture people...or for safe water...all this is addressed through the *Sarpanch* or BDO’ (I.F.1.7).

#### **I.4.5 With Others**

The faculty have research partnerships with local (like Punjab University; Institute of Microbial Technology), national (like Indian Institute of Technology) and international Institutions (like University of Oslo, International Union against Tuberculosis and Lung Diseases). They have been instrumental in formation of PH (like World NCD Federation, Association of Health Systems Analysis and Strengthening), or are part of such networks (like the White Ribbon Alliance).

Depending on the needs of the project, the faculty collaborate with, or take help from, diverse professionals ranging from nutritionists to engineers and from chemists to mathematicians. The faculty work with staff from different backgrounds like Sociology, Anthropology, Economics, Social work and Law. Some of the faculty have formed health committees in their field practice areas in which they interact with people from varying socio-economic status.

Two of the present faculty, one of whom is a sociologist, attended the Fourth National Health Assembly called by *Jan Swasthya Abhiyaan* in 2018. However, most of the faculty didn’t have any linkages with, and were not even aware of, organizations and movements working towards empowering people at the grassroots and mobilizing them for PH advocacy.

Some faculty had a bias for NGOs. In one of the Journal Club meetings, a faculty highlighted the background of authors as being from an ‘NGO’, and associated this with the weaknesses of the study (O.C.1.4). However, the department had been inviting famous and dedicated Doctors from NGO-side for annual lectures on the foundation day of the School of Public Health.

## **I.5 Intra-departmental Interactions**

The DoCM-SPH, among faculty as well as students, has people from medical background and from backgrounds other than medicine. Those with medical backgrounds generally address one another as 'Dr.' X and 'Dr.' Y.

### **I.5.1 Faculty-Faculty**

The faculty at DoCM-SPH have different field areas in which they engage in their own ways. They also have distinct and declared areas of interest, based on which they plan their work and interactions. Often, the faculty work collaboratively across these boundaries. But at times, these boundaries are crossed without taking the other person in confidence (I.F.1.7). Overtime, such and other issues have led to formation of groups within the department (I.F.1.2). Faculty meetings, which used to regularly happen earlier, are now rare (I.F.1.4). But at the same time, one can find a group of faculty enjoying tea together at a nearby stall.

Besides those who are MD-CM, DoCM-SPH has four faculty who have different backgrounds. This includes Environmental Science, Laboratory Science, Nutrition, and Sociology. There are mixed views about this fusion. Most of the MD faculty are comfortable with it, and some find it enriching (I.F.1.1, I.F.1.3, I.F.1.4, I.F.1.6, I.F.1.8, I.F.1.9, I.F.1.10, I.F.1.12). 'Our orientation is gradually getting wider...(the) department has grown, and we have grown as individuals by working together with different disciplines' (I.F.1.6). Explaining how she personally benefitted while working with the social scientist, a faculty said, 'I realized how she is approaching the patient, and what were the problems in me' (I.F.1.1). And some even advocated that 'we need to open our doors for other people so that we become more inclusive to address the issue(s)' (I.F.1.4). However, a few faculty were not happy with entry of non-medicos in the department.

The faculty from other disciplines, being in a MC set-up, find 'that intellectual discussion and interaction' as sometimes lacking (I.F.1.13). At times, they also feel discriminated. 'There is always a resistance. There is no easy acceptance. So I face these things. But I am making my own space' (I.F.1.13). 'I don't feel equal. Certainly, I don't feel. I don't feel equal...you say "do whatever I am asking you to do". You don't let me contribute as a professional in my field. They don't give them that space...there is a struggle, quite a lot of struggle' (I.F.1.5).

### **I.5.2 Faculty-Student**

While the faculty do not make the medico versus non-medico hierarchy felt in the class or in personal interactions, they allow it to become evident in other ways. When advertising for positions in 'research' project, the department would ask for work experience from PhD candidates, but not from those having MD in CM (FGD.PH.1). Subtle references to considering MD students as more capable than others were made during some of the faculty interviews (like the one with I.F.1.2).

Even the students felt differently for the two types of faculty. While they may get non-medical faculty as guides, there has been at least one case in which a request for change of guide was made (shared by I.F.1.3). Even in teaching, students feel that the non-medico faculty largely talk about the technicalities of their own discipline and are not able to link those things adequately with health. Moreover, in addition to the MD students, the background of even most of the MPH/PhD students is also from science stream (BDS or BAMS). So, while they can still digest the technicalities of environmental health, lab sciences and nutrition, social science disciplines may still be Greek for them.

### **I.5.3 Student-Student**

The interaction between MPH/PhD students and the JRs/SRs is limited. Even in this limited interaction, the students with non-medical backgrounds feel that, in general, 'they think that we are inferior' (FGD.PH.1). This may decrease with time as the medicos see the quality of their work and find the faculty appreciating their efforts. But it mostly doesn't (FGD.PH.1).

### **Summary Statement**

DoCM-SPH conducts MD and MPH courses and also offers PhDs. The department has several field practice sites, including a residential RHTC and a UHTC, used for training students and conducting research. The faculty are especially focussed on public-funded research projects and publications, and have been producing useful evidence for policy at State and National level. However, its field interventions are project-led (i.e. top-down and time bound), and its community-based teaching has become weaker over a period of time.

## II. Department of Community Medicine, The Second Institute (DoCM-TSI)

### II.1 Background

The State where The Second Institute (TSI) is located is one of those whose socio-economic and health indicators are better than the national average. The State's Directorate of Public Health (DirPH) is led by PH/CM qualified doctors. These doctors acquire key health administrative positions at District and State level, in local bodies, and in other departments linked to health.

The Second Institute (TSI) is one of the older Government MCs, located in the capital of the State. 'Mighty', 'prestigious' and 'apex' were some of the adjectives used for the Institute by the faculty and students. It had an UG intake of 165 students till three years back when it got increased to 250.

Like TSI, its department of Community Medicine (DoCM-TSI) is also one of the older departments. Earlier, the department was responsible for the PH aspects of the entire city. 'They were doing the meteorological works...sanitation works everything was controlled by this department along with <name of the Municipal Corporation>' (I.F.2.7). This mandate started receding once the State formed a separate DirPH. However, the key administrative post in the DoCM-TSI was kept reserved for senior officials from the DirPH. A faculty shared that this arrangement was actually created to maintain a close co-ordination between these two entities (I.F.2.7). The same arrangement, where a senior DirPH official holds the key administrative post in the DoCM-TSI, was continuing till the time of this study.

Similarly, some of the faculty positions in DoCM-TSI have also historically been filled by officials from DirPH. This was based on the philosophy that 'the implementer should be the educator' (I.F.2.10). The remaining positions have been filled in the conventional way, which is through the Directorate of Medical Education (DME). Though there were issues<sup>5</sup>, this

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<sup>5</sup> Firstly, DirPH officials could join DoCM as Assistant, Associate or Professor based on their years of service in the PH Directorate and not based on years of teaching experience (I.F.2.3, I.F.2.9). The requirement of certain number of publications didn't apply to them. And even those having a Diploma in PH, not an MD-CM, could also join (I.F.2.3, I.F.2.9). Secondly, many DirPH officials in past saw posting in DoCM as something inferior, and so, they didn't take much interest in department activities (I.F.2.3, I.F.2.7, I.F.2.9, I.PF.3). Thirdly, the Researcher could sense an element of adhocism in functioning of the department where things would suddenly happen. This, he thinks, was because the leadership was from the 'program side'. However, for

linkage between the CM department and PH services was considered desirable by several faculty (I.F.2.3, I.F.2.4, I.F.2.7, I.F.2.10, I.PF.3). The faculty and PG students were able to get updates about recent changes in policies and programs and the rationale behind those changes. Also, the PG students and some of the junior faculty were able to get hands-on experience in how programs are implemented and monitored.

However, DoCM-TSI was deficient in number of faculty till very recently (I.F.2.1, I.F.2.4, I.F.2.7). 'We were really very skeletal...from 2001 till about one year back, we were just one Professor, one Associate, two APs...that was the entire department. No tutors, nothing' (I.F.2.4). Consequently, the faculty were dependent on the PG students for UG teaching and struggled to go beyond classroom. For last two years or so, the department has had sufficient number of faculty. One thing specific to DoCM-TSI faculty was that most of them had worked at a Primary Health Centre for three or more years before joining PG and becoming a faculty (Table 8).

Besides UG course, the DoCM-TSI also offers two PG courses: Diploma in PH (DipPH; ten seats) and MD in CM (four seats). UG students (UGs) who enter TSI are the highest scoring ones in the State. And so, faculty said, they have an 'attitude' unlike their counterparts in peripheral MCs (I.F.2.2, I.F.2.5, I.F.2.9, I.PF.3). The selection of students was earlier based on a State-level process, but was now happening through NEET. This had changed the class character of UGs. A faculty, during informal conversation, shared that 'I could find a housemaid's child in the class earlier. Now, most of them are from cities. Many have at least one of the parents as a doctor or in class-I job'.

PG students (DipPH as well as MD) at DoCM-TSI are of two types: in-service candidates sponsored by the government, and fresh ('private') candidates. While the in-service ones have to compulsorily join government service after the course, even the 'private' ones have to serve the State for two years. Three out of every four PG students (MD and DipPH) are from the health services, and thus, come with field experience.

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various reasons, this arrangement has been undergoing a transition since last few years. Though DirPH officials still join DoCM, it is ensured that they are MDs (I.F.2.3).



## II.2 Department Infrastructure

TSI has a spread-out campus. The MC Hospital and core clinical departments are located in the old campus. About half-a-kilometre away is the new campus that houses UG hostels and the academic block. Some clinical departments like Paediatrics and Obstetrics and Gynaecology, have separate campuses a bit far from the main hospital. The distance is a challenge for the students when they have to go for taking clinico-social history as a part of their half-day CM postings (O.C.2.1).

As one walks towards the new campus, a river heavily polluted by urban sewage can be seen sluggishly flowing on the left. Posters of coaching institutes for PG entrance greets at the main gate. This campus was built just a couple of years ago so as to accommodate the increased intake at UG-level. The new college building has a robust look. It is a ground plus six floor structure in which DoCM-TSI shares the fifth floor with Forensic Medicine.

All Professors have a separate room, Associates and Assistants share rooms partitioned into cubicles, and there is a designated room for the PG students. There is one giant lecture hall equipped with audio-visual aids where CM classes are held for the UG batch of 250. In addition, the department has a smaller classroom having a giant rotating blackboard with wooden frame. The department's office has a biometric equipment for recording attendance. Right across the office is a meeting room. Somebody had written 'Community Medicine' on the door of the meeting room with a chalk, and had drawn a small Stethoscope next to 'Medicine'. This room also has facility for projection. Only the meeting room and the room of the Head have Air-conditioners, which are used sparingly. Otherwise, given the excellent ventilation, fans suffice.

The lobby has posters on National Health Programs like RNTCP and Vector Borne Disease Control Programs. Some posters have been hand-made or digitally-made on the occasion of World Water Day, World Disability Day and World Health Day. One poster announces a cooking contest held during National Nutritional Month.

The Institute has three Primary Health Centres and one Urban Health Centre 'affiliated' for teaching purpose (I.F.2.2). While the former are under DirPH, the latter comes under the city corporation (I.F.2.1). These centres have their own staff and the TSI/DoCM-TSI has no control over their activities (I.F.2.6, I.F.2.9). Further, DoCM-TSI is entirely dependent on the

MC administration for making vehicles available for visits by its students and faculty to these centres.

## **II.3 Department Activities**

### **II.3.1 Teaching and Training**

#### **Activities with Undergraduate Students**

##### ***Classroom Activities***

The classroom activities consist of lectures, seminars, presentations on clinico-social history and practicals. All lectures are taken in batch of 250. The faculty talk about the concept of PHC, about the principles, about functions of health facilities at primary-level and the duties of the involved staff (I.F.2.5). 'I will ask them to imagine themselves as the Medical Officer of a Centre where there are no other lab facilities. Then only they will have (an idea) what they are supposed to do' (I.F.2.2). The faculty quote examples from their own field experiences and give case scenarios to set the students thinking (I.F.2.9). 'Today it might sound very theoretical to you. But this is what ultimately you will be practicing. You will not be seeing a tricuspid incompetence with...mitral competence with this and that...' (I.F.2.4). The faculty stresses on the students that they owe a lot to the community. 'You are studying in a government college...Forget the cost part, the exposure that you get in this college, you will not get anywhere...(So) always remember, when some patient comes, you must be in a position to talk to them, explain to them' (I.F.2.1).

A senior faculty listed the three key domains of CM: practice as a community health physician, research and health administration (I.F.2.3). 'Each doctor who goes out should have all the three roles. In a Primary Health Centre...He should be responsible for that area. He should feel that the health of those people is in his hands. If he thinks that I have to just clear-off the OPs, like any clinician in the hospital, he is not going to become the right kind of person for the Primary Health Centre'; further, 'he should be equipped to be able to plan, to implement something. He should be able to understand what the problem is. He should have a questioning mind. He should do research at that time' (I.F.2.3). That's how she taught the UGs.

For the Seminars, groups of students are given topics which are most relevant for exams and are asked to make presentations. The Researcher could attend one such seminar on Zoonosis in which students of 7<sup>th</sup> semester made presentations on diseases like Nipah, Ebola and Scrub Typhus (O.C.2.2). The young faculty, accompanied by a PG, was appreciative of every presenter and would initiate discussion after each presentation. She would go on to add useful and interesting details like, 'why should we be reading about this disease even if this has never ever been reported from our country?' She would also use the presentation to drive across basic epidemiology concepts like 'Case Fatality Rate' and 'Endemic'. She stressed more than once that one should also care about animal health to ensure human health, and that one need to co-ordinate with the Veterinarians. The discussion at times went on the clinical side, like how would one detect internal haemorrhage, but that part didn't dominate. The students keenly listened to the presentations; though, they didn't ask questions.

For block postings, students come in batch of seventy-five. During the posting in 6<sup>th</sup> semester, students take clinico-social histories of ante-natal women, under-5 children, children with ARI or diarrhoea, patients with fever, TB, Leprosy, Diabetes and Hypertension from hospital OPDs/wards. They then present these cases in the department. The Researcher could observe one such history-taking and presentation as a part of the Model Practicum Examination (internal assessment) for the 7<sup>th</sup> semester student (O.C.2.1). The student took clinico-social history of a 50 years old lady admitted in the Medicine ward for some complication related to hypertension. The student did general physical examination of the patient and asked questions like how many members were there in the family, how much they earned, what type of a house they lived in, what was the size of the rooms and what kind of toilet they used.

Apart from this case, those having Fever, Tuberculosis and Leprosy were also presented to the Faculty-examiner with whom the Researcher had the opportunity to sit (O.C.2.1). The students shared patient's vitals, findings of systemic examination, type of family (nuclear, extended, joint), socio-economic classification (as per Modified Kuppaswamy Scale), diet deficits (24-hour recall), type of house (*kuccha*, *pukka*), type of latrine, etcetera. The faculty asked questions related to the social history ('Where did the patient take TB treatment from: private or government?') and on related epidemiological concepts ('What is active

and passive surveillance?'). She also asked clinical questions ('What are the signs of Rheumatic Fever?'; 'How do you grade breathlessness?'). The lady with hypertension had a 31-year old unmarried daughter. That this could be adding to the stress, didn't come-up in the discussion. While this particular clinico-social case presentation was a part of internal assessment, in normal course, such presentations are a good opportunity to discuss with students how to comprehensively manage patients at primary, secondary and tertiary level (I.F.2.3).

Concerns were expressed about the poor attendance of students in classroom activities. 'If 75 are posted, only 35 will come' (I.F.2.9). The senior students would tell the juniors that it was a light subject; that they could clear it even if they study in the last; and that the department wouldn't harm them much (I.F.2.4; I.PF.3). One faculty acknowledged that there were problems with the department too. 'We have to fulfil their objective for coming. If you are not teaching them, they will not come' (I.F.2.9).

A 7<sup>th</sup> semester UG student, during informal conversation, shared that the situation in DoCM-TSI had become much better in last two years. The department had got somewhat strict about attendance, and so, the students have started taking things seriously. As a subject, he liked 'the part dealing with health', by which he meant the National Health Programs, 'where you have to distribute medicines, the ante-natal care, post-natal care, vaccination etcetera'. But he was not comfortable with the part dealing with 'policy', 'planning cycle', 'study', 'experiment', and the 'social'. Much of it, according to him, was meant for senior people working at higher positions.

### ***Field Activities***

With increase in number of faculty, the department is now able to take the students for field visits (Table 19; I.F.2.1, I.F.2.4). The faculty opined that while real experience would come only when one actually starts working, the field visits do expose the students to facilities available on ground (I.F.2.2). Students become aware about deprivations when they visit families and ask about socio-economic class, diet, storage and usage of water, environmental cleanliness etcetera (I.F.2.6). Some faculty use 'photo-voice' where UGs click photos on their mobile-phones when they are in field and a discussion is held on these photos after they return. During 4<sup>th</sup> semester, students perform a health education activity

in field. For instance, the recent batch conducted a flash-mob at a public place on World Diabetes Day. Through all these activities/exposures, students understand the subject better and develop interest in it (I.F.2.1). The feedback from students about these visits has been very good (I.F.2.4).

**Table 19: Field activities for Undergraduate Students at Department of Community Medicine, The Second Institute**

Period	Program	Duration	Nature
1 <sup>st</sup> Year (2 <sup>nd</sup> Sem)	Field Visits	One day per month	Visit to Water Purification System, Sewage Treatment Plant, Pasteurization Unit etcetera; Soft skills training in the Department
2 <sup>nd</sup> Year (3 <sup>rd</sup> Sem)	Block Posting in DoCM-TSI	One month (morning session only)	Visit to Primary Health Centre, Sub-centre, ICDS Centre etcetera; Family Visits

While the field activities at DoCM-TSI were picking-up, faculties who had studied in other MCs, or had worked in other DoCMs, still didn't find them satisfactory in terms of regularity and quality (I.F.2.7, I.F.2.9). It is like 'you just go and show your students' (I.F.2.1). 'They say, in first year, we have to allot two families and the students will go and observe for two days what's going on...Here we are going and just collecting the data, like census, and coming back, without knowing what is the importance' (I.F.2.9). As the urban and rural Primary Health Centres are 'affiliated' to TSI and not owned or managed by it, the department hasn't been able to develop rapport with the community around these centres; the engagement is only at a superficial level. In this regards, a faculty said, 'we are teaching Community Medicine without Community' (I.F.2.9).

The Researcher could accompany the second year UGs for a half-day visit to a Sub-centre (O.F.2.1). As the bus-driver arrived late by around 45 minutes, the AP found time to do a recap on the lecture on Health Care System taken two weeks back. The number of students exceeded the seating capacity of the bus, and around a dozen students had to keep standing during the journey. A bigger bus was available, but was not sent because Institute's administration believed not many students turn-up for the field visits. After an hour-long travel, the group reached the subcentre. The area it catered to was officially rural but practically urban. In preparation for today's visit, the ANM had hanged a variety of posters

on ropes criss-crossing the small subcentre room. The students took turns in groups of ten to see the 'display'. The AP directed the students to note how many rooms the sub-centre had, and what kind of roof it was. Thereafter, the group sat in an adjoining community hall to listen to the ANM and her Supervisor about the services delivered by and records maintained at the Sub-centre. The AP would interject to stress on things like the conditional payments made to a women around her delivery. 'Money increases the acceptance rates', he said. After the 5-10 minutes talk by the field staff, there was a 30-minutes monologue by the AP. He touched upon several topics ranging from Maternal and Child Protection Card, recording and reporting, fund flow and supportive supervision to his own experiences of working at Primary Health Centres. He even talked about the 'famous-four' principles of PHC: Equity (so that everybody has access), Community participation (referring to the mechanisms of *Gram Sabhas*, and Patient Welfare Societies), Intersectoral Co-ordination, and Appropriate Technology (ORS, smokeless *chulah*). He gave examples, but didn't talk about the concepts per se. Five minutes before concluding, he asked if there were any doubts. There were none. The group didn't go in the community.

### **Research Activities**

At DoCM-TSI, it is compulsory for every UG to get engaged with research. In the 2<sup>nd</sup> year (4<sup>th</sup> semester) students are taught about Research Methodology and are asked to draft a research protocol in groups of three. In the 3<sup>rd</sup> year (6<sup>th</sup> semester), they plan a research study in groups of three under guidance of assigned faculty, on a topic of their interest. The students initiate the process of ethics clearance and start data collection. The study is completed over the 7<sup>th</sup> semester and presented in the department. These studies are largely, if not always, quantitative in nature. A faculty, during informal conversation, shared that this was because a) faculty were generally more comfortable with quantitative methods, and b) qualitative research requires a level of maturity which may not be expected from UGs.

The studies presented during the Model Practicum Examination were on awareness about dog-bite management (pre-post after an awareness program), on needle-stick injury (prevalence, how many take post-exposure prophylaxis), and on menstrual irregularities among female UGs (and its association with dietary habits and lifestyle) (O.C.2.1). It was a difficult task for DoCM-TSI to find 70 new topics every year, and so, sometimes they got

repeated. These research projects form a (small) part of students' evaluation. As observed during the practicum, the faculty had much to evaluate and couldn't spend much time assessing these studies except asking what the key findings were or which test of significance was used (O.C.2.1).

### ***Other activities***

Besides the regular academic activities, the DoCM-TSI holds a Nutrition Prize Exam. It is a combination of essay and elocution competition. Some quiz programs are also organized for the UGs.

### **Activities with Interns**

The Interns get a two months posting in DoCM-TSI. They are posted for a week each in the three rural and one urban Primary Health Centres where they see patients in the OPD (I.F.2.7). In the second month, they are sent for 3-days each to fever clinic, Communicable Disease Hospital and in Leprosy Hospital. A senior faculty expressed disappointment with the fact that a significant period of the second month of what officially is a CM posting, is actually consumed by postings in departments like Ophthalmology and ENT (I.F.2.10).

The faculty motivate Interns to join Primary Health Centres for some time after graduating as it would give them a very good exposure, and a confidence that they know the basics (I.F.2.1).

### **Activities with Postgraduate Students**

The department offers two PG courses: DipPH and MD in CM. They are taught in a very similar fashion (I.F.2.1, I.F.2.4, I.F.2.6); 'Ultimately, we all study the same Park' (I.F.2.4). The key differences between these two courses are shown in Table 20.

### ***Classroom Activities***

As per the schedule, there is a two-hour PG activity in the post lunch session every day. On Mondays, there are theory lectures. The faculty share their own experiences in field with the PG students (I.F.2.2). While in UG, students are only 'told' about concepts like needs assessment and epidemiology, in PG 'you empower them how to do it' (I.PF.3). The students as well as faculty refer to Park's textbook of Preventive and Social Medicine.

**Table 20: Key differences between the two Postgraduate courses offered at Department of Community Medicine, The Second Institute**

	<b>Diploma in Public Health</b>	<b>MD Community Medicine</b>
Course Duration	2 years	3 years
Classroom Activities	More focus on PH Acts and Rules, and on administration	More focus on Research and Teaching skills
Field	Hospital and Lodge Inspection	Family Study
Research	No dissertation	Dissertation mandatory
Evaluation	Relatively less rigorous Includes assessment of Hotel/Lodge inspection	Relatively more rigorous Includes assessment of pedagogical skills
Typical role after Postgraduation	Join Directorate of Public Health and get engaged with field-based activities (like outbreak investigation, vector control); 'They plan for the City' (I.F.2.4).	Join Medical College as a Community Medicine faculty

On Tuesdays and Fridays, there is a Seminar in which a PG student makes a presentation on a specific topic. The list of Seminar topics on the department's webpage shows a predominance of legislations (Clinical Establishment Act, Food Safety and Standards Act, Epidemic Disease Act, Factories Act etcetera). The list includes various National/State Health Programs (like Adolescent Health and PEM), and topics on Management (like Inventory Management and Budget). The list also includes topics like 'Universal Health Coverage', 'Community Participation', 'Social Audit', 'Preventive Siddha', 'MNREGA' and 'Medical Tourism'. Health Committee Reports, National Health Policies and World Health Reports are also discussed in this format. At times, a group discussion or a debate also happens after a shorter Seminar. 'So many issues come out of it...sitting alone, you wouldn't even think of it...that's how we make them think, encourage them to come out with ideas and discuss' (I.F.2.4). To make students go through the process of thinking is more important than the issue on which they think, because 'they are going to face different different situations...not exactly (what) they came across while they were here' (I.F.2.4). The faculty also try to develop the art of expressing one's views while staying 'clear of controversies' (I.F.2.4).

Wednesdays are for Case Presentation in which a Management Case Study or a Family Case or a Clinico-social Case is presented. Critical appraisal of a Journal article is presented by MD students on 1<sup>st</sup> and 3<sup>rd</sup> Thursday, and DipPH students make a presentation on Hotel/Lodge



inspection on 2<sup>nd</sup> and 4<sup>th</sup> Thursday. Every 1<sup>st</sup> Saturday, the PG students appear for a small department-level written exam. On one Saturday, progress made by PG students in terms of their academic obligations (e-journal publication, poster/paper presentation and dissertation) is reviewed. Other Saturdays are left for PG students to update their log-books. Once a month, the DoCM-TSI organizes a guest lecture for the PG students. A lecture on 'LGBT and Sustainable Development Goals' was delivered in the previous month by an alumni of TSI currently engaged with this issue. PG students are also involved in UG teaching. In fact, they are a big help in delivering UG teaching (I.F.2.2).

Of all these activities, the Researcher could observe one guest lecture on the latest Central Government Guidelines on Management of Bio-medical Waste (O.C.2.3). It was delivered by a senior Microbiologist from within TSI. This topic was very relevant for exams; PG students listened to it with interest and also asked a few questions.

### ***Field Activities***

PG students undertake activities in hospital or field during the pre-lunch session every day. If the place of posting is far, or work is demanding, they are spared from coming to the department post-lunch for classroom activities.

During the first year, PG students get 2-month postings in the major clinical departments of the MC hospital. In second year, they are posted at the District Hospital and at the Primary Health Centres affiliated to the DoCM-TSI. A faculty informed that the PG students undertake administrative work and manage National/State Health Programs during these postings rather than focusing on clinical work (I.F.2.6). During third year, they get posted in the District Health Offices, in Corporations and in the DirPH. They shadow the program officers to understand the various aspects of the program (I.F.2.1). The PG students also take turns to manage the Fever Clinic in the MC Hospital (I.F.2.5). And they accompany the APs when they take UGs for field visits (O.F.2.1).

The relatively non-clinical nature of PG training at DoCM-TSI may be attributed to its historical linkage with PH administration and DirPH.

### ***Research Activities***

A published paper in Institute's e-journal, a poster presentation and a paper presentation in Conference is mandatory for all PG students - DipPH as well as MD (I.F.2.6). MD candidates,

in addition, also have to prepare a dissertation. However, this aspect has started getting due attention only recently. Earlier, due to shortage of qualified faculty, 'nobody was there to guide first of all' (I.F.2.9). Even the qualified faculty would not have much experience in guiding MD thesis because there were just four government MD seats in the entire State. And due to the dominant influence of DirPH, the emphasis used to be more on administration and management of health programs.

Professors and Associate Professors are allotted as guides to PG students on a random basis (I.F.2.4, I.F.2.5). The faculty are fine with this arrangement as they do not believe in having niche areas of interest. 'In Community Medicine, we can't keep no. Community Medicine is almost in every field' (I.F.2.2). In addition, APs may be allotted as co-guides (I.F.2.5).

### How is the topic finalized

The topic for research is largely chosen by the students themselves (I.F.2.1, I.F.2.2, I.F.2.4, I.F.2.5, I.F.2.8, I.F.2.9). 'At the end of the day, they are ones doing the research' (I.F.2.4). The faculty may tell them what are the emerging issues, but it is the students who come-up with a list of topics based on their interests (I.F.2.1, I.F.2.5). Their guides assess the options based on 'feasibility, novelty, and the capacity of the students' (I.F.2.7). The topic should be doable within the given time-frame and should not be too demanding in financial terms (I.F.2.1, I.F.2.4, I.F.2.5). 'Feasibility' also mean that 'you cannot go against government policies. You cannot pierce more on to the government side' (I.F.2.7). The topic should not be a repeat of what has already been done in, say, last five years (I.F.2.1, I.F.2.5). The topic should also not be too simple for an MD-level thesis (I.F.2.4). Once the protocol is ready, they present it in the department to get feedback from different faculty (I.F.2.1).

### What are the Studies

The Researcher referred to the list available on the DoCM-TSI's webpage. He was also provided with a list of ten topics chosen by MD students in last three years (2015-17). The studies were largely based in community, and many were conducted in Schools; a few were based in healthcare facilities. The students either work in the area of the Urban/Rural Primary Health Centres affiliated to the Institute, or, they go to their place of earlier work or where they have acquaintances so that they can collect data easily (I.F.2.1). So, the studies were set in different districts of the State.

The studies were conducted with specific population groups like school students, college students (medical, non-medical), inmates of juvenile homes, traffic police, IT professionals, healthcare workers, ICDS workers, other workers (industrial, construction, sanitation, agricultural, salt pan, rubber plantation, *beedi*, brick-kiln, stone quarry), street food vendors, drivers (auto-rikshaw, bus), refugees, fishermen, slum dwellers, tribals, rural community, elderly or their caregivers, adolescent girls, male partners, women (ante-natal women, post-natal women, women who had a stillbirth) and people living with diabetes.

The studies looked at general morbidity profile, or at prevalence of health conditions (hearing loss, dental caries, ocular morbidity, refractive errors, malnutrition, anaemia, post-natal depression, thyroid dysfunction, Diabetes, COPD, low bone density, peripheral vascular disease and peripheral neuropathy, depression, or stress and frailty, physical activity, loneliness, burnout); or events (accidents, self-medication); and/or prevalence of risk factors (alcoholism, smoking). One study assessed the quality of life among people living with NCDs.

Several studies looked at Knowledge and/or Attitude and/or practice among health staff (management of diarrhoea and ARI, dog bite management, male contraception, TB notification, bio-medical waste management); or among different community groups (birth preparedness and complication readiness, exclusive breast feeding, PCPNDT Act, childhood learning disability, abuse during childhood, Dengue, health seeking behaviour, organ donation, carbonated drinks, high-fat-salt-sugar food, iodized salt, hand washing, food safety, road safety, air pollution, usage of personal protective equipments, disaster preparedness). Two studies assessed the effect of health education intervention on behaviours.

A few studies evaluated the coverage of healthcare services like Pulse Polio Immunization, routine immunization and ante-natal care and the factors influencing the coverage; or, factors leading to treatment defaults; or availability of NCD service at primary and secondary level facilities. One study attempted to validate urine dip-stick test for early diagnosis of Chronic Kidney Disease, and another assessed the feasibility of partograph usage in field. There was a study documenting out-of-pocket health expenditures; another

one assessing job satisfaction among health worker; and one correlating TV viewing with physical health and academic performance.

A faculty expressed his disappointment with the students largely doing prevalence studies and looking at risk factors, something he referred to as a 'cakewalk'. 'We are lagging in strong research questions here' (I.F.2.7). He added, 'we are doing better thing (now), but we have to bring much more depth into it' (I.F.2.7).

### **Follow-up**

The findings of the studies are shared in the department with the administrative head, who is from DirPH. But as these studies are small in size and scope, they can't be expected to contribute to programs and policy (I.F.2.4).

For community-based studies, the data is collected with permission of the concerned district officials. If the findings are good, they may be shared with those officials (I.F.2.5, I.F.2.9). A faculty opined that sharing the findings with those officials was mandatory; 'then only I can use it for publication. If not, that is not ethical' (I.F.2.2).

Most commonly, the findings of the research are presented in conferences as a paper or a poster, and published in the Institute's e-journal (I.F.2.1, I.F.2.2). Taking it further is desirable, but has not been a common practice so far (I.F.2.7).

### ***Other Exposures***

As the key administrative position in DoCM-TSI is held by a DirPH personnel, the PG students get opportunity to become part of several ad hoc ground-level activities (I.F.2.7). This includes relief work during disasters, like floods; events, like fairs; campaigns, like Pulse Polio Immunization and the one for Measles-Rubella vaccination; or facility surveys, like the one's on Water, Sanitation and Hygiene (WaSH) and on Accident and Emergency Care (I.F.2.4, I.F.2.5). Some PG students also participate in capacity building workshops/courses, like the one on Health System Strengthening organized by DoCM-SPH, PGI.

### **Other Teaching-Training Activities**

Besides medical students, DoCM-TSI also teaches Nursing, Physiotherapy, Pharmacy and Optometry students. They conduct a 3-month long training for Engineers from the Directorate of Industrial Safety and Health on industry related health issues (I.F.2.1, I.F.2.2).

The department also conduct a 3-day Research Methodology workshop once or twice a year in which PG students, and also faculty, from various departments of the Institute participate (I.F.2.1). Occasionally, the department holds trainings on behalf of DirPH, like the one conducted on Entomology.

## **II.3.2 Research**

### **Challenges in Research**

Research, for long, has been a neglected aspect at DoCM-TSI. Firstly, the department had struggled to get adequate faculty strength. 'We were very few people. Where is the time think of research' (I.F.2.4). Secondly, the State's DirPH, which could have been a demand centre for DoCM-TSI's research expertise, has itself been very capable in identifying issues, exploring them and finding solutions. This leaves little scope for the department to intervene in government managed healthcare system (I.F.2.1, I.F.2.4, I.F.2.6). A faculty also shared that it was not easy to get permission from the college administration to conduct field-based research (I.F.2.9).

Though engagement of faculty in student research (UG and PG) had been happening, there had been little independent research by the faculty themselves beyond what was mandatory for promotions (I.F.2.1, I.F.2.2, I.F.2.4, I.F.2.7, I.F.2.8). At the time of this study, the department was not engaged in any project (I.F.2.1, I.F.2.2). But then, things seemed to be changing. The present administrative head of DoCM-TSI has been pushing the faculty to come-up with proposals, because 'that gives a visibility for the department' (I.F.2.4). In response to this, the faculty have started thinking and one of them had also submitted a proposal to State NRHM (I.F.2.1).

A past faculty shared that research require funding, and funding agencies have their own agenda. 'ICMR also, they see us as manpower' (I.PF.3). If one is ready to implement their project, it is fine; but if one writes one's own project, they may not accept it (I.PF.3).

### **Perspective about Research**

While the younger faculty have developed a taste for 'publication', at least some of the seniors didn't see it as the purpose of research. 'Whether we are going to put it in words or in publications, that is not important. Are we really doing what is (required), is it reaching the community, is what each one should be thinking about' (I.F.2.3). This faculty had

earnestly guided several students all these years but didn't have many publications to her credit. However, a younger faculty opined that unless it's published, people don't believe it (I.F.2.6).

Another senior faculty was concerned that 'people do research for the sake of doing research' (I.F.2.4). 'We also do the same thing and people can say the same thing about us. But...how much of it is literally implementation research...Just go and do some morbidity pattern, mortality pattern, this, that...we just take up something and we just do...to get our promotions. That's what is happening at the moment' (I.F.2.4). Instead, 'I would go by my experience at the field level. My interaction with the people has given me quite an insight. I know where, what problems they face in accessing...utilizing...Now, coupled with this theoretical knowledge, I will try to assess how best it can improve their accessibility, their satisfaction, that sort of thing' (I.F.2.4).

### **Type of Research**

A faculty had recently submitted a proposal to NRHM to explore the factors underlying high Caesarean-section rates in government health facilities in different districts of the State (I.F.2.1). The department was also slated to get engaged with STEPS survey for NCD (I.F.2.1). One of the faculty was collaborating with one of IITs for a study on air pollution. DirPH has sometimes engaged department's PG students and faculty in facility surveys on issues like water, sanitation and hygiene.

A few faculty had shared their list of publications, and there was a list of publications available on the DoCM-TSI's webpage. Many of these were prevalence or KAP studies, probably because they were emerging from PG dissertations. These were done in Schools with students or teachers, or with specific population groups like women who had pre-term deliveries. Some of them compared two population groups on issues like mental health or contraceptive choice. There were studies exploring health seeking behaviours (ante-natal care, intra-natal care, abortion care) and associated factors (government policy, focussed counselling etcetera). Some studies were on facility-assessment in terms of available health staff or specific health services. One study was on discrimination faced by trans-genders in healthcare facilities and another one tracked the effect of ante-natal depression on birth outcomes. One study was titled "Tribals' Education and Health-The Magic Link".

DoCM-TSI has not so far engaged with critical research that deals with program evaluations and impact evaluations (I.F.2.7). This may be because of an in-built censorship within the department as it has been headed by a DirPH official. The scope, at best, is therefore to only explore and improve the operational aspects.

### **II.3.3 Field Activities**

Due to its historical linkages with DirPH, and because most of the health administrators are its alumni<sup>6</sup>, the opportunities 'available' to DoCM-TSI are better than most other CM departments in the State (I.F.2.1, I.F.2.5, I.F.2.7). However, because of staff shortage, these opportunities could not be adequately tapped so far. Of late, given a proactive administrative head, the junior faculty and PG students have started getting involved in government surveys and relief activities during disasters.

The faculty, especially the APs, take the UGs for exposure visits. Interns and PG students are posted at the Urban and Rural facilities affiliated with the department. Though, it is not clear how much are these postings supervised because the Professors and Associates also have to manage the administrative works, which are frequent and unpredictable.

Now that the faculty strength has increased and there is a proactive leadership, the things are changing. 'Probably, in another five years I think, that will go fine' (I.F.2.7).

## **II.4 Department Interactions**

### **II.4.1 With other Departments of the Institute**

#### **Teaching and Training**

The faculty participate in integrated teaching sessions organized by the Medical Education Unit; though, this activity happens very infrequently (I.F.2.7). PG students are posted in major clinical departments in their first year. DoCM-TSI conducts Research methodology workshops in which PG students from all departments participate.

Issue specific workshops, like on 'Nutrition', are occasionally held. During the recent outbreak of H1N1 influenza, the department had conducted a session on epidemiological aspects of the disease for the faculty of other departments and had trained hospital staff on

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<sup>6</sup> Till a few years back, DoCM-TSI was the only Government CM department in the State offering post-graduate courses (I.F.2.1, I.PF.3).

hand-washing. DoCM-TSI faculty go as trainers if invited by other department, and they sometimes calls faculty from other department to deliver guest lecture for the PG students (O.C.2.3). The faculty also participate in CMEs organized by other departments.

### **Research**

UGs may choose research topics that require them to go to other departments. PG students from different departments approach DoCM-TSI for things like sample size calculation and data analysis. This, in addition to the faculty-level interactions during meetings and CMEs, makes other departments know about DoCM-TSI's role and capabilities (I.F.2.3). Especially, departments 'where National Programs are going on, they know our importance' (I.F.2.3). So, of late, other departments have starting realizing a need to collaborate, and DoCM-TSI has also started making efforts for joint researches (I.F.2.2, I.F.2.3, I.F.2.4).

### **Service**

DoCM-TSI manages a Fever OPD in the MC hospital where different department refer cases. The department is a nodal centre for Integrated Disease Surveillance Project; though a faculty jokingly referred to this as being 'more like a postman's job' (I.F.2.1). During recent floods, the department had organized medical camps in which PG students from other departments had also come.

### **Participation in Institutional Activities**

DoCM-TSI is invariably a part of any inter-departmental committee formed by the Institute during, or in anticipation of, any outbreak/epidemic. The department contributes by facilitating epidemiological investigations and guiding control measures.

DoCM-TSI faculty are part of institute-level forums like Medical Education Unit and Infection Control Committee. They are entrusted with the responsibility of regularly inspecting all the hostels with reference to sanitation and hygiene issues. If the faculty find issues like mosquito breeding, they inform the local body or the Public Works Department. The Dean, and also heads of other departments, expects DoCM-TSI to celebrate 'days', like World Disability Day or World Anti-Tobacco Day (I.F.2.4, I.F.2.5).

Some faculty found the interaction of DoCM-TSI with other departments of the Institute to be 'very very less' and 'still very lagging' (I.F.2.3, I.F.2.7, I.F.2.9). The department did not, as



yet, have a representation in Institutional Ethics Committee and Medical Research Unit (I.F.2.7).

### **Department Status**

Despite these interactions, faculty felt that the department was at the lower side of an unsaid hierarchy. Some found it to be too overt (I.F.2.3, I.F.2.7, I.F.2.9), and others said that it's 'subtle' (I.F.2.2, I.F.2.4, I.F.2.5), but it's always there. Some didn't think that there was any such thing (I.F.2.1, I.F.2.6). However, a faculty felt that lately, other departments had started realizing the significance of CM (I.F.2.9).

### **II.4.2 With Department/Faculty of CM of other Medical Colleges**

DoCM-TSI faculty rarely attend national-level PH conferences. For logistical reasons, they prefer those happening within the State (I.F.2.2, I.F.2.8). Conferences of IPHA and IAPSM have only lately started happening in/around the State. The State Chapter of IAPSM was formed just last year (I.PF.3).

Even otherwise, faculty are not very much into attending conferences (I.F.2.1, I.F.2.4, I.F.2.6, I.F.2.7, I.F.2.9, I.PF.3). 'I sometimes find it really boring. What they talk...how far is it applicable' (I.F.2.4). One faculty said that conferences are only for 'partying and boozing'. However, the PG students need to go so as to fulfil the academic requirements of presenting posters and papers as mandated by the University.

### **II.4.3 With Government Health Department**

#### **Facility level**

One urban Primary Health Centre (coming under City Corporation) and three rural Primary Health Centres (coming under DirPH) are 'affiliated' to TSI. DoCM-TSI takes its UGs to these Centres for exposure visits. It posts its Interns and PG students at these centres. However, there is little 'engagement' of DoCM-TSI with the local government healthcare system and with the community around these facilities (I.F.2.7).

#### **District/Corporation level**

DoCM-TSI routinely collects IDSP data, and the specific disease data in times of outbreaks, and submits it to concerned health authorities. The junior faculty get posted at MLA hostel once or twice a month, and sometimes they are asked to manage OPD in the High Court

premises (I.F.2.6). PG students get posted in District Health Office, and they participate in PH campaigns like Pulse Polio Immunization rounds. The authorities also value the workload shared by Interns and CM-PG students at Primary Health Centres (I.F.2.9). 'Other than that, it (Community Medicine) has no meaning for them' (I.PF.3). A faculty recalled her experience while working in another government MC. 'Whenever I go there (District Health Office), I used to say...any meeting, please call us, so that we know what is happening...They never used to call. It still is the condition' (I.F.2.3).

### **State level**

The key administrative position at DoCM-TSI is held by a personnel from DirPH. So, the Department has a formal and direct linkage with the State-level health authorities. At the time of this study, the person acquiring this chair was very proactive. And so, the faculty of DoCM-TSI stay relatively better informed and in-touch with what's happening; the PG students get opportunities to be part of some government surveys and to get involved in DirPH's response to disasters within or outside the State. The PG students also get posted in the DirPH. The faculty have started thinking of submitting project proposals to the State's health department for funding.

However, the administrative head of DoCM-TSI seems to be the only person in the department who was in communication with the DirPH. It was only through this channel that other faculty would sometimes be called for any trainings or meeting, like the one on upcoming Health Systems Project (I.F.2.1, I.F.2.2, I.F.2.4). Otherwise, the faculty do not have any role in planning (I.F.2.6).

Even this channel may not work if the administrative head is not active, which had been the case in past. 'Here, Rotavirus was started. We were not a part of that. Like any other third person, we also heard...Ok, in our state, Rotavirus is being (introduced)' (I.F.2.1).

### **National level**

None known to the Researcher.

### **II.4.4 With other Government Departments**

DoCM-TSI conducts IEC session in schools for raising awareness regarding diseases like Dengue and H1N1 influenza, and training them on healthy practices like proper hand-

washing (I.F.2.4, I.F.2.5, I.F.2.6, I.F.2.8). A lot of PG dissertations are based in schools, or school teachers. DoCM-TSI conducts a 3-month long training for their engineers of the Directorate of Industrial Safety and Health (I.F.2.1, I.F.2.2, I.F.2.3). As DoCM-TSI takes UGs for exposure visits to water and sewage treatment plants, it has liaisons with the State Water Supply and Drainage Board (I.F.2.3). Once in a while, the DoCM-TSI conducts some training or plans some check-ups for ICDS staff (I.F.2.4). But largely, apart from health department, the interactions are not much (I.F.2.7, I.F.2.8).

#### **II.4.5 With Others**

One or two faculty had occasionally engaged with some Institutes for research; had attended a capacity building course with some international/national organization; or had been helping out some grassroots organization (I.F.2.2, I.F.2.3). Otherwise, the department doesn't have much interaction with others (I.F.2.4, I.F.2.7).

#### **II.5 Intra-departmental Interactions**

The faculty have a staff meeting, at least, once a week. They share a WhatsApp group for quicker communication. They could often be seen in each other's rooms/cubicles during their free time. During this study period, a senior faculty had her birthday and the entire department got together to celebrate. When a faculty was getting retired, the department planned a big farewell party for her. However, there have been some chronic tensions between faculty from DME and those from DirPH (I.F.2.3, I.F.2.10). This is largely because the DirPH officials limit the promotional avenues of the faculty from DME side (I.F.2.3, I.F.2.4, I.F.2.10).

Some faculty of DoCM-TSI were extraordinarily dedicated. On one particular day during the study, one of the APs was engaged with the Model Practicum from 8 am till 2 pm. She then chaired a UG Seminar till 4:30 pm. Thereafter, a group of UGs came to seek her help with their research work. As the department rooms had to be locked, this faculty took the group to the Institute's reading room and sat with them till late in the evening. But, generally speaking, the department had a laid-back feel in comparison to other departments visited by the Researcher.

## Summary Statement

DoCM-TSI had been directly engaged with PH administration in the past. Even now, the administrative head of the department, and some of its faculty, come from State's Directorate of Public Health. In addition, most of the faculty as well as the postgraduate students of the department come with experience of working at government Primary Health Centres. Due to close linkages with DirPH, the PG students get opportunities to see PH administration at different levels. However, department's engagement with the local health system and communities has been weak. The undergraduate teaching has been largely classroom-based, though the field exposure has picked-up in last two years. Faculty's engagement with research has been little beyond what is officially required, but things have started changing.

## III. Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS-Sevagram (SNSPH-DoCM)

### III.1 Department History

#### III.1.1 About Sevagram

Sevagram is a small town located in Central India, having a population of 8000 as per the latest census. It lies in the *Vidarbha* region of Maharashtra, which is infamous for farmer suicides. The town is eight kilometers from its District headquarter in Wardha. In 1936, Mahatma Gandhi ('*Bapu*', '*Gandhiji*') had established an *Ashram* in this village, and stayed there till 1946. Many institutions of village development grew in Sevagram during and after this time, like the All India Spinner's Association, *Nai Taleem* Centre for basic education, *Khadi Vidhyalaya*, a dairy co-operative etcetera. Kasturba Hospital was one such institution.

Another notable personality, Vinoba Bhave, spent the later part of his life in this area. He furthered Gandhiji's idea of *Sarvodaya* ('Upliftment of All') and led the *Bhoodaan* ('Land Gift') movement in the country. He was an inspiration for some of the early faculty and students of MGIMS.

### **III.1.2 About Sevagram Ashram ('Bapu Kuti')**

One of the reasons why Gandhiji decided to make a base in Sevagram was that it was located in the centre of the country. In order to be able to directly engage in the work of rural reconstruction, he established the Sevagram *Ashram*. The *Ashram* has a couple of huts of different sizes which were built one after the other, as and when the need arose. Those built initially for Gandhiji, his wife Kasturba ('Ba') and other staffs were similar to the typical village homes. All the material used and the artisans deployed to build the *Ashram* were from the local area. The *Ashram* employed *harijans* in the common kitchen to break the caste barrier. It served simple vegetarian food. Gandhiji had personally nursed some of his sick acquaintances using nature cure in this *Ashram*. 'The primary health care aspect came later, but if we think in that way, Gandhiji had the vision in those days' (I.F.3.4).

The UG students at MGIMS spend the first fifteen days of their MBBS course in the compound of this *Ashram*. Given its simplicity and serenity, some students keep visiting this place even later. Many seminars, symposiums and conferences of different disciplines, looking at contemporary issues from diverse ideological perspectives (including the Gandhian perspective), keep happening here. Some students make use of these opportunities. The faculty and college administration are supportive in this regards.

### **III.1.3 About Dr. Sushila Nayar ('Badi Behenji')**

In 1938, Dr. Sushila Nayar (SN), as a 22 year graduate from Lady Hardinge Medical College, visited Sevagram to meet her brother who was the secretary to Gandhiji. Drawn by Gandhiji's charismatic leadership, she stayed back. Her first exposure to PH happened soon when Cholera broke out in the village and Gandhiji asked her to do something about it. There was no other MBBS doctor around, no medicines, no trained staff and no facilities. She identified some village volunteers and trained them in how to dispose-off the vomit and cover the stool with soil, how to protect and disinfect the well water, and how to keep the village clean. With this, she was able to halt the outbreak. 'So that was a wonderful experience that if we involve community, if we have partnership with community...people have competence'; 'what else is primary health care?' (I.F.3.3).

SN went to do her MD in Medicine and returned in 1942. Soon, she started a small dispensary in *Ashram* premises which gradually developed into the Kasturba Hospital. After

Gandhiji's demise, she went to John's Hopkins to study PH. After returning, she got drawn into political field. She served as the Health Minister in Union Cabinet from 1962 to 1967.

SN played an instrumental role in establishing MGIMS in a place as remote as Sewagram. She was fondly called '*Badi Behenji*'. She had two strong colleagues with her - Manimala Choudhary ('*Choti Behenji*') and Kamla Desikan. 'It was not that they were highly educated. But they had lot of responsibility for the community. And that is how they developed the whole Institute' (I.F.3.3). So as to keep the campus alive, SN used to insist on lively evenings at the staff club. She wanted all the staff to come with their families and she would use this occasion to enquire into their wellbeing. She regularly addressed the gathering at Friday evening prayers. To medical students, SN used to say 'we just don't want you to become good doctors but we want you to become good citizens also' (I.F.3.5).

Apart from being the Founder-Director of the Institute, SN was also the first Professor in the DoCM. The senior CM faculty recall that she was always very encouraging and supportive for community-based work (I.F.3.11). Every year, she would host the women's self-help group members for lunch and would address them (I.F.3.3). Till her demise in 2001, SN devoted herself entirely to develop and extend the Institute (I.F.3.4).

### **III.1.4 About Kasturba Hospital**

The clinic that SN started in 1944 in the *Ashram* premises, was soon shifted to larger space a little distance away. This new facility, named after Kasturba, started with 15 beds for women and children. Later, it was opened for men as well, and the bed strength was progressively increased. Initially, it was under the *Ashram* management. In 1964, Kasturba Health Society was formed to manage the hospital.

When Gandhiji came to inaugurate this hospital, he said, 'it would have been better if you would have called me to close the hospital. Why you require a hospital? I don't want people to get sick' (shared by I.F.3.3). Since beginning, the hospital took up the task of training ANMs who would work in villages surrounding Sevagram. They would give medicines and vaccines, they would chlorinate wells and do preventive work for Malaria, Filaria and Leprosy. Even for the hospital, village boys were trained to dress wounds and work as Lab Technicians.

'Human worth, human dignity and the human hand were key to the Gandhian concept of mass employment' (Kalantri and Anshu in Nundy et al. 2018). The concept of dignity of labour was inculcated into the hospital staff right from the beginning. Everybody was involved in cleaning the campus (including latrines and septic tanks). Even the foreign educated professor would be grinding the wheat at 4 am in the morning. And, the seeds of a family feeling were sown on them. People addressed each other as '*behenji*' and '*bhaiji*', wore *khadi*, participated in *shramdaan* and attended the daily common prayer.

The Kasturba Hospital became the teaching hospital for MGIMS.

### **III.1.5 About MGIMS**

In his address to the Central Council of Health in 1964, the then Prime Minister, Shri Lal Bahadur Shastri suggested starting MCs in rural areas to correct the skewed doctor-patient distribution between rural and urban India. SN, being the Union Health Minister at that time, chose Sewagram as the site for setting-up the first rural MC in Maharashtra. Sewagram had no buses, no rickshaws and no roads at that time, and people would travel on bullock carts. There was only one *tonga*, belonging to the *Ashram*, that plied between Wardha and Sewagram. The Health Minister of the State was not in favour of building such a large hospital and a MC in such a small place. Even if constructed, who would come to serve here was the obvious concern. In five years time, SN turned this into reality. Mahatma Gandhi Institute of Medical Sciences (MGIMS) was started in 1969, the Gandhi Centenary Year. Faculty, not only from Maharashtra, but from across the country, from All India Institute of Medical Sciences (AIIMS) and PGI, joined the Institute. Staff quarters were built and a school up to 10th standard was started to cater to the basic needs of the staff.

The college was established as a tripartite agreement between the Centre, Maharashtra State and Kasturba Health Society. There was an initial financial support from agencies like USAID, but otherwise, the expenditure has been largely borne by the three abovementioned parties (Centre: 50%, State: 25% and Society: 25%).

It began as a 60-65 seat MC. Half of the seats were to be filled with students from within Maharashtra, and the other half was open for rest of the country. 'So, it was a very good sort-of national integration' (I.F.3.5). Further, sixteen seats were reserved for students who had been educated in village based schools, or whose parents resided in a rural area

(Kalantri and Anshu in Nundy et al. 2018), and two seats were reserved for children of staff working in MGIMS. At present, the number of UG seats stands at hundred (100).

To begin with, the admissions were through an entrance test common for AIIMS, BHU and MGIMS. In 1974, the Institute designed its own selection methods which included a paper on Gandhian thought besides Physics, Chemistry and Biology (Kalantri and Anshu in Nundy et al. 2018). It used to be a two days exam, followed by an interview (I.F.3.5).

For the first decade, the college authorities were against starting PG courses. They felt that the Institute was there for making basic doctors who would serve in the villages, and not for producing specialists who would serve the urban population. But there was a massive strike by the students demanding PG courses (Desikan 1994). Subsequently, in 1980, PG courses were started at MGIMS.

In late 1980s, MGIMS made a two-year rural service mandatory for its UG students (I.PF.6). Those who completed the service used to get a PG seat at MGIMS based on their marks in UG. Until 2014-15, 24 batches (1,155 students) had been posted to over 80 rural centres across India (Kalantri and Anshu in Nundy et al. 2018).

The Institute has taken several bold initiatives in the last decade or so. The Institute doesn't allow drug representatives in the campus. The pharmacy doesn't stock irrational drug combinations and encourages doctors to prescribe generic medicines. No workshop, seminars or conference hosted by the Institute, or any of its department or individual faculty, accepts any support from drug or medical equipment manufacturers. Such events are kept simple. The necessary costs are borne partly by the Institute, partly by the delegates and partly from grants from funding agencies (Kalantri and Anshu in Nundy et al. 2018).

The vision of MGIMS has been to develop a replicable model of community-oriented medical education (ME) which is responsive to the changing needs of the country and is rooted in an ethos of professional excellence (Kalantri and Anshu in Nundy et al. 2018). It was started with an aim to mould the system of modern medicine to the needs of villages. It was an attempt to open the doors for the young generation to absorb some of the basic



principles of Gandhian ideology, and be willing and equipped to work in rural India (Desikan 94). It was, and continues to be, an experiment in ME (I.F.3.5).

The Institute's creative and innovative initiatives have been attributed to the relative autonomy it enjoyed in comparison to other government institutes (Kalantri and Anshu in Nundy et al. 2018). However, this autonomy has lately been a victim of MCI norms and directives. From 2016, the UG admission process has changed. Earlier, 'whoever was applying over here, they had a mindset; their parents had a mindset, "it's good; this college is good; they are talking about Gandhian thoughts and all those things". Many of the parents were themselves Gandhian followers. 'Now people are coming by NEET' (I.F.3.8). There had been legal hurdles for the rural service bond right from the beginning (Desikan 1994). But with coming-in of NEET for PG admissions in 2017, this scheme lost its ground almost entirely.

### **The Community Work**

Since the beginning of the Institute, several departments had been working in the community. Regular health clinics were conducted in villages where Interns were posted and faculty also used to go. Besides, diagnostic and treatment camps were held in surrounding villages (Desikan 1994).

In 2012, MGIMS started a multi-specialty centre in the Melghat region (District Amravati) to provide round the clock primary and secondary-level clinical services to the tribal population. The centre is managed by a team comprising of Obstetrician-Gynaecologist, Paediatrician, Anaesthetist, Medical Officers, Interns, Nurses and para-medical staff. The team also provides promotive and preventive services in surrounding villages. The work in this region was started way back in 1998, independently, by a Physician-Ophthalmologist couple after they left their faculty jobs at MGIMS.

The Department of Obstetrics and Gynaecology has been conducting community-based reproductive health care camps that includes screening for cervical cancer, and have been providing family life education in schools. They have also been running 'Sevagram Project' under which unwed, divorced, separated women who present late for termination of pregnancy are admitted and delivered. The babies are cared for in *Aakanksha*, an on-campus facility, till they get adopted as per the process laid out by the Government.

The Department of Ophthalmology conducts eye camps in the periphery, screens out those requiring cataract surgeries, operates them at the base hospital with lens implantation, and follows them up in field, entirely free of cost. The Department of Psychiatry runs a de-addiction centre for alcohol and substance abuse. Even other departments conduct medical camps in schools and villages, and specialist clinics at Primary Health Centres. A senior Physician has been overseeing an interesting model of health insurance laced with components of village development (The *Jowar* Scheme; explained later).

So, it is not only SNSPH-DoCM which is working at the community level (I.F.3.3, I.F.3.4). 'This is the strength of (MGIMS) Sewagram' (I.PF.6). It may be the satisfaction one gets, or maybe, the recognition one receives; or maybe, 'when you come to Sevagram, something happens to you' (I.PF.6).

Given that Sewagram is very small town, all the faculty live on campus, or close by. Thus, MGIMS campus is a 'closely knit community' and 'an extended family of sorts' (I.F.3.7). The flip side is that the elders of the family are too attached to hand-over the reins to the younger ones.

### **About Jowar Health Assurance Scheme**

When the services of Kasturba Hospital were becoming financially unsustainable, the idea of handing it over to the Government came under consideration. The leaders of the village communities, who the hospital had been serving, were opposed to this idea and they offered to make contributions. Senior hospital staff started going around in bullock cart, collecting *Jowar* (Sorghum or white millet) at the time of harvest. Everyone gave as much as they could afford. Overtime, this arrangement developed into a Community Health Insurance Scheme. At present, the hospital offers 50 percent subsidy on OPD and in-patient services to more than 60,000 families enrolled in this insurance scheme.

There are several variants to the insurance scheme. The most ingenious one is the *Jowar* scheme. It gives 50 percent subsidy on OPD services and 100% subsidy on in-patient services (except for elective procedures). The criteria to join the *Jowar* scheme have changed over time. Earlier, it would cover the entire village if 75 percent of families were ready to contribute. Subsequently, the criteria required the village to, in addition, satisfy one of the following conditions: a) 100 percent coverage of village families in 'one-house-one-latrine'

scheme, b) organising lift irrigation scheme for 'all' village families, c) organising milk co-operative for all village families, or d) electing village *Panchayat* by consensus (unopposed election). Later, the criteria was brought at family level. For a family to be eligible to enrol under this scheme, they should satisfy one of the following conditions: a) membership of a Self Help Group, b) experiment with organic farming, c) vow for spinning their own cloth, or d) be active in the village study circle (Jajoo 2012). The scheme has, thus, been used as a carrot/stick for promoting other measures for village development. The senior Physician behind this experiment continuing over last four decades calls it Health 'Assurance' Scheme.

Only ten percent of the expenditure incurred by MGIMS in serving the beneficiaries of these schemes comes from the premiums. Rest ninety percent is made-up from the funds that the Institute receives from the Governments. But the success of the scheme is that 'the hospital has now become much more accessible to the community and this has helped to bring down the incidence of deaths from diseases like pneumonia and diarrhoea' (Jajoo 2012). And then, it's a question of 'dignity'. It's based on the principle of contributing as per capacity and getting services as per need. That's how villagers have been financing all their common events. '*Behenji* always said that people should make some provision about health. They make a provision for clothes, food and other things...even for liquor...People should have this understanding that they have to think about health' (I.F.3.4).

### **About Arogyadham**

Gandhiji believed in, and also practiced, nature cure. Even SN desired to 'develop the traditional systems of Medicine, and apply modern scientific methods of research so that we could come out with something useful and better than what is available' (Desikan 94). In early 2000s, MGIMS started *Arogyadham*, an 'integrative healthcare and research project'. It has been a recipient of grants from Central Council for Research in Yoga and Naturopathy.

The centre is located close to the main hospital campus and offers nature cure services like Hydrotherapy, Mud therapy, Diet therapy, massage etcetera, besides *Yoga*. The centre also maintains a herbal garden. The staff conducts a daily OPD in this compound as well as in the main hospital. The centre gets referrals from different clinical departments. Many faculty get their relatives, or themselves, treated here even if they hesitate in referring their

patients. The centre also receives walk-in patients from nearby areas as well as from far off places.

### **MGIMS and Gandhian Philosophy**

The Institute conducts a two-week Orientation Camp in the Sevagram *Ashram* for its newly joined MBBS students (explained later). The faculty, staff and students are encouraged to wear *khadi* clothes. Every Friday, there is an hour fixed in the evening for *Shramdaan* which may be done wherever the person is placed (Department, UHC, RHTC). There is a common prayer session conducted at the *Adhyayan Mandir* on Friday evenings, where hymns from different religions, and those like '*Vaishnav Jan to*', are recited. Hostel messes serve only vegetarian food, and consumption of alcohol in the campus is prohibited. All functions start with tribute to '*Ba, Bapu and Behenji*' and guests are welcomed with a *soot gothi* (spindle of cotton thread). On 2<sup>nd</sup> October, essay writing, speech and poster making competitions are held. While some of these activities, in effect, become mandatory, participation in others is purely voluntary. The students get exposed to, but are not forced to adopt, a particular thought process.

Some of the faculty interviewed and students interacted with felt that the influence of this philosophy has been gradually waning-off. The Institute, which was once against starting post-graduate courses, has now allowed a private company to give PG entrance coaching on its campus. The Institute had invited an alumnus, who was the CEO of a corporate hospital, to present degrees to the graduating batch. The Institute's website celebrates those working in foreign Universities and Hospitals as its 'distinguished alumni'. 'It started with the ideas of creating rural bias...(But) gradually, the ideology gets diluted. The kind of people who join the Institute later on, they do not have that ideology, and the things get diluted' (I.PF.5).

### **III.1.6 About SNSPH-DoCM**

The Department of CM was established with the Institute in 1969. The mission of the Department has been: a) to create a model for decentralized community health care delivery; b) develop networking with other organizations; c) to initiate policy advocacy for health needs of the underprivileged section of the community; d) to conduct and promote

research on priority health problems; and e) to develop doctors with a service orientation towards underprivileged communities.<sup>7</sup>

## **Staff**

Though there had been periods in the initial few decades when DoCM faced a shortage, there had otherwise been adequate staff in the department (I.F.3.2). Besides having faculty with a background in CM, the department has a position for Social Paediatrician. Earlier, the department also had a Social Psychiatrist. Even people having backgrounds other than medicine have been accorded the status of teaching faculty. This includes a Social Scientist, and a Statistician. Besides, there are Health Educators cum Social workers, Auxiliary Nurse Midwives, PH Nurse and Lab Technicians deployed at RHTCs and UHC. Such positions were created by the founders of the Institute out of a realization that ‘unless we understand the community, it (understanding health) will be difficult’ (I.F.3.4). Many faculty acknowledged the role of paramedical staff in the department as crucial, and that they all work as a team (I.F.3.1, I.F.3.3, I.F.3.4, I.F.3.9, I.F.3.11). And the faculty make a conscious effort to tell the same to their students, that ‘health is a team concept’ (I.F.3.1).

## **Field Centres**

Following the ROME scheme, the department established its first Rural Health Training Centre at Anji in 1984. The purpose for setting up the RHTC was a) to teach and train UGs, Interns, PG students and Nursing students; b) to provide health services to rural population. Another RHTC came-up at Bhidi in 1996-7. In 1999, following the MCI’s mandate, the department started an Urban Health Centre in the premises of Gandhi Memorial Leprosy Foundation in Wardha.

Each of these centres is managed by an Assistant Professor, who stays there. A set of villages are attached to each of three centres [Anji: 20 villages; Bhidi: 11 villages; UHC: 6 villages] where the department does community mobilization activities. The UHC, in addition, has a defined semi-urban population attached to it for which family folders are maintained. Besides these three centres, the department also provide service at and around Primary Health Centre Talegaon.

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<sup>7</sup> <https://www.mgims.ac.in/index.php/academics/departments/item/community-medicine>

## **School of Public Health**

In 2007, Dr. Sushila Nayar School of Public Health was started 'to increase the horizon of work of the Department of Community Medicine' (I.F.3.11). Interestingly, the name of the department at present reads as 'Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine'. 'Community Medicine' had to be retained because of MCI regulations (I.F.3.11).

The School has been designated as WHO Collaborative Centre for research and training in community based maternal, newborn and child health. It has worked as State level centre for monitoring and supervision of ICDS under a MoU with NIPCCD. The School has organized modular training for ASHAs, and IDSP training for Medical Officers. Besides, it conducts a series of workshops every year on Statistics, Study Design, Data Analysis, Qualitative Research and one on Integrated Management of Neonatal and Childhood Illness (IMNCI) (I.F.3.9). 'We are soon going to start Demographic Surveillance System' (I.F.3.11).

A senior faculty shared that the initial idea behind starting the School was to develop different divisions in the department, and to start new courses (I.F.3.2). This was yet to happen.

## **Courses offered by the Department**

The UG course has been in-place since the beginning of the Institute. Besides classroom teaching, the department has been conducting Orientation Camps and the Social Service Camps for the UGs since 1969; ROME Camps started in mid-1980s (explained later). Post-graduate course in CM was started in 1980 with two seats. At present, there are five seats. Except for one or two years in between, the seats have never remained vacant.

In 1998, it was decided to start MD-Family Medicine in the department in collaboration with other departments of the Institute (Annual Report 1999). A curriculum was submitted for approval to the University. It didn't happen though. The SNSPH conducted Diploma in Public Health Management course for two batches of in-services doctors from Karnataka State (2009 and 2010). In 2012, it was recognized as Study Centre for Post Graduate Diploma in Maternal & Child Health by Indira Gandhi National Open University (IGNOU).

### **Changing Status of Department within the Institute**

Being directly associated with SN, and given the ethos of the Institute, the department has always had full management support (I.F.3.2, I.F.3.5, I.F.3.11, I.PF.5). However, the faculty shared that it was not as well respected within the Institute till early 1990s (I.PF.6). Except for the three camps and the follow-up visits in the adopted villages, the Department did not have many activities in field (I.F.3.2). There were problems even in the way these camps were conducted, especially the ROME camp. Seniors students, and also clinicians from other department, would give very negative vibes to the students proceeding for the camp (I.F.3.2). It was considered just a fun activity with no scope or intent for any learning. The Department ANMs would provide some MCH services in certain villages around the Institute. And occasionally, the Department would get a project, like the one on Short-course Intermittent Chemotherapy for TB funded by ICMR. The DoCM's focus in those times was more on teaching (I.F.3.2).

The latter half of 1990s was a watershed period for the department (I.F.3.2, I.F.3.4, I.PF.6, I.F.3.9). The faculty and the para-medical staff who joined during this time brought new ideas, invested themselves in the field and brought significant changes in how things were running. The quality of ROME Camps improved (I.F.3.2). One after the other, several community-based projects started coming in (I.F.3.9; explained later). The new set of faculty had good understanding of research methods and they started helping other departments in designing their research and analyzing their data (I.PF.6). All this led to a change in the way the DoCM was seen by other Departments within MGIMS (I.F.3.2, I.PF.6).

### **III.2 Department Infrastructure**

The SNSPH-DoCM occupies first floor of the building that once housed the entire Kasturba Hospital. This building is located about 500 meters from the main MC building. It is a different campus, separated by public roads, and most faculty simply walk this distance.

As one climbs the ramp spiralling up from the small garden, the board carrying the name of the department, and of all the faculty members, para-medical staff, drivers and attendants, welcomes you. All Professors and Associate Professors have separate chambers, and Assistant Professors share one big room divided into cubicles. PG students and Interns occupy the Library space whenever they are in the department. The department also has a

lecture hall and a seminar hall equipped with audio-visual aids, and a committee room. The entire area, like the college, has wifi. The space is very simple, and very clean. In fact, the spaces in the MC and the hospital are also very basic, syncing well with the ethos of the town. However, the newly built central library, with its sensor-controlled glass doors and water faucets, is a stark contrast.

The department has adequate number of four-wheelers to ferry faculty to the field. Though, if required, some faculty don't mind taking an auto-rickshaw. Both RHTCs have a four-wheeler for their field work. For the camps and monthly follow-up visits of UG students, the buses of the school run by Kasturba Health Society are used. The Institute has a vehicle committee which ensures that every department/faculty that needs a vehicle gets one on time.

### **III.2.1 GOPD**

General OPD is located in the main MC Hospital OPD building. There is one big hall which has been partitioned to make rooms for the Immunization Clinic and chambers for the doctors. On one side is a cubicle for counselling. The OPD, like all operations of the hospital, is computerized. Smaller wall-mounted screens display the OPD token numbers. The gate at the far end of the hall leads to the Designated Microscopic Centre, a small lecture hall and the DOT Centre.

### **III.2.2 RHTC, Anji**

It is located in the middle of the town, just besides the bus stop, about 20 kilometers from MGIMS. The first thing once notices after entering the compound is the big white van (the 'White Elephant'), received long back as a part of ROME, lying as a specimen of inappropriate technology. There are two double-storey buildings housing a classroom, a lab, an office; living rooms for the AP, PG students, Interns posted at the RHTC and a few for occasional visitors; dormitories for UG students; mess and kitchen. There is enough open space between the built area for group activities and games during UG camps. The campus has wifi which becomes essential to operate the video-conferencing facility.

### **III.2.3 RHTC, Bhidi**

It is located on a National Highway, around one kilometer from Bhidi village and about 35 kilometers from MGIMS. Unlike Anji, it has no habitation in the immediate surroundings.



There is adequate space for office work, a teaching hall; rooms for the AP, PG students and Interns; and dormitories for UGs. Wifi facility and the teleconferencing equipments are available here as well. The campus is almost three times that of Anji, but is not as well maintained. The area of RHTC Bhidi is relatively less accessible, making it a less preferred location for projects and for postings (I.F.3.6).

### **III.2.4 UHC**

The Urban Health Centre is located in a well populated area of Wardha town. It functions in a rented space within the compound of Gandhi Memorial Leprosy Foundation, about eight kilometers from MGIMS. It houses a consultation room, a pharmacy, an office of the in-charge AP, a lab, a room for physiotherapy, and a small classroom. The quarter for AP is located within the same compound.

## **III.3 Department Activities**

*‘Whatever we do, there is always a thought how we can integrate the three things (teaching, service and research)’ (I.F.3.1)*

### **III.3.1 Teaching and Training**

#### **Activities with Undergraduate Students**

##### ***Classroom Activities***

The classroom activities consist of lectures, seminars, demonstrations and practicals. The students are taught topics like ‘Society’, ‘Social Medicine’ and ‘Community Mobilization’ by the Social Scientist, mainly in their first year. Though classroom teaching is an essential part of pedagogy, the effort is to make as many things practically demonstrable as possible. So, for instance, if they want to cover the topic of ASHA, instead of giving a lecture, they would call one of the ASHAs and make her talk to the students (I.F.3.1).

The faculty make conscious efforts to drive-in the concept of ‘health team’. ‘It’s not that health can be delivered by doctors alone. So, there is a definite role for each one...the paramedical staff, the community health worker, even the driver of your ambulance’ (I.F.3.1). The faculty themselves reflect this in their conduct. Taking the example of ASHAs, a faculty said that she is the ‘face’ of health system in her village. Sometimes, she may be

wrong. 'But the moment you demean her in front of your students, from that day onwards, they are never going to respect ASHA' (I.F.3.1).

There are seminars in which students, in groups, make brief presentations on a given topic. For instance, each group may be given a contraceptive method, or a program indicator to present on. The department is also experimenting with e-classrooms. Many readings, presentations, formats of CM are shared online with the students on moodle (I.F.3.1). E-learning courses on 'Community Health and Development', 'Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA)' and 'Basic of Epidemiology' have been developed.

Interestingly, the senior-most faculty, who may not take lectures for PG students, make it a point to teach the UGs. And, the junior-most faculty have to first gain field experience by staying for a couple of years at RHTCs/UHC before they can start regular teaching in the department. The Researcher could attend a UG lecture which was taken by a junior faculty in presence of a senior Professor (O.C.3.3). The faculty chose to use white-board instead of power point slides. It was a very interactive session as the faculty kept posing simple questions to the students and appreciating their responses each time.

Comparing his experiences during UG and PG in other departments, a young faculty said that while the classroom teaching at SNSPH-DoCM was less, the focus on field was more (I.F.3.10).

### ***Field Activities***

#### **Orientation Camp**

The main objective of Orientation Camp is to expose students to the Gandhian philosophy and to the Gandhian way of dealing with the health problems of the country (I.F.3.4). It is the first thing a medical student experiences after joining MGIMS ([Table 21](#)). Students stay in *Bapu Kuti* and lead an *Ashram* life. This involves waking up early, participating in prayers and *shramdaan*, spinning *khadi* and eating simple vegetarian food. Besides a few introductory lectures on Anatomy, Physiology and Biochemistry, majority of the time is spent on Gandhian thought. External resource persons, who are mostly from a non-health background, come.

On being asked how this camp benefits the students, a faculty said that it helps in ‘imbibing the feelings about this place’ (I.F.3.8). For instance, ‘the Institute demands wearing *Khadi*, but unless and until we have that “feeling”, there is no point in wearing *Khadi*’ (I.F.3.8).

**Table 21: Field activities for Undergraduate Students at Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS**

Period	Program	Duration	Nature
1st Year (1st Sem)	Orientation Camp	2 weeks (July-August)	
	Social Service Camp	2 weeks (October)	
	Brief Exposure Visits	Half day (Every Monday)	Hospital (CSSD), <i>Goras Bhandar</i> , Water purification plant, cotton mill (talk about occupational health, ESI), <i>Arogyadham, Magan Sangrahalaya</i> (Rural Technology); Adoption Centre etcetera.
1 <sup>st</sup> Year	Family Visit	Half Day (Every 1 <sup>st</sup> Saturday)	
2 <sup>nd</sup> Year	Family Visit	Half Day (Every 2nd Saturday)	
	Posting in SNSPH-DoCM	Five Weeks (morning sessions only)	GOPD; Sessions in the Department
Vacation after 2 <sup>nd</sup> Year	ROME Camp	12 days (December)	
3rd Year (6 <sup>th</sup> & 7 <sup>th</sup> Sem)	Family Visit	Half Day (Every 3rd Saturday)	
3rd Year (Pre-final)	Posting in SNSPH-DoCM	Five Weeks (morning sessions only)	Sessions in the Department

### Social Service Camp

The main idea behind Social Service Camp is to make the students experience the conditions in which the villagers live.

## *Structure*

Social Service Camp is organized for first year UGs about three months after their admission to MGIMS. It is a two-week fully residential camp based out of a mid-sized village, having a population of at least 2000. Each year, a new village is selected. Dormitory accommodation is arranged in village school, in *Panchayat* or in the house of some well-off person. Students come with their own bedding, and they wash their clothes and utensils during the camp. The toilet facilities from last few years are better. Earlier, temporary pit latrines used to be built which would start stinking after a few days, and would get flooded if it rained (I.F.3.1).

Each student, individually, is allotted 3-5 families on the first or second day of the camp. Every day, there are lectures and orientations on the task students are expected to do at village level, and in their allotted families. Even the senior students come and share what they have been able to contribute in their allotted families and in their adopted village, and what they have learnt (I.F.3.1). At village level, students are engaged in activities like chlorination of well and draining of vector breeding sites. In their allotted families, the students are initially left to have casual interactions. But then, each day they have to fill some format/schedule for children, adolescent, pregnant/nursing mother or elderly. The students also organize health education activity in the village school.

Medical camps and specialty clinics are organized in the village during these two weeks in coordination with all other departments of the MC. The students bring members of their allotted families who are in need of medical care to these clinics. Those requiring specialized services are referred to the MC hospital where they get free care during this period. Besides, general medical check-up and lab-based screening (blood, urine and stool examination) is done for the entire village.

Early on in the camp, the students are sensitised to deal with any superiority complex that they might have. 'You are lucky that you have got opportunity to become a doctor...They (villagers) may not have diplomas and degrees. But, they have degrees and diplomas of experience, which has come from generation to generation'; 'even the illiterate and poor can decide when to sow, which crops they should take, which market they should go, what should be the price...they arrange the marriage of their daughters...They are knowledgeable, only (that) they are not stamped' (I.F.3.4, a Social Scientist).

### *Benefits*

The students, most of whom do not have any understanding about village communities, may get realizations which are not possible in a classroom setting. They observe 'how they (villagers) fetch water...how they cook the food...how they manage their household economy' (I.F.3.4). Visiting the families every day creates a strong relationship. 'On the last day when the students leave the village, both are weeping, the family members as well as the students' (I.F.3.4).

This camp is the toughest one to participate-in. Students, as most of them are from an urban background, find it difficult to live in those conditions. It is also the toughest camp to organize. Faculty often compare it with organizing a daughter's marriage! But, they find it worth because even they learn so much from it (I.F.3.3).

The department, however, observes a very strict discipline during the camp. A student vented-out in his graduation speech how he once got punished for sneaking-out to have some snacks during this camp. An Intern felt that this made the camp unnecessarily 'heavy' and killed the fun part.

### **Village and Family Follow-up**

The idea behind instituting monthly visits to the 'adopted' village and 'adopted' families is to follow the issues identified during the Social Service Camp or later, and to try bringing some change in the lives of those people. 'That is why we say it is a village adoption scheme' (I.F.3.4). 'In the process, whatever learning happens, that is a collateral benefit' (I.F.3.1).

### *Structure*

This starts soon after the Social Service Camp and continues for next three years, till the pre-final year is over. In every visit, they have individual tasks to be done in the families, and group tasks to be done in the village. Individual tasks include filling a format, and giving health education on a pre-decided issue. Group task may be something like going and talking to the ASHA about Iron-Folic Acid tablet distribution and related challenges.

The Researcher could observe two such follow-up visits. The first one was with 6<sup>th</sup> semester students (O.F.3.4). The group assembled in an under-construction temple. The students were briefed about a 7-page family study format that they were supposed to fill in one of their allotted families. The Researcher could accompany three students to three different

households. Familiarity between the student and the family was obvious, though the intimacy was more if the student could speak the local language. The students faced problems with the long and structured format. However, the conversation did go beyond the format. The families would ask about how to renew their health insurance cards, or the students would insist the elderly to come and show at the MC hospital. And then, there would be random chats. All three families were courteous, and served tea; the third one also served breakfast. On asking what do they think about these students, the elderly in these households said that the students were doing a *seva* (service), and that they appeared to them as their own children. After about one-and-a-half hours, the group reassembled in the temple where some of the students presented the information they had collected as per the format. The faculty stressed the importance of family study from exam point of view.

The second visit was with 1<sup>st</sup> semester students (O.F.3.7). The task for the day was to give health education in allotted families on Acute Respiratory Infections (ARI). Some students were given additional tasks like enquiring about the cooking fuel used by families, their health seeking behaviour in case of ARIs, home remedies used for this problem and what ASHA/*Anganwadi* Worker knew about the danger signs. After a briefing in an open ground, students left to meet their allotted families. The researcher could accompany one of the students to a few adjacent tribal households. Talking about their traditional practices, one person said, 'Now *kaadha* is not used, times have changed. Now there is a doctor in every direction.' The student didn't pause to ponder over how the so called modernization was killing the traditions. Instead, he started advising the tribal household to use LPG instead of *chulah*, to use a long handle vessel to draw water, and regarding the importance of cross ventilation in the house. In another household, which didn't have any under-5 child, he told how to use breath-counting to assess the severity of ARI among children. After about one-and-a-half hours, everybody gathered in the same open ground where students shared the findings on their group tasks. The one tasked to assess cooking fuels shared interesting reasons people gave for still using *chulah*: the food cooks tastier on it; or the smoke of *chulah* doesn't let mosquitoes in. The faculty urged the students to explore the concept of smokeless *chulah*. He also explained how to calculate the requirement of ARI drugs for a village like this. Students asked a lot of questions. In the end, the faculty offered to leave a vehicle behind if some students wanted to stay a little while more in the village.

### *Benefits to the Community*

These repeated visits allow the students to identify and follow issues for a real long term. And so, many times, students are able to bring tangible changes like convincing the family to build a toilet, or to start using an existing one, or, to inspire the teenager to leave some addiction. Once, when a faculty asked the family if the student has made any difference to them, a 22-year old boy replied, 'Sir, I failed in 10<sup>th</sup> standard two-three times, and I practically gave-up on my studies. But this *didi* (sister) would come every month and eat my head. So, because of her pestering, I appeared in the exam for an attendant's job in Railways' (shared by I.F.3.1). 'Such things...the stories are very humanistic, they touch you. The more you interact with the students, the more your faith in this process gets stronger and stronger' (I.F.3.1).

The families also get guidance on medical and health issues from these students. One, the students motivate them to take preventive measures (FGD.Intern.3). For instance, they would ask an adolescent having anaemia to consume ground-nuts and jaggery. Two, the students guide them where to go and whom to consult when somebody actually falls ill. They inform/accompany them about the Intern-led OPD being held in the village on the day of visit, and also assist those who come to the MC hospital. The families also share with the students if they have any stress. And 'when we do counselling, they listen to it very attentively. They treat us as if we are their own children' (FGD.Intern.3).

### *Benefits to the Students*

This mechanism is fundamentally different from the 'touch-and-go' exposure visits to health facilities and communities. Instead of just getting the tour of an *Anganwadi* once in a while, here 'you have developed a relationship with the *Anganwadi* Worker. You are going there; you are helping her taking the weight of the child. Sometimes, you even bring the child of your allotted family to check the weight' (I.F.3.8). This 'engagement' is of a different kind. It allows for 'self-learning' and 'self- reflection' (I.F.3.1).

'Students themselves get a sense of achievement' (I.F.3.1). 'They, over the period of two or three years, see how their efforts in the community have changed lives, have made health behaviours better. And those subtle things make a huge dent in the way a person thinks'

(I.F.3.7). Even if they are not able to do something tangible, the process is still very educative.

Students felt that these exposures made them aware about the 'difficulties, different-different social and economic strains' that families in rural areas have to face (FGD.Intern.3). This exposed them to the 'basic necessities' of people, related to health as well as others, and what all is actually available at that level. All this leads to development of an individual's 'ethical side'. Though none from the group of Interns wanted to work in a village, they felt that such intense exposure may inspire some of the students to do so. They said that while a medical procedure could also be understood through online resources, there was no way but to come to villages in this manner so as to learn all this. They also felt that these interactions improved their communication skills and clinical acumen (FGD.Intern.3). Though, when the Researcher asked if students found anything worth learning 'from' the villagers (as against 'about' them), there was silence.

One of the Interns was a bit critical of the exercise. 'It's done as an activity, but you don't know what you are supposed to achieve out of it'. It was suggested that the department should decide on a basic minimum, and should ensure that every student does that. At the same time, the department should leave a large part for exploration where students go as they feel like, and faculty are there just to support and guide.

Overall, this experience is something that students cherish for long. Some of them would receive calls to join for festivities from their allotted families during these three years. 'Even there are instances that the families who had camp 10-15 years back, they send invitation card of the marriage of their daughters, sisters to the student. And even the students also (send)' (I.F.3.4). Whenever the Alumni come for a re-union, they make it a point to visit their adopted village.

A past faculty shared that the 'affective domain' is the 'hidden' part of any (medical) curriculum. 'At Sewagram, through these social service camps, and the village adoption scheme, they have spelt that out' (I.PF.6).



## ROME Camp

There are two main purposes of ROME Camp. First is to orient the students in the government's health system and health programs (I.F.3.4). And second is to expose them to the linkages between clinical conditions and the social determinants (I.F.3.8). They were started in mid-80s following the ROME Scheme launched by the Central government.

It is a 12-days fully residential camp. As it is scheduled immediately after the second year final exams, it has been consciously kept relatively 'airy' with a work-play balance. It is very popular among the students. The Researcher could attend this camp at RHTC Anji for a period of four days (O.F.3.1), and also for a day with the batch at RHTC Bhidi (O.F.3.2). The atmosphere was very charged. The mornings would have classroom sessions or facility visits. Afternoons would be for development of study tools, and later, for collecting data. The students would spend the evening at leisure. And the day would end with a post-dinner de-briefing of the day and briefing for the next day. All through the camp, food arrangements were managed by a student's committee.

In a session on RMNCHA, the students were divided in four groups to chart out the main components of R, M, NC, and A. Two real-life case studies were given, one of a maternal death, and other of a child death. Two groups were asked to depict the story pictographically. And other two groups were asked to cull out the technical, social, health system, and rights issues from the case. While explaining these charts, a student said, 'we can't neatly separate out these issues from each other. They are all linked' (O.F.3.1).

In order to explain the concept of equity, a faculty engaged the students in an adapted version of 'Privilege Walk' (O.F.3.1). The students were assigned roles, like that of a tribal woman, a person suffering from mental illness, an orphan child, an elderly person etcetera. At the start, they were all made to stand on a line, side-by-side. They were then asked a series of questions, like 'do you think you have a say in the way health services are delivered in your area', or, 'do you think you will be able to buy all the medicine that the doctor prescribes you'. If the participant's character thought in affirmative, they would take a step ahead; otherwise, they would keep standing wherever they were. At the end of the game, everybody was at a different distance from the baseline. This was followed by a discussion on which characters could step ahead, and how much, and who remained behind.

Thereafter, students were given the task of searching NFHS-4 database and come out with data differentials across rural-urban divide, income quintiles and gender. The point made was that 'equality' was not sufficient, and it was 'equity' that had to be ensured. The game, in principle, was good. But practically, things appeared pretty obvious. Students were prompt in answering, but it is doubtful if there was any 'realization'.

Research activity was organized at two levels. There was one 30-by-7 cluster survey planned to capture the health and social needs of elderly. The students were guided to frame a questionnaire and put it on an open source data entry application. It had questions like 'Do you feel alone?', and the responses had to be rated on a scale of 1 to 10. All students, in pairs, were supposed to participate in this survey. For the second task, the batch was divided into five groups and given five different activities. One group would assess enabling factors for completing TB treatment by interviewing patients who could do so, and comparing it with those who couldn't. Another group would assess physical activity among adolescents through a self-administered questionnaire for 9<sup>th</sup> standard school children. The third group would free-list 24-hour activities done by parents for their child by talking to fathers and mothers separately, and then, make the two sit together and sort the list as per who does what (mothers versus fathers). The fourth group would interact with ASHAs and find out what they do, and what challenges do they face. The last group would take clinico-social case histories of Paediatrics, Obstetrics, Medicine and Surgery (O.F.3.1).

For clinico-social case discussion, an Assistant Professor from the Department of Paediatrics and another from the Department of Obstetrics and Gynaecology had come. The paediatric case was discussed in a household, and the Obstetrics case was discussed in an open area. The discussion didn't, however, go beyond clinical. Till a few years ago, such discussions would be held almost daily. But as the interest among the clinical departments diminished, this component was reduced (I.F.3.2, I.F.3.8, I.PF.5). The case discussion was followed by a rushed visit to an *Anganwadi* (O.F.3.1). The students had also visited a nearby Primary Health Centre and Sub-centre on previous days. They were also preparing IEC material to conduct a health education activity in the village school towards the end of the camp.

In one group activity, students were asked to make posters on various Central and State Government funded schemes on health/social welfare. Though it was not so planned, the

posters sparked a debate on health insurance and private sector engagement between the UG students (O.F.3.2). In a session on NVBDCP, two government field staff demonstrated the mosquito, larvae and Guppy fish (O.F.3.2). District officials managing other National Health Programs, like RNTCP, were also scheduled to address the students. In another interactive session, while the students were sitting on the floor, the ASHAs and the beneficiaries of JSY/JSSK were on chairs (O.F.3.2). The Researcher was later told that these are subtle ways of breaking the hierarchies.

### Self-critique of the Field-based Training

To commemorate 25 years of the Institution, several senior people associated with MGIMS came together to write a volume titled '*Pillars Speak*' (Desikan 1994). In the preface, Kamala Desikan writes, 'The object of this Institute was to prepare doctors for serving in the rural areas. Unfortunately, we have not made any substantial achievements in this regard' (Desikan 1994). In the next chapter, Devendra Kumar says 'Professional careerism runs through the ethos of the students (here) as in any other college'. He finds the root of this problem in the selection process which is competitive and not based on the aptitude towards rural service; and in the standardised curriculum that cannot be tailored according to the needs of the villages. Several of the present faculty agreed with this assertion as well as the reasoning (I.F.3.4, I.F.3.6, I.PF.6). They further added the societal pressures faced by students which push them towards a different career pathway (I.F.3.2, I.F.3.8).

However, the faculty stressed that even if MGIMS graduates do not opt for rural services, they are still very different (I.F.3.3, I.F.3.4, I.F.3.6, I.F.3.7, I.PF.6). They have a deeper understanding of 'health' and are sensitive to 'the other aspects'. For instance, 'they would always gauge whether this patient would be able to afford these drugs; whether these investigations are absolutely vital...can I do it in some other way?' (I.F.3.6). 'That sense only arrives because we are all exposed to those families...we have lived with them, we have seen what their problems are, we have seen what the resources are' (I.F.3.7).

While agreeing that MGIMS's field-based training program had a significant impact on the students, a faculty was critical of the structured and instructional way of dealing with the students, and of the strict discipline observed during the camps (I.F.3.2). 'When we over-manage the students, they develop apathy' (I.F.3.2). He compared this with how small

children behave. 'When you give him a toy, he doesn't play with it the way you tell him to. He plays in his own way. He explores'. He felt that the UGs should also be allowed 'to explore...to explore their potential, to explore community health...to sit with people and understand issues...to engage with other groups...' (I.F.3.2).

Faculty from other MCs often come to MGIMS to see all these initiatives and wish to replicate. A faculty said, 'it's not that easy...because you have to develop the culture...and it takes time...it's a long journey' (I.F.3.4). Another faculty found this 'holier-than-thou' attitude among his colleagues as problematic. 'Whenever we interact with a group, we give a lot of emphasis on this thing that *because* we are very dedicated, *because* we have these values, that's why we are able to do this. So, (in a way) we tell them (that) you cannot do it' (I.F.3.2). And 'if some Medical College starts doing this, we may try finding problems...“they are doing it, but they are not doing it like us” (I.F.3.2). He accepts that replicating these initiatives may not be easy. But if there is an open discussion on what is feasible in a given context and timeframe, and an appreciation for even small breakthroughs, things can change (I.F.3.2). He also stressed on the need for strategizing with groups beyond medicos to disseminate these initiatives.

### **Research Activities**

The department makes conscious efforts to inculcate an aptitude for research among the UGs. Besides engaging all of them in research during the ROME Camp, the Department also hold a 2-day Essential National Health Research Program (ENHR) for interested UGs. They orient them in research methodology and support them to develop research protocol in groups. The proposals are presented to IEC. The funding may be sought from MUHS or ICMR. Recently, MGIMS itself had set aside a fund for this purpose. The data may be collected from the adopted villages, or from the hospital. After analysis, the findings are presented in the Department. The faculty also provide guidance for publication. The positive impact these initiatives can be seen in the way these students approach their thesis at PG-level. Earlier, they 'would not even know what topic to select, what a topic means. So, (they would) say, "I want to work on Tuberculosis". That is not a topic. That is an area of work'; 'Now, the students would come (and say) "Sir I want to assess the risk factors of Hypertension in this community"' (I.F.3.7).

## ***Other Activities***

### **Formal**

- Medical Education Technology Unit (MET): The Institute has an active Medical Education Unit. Though the non-clinical departments are more active, the unit has representation from most of the Departments. The unit has brought several changes in the evaluation systems (like introducing OSCE and OSPE). It also conducts sessions on 'Good Reading' for the UGs. The unit, along with the Curriculum Committee, co-ordinates the once-a-month integrated teaching sessions covering topics like TB, Diabetes, Vitamin-A Deficiency Disorders, and Ethics. This practice has been in place at MGIMS since decades, but 'real integration is still not happening. It has to first happen in the minds of people' (informal communication with a MET faculty).
- Bio-ethics Committee: This committee has been formed under the directives of MUHS. It attracts many UG students and is supported by motivated PG students and Faculty. A few years back, this committee had organized a National Conference on Bio-ethics for UG students.
- Occasionally, the Institute organizes open lectures and documentary screening. For instance, the Researcher could attend the screening of a documentary titled '*Hippocratic*' based on the life and work of Dr. MR Rajagopal. It called for an ethical and holistic view on health through the lens of palliative care.

### **Informal**

- White Coat Army: This refers to a group of UG students who spread awareness regarding the hazards of addictions, especially to alcohol. This 'army' was initiated by a young and energetic faculty in the Department of Psychiatry. He shared information regarding this topic with a group of interested UG students and let them decide if they could do something about it. The students started giving talks and performing plays on the medical, social and economic impact of substances like alcohol for the indoor patients and their attendants. Later this activity was extended beyond the hospital into villages and schools. The 'army' also started sensitizing the new MBBS students for abstaining from substances. Overtime, as that faculty left the Institute, and as the first wave of students trained by him are passing out, this activity is getting weakened.

- Sunday Meets: Socially sensitive UGs often feel isolated in the MC. 'If you talk on serious issues, you will not find friends', a student said. Sunday Meets is a small group to bring such students together. They meet on every Sunday, share information and emotions about personally and socially relevant issues and try to understand oneself and the society better. At times, the group also engages in social action like *shramdaan* in neighbouring villages and participating in disaster relief.

### **Activities with Interns**

The internship begins with a five day orientation program during which there are sessions on professionalism, bio-ethics, communications skills, doctor-patient relationship, alternative health systems, Right to Information Act, rational use of drugs, medico-legal issues, prescription writing, Bio-medical Waste, Hospital Information System, sample collection, filling investigation form, interpreting the result etcetera. Faculty from different departments, including DoCM, participate in this program (O.C.3.1).

Interns get a two month posting in CM during which they are posted for fifteen days each at GOPD, RHTC (Anji/Bhidi), UHC and Primary Health Centre Talegaon. The posting at Anji/Bhidi is residential. The Interns participate in facility-based OPD and also attend the *Kiran Clinics* scheduled in villages around their place of posting. This is unlike other postings where they just take samples and fill investigation forms. 'Here we prescribe the treatment' (FGD.Intern.3).

The Interns also attend any CBO meeting (SHGs, KVMs, Kishori Panchayat or VHNSC) that happens during their posting. They may go for School Health Education program and may also get exposed to department projects during this period. 'Going to these places makes us understand the awareness gap that exists in the periphery' (FGD.Intern.3).

Besides, the Interns also get a posting at the outreach hospital located in located in the tribal area Melghat.

### **Activities with Postgraduate Students**

#### ***Field Activities***

PG students get posting in different field areas where they manage facility level or outreach OPDs, undertake short research studies, impart health education in schools and in meeting

of CBOs (women SHG, *Kishori Panchayat* and *Kisan Vikas Manch*). Relative to GOPD, the PG students are able to spend more time with patients and educate them in these field OPDs. They also support the UG training in field (family visits and family studies). However, PG students, who have done UG from elsewhere, expect the department to first train them in these pedagogical methods (O.F.3.4).

Some faculty use these posting to facilitate more basic learning. 'I ask these people (PG students) to spend a day with the ANM, with the ASHA and see what difficulties they face. See how integration of programs makes things difficult or easy for them' (I.F.3.10). The PG students also get posted in the District Health Office where they see the management of different health programs. They also get posted in the outreach hospital located in the tribal area of Melghat.

**Table 22: Field activities for Postgraduate Students at Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine, MGIMS**

Period	Program	Duration	Nature
First Year	GOPD	2 months (8 am - 1 pm)	Screening and managing/referring patients; hospital-based Surveillance
	Peripheral Postings: RHTC Anji; RHTC Bhidi; UHC; Talegaon	2 months each	Facility based OPD; <i>Kiran Clinics</i> ; Meetings with SHGs, KVMs, KPs
	Posting in District Health Office and Civil Surgeon Office	1 month	Observe the monitoring of National Health Programs
Second Year	GOPD	8 months (8 am - 1 pm)	Screening and managing/referring patients; hospital-based Surveillance
	Clinical Postings: Medicine; Obstetrics and Gynaecology; Paediatrics	1 month each	Learn primary-level clinical skills
	Posting in District Health Office and Civil Surgeon Office	1 month	Observe the monitoring of National Health Programs
Third Year	GOPD	8 months (8 am - 1 pm)	Screening and managing/referring patients; hospital-based Surveillance
	Peripheral Posting	2 months	Facility based OPD; <i>Kiran Clinics</i> ; Meetings with SHGs, KVMs, KPs

GOPD: General Out-patient Department; RHTC: Rural Health Training Centre; SHGs: Self-help Groups; KVMs: *Kisan Vikas Manch*; KPs: *Kishori Panchayat*

As can be seen in [Table 22](#), significant proportion of PG's time is spent in GOPD. Some like this, as its 'clinical' work. 'From 8 am to 1 pm, like other clinical departments sit in OPD, Community Medicine in MGIMS also sees OPD' (FGD.PG.3). And others are content that it keeps them productively engaged unlike in other MCs where the PG students just sit in the department (FGD.PG.3). PG students also get three month rotation in clinical departments relevant to primary-level medical practice (like Medicine, Obstetrics and Gynaecology and Paediatrics). However, the department consciously tries to maintain a balance and refrains from doing 'too many clinical things' (I.F.3.1).

### **Research Activities**

The allotment of guides is done randomly, using a lucky draw. And this is not a very water-tight thing. The student belongs more to the department, and not to just one faculty. So every faculty knows what every student is doing. The student can seek anybody's help (I.F.3.1).

#### **How are the topics decided?**

If the student has something in mind, s/he can explore it further with the help of the guide and other faculty. Otherwise, the student may consider working in an area suggested by the guide. In either case, 'it's a participatory process' (I.F.3.1). However, being new to research, most students would 'let the guide guide them' (I.F.3.6, I.F.3.7). A faculty expressed concerns about such 'spoon-feeding' which may actually hamper the independent learning of the student. 'I feel that somewhere it is very important to allow students to struggle also' (I.F.3.1).

The guide may suggest the student to plan the thesis within the broad domain of an on-going project (I.F.3.6, I.F.3.7). This was corroborated by seeing the list of thesis topics and the list of projects going on in the department around that time. 'The intent is dual. One is we get technically qualified people to overlook and supervise the implementation of the project, whom we can trust. The post-graduates in-turn get a first-hand experience of managing a project' (I.F.3.1). And sometimes, it happens the other way round also. The knowledge gained through a PG thesis may feed into a later day project. For instance, there was a thesis assessing effects of psychosocial stimulation on physical growth of pre-school children (in 2013), and another one assessing effects of early childhood interventions on



child feeding practice and nutritional status of children below two years (in 2015). In 2017, department started a project on empowering family and community for responsive care-giving. The department also gets in-service PG students. To them, topics related to some National Health Program are given considering that this learning will help them once they go back in the system (I.F.3.1).

### What are the Topics?

PG theses have largely been epidemiological studies on issues related to women's/maternal health (anaemia, Reproductive Tract Infections, maternal mortality/morbidity, fertility, unmet need of contraception, pregnancy wastage, psycho-social morbidity among pregnant women, mental disorders, chronic respiratory morbidity, gestational diabetes), child health (low birth weight, neonatal sepsis, growth faltering, malnutrition, Acute Respiratory Infections, Diarrhoea, psycho-social development), elderly health (quality of life, ocular morbidity), non-communicable diseases and their risk factors (hypertension, diabetes, obesity). Others dealt with issues like adverse treatment outcomes in RNTCP, or with Sickle Cell Disorders. One thesis dealt with intimate partner violence.

Another domain of PG theses have been assessments, of: a) service quality (GOPD, Primary Health Centres, EmOC/LSAS training), b) effectiveness of initiatives (Village Coordination Committees, VHNSCs, behaviour modification, parenting workshops, early childhood development initiatives), c) tools (verbal autopsy, PHC-MAP modules), d) programs (RBSK, weekly IFA supplementation). One thesis documented the process of developing community-based health management information system.

There were some theses dealing with cost-benefit analysis (of *Kiran Clinics*), household health expenditure, and psychosocial and economic impact of diseases on patient and caregivers. There were others exploring the knowledge (health literacy, newborn danger signs), attitude (readiness to quit tobacco) and practices (treatment seeking).

Almost all of the PG studies have been field-based - largely at community level; a few based in schools, *Anganwadi* or Primary Health Centres.

### PG Research other than Thesis

Besides thesis, the PG students are supposed to do two short-projects in their first year. These may be assessing knowledge, attitude and practices regarding a health issue, like

HIV/AIDS or hypertension, among a specific group of individuals or across groups. Or, they may be trying to understand the challenges of health functionaries like ASHAs or Health Assistants. PG students may get involved in departmental projects even if their thesis is on a different topic.

### Use of Research Findings

'Most of the MD theses are a kind of learning exercise' (I.F.3.1). Given their scale and scope, PG research can't aspire to inform the policy (I.PF.5, I.F.3.6). The findings of some of them may lead to change in a departmental activity, or may be used for advocacy at local-level (I.F.3.6). Some may inform another research in the department. Those, which have been part of a project, may get presented at an external forum. Otherwise, they may get presented in professional conferences and may get published. And for some, the journey may end with thesis submission.

### ***Classroom Activities***

In the first two months or so, PG students get an orientation to the Department and various activities. They also undergo a month-long schedule of post-lunch classes on research. In fact, they have an academic activity in the post-lunch session on most weekdays for all three years. There is a Journal Club every Tuesday, a Seminar every Thursday and Clinico-social Case Presentation on Wednesdays and Fridays. PG students make presentations as per their turn. In case they are posted in the periphery, they come to the Department for this task. The department has established Video-conferencing facility at both the RHTCs so that the Junior Faculty and the PG students posted there do not miss-out on these academic activities. Whenever the PG students are in Sewagram, they are expected to attend the UG classes taken by the Professors. Sometimes, the professors would delegate their UG lectures to their PG students, or to the junior faculty to develop their pedagogical skills. The professors would also remain present and watch how the class is being taken (O.C.3.3). Besides, PG students are asked to prepare new e-learning course material or update the existing one.

The Researcher could attend a Journal Club session (O.C.3.2). The article presented had country-level data, but the faculty steered the discussion more towards what was happening in Maharashtra State, and in Wardha district. They posed concept-based

questions like ‘what are the factors other than health which affect neonatal and under-5 mortality rates?’ The students were free to speak, and they did speak.

Some of the junior faculty, though they were appreciative of the field exposure that students get here, felt that classroom activities at SNSPH-DoCM get a bit compromised because of that (I.F.3.10). This affects PG’s grip on the theory (I.F.3.6).

### ***Other Exposures***

PG students get opportunity to interact with visitors, including students, from within the country and without. Some PG students get chance to attend a short-course on Global Health at Ben Gurion University. In addition, PG students participate in various state and national-level conferences. And, if a disaster has struck somewhere in the country, they are part of the relief team.

### **Other Teaching-Training Activities**

Besides UGs, Interns and CM PG students, the department is involved in following teaching and training activities:

- Every year, the department holds a series of research workshops open for CM and PH students, faculty and professionals. This series include one each on Study Designs; Data Analysis using Statistical Softwares (EpiInfo, R); Qualitative Methods.
- The Department conducts Research Methodology Workshop for PG students of different departments of MGIMS.
- One faculty takes the course on statistics for Nursing students (Bachelors and Masters).
- Faculty who are in the Institute’s Medical Education Unit are engaged in the Basic Workshop on Medical Education Technology.
- The faculty posted in the periphery taken sessions for the ANMs and Anganwadi Workers during their monthly meetings.
- The department have been, off and on, receiving students from institutes like Tata Institute of Social Sciences (Mumbai), Maastricht University (Netherlands) and Ben Gurion University, (Israel). In between, it also received student through WHO In-country Fellowship Program.
- The department has been engaged in capacity building efforts of government health staff (ASHAs, ANMS, Staff Nurses, Medical Officers) from the district. They have trained faculty

of other MCs under specific projects. They have also trained MOs from other States on IDSP.

### **III.3.2 Field Activities**

#### **Community Mobilization**

Going beyond the traditional role of a CM department, the one at MGIMS has invested a lot of efforts in community mobilization. The reputation of the Institute has helped the department in initiating these community partnerships (I.F.3.3). 'Mobilizing specific groups of people, bringing them together based on their interests, and then introducing health has been the way followed' (I.F.3.7).

#### ***Women's Self-Help Groups***

##### **History and Development**

DoCM was engaged in community health education for long. But gathering women on health issues was difficult. Secondly, the set of individuals whom the department's team meet would change in every visit. So there would be no continuity and reinforcement (I.F.3.4, I.F.3.11). In an exposure visit, the team of faculty saw Women's Self Help Groups formed by an organization called BAIF<sup>8</sup> for economic empowerment of women, and also utilized for agriculture purpose (I.F.3.4). This inspired them to undertake similar experiment for health purpose. This work began in late 1990s.

In the initial period, the faculty would themselves go in field and stay till late to convince the women to form groups (I.PF.5). They would also deal with the apprehensions held by the husbands of these women. Once the groups were formed, the women feared that their husbands would take away the money they were collecting (I.F.3.4). So, the groups had to be linked with banks. To do this, training workshops were organized for the group members in collaboration with National Bank for Agricultural and Rural Development (NABARD).

For the initial period, the team would not talk about health at all. Vocational Training programs were organized in coordination with *Khadi* Village Food Industry Training Institute, Wardha. Sewing machines, *papad* making machines and grinders for making condiments were provided to women for income generation. Several women started small business

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<sup>8</sup> Bharat Agro Industries Foundation

ventures (*lassi* centre, chilli-powder selling). When the women learnt to handle the economic activities on their own, and developed a level of trust in the team, the agenda of health was brought to the fore. 'Mahila Melawas' were organized where issues like alcoholism, PCPNDT Act and gender bias were discussed and activities like ensuring prohibition and social marketing of sanitary pads were talked about. Later, these groups were made eligible for getting enrolled under the Institute's health insurance scheme. It was expected that these women would be the change agents for other women.

Many faculty shared that economic empowerment of women was not the department's purpose behind forming SHGs (I.F.3.7, I.F.3.9, I.F.3.11). 'We developed (SHGs) for the purpose that we will have a stable forum with which we can dialogue. That was our intention' (I.F.3.11). One faculty, however, said, 'health messages would be futile if the women are not capable or empowered to face their families and have some money at their disposal to spend on health issues, if required' (I.F.3.8, during O.F.3.3).

This intervention flourished over a decade because of support of a concurrent project ('CLICS'; explained later). The department was able to form close to 300 such SHGs. But when the project got over, and the staff reduced, the activity got affected. Recently, the State Government launched an economically attractive scheme to promote Women's SHGs. As a result, the SHGs formed by the department are shifting under that scheme. The department is fine with this and has started approaching the federation of these new SHGs so as to use that as a platform for giving health education (I.F.3.6, I.F.3.7).

### Observation

The Researcher could observe a meeting of one such Women's SHG (O.F.3.6). It was one of the oldest groups formed by the department, and the economic conditions of its members had improved a great deal from the time they started the group. The group accumulates a huge corpus and lend money to its members for activities like starting a beauty parlour. Every few years, the members divide the accumulated corpus amongst themselves but they seldom spend it on any common health-related activity for the village. After the group was done discussing its fund-related issues, the Health Educator from SNSPH-DoCM gave a talk on Tuberculosis. Given it was the month of March, in which the World TB Day falls, this was

the topic given by the department. At other times, they may get a different topic, like *Ayushman Bharat*.

### Benefits to the Department

Self-help Groups have served as the 'backbone' of department's community mobilization (I.F.3.7). The goodwill and relations that developed has helped the department initiate other activities in the village, like formation of Village Coordination Committees and starting *Kiran Clinics*. These groups have also been of help during camps and visits of UG students. The SHGs are utilized to demonstrate the qualitative methods like FGD; the SHG members help the students in social mapping. In such interactions, the students can see how differently these women understand various social and health issues (I.F.3.2, I.F.3.11).

### ***Kisan Vikas Manch***

After witnessing the effectiveness of Women's SHGs, the department organized the men folk. *Kisan Mela* were held, and residential trainings on issues like animal husbandry, medicinal plants, social forestry and entrepreneurship were conducted in collaboration with NABARD, Government Agriculture School and local NGOs involved in such work. Gradually, the health component was added. The participants were expected to further train their peers and initiate health action at village level. This initiative reached its peak during the CLICS project (2003-08) when around 70-75 such SHGs were formed. In 2008, members of *KVMs* in the area of Primary Health Centre Anji formed a federation. As the project staff got withdrawn, it became difficult to support this activity. Around ten *KVMs* are still active. The Researcher could attend a meeting of one such *KVM* (O.F.3.6). It began with a discussion on their pooled funds, followed by a talk about the products of a private agro firm by one of the group members. Thereafter, the health educator gave a talk on Tuberculosis.

### ***Kishori Panchayat***

#### History

*Kishori Panchayats* began as Self-help groups of non-school going adolescent girls. Initially, they would contribute a small fixed amount each month to a pool, and use it whenever required. This initiative received a big push with the beginning of CLICS project (2003-2008). During this time, some of the members were sent for a 6-month tailoring course in collaboration with a Rural Polytechnic College. Large gathering of adolescents (*'Kishori*

*Melava'*) were organized. During 2008-09, libraries were developed for adolescent girls at RHTC Bhidi and in some schools of surrounding villages.

At present, the SNSPH-DoCM is in touch with about 90 such groups. Each month, the Social Worker educates the group on issues like adolescent health, maternal health, child survival, environmental health, family life education, age at marriage, RTI/STD, HIV/AIDS etcetera. Other village development related issues are also discussed with the groups. These girls are expected to share this knowledge with their peers and families. The purpose of these groups is also to develop leadership quality in these girls and utilize them for health action at village level, like insisting the shopkeepers to sell only iodized salt.

The groups are called a *Panchayat*, because they have elected office bearers. They discuss, take decisions, and review the implementation next month (I.F.3.1). They also participate in Village *Panchayat* meetings.

### Observation

The Researcher could attend a *Kishori Panchayat* meeting (O.F.3.3). Around 15-20 adolescent girls were called from their classes to the *Anganwadi* centre which was located in the same School compound. The lady Social Worker took a session on cancers, especially focussing on oral and breast cancer. It was told that tobacco chewing causes oral cancer, and that the one with this habit may not open his/her mouth wide enough to accommodate four fingers. The girls were asked to discourage tobacco use among their own families, and also to do this four finger test. They were also told about Breast Cancer, that it can be detected early by self-examination, and that they should tell this to their elder sisters and other women. Later, the Social Worker took feedback on the task given last month when these girls were informed about the importance of iodine. They had been asked to give five key messages regarding how the iodine content of salt can be preserved, and to test the salt used in their neighbouring houses for the presence of iodine.

The Researcher could also attend one *Kishori Melava* (O.F.3.7). A group of around 30-40 girls assembled in an under-construction common village hall. A team of department faculty and social workers was present, besides the government ANM, ASHA and *Panchayat* members. A session on nutrition, and another on Menstrual Cycle were taken. Thereafter, the girls were taken through an exhibition on tobacco and cancers. This was followed by a

health quiz, and then, they played musical chair. Finally, prizes were distributed. The prizes were sponsored by the VHNSC. Locally prepared snacks were served to all present.

### **VHSNC**

The Department had started forming Village Coordination Committees (VCC) under the CLICS Project. These VCCs had representation from Women's SHGs, KVMs, *Kishori Panchayat* and Gram Panchayat. There were more than sixty such committees, and most of these were chaired by women (I.F.3.11). As the project came to an end, and NRHM got launched, these VCCs were merged with VHNSCs. At present, the para-medical team (social worker and/or ANM) attends the monthly VHNSC meetings and use this platform for health education. The senior faculty give credits to the para-medical staff for keeping many of the VHNSCs functional, which is usually not the case in other areas (I.F.3.11).

Sometimes, same health topic is discussed at all the above mentioned forums. So, it kind-of becomes the talk of the town. And when done repeatedly, this may lead to a change in behaviour. Healthy behaviours, when developed in groups, are more likely to sustain, and then be transmitted to the next generation.

### ***Self-critique of Community Mobilization Activities***

The faculty called the role of paramedical staff 'pivotal' for the department's community mobilization activities (I.F.3.4, I.F.3.11). The faculty used to themselves engage in these activities earlier. But now, most of them seemed to be just monitoring (I.PF.6), or going only when some big gathering is planned (as shared by a social worker). Community mobilization activities are not as much at the core of the projects that are coming now as they used to be in the last decade.

The junior faculty and PG students imbibe what they see their seniors to be doing or not doing. The *Kishori Panchayat* meeting that the Researcher attended ran parallel to a not-so-busy *Kiran Clinic*. But the PG student came to the meeting only in the passing (O.F.3.3). Even the para-medical staffs have developed a 'comfort zone'. 'They attend meeting only in those villages where people are supportive. Where this is not the case, and so more efforts are needed to be put, those villages are getting skipped here as well' (I.F.3.10).

While some bit of 'dilution' is natural and obvious as new people join, the process may get hastened if the senior faculty take a high-handed approach, and if they do not give due



credits to the juniors (I.PF.6). On the other hand, the senior feels that the new generation is more interested in clinical/centre-based activities rather than community-based ones (I.F.3.11).

## **Clinics**

### ***GOPD***

General OPD (GOPD) has been in place since the beginning of the Institute. It was conceived as a replica of a Primary Health Centre within a MC set-up, and it continues to be so. It has facility for primary-level medical consultation, sputum-smear examination for diagnosing TB, DOTS, immunization and counselling (psycho-social, nutritional, family welfare, de-addiction). Besides, it collects data on a set of communicable diseases (like Acute Flaccid Paralysis, Measles and Dengue) from different departments of the hospital as a part of Epidemiological surveillance.

Every new patient in the hospital first comes to GOPD and is seen by the PG student or Intern. If the complaints are of a primary nature, the patient is managed at this level; if complaints merit a specialist consultation, the patient is referred and guided to the concerned department. In this way, GOPD reduces the load of specialty department and saves the patients from unnecessary hassles. Each year, GOPD screens close to 2 lakh patients, and is able to manage around ten percent of them on its own.

Every CM faculty, on rotation, oversees the day-to-day functioning of GOPD. They utilize this time to take lectures for UG students and Interns, and guide the PG students on their research work. PG students appreciated this exposure, but shared that they were not able to spend adequate time with the patients. 'We talk about levels of prevention, about counselling...but the patient load is so high that we are not able to do all that' (FGD.PG.3). While acknowledging the utility of GOPD in a busy hospital, a past faculty was opposed to having a DoCM to manage it (I.PF.6).

### ***Kiran Clinics***

#### **History and Development**

Under an Area Development Project funded by Aga Khan Foundation, the department did community needs assessment using qualitative methods in around 20 villages of Talegaon

area (I.F.3.4). This exercise threw a lot of problems that villages had, like those related to water supply, electricity etcetera. One, which the Department could possibly address, was the need for clinical services in the village by qualified personnel. The dialogue in this regard began, and the community agreed to give space, basic furniture, and a few volunteers for the clinic. The Department would send its PG students and/or Interns on a fixed day every week.

A village-level committee was formed, in consultation with *Panchayat*, to plan and monitor the clinics. Regarding drugs, it was suggested to create a village fund in which each family would contribute a small initial amount. In some villages, a well-off person would express desire to single-handedly fund the clinic. But such offers were discouraged by the committee as it would not let the sense of ownership develop among others.

A list of essential drugs was prepared by the Department; purchases were made by the Committee at wholesale rates. The drugs were sold with a 20 percent margin over the cost, so as to take care of expiry. A minimum case fee was also charged, which was a bit higher for those who didn't make the initial contribution. The money so collected was deposited in bank and used as a revolving fund for the clinic. So, in that sense, the clinics were financed and managed by the community.

One after the other, several villages raised demands for the clinic. Earlier, these were called 'Community-owned Health Program (COHP)' clinics. Later, when CLICS program started, they were renamed as '*Kiran Clinics*' (I.F.3.4). In some villages, because of low turn-out or because of lack of support, they were discontinued. If any VHNSC demands, and if it's possible for the Department, new clinics are started. At present, more than 20 such clinics are functioning.

### Observation

The Researcher could observe two such clinics (O.F.3.3, O.F.3.6). Both were held in a *Panchayat* room and managed by a team of a PG student, an Intern, a Department ANM and the village ASHA, besides a community volunteer. The patients were largely the aged ones with complains of hypertension and/or diabetes, general body pains or weakness. There were some children presenting with cough and cold. The clinics ran for about two hours in which about 25 to 40 patients were seen. The Researcher could talk to a committee

member regarding whether they find this clinic useful. And the response was positive. He said that the Primary Health Centre was seven kilometers far, and the staff was not very responsive. So, people would just not go there till it became absolutely essential. Now, because of these village-level clinics, they were coming for consultation early in the course of illness.

It is important to note that while the SNSPH-DoCM faculty monitor this activity, they are not consumed in these clinics on a day-to-day basis. The Interns feel satisfied doing this work, because a) it is clinical, and b) they are able to treat village people, who lack money as well as information, at their doorstep. Their weekly visits ensure regular supply of medicines for those suffering from NCDs (FGD.Intern.3). Some CM PG students also thought this way. 'Being a doctor, I get the satisfaction that I treated a few patients. It may be just ten cases in a day, but I get that satisfaction here' (FGD.PG.3). One faculty, however, had a concern. 'These people don't know what they have to do other than attending the *Kiran Clinic*...So, though we say they have gone in field, practically they have just seen patients' (I.F.3.10).

### ***Specialist Clinics***

SNSPH-DoCM co-ordinates specialist OPDs in the periphery. Specialists from the various departments of MGIMS go to Primary Health Centre Anji and Rural Hospital Bhidi on designated days. The younger CM faculty saw these clinics as something that helped them build a rapport with the community (I.F.3.7, I.F.3.8). However, there were challenges in running these OPDs (I.F.3.6). The Primary Health Centre and Rural Hospital do not have the medicine and other logistics that the specialists require. As the clinics are not daily, the patients do not always remember which day they are supposed to go. Given a lack of material support, a small number of patients, and the workload in their own departments, the specialists are not very keen to attend these peripheral clinics.

### **Other Services**

SNSPH-DoCM faculty have been part of teams sent for relief and support during disasters. They have been there after Odisha cyclone, Gujarat earthquake, tsunami in Bay of Bengal, during floods in Bihar, and more recently in Kerala Floods.

The para-medical staff of SNSPH-DoCM facilitates families, groups and villages in their area in getting enrolled under the MGIMS's Health Insurance Scheme. 'That is another thing that helps in community mobilization (I.F.3.8).

### **III.3.3 Research**

The information about department's projects was taken from the Annual Reports since the year 1996, and through the interviews with faculty. From whatever little information that was available for the first 25 years, it seems that the department wasn't as much engaged in projects till mid 90's.

#### **How are the topics chosen**

The faculty in the department are well networked (I.F.3.4). Over the years, they have built a reputation for credible and quality work (I.F.3.5, I.PF.5). So, most of the times, it is the commissioning agency that invite them to participate in their research project (I.F.3.1). Sometimes, they also compete for grants.

Most of the research projects undertaken by the faculty are community-based, participatory and involve components of service and community mobilization (I.F.3.1). 'Just research for the purpose of research, mostly we do not engage' (I.F.3.2). 'Our field practice area is our research area' (I.F.3.5). 'The service and research is inseparable for this Institute' (I.F.3.2).

#### **What are the Projects?**

The major focus of the department projects has been on community resource mobilization, partnerships and health action. The initiatives of forming Self-help Groups of women, of farmers (*Kisan Vikas Manch'*) and of adolescent girls (*Kishori Panchayat'*); forming Village Coordination Committees and appointing Community Health Workers; and starting community-owned clinics at village level (*Kiran Clinics'*) as a part of decentralized model of health care delivery - these were all woven into community-based projects. They also did a project titled 'Community-owned Management Information System: an Alternative Model of Community Monitoring for Health'.

A lot of the research work in the Department has happened in the field of Maternal, Neonatal and Child Health and Nutrition (MNCHN). The department is also a WHO Collaborative Centre for Research and Training, and an ICMR Centre for Advanced Research, on Community-based MNCH. The department has worked on RTIs/STDs, Anaemia,

hypertensive disorders of pregnancy, neonatal infections, malnutrition deaths (in the tribals of Melghat region), home-based management of young infants and on early childhood development. The department has been following a cohort of rural pregnancies. It has been part of base-line surveys and mid-term assessments of projects on MNCHN managed by other agencies. They have done Knowledge, Attitude, Belief and Practice (KABP) Surveys; impact evaluation of services and schemes (like JSY); and desk reviews. The department has facilitated setting up of quality assurance cells, EmOC and LSAS trainings, and has been engaged with concurrent monitoring of quality of ICDS services in the State.

The department has undertaken several projects on capacity building of: NGOs; ANMs, Staff Nurses and Lady Health Visitors (Integrated Skilled Birth Attendant and IMNCI training); Interns (prescription practices, epidemiological skills); MC faculty (on Primary Health Care - Management Advancement Program Modules); and Parents (responsive care giving).

Department has done epidemiological studies on Sickle Cell Disorders, Malaria and Sleep Apnoea, and has been involved with surveillance of blindness, NCDs and zoonotic diseases. One faculty is involved with IIT Delhi in developing algorithms that can report on CT Scan images using Artificial Intelligence.

Department was part of a study assessing safety, tolerability and efficacy of DEC-Albendazole co-administration in Filariasis, and another one assessing the efficacy of a probiotic in neonatal sepsis. The Department has also been part of several vaccine trials [DTP Booster, Pentavac, RotaSiIL (against Rota Virus), VPM1002 (against TB) and qHPV]. The number of such projects has increased in last decade.

The department has been funded by government agencies [National (ICMR, NIPPCD, MoHFW, DST, NIHFW, NACO, NAMP), International (USAID), State (SHSRC) and District (District Reproductive Health Society)], UN agencies [WHO (ICO and SEARO), Unicef and UNFPA] and non-government agencies (Aga Khan Foundation, Population Foundation of India, INCLIN and SOSVA). Funded projects have also come from Umea University, Sweden and through Tata-Cornell Agricultural Initiative. The vaccine trials have been funded by Serum Institute.

Besides, the faculty offer consultancy to Government and Non-government agencies. For instance, they supported District Jalna in preparation of Health Action Plans; they have assisted in monitoring Leprosy Elimination activities in neighbouring districts.

Most of these projects have been based within Wardha district, especially in Talegaon area. A few projects involved districts in the immediate neighbourhood of Wardha (Amravati, Chandarpur, Nagpur, Yavatmal), or within the same State (Aurangabad, Nashik). One project was based in the neighbouring State (MP).

Some of the major projects handled by the department are as follows:

### ***PVOH-2***

This USAID funded project was aimed at building the capacity of Private Voluntary Organizations for Health (PVOH). DoCM was entrusted to strengthen seven NGOs working in the neighbouring State of Madhya Pradesh over a three year period (1994-97). The department conducted IEC trainings and MIS workshops, and also did field-based monitoring.

### ***CLICS***

'Community-led Initiatives for Child Survival', or 'CLICS', was a five-year project funded by USAID through Aga Khan Foundation (2003-2008). It covered sixty-seven villages from the areas of three Primary Health Centres (Talegaon, Gaul and Anji). Several activities initiated in previous projects, like forming Self-help Groups of Women, of Farmers and of adolescent girls, and starting community-owned clinics, got a major boost under this project. The faculty invested themselves on ground, and a lot of staff was recruited under the project. Most notably, one or more Community Health Worker ('CLICS *Doot*') was appointed in each project village. And, a Village Coordination Committee (VCC) was formed in each village. All this happened before the launch of NRHM!

As the project was coming to an end, members of the VCC were taken on an exposure trip to ideal villages like Ralegan-Siddhi, Hiware Bazaar and Jamkhed. The CLICS *Doot* were taken to organizations like *Amhi Amchya Arogya Sathi*. The Department could convince the District Administration to recognize the VCCs as Village Health Nutrition and Sanitation Committees, and many of the CLICS *Doot* have been taken-up as ASHAs. However, due to

withdrawal of project resources, many of the initiatives had to be left to run on an auto-mode.

### ***ECD***

'Early Childhood Development', or 'ECD' project is a Unicef funded project being implemented in Maharashtra and Rajasthan. In Maharashtra, the project covers four districts: Pune, Palghar, Yawatmal and Aurangabad. SNSPH-DoCM is the implementing agency for Yawatmal (six blocks) and Aurangabad (four blocks). This is the largest project taken-up by the department in terms of scale.

Internationally, it has been found that the environment a child gets in first eight years of life decides a lot about its future. The growth and development of children is better if the parents 'eat, love and play' with them. Under this project, the age cut-off has been kept at 6-years, so as to coincide with the pre-school age-group covered under ICDS. And, the task for the parents has been modified to 'talk, touch and play'. The project is aimed at taking this message, and the know-how, to each family.

The message for the parents is that their 'kids need play, not toys' (I.F.3.1). It's not a question of how much money one can spend. It's about time, and about engaging with the child. The plan is to train *Anganwadi* Supervisors, who will then train *Anganwadi* Workers, who will then train the parents. In addition, the *Anganwadi* Worker will also create an enabling environment in the village through Parent Meetings, *Mela* and other initiatives.

The Researcher could observe pilot testing of a Community Resource Mobilization exercise for the project (O.F.3.5). A group consisting of ASHA, *Anganwadi* Worker, members of women's SHG and of *Panchayat*, the Headmistress of school, adolescent girls and some other people were made to 'dream' what they want their village children to be, and then work on strategies to realize that dream. The project staff suggested ideas like a common safe playing area for small kids, a children's library, parents *mela* and healthy baby competitions. The group agreed on these ideas, and was ready to mobilize resources to make these happen.

### **Follow-up of Research/Projects**

Community mobilization has been an important component of the departmental projects. The community-based organizations that emerged from initial projects, like the Women's

Self-help Groups, are continuing even now. In fact, such organizations have been of great help to the projects that came later. In that sense, the learning from earlier projects directly fed into newer projects. And each of them helped in strengthening and sustaining department's community based initiatives.

Publications do happen, but they are seen only as an academic end-point; things do not stop there (I.F.3.1). The faculty try to follow the findings with advocacy, at least at the district-level (I.F.3.1).

Distinctly, a young faculty expressed disinterest in projects. 'So many things have been researched; so many things have been written...now it's time to do something' (I.F.3.10).

### **Benefits and Challenges**

Faculty give credit to projects for the intellectual and material development of the department. Community-based projects 'gave us a great opportunity to explore the things, as well as to expand our knowledge itself...Earlier, we were just confined to teaching and departmental activities' (I.F.3.9). 'Projects really made us develop' (I.F.3.5).

A past faculty saw several challenges in undertaking research. Firstly, funding for research in health was scarce. 'As "health" itself is not a priority, the research component in health gets neglected even more' (I.PF.5). Second issue was regarding what type of research gets funded (I.PF.5). And thirdly, how much is the research able to influence the policy (I.PF.5).

## **III.4 Department Interactions**

### **III.4.1 With other Departments of the Institute**

#### **Teaching**

During the ROME Camp for UG students, faculty from other Departments of MGIMS come to RHTC and take clinico-social cases at household level. Sessions on National Health Programs on Blindness or Mental Health would be taken by faculty from Department of Ophthalmology or Psychiatry. While earlier, senior faculty would come for these activities, now it is mostly junior faculty or PG students who come (I.F.3.6).

At times, there are integrated teaching sessions on topics like Tuberculosis or Diabetes in which different department would participate and cover their specialty's part of the topic.



For topics like IMNCI, while the theory is taken in the DoCM, students go to Paediatric wards for practical demonstrations. Sometimes, the students find it difficult to reconcile the clinical protocols told by clinical department and the PH guidelines explained by SNSPH-DoCM (I.F.3.1).

Academy of Medical Sciences is an institute-level forum where different departments may interact.

### **Service**

During Social Service Camps, faculty from different departments run Speciality Clinics in the adopted village. Even diagnostic department come to the village to screen the population. Similar specialty clinics are run at Primary Health Centre Anji and Rural Hospital Bhidi on designated days. It is mostly junior faculty or PG students who come for these clinics now. Several departments of MGIMS are also independently active at community level.

The SNSPH-DoCM runs a daily General OPD in the MC Hospital to filter-out primary-level cases and to channelize others to specific departments.

### **Research**

Faculty informed that the department has been in collaboration with most of the MGIMS departments on research projects (I.F.3.1, I.F.3.5, I.PF.6). For instance, Department of Microbiology did a project on Scrub Typhus in collaboration with SNSPH-DoCM (I.F.3.8).

Secondly, the SNSPH-DoCM conducts research workshops for all PG students of MGIMS, and further guide these students in designing their research and data analysis (I.F.3.9). The research topics selected by interested UGs during the ENHR workshops, which are conducted by SNSPH-DoCM, may be based in other department of the Institute.

### **Participation in Institutional Activities**

SNSPH-DoCM faculty have always been parts of different Institute-level committees, be it related to the a) clinical activities (like Internal Quality Assurance Committee, Clinical Epidemiology Unit, RNTCP Core Committee); b) academic work (like Research Committee, Medical Education Technology Unit, Editorial Board of MGIMS Journal); c) student-related (like Rural Placement Committee); or d) general management (like Vehicle Management). The department has been a part of the team in all disaster responses. One of the CM

faculty, especially interested in IT, supports the hospital information system. This involvement keeps the department in constant conversation with rest of the Institute.

### **Department Status**

While the faculty acknowledge that CM departments do not get much importance by other Departments in most MCs, this is not as much an issue in MGIMS. This is because a) since the beginning, the Institute's top-level management has been close to the department. Even at the time of this study, the Director-Professor of the SNSPH-DoCM was the Secretary of the Kasturba Health Society; b) the department itself has been very active, especially in last 20-25 years; and c) the attitude of faculty at MGIMS, in general, is somewhat different from other MCs (I.F.3.5). On the contrary, some faculty shared it's the CM department which may be dominating at MGIMS (I.F.3.2, I.F.3.8).

However, undercurrents of 'academic arrogance' were felt by the faculty here as well (I.F.3.2). 'Some ego issues are bound to happen when so many technical experts are going to work together' (I.F.3.1). The faculty opined that collaborations with other departments could be further improved if there was more space for dialogue (I.F.3.2, I.F.3.7, I.PF.6).

### **III.4.2 With Department/Faculty of CM of other Medical Colleges**

Senior faculty of the department have been members/office-bearers in several Associations/Networks at, State, National (IPHA, IAPSM, IndiaCLEN, Academy of Health Professions Educators) and International level (The Network towards Unity for Health). They have been on the editorial boards of different journals (IJCM, IJCH). Even others regularly attend, generic and specific, state and national conferences and training workshops related to the discipline. They find these as opportunities for 'cross learning' (I.F.3.3), and the topics covered there to be 'very relevant' (I.F.3.5). Another faculty found the conference discussions to be 'fruitful', though he was not sure if they actually attract government's attention (I.F.3.8). However, others opined that not much 'serious discussions' or 'academic exchange' happen at conferences, and that they are meant for visiting interesting places and for shopping (I.F.3.6, I.PF.5). 'It's more like a political thing and getting some orations, getting some fellowships, getting some recognition for oneself rather than for the discipline' (I.PF.6).

### **III.4.3 With Government Health Department**

#### **Facility level**

The SNSPH-DoCM faculty conducts capacity building sessions in monthly meeting of Primary Health Centre Staff. They give inputs in preparation of Health Action Plans. The government staffs are involved in the community mobilization activities initiated by the department. Many of the ASHAs started-off as CHWs under CLICS project, where they were recruited and trained by the DoCM. 'They feel in a way obliged and attached, connected to this department' (I.F.3.2). SNSPH-DoCM has 'etched that niche here where the government workers also understand that we are there for them' (I.F.3.7). This relationship has developed over years, and it holds irrespective of department's relationship at district level. 'Even if the DHO says no to something, things can get done at village level through them (ANMs/ASHAs)' (I.F.3.2).

Besides, the SNSPH-DoCM supports OPD at Primary Health Centres at Talegaon and at Anji. It co-ordinates specialty clinics through MGIMS faculty at Primary Health Centre Anji and Rural Hospital Bhidi. The ANMs of SNSPH-DoCM helps government staff in immunization and other activities on Village Health and Nutrition Days. However, the department does not duplicate what government is already doing (I.F.3.8).

#### **District**

The Department works on the concept of 'empowering communities and generating demand on one hand, and working with health system to meet that demand' (I.PF.6). So, advocacy with district authorities has been a constant feature. The Department keeps District authorities in the loop while initiating projects in the field.

The Department conducts training for government staff (Medical Officers, ANMs, Staff Nurses, ASHAs) whenever asked. At the same time, district program officers are invited to take session on National Health Programs during ROME Camp. PG students get posted in the District Health Office.

At times, the department has helped the district prepare its health action plan. District officials seek department's expertise whenever there is some outbreak. Support is also extended during activities like Pulse Polio Immunization and MR campaign.

The SNSPH-DoCM faculty have been members in District Health Society, District Adverse Event Monitoring Committee and District AIDS Society. Any requirement emerging from such forums are addressed. Recently, SNSPH-DoCM has signed a Memorandum of Understanding (MoU) with DHS for technical support to two Primary Health Centres (Talegaon and Anji), and with the Municipal Council of Wardha for technical support to two Urban Primary Health Centres.

Besides, the SNSPH-DoCM has a DMC, a DOT Centre and an immunization clinic in the GOPD. All the logistics for these activities come from district health department. MGIMS is empanelled under the State-funded Health Insurance Scheme.

### **State**

The department has done some projects funded by State Health Systems Resource Centre. The Faculty have been members in some of the committees of Maharashtra University of Health Sciences. However, except sometimes for advocacy, the department has not been able to engage with the health services department at State level. The distance from headquarter (Mumbai/Pune) is a hindrance to such engagement (I.F.3.2, I.F.3.7).

### **National**

The Department has done a large number of projects funded by national level government agencies (ICMR, NIPPCD, MoHFW, DST, NIHFW, NACO, NAMP). The faculty have served as members in national level committees like Steering Committee on Rashtriya Bal Swasthya Karyakram, Sub-committee on Health Systems Research (DHR), Technical Advisory Committee on Stillbirth (MoHFW), and on several ICMR Task Forces. The Department has contributed to the development of IGNOU's Bridge Course in Community Health for Nurses.

### **III.4.4 With other Government Departments**

Faculty of SNSPH-DoCM take capacity building sessions of *Anganwadi* Workers in their monthly meetings. The faculty have helped them strengthen their pre-school education. These workers are involved in the community mobilization activities of the department. The ICDS department has played a pivotal role in some of the research projects of the department, including the ongoing project on Early Childhood Development. The faculty have been officially engaged in monitoring of ICDS activities in Wardha and neighbouring districts.

Another government department with which SNSPH-DoCM has consistently engaged with is Education. Under CLICS projects, teachers were trained to deliver Family Life Education to their students. Now, the faculty themselves also take sessions in government high schools located in their field areas. The village-level school buildings are sometimes used as temporary accommodation for UG students during Social Service Camps. Some of the PG theses are based out of schools.

The Department is in regular contact with members of village *Panchayat*. These people are part of the VHNSCs, and the SNSPH-DoCM tries to build their awareness and capacity to act on local health issues.

As a part of an ongoing project on zoonosis, the faculty are in touch with Agriculture College and Department of Animal Husbandry.

### **III.4.5 With Others**

The Department has been engaging with local (Nehru Yuva Kendra, Bajaj Foundation), regional [SEARCH (Gadchiroli), IHMP (Pachod)], national (Population Foundation of India) and international NGOs (Aga Khan Foundation). The department faculty have engaged with NGOs in different capacities: as trainers, as visitors, as recipient of funds and as collaborators for some health action.

The department has been, off and on, receiving students from national (TISS, Mumbai) and foreign institutions [Ben Gurion University (Israel), Maastricht University (Netherlands)]. Faculty from other MCs often visit the department.

Faculty of the department have been members/office-bearers in several Associations/Networks at District (Society for Prevention of Blindness, Breast-feeding Promotion Network), State, National level (VHAI). Medico Friend Circle is a 45 years old group of PH professionals which has its origins in Sevagram. Several of its annual conferences of this group have happened in this town, including the one held in 2019. MGIMS supported some of its student to attend this meeting, and one of the SNSPH-DoCM faculty also participated in some sessions. *Jan Swasthya Abhiyaan* is another similar group. Though, not many faculty have heard of it.

### **III.5 Intra-departmental Interactions**

Going with the ethos of the Institute, the department has a culture of giving due respect to each of its members. Faculty having backgrounds other than medicine acknowledged that, while their peers in other MCs were treated as somewhat lesser by the medicos, this was not so in SNSPH-DoCM. And this was not just because they held a ‘teaching’ post. Even otherwise, the CM faculty, and especially the Head, respected them and valued their work (I.F.3.4, I.F.3.9).

Some of the faculty said that the department provided them ‘full professional freedom’ and ‘space’ (I.F.3.5, I.F.3.7). In fact, this was told to be generally true for the entire Institute (I.F.3.5). But not everybody felt that way. A junior faculty shared that one had to hard-sell even small little ideas (I.F.3.10). A past faculty said ‘when we were there, things were de-centralized...But probably, that is not the same thing now’ (I.PF.6). Speaking from the other side, a senior faculty said, ‘We give liberty and freedom also to them (juniors)...they can do some little bit change and all. But, in case they want to destroy it, we don’t allow’ (I.F.3.11).

The faculty were appreciative of the work-culture in the department and found the team to be committed and dedicated to make the department grow (I.F.3.2). There is a ‘tempo to work, to not to sit idle’ (I.F.3.8).

### **Summary Statement**

Mahatma Gandhi Institute of Medical Sciences stands on the foundation of Gandhian thought and values. Despite some dilutions over time, Institute’s location in Sevagram continues to reinforce that philosophy. While several departments of the Institute have been working at community-level, DoCM has been at the forefront. The faculty of this department had been intensively engaged with community mobilization activity since mid-1990s, and its social work team is playing a crucial role in sustaining those initiatives. As one of its initiatives for community-based ME, the department has been conducting Social Service Camp for first year UGs where the students live in the village for two weeks with limited facilities. This is followed by monthly visits to the same village and same set of families for next three years by each student. Even the junior faculty of the department are made to stay for initial couple of years at the Rural Health Training Centres and get in-tune with the rural culture. The department has been closely working with the government’s

health system at district and sub-district level. However, its involvement at State and National-level has not been as great, largely because of its remote location.

## **IV. Department of Community Health, St. John's Medical College, Bengaluru (DoCH)**

### **IV.1 Department History**

#### **IV.1.1 About Bangalore**

Bangalore is the 3<sup>rd</sup> most populous city in the country. It is hailed as the Garden City of India, and at the same time, as the Silicon Valley of the country. It is home to several notable institutions (like Indian Institute of Science), organizations (like Indian Space Research Organization) and industries (like Infosys). There are 16 MCs in and around the city, of which 12 are trust-owned. St. John's Medical College (St. John's) is one of the oldest among these (MCI 2019).

#### **IV.1.2 About St. John's**

St. John's National Academy of Health Sciences, of which the MC is a part, strives to train and encourage health care professionals to 'reach out to the medically underserved of the nation'. It harmonizes 'dedication to excellence' with 'commitment to social justice in health care'. The objectives of the Academy includes: compassion towards the patients and their families as persons; community health, fostering the dimensions of participatory team work; promoting holistic health; steadfastness to principles and moral values so as to be witness to a life of honesty and integrity.<sup>9</sup> 'Not many colleges have that as their founding mandate' (I.PF.7).

St. John's was established in 1963 by the Catholic Bishops' Conference of India (CBCI). One of the main purposes of setting-up a MC was to ensure a steady supply of doctors to the facilities located in the remote corners of India, especially those under the Catholic Hospital Association of India (CHAI). For two prior decades, church collections of one Sunday per year across the country were being set aside for this 'dream' (Narayan 2014).

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<sup>9</sup> [https://www.stjohns.in/about\\_us/objectives](https://www.stjohns.in/about_us/objectives)

The faculty and students, since the very beginning, have been selected from all over the country. For many decades, the Institute had its own process for student selection based on well established technical, social and psychological principles. Initially, the UG batch consisted of 50, and then, 60 students. After a long time, in 2016, the batch size increased to 150. Majority of seats are reserved for students belonging to Catholic faith. Among Catholics, there are sub-categories like dalits, tribal and religious sisters for whom seats are reserved (Ravindran G.D. in Nundy et al. 2018). At present, the selections are through National Eligibility-cum-Entrance Test (NEET). The reservation policy of the Institute, however, has stayed same.

For last several years, it has been ranked among the top five MCs in the country. It is a trust-managed college whose fee structure is transparent and lower than several other non-government MCs. The college gives need-based waivers to the students. Still, a section of students have to take study loans (I.F.4.5, I.F.4.7).

A past faculty recalled that in earlier times, it was not just one department, but the whole Institute was community health oriented (I.PF.8). The Governance Bodies were able to maintain a close connect with the faculty and the students. 'There was much more time for conversation' (I.PF.7). Over the years, however, the size and complexity of the Institute has multiplied, and such direct involvement has been somewhat 'diminishing' (I.PF.7).

### **IV.1.3 About DoCH**

The department of Preventive and Social Medicine started with the Institute in 1963. Sometime in mid-80s, it was renamed as a department of 'Community Health'. 'They (the then faculty) looked at community health in a holistic way. It wasn't just about medical care...therefore, they didn't want that world "Medicine"' (I.F.4.6). Several faculty justified the name of the department based on its continued engagement with the communities beyond just delivering healthcare services (I.F.4.1, I.F.4.3, I.F.4.6). Given the objectives of the Institute, the department has always been strongly supported by the Management (I.F.4.7).

The department was conducting UG course since beginning. Post-graduation in CM began in 1991 with two seats. At that time, there were just two faculty in the department, of which only one had an MD in CM (I.F.4.1). Since 2013, there are six PG seats and there are twelve



faculty in the department at present. No PG seat in CM has gone vacant in last decade or so. The sex-ratio among the faculty as well as PG students is tilted in favour of females (Table 6).

### **Engagement in rural area**

In the first decade, the Department used the outreach facility of St. Martha's Hospital<sup>10</sup> as its rural field practice area. Even in those times, a Professor from Department of Gynaecology and another from Department of Paediatrics used to visit this centre in collaboration with the Department of PSM (Narayan 2014).

In 1972, CBCI Society of Medical Education reviewed the working of the college in the past decade. One of the findings of the report was that 'if you want doctors and nurses from this college to go and work in small mission hospitals, you have to give them some training in that. Only Park's textbook is not useful' (I.PF.8). As a follow-up action, it was decided to develop community health projects that could be used for student and staff orientation to community health. On the lines of the dairy cooperative in Gujarat, AMUL, a health cooperative project was experimented in Mallur, a village around 75 kilometers from the college.

A rural health centre was started at Mallur with technical support from St. John's and financial contribution from the village. The contribution was in the form of a health cess of 3 *paise* per litre of milk sold to the dairy. 'We were working "for" the co-operative. It was owned by the local people...power sharing, not just task sharing' (I.PF.7). Besides providing general, specialist and school health services, developmental activities were also initiated. A *Mahila Mandal* and a youth association were started to ensure community participation in health work. Attempts were made to develop local handicraft work and sericulture, and to increase the membership of milk cooperative by purchase of more cows. In a decade's time, the health centre grew into a self-sustaining hospital. Another experiment was supported at Silvepura as a convergence of health, education and community empowerment.

Under ROME, St John's was linked to three Primary Health Centres: Dommasandra, Anekal and Bidadi. Around 1980s, four Sub-centre villages of Primary Health Centre Dommasandra were selected under the Health and Development Project funded by State Bank of India:

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<sup>10</sup> Till 1975, St. Martha's Hospital served as the clinical facility for the St. John's Medical College.

Bidraguppe, Huskur, Yedavandahalli and Mugalur. Under the project, a Village Health Committee was formed and space was identified where a pair of Interns could stay and run a clinic. Faculty of DoCH would run weekly MCH clinics at these centres. Besides, there would be specialty camps and mobile clinics. The project also had a Sociologist who, besides other things, would mobilize theatre groups to perform street plays in these villages in the night when the people were free. School health programs were also being held.

All these experiments happened before, or immediately after, the Alma-Ata Conference. The conference only 'endorsed' the thinking which institutions like St. John's were already working with (I.PF.8). Other documents, like *The New Orientation of Health Services with respect to Primary Health Care Work* released by the Pontification Council Cor Unum in 1976, were more instrumental in this set-up (I.PF.8).

In 1987, at the Silver Jubilee celebration of the Institute, it was decided to start a Community Health Training Centre (CHTC). Mugalur was selected as the site as it was the last village of Dommasandra Primary Health Centre, and was most backward even by the standards of those times (I.F.4.1, I.F.4.2). In 1993, the CHTC building was inaugurated. A decade later, the building got an additional block, comprising of an Eye and Ear OPD and a Cataract Surgical Unit, through a funding from CBM, Germany. Around the same time, DoCH started forming *Mahila Mandals* in villages around Mugalur under 'Women in Health and Development - *Mahila Vikas*' Project funded by Ford Foundation. Women were trained in income generating activities like tailoring, goat rearing, chicken rearing, rabbit rearing, *papad* making and *agarbatti* making (I.F.4.1).

Sarjapur, which was earlier a Primary Health Unit under Dommasandra, is now itself a Primary Health Centre. Three of its Sub-centres, and some villages form adjoining Primary Health Centres at Lakkur and Anugondanahalli, together constitute the area of CHTC Mugalur. The CHTC covers 30 villages having 4,000 households and a population of about 25,000. The department has deployed Community Health Workers (CHWs) to cater to the CHTC area. CHTC Mugalur is where the department's outreach work is mostly based at present.

Mugalur and surrounding area has changed with time and is not typically 'rural' anymore. The connectivity has improved, the socio-economic status of families has become better,

and the occupation has been shifting from agriculture within local area to factory and service-sector jobs in Bangalore. This is partly because of the distress in agriculture (poor rains; poor returns), and partly because of charm of the city. Those who are continuing with agriculture have changed the crop pattern (floriculture, sericulture and eucalyptus cultivation instead of paddy, as it requires more water). Now, almost every house has a sanitary latrine; the number of children attending *Anganwadis* is going down; and delivery cases bypass even the CHTC (I.F.4.2). 'If we have to find a remote village...something raw and rural, we literally have to travel to another district or state. That is our constraint' (I.F.4.6).

### **Engagement in urban area**

In the first decade, the engagement of the Department in urban area was limited to participation of a faculty in the activities of one of the Urban Health Centre of the City Corporation. Later, the department explored some peri-urban villages close to St. John's for family visits by medical students, and started a weekly clinic at Lakkasandra. More recently, efforts were made to develop a base in Lakshman Rao Nagar and in a migrant colony near Bannerghatta (I.F.4.5). But these attempts didn't succeed.

The CSR division of a corporate company approached DoCH as it was finding it difficult to get Doctors for its Health Clinics. The department agreed to send a PG on a daily basis to one of their Centre. Besides, faculty visit the centre for special clinics (Geriatrics, NCD, Child Health, Gynae-Oncology). There are some community-based activities also, like follow-up of SAM children and home visits of people having mental health issues. This is the Urban Health Training Centre of the department. In addition, the department posts its PG students at a Government Urban Health Centre and at a *Taluk* Hospital. The land prices in urban areas are prohibitive, so it is difficult to build infrastructure similar to the one at Mugalur. Taking charge of an existing government facility is difficult for reasons explained later.

## **IV.2 Department Infrastructure**

The MC and the hospital are located on the same campus, and it's very green and clean. The Institute celebrated its golden jubilee in 2013 following which the college building got a new block, and even the older block got an aesthetic facelift. The new structure gives a corporate feel. Every entry and exit to the college has a uniformed guard. There are CCTVs placed all

over, including in the Departments and classrooms. Every student, staff and faculty invariably wears the official Identity-card.

The DoCH occupies the first floor of the old block. All Professors have separate rooms while Associates and Assistants share larger rooms divided into cubicles. The department has a Seminar Room, a Committee room, research labs for UGs and PGs, a museum, two demo rooms and a designated room for the PG students. All the rooms are well ventilated, and everybody prefers natural light. None of the rooms has an Air-conditioner, except the Committee Room which is used for presentations and staff meetings. While field visit orientation of UG students are held in the Demo Room of the department itself, their theory classes are taken in the college's common lecture halls designated for each batch. These halls have a theatre like seating arrangements; have facilities for projection and voice amplification. The students as well as the faculty have to digitally register their attendance in a biometric device both before and after the lectures.

The lobby in the department has several message boards displaying posters made by students, papers presented by the students and faculty etcetera. One such board has paper-cuttings carrying news on issues like agriculture, on the need of wells in Bangalore and about PH ethics.

DoCH has adequate number of four-wheelers to move teams of faculty and PG students in the field. For UG students, it has two 30-seater buses. Whenever required, bigger buses (50-seater) are requested from the nursing college, and there is no problem getting the vehicles or the drivers (I.F.4.6, I.F.4.9).

#### **IV.2.1 CHTC**

It has two connected blocks. The older block houses the general OPD, dressing room, lab, counselling room, physiotherapy room, separate rooms for male and female Interns and PG students, and separate dormitories for male and female UG students. It also has a mess, and a Chapel. The new block has rooms for Eye and Ear OPD, and a two-table Operation Theatre with ophthalmic microscopes and phaco-machine. On the first floor, there is a hall named after a cheerful ex-faculty who had an untimely demise. It is used for lectures and presentations during ROP and Rural CHAP. Across the road, there is a small structure housing the tailoring centre. The CHTC has a separate four-wheeler for the outreach clinic

and team visits, and a two-wheeler for family visits by individuals. Mopeds have been given to the Department's CHWs.

The Researcher didn't visit the Department's UHTC.

## **IV.3 Department Activities**

### **IV.3.1 Teaching and Training**

#### **Activities with Undergraduate Students**

'We try and ensure that our students know the clinical components...meshed with the preventive and promotive part' (I.F.4.7).

#### ***Classroom Activities***

The classroom activities in DoCH include lectures, demonstrations, seminars, workshops, exercises and practicals. Unlike many CM departments, DoCH doesn't take any lectures in the first year, except during the newly started Foundation Course. Instead, they conduct the Rural Orientation Program (ROP; detailed in next section). 'Instead of sitting and listening what a "family" is, they see that...' (I.F.4.5).

There is a lecture on 'PHC' in which students are told about the definition, principles and elements. There is another lecture on 'Healthcare in the Community' in which health facilities and functionaries available in the periphery are explained. And there is a lecture on determinants of health, in which the faculty also touch upon 'how politics can impact health' (I.F.4.4).

Then there are topics in which PHC would indirectly get discussed. A faculty shared that while introducing 'Occupational Health' to the students, he would stress that in factories/Plantations, 'most of the patients coming to you will not be coming for Occupational Health issues, but mainly for Primary Health Care issues' (I.F.4.1). In the session on 'Alternative Systems of Medicine', students would be asked if they, or their parents, have used any remedy which didn't have a basis in Allopathy (I.F.4.1). Sometimes videos are shown in the class. A faculty told about one titled '*Why did Mrs. X die?*' which looks at different reasons contributing to the death of a lady in labour. 'No transport, bullock cart, bumpy roads, reached late, no doctor, no blood bank...various things...' (I.F.4.7). It brings out what is in the hands of doctors and what is beyond. During clinico-

social case presentation, faculty would make the students think about the steps for primary, secondary and tertiary-level prevention that they would take sitting in a rural centre. 'I have done my rural service. (So) I look at it from that angle' (I.F.4.1).

The faculty believe that a patient is not just an individual with disease. 'There is a family, there is a community, there is a society...there may be other things which might be bothering him (the patient)' (I.F.4.2). And this is what they stress upon their students as well. They refresh the memories that students would have had from the field, and link them with the concept being discussed in the class. So, the students don't have to 'imagine' many things; they can visualize. For instance, they can appreciate low frequency of public transport in rural areas as an important reason for delay in care seeking, because they have seen it. 'Otherwise, it is difficult to teach (CM) in a classroom setting' (I.F.4.4). Faculty also give examples from their own work experience to make things more relatable (I.F.4.2). They give PHC scenarios, like 'a child coming with Chicken Pox', and make the students think, step by step, what all they would do (I.F.4.4).

One faculty shared that 'the philosophy of the community being an important player in the game and the fact that you must be sensitive to the needs of the community at all times is something that I try to bring in whatever kind of communication I have with these guys' (I.F.4.10). Without 'holifying' by calling it a 'service', he would urge students to 'look slightly beyond'. And he would give examples of real-life people who have been doing that. 'I am not saying all of them should rush into Missions. I am saying whatever you do, be aware that this is the situation here' (I.F.4.10).

In an introductory lecture on the subject with 3<sup>rd</sup> term students, the faculty talked about the 'balloonist view' versus the 'intra-cellularist view' in medicine (O.C.4.2). He related the 'determinants of ill health' and 'levels of prevention' with what students had seen during the recently held ROP. He included the work done by the Social Work team, like the *Mahila Mandals*, and hailed the CHWs while talking about the activities of the department.

In another lecture on the 'Changing concepts of Public Health', the faculty presented many interesting historical facts (O.C.4.3). On the sidelines, he also prodded students with basic questions like 'what is medicine' and 'who is a doctor'. He criticized the indiscriminate use

and dependence on technology in medicine and stressed that ‘we have been “reduced” to writing prescriptions’ (emphasis added).

### ***Field Activities***

#### **Rural Orientation Program (ROP)**

ROP was conceived by the Department following the ROME scheme (I.F.4.1). It is a one-week residential camp held at CHTC during the vacation after the first year (Table 23). Students attend the camp in groups of fifty. During the week, students are oriented on how to frame questions on a topic, how to approach a rural household and how to seek sensitive information. The Faculty/PG students/Social Workers perform role plays for making the student understand these things. The students participate in a simulation exercise on rural life (‘Monsoon’). They perform house-to-house survey to collect information, summarize it and present to the faculty. One day, they are given hundred rupees to buy grocery from the local market, and are asked to cook something with it which is nutritious. On another day, they are asked to train a group of school children on a health topic. On their last evening of the camp, the students present an infotainment program in the village visited by them. All logistic arrangements are made by the concerned Village *Panchayat*. A presentation and feedback session happens on the last day of the program. As many, if not most, of the students are from cities, this may be their first exposure to rural communities. Students ‘see the socio-cultural aspect of a village, of a family to which an individual belongs. They keep this in mind when they go for their clinics and take a case’ (I.F.4.2).

#### **Urban Orientation Program (UOP)**

A batch of thirty students is posted for five weeks in the DoCH during second year for UOP. It consists of lectures and videos in the department on basic concepts of CM, orientation about clinico-social history taking in the hospital, family study in urban under-privileged areas (slums) using structured formats, analysis of data and its presentation. There are four slums identified by the department for this purpose. Though, the department doesn’t provide any regular services in these areas.

The Researcher could accompany the students for family study in one of the slum areas (O.F.4.5). ‘All your senses will be stimulated’, the faculty had told the students (O.C.4.5). Students were divided in groups of three and sent to random households. Each of the three

students was supposed to fill one 4-page format. They were given about 90 minutes to finish the task, which they did.

**Table 23: Field activities for UG Students at Department of Community Health, St. John's Medical College**

Period	Program	Duration	Nature
1st Year (1 <sup>st</sup> month)	Foundation Course	One day	Brief orientation visit to CHTC, Mugalur*
Vacation after 1st Year	Rural Orientation Program (ROP)	One week	Residential camp at CHTC Mugalur
2nd Year	Urban Orientation Program (UOP)	Five Weeks <sup>#</sup>	Sessions in department, Visits to Hospital, visits to urban underprivileged area
3rd Year	Community Health Action Program (CHAP)	Three weeks	One week each in CHTC Mugalur (residential), Urban area, and in the Hospital
	Clinico-social Posting	Five Weeks <sup>#</sup>	Case-taking in the Hospital, Sessions in department

\*Students meet health staff like ASHA and ANM. 'This is just to tell them that we are not the only one. It's a team. It's a group of people, not just doctors' (I.F.4.2); # morning sessions only

### Community Health Action Program (CHAP)

The program has three weekly components: rural, urban and hospital. The students come in batch of fifty.

#### *Rural CHAP*

This is the residential component where students stay at CHTC Mugalur. Faculty take turns to stay with the students. They all take meals in the CHTC kitchen, and they wash the utensil they have used.

The program consists of visits to government health facilities (Primary Health Centre, Sub-centre, *Anganwadi*) and interaction with their staff, demonstration of Participatory Rural Appraisal techniques, Health Needs Assessment, School Health (Check-up and Health Education) and Clinico-social history taking with clinicians in the community. Each of these activities is preceded by a formal orientation about the task, and is followed by a presentation of the findings. They also have a scheduled interaction with the department's CHWs to understand the work they do, the challenges they face and the changes that they



have seen in themselves and their surroundings over time. Thus far, as urbanites, the students would have only been to 'big-big hospitals' (FGD.Intern.4). They would have only read about Primary Health Centres and Sub-centres in the textbook. In this camp, they actually 'see' how health care is being delivered at primary level by different individuals who are not doctors.

The Researcher could be with the students on two days during this program. On one day, students were divided in five groups and each group used one of the following qualitative methods: FGD (with groups of men and women), Key Informant Interview (with community members in the *Panchayat* building), Social Mapping, and Transect Walk (in a small stretch of Scheduled Caste community). They were asked to 'observe, ask, listen and record'. They were encouraged to click pictures, with consent if there were humans in the frame. After returning to the CHTC, they prepared charts on what they did and what they found, and presented these in the post-lunch session.

On the next day, the students went for Health Needs Assessment in households using a 4-page exhaustive format (O.F.4.2). It had sections on demographic details, description of house (*kaccha/pukka*; number of rooms; type of fuel used in kitchen; type of latrine; source of drinking water; filtration process, pets, mosquitoes, breeding sites); history of under-five children, ante-natal woman, post-natal woman (as applicable); family planning awareness and practice among eligible couples; acute/chronic morbidity; mortality; source of health information; felt health need, and how can that be satisfied. In one of the visited households, the respondent had to go to pick her child from school. The faculty was considerate and asked the students to finish the interaction fast.

Like the previous day, the students collated the data, prepared charts on the findings and presented these in the post-lunch session at the CHTC. The faculty said that 'I don't expect many of you to practice at a population level. But you should be able to appreciate statistics.' She added that one should always make an attempt to know about one's surroundings. The issue of class and caste also came in the discussion, but very briefly.

### *Urban CHAP*

This consists of a series of visits to NGOs working with vulnerable groups (elderly, terminally ill, PLHIV, children with special needs), a sewage treatment plant, a co-operative dairy, a

government referral hospital and a day of going around the college campus focussing on an environmental issue. Each visit has a formal learning objective, and is facilitated by faculty/Social Workers and PG students. On the last day of the week, students present their learning from these visits, and also give their feedback. This feedback is shared with the participating institutions. The Researcher attended the last day presentations of two batches (O.C.4.1, O.C.4.4).

Visit to NGOs tickled the sensitivity of the students. They realized that the conversation about PLHIV should be normalized. Seeing the patience of trainers working with children having special needs, and the confidence and perseverance of these children, they understood that everybody can be productive provided they receive training with some love and compassion. Looking at the functioning of co-operative dairy, they could appreciate what wonders can simple farmers do when they come together and work collectively. At the day care centre for the elderly, students joined the elderly in making paper envelopes, performed a skit and danced with them. Visit to the 'Unit of Hope', the multi-disciplinary unit of St. John's for children with development disorders and disability, made the students understand how the doctors can ease-out the care seeking experience of parents of these children just by coming together under one roof. And seeing the terminally ill people at the hospice, they realized that it is worthwhile to reduce suffering even if cure is no more possible, and that 'cooking *biryani* in the middle of the night' can also be an act of care, 'because it could be his last *biryani*'.

Through these visits, students made out, and faculty reinforced, that there were so many people working towards health. 'It is not just us', and so, 'we should not keep ourselves on a high pedestal'. They also realized that, as doctors, 'we are focusing only on the physical, and not on the psychological, social and the spiritual aspects'. The faculty stressed that students should keep these experiences close to their hearts, and be guided by them once they start their practice.

The issue taken for campus visit was to look-out for vectors and breeding sites. When the presenter mentioned that one should crush the coffee cups before discarding them, the HoD said that while that is necessary, one should try to 'reduce' the use of disposable cups in the first place. The HoD informed the students that he would be using the pictures clicked

by the students for advocacy with the college/hospital authorities. During 2009-13, the issue of plastic waste on the campus was taken-up, and this activity could produce a visible change (I.F.4.6).

### *Clinico-social Posting*

This is a five week posting in the DoCH in third year during which students go to hospital wards and take clinico-social history. They cover cases of Acute Respiratory Infections, Gastro-intestinal infections, Protein-energy Malnutrition, Low Birth Weight, Ante-/post-natal Case, TB, Leprosy, HIV, Diabetes, Hypertension and Coronary Heart Disease, and try to relate patient's condition with his/her environment. These cases are then presented in the department. This provides opportunity for closer faculty-student interaction as the batch size is very small.

The faculty try to dig-in the non-medical aspects (the social determinant) in the patient's history, and discuss how these aspects may be related to patient's health status and treatment seeking behaviour. For instance, the backache of a female patient may be traced to the posture in which she has to work in the factory (I.F.4.1). Or, the reason why a pregnant lady travels such long distance to reach St. John's, bypassing several other hospitals, could be her belief that doctors here would not push for an unnecessary Caesarean section which she can't afford (I.F.4.1). The faculty also make the student think what they would do, on clinical and preventive side, for the case under discussion if they are in a resource-limited PHC set-up; and regarding when and how would they refer the case (I.F.4.11).

### **Summary of field-based Undergraduate Teaching**

All field activities are meticulously planned. There is a prior ground-work of field area by the social work team. There is a briefing of students on what has to be done. They are also hinted about dressing and decorum. They are divided into groups and explained in detail about the task they need to accomplish, include the formats that need to be filled. Each group is facilitated by the faculty/PG/MSW/CHW during the visit, as well as while they are preparing their presentations. And then, the groups present, and are questioned by the faculty. Some faculty encourage students to ask question (I.F.4.5, I.F.4.10), but student's still don't do that often. Faculties would sometimes ask thought provoking questions like 'Ok,

institutional deliveries are 100%, but where are people going?' But more often, there would be information-based questions, like 'What is the problem with Modified Kuppuswamy classification', or 'What are the other scales you could have used for SE classification?'

Diverse exposures through these programs (ROP, UOP, CHAP) open students to 'other challenges that are there in the community', and help them 'make connections' (I.F.4.3). 'They get that understanding that, as a physician, if you want to tackle disease, you can't be a mopper. You have to be a tap turner' (I.F.4.6). This 'going out, talking to people, discussing cases in the community...when all this happens, the student will be really confident to take up that job' (I.F.4.5). How many of them opt for CM or decide to work at a PHC level is a 'different thing' (I.F.4.5, I.F.4.6). But such exposures give the student a 'more grounded idea of health...not just hospital, but beyond the hospital' (I.F.4.6). Wherever they practice in future, 'when a patient has come and he is from a rural area, at least he will ask him "how many meals you have?"' (I.F.4.6).

### ***Research Activities***

Research during UG period is voluntary. DoCH faculty are happy to guide any student who approaches them, and they are seeing an increasing level of interest for research among the UGs. 'Many have one or two publications by the time they complete MBBS' (I.F.4.6).

### ***Programs coordinated/facilitated by others***

#### **Division of Humanities**

The Division of Humanities 'influences the students like a catalyst' (I.PF.7). They conduct a Citizen-Doctor program for the first year medical students. It is in compliance with the mandate given by the University to expose all UGs to the Constitution of India, and to environmental issues. The purpose is to groom medical students as informed citizens besides being sensitive doctors. 'In effect, we are seeing doctor as a part of society, not removed from it' (I.OF.4.1).

The faculty use Acts like the one on Clinical Establishments to explain the process of how a Bill becomes an Act, when and how is public opinion sought, how doctors can contribute, and what may happen if doctors remain silent spectators. They also discuss other health related issues debated in the Parliament, like Surrogacy. Regarding Environment, the faculty pick issues which the students can easily relate to, like outdoor air pollution and the scarcity

of potable water in urban areas. Inspired by such sessions in past, students have sent letters to the local Corporator asking him to do something about the garbage generated by food vendors outside the MC hospital. The Division also calls personalities who have got extensive experience of working on such issues to interact with the students. These people discuss the issues from the angle of citizenship, and not just as determinants of health. In order to fill the possible gaps between such speakers and the medical students, the division keeps a medical person as a facilitator. 'And we have found that medical students are not removed from these issues just because they are not medical. In fact they feel very strongly that we also need to be a part of this' (I.OF.1).

Besides, the division gives an enabling environment to any student who comes-up with an idea. In this way, they have been able to nurture a theatre group, an environment group ('Ecologics'), a writing group and a book club ('Quilosophical'). The number of students participating in these initiatives is not high, but the Division is fine with that (I.OF.4.1).

### Department of Ethics

While MCI has recently introduced Ethics in the medical curriculum, they have been a part of UG teaching at St. John's since its inception. Earlier, it was done by religious priests. But it was realized that as these people didn't themselves practice medicine, they couldn't relate the ethics to real life scenarios (I.OF.4.2). Subsequently, this task has shifted to clinicians who are passionate about orienting students on ethics.

The faculty teaching ethics talk about the theory, but they also talk about their personal struggles, their dilemmas and their mistakes. Issues like medical uncertainties, euthanasia, violence against doctors, sexual boundaries etcetera are discussed. Lecture discussion is one of the pedagogical methods used to teach ethics. Films and reflective narratives are also used. A past faculty recalls that back then 'social justice as a part of ethics was not something that caught everybody's attention' (I.PF.7). It is not clear if things have changed now.

Besides teaching, the Institute has built mechanisms to ensure that ethics are followed while delivering services and doing research. So, there is a Hospital Ethics Committee, and an Institutional Ethics Committee. There have been instances of breach of ethics in clinical

practice. And the Institute has taken hard decisions to uphold its values. The Institute is equally serious about research ethics.

### **Medical Education Unit**

The Medical Education Unit of St. John's co-ordinates/facilitates the Foundation Course (First Year), Externist Posting (Second Year), Basic Clinical Skills Workshop (Second Year), Advance Communication Skills Workshop (Third Year), Problem-based Learning Module (Third Year). The externist posting is a one week long half-day posting in which the student goes to different wards of the hospital. S/he just observes how the doctor there interacts with the patient, what is the body language of the doctor, how is informed consent taken, is the doctor sensitive to various needs of those individuals, and who are the other team members working there. In the Basic Clinical Skills Workshop, they learn things like how to talk to the patient. In the Advance Communication Skills Workshop, they learn things like how to break bad news and how to talk to angry patients. These components have been part of UG curriculum at St. John's for last many years.

### **Voluntary Exposure Visits**

In additions to the compulsory programs described above, the college offers two-week voluntary exposure visits duration during the vacation after 2<sup>nd</sup> Year and after Final Year to Mission Hospitals located in different remote areas of the country. The students see the extensive and diverse medical needs that have to be met, and are able to appreciate the role of a doctor who can multi-task rather than deal with one specialty. This is one of ways in which college tries to develop their interest in the rural service under the bond.

### **Activities with Interns**

#### ***Field Posting***

There are three internship training sites: CHTC, Mugalur; a Government *Taluk* Hospital; and a NGO Hospital. The Interns are posted for two months at any one of these three sites, and it is a residential posting. They work more independently during this posting when compared to the other postings during internship. But, as they are not rotated across the three sites, all of them do not get similar type and intensity of exposure.

CHTC offers an opportunity to see: the diverse activities conducted by the department; how village people, through the Health Committee, can influence the work of a health facility;

what all can local women with limited education, working as CHWs, do. The kind of cases that come here, and the facilities available to treat them, are more basic than what one sees in the MC hospital (I.F.4.5). Besides taking clinical decisions, the Interns also have to see that the treatment is affordable for the patient (I.F.4.2). 'So, as an Intern, you get a bird's eye view of what Community Medicine is' (I.F.4.5). *Taluk* Hospital gives a chance to work in government set-up. They may see the functioning of ART centre, the DMC and the DOT centre. Though, practically, the work here is largely that of clearing the OPD. The NGO hospital gives a lot of exposure to MCH services, especially deliveries. However, only female Interns are sent there.

The Researcher visited CHTC Mugalur and saw Interns handling the routine OPD and helping in the specialty OPDs (O.F.4.2). They were also dispensing medicine, collecting the contributions from the patients and keeping an e-record of the same. They would even administer prescribed physiotherapy to patients which they learn during the Physiotherapist's weekly visit at CHTC. Besides, they assisted in the outreach clinics in a neighbouring village (O.F.4.3).

The Interns feel quite satisfied with CM posting. 'We reach out to the communities at a place closer to them' (FGD.Intern.4). 'We understand their situation better because we have seen where they are coming from, and the other problems that they have...the social, economic problems that they have' (FGD.Intern.4). And they find these practices worth continuing later in their lives. 'Whichever specialty we take, whichever hospital we decide to work in...it is our responsibility to make sure we give them health education, make sure we focus on the preventive part as well and not just treat their illness' (FGD.Intern.4).

### ***Research Project***

Besides the facility-based and outreach clinical work, the Interns are required to do a research project during these two months. All Interns posted at one site work together on one project. This research is closely guided by a PG student, and a faculty also supervises these projects. Towards the end of their posting, the Interns present their findings in the department. Many of these projects are also presented by the Interns, or the PG students, in State/National Conferences, and some are also published.

### ***Other activities***

Every quarter, on one of the Friday afternoon's, an Interns' debate is held at the level of Institute on a topic related to ethics. It is open for all and many faculties from the college and hospital attend the debate.

In case some disaster strikes anywhere in the country, the Institute invariably sends a medical team consisting of faculty, PG students, para-medical staff and Interns. For some, this opportunity is a life changing experience (I.PF.7, I.PF.8).

At the end of their internship, the Interns are evaluated using OSCE on a set of skills that they are expected to have developed. It includes skills like suturing, conducting a normal delivery and counselling (I.F.4.9).

### **Activities with the Graduates (Rural Bond Scheme)**

St. John's has a Rural Bond Scheme since late 1970s. It was one of the recommendations made in the first decadal review of the functioning of the college. Every medical student who graduates from the Institute has to serve for two years in any of the identified 'Bond-Centres' spread across the country. Those who do not complete this two-year obligation have to pay a hefty amount, currently to the tune of 25 Lakhs INR. Those who complete the full period of service have a separate category for PG allotment in St. John's. The Rural Bond Scheme has remained in place even as Institute's own selection process has got replaced by NEET at UG and PG level. In fact, since last year, the Institute has brought a one-year post-PG bond also (FGD.PG.4).

Faculty find this service very useful because, unlike in Internship, the person has to function more independently during this period. The graduates are able to appreciate the need for doctors to learn and undertake tasks across specialties. Moreover, if required, the graduates can directly intervene at the community level, which they can't do while interning at the tertiary level. It is during this period 'when all this knowledge, attitude and practice distils and crystallizes into true Primary Health Care physician' (I.F.4.6). 'They can start thinking about application of Community Medicine and Community Health' (I.F.4.4). And then, working in a resource-limited setting and living in not so familiar conditions prepares them for future challenges (I.F.4.7). This experience may also be transformative for many. 'If we look at our own faculty in St. John's, those who had worked in rural area as a part of their



rural service bond, you can see that their attitudes, both towards teaching students as well as their own attitudes, is definitely affected by what their experiences were in those two years' (O.F.4.1).

There are several reasons why graduates may 'want' to go for this rural service. 'The ideals of the institution matter' (I.F.4.7). One of the stated objectives St. John's is 'serving the health needs of medically underserved areas of our country'. In line with this objective, the Institute has reserved UG seats for students from underserved populations, and for religious sisters. These sisters go back and serve in some of the most interior areas. 'Our students also see those things and get encouragement to do this kind of work' (I.F.4.7). Then, as detailed above, the several programs to which the students get exposed during UG years also play an important role (I.F.4.7). Senior faculty and Alumni hold meetings with students who are due for rural service to explain why such kind of work is required (I.F.4.7). While students are actually doing the rural service, they are encouraged to share personal and professional challenges with the college faculty, and all possible help is extended to them (I.F.4.4). Recently, a one-year certificate course in Family Medicine has been started by the Institute which has online classes and contact sessions. Students doing rural service can also register for it. It is yet another way to facilitate their work during those two years (I.F.4.7).

But all these efforts to develop the 'inner-drive' are limited by external factors (I.F.4.7, I.F.4.8). Only about half of the graduates actually go for the rural service. And many of them do so because they can't afford to pay the financial penalty.

Interaction with a group of Interns informed that students are mentally prepared for the rural service. 'We came to St. John's knowing that we would have this' (FGD.Intern.4). Some of them identify rural service as 'serving the underserved'. 'That's the point why this Institution was started' (FGD.Intern.4). They see this as an opportunity to gain more experience as a basic doctor as 'the experience during internship may not be enough' (FGD.Intern.4). This, they say, will help them better decide which branch to specialize in, and prepare them to handle general case even after specialization (FGD.Intern.4). However, others feel that one year period would have been enough, that the amount to be paid in-lieu of bond is 'a lot', and that 'if they get a (PG) seat, most people will give away the bond' (FGD.Intern.4).

A faculty from the Division of Humanities opined that even if students decide not to go for the rural service, they still think about it. 'Why we move towards a certain moral view is very often because we don't want to be the outsiders in something that is commonly felt...There is this whole common sort of goal which they are surrounded by, which is constantly impinging on their conscience and consciousness' (I.OF.4.1). Even majority of those, who actually go for the rural services, may not stay on and continue similar work. 'But I think people do change from within' (O.F.4.1).

## **Activities with Postgraduate Students**

### ***Field Activities***

In the initial months of their first year, PG students accompany faculty in field to understand the diverse activities of the department. Besides, they spend three months in different clinical departments of the hospital. They also help manage the Staff Clinic in the hospital premises. For two weeks, the students go to Jan Swasthya Sahyog (JSS)<sup>11</sup> in Bilaspur to get a taste of health needs and services in remote rural areas. When they see areas where there are no roads, where one has to walk miles to reach the school, where a lady in labour has to be taken across hills and rivers to get to a hospital, where power supply (electricity) is an issue, where patient in OPD may have to wait for more than a day to see the doctor...they don't feel like complaining about the weak mobile network. They see many city people, both doctors and non-doctors, actually working in these circumstances, which makes them realize that it's not as difficult as it *prima facie* seems to be. It's stimulating to see JSS's solutions for the problems at hand, like *Phulwari* for children under three years age so as to set free their mothers to go to work and their elder siblings to go to school. The students are very appreciative of this brief exposure. 'I fell in love with the subject even more after going there' (FGD.PG.4).

During the second year, PG students have six months posting each in rural and urban areas. During the rural posting, they spend two months as the Resident Medical Officer when they are administratively responsible for the functioning of the CHTC. They spend another two months as Outreach Medical Officer when they are involved with the community level activities. The remaining two months are split between posting at the nearby Primary

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<sup>11</sup> <http://www.jssbilaspur.org/>

Health Centre (Sarjapur) for 30 days, and shouldering responsibilities at the CHTC, like updating the HMIS. During the Urban posting, students go for two months each to a *Taluk* Hospital, a Government UHC and the Department's UHTC.

Besides handling the clinical work at these facilities and in the outreach clinics, the PG students follow-up on under-nourished children and counsel their mothers. If they find a patient who is not adhering to treatment, or if the CHWs draw their attention to a particular case, they do home visits and try to identify the problem: financial, social or something else (FGD.PG.4). They conduct verbal autopsy of each death that happens in the area. They take health education sessions for *Mahila Mandals* and make presentations in the Health Committee meetings and CHW meetings. They also give support in field training of UGs during the ROP, UOP and CHAP, and guide the Interns in their work. In this way, they get a first-hand experience of the challenges in working with communities.

In the third year, the PG students go for the 'Global Summer Health Program' conducted by the Ben Gurion University, Israel. It's a three weeks program attended by students with diverse backgrounds (medicos, pharmacists, health managers) and from different continents (Asia, America, Africa). The pedagogy includes lectures, simulations and field visits to a rural Bedouin community (FGD.PG.4). 'Once they come back, they understand health in a different way. They understand that lot of health related work is done by non-medical people...they also contribute to health' (I.F.4.9). Besides attending this program, the students continue to participate in various clinics conducted by the department and prepare for their final exams.

Apart from these, PG students are engaged in activities like check-up at some Children's Home, or in the monthly camp organized by the Institute in different congregations of the Catholic Church, or if the City Corporation's health department asks for support in field. Like the Interns, PG students are also sent for disaster relief when and where required.

So, 'whatever service we do, we make sure that our students know about it, so that they can do similar things wherever they are going' (I.F.4.2). Such diverse exposures equip the students to adjust in different and difficult situations. The faculty support them even beyond the three years of PG.

Apart from PG students of CH, those of Paediatrics also get a residential posting at CHTC for two weeks. They mainly go for health check-ups in *Anganwadis* and Schools. Besides, PG students of Ophthalmology come to perform Cataract surgeries once a week. PG students of other departments come for the monthly specialty clinic.

### **Research Activities**

Once the PG students have spent one or two months in the department, and they become aware of the activities and interests that different faculties pursue, they are offered the list of faculties who may be chosen as guides. As the number of faculty eligible to guide is more than the number of PG students coming each year, the faculty get this opportunity as per turns. Depending on their broad areas of interest, the students opt for guides. However, an even distribution of students across faculty is ensured. One of the DoCH Social Workers, a PhD herself, remains available to help students with qualitative research.

### **How are the topics decided?**

Usually, students don't find it problematic to align their topic with the guide's interests. This may be because, fresh out of UG, they are yet to discover their own interests (I.F.4.3). The faculty find this justified as they can guide the student better if s/he is working in faculty's own domain. 'It is easy for us to co-relate, easy for us to co-ordinate' (I.F.4.2). However, in case the interests of the two are a bit divergent, efforts are made to find a middle path (I.F.4.9). Though it's rare, if a student comes with a very formed mind, and his/her interest matches more with some other faculty, the department may allow a change of guide. Though, a faculty, who had done PG from the same department, recalled having had to unwillingly work in an area suggested by her guide (I.F.4.3). However, she understood the issue now when she was herself guiding students. 'I do not have the band-width to guide someone doing something other than <name of a research domain>. I can, but I am a little bit tied-up in what I am doing, and I do not want to split my mind into two' (I.F.4.3).

### **What are the Topics?**

A senior faculty informed that most of the PG studies are based on the work that the department is already doing (I.F.4.1). This gets substantiated by looking at the list of topics of 79 thesis submitted, or due to be submitted, since 1993. They are on Occupational Health, Eye Care, Ear Care, Elderly Care, RMNCHA, Mental Health, CBR and NCDs. Besides, there have been studies on manual scavengers, animal bites, injuries, intimate partner

violence, stigma associated with mental illness and impact on care givers. Most of them have been done in rural communities, though some were set in Plantations, other Industries and within the Hospital (with the nursing staff). A few studies in the last decade have been based in urban under-privileged communities. The studies have done health profiling, estimated incidence and prevalence, assessed morbidity, health needs, perceptions, health seeking, Knowledge-Attitude-Practice (KAP), utilization and effectiveness of services, quality of life, adherence to treatment, cost of care and the outcome.

### PG Research other than Thesis

The students cannot present or publish any part of their thesis before completion of their final exams as it is a part of their evaluation process. Since last few years, the University has made it mandatory for them to have one poster presentation, one oral presentation and one accepted publication before they sit for their exams. This has given a boost to student-driven research apart from thesis. Besides, they are involved in studies undertaken by the Interns. Some of the areas covered through such research are as follows: use of mobile phones for accessing MCH information; use of MCH card (*'Thayi'* card) as a teaching tool for the mothers; awareness, perceptions and practices of AYUSH; and barriers to accessing healthcare among migrants.

### Use of Research Findings

The findings of research are presented at State/National Conferences. A mock presentation is made in the department for inputs from different faculty members before any student goes to the Conference. The college administration fully sponsors the student for presenting at Conferences. As a policy, the department doesn't allow the data once presented to be presented again. 'PG students know it for sure, and we expect them to follow this throughout their lives' (I.F.4.4). Students are encouraged to get their studies published, though it is very difficult to do so in good journals because of their long waiting lists (I.F.4.1). Further, if the student is interested in the topic, s/he may continue exploring it after the PG (I.F.4.4).

As in many cases the research topics are related to the ongoing work of the department, the findings directly feed into it (I.F.4.1). For instance, a study on 'The Morbidity Profile of Adults with Disability' found that 40% of the respondents had NCDs, and that only 10% were

under treatment. These people were subsequently linked to the NCD clinic, and to the CHWs who would ensure that they comply with the prescribed drugs and diagnostics (I.F.4.2). Another study assessed the effectiveness of a CHW driven intervention in improving the quality of life of caregivers of children with disability, and in the process, developed their capacities (I.F.4.2). One of the present students is working on Musculoskeletal Disorders among the Nursing Staff. There are plans to share the findings with the nurses and train them on how to deal with the issue (I.F.4.1). Similarly, findings of an Interns' study on Solid Waste Management were presented to the Health Committee, and were also shared with the *Panchayat* (I.F.4.9). Another group did a study on noise-induced hearing loss which was followed by a health education session with the target audience of the village on use of personal protective equipment (I.F.4.9). 'So we are not in pure research at all. It is always with a service component' (I.F.4.2).

### ***Classroom Activities***

There are PG sessions in the DoCH on every Saturday and Monday. It may be a seminar on a topic, critique of a journal article or presentation of a clinico-social case or a family study.

The Seminars offer an opportunity for the PG students to explore a different setting. They may have to visit some NGOs, or go to the Directorate and meet program officers to prepare the seminar. Some of the seminars may be on non-routine topics like health of people in difficult circumstances: natural calamity, civil war, armed conflicts etcetera (I.F.4.6). Though, the health situation in the State of Kashmir because of the restrictions imposed after abrogation of Article 370 in August 2019 was yet to be discussed.

Contemporary health issues at local, national or global level, like 'Nipah', get discussed as and when they arise. Faculty encourage the students to read newspaper articles. 'It's not only health but other issues like something on tribal in terms of their culture, their food, their health, their empowerment, their education, in terms of how they have been exploited. Where else would you know about that?' (I.F.4.5). Often, during PG sessions, such issues would be brought-in and linked with ongoing programs (I.F.4.5). On being asked if such things shouldn't be part of the formal curriculum, the faculty said 'we have limited time' (I.F.4.5).

Apart from these teaching activities within the DoCH, the Medical Education Unit conducts Teacher Training Workshop for the PG students. Recently, the department of Ethics has started a course for PG students which has fortnightly classes. These courses are open for all, but not compulsory. It is mostly the PG students of pre- and para-clinical departments who subscribe for these courses (I.OF.4.2).

The PG students were appreciative of the fact that the Department offered a right mix of field postings, research and classroom teaching. They also admired the faculty, including the Head, for being easily approachable (FGD.PG.4).

### **Other Teaching-Training Activities**

Apart from teaching and training medical students (UG and PG), the faculty of CH also take session with students of Nursing, Physiotherapy, and Health Administration. The faculty take health education sessions with different cadres of the MC and hospital, like the security staff.

The department has been conducting Community Health Worker program since 1978 as and when there is a demand from NGOs and Church-based organizations like Missionaries of Charity. It's a three month program for candidates who are 10<sup>th</sup>-12<sup>th</sup> standard pass. Earlier, it had a strong field component, so as to equip the candidates with skills to motivate the community, to do some basic work related to issues of water supply and sanitation, and take care of simple illnesses. Now, it is more classroom and hospital based, so as to equip the candidate take better care of the elderly, and of people with diseases like HIV and TB.

Then, there are trainings specific to the projects or domains of the CH faculty. Those working on Occupational Health, give trainings to factory workers on First Aid and other health issues. Those working on Community-based Rehabilitation conduct trainings with Teachers and with Medical Officers working at Primary Health Centres. Medical Officers have also been trained on mental health issues and on NCDs by the faculty. Some training have also been held for ANMs and Anganwadi workers.

### **IV.3.2 Field Activities**

The Department has been engaged with field projects since very long. Mallur Health Co-operative project in mid-70s, SBI supported project in early 80s and Multi-Indicator Cluster

Surveys, *Mahila Vikas Project* and PVOH-2 in early 90s are some of the earlier ones. Except the projects on evaluation of targeted interventions under the HIV-AIDS program, the focus of the department till this while was largely on MCH services.

Since late 90s, the faculty have forayed into diverse domains. This diversification was possible because of increase in the number of faculty and a free hand given by the then HoD to these new faculty (I.F.4.1). Presently, the department is into ear care, eye care, mental health, services for the elderly, and for those with disability. MCH services include ante-natal care and immunization and also screening women for NCDs and cancers. Occupational Health activities restarted in mid-90s. Even within each domain, the number of activities and sites has increased (I.F.4.7, I.F.4.10). The activities have become more regular and sustained instead of the earlier 'touch-and-go' approach of having camps (I.F.4.2). The faculty are now invited by other MCs and NGOs to talk about these different endeavours (I.F.4.10).

The social work team plays a very important role in the field activities of the department. It consists of two Medical Social Workers (MSWs), and ten Community Health Workers (CHWs). The CHWs are all at least 10<sup>th</sup> standard pass and are daughter-in-laws of families in and around Mugalur. They had been hand-picked from the *Mahila Mandals* (I.F.4.2). Though they have been recruited under specific projects, they all contribute to all projects. They go house-to-house in their assigned villages, give health education, identify other medical and social needs, refer individuals to CHTC and follow-up the operated patients and those under treatment. They visit *Anganwadi* and do basic check-ups of children and liaise with village school and *Panchayat*. They flag the need for MSWs/PG students/Faculty to visit a particular individual or family or group. The faculty acknowledge their role and call them department's 'eyes' in the community (I.F.4.2). The MSWs support the CHWs, facilitate various self-help groups, and counsel individuals (like on substance abuse) and families (like on domestic violence). They also coordinate health awareness events, like the cycle rally from St. John's campus to Mugalur to spread awareness on vector-borne diseases (Dengue).

CHTC Mugalur, since beginning, has a Health Committee consisting of members from Mugalur and surrounding villages. It meets every month, and the Interns, PG students posted at Mugalur, and the faculty of the department also join. During the meeting, the department presents its work of last one month. The members and the department share



each others' expectations and concerns, discuss issues and grievances and plan future activities.

Many years back, the department had started facilitating formation of *Mahila Mandals*. Initially, it was difficult even to bring the women out of their homes for meetings. But with time, they have become 'empowered'. They meet regularly now, and in fact, they invite the department people to come and talk about a particular topic that they have decided. They have now formed a Federation and are also planning to start a cooperative bank (I.F.4.9). These groups often assert themselves very emphatically. For instance, the tailoring classes in Mugalur have been stalled for few months because of local politics. The *Mahila Mandal* is miffed and has decided to approach concerned authorities to get covered under the government scheme, all by themselves (O.F.4.1). It has taken a long time to reach at this stage.

### **Senior Citizens Health Service Program**

Over a decade and a half, the program has grown from clinic and medicine to beyond. Following are the components of the program, roughly in the order they came into being:

#### ***Fixed-day clinics***

The program began as a once-a-month clinic at CHTC Mugalur specifically for the elderly. As the demand grew, the number of sites increased. At present, there are around ten rural sites in and around Mugalur. Also, one clinic is conducted at the UHTC. These clinics are supported by the North American Chapter of St. John's Alumni. The Researcher could see one such rural clinic (O.F.4.3). It was held in the *Panchayat* building of the concerned village. There were around 30-40 elderly persons, largely with cardiovascular, respiratory and musculoskeletal issues. The faculty were greeting every person ('*Namaskara*'), looking at them, and asking for their well-being. In order to auscultate the back, the Professor would himself stand-up rather than asking the elderly to turn. Even if the PG student had seen the patients, the Professor would still have a small chat with the patient so that s/he doesn't feel lesser cared. The doctors would explain/demonstrate how the medicine needs to be taken, how to perform an exercise or how to take the puff from the inhaler, and then ask the elderly to repeat. One of the elderly had brought tea for the team.

### ***Geriatric services at St. John's***

A Senior Faculty in the Department of Medicine started a Division of Geriatric Medicine a few years back. It runs an OPD specifically for the elderly, and co-ordinates other hospital-based services for them. Cases from the outreach geriatric clinic, home health services and old-age homes get referred to this division.

### ***Medical services at Old-age Homes***

This started with a small Old-age home caring for destitute elderly. Soon, another similar institution was included. Later, an elite old-age home approached the Faculty for periodic medical services on payment. A separate Medical Officer has been hired for this purpose.

### ***Home Health Service***

This service is extended to elderly living alone, within a two kilometers radius of St. John's campus. Once a month, the Medical Officer and a nurse visit these people at their home. Apart from a basic medical interaction, the duo spends some idle time with these people and patiently listens to their other concerns, like differences with children, loneliness or abuse. To ensure that same faces meet the elderly every time, PG students are not posted for this activity. The elderly not only make a fixed financial contribution for this service, but also support the cause by donating medicines and equipments that they no longer need, like walking sticks, glucometer or nebulizer.

### ***Village Elderly Centre (GHK)***

Like there are *Anganwadi* Centres for children, the Faculty have developed GHK for the elderly in two villages. The concept originated from the realization that medical care is not sufficient to take care of the health of the elderly. So, a place was rented where elderly people could come, engage in activities like praying, do some physical exercises, cook a meal for themselves and do other things which they like. The elderly spend three-four hours a day with each other at these centres. The project was initially supported by Tata Trusts, but is now sustained through resources from within the village. Both the GHKs are Trusts with office bearers from among the elderly group. Inspired by this initiative, similar centre has been started by another organization in a nearby district.

The faculty are also working with Tata Trusts and the concerned government departments in three States to implement the National Program for Health Care of the Elderly (NPHCE).

### **Community-based Rehabilitation**

The Community-based Rehabilitation project has three components: Ear Care ('Asha Dhvani'), Eye Care ('Drishti') and care of people having disability (especially children).

For ear care, an ENT specialist, an Audiologist and a Speech Therapist comes to CHTC once a month. Otherwise, on every Monday, PG student sees the patients having ear problem. The project has capacitated a CHW to do audiometry, give hearing aids and do minor procedures like removal of foreign bodies and wax. If they are not able to identify the problem, they consult with the specialists on phone. If they are not able to resolve the issue, they refer the patient to St. John's Hospital.

For eye care, Ophthalmologist comes every Monday to CHTC and performs Cataract and other basic surgeries. On Tuesdays, they run an eye care OPD. An Optometrist, again nurtured from the local area, does refractions. Patients requiring complex surgeries are ferried to St. John's Hospital. Operated cases are followed by the CHWs. This work is very popular in the community, so much so that people identify the CHTC as an eye hospital.

For the children having disability, a multi-disciplinary team from St. John's 'Unit of Hope' comes once in two months to CHTC. Children requiring advanced treatment are called at the Unit. The parents are trained for special needs of the child. They are also organized into support groups to help each other out. CHWs ensure that these children are enrolled in local schools, because without that 'rehabilitation is incomplete' (I.F.4.2). The school teachers are periodically trained to deal with the special needs of these children. Once, a set of physiotherapy and stimulation equipments was also supplied to schools in the project area. A Therapy Assistant follows up these children in school and at their homes. Adults having disability are also catered through the project. They have been organized in self-help groups which not only do micro-financing, but also serve as a platform for dissemination of information and assistance from government side (like certificates, bus concessions etcetera). There are nine such groups in place, and they have now formed a federation. Besides the service component, several trainings have been given to government health staff (Medical Officers, ANMs, ASHAs) and *Anganwadi* staff. The project also has a research

component under which two grants of around INR 50,000 are sanctioned for student research on disability every year.

Going into the history, the program started in late 1990s with a project on ear care written by DoCH and Department of ENT to Chritoffel Blinden Mission, Germany (CBM). A set of CHWs were selected from the local area and trained in basic house-to-house screening for ear problems. These cases were then seen and treated by specialists. Most of the hearing impairment was because of ear infections among the children. Overtime, as the awareness increased, mothers started bringing their children with ear infection quite early. So, gradually, hearing impairment following infections decreased. Now the share of age related hearing loss increased. Also, as there are a lot of home-based power looms in the area, there were cases of noise-induced hearing loss. The project also included these people in its beneficiary group.

Soon, the elderly started asking if something could be done for the problems with their vision. Another project was written to CBM in collaboration with Department of Ophthalmology. Subsequently, in 2004, a new block with an OPD and a Cataract Surgical Unit was built in the CHTC compound. CHWs were trained in screening for basic eye problems.

In 2006, the WHO released guidelines for Community-based Rehabilitation which listed five kind of needs - health, education, livelihood, empowerment and social. The funding agency, CBM, asked the faculty to expand the project as per these guidelines. A comprehensive needs assessment was done. The medical component was linked to the recently constituted Unit of Hope at St. John's. For other components, links were established with schools; and support groups and self-help groups were formed.

### **Mental Health Program ('Maanasi')**

*Maanasi* project has a weekly clinic at CHTC Mugalur which is run by a Psychiatrist and a DoCH faculty. This combination ensures that not just the mental health needs but all the medical needs that a person with mental health problems might have, get addressed. The MSW takes care of the counselling part. The CHWs maintain a follow-up, ensure adherence to treatment, flag the need for counselling, and explore opportunities for community-based support to the affected individual. The project is supported by Rotary Club Bangalore

(Midtown and Koramangala) and that of Columbia and Howard West-Maryland, USA. On a case-to-case basis, the team tries to raise resource for rehabilitating the patients, like by developing their tailoring skills. The faculty recognize that there is scope to expand and formalize such empowerment activities, like by organizing the people with mental illness or their caregivers for peer support. But the project, at present, lacks resources to do that (I.F.4.11).

Going into the history, a survey was done in 2001 in collaboration with the Department of Psychiatry to assess the burden of mental health problems in 27 villages around Mugalur. CHWs were trained for basic mental health screening. These cases were subsequently seen by specialists coming from St. John's to CHTC, and those found to have mental illness were started on treatment. The clinic has been running since then. The project also undertook street plays to create awareness about mental health in villages.

### **Occupational Health**

The Occupational Health activities started in DoCH in mid-1970s with opening of a Unit of Occupational Health as a tripartite arrangement between the Department, the Ross Institute of London School of Hygiene and Tropical Medicine, and the United Planters Association of South India. This unit used to hold seminars and annual refresher courses on PHC for the plantation health staff. Besides, Interns were posted at plantation hospitals, where they would engage themselves in short PH research projects besides performing clinical duties.

The formal association with Ross Institute started withering since mid-80s as there was no faculty earmarked for this work (I.F.4.1). The work re-started in mid-90s. Though the Unit doesn't formally exist anymore, Occupational Health activities in Plantations continue. In last two decades, they have extended to garment factories as well. The Department also manages a clinic for the staff of St. John's. Depending on their interests, some of the PG students take up Occupational Health issues in Plantation, Factories or Hospital for their thesis work.

### ***Plantations***

The Tea and Coffee Estates are labour-intensive industries. The workforce lives on the Estates, in the 'Lines'. The Law mandates the management of these Plantation to take care

of the safety, health and welfare of its workers. These Estates have a health team of their own (Doctors, Para-medics, Link Workers). The management invites the DoCH faculty as consultants to do annual Health and Welfare audits so as to be really sure about the adequacy and effectiveness of their health team, and the health situation in the Estate.

When called, the faculty look at the first-aid stations, crèches, lines and community clubs. They assess the condition of housing, water supply, sanitation etcetera. They review the morbidity and mortality data of the past year. And based on all this, they submit a report to the management highlighting issues and giving recommendations. Through these efforts, the faculty try to ensure basic health services to the plantation workers.

### ***Factories***

Like Plantations, factories are also mandated by Law to take care of the safety, health and welfare of its workforce. A lot of garment factories actually work for international brands based in the West. These brands fear being accused of sourcing work from 'sweat shops'. So, they hire DoCH faculty as consultants to ensure that these garment factories take adequate care of their workers. The faculty help the factories set-up systems as per the Factories Act. They train their Doctors and Nurses. They also train their workers in First Aid and other health issues. The faculty had developed a model of modular training for workers using peer-educators (HERhealth Project). This model is now being used in several countries.

As a part of a team that also has a Social Scientist and a Financial Auditor, the faculty do Social Compliance Audit. Here, they verify if the worker has a tenable employment (appointment letter, contract, PF account, registration under ESI Act, and wage slip), that they are not harassed or abused at workplace, their hours of work are as per the Act, there is no child labour, there is equal pay for equal work, and there are adequate arrangements for health and safety of the workers. Based on this, they submit a report to the brands. They encourage the brands to not just comply with Indian Laws, but look up to the more liberal international standards regarding labour welfare. For instance, they would urge the factory management to refrain from employing even those between sixteen and eighteen years of age, and to pay a 'living wage' instead of just the minimum wage.

## **Hospitals**

The department runs clinic for pre-placement examination, periodic check-up and routine medical care of the staff. The faculty stress on preventive and promotive measures like exercises in case the Body Mass Index is a concern. They also take health education sessions with different cadres of the staff.

## **Other Clinics**

Besides the geriatric clinic, eye and ear clinic, clinic for children with disability, mental health clinic and the staff clinic which have been described above, the department conduct regular clinics for MCH and for NCDs at CHTC, in villages around Mugalur, and at UHTC. Then there are monthly clinics for screening of cancers in women (especially Breast and Cervix) in collaboration with the Gynae-Oncology department and the CSR division of a corporate company. These clinics have, in past, generated evidence for screening devices like 'Gynocular' and 'I-Breast' (I.F.4.5). Specialties like Chest Medicine, Dermatology and Orthopaedics also come together for monthly clinics. Super-specialty clinic in Cardiology and Neurology were started as per demands raised by the Health Committee at CHTC, but it didn't work-out because of insufficient case load. Besides, there is a daily general OPD at the CHTC and UHTC. In addition, the department participates in medical camps organized by the hospital.

For the last few years, CHTC has stopped providing delivery services. The faculty say this is because the demand has come down. Connectivity has improved; socio-economic standard of the population, in general, has become better; well-equipped private facilities have developed in the vicinity, for those who can afford. And for those who can't, government facilities are not only providing free services but also giving incentives. The faculty and CHTC staff makes women aware about such benefits and encourage them to approach government facilities. Though, one faculty thought this to be because department's focus on MCH has got diluted over time (I.F.4.3). The Interns posted at the CHTC find this as a lost learning opportunity (FGD.Intern.4).

All clinical services provided at CHTC or in the outreach, which includes consultation, investigation, medicines and procedures, are chargeable. The purpose is not to earn, but to keep the services running. The charges are nominal. Most of the medicines are generic.

Even branded ones are given at cost price. In addition, need based waivers are given. The Social Work team of the department assess the eligibility of patients for concessions. Patients are never turned back because they can't pay. At times, the team also mobilize resources for patients in need. Cases referred to St. John's are fast tracked at the hospital, and are followed-up by the CHW after they return. This guarantees quality medical care at affordable cost to the community. At the same time, this ensures that the resources of the Institute are optimally utilized, and the PG students get adequate clinical exposure (I.F.4.2, I.F.4.5).

This diversity in field activities, the faculty informs, is rare to find in other CM departments. Most departments conduct a general OPD at their rural and urban health training centres; they do not have any focussed project or program (I.F.4.1). The better ones may be doing intensive and exceptional work, but they may be focussed on just one or two domains, like, say, animal bites, or hospital waste management (I.F.4.7, I.F.4.9, I.F.4.11), or may be consumed in providing secondary level in-patient care (FGD.PG.4). Almost all DoCH faculty are involved in these field-level activities on most of the weekdays. They have their specific projects, but they also participate in each other's projects. 'These activities don't just give us satisfaction, but they are also a learning for our Interns and PG students' (I.F.4.2).

### **IV.3.3 Research**

Since the beginning, the department has focussed on service, and not on research (I.F.4.3). However, the research output has tremendously increased over the years (I.F.4.3, I.F.4.4, I.F.4.6). One big reason behind this is the University's requirement for PG students to have a poster presentation, an oral presentation and one accepted publication before they sit for their final exams. 'When students want to do research, they co-opt the faculty to mentor them. So, we also get involved with more research' (I.F.4.6). The MCI's requirement for faculty publications is another push. But still, the feeling is that 'we are not the research types...' (I.F.4.2).

The faculty follow the dictum of 'no survey without service' for their own as well as their student's research. They try to follow every study with some action, like some health education initiative (I.F.4.9). Mostly, the research springs from and feeds into the department's ongoing work (I.F.4.1).



The college administration is very supportive of faculties presenting their research findings at conferences. It fully sponsors the expenses incurred in attending conferences besides granting leaves (I.F.4.6). The Institute allowed a DoCH faculty and a Social Worker to do their PhDs, which involved primary research, while retaining their jobs. The management is very accommodative for project work as well.

### **Type of Research**

Each faculty has an identified area of interest, like Occupational Health, Mental Health, Community-based Rehabilitation, Geriatrics, NCDs and MCH. The faculty take up research projects accordingly, though sometimes these contain overlapping themes. For instance, a project on 'Effectiveness of colour coded Diabetic control monitoring charts among elderly diabetics' would bring together the faculty working with elderly and those working on NCDs. Except the projects on Occupational Health, which are based in a factory or the hospital, most of the projects are community-based. The projects involve components of needs assessment, capacity building, improving access to services or direct service provisioning or implementation of an initiative. For instance, 'Assessment of attitudinal barriers of government school teachers to inclusive Education', or 'Economic evaluation of models for integration of mental health with primary care'. Some projects are unrelated to the work of the department. For example, 'Randomized Trial of mobile phone based adherence support (mTB support) for Tuberculosis in India'. One of the faculty, in late 90s, was involved in an unconventional project called *Gram Arogya* Project funded by the then Department of Indian System of Medicine (I.F.4.1). It involved interaction with *Vaidyas*, eliciting their practices and exploring the underlying rationale through local *Ayurvedic* MCs.

At times, a project may not be from the interest area of the faculty, but it may be a 'good opportunity' (I.F.4.3). However, the faculty are high on ethics while doing research projects. They would confidently admit even if the intervention is found to be having no effect (I.F.4.3).

### **Funders**

As per last five-year's annual reports, majority of the department projects have been funded by International Organizations like Cristoffel Blinden Mission-Germany, Business for Social Responsibility-San Francisco, Swedish Research Council, UK Medical Research Council and

others; and Institutions like Johns Hopkins University, Universities of Iowa, California and Miami, Harvard School of Public Health and Yale School of Medicine. Many projects have been funded by agencies within the country like Translational Health Science and Technology Institute (THSTI), Welcome-DBT Alliance, Tata Trusts and St. John's own Research Institute. Occupational Health projects have been funded by concerned industries like 3M, Apple, ITX, Primark and Levi Strauss. In 2018-19, a few projects have been funded by ICMR, mostly as Short-term Studentship.

### **Challenges in Research**

Publications have become mandatory for the faculty to get promoted. So, 'sometimes, research is done just because you have to publish papers' (I.F.4.5). Some still find this push to be good, though 'there may be a problem with the quality of writing' (I.F.4.3).

While this mandate has increased the demand for publishing, the frequency of issue of good journals has remained the same (I.F.4.4). This demand-supply mismatch has opened space for predatory journals. Sometimes, students, and even the faculty, have no option but to resort to them (I.F.4.1).

A faculty alleged that, with certain journals, 'the name of the institution and the author, their relation to the editors or the board of publication, that plays a major role rather than the content and quality' (I.F.4.4).

## **IV.4 Department Interactions**

### **IV.4.1 With other Departments of the Institute**

#### **Service**

As explained in a previous section, several of the field projects of DoCH involve different clinical departments: Asha Dhvani (ENT), Drishti (Ophthalmology), Maanasi (Psychiatry) and Cancer Screening in women (Onco-Gynaecology). All these projects were, wholly or partly, conceptualized in collaboration with other departments, and specialists from these departments regularly visit CHTC to deliver required clinical services. Besides, there are referral linkage between the CHTC and the base hospital.

The faculty of CH are confident that they can directly approach any department in the college/hospital (I.F.4.2). There are two reasons for this. Firstly, the motto of St. John's itself

is 'reaching the unreached'. So, DoCH is one of the flagship departments and has a lot of Management support (I.F.4.9). Secondly, most of the St. John's faculty have done their UG and/or PG from the same Institute. 'So, more or less, they are happy to come back to Mugalur' (I.F.4.9). However, while many experts want to do something beyond the hospital, there are others who ask 'why should I do that?', because 'the Institute doesn't mandate them to go and work in a rural area' (I.F.4.4).

## **Teaching**

Some amount of integrated teaching, both in classroom and in field, has been happening at St. John's since long. Though not very frequent, there are classroom sessions on topics like TB and Malaria which are taken by faculty of more than one department. As a part of the Rural CHAP, specialists from clinical departments accompany those from CH to demonstrate clinico-social history taking at patient's home to the UG students. The department has one-page instructions on what they really expect from the faculty of other departments. Still, 'sometimes we feel these people from other specialties don't add much value to it' (I.F.4.8). When senior faculty come, the sessions are good. But they are not the ones who come these days. 'They were all Johnites. So they knew what happens and what should happen. But it has come down. It is not senior faculty anymore' (I.F.4.8).

Another forum for faculty to collaborate and interact in a teaching-learning mode is the 'Friday Meeting'. Every department is expected to keep the post-lunch session on Fridays free so that the faculty can attend this common event. This slot may see a joint session of different departments on a contemporary topic; it may have a clinic-pathological conference; it may have an Interns' debate on ethics; or, some department may present its work. 'But mostly, many of us don't go for it' (I.F.4.8).

Besides, PG students from DoCH are posted in different clinical departments of the hospital in their first year. Similarly, PG students from Paediatrics department get posted at CHTC.

## **Research**

Most of the service projects listed above have a research component also on which the departments collaborate. Besides, the CH faculty teams-up with St. John's Research Institute on various research projects.

### **Participation in Institutional Activities**

The faculty of CH are active part of several forums and committees in the college and hospital. This includes Governing Council, Board of Administration, Institutional Ethics Committee, Scientific Committee, Research Society, Hospital Safety Unit, Hospital Infection Control Committee, Department of Medical Education, Disaster Management Unit, Library Committee, Elective Student Support Cell, Staff Cultural Committee, Alumni Association Executive Committee and 'Ecologics' (a group working on environment issues). 'Everybody sees us as somebody who can contribute' (I.F.4.11).

### **Department Status**

Because of the quality work done by CH faculty, their close involvement in institutional affairs and the Management support, they are very well respected in the Institute. Though other departments may envy the 'cooler life' of CH faculty, 'they know we do a lot of work' (I.F.4.8). 'I have never felt that they think Community Health is inferior' (I.F.4.2). Being in the same Institute for so long, it is natural to have developed camaraderie with others (I.F.4.4). 'Initially, when you first meet them, they have that thing, that we are clinicians. But when they come to know the kind of work we do, and you get to know them personally...all that just disappears' (I.F.4.6). The work of DoCH is visible to others when they come to Mugalur. Sometimes, the department also presents its work in the Friday meetings (I.F.4.8).

### **IV.4.2 With Department/Faculty of CM of other Medical Colleges**

The faculty at DoCH do attend conferences, but they prefer those which are held nearby. National conferences are generally conducted in the North (I.F.4.2, I.F.4.3). It is also difficult to find company in these conferences. 'It's like you are one in that whole world' (I.F.4.2). Moreover, the popular national conferences are generic (I.F.4.1, I.F.4.2, I.F.4.4, I.F.4.9, I.F.4.10). So, faculty prefer those organized around focussed issues (Occupational Health, Geriatrics, Disability, NCDs).

'Networking' is one purpose why people generally go to conferences (I.F.4.8). But DoCH faculty, by virtue of being in St. John's, already have many opportunities (I.F.4.9). And then, given the nature of the department's work, networking at community-level is more useful (I.F.4.9). One faculty was averse to attending conferences, and would only go if invited. 'I don't see what the point is, many a times. People talk about abstruse things. One guy

speaks things totally unrelated to the previous guy. So I don't find myself gaining too much by going to conferences' (I.F.4.10).

### **IV.4.3 With Government Health Department**

#### **Facility level**

The Department posts its PG students at a Government Urban Health Centre, a Sub-divisional Hospital and at the Primary Health Centre, Sarjapur. Interns also get posted at the Sub-divisional Hospital. During Urban CHAP, UG students are taken to a government referral hospital in the city. But, being a Catholic institution, they cannot promote Family Planning methods in any way (I.F.4.5). And so, they cannot full charge of a government facility (I.F.4.9).

As CHTC area overlaps with that of Primary Health Centre Sarjapur, 'whatever action we take, we always discuss with the Medical Officer' (I.F.4.9). The faculty are trying to start a NCD clinic at Sarjapur. But such collaborations are not generally easy to build because a) there are multiple authorities who need to agree to the idea, and the officials keep changing; and b) the lab services and drug availability at government facility are not adequate, and St. John's won't be allowed to recover the actual cost it incurs in filling these gaps (I.F.4.5, I.F.4.8). Even the patients will object if they are asked to pay in a government facility (I.F.4.5). These hurdles put-the faculty off. 'That's why that parallel system comes-up' (I.F.4.8).

Besides, as a MC Hospital, St. John's participates in all National Health Programs. The hospital is also empanelled under *Arogya Karnataka*, which is the State-funded health insurance scheme.

#### **District/Corporation level**

The Department helps out the city's Municipal Corporation whenever asked to. It may be ground-level support during Pulse Polio Immunization (PPI) campaigns, or for NCD screening; or it may be a monitoring and evaluation exercise. One of the faculty is a member of the Coordination Committee for Mission *Indradhanush* and of the PPI Task Force for the city. Another faculty is collaborating with the Corporation for conducting a RCT on video-DOT.

## **State level**

The faculty have been training Primary Health Centre Medical Officers on different aspects of disability under the CBR projects. One of the faculty did a UNICEF-funded RMNCHA gap-analysis for the State's Health Mission. The same faculty is a part of the State's Newborn Action Plan, and a member of the Committee on Adverse Effects following Immunization (AEFI). The faculty working for the elderly have been interacting with governments of three States to implement the National Program for Healthcare of the Elderly (NPHCE). Another faculty has been a State-level Master Trainer for Bio-medical Waste Management.

## **National-level**

Some faculty, not from DoCH, but from other departments of the Institute have contributed to the MCI's new Competency-based Undergraduate Medical Curriculum, especially the AEtCom Module and the one on Foundation Course. A past faculty from the department was involved in designing of the NRHM's framework for communitization at the national level.

However, there is a feeling that the department loses out on opportunities offered by the government, be it projects, trainings, referrals or to be a part of the planning process because, despite its reputation, it is still 'non-government' (I.F.4.4, I.F.4.10, I.F.4.11). Frustrated, one of them asked, 'Are people working in private institutions lesser than those working in government institutions?' (I.F.4.4).

At the same time, the faculty acknowledge that department's interaction with the government are not 'as robust as they can be, or should be' (I.F.4.10). 'We had probably taken an easy way initially...we just ran things out of Mugalur' (I.F.4.8). 'We haven't been hand-in-hand with the government to a large extent' (I.F.4.1). But for last two-three years, the department, under its new Head, is trying to collaborate more with the government. Efforts are being made to have a greater engagement in service delivery, referrals as well as research. However, the task of liaising with government officials, and facing associated challenges, needs to be shared by all the faculty (I.F.4.11).

## **IV.4.4 With Other Government Departments**

The faculty at DoCH are in regular touch with ICDS functionaries: Anganwadi staff and CDPOs working in and around Mugalur. Besides, they liaise with the School Teachers and

Block Education Officers of the area. The faculty engaged in Occupational Health are in touch with Directorate of Factories, Boilers, Industrial Safety and Health and with the Regional Occupational Health Centre. Another faculty working on CBR is in touch with the Directorate of Welfare of Disabled and Senior Citizens. Those engaged with the Senior Citizens Services also liaise with this Directorate, in Karnataka as well as in a few other States where they are assisting implementation of NPHCE. The department, as a whole, is in close and regular contact with *Panchayat* offices in and around Mugalur.

#### **IV.4.5 With Others**

The department has collaborated with several NGOs and Institutions to orient their UG students (*Snehadaan, Karunashraya, Sandhyakiran, Spastic Society* - all in Bengaluru), Interns (*Gnanajyothi - Anekal, Snehalaya - Solur*) and PG students (*Jan Swasthya Sahyog - Ganiyari, Ben Guerin University, Israel*). The department is in constant dialogue with these organizations for a mutually beneficial association, and it also extends a helping hand whenever requested. The department's UHTC operates in collaboration with the CSR division of a corporate company. Individual faculty works with NGOs related to their specific domains. Some of them are also associated with PH organizations and people working at the grassroots even beyond their direct area of interest (I.F.4.10). Representatives of NGOs and Institutions from within the country and beyond often visit the department to learn from the ongoing programs, and to explore opportunities to collaborate. Most of the department's field activities are supported by different donor organizations.

The department has facilitated formation of groups and federations of women, of elderly and of parents of children with disability in the villages around Mugalur. But not many faculty are in touch, or aware, about contemporary health movements in the country. 'We are happy taking care of the people who come in our field practice area and who come to our PHCs' (I.F.4.9). The Department was probably bit more outgoing a few decades earlier. A past faculty informed about how people from institutes like Indian Social Institute and forums like Medico Friend Circle deeply influenced the work of the department (I.PF.7).

#### **IV.5 Intra-departmental Interactions**

The faculty in DoCH have known each other for long, and closely. They sit together every Saturday morning to share what they have been doing in the bygone week, and what they

intend to do in the coming one. Often, the faculty share coffee breaks. Most of them are on a first name basis with each other. Some use 'Sir', but, there is no Dr. X and Dr. Y business. Interestingly, the position of the Head rotates between the Professors every four years.

Many of the DoCH faculty have been students in the same department. They, and also the current PG students, feel that the faculty-student relationship is less hierarchical here compared to other departments (I.F.4.1, I.F.4.6, FGD.PG.4). A senior faculty didn't mind leaving the front seat for a PG student having a back-problem and he himself sat on the back of the vehicle. This informality and respect is also present between the medical faculty and the social work team. The senior Social Worker calls most of the faculty by their first names as she has seen them as PG students in the department. Though she has some grudges regarding her promotion, and cites some incidents of discrimination during her initial period in the department, she is very appreciative of the department for the amount of freedom she enjoys here. A senior faculty, who also does theatre, quotes the character of Eliza from one of his plays 'My Fair Lady' in his Tedx Talk - 'The difference between a flower girl and a lady is not in the way she behaves, but in the way she is treated'. The whole department seems to have realized this.

As the students observe their faculty, they imbibe a lot of this sensitivity and etiquettes. Sometimes, students are also told about the need to shed any sense of superiority they might have. For instance, when the PG students are going for some conference, the faculty caution them - 'when you go there, remove all your hats. Become one among the many there' (I.F.4.11).

## **Summary Statement**

Department of Community Health at St. John's Medical College has a long history of community-level service, engagement and experimentation. This kind of work has been possible because of a supportive institutional ethos and dedicated faculty. The department tries hard to transmit its understanding about PHC to the students through a series of community orientation programs and exposure to diverse setting. In this endeavour, it is supported by the parallel work of St. John's Division of Humanities and Department of Ethics. DoCH's activities are largely based at and around its Community Health Training Centre at Mugalur. Its engagement with urban communities, with macro-level issues and



policy, and with government in general, has not been as great as its work for the rural people.

## Summary

This chapter gave a detailed description of the history, activities (teaching-training, field, research), and interactions of the four CM departments included in the study.

DoCM-SPH is focussed on research, a significant proportion of which is aimed at influencing policy. It has several national and international collaborations. Unlike the other three departments, it has only postgraduate teaching. Besides MD in CM, it also offers MPH course and guide PhDs. It, thus, has a 'Research and Policy' orientation.

DoCM-TSI has a mix of faculty from Directorates of Medical Education as well as that of PH. Owing to resource constraints, it has been largely been limited to teaching-training, which, at least for UGs, is largely restricted to classrooms. Most of the faculty as well as students come with experience of working at government Primary Health Centres. For these reasons, and owing to its historical roots, the department has a 'Public Health Administration' orientation.

SNSPH-DoCM has been able to maintain a balance between teaching, service and research, and between working with government health system and the communities. It has a series of residential camps and long-term family follow-up mechanisms for rural orientation of UG students. It also has been involved in community mobilization activities. The department has a 'Community Development' orientation.

DoCH has been focussing on community service, and on making its students sensitive about 'the last, the lost and the least'. The Institute has seats reserved for seats for students from underserved populations, and for religious sisters. The Institute's Division of Humanities and the Department of Ethics complements the endeavours of DoCH. It has a 'Community Service' orientation.

The next chapter presents the understanding of PHC among the faculty of CM in these four departments.

# Chapter 4: Understanding of Primary Health Care among the Faculty of Community Medicine

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This chapter presents the understanding of the faculty about Primary Health Care (PHC) assessed across eleven themes. The larger section of the chapter presents the qualitative analysis of faculty responses. Each theme has the responses divided in five sets, numbered from 1 to 5. The responses in Set-1 are farthest, and those in Set-5 are closest to the poles fixed for this assessment. More about the method of analysis may be found in Chapter 2. There is a smaller section in the end which presents a quantitative analysis of the scores assigned to the faculty on various themes. While the qualitative part gives an in-depth sense regarding the variations in understanding of PHC at individual and department level, the quantitative part conveys the same in a nut shell.

## Theme I: Understanding of Health

Way back in 1946, the WHO Constitution incorporated a definition of health proposed by a Croatian public health person named Andrija Stampar (Tejada 2003). 'Health', as per this definition, is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition has been called the 'basis' of PHC (Rifkin and Walt 1986). This was the 'health' that was to be achieved 'for all' by the year 2000 through PHC approach as per the resolve of Alma-Ata Declaration (WHO-UNICEF 1978). If one understands the dimensions of health mentioned in this definition, and the determinants of these dimensions, many of the PHC principles will appear but obvious. A comprehensive understanding of health is, thus, fundamental to understanding PHC.

Farthest Response	Closest Response
<i>They agreed with the definition, called it 'complete', but didn't have much to say.</i>	<i>They saw 'Health' as something beyond the 'physical', and talked about different dimensions and determinants.</i>

When the faculty were asked about their opinion on this definition, all of them were appreciative of it. Many of them went on to draw linkages between the different

dimensions, and talked about the various determinants. Some of them also explained the process involved in developing a deeper understanding about this concept.

### **Set-1 (n=2)**

The faculty farthest from the pole stopped at saying that the WHO's definition of health was 'quite encompassing', or 'correct' (I.F.1.6, I.F.2.2).

### **Set-2 (n=2)**

The next set of faculty appreciated the definition (I.F.2.6, I.F.2.9). They agreed that clinicians generally do not look beyond the physical. Speaking from a common man's perspective, a faculty said, 'even we don't consider no. Only when we are free of some sickness or illness, we think we are in a healthy state' (I.F.2.9). Another faculty saw 'going beyond' as the job of CM people; clinicians had a different role (I.F.2.6).

### **Set-3 (n=13)**

The next set of faculty also found the definition comprehensive and reasonably broad. Though it may be 'overambitious' and 'not at all an achievable goal', 'if we point high, we will reach somewhere' (I.F.3.8). 'At what percentage we achieve, is different. But what is your destination, it tells you' (I.F.2.1).

A faculty identified women's education and women's rights as important determinants of health, besides health system issues like the budget and fund flows (I.F.2.8). Another faculty, during a lecture, identified illiteracy as one of the barriers to low immunization coverage. Though, he said 'It is a problem beyond the purview of people like us' (I.F.1.8).

Several faculty in this set agreed that clinicians don't go beyond the 'physical' (I.F.1.8, I.F.2.5, I.F.2.7, I.F.2.8, I.F.3.6, I.F.3.7, I.F.4.3, I.F.4.5). There were three mutually exclusive explanations for this. First, it was about lack of time and excess workload (I.F.2.8, I.F.3.6). Otherwise, 'I am sure (there is) nobody (who) doesn't want to see the social and emotional aspect of the patient' (I.F.2.8). Second, it was about clinicians having a different role, and so, a different 'working definition' of health (I.F.3.7). Third, it was about the way doctors were getting trained (I.F.1.7, I.F.3.6, I.F.4.3). 'Doctors study so much of clinical medicine that, naturally, their priority is to treat the patients and get them cured in the immediate time-frame...they fail to see that the illness may be related to issues in the family or at workplace'

(I.F.4.3). Even in the face of evidence favouring a comprehensive approach, 'it is very difficult to unlearn' (I.F.1.8).

But then, even general public lacked that understanding; they were also concerned only about their physical illness and wanted an immediate cure (I.F.4.3). Only when both sides understand the other dimensions and determinants that 'health' can be realized (I.F.4.5).

While the faculty generally considered that CM people held a 'bird's eye view' on health (I.F.2.8, I.F.3.7, I.F.4.3), one of them was of different opinion. He said, 'most of them here define health within only a "range"...You have to be within the two standard deviations' (I.F.2.7).

In reference to developing a comprehensive understanding about health, a faculty said that this happens only when one gets at the receiving end (as a patient or as a caregiver), and not by reading about it (I.F.2.8).

## **Set-4 (n=13)**

### **I.4.1 Definition**

The faculty in this group also hailed the definition. A faculty from SNSPH-DoCM shared what Dr. Sushila Nayar used to say about health: "*Swasth*" (being healthy) means "*swayam mein sthir*" (being stable within self)' (I.F.3.5). A faculty from DoCM-SPH considered health as a 'development issue' (I.F.1.4). Another faculty from the same department found the way health was defined as quite important because that would set the scope for subsequent measurement methodology. 'If you are measuring only the physical aspects, you are making a skewed assessment of what health is. That's a bio-medical view' (I.F.1.3). A third faculty from this department stated that the WHO's definition was not supposed to be used in an operational sense, because then nobody would be 'healthy'. The beauty of the definition was that 'it forces you to think that if you search health in any one dimension, it is futile' (I.F.1.7). A few faculty gave the cliché critique<sup>1</sup> that WHO's definition lacked the spiritual dimension (I.F.1.3, I.F.1.10).

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<sup>1</sup> The researcher later came to know that to critique WHO's definition of Health is a common exam question in CM, and that the definition lacks spiritual dimension is a common answer.

## **I.4.2 Dimensions**

A faculty from DoCH informed that if a patient presented to her repeatedly with multiple non-specific symptoms, she would look at it from a mental health angle. And oftentimes, it would also have a social angle. She found it necessary to try and solve these issues so as to be able to treat the physical illness. A DoCM-SPH faculty saw similar linkages between stress and hypertension, and appreciated the importance of social networks for one's health and quality of life (I.F.1.10). Another faculty from this department appreciated *Yoga* as it blended the physical, mental and spiritual dimensions of health. He would arrange *Yoga* training sessions for the chronic disease patients attending his field clinic (I.F.1.7).

A faculty from DoCH was working for community-based rehabilitation of people with disability, including children. 'Unless this child is enrolled in school, my rehabilitation is incomplete', she said (I.F.4.2). Another DoCH faculty, talking about the Home Health Service for the elderly, shared that medical check-up was just one small component of the monthly home visit made the Doctor-Nurse duo. 'Many of these (elderly) people look forward to the visit of the team, because they spend time. They say, "hello, how are you doing"; they hold their hand; they sit and have a cup of tea with them' (I.F.4.7). A third faculty from DoCH was conducting a comprehensive health clinic for people with mental illness. Due to limited resources, his team was not presently able to go much beyond the clinic. However, he believed that 'empowerment is one of the keys, merely clinics will not help' (I.F.4.11).

## **I.4.3 Determinants**

Faculty mentioned water, sanitation, housing, quality of roads, agriculture, education, employment, and political and administrative will as the determinants of health and healthcare services (I.F.3.3, I.F.4.4, I.F.4.7). A faculty from DoCM-TSI attributed State's success in terms of health indicators to its focus on education, especially among women. 'You are educated, you understand things better, you ask for your rights, you demand' (I.F.2.4).

Health can't be looked at in isolation and the health status of population can improve only when all these components are acted upon (I.F.3.3, I.F.3.5, I.F.4.7). A faculty from DoCM-SPH expressed the need for multi-disciplinary contribution in health - from social sciences, economics, demography, nutrition, environment science etcetera (I.F.1.4).

#### **I.4.4 Understanding of Clinicians**

Faculty agreed that clinicians do not go much beyond medically treating the patient (I.F.1.4, I.F.2.4, I.F.3.10, I.F.4.4). They carry the same mentality into PH programs. For instance, when there is a Dengue outbreak, such program officers would think about arranging more beds and more platelets (I.F.1.4).

The reasons were similar to those given in previous section. One was that while those working at PHC level have time, those working at higher levels of care are too busy to go beyond (I.F.2.4). Another was that clinicians don't think it's their job<sup>2</sup> (I.F.4.4). A young faculty from SNSPH-DoCM related this to a very fundamental issue. 'First and foremost, the goal of our (medical) education system (itself) is not to keep people healthy' (I.F.3.10). He meant that the ME system was, instead, oriented towards treating the sick. Moreover, even in CM, 'we have reduced the definition of health to a viva voce question or a long question' (I.F.4.11). A faculty went on to say that even CM faculty, who had joined the discipline without a genuine interest in it, would fail to ever develop this perspective (I.F.3.10).

A faculty said that with rise in non-communicable diseases, the understanding about dimensions of health other than physical was becoming better (I.F.3.5). Doctors had come 'a little further' as they were now looking at things like screening of diseases; though, common man still thought health as just absence of disease (I.F.2.3).

#### **Set-5 (n=8)**

##### **I.5.1 Definition**

This group of faculty also appreciated the WHO's definition of health. A senior faculty from DoCM-SPH compared 'health' to concepts like 'honesty', 'truthfulness' and 'democracy' to clarify that such concepts are not meant to be assessed from an angle of 'practicability'; instead, they are meant to be understood (I.F.1.2). A senior faculty from SNSPH-DoCM called '*Swasthya*' (the word in Hindi for 'health' meaning 'a state of being stable within self'), as the 'most holistic definition' of health. Another faculty recalled his Professor's message to look at health as 'a medium of socio-economic development' (I.F.3.1). A faculty

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<sup>2</sup> It is important to note that unlike in previous sections, the respondents here didn't fully approve this way of thinking and acting on the part of clinicians.

from DoCH, however, found the WHO's definition as 'utopian'. Instead, she thought that defining 'health' as 'the ability to lead a socially and economically productive life' was more 'realistic' (I.F.4.6).

### **I.5.2 Dimensions**

The faculty reflected an understanding of the inter-linkages between various dimensions of health. A DoCH faculty working in the field of Occupational Health shared, 'health is not the only issue there. You have issues with overtime, you have issues with poor pay, you have issues with harassment...all those things. Unless you address those issues also in some way, you are not going to have a healthy worker' (I.F.4.1). Another faculty from the same department recalled a patient having HIV-TB co-infection who was not willing to take treatment even after they arranged drug distribution from the local Primary Health Centre. Later, they found that his wife had left him, and he saw no purpose in getting better (I.F.4.9). The Senior Citizens Health Services of DoCH had grown organically from geriatric clinics to establishing Village Elderly Centres where the elderly could have meaningful engagements. The concerned faculty informed that this happened out of a realization that medical care was not sufficient to take care of the health of the elderly (I.F.4.10). Once, during a 'Clinico-Pscho-Social' case presentation at DoCM-SPH, when the resident went into the clinical details of a Leprosy patient's foot ulcer, a senior faculty commented that 'even after so many years, the clinical mindset has not left the department' (I.F.1.2). He went on to ask if the resident had 'touched' the ulcer, or if anybody had 'hugged' the patient.

### **I.5.3 Determinants**

Talking about his work in Plantations, a DoCH faculty informed that apart from ensuring primary medical care, he had also been looking at environment, water-supply and sanitation issues in the 'lines' where the workers lived. But the health-gains achieved over last two decades were now getting diluted because of migrant labour joining the plantations. The next generation of existing workers was educated and was no more willing to take up these jobs (I.F.4.1).

Talking about Protein-Energy Malnutrition, a DoCH faculty said that it can't be controlled by just giving supplementary nutrition. 'You need to look at water, you need to look at

sanitation, you need to look at, may be, home economics, you need to look at corruption, you need to look at agricultural, you need to look at natural disasters’ (I.F.4.9). Another DoCH faculty opined that while specific interventions like vaccines were essential to take care of the problem in the immediate time-frame, ‘you also need to focus on education, water, sanitation, housing...because that’s a long term solution’ (I.F.4.6). She considered the chronically low Minimum Support Price, which was leading to distress among the farmers and discouraging the youth from taking-up farming as a vocation, as something impacting health. She also expressed concern about tonnes and tonnes of food-grains rotting in the field due to lack of granaries (I.F.4.6).

SNSPH-DoCM had established Women’s Self-help Groups and Farmer’s Clubs in the late 1990s. A faculty shared that the initial effort of the department was to help the members of these groups to become economically better-off. Vocational trainings were arranged for women (in skills like *papad* making) and men (in new farming techniques). ‘Health is not going to improve in isolation’, he said (I.F.3.1).

Non-health factors affect health by affecting healthcare services also. A faculty shared example of a district where a poor road network was keeping the otherwise well-provided healthcare facilities underutilized (I.F.4.6). Another faculty called (petty-) ‘politics’ as ‘a major determinant of health’. She shared how the newly elected *Panchayat* leader had become non-cooperative for her NCD services because the previous leader, who was from a different political party, was a diabetic (I.F.4.9). She shared another example where a chain of State-funded public canteens started by the previous government was being smothered by the new one.

A faculty said that health has ‘a broader socio-political-economic basis’ and interventions were required at that level to have a big change in the health outcomes (I.F.1.12). Others referred to the history of PH in western countries, including the 19<sup>th</sup> Century’s Great Sanitary Awakening, to stress on this linkage (I.F.3.2, I.F.4.9). Going a step further, a SNSPH-DoCM faculty urged policy makers/influencers to understand health as a ‘right’ of the people (I.F.3.2). A senior DoCM-SPH faculty told that health becomes a political issue when politicians talk about it in front of people, and/or when people talk about it in front of



politicians. 'Once the issue goes into the public, beyond the academic boundaries, beyond the Universities, then, the change occurs' (I.F.1.12).

### **I.5.4 Understanding of Clinicians**

Several faculty felt that doctors do not go beyond the physical (I.F.1.12, I.F.3.1, I.F.3.2, I.F.4.6, I.F.4.9, I.F.4.10). One of them was surprised when an Orthopaedician noticed her pallor and asked her to get a haemoglobin test done because, till then, 'the moment I say knee pain, (the doctor) looks at my knee and the rest of me is forgotten' (I.F.4.6). She felt 'it would be a great thing if they (doctors) even look at you as a person, as a combination of systems rather than (just) a specialty' (I.F.4.6). There is more trouble when they are made to handle PH. 'If you engage doctors to work on the issue of nutrition, they will talk about managing malnutrition. Your whole program will get deviated from what needs to be done for every child...to what should be done for complicated SAM<sup>3</sup>' (I.F.3.2). Another faculty critiqued the approach of establishing Cardiac Care Units at district hospitals for addressing the issue of NCDs rather than taking a holistic approach (I.F.4.9).

The faculty saw the root of this problem in ME which had some inherent biases. One, it focused on 'individuals' (I.F.3.2). Two, it focused on what was 'wrong' with individuals (I.F.3.1, I.F.3.2). Three, it held a narrow 'bio-medical' view even while looking at what was wrong with individuals (I.F.1.12, I.F.4.10). 'Body being a bunch of systems...they break it down, and you have to repair them at all costs...that's the philosophy' (I.F.4.10). Sarcastically, a faculty said that 'it's good that the degree we get is actually called "Bachelor in Medicine and Bachelor in Surgery". It's not called "Bachelor in Health"...they don't teach you "Health"' (I.F.3.2). He said that 'understanding of holistic health is better among lay people as compared to doctors', and called the minds with such biases as 'unfit' to deal with the needs of normal population (I.F.3.2).

One of them, however, opined that this 'abnormality bias' plagued not just ME but the education system in general, or it was a 'basic human psyche'; so the problem was not just limited to doctors (I.F.3.1). Similarly, another faculty said that, historically, even lay people have been concerned only with 'physical' illness and have looked at *Vaid/Hakim/Doctor* as

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<sup>3</sup> Severe Acute Malnutrition

somebody who would relieve them. 'People do not have that kind of idea that how disease originates from social system' (I.F.1.12).

One faculty raised a few operational problems. She said that while every Doctor reads the definition of health and related concepts during UG, 'just like you forget (most of) Anatomy, Physiology, Bio-chemistry, Pathology...you forget (the wider concept of health) with time' (I.F.4.6). Moreover, their workload may not allow them to be more holistic (I.F.4.6).

With regards to the understanding of CM people, there were two views. One was that, though they might not be able to put it into practice, their understanding was indeed more comprehensive (I.F.4.6, I.F.4.10). Another view was that even CM people had gaps in understanding (I.F.1.12, I.F.3.1, I.F.3.2). 'Essentially, they are physicians. So, it is very very difficult to bring them out of this bio-medical field to another level, another paradigm' (I.F.1.12).

### **I.5.5 How understanding develops**

A senior faculty from SNSPH-DoCM underplayed the importance of using a standard definition for developing an understanding about any concept. 'Forget all these definitions. If you simply sit and talk to people, or, just ask yourself that "what does health means to me...what it means to be healthy", you reach there' (I.F.3.2). He felt that people were complicating things by incarcerating the concepts in statements.

The faculty opined that understanding about concepts like 'health' develops with time and experience (I.F.4.6, I.F.4.9). Diverse exposures enrich the understanding at an accelerated pace as compared to the situation where one is doing same type of work in same type of setting. Seeing patients, interacting with community, attending conferences, meeting people from different disciplines - all this adds-up (I.F.4.9). Even Clinicians, as they gain more experience, start looking little beyond medicine (I.F.3.1, I.F.4.9). Understanding health is 'not a certifiable skill that you finish your MBBS and you know everything about it' (I.F.4.9).

## **Theme II: About Primary Health Care**

'Primary Health Care', as detailed in Chapter 1, has historically been understood in a variety of ways. The most peripheral level in the 3-tier structure of the healthcare system is called

'primary'-level, and so, 'Primary Health Care' is often considered as referring to the care provided at this level. In India, the primary-level government health facilities are called 'Primary Health Centres', or 'PHC'. The same acronym is used for 'Primary Health Care' in literature which adds to the confusion. 'Primary Health Care', as discussed at the Alma-Ata Conference (1978), is an approach for health systems organization and development. The definition of this concept talks about 'essential healthcare', but sets forth a series of principles based on which this essential healthcare has to be thought about. While it does include provision of primary-level medical services, it is not limited to that. In fact, it goes beyond the health sector itself.

While the faculty's understanding on the key principles of PHC approach have been discussed in subsequent sections, their understanding about this term, 'Primary Health Care', has been presented here. Besides, this section also includes the challenges that the faculty saw in PHC, and their suggestions for improvement. This also gives an idea about how they view PHC.

Farthest Response	Closest Response
<i>They saw Primary Health Care only as provision of primary-level medical care (curative and preventive).</i>	<i>They saw Primary Health Care as a 'concept', as an 'approach', as a 'set of principles'. While they did talk about the healthcare system at primary-level and its challenges in detail, they could distinguish this from 'Primary Health Care'.</i>

### **Set-1 (n=1)**

A faculty said that every doctor was actually doing PHC most of the times. 'Even for an Ogycian, most cases will be of anaemia, body pain, irregular periods...how much of (it is) specialized care?' (I.F.2.4). Having worked for more than a decade at an Urban Health Post, she shared the challenges of implementing multiple programs through the same set of staff.

### **Set-2 (n=5)**

A faculty said that she strongly believed in PHC. 'Once you strengthen the Primary Health Systems, and you are able to manage the basic things at a lower level, definitely, the load on other two systems (secondary and tertiary levels) come down' (I.F.2.1).

The faculty were critical of the target-based reviews that were being conducted at district-level where the senior officer would not even listen to the underlying problems (I.F.2.3, I.F.2.9). For instance, a faculty recalled that her seniors would keep pestering her to increase the out-patient numbers even when there was no road to access her Primary Health (I.F.2.9). Even worse was that they would ask her to give only two days drugs to the patients, many of whom would be coming from the hills (I.F.2.9).

The faculty shared challenges like shortage of human resource, poor quality of training of the peripheral staff, excessive workload on the so-called 'honorary' or 'voluntary' workers (AHSAs), and the local political interference faced by the staff working at primary level (I.F.2.1, I.F.2.3, I.F.4.8). A faculty mentioned the issue of misreporting of data in her State (I.F.2.3). Another faculty expressed concern about high income people not paying taxes, because of which government was not able to spend enough on health (I.F.4.8).

A faculty thought that placing a doctor at Health and Wellness Centres would 'automatically' improve PHC (I.F.3.8). The doctor, with his clinical and managerial skills, would be able to bring the necessary change. Another faculty found it desirable that experts create strong evidence and come together to voice their concerns regarding government policies. Though, she had doubts if such activism work, because, 'finally it is dependent on that one individual, that one politician who will take that decision' (I.F.4.8).

## **Set-3 (n=22)**

### **II.3.1 Concept of PHC**

A DoCM-TSI faculty said 'Primary Health Care is the first level of healthcare which is available to the patient' (I.F.2.6). Unlike secondary health care, which focused on complications, PHC focused on prevention. So, it was more than just 'sitting in a room and writing prescriptions' (I.F.2.2). The faculty went on to talk about Health Education that would convince people suffering from stigmatized diseases like Leprosy to come forward and take treatment (I.F.2.6). They talked about MCH and other health programs, including ICDS. The faculty mentioned 'comprehensive', 'accessible', 'affordable', 'acceptable', 'appropriate' and 'quality' while talking about PHC (I.F.1.6, I.F.2.5, I.F.2.6). One of them called 'community participation' and 'inter-sectoral co-ordination' as the most important principles of PHC (I.F.2.2).

A DoCH faculty considered PHC as 'looking at the community at large, and how community can work together to improve the health status of an individual, or a family or the community itself; and how individual's can contribute to the health of the populations' (I.F.4.4). A DoCM-SPH faculty contrasted PHC approach from the clinical approach saying that while the latter revolved around individual patient, the former required collaboration with other sectors (I.F.1.8). He found PHC approach 'quite embedded' in all health programs. For instance, the leprosy program had components of health education, treatment, and community-based rehabilitation (I.F.1.8). A DoCH faculty highlighted the decentralized distribution of Anti-retroviral and Anti-TB medicines as a mark of PHC approach being followed. She added that the AIDS Control program (NACP) was also working with family members and employers to ensure that the affected person didn't lose the social and emotional support because of the stigma associated with the disease (I.F.4.3). A DoCM-SPH faculty claimed that strengthening of PHC infrastructure and human resource could improve the performance of all health programs. This, he said, was the 'backbone' of the health system (I.F.1.6).

A faculty from DoCM-SPH considered primary care physician as very important (I.F.1.10). This was because a) 90% of the problems could be tackled at that level, and so, the workload at other levels could be reduced; b) this person had time to delve in non-medical aspects like diet and exercise in greater depths; and c) this person had a connect with the community. 'This is the person people can correlate to, this is the person with whom they can communicate, this is the person who knows the needs of the people' (I.F.1.10).

In order to orient medical students on PHC, the faculty shared that they would ask the students to imagine themselves as sitting in a rural centre with limited facilities and then think about the steps for primary, secondary and tertiary-level prevention (I.F.2.2, I.F.4.1). A faculty shared that while introducing 'Occupational Health', he would stress that, in Factories and Plantations, most of the patients would be coming not for Occupational Health issues, but mainly for PHC issues (I.F.4.1).

When asked whether PHC was discussed at popular PH conferences, a faculty affirmed and referred to topics like 'the role and functions of ASHAs' that would be discussed at every conference (I.F.1.6). When asked if popular PH journals reflected PHC in their articles, a

faculty referred to the 'studies done at community level' that would be published in those journals (I.F.2.2). Another faculty said that he didn't read a lot 'on' PHC; instead, he read about Information and Technology (IT) aspects of health because that was his interest area (I.F.3.7).

### **II.3.2 Challenges to PHC**

The faculty mentioned shortage of human resource, including doctors, as a key challenge to PHC (I.F.1.10, I.F.2.5, I.F.3.3). A faculty added that doctors who joined PHC lacked basic clinical skills (I.F.3.3). Another issue was lack of motivation among the staff (I.F.1.10). Many of them would spend half the time commuting rather than stay at their place of work (I.F.4.5). The faculty, at the same time, also shared that the staff would be offered dilapidated quarters to live in (I.F.4.5). They would be deployed without any consideration for their specific skills (I.F.4.6). Instead of extending technical and emotional support, their supervisors would just ask for reports (I.F.1.10). And then, there would be shortage/stock-out of essential medicines and dumping near-expiry medicines in peripheral facilities (I.F.1.10). The system itself would be promoting antibiotic resistance by not dispensing full course to the patients (I.F.4.5). At times, there would be resource mismatch. The centre having a four-wheeler would not have a driver, and vice versa (I.F.4.6). Faculty also shared the problem of misreporting of data at peripheral levels (I.F.4.9). The faculty would bring all these things to the notice of concerned authorities. But the whole machinery would be moving very slowly, or not at all (I.F.4.6).

A DoCH faculty said, 'We are very good at preparing stuff and saying stuff. But actually we don't do anything' (I.F.4.10). That was why, he thought, even after so long, the social determinants of health were what they were (I.F.4.10). However, while acknowledging that the government (health) system had many limitations, a SNSPH-DoCM faculty said that it was the only system which had the potential to reach the majority. He agreed that it lacked the necessary dynamism, but opined that the only way to improve it was to get involved with it, directly or indirectly (I.F.3.1).

Though they didn't call it so, the faculty did refer to lack of self-determination at the level of policy and planning (I.F.1.7, I.F.3.6, I.F.4.3). International organizations/alliances would aggressively push their agenda, like NCDs or neonatal health, which would

disproportionately skew the national priorities and needs (I.F.1.7). Also, they would push product, like some vaccine or some IT solution, without adequate (local) evidence of its effectiveness (I.F.1.7, I.F.4.3).

A disregard for evidence was a problem even when there were no external influences (I.F.1.7, I.F.3.6). The policies would often be based on experience than evidence (I.F.4.3). If at all, the policymakers would look for 'branded' evidence. 'You quote <names of two popular international journals>, and they will be fascinated by that, even if it's trash'; 'So, a lot depends on the name' (I.F.3.6).

PH academia would be a part of this process, but only those who are stationed in National/State capital (I.F.3.2). Those working in the field, in different contexts, would be left out (I.F.3.2). And then, like everywhere else, there would be 'yes Sir' type people who would not want to displease the 'Boss' (I.F.1.7).

The impact of these policy vulnerabilities was obvious. Citing an analysis of the 2018 budget speech, a DoCM-SPH faculty shared that there were more than seventy references to National Health Protection Mission (NHPM) and less than ten references to the Health and Wellness Centres (I.F.1.3). He called policy discourse as a 'tug-of-war' kind of thing. 'It ultimately boils down to the power dynamics...who is able to exert more: the community which argues more for Primary Health Care, or the community which is more in favour of insurance based mechanisms' (I.F.1.3).

A DoCH faculty agreed that medical fraternity was, indeed, a stakeholder in the demand for change; that doctors did hold opinions different from the dominant view; and that they did discuss issues with each other (I.F.4.9). But this was not being done in an organized way. She also said that 'if you want to change the situation, doctors should involve in politics' (I.F.4.9). But she submitted that there was an aversion for politics among doctors because, in India, it was considered as something done by less educated people with the aim of making money (I.F.4.9).

### **II.3.3 Suggestions for PHC**

A faculty suggested starting a Medical College (MC) in every district so as to address the shortage of doctors (I.F.3.3). Another faculty added that the cadre of primary care

physicians needed to be strengthened and given more importance so that people get interested in joining it (I.F.1.10). At the same time, those working at tertiary levels needed to be oriented in the non-medical aspects of health even if they would not have time to act on them (I.F.1.10). Another faculty expressed a definite need for people with PH background in the system (I.F.3.2).

A DoCM-SPH faculty opined that the PH experts of the country needed to fearlessly question the claims of international organizations so as to bring a balance of power in policy discussions (I.F.1.7). And this could be done even by those outside the official committees. For instance, the kind of opinions that came in newspapers and other media after the 2018 budget speech shifted the official focus, at least for the sake of presentation, to HWCs instead of NHPM (I.F.1.3).

The faculty also mentioned the need to raise the budgetary allocation for health, and to address the fund-flow issues (I.F.3.3).

## **Set-4 (n=7)**

### **II.4.1 Concept of PHC**

The faculty in this set also referred to PHC as the ‘basic minimum service that we have to provide’ (I.F.1.9). But they acknowledged that it went beyond the care provided at Primary Health Centres; it was not just the ‘treatment of cough, cold or back pain’ (I.F.4.7). The ‘service’ included curative care, but ‘80% is the preventive, and looking at the social determinants of health’ (I.F.1.9). It comprised of looking at risk factors in the communities and covered issues like food, water and the environment (I.F.1.9, I.F.4.7). And this has to be provided by the ‘system’, ‘not just the health system’; and through ‘community approach’ (I.F.1.9).

A SNSPH-DoCM faculty believed that ‘for India, Primary Health Care means “move towards village”’ (I.F.3.10). He talked about teaching people how to remain healthy, and about developing sustainable care mechanisms at village level which were appropriate to their context and culture; hospital care, if needed, should be made available as close to them as possible (I.F.3.10).



A DoCH faculty called PHC an 'approach', which was applicable even to tertiary-level facilities and across specialties (I.F.4.11). By this, he meant that the specialists should avoid unnecessary investigation and excessive medications; and if they get a case having primary-level complain, they should manage it just like it would be managed at primary-level. He shared that whenever he got an opportunity, he would make the medical students think what they could do for a given common health problem with their MBBS-level knowledge. He also opined that every specialty should talk about PHC, as relevant to their subject, to their students. 'When we do that, the concept, the depth, the breadth, the essence of primary care will sink into the minds of these future basic doctors' (I.F.4.11).

The faculty said that a strong PHC system and good PHC services would decongest the secondary and tertiary levels, thus allowing them to offer better quality services (I.F.1.1, I.F.1.4, I.F.4.11). This would also reduce the incidents of violence on the healthcare staff (I.F.1.4). At the same time, a good PHC system would need a good referral support from the other two levels (I.F.1.4). Though, while making referrals, those working at the primary level needed to take an 'enlightened' approach, 'like the parents handing over their girl child in marriage to a boy' (I.F.4.11).

On being asked if he saw the principles of PHC as being practical, a DoCM-SPH faculty said, 'sometimes no. But those principles are helpful to make my thinking go in-depth of it' (I.F.1.9). He meant that the principles would give a frame to understand what one was seeing and experiencing in field. He talked about inequities based on caste and based on where a person lived. 'Even in the same caste, the person living in the urban area gets better health services than the person from same caste in rural area' (I.F.1.9). Another faculty from the same department opined that while major reasons behind inequity were socio-political, the Health System, being an intermediate determinant, could somewhat reduce it by making healthcare services available, accessible and affordable (I.F.1.1). In a way, PHC was about ensuring services 'wherever they are staying, whatever they are earning, whatever their age' (I.F.1.9).

Talking about technology appropriate for PHC, a DoCM-SPH faculty informed that he had once shared several such ideas with a group of IITians (I.F.1.4). One such idea was to develop an instrument which could read the BP just by inserting a finger. This would make it

feasible for the Medical Officer handling a busy OPD to still screen everybody above 30 years of age for hypertension. It would also save the environment from mercury waste (I.F.1.4). With regards to follow-up services for people having hypertension and/or diabetes, this faculty said that health workers could do that just as well as any doctor (I.F.1.4). Another faculty gave example of open gyms established by the city corporation in public parks as an appropriate preventive step for NCDs which was accessible to all classes of people (I.F.1.1). She also hailed the concept of Health and Wellness Centres as 'comprehensive' because: in addition to focussing on MCH and communicable diseases, they were also going to concentrate on NCDs (screening and follow-up management); they would integrate AYUSH systems with Allopathy; and, they would promote health through *Yoga* and counselling. So, it would be a mix of promotive, preventive and curative services (I.F.1.1).

A SNSPH-DoCM faculty said that PHC consisted of four A's: 'availability', 'affordability', 'accessibility' and 'acceptability' to the community (I.F.3.5). Though, he saw PHC as one of the many issues that CM had to deal with. 'Community Medicine...is not (only) just Primary Health Care' (I.F.3.5).

#### **II.4.2 Challenges to PHC**

The faculty shared that the staff working in the periphery would have to maintain multiple records and generate numerous reports. The formats of these records and reports would change frequently, sometimes only for political reasons (I.F.1.9). The staff would be given administrative responsibilities, and would be called for meetings and trainings every now and then, which would compromise service delivery (I.F.1.9).

The faculty saw target-based reviews as a big problem (I.F.4.7). In order to fulfil the OPD targets, the clinician would call the NCD patients every three days to collect their routine medicines (I.F.1.9). The health centres would show full coverage during Pulse Polio Immunization rounds even when they didn't actually have as many under-5 children as recorded in the district database. A faculty, who had served as an external monitor for one such round, shared that the staff had simply thrown the excess vaccine in the sink to ensure that the number of empty vials tallied with the inflated number of vaccinated children (I.F.4.7). Whether it was number of cases of Malaria/Dengue or number of people screened

for NCDs, 'left, right and centre...just anything is being entered' (I.F.4.7). Officials themselves would sometimes admit that 'we just send some figures...because figures have to be sent' (shared by I.F.4.7). In case of outbreaks, the officials would remain in a denial mode for as long as possible (I.F.1.9). But they would 'upgrade' an urban health centre into a Health and Wellness Centre overnight, even without the knowledge of centre's staff (I.F.1.9). All this, according to the faculty, was so because of lack of accountability and motivation (I.F.4.7).

A DoCM-SPH faculty raised the issue of lack of PH qualified people on PH positions (I.F.1.4). He had seen Anaesthetist working as District Health Officer and Urologist working as Director, Family Planning. He shared that a Neurologist was appointed as Malaria Officer in a State just because the Director-Health Service liked the way he drafted official letters! So, for instance, if there was a Dengue outbreak, their response would be to increase number of beds and stock platelets (I.F.1.4).

The faculty acknowledged the international influences on national policies, but opined that certain global commitments had to be respected (I.F.1.1). They stated under-funding as a major challenge to PHC (I.F.1.4). They were irked that while the defence budget was so high, sectors like health and education were getting neglected (I.F.4.7).

### **II.4.3 Suggestions for PHC**

A faculty named States having a PH cadre and attributed their better performance on PH indicators to this cadre (I.F.1.4). He said that even clinicians could take PH positions, but first they would have to 'conceptually understand' this thing by taking a course in PH. He believed that having a PH cadre would give PH the priority it deserved (I.F.1.4).

In reference to policy making, a faculty said that it was crucial to first experience and understand PHC; otherwise, the policy wouldn't have any connection with the ground, and would be practically inapplicable (I.F.3.10). Referring to vested interests, a faculty said that the policy makers were not always waiting for somebody to come and tell them what was needed to be done. 'They know it' (I.F.4.7). What was important was to ensure that they do that.

A faculty saw schools as important channel to formally train the population in PHC practices like personal hygiene (I.F.1.9). He also opined that technology, if robust enough, could ease-out the day-to-day processes in the periphery (I.F.1.9).

## **Set-5 (n=3)**

### **II.5.1 Concept**

A senior DoCM-SPH faculty listed three sets of people based on the understanding of PHC (I.F.1.12). 'Most people generally understand Primary Health Care as primary care...which is first contact medical care'. It refers to making provisions for basic treatment of common illnesses through a doctor or a health worker. The second set of people think that PHC also involves preventive measures like immunization, or some nutritional supplements; that is, individual-level interventions. The people in the third set are able to '...comprehend and understand that it goes beyond...that it has aspects of health promotion, and issues related to water supply, sanitation. And more than that is how it involves communities...get them involved in planning, monitoring and evaluation. And beyond health, they also coordinate with many other sectors, and implement programs which contribute to Public Health' (I.F.1.12).

Another senior faculty from DoCM-SPH saw PHC as an 'approach' to provide healthcare 'as near to people as possible, through appropriate technology, at a cost that they can afford...' (I.F.1.2). He called the practice of prescribing standard norms for organizing health services as an 'oversimplification' of reality. For instance, a Sub-centre in hilly regions is supposed to be for a population of 3000. He informed that in some hilly areas, providing services to even this much population would be extremely exhaustive. So, instead of mechanically following a fixed norm everywhere, a wiser thing would be to stick to the basic PHC principle of going as close to people as possible, and plan accordingly (I.F.1.2).

A DoCH faculty felt that if there was anything impacting the mental, physical or social health of a person, it was essential for a primary care physician to go out of the way. Guiding people regarding how to get elderly pension or how to get disability certificate, she felt, was part of her duty. Though, she acknowledged that it may not always be possible to take that extra step. 'I cannot reach the moon. But I should try to reach the clouds' (I.F.4.2). She further added that the PHC principles were not limited only to primary-level of care. Even

those working in a tertiary-level set-up could try to reduce the economic burden on patients from lower socio-economic class by using generic drugs or by arranging donations. 'Every principle of Primary Health Care applies there...(but) this is possible only when you think that way' (I.F.4.2). Going a step further, she said while the principles would remain the same, the PHC 'model' need not be same all over the world. Even within the country, it may evolve over time. Similarly, a DoCM-SPH faculty said that it was wrong to consider PHC approach as something applicable only to poor countries (I.F.1.2). The number and sophistication of services may vary from country to country, depending on their level of development, but the principles underlying the organization of those services would not change (I.F.1.2). The faculty also clarified that the planners should not stick to any prescribed set of services. 'The concept of Primary Health Care is more important than the list. The components can be eight, or ten or four' (I.F.1.2).

A faculty said that making people realize the importance of healthy behaviour was the best way to ensure sustainable change (I.F.4.2). The complexity involved in doing so became evident from the experience of another faculty with the Rural Sanitary Latrine Construction Program (I.F.1.2). People constructed latrines from government funds, but were not using them. Men found this to be against their manhood, and women didn't want to lose their only chance to get out of home. The situation was different in villages: which were closer to roads and thus, more exposed to the 'outer world'; which were larger in size and had a lot of buildings that had pushed the open spaces too far to walk; and where more people were educated and even girls had started asserting the need for a toilet in the house they were being married into (I.F.1.2). Such complexities were present in every program. For instance, in reference to the Family Planning program, the faculty brought in the role played by international organizations, the after-effects of the Emergency period in India and the electoral concerns of the more populated States like UP and Bihar (I.F.1.2).

### **II.5.2 Challenges**

The faculty talked about lack of human resource in health, the contractual nature of employment and low salaries (I.F.1.2). He shared the issue of repetitive and ever increasing recording and reporting workload on the field staff that would ultimately make them 'callous', 'insensitive', and 'apathetic'; and the non-health work that they were often expected to do. He called target-free approach as a 'drama', because it was conspicuous by

its absence in every review meeting. He also shared the reasons because of which many staffs didn't stay at their duty stations, and the problems that this led to (I.F.1.2).

The faculty talked at length about misreporting of data in different programs (Child Malnutrition, Malaria, Leprosy); about concealment of outbreaks (Plague, Cholera); and about change of definitions to produce desired numbers (I.F.1.2). He said that no government wanted unpleasant statistics, and so would pressurize the PH officials to manipulate the data. Disappointed, he said, 'I think the Epidemiology should be disbanded if it has to be only used to conceal and suppress the facts' (I.F.1.2). Though, at local level, even the staff would want to avoid reporting of adverse events as it would bring extra work (I.F.1.2). The faculty also referred to the corrupt nexus of politicians and bureaucrats that would destroy even a conceptually good program (I.F.1.2, I.F.4.2).

The faculty considered lack of accountability as the 'biggest problem' in the healthcare system (I.F.1.2). A pregnant lady would not be registered if she has recently arrived in the area, because she may not complete the full course of Iron-Folic Acid tablets which would reflect badly on the part of the health worker; a migrant lady would be denied abortion services because she doesn't have an Aadhaar Card; and nobody would ask why it so happened. Even if somebody asked, a local politician would come to take sides (I.F.1.2).

The faculty expressed concern that budgetary allocation for health and other development sectors like education were way below what these sectors needed (I.F.4.2). These were the sectors that 'government has to prioritize, not for this generation, but for the future generation. If they don't do it, whatever we tell about Primary Health Care is all lost' (I.F.4.2). They also referred to the delays in release of budgets (I.F.1.2).

A senior DoCM-SPH faculty said that Indians were still slaves to an 'English mentality' (I.F.1.2). Questions raised locally would not be given any heed till the time some international journal raises them. 'We feel we are helpless, being controlled by somebody sitting in Washington, New York or Switzerland. There is no "originality" in what we are doing' (I.F.1.2). He said that people neither had capacity, nor interest to advocate for PHC. And if at all there were some such people, the policy makers, under the influence of international agencies, would not listen to them. PH or CM persons present in high-level meetings where such decisions get taken would generally concur with what has been

proposed, or keep mum. This, they do, either out of fear of being reprimanded, or to score a point in the eyes of the senior officer. The faculty asked what was the use of learning ‘Odds ratio, multiple logistic regression, EpiInfo, SPSS’ if one just had to remain silent (I.F.1.2). Frustrated, he said, ‘why should we be even thinking and discussing Primary Health Care’ (I.F.1.2).

Another senior faculty from DoCM-SPH told about a fundamental flaw. He said that the understanding about PHC in India, unlike in the West, didn’t develop from the ground. Referring to the establishment of Primary Health Centres, he said ‘It was a decision taken at the top and then implemented, like creation of CM departments’ (I.F.1.12).

The faculty called PHC ‘a good idea’. To say that it failed would be incorrect. It never took off (I.F.1.2). He also called it a ‘paper horse’. ‘Theoretically, everything was solvable...not practically’ (I.F.1.2).

### Theme III: Terminology

‘What’s in a name? That which we call a rose by any other name would smell as sweet’, wrote Shakespeare. The same could be said about terms like Comprehensive PHC, Selective PHC and Universal Health Coverage. But, as explained in Chapter 1, each of these terms has a context; they actually differ in their meaning; and the meaning has had serious implications on the policy. How subsequent approaches differ from Comprehensive PHC can be appreciated only when one understands Comprehensive PHC as it was laid out in Alma-Ata Declaration. When the faculty were asked about their opinion on this shifting terminology, many of them found the terms same or similar. Some found the ‘name’ irrelevant because the situation on ground had remained the same. A few could see the difference between these approaches, and could also refer to the factors that led to the shifts. The Researcher acknowledges that this theme, to an extent, is based on ‘information’. However, this is only one of the eleven themes on which the overall understanding about PHC has been assessed.

Farthest Response	Closest Response
<i>They saw Comprehensive PHC, Selective PHC and Universal Health Coverage as basically same.</i>	<i>They appreciated the differences between the three approaches and also contextualized the shifts.</i>

### **Set-1 (n=2)**

The faculty considered PHC, Selective PHC and Universal Health Coverage (UHC) as same (I.F.4.1). Another faculty said that it was difficult to comment on UHC because it was yet to be implemented (I.F.2.9). She took it as a question on the success or failure of an approach rather than on the approach itself.

### **Set-2 (n=15)**

This set of faculty also considered the three approaches as same, but had more to say. 'What is there in Primary Health Care? That everybody should get (the basic services). You have to cover all...(which is same as) universal (health) coverage' (I.F.1.1). They saw the same four principles<sup>4</sup> of PHC and the same goal of 'Health For All' in all these approaches (I.F.1.8, I.F.1.10, I.F.2.2, I.F.2.4, I.F.3.8, I.F.4.2, I.F.4.8). Some of them felt that the approach had become more organized and structured over time, and that the scope has got broadened (I.F.4.2, I.F.4.6). One faculty also explained the 'cube' of UHC (I.F.2.1).

The faculty saw change in terminology as a marketing strategy; as repackaging the 'old wine in a new bottle' (I.F.1.10, I.F.3.8, I.F.4.7). 'When one approach didn't work, they changed the name, hoping that now it would work' (I.F.3.8). Another faculty thought this was done to 're-emphasize the same concept again and again' (I.F.1.6).

The faculty opined that it was more important to understand the essence of the approach and to implement it rather than giving it one name or the other (I.F.3.8, I.F.4.6, I.F.4.7).

### **Set-3 (n=11)**

This set of faculty also viewed changing terminology largely as 'repacking', 'rebranding', and a 'way of creating that excitement' (I.F.3.1). They also considered these approaches as having same underlying principles and objective (I.F.3.1, I.F.4.5). However, they found UHC to be somewhat different. They saw it as more comprehensive and having a higher focus on 'affordability', on reducing 'out of pocket expenditure' by using insurance mechanism (I.F.2.3, I.F.3.5, I.F.4.5). One of them, however, thought that UHC lacked an emphasis on the role of other sectors in health (I.F.3.1).

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<sup>4</sup> Park's textbook of Preventive and Social Medicine mentions Equity, Community Participation, Inter-sectoral Coordination and Appropriate Technology as the four principles of Primary Health Care



### **Set-4 (n=8)**

A DoCH faculty saw Selective PHC as a case of ‘missing the wood for the trees’ (I.F.4.10). Another faculty from SNSPH-DoCM accepted that use of a selective approach led to certain problems, but ‘some of those things were probably required because of the (limited) finances you had available for health’ (I.F.3.2). He saw little use in ‘theoretical criticism’ of different approaches. He believed that what happened was helpful, though much more could have been achieved. A faculty found the use of the word ‘comprehensive’ as a prefix for PHC as unnecessary. He would say, ‘Don’t you think that Primary Health Care is inherently comprehensive? Will it become more comprehensive by adding “Comprehensive”?’ (I.F.1.4)

With regards to UHC, faculty opined that it had left a lot of scope for private providers (I.F.1.2, I.F.3.2, I.F.4.10). A senior faculty from DoCM-SPH could see a clear shift in government’s approach towards health after the liberalization-privatization-globalization of early 1990s, and saw the incorporation of insurance in UHC as a continuation of that (I.F.1.2). A DoCH faculty shared that instead of strengthening the healthcare infrastructure in public sector and taking a comprehensive view of health, UHC was aiming to just ‘cover’ the hospital expenses through an insurance approach (I.F.4.10). For this reason, he was ‘uneasy’ with the term ‘coverage’ as against ‘care’. He further added that UHC approach didn’t have any space for engaging communities (I.F.4.10). A DoCM-SPH faculty stressed that even UHC could be achieved only by strengthening PHC, and not by building hospitals (I.F.1.4).

### **Set-5 (n=2)**

Two faculty from DoCM-SPH explained the shifts in approach over time along with the ‘socio-political and contextual factors’ that led to these shifts (I.F.1.3, I.F.1.12).

### **III.5.1 (Comprehensive) PHC to Selective PHC**

The faculty shared that the (comprehensive) PHC approach propounded at WHO-UNICEF’s international conference at Alma-Ata was soon argued out for being well-intentioned but too ambitious. Many countries of the world were just emerging from colonial domination and were still trying to stabilize themselves politically and economically. Comprehensive

PHC was too much to do with the limited resources available with such countries. And so, the Selective PHC approach proposed by the likes of Walsh and Warren had many takers.

The faculty also talked about the change in the power dynamics of global health policy making that would have facilitated this shift in approach. Halfdan Mahler was the Director General of WHO from mid 70s to late 80s. Apart from directly pushing the concept of (comprehensive) PHC, he had been instrumental in bringing policies on breast milk substitutes and essential drugs. Furious with such anti-market policies, the United States of America had started withdrawing its financial support to the WHO. This made Mahler an unpopular person within his own organization. Around the same time, James Grant, an ardent supporter of selective approaches, took the reins of UNICEF and launched GOBI-FFF. So, the same organizations which had pushed for (comprehensive) PHC, were now convincing the countries to launch vertical programs against selective health issues.

### **III.5.2 Selective PHC to UHC**

The faculty informed that successive Oil Crises of 70s had badly affected the already poor countries. In such times, 'the one who gives you loan also determines the policy' (I.F.1.3). And that's how the World Bank started pushing for liberalization of economy and advocating for cost-effectiveness in social sectors including health sector in the name of 'reforms'. But soon it was realized, even by World Bank itself, that the selective approaches and the reforms were not working, and that any and every program would require a robust general health system to be successful. And so, the discourse once again changed to 'revitalizing' PHC. The countries were also now in a better position than in 1970s to invest in comprehensive measures.

The faculty shared that the professionals and activists within India echoed the change in international thinking. Coincidentally, the political scenario in Delhi changed and several small political formulations got a voice in the Union government. This synergy resulted in formulation of NRHM in 2005. Later, going with the global experience, the new National Health Policy (2017) saw UHC as the way to achieve Health for All. Consequently, *Ayushman Bharat* program got launched with one component of financial protection through insurance and another component of Health and Wellness Centres.

## Theme IV: Community Participation

Community Participation is one the key tenets of PHC as is reflected from its definition itself ('essential healthcare...made universally accessible to individuals and families in the community through their full participation...'). In fact this was what most distinguished PHC approach from its predecessor - the Basic Health Services approach (Mahler 1986). Participation of the community has to be sought in the entire planning cycle: right from assessment of health needs, to prioritizing the needs, figuring out an appropriate intervention to address the priority needs, mobilizing resources, implementing the intervention, monitoring and modifying the strategy. It calls for respecting the community, its knowledge, values and practices, and recognizing its potential.

When the faculty were asked about their opinion on this theme, all of them found it important. However, the reason why they found it important varied across faculty. Besides the rationale, the faculty also talked about the mechanism through which community participation was being ensured, and the challenges involved in the process.

Farthest Response	Closest Response
<i>They found Community Participation important because it improves acceptance of services.</i>	<i>They believed that community is capable to identify most of its problems, figure out their solutions and arrange resources to implement those solutions.</i>

### Set-1 (n=1)

A faculty shared that forum of Patient Welfare Society at Primary Health Centre as a mechanism for community participation. While the fund allotted to this Society could be spent only with the consent of the Society members, he said, 'as a Medical Officer, we know the needs of the people, what are the schemes to be implemented, and how can the fund be spent for the welfare of the people. So, we explain to them (Society members), and they accept, they sign it' (I.F.2.6).

### Set-2 (n=7)

The faculty called the community as 'the most important stakeholders' (I.F.4.8). If programmatic decisions are taken in consultation with the people, and regular feedback is taken, the program would be successful. Otherwise, people may not accept it. The

community also develops a sense of ‘ownership’ when it is involved. ‘They think that the centre and the hospital belong to them’ (I.F.3.3).

A faculty from DoCM-TSI recalled the important role played by *Panchayat* during Pulse Polio Immunization rounds, and how the educated people in community (like teachers and post-masters) helped in the DOTS program (I.F.2.2). Another faculty from this department remembered how a commitment from *Panchayat* to supply water on alternate days instead of once in four days changed the practice of storing it, and thus, helped in vector control (I.F.2.5). A DoCH faculty referred to Citizen’s Charter and the mechanism of *Rogi Kalyan Samiti* (RKS) which could be, and were being, used by the community (I.F.4.5).

A young faculty from DoCM-SPH, however, opined that community participation was only ‘in paper’. ‘The community is not actually empowered, not informed properly to take the necessary actions’ (I.F.1.9).

The DoCH faculty shared the problems they sometimes faced from community’s side (I.F.4.5, I.F.4.8). The women would show little interest in Cervical Cancer screening program till they developed symptoms. The picture of a big Cusco’s speculum inserted for internal examination, and presence of male staff around would make the matter worse. The community would ask for a super-specialty clinic, but then, would not turn up in adequate numbers on the day of the clinic. Individuals would revert to unhealthy habits even after undergoing highly sophisticated life-saving medical procedures.

### **Set-3 (n=15)**

#### **IV.3.1 Why is Community Participation important?**

The needs of the community may be different from what experts think (I.F.4.4, I.F.4.6). For instance, mending an open drain in the village may be more of their concern than some disease specific intervention (I.F.1.8). They may want something like a master health check-up which the experts may never have thought of (I.F.4.6). At the same time, while the experts may see a toilet in the house as offering privacy, sanitation and convenience, the community may not still accept it if supply of water is an issue (I.F.2.8).

While technical issues can’t be left on the community, its involvement otherwise makes healthcare delivery effective and smooth (I.F.1.6, I.F.2.1). This was especially true in the

preventive and promotive domain. For instance, use of tobacco products cannot be controlled only by enacting a law (I.F.1.8).

Several faculty expressed that it is ultimately the community which has to utilize the services. If they do not accept what healthcare system has to offer, the program is a failure (I.F.1.1, I.F.2.3, I.F.2.4, I.F.2.7, I.F.4.4). So, not involving them is 'not going to be right' (I.F.2.3).

And then, the community may contribute resources in the form of logistics and even infrastructure for health activities (I.F.1.6, I.F.1.7). Involving community leaders lends credibility to such initiatives (I.F.1.6).

### **IV.3.2 How the Faculty were ensuring Community Participation?**

Clinical interaction offers an opportunity to involve individuals and families in decisions related to their health, like making contraceptive choices (I.F.1.1, I.F.2.1). Such individual interactions also tell a lot about the needs in the community and the gaps in service delivery (I.F.1.1). Sensitizing the community on health issues using locally popular media and involving their leaders was another way that faculty used (I.F.1.6, I.F.2.1).

Faculty appreciated the idea of developing individuals from the community as health volunteers, like the cadre of ASHAs. The familiarity of these volunteers made the health services like institutional delivery more acceptable (I.F.1.1).

Faculty mentioned Community Need Assessment Surveys as a tool to help in setting targets (I.F.4.4). Involving community while preparing Health Action Plans was another method to gather and incorporate community's viewpoint (I.F.2.4). 'When they come forward to make the plan, they feel empowered. They feel, yes, it is our job to do' (I.F.1.7).

Faculty talked about Village Health Nutrition and Sanitation Committees (VHNSC) and Patient Welfare Committees established under NRHM as the formal mechanisms for community participation (I.F.1.4, I.F.1.6, I.F.1.10). However, these forums were not functional everywhere. While at some places they were working 'mechanically' (I.F.1.6), at other places, they were simply 'defunct' (I.F.1.4).

DoCH faculty shared the functioning of their Village Health Committee at CHTC (I.F.4.6, I.F.4.9). 'They have a say in what programs we run, how we run, when we run, how often should we run, what we need to add to the programs. And they are the ones who convey the felt needs of the community to us' (I.F.4.6). One of them also mentioned about the women's SHGs formed by the department. Two faculty of DoCM-SPH had also formed similar committees in their respective field areas (I.F.1.4, I.F.1.7).

### **IV.3.3 What challenges did the faculty see?**

The faculty shared challenges faced by forums like the VHNSC and RKS (I.F.1.6, I.F.1.10). The officials were not proactive in involving the community members. They were not making the community members aware about their role in the forum. Consequently, the members would narrowly see it as a committee which has to approve the expenditure of a fund coming from above. 'They don't know it is their right to see if ANM is coming or not, whether the ASHA is doing her job or not; (that) they can question the functioning of Primary Health Centre...Sub-centre...(that) it is ultimately their money' (I.F.1.10). They were often not aware about how even that fund was to be used. Further, the suggestions given by the community members were seldom acted upon because of which they would gradually lose interest. Also, there were delays in release of funds, and its mis-utilization. And then, nobody was monitoring what was happening in these forums.

At times, the community would be in a confrontational mode. For instance, a faculty recalled the resistance posed by ill-informed parents regarding the Measles-Rubella campaign (I.F.1.6). Then, there would be individuals who would try to make a mountain out of a molehill (I.F.2.1). And, at times, it might not just be possible to accept what community says (I.F.2.4). But the solution to all such issues, the faculty opined, was 'dialogue' (I.F.1.1, I.F.1.6, I.F.2.1, I.F.2.7). Though, the community would be interested in any dialogue only when they feel that the needs expressed by them would be respected (I.F.4.6). Further, the community should be 'enabled' to accept change (I.F.2.8). Another faculty underscored the importance of 'persistence' while dealing with communities (I.F.4.9). Earlier when she would advice village women having NCDs to walk daily, they would just refuse for the fear of being ridiculed. This attitude changed over time.

## Set-4 (n=9)

### IV.4.1 Why is Community Participation important?

The community was seen by this group of faculty as 'rich' and capable. Referring to the approach used by Drs. Prakash and Mandatai Amte at Hemalkasa, a SNSPH-DoCM faculty said, 'They learned from the people what their needs were, what were their requirements, what were their priorities' (I.F.3.5). Another faculty from the same department said, 'Who knows my house best? It's me...Somebody from outside cannot tell me what is the problem in my house' (I.F.3.8).

A DoCH faculty shared the story of a patient from the Mental Health Clinic (I.F.4.11). While the clinic staff ensured that she adhered to the treatment, it was the support extended by the community that helped her recover. 'One fellow gave her a calf, another fellow helped her construct a small home, somebody gave door, and somebody else gave windows'. Later, she learnt tailoring at the Department's centre. When she wanted to start a tailoring centre in her village, the SHG she belonged to gave an interest-free loan, the land-owner reduced the price, and the project could arrange some sewing machines and fund for furniture from Rotarians.

Another DoCH faculty shared the story of how the two Village Elderly Centres (GHK), which they had established under a project, sustained even after the funding stopped (I.F.4.7). 'We thought, let's go to the community. Let's seed an idea in their head.' The elderly were able to mobilize resources from the milk dairy and from the *Panchayat*. One of them got ready to give space to run the GHK. 'They were able to do it because they were experiencing the program. They knew what it was like' (I.F.4.7).

### IV.4.2 How the Faculty were ensuring Community Participation?

A faculty from SNSPH-DoCM said that community participation means 'we involve them in planning, we make our plan specific to their context, we ask them what should be done, our services should be according to their needs' (I.F.3.10). He, and others, saw RKS and VHNSCs formed under NRHM as one way to ensure community participation.

The faculty from DoCH talked about their CHWs who were all from the local community and could tell the background details of every patient (I.F.4.2). A faculty linked the lesser stigma

for mental illness in his project area to the fact that the project was led by these CHWs (I.F.4.11).

The DoCH faculty also talked about Women's SHG. Initially, it was difficult even to bring these women out of their homes for meetings. But with time, they got 'empowered'. They were meeting regularly now, and in fact, they would invite the department people to come and talk about a particular topic that they themselves would have decided. They were extending financial as well as non-financial help to their members. The DoCH faculty also informed about Parents' support groups that would serve as a platform for sharing information about government schemes regarding special children (I.F.4.2).

DoCH faculty also talked about the Village Health Committee at the CHTC (I.F.4.1, I.F.4.2). The department shares its work and plan with the committee to get a go-ahead. 'They are a part of all our decision making' (I.F.4.2). 'They (committee members) know what's happening there, and they ask us to do something about it' (I.F.4.1). A faculty shared an incident when *Panchayat* people got together, used the bus provided by the department and went around neighbouring villages to spread awareness about Dengue (I.F.4.1). A faculty admitted that 'we require that community network for us to function well'. At the same time, she also said that 'in years to come, I envisage these groups to be functioning on their own, without us facilitating, and we shifting to a new area' (I.F.4.2).

One of the DoCH faculty distinctly believed in making oneself familiar with the community by deliberately coming out of the clinical setting, meeting people and shaking hands and clicking selfies. This was his way of 'demystifying medicine' (I.F.4.11).

#### **IV.4.3 What challenges did the faculty see?**

The faculty saw loopholes in the functioning of RKS and VHNSCs (I.F.1.3, I.F.3.10, I.F.4.7). The reason why these mechanisms were not performing well was that the members were not made aware about their role except to spend the fund. (I.F.3.8). The field staff would develop a 'comfort zone' and would conduct meetings only in villages where people were forthcoming (I.F.3.10). There was a lack of monitoring and supervision of the functioning of these forums (I.F.3.8). 'Are we truly doing those things the way they are supposed to be done? Or is it just being done because it is supposed to be shown on paper' (I.F.4.7).



One faculty from DoCM-SPH took a broader view and said that efforts to ensure community participation were weak not just in health but in general. He informed that while 73<sup>rd</sup> Constitutional Amendment gave recognition to *Panchayati Raj* Institutions, the capacity of *Panchayats* to manage issues like health was not built. At the same time, the bureaucratic counterparts (Medical Officers, in case of healthcare) were also happy not to partner with people 'outside their domain' whom they think were 'not technically competent' (I.F.1.3). And so, many times, it would be just a register which rotates in the name of meeting (I.F.1.3). Moreover, even if such forums were functional, the members would place demands like organizing specialist clinics in the village, which might not always be justifiable (I.F.3.10).

A more fundamental concern expressed by some faculty was that healthcare was often not a priority for the community (I.F.3.5, I.F.3.7, I.F.3.10). This might be because they had more basic needs, like food (I.F.3.7). Going a layer above, a DoCM-SPH faculty brought-in the role of overarching societal values in this regards. While paying for personal healthcare was considered 'natural' by people in India, those in, say UK, would fight for their National Health Service (NHS). He quoted a study by Amartya Sen and Jene Dreze which found the proportion of editorials covering health in leading Indian dailies to be in decimal. Contrasting this with the situation in UK, he said 'there is not a day when there is no criticism against the NHS in the newspaper.' Consequently, 'there is a continuous community pressure on the system to perform', and also, health becomes an electoral issue in those countries. But then, a faculty shared, as such form of participation would go against the interests of those sitting at the top, they would keep people distracted with things which are non-issues (I.F.4.7).

Faculty from SNSPH-DoCM stressed on the need to make the community understand the immediate relevance of health in addressing other priorities, and its long term benefits (I.F.3.7, I.F.3.10). Based on his experience, the faculty found this possible to do (I.F.3.7). He said he could see the difference between the people from the area where Department had been working for years, and those from other areas. When the community understands, it starts taking ownership (I.F.3.7). Once this stage is reached, it becomes all the more important to make the healthcare system receptive to what the community says (I.F.3.10).

However, this line of thinking can develop only when the external actors first ask themselves whether it is community's priority or their own (I.F.3.5).

## **Set-5 (n=6)**

### **IV.5.1 Why is Community Participation important?**

The faculty of this group considered that 'communities understand their issues, and they also think and plan how, within the given circumstances (and) resources, they can best promote health and prevent disease' (I.F.1.12). 'If they could find ways to deal with different problems that arise in the family, they could also deal with health' (I.F.3.6). In fact, the community may find better solution. A faculty shared example of a market association in the city which, contrary to the approach of the municipality, decided to bear the cost of managing the parking space and keeping it free for the customers (I.F.1.2). This solution worked well as more customers preferred this market over others. Another faculty was witness to how the elderly could mobilize resources to sustain their care centres without any external funding (I.F.4.10). So, 'the discourse should be on public empowerment. People are themselves capable' (I.F.1.2).

### **IV.5.2 How the Faculty were ensuring Community Participation?**

A SNSPH-DoCM faculty shared how the department initiated the *Kisan Vikas Manch* (Farmers Clubs) in late 90s. The faculty first asked the members of the club what they wanted. When they expressed the need to know how to increase crop yield, the faculty got them trained in new farming techniques that helped them improve their earnings. Some of the club members got together and started co-operative farming, and later, started their own small enterprises. This entrepreneurial spirit was there in them; the department just 'catalysed' the process. The faculty began talking about health only after that felt need of those people was catered to. 'If we say that we don't care what happens to your farming, but we want you to listen to our health messages and keep on abiding by them...that's not going to happen' (I.F.3.1).

Another faculty from the SNSPH-DoCM gave example of *Mahila Melava* (Women's gathering) where the women were left free to decide what they would want the faculty to discuss (I.F.3.6). In one of the field visits, the Researcher could see a senior faculty from the

department quietly sitting with a group of village folks and listening to what they had to say about operationalizing the concept of early childhood development in their village (I.F.3.2).

However, the faculty were not very appreciative of the way NRHM's 'communitization' was being operationalized. 'It (has) just remained on paper' (I.F.3.2).

### **IV.5.3 What challenges did the faculty see?**

A SNSPH-DoCM faculty called the community participation that he had seen in his UG and PG department, and in an NGO he was associated with, as 'a nominal kind of a thing'. 'They go to a community, and they provide some services, and the community avails those services' (I.F.3.1). His idea of community participation was 'when people themselves decide regarding what they want, and then mobilize resources for that and act upon that' (I.F.3.1). A DoCM-SPH faculty, similarly, saw community participation as involvement of communities in planning, monitoring, and evaluation (I.F.1.12). The faculty opined that it was essential to develop such an understanding of this concept among the UG and PG students (I.F.3.2).

The faculty shared that community might have felt needs more basic than healthcare, and so, they might get concerned about health only when somebody actually fell ill (I.F.1.6). In such a scenario, he stressed on making the community realize the importance of prevention; and, to set them free to decide for themselves, with some support for execution of those decisions (I.F.1.6).

A faculty from DoCM-SPH cautioned that everything that community says might not be acceptable (I.F.1.2). Moreover, the local power dynamics might sometimes make 'community participation' counterproductive. For instance, in case of selection of Community Health Volunteers, influential people in the village would get their candidates selected even when they might not be the best choices (I.F.1.2).

With regards to the formal mechanism like VHNSCs, a faculty shared his disappointment with the inordinate delays in fund transfers. 'It will come in the first week of March, and they have to show expenditure by 31<sup>st</sup> March' (I.F.3.2). This would discourage even the active committees.

## Theme V: Inter-sectoral Co-ordination

The understanding of health, as reflected in the Alma-Ata's PHC approach, goes beyond mere absence of disease. Even within the domain of disease, the understanding goes much beyond the proximal (bio-medical) causes and remedies. As per the PHC approach, health sector is only one of the many sectors that have a role in attainment of health. The health professionals first need to realize the importance of other sectors; next, they need to make professionals in those other sectors realize their role in health; and then, all of them need to work in a coordinated manner so as to attain that holistic ideal of health.

When the faculty were asked their opinion on this fundamental principle of PHC, they invariably agreed about its desirability. Many of them also gave illustrations of how it was already happening at different levels, what were the challenges and how these could be surmounted.

Farthest Response	Closest Response
<i>They considered inter-sectoral coordination as desirable, but didn't have much to say.</i>	<i>They appreciated the role that sectors other than healthcare have in health.</i>

### Set-1 (n=3)

The faculty recalled having worked with ICDS (*Anganwadi*) and with Schools during their Primary Health Centre days (I.F.2.2, I.F.2.6, I.F.2.9). They didn't find it easy to coordinate as every department had its own commitments (I.F.2.6). But as it had been possible to work with these two departments, the faculty opined that coordination could be established with others as well, if needed (I.F.2.9).

### Set-2 (n=2)

The faculty said that coordination was difficult to establish even within the health sector itself. But if those at the top had the will, this could be done (I.F.2.7). To stimulate that will, one could undertake research and show how coordination helps (I.F.2.7).

### Set-3 (n=14)

#### V.3.1 Why is Intersectoral Coordination needed?

The faculty in this set considered inter-sectoral coordination important because health department alone couldn't do all that was required for health (I.F.1.1, I.F.1.8, I.F.4.3, I.F.4.4). Departments dealing with water, food, sanitation, housing, education etcetera also had a

role to play, especially for long term health gains (I.F.1.10, I.F.2.8, I.F.3.3, I.F.4.9). Sharing a conclusion of his PG thesis, a faculty said that households having a patient with respiratory problems needed to be brought under *Ujjwala Program*<sup>5</sup> on priority so that they could shift to smokeless kitchens (I.F.3.6). Besides, inter-sectoral coordination would also prevent wastage of resources by merging similar activities across departments (I.F.1.8).

A few faculty, while acknowledging the role of other sectors in health, were not convinced that health people could do something to invoke that (I.F.2.4, I.F.2.8). They believed that the responsibility of health department was to provide health education on preventive aspects, treat illness and control the spread of diseases (I.F.2.8). Beyond this, 'it has to come from individual sectors' (I.F.2.4).

### **V.3.2 How is Intersectoral Coordination happening?**

The faculty informed about inter-departmental meetings periodically happening at State and District level under the chairpersonship of Secretary and Collector respectively where issues requiring support from other departments would be sometimes discussed (I.F.1.6, I.F.1.8, I.F.3.10). Meeting were also being held between specific departments for specific purposes, like those between the health and urban local bodies during vector breeding season. However, these mechanisms were not being fully utilized (I.F.1.6).

Inter-sectoral coordination at the grassroot level was attempted through forum like VHNSCs, or similar committees formed by the departments in their field areas (I.F.3.5, I.F.4.9). For instance, DoCH faculty were presently coordinating with the Village *Panchayats* on the issue of Solid Waste Management (I.F.4.9).

The linkage with other sectors may also be established for a limited period for a specific purpose. For instance, a faculty informed how they were collaborating with the Department of Agriculture and Animal Husbandry for a project on Zoonosis (I.F.3.3). Coordination with *Anganwadi* staff and Schools was cited by all faculty.

### **V.3.3 What are the challenges in Intersectoral Coordination?**

The faculty said that the first challenge was a lack of initiative from the side of health people (I.F.1.1, I.F.1.6). 'Nobody wants to go and coordinate' (I.F.1.1). While personal ego could be

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<sup>5</sup> *Ujjwala Yojana* is a Government of India's scheme to provide LPG (Liquefied Petroleum Gas) connections to BPL (Below Poverty Line) Families (<https://pmuy.gov.in/>)

one reason, a faculty also thought, ‘we don’t want others to take credits for what we can get credit for’ (I.F.1.6). For instance, the health department would want to take credit of controlling malaria by detecting and treating maximum number of cases when collaborating for prevention through environmental measures would have made more sense. Another faculty gave example of a government owned company in his home State that was entrusted to purchase and distribute India Made Foreign Liquor in the entire State. He suspected that Doctors were consciously kept away from the board of this company because, being concerned about health of the people, they would not (completely) be in favour of selling alcohol for revenue. He said that health people may have similar hesitations. ‘They may actually see that these people (from other sectors) may be threatening to the group’ (I.F.1.9).

While the faculty referred to inter-departmental committee meetings at various levels, they shared that participation of different departments in such forums was poor (I.F.1.8). Moreover, inter-sectoral issues would rarely get discussed in those platforms (I.F.3.6). Even if an issue was raised, departments would end-up blaming each other, leaving the issue unresolved. For instance, a faculty shared that the Primary Health Centre where he worked used to get one or two casualties every month because of crocodile attacks on women who went to wash clothes near the river. To prevent such attacks, the concerned department had constructed a *ghaat* six years back. But the responsibility to lay the pipeline rested with some other department, and it was not happening. This issue was raised the Collector’s meeting but couldn’t be sorted out (I.F.3.10).

#### **V.3.4 How can Intersectoral Coordination be improved?**

A faculty said that ‘we need to keep “health” as the central idea in all the departments’ (I.F.3.10). They suggested different ways to do so: having a written MoU with other departments (I.F.1.1, I.F.1.8); having an earmarked contact person in other departments, like the Health Officer in the Municipal Corporation (I.F.1.1); forming inter-departmental committees at district, State and National level, where they do not already exist (I.F.1.10); monitoring the activities of inter-departmental committees to see who all attend the meetings, what gets discussed and decided, and whether the concerned departments implement the decisions (I.F.1.6). The faculty said that the top level bureaucrats and politicians need to be convinced regarding the importance of inter-sectoral coordination, so

that they keep these mechanisms functional (I.F.1.10, I.F.3.6, I.F.4.4). And, any successful model, at any level, should be projected so as to inspire others (I.F.1.10). One faculty suggested having a separate department with the sole responsibility to establish coordination and to ensure health in all policies (I.F.1.1). Another faculty went quite upstream and suggested that this thing required a focus during the formative years of ME to tell the students that ‘look, you need to go beyond. Health is affected by so many things’ (I.F.4.3).

## **Set-4 (n=10)**

### **V.4.1 Why is Intersectoral Coordination needed?**

The faculty saw health as being multi-factorial, and said that health personnel alone would not be able to do everything. A faculty gave example of *Taluk*-level hospitals of a district which had very low footfalls despite having adequate infrastructure and human resource (I.F.4.6). She, as part of a team, figured out that it was the poor road network because of which patients were not able to reach these hospitals. In situations like these, one would have to reach out to the concerned department. Another faculty brought in the concept of ‘One Health’ where the scope would extend beyond just human health (I.F.3.8). This would call for even wider coordination. Yet another faculty opined that interacting with other sector would enrich one’s own understanding about health (I.F.4.11).

Talking further on the issue at *Taluk*-level hospitals, the faculty said it was true that doctors, or the health department, were not responsible to build roads (I.F.4.6). But they should be able to figure out that the hospital attendance was low because of poor roads, and not because there was some problem with the hospitals. ‘You need to look at the bigger picture’ (I.F.3.7). And then, it was equally important to set the other sector ‘thinking about health’ (I.F.4.1). Those doctors should be able to advocate for improved roads with the concerned authority (I.F.4.6). Only with such coordination would the ‘ultimate definition of health’ be realized (I.F.4.11).

A SNSPH-DoCM faculty said that this concept had to be understood at a ‘philosophical’ level, and that ‘it’s more of a calling’ (I.F.3.7). However, another faculty from the same department, referring to the operational limitations of doctors, said, ‘we cannot, and we should not try to, open all the locks with the same key’ (I.F.3.8).

## **V.4.2 How is Intersectoral Coordination happening?**

The faculty referred to mechanism like VHNSCs through which personnel of other departments could be reached out (I.F.1.4, I.F.3.8). One of them had formed a similar committee, having members from sectors like Education and Public Works Department, in his field areas (I.F.1.4).

A DoCH faculty, who was working for community-based rehabilitation of differently-abled children, shared that getting these children enrolled in a regular school was an important part of her rehabilitation (I.F.4.2). She would periodically train the teachers on how to deal with special needs of these children. Once, when the project had to supply a set of physiotherapy and stimulation equipments, she let the Department of Education earmark the schools. Other faculty also shared about working with Schools and with *Anganwadi* centres.

## **V.4.3 What are the challenges in Intersectoral Coordination?**

### **The issues with the people in Health sector**

The faculty said that the first problem was lack of a broader perspective on health among the health people. For instance, a faculty shared that 30-40 percent people with diabetes would also have depression. If such a patient presented with non-specific aches and pains to an Endocrinologist, he would do everything except making a referral to the Psychiatrist. He would not realize that the aim shouldn't be only to bring the sugar-levels down (I.F.4.11). The same would be true for many CM people also (I.F.3.7). Secondly, there may be already enough to do within the boundaries of health sector that they can't go beyond, even if they realize the need to do so (I.F.3.8, I.F.4.5). Thirdly, ego could prevent health people from reaching out to others. 'Why should I ask?' (I.F.4.8).

### **The issues with the people in Other sectors**

The other sectors may not understand why they should invest their resources for health. A faculty shared his experience from Plantations where the profit-minded management would ask such question (I.F.4.1). So then, he would show them how many man-days they would save if the labour didn't fall ill. He also shared his experience with the Education Board which took years to realize the need for introducing a chapter on NCDs for the school children. 'I think it is persistence which is required, a hard-headedness of going and again



and again telling them “this is important” (I.F.4.1). Secondly, other departments may be too busy with their own stuff to be able to collaborate. Though, a faculty called this a ‘commonly given excuse’ (I.F.3.7). Thirdly, it may do with credit sharing. Person in other sector may think, ‘(even) if I do, he (health person) will take away the credit’ (I.F.4.8).

#### **V.4.4 How can Intersectoral Coordination be improved?**

The faculty said that inter-sectoral coordination would first require people to come together, and this could be ensured by administrative heads at various levels (I.F.3.8). At the District level, it could be the Collector, and at the Block-level, it could be the Block Development Officer (I.F.3.8). However, somebody from the health side would still have to take the initiative of placing the issue for discussion in these forums (I.F.4.5). The faculty also acknowledged that the administrative effectiveness would vary from person to person (I.F.4.5, I.F.4.6). There was no answer regarding what was supposed to be done if the administrator didn’t act.

Another faculty opined that, somehow, the system should be made into ‘a fine web’ that forces everybody to work together (I.F.4.8). In short-term, she suggested imposing penalty if coordination didn’t happen. Overtime, she hoped, the mindsets would change and people would realize that it's for the larger good (I.F.4.8).

### **Set-5 (n=9)**

#### **V.5.1 Why is Intersectoral Coordination needed?**

The faculty were convinced that most of the determinants of health were outside the health sector (I.F.1.2, I.F.3.1, I.F.4.7). ‘They are to do with road, water, power, rights, livelihood, land, caste...all that’ (I.F.4.10). Health was just a ‘reflection’ of what was happening in these other sectors (I.F.3.1). The same was true, to an extent, for healthcare services. For instance, if a lady in labour was not able to reach hospital in time because the road she took was bumpy, there was little that the health sector could have directly done (I.F.4.7).

Most of this is not in the hands of doctors; they only bear the brunt of its absence (I.F.1.2, I.F.2.1, I.F.4.7). Doctors could focus only on secondary prevention and a little bit on primary prevention. ‘As health personnel, I have no authority or power over the water provision. I can only say what water you get, you make it safe. Boil and (drink)’ (I.F.2.3). That was why,

inter-sectoral coordination is necessary (I.F.2.1, I.F.4.7). ‘Unless they all provide some facilities for healthy living, it is difficult for the medical people to do anything further’ (I.F.2.3).

Lack of such coordination may also lead to wastage of resources because of duplication. A faculty recalled how several NGOs were distributing tarpaulin to the same set of flood victims, while these people were not getting other relief support (I.F.4.7). And at times, such lack of coordination may lead to a mess-up. For example, an enthusiastic charitable organization painted the walls of *Anganwadi* centres clean and bright. But in the process, they, unintentionally, removed the colourful and stimulating paintings that had adorned the walls earlier (I.F.4.7).

One faculty in this set, while in favour of bringing an ‘attitudinal shift’, was very clear that the primary task of a doctor was to diagnose and treat (I.F.4.10). They may not be comfortable going too far beyond this mandate because that was not what they had been trained for. As citizens, they may do that. But to expect them to do so as a part of their profession would be an over-expectation (I.F.4.10).<sup>6</sup>

### **V.5.2 How is Intersectoral Coordination happening?**

A SNSPH-DoCM faculty shared how the department had facilitated training of Farmer’s Club members in new farming techniques by collaborating with people from local agriculture school (I.F.3.1). Two DoCH faculty shared how they were trying to bring the Health Department and the Social Justice Department together for implementation of National Program for Health Care of the Elderly (NPHCE) (I.F.4.7, I.F.4.11). They also told how the elderly themselves had mobilized resources from different sectors to sustain their Village Elderly Centres when the project funding stopped. A DoCM-TSI faculty shared that she had been contemplating to initiate some informal dialogue with the City’s Development Authority regarding healthy housing (I.F.2.3). Faculty also talked about collaborative work between health department and ICDS and Schools (I.F.1.7, I.F.2.1).

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<sup>6</sup> Interestingly, the Division of Humanities of the same institute (St. John’s) runs a Citizen-Doctor program so as to groom medical students as informed citizens besides being sensitive doctors.

### **V.5.3 What are the challenges in Intersectoral Coordination?**

#### **The issues with the people in Health sector**

A senior DoCM-SPH faculty said that even if Doctors could appreciate the need to go beyond, they would still think that it was somebody else's domain (I.F.1.12). And even if some of them wanted to go beyond, they would be lacking in competencies to do so. They would not be comfortable doing something that involved 'talking to others, advocating and canvassing' (I.F.1.12). Faculty from SNSPH-DoCM said that doctors were more egoistic than anybody else (I.F.3.1, I.F.3.2). 'When we are trained as a doctor, we are given a kind of superiority complex that we are better than others. The problem lies there' (I.F.3.2). So, the Psychiatrists wouldn't collaborate with Counsellors. The Obstetricians and Anaesthetists would oppose training MBBS graduates in Emergency Obstetric Care (EmOC) and Life-saving Anaesthetic Skills (LSAS) (I.F.3.2). The faculty went on to say that 'professors in Community Medicine, who otherwise will talk about inter-sectoral co-ordination, but on the table, when they are with other people...they have not been able to shed that superiority complex' (I.F.3.2). Everybody is 'guarding the territory'; 'barriers are in our mindsets' (I.F.3.2).

#### **The issues with the people in Other sectors**

The faculty acknowledged how the work done by other departments was having a positive impact on health. For instance, improvement in road network was enhancing people's access to healthcare facilities. But these benefits were incidental. 'Nobody is thinking of health as part of their planning or part of their work' (I.F.2.3).

When approached specifically for health-related collaborative work, people in other sectors would think: 'it's their work, why should I get involved'; 'where are my objectives reflected in it'; 'what will I get' (I.F.1.7). They don't realize that it is ultimately for a public cause (I.F.2.1). The typical bureaucratic mentality of avoiding responsibility, being defensive and keeping oneself safe would make the coordination more difficult to establish (I.F.1.2).

#### **Overarching Issues**

A faculty expressed that the difficulty in establishing coordination was basically a problem of perspective. 'In all our bits, in all our lives in fact, it's a target based approach that we are following. We would like to do what we are reviewed on' (I.F.4.7). One would not be able to think about going beyond while having such narrow perspective.

Secondly, co-ordination was often lacking at the upper echelons (I.F.2.1, I.F.4.7). Given the top-down culture in administration, the same attitude trickles down.

#### **V.5.4 How can Intersectoral Coordination be improved?**

A senior DoCM-SPH faculty referred to human body as the best model to understand how inter-sectoral coordination could be established (I.F.1.7). The simple act of eating food, for instance, involves coordination between the nervous system, the musculo-skeletal system and the digestive system. And, at the end, every system gets nutrients and energy. So, the system has to be designed in such a way that its actors are inter-dependent. To work together is not left as a choice, but is set as a default way to work (I.F.1.7).

Secondly, it has to be seen as a 'partnership', and not as one actor directing the other. It is important to self-reflect on one's role in the partnership rather than trying to dominate (I.F.3.1). The roles should be clearly defined and all the actors should have the means to fulfil this role; and there should be clear channels of communication in place (I.F.1.7). The faculty shared how he had set a system of regular medical check-up of children coming to *Anganwadi* Centres in co-ordination with the ICDS department. While the department would provide its PG students and vehicle, the CDPO would prepare monthly roster and make local arrangements (I.F.1.7).

Thirdly, each actor should have something to gain from the collaboration (I.F.1.7). This would include sharing credits for the collaborative work. He gave the example of organizing a cancer screening camps in a village for which he formally acknowledged the *Sarpanch* and others in the press brief. He also applauded the *Sarpanch* in front of the local MLA. These soft skills were the 'crux' of getting inter-sectoral coordination (I.F.1.7).

The faculty opined that those at the top of the hierarchy, the Secretaries and Directors, need to imbibe this approach first before expecting the peripheral staff to work in synergy (I.F.2.1, I.F.4.7). Also, they need to de-emphasize the target-based approach so that people could think beyond (I.F.4.7). Another faculty called for an orientation of the political leadership on issues like health, environment etcetera, and their inter-linkages (I.F.2.3). This would help in making health central to the overall planning.

However, ‘it’s not that you can get a perfect system at any anytime, at any point, in any country’ (I.F.2.3). Even then, the doctors need to develop a holistic view of health and develop that ‘mental attitude’ (I.F.2.3). Though they may not do anything about it, all doctors should understand how other sectors are important for health (I.F.3.2). They should not stop at prescribing medicines, but should be sensitive to go ‘a little beyond’ (I.F.4.10). And a section of them, especially the CM people, should proactively push for ‘Health in All Policies’ by learning how to work with others (I.F.3.2). Even small working models of inter-sectoral coordination at local level may inspire larger change (I.F.3.1, I.F.4.7).

While recognizing the role of other sectors in health, a senior DoCM-SPH faculty reflected that the purpose would get adequately served ‘if every person just does his own work sincerely...the civil engineer does his work, the health worker does his work, and the doctor does his work’ (I.F.1.2).

## Theme VI: Decentralization

Controlled decentralization to the level of District had been an important component of PHC approach (Mahler 1986). By ‘controlled’ was meant an oversight of a broad national health policy. But given its emphasis on involvement and empowerment of community right from need assessment, planning, implementation and monitoring, it may be inferred that PHC approach means much more when it talks about decentralization.

When asked about their views on ‘Decentralization’, the faculty invariably appreciated the concept. Many could also give reasons behind this appreciation, and the challenges involved in decentralizing.

Farthest Response	Closest Response
<i>They found decentralization important, but didn't have much to say.</i>	<i>They believed that the staff working in the periphery know the local context better, and so, should be heard and allowed to take decisions</i>

### Set-1 (n=1)

The faculty said that the same program may face different challenges while being implemented in different communities. So, it was better to decentralize (I.F.2.6).

## **Set-2 (n=4)**

A faculty said that a decentralized approach saves time as one doesn't have to every time wait for inputs from above (I.F.2.2). Another faculty supported this approach from a different vantage point. They thought that inputs for planning should come from below because every area has different requirement (I.F.4.8).

A faculty hailed NRHM for allowing program targets to emerge from below (I.F.4.4). However, given the 'Indian mindset', the faculty opined that some minimum targets need to come from above, and that there should be an oversight (I.F.4.4). 'Why would you do it if you are left to yourself?' (I.F.4.8).

## **Set-3 (n=16)**

### **VI.3.1 Concept**

The faculty considered decentralized planning better because the needs and challenges of each area would be different (I.F.2.8, I.F.2.9,). The feasibility of program implementation improves when the perspectives of peripheral functionaries are heard and local context is taken into account (I.F.1.8, I.F.2.7, I.F.3.3, I.F.3.8, I.F.4.1, I.F.4.5). To convey that decentralization helps the periphery in making quicker response, a faculty gave the corollary of spinal reflexes in human body (I.F.1.7). However, everything can't be decentralized (I.F.1.8). And even for what can be decentralized, a broad guideline from central authority, allowing enough flexibility, was desirable (I.F.2.8).

Though decentralization was desirable, there were certain limitations and challenges. The Constitution of India has defined the level of policy making by classifying issues into Union, State and Concurrent lists. The extent of decentralization could, at best, be within these boundaries (I.F.1.2). But even these boundaries were often not respected. Despite Health being a State subject, practically, 'many things are governed by Centre...there are lot of infringements' (I.F.1.8). For instance, well functioning State-specific health insurance schemes were being subsumed under Prime Minister's *Jan Arogya Yojna* (I.F.1.9). However, at the same time, the States want to add as minimum as possible to the budget that they get from the Centre (I.F.1.2).

At times, decentralization would complicate the matters as it would expose the peripheral staff to local politics (I.F.1.9, I.F.4.5). The process of selection of ASHAs was given as an example. So, to fully realize the gains of decentralization, larger reforms at societal level were needed (I.F.1.9).

### **VI.3.2 Initiatives under NRHM**

Several faculty referred to decentralized process of preparation of Annual Action Plans and Program Implementation Plans (PIPs) starting from village-level as proposed under NRHM. However, they shared that it was not always getting translated into practice. Practically, at most places, the process was starting at the District-level or above (I.F.1.1, I.F.3.6). Even this would take a long time, which would lead to inordinately delay the sanction and disbursement of funds for the next financial year (I.F.1.8, I.F.2.9). Also, the innovative ideas coming from periphery would often be diluted or disregarded by the central levels, which would discourage the people from investing energies in this process in future (I.F.1.8). So, despite these initiatives, a large part of what the periphery would do was still being decided centrally (I.F.2.7).

The faculty also referred to the provision of untied funds proposed to peripheral facilities under NRHM (I.F.2.9, I.F.4.5). One of them had herself experienced the relief this brought while working at a Primary Health Centre (I.F.2.9).

## **Set-4 (n=13)**

### **VI.4.1 Concept**

The faculty favoured decentralization because needs and challenges varied from place to place. A faculty said, 'India is a country where every hundred kilometers, the dress changes, the language changes, the food habits change, the culture changes. So it is difficult to have a one size fits all policy for a country like India' (I.F.4.9). Sharing her field experience, a faculty informed that while for one district, Vector-borne diseases were a major health problem; NCDs were more of a concern for the adjacent district (I.F.4.2). Another faculty shared findings of a gap-assessment study she was part of where health services in one district suffered because of a poor road network, while the issue in a neighbouring district was that of human resource (I.F.4.6). Yet another faculty told how different two groups of elderly, living in two nearby villages, were in terms of their expectations from the Village Elderly

Centre (I.F.4.10). Similar views were expressed by other faculty (I.F.2.1, I.F.3.7, I.F.3.10). As the staff working in the periphery would know the local context much better, their perspectives needed to be heard while making guidelines (I.F.4.2). And these guidelines need to have flexibility to adapt as per the local situation (I.F.4.9).

Another reason in favour of decentralization, given by DoCM-TSI faculty, was that when people are given freedom, they come up with new things and perform much better (I.F.2.1). 'When you are able to discuss issues, and alter, modify as per your needs...if you are able to have that flexibility...that all would help...Decentralization would be *more satisfying*' (I.F.2.4, emphasis added).

A third view was that decentralization was a more 'democratic', a more 'inclusive' way of doing things (I.F.3.5, I.F.3.7). A 'bottom-up' approach was even more important when it came to health (I.F.3.5). Centralization, on the other hand, was 'autocratic' (I.F.2.4).

However, decentralization was not easy to execute. It would require more efforts, more trainings and more monitoring (I.F.2.4). Even before these operational challenges arise, there has to be a willingness at the central levels to decentralize, and at the periphery to accept it, which may not always be the case. A faculty, for instance, shared that each State had its own food culture; and based on this, they would come-up with their own ways to deal with the issue of malnutrition (I.F.3.2). But when the Central Government issues a guideline, they usually forego their own innovations.

#### **VI.4.2 Initiatives under NRHM**

The faculty appreciated the decentralized process of annual planning that began under NRHM. This enabled States to come-up with innovative ideas, like 108 Ambulance which came from Andhra Pradesh and was subsequently adopted/adapted by several other States (I.F.2.2). A faculty opined that this form of planning also made the peripheral staff more accountable. 'When you ask for money for a specific program, you also have to report on that. Your target is your own target' (I.F.4.2). Recalling his experience of working at a Primary Health Centre, a faculty said that the fact that their inputs were considered while making the District Action Plan was in itself an empowering thing (I.F.3.10).



The faculty also appreciated the provision of untied funds under NRHM which had given ‘a little bit of leeway’ to the peripheral staff and enabled them to tide over those ‘small hitches’ that would earlier trouble them (I.F.2.4, I.F.3.10, I.F.4.2, I.F.4.6).

## **Set-5 (n=4)**

### **VI.5.1 Concepts**

The faculty considered that taking ‘one size fits all’ decisions centrally was an ‘oversimplification of things’, and it may not satisfy the local requirements (I.F.1.6). Implementing such decisions may, in-fact, take more time and may lead to wastage of resources. For instance, a State decided to launch Mission *Indradhanush* in all its districts, including the ones which already had full immunization coverage of more than 85% (I.F.1.3).

At the same time, success of decentralization depended on the preparedness, and willingness, of the periphery (I.F.1.3, I.F.1.6). The guidelines framed for a decentralized system would be broad and a lot would be left open for peripheral staff to interpret and decide. The enthusiastic people would tend to take advantage of this openness, with some of them even exploiting it for personal benefits (I.F.1.3). Others would see this as ‘lack of clarity’ (I.F.1.3). And fearing ‘objections, inquiries and audit’, they would avoid taking any risk (I.F.1.6). At times, such information would be consciously withheld by those located more centrally so as to retain the power (I.F.1.6).

### **VI.5.2 Initiatives under NRHM**

The faculty hailed NRHM for decentralizing the planning process. This had empowered the States, Districts, Blocks and Villages to propose initiatives as per their need. So, while one State may ask for vehicles, another one may ask for human resource, and a third may ask for infrastructure. The salary offered to Medical Officers may vary within the same State, depending on the remoteness of the district (I.F.1.3).

A faculty recalled his days as a PG student at a rural Primary Health Centre where the Medical Officer would not have the authority to even get a bulb changed. With provision of untied funds, NRHM had made things lot better (I.F.1.3).

## Theme VII: Integration

Failure of the vertical approach in controlling diseases like malaria was one of the factors that shaped the context of Alma-Ata Conference on PHC. The Declaration and the related report of the conference talked about integration of health and development; integration of single-purpose programs into general health system; and integration of various levels of healthcare system through a referral mechanism. The approach also called for comprehensive services, not limited to health sector.

When the faculty were asked about their opinion about 'Integration', everybody found it desirable. Many of them also pointed out the problems arising because of an un-wise integration. Some faculty clarified that there was nothing like complete integration and talked about a 'mixed' or a 'diagonal' approach.

Farthest Response	Closest Response
<i>They saw integration as a better approach, but didn't have much to say.</i>	<i>They believed that reasonable integration between programs bring efficiency in the system and makes the services comprehensive for the beneficiary.</i>

### Set-1 (n=3)

The faculty found a horizontal integrated approach better than having vertical program (I.F.2.5, I.F.2.6, I.F.2.9). While working at Primary Health Centres, they had seen different programs being implemented in an integrated fashion by the same set of grassroot health workers (I.F.2.6).

### Set-2 (n=6)

The faculty agreed that having dedicated staff for a program would lend more focus on it (I.F.2.7, I.F.2.8), and that vertical programs were also easy to monitor (I.F.3.3). But they felt that integrated approach was better as the work could be done in a more coordinated manner (I.F.2.7, I.F.2.8, I.F.3.3).

At the grassroot, the same health workers were distributing ORS packets to diarrhoea cases and taking blood samples from fever cases. So, the programs were integrated at that level (I.F.4.5). However, having to handle multiple programs was burdening the peripheral staff (I.F.4.5).

Moreover, such integration was not seen in all aspects and at all levels. For instance, the surveillance system for NCDs was running separate from that of communicable diseases (I.F.1.9). While NRHM gave an impression of integrating everything, but still, it had a lot of verticality (I.F.2.7).

### **Set-3 (n=10)**

The faculty in this set believed that whether a program should be vertical or horizontal depends on the requirements of the program (I.F.1.8, I.F.3.5, I.F.3.6, I.F.4.9). It would not be wise to integrate programs on diseases like HIV-AIDS as it could compromise the confidentiality of the beneficiary (I.F.3.6). And most programs would need to be vertical in the initial phase (I.F.1.8). But otherwise, it was better to take a horizontal approach (I.F.1.8, I.F.3.5, I.F.3.6, I.F.3.10). A faculty used the scenario of a Sub-centre to explain the relevance of integration. The ANM would be well aware of the condition in the villages; she would be repeatedly going there and she would have developed a rapport. So, it made sense to route different programs through her rather than keeping separate staff for each (I.F.3.10).

Another explanation in favour of integration was that it made the services comprehensive (I.F.2.3, I.F.4.11). If a health worker treated the diarrhoea of a child but missed the cough which the mother didn't find important to mention at that time, the child might develop pneumonia and die. That was why the idea 'Integrated' Management of Neonatal and Childhood Illness came up (I.F.2.3). A DoCH faculty informed that the clinic conducted under the mental health project was not a clinic for mental illness alone. It catered to any illness/health condition that those people might have. 'When the same face, which is talking about mental health issues, also talks about diarrhoea and fever, the clinic is not seen as a "clinic for the mad people"' (I.F.4.11).

The faculty also shared the flip side of integration. It may burden the peripheral workers beyond their capacity, which may be counterproductive for all the programs (I.F.3.5, I.F.3.10). Secondly, in a set-up where the same set of staff was supposed to implement every program, if the people at the top focussed only on one or two programs, everything else would badly suffer (I.F.1.1, I.F.2.2). A faculty shared the example of Pulse Polio Immunization rounds that would affect the routine immunization and other MCH services as

the staff could do only so much (I.F.1.1). In comparison to this scenario, a faculty opined that it would be better to keep dedicated staff for priority problems (I.F.2.2).

#### **Set-4 (n=12)**

A faculty opined that when the PHC set-up was not strong, one had to adopt a vertical approach for implementing every program (I.F.1.6). This approach would also be needed if the disease/PH issue to be tackled was serious and of a big magnitude (I.F.3.7). As a vertical approach would ensure more focus, any program would require it in the initial period (I.F.2.4, I.F.4.4, I.F.4.6, I.F.4.8). But this approach was resource intensive (I.F.2.4, I.F.4.4). So, once the problem at hand had been brought down so much that it was no longer a PH threat, or when the PHC set-up had improved to a certain level, the program should be integrated (I.F.1.6, I.F.2.4, I.F.3.7, I.F.4.6). This would lead to appropriate utilization of resources by avoiding duplication (I.F.1.4, I.F.1.6, I.F.4.3, I.F.4.4, I.F.4.8, I.F.4.10). Though, at the same time, even vertical programs contribute towards health system strengthening (I.F.1.6). For instance, even if an ANM had been going in the community only for immunization, the rapport that she had built over time would help all other programs of the future.

The faculty saw the transition of a vertical program to a horizontal one as a critical process. Integration would expectedly dilute the intensity of the program by making it one among the many things that the general health system does (I.F.2.4, I.F.4.4). So, if it was done prematurely, before the problem had come down to a very good level, integration might be counter-productive (I.F.2.1). Secondly, the general health system staff had to be prepared to take this new responsibility. Similarly, the staff getting released from the vertical program would have to be accommodated. If this change was not managed carefully, the gains achieved so far might get reversed. The faculty gave the example of the national program for Leprosy in this regards (I.F.2.1, I.F.3.7).

The faculty clarified that there was nothing like 'complete' integration (I.F.1.6, I.F.4.2, I.F.4.3). While different programs may be integrated at the level of implementation, they would have to 'branch-out' as one went higher up. Specific people would be required to monitor and supervise specific programs.

Another argument in favour of integration was that it would allow people to access everything at one point or through one person (I.F.2.1). For instance, the same ASHA would be implementing all the programs in her area (I.F.4.3). Similarly, the CHWs hired by DoCH under different projects were delivering services across projects (I.F.4.8). While this approach sounded good, it may have unintended consequences. A faculty recalled her experience of working in an urban health post when the government kept ‘adding and adding and adding’ one program after the other, and how it affected the general quality of work (I.F.2.4).

Another issue was that when too much was loaded on the same set of people, ‘whatever the top bosses are monitoring, (only that) becomes important to them’ (I.F.2.4). ‘They do not have time to do everything...if this month is dedicated to NCD, they do NCD’ (I.F.4.4). Many faculty used the example of Pulse Polio Immunization rounds to convey how focussing too much on one program affected the routine services (I.F.1.6, I.F.4.2, I.F.4.4). ‘During the Pulse Polio, the entire health machinery is put only for pulse polio. So, your family planning program goes down, your infectious diseases...you go to those centres, nothing is happening except for pulse polio’ (I.F.4.2). The faculty opined that without adequate human resource, and its planning, integration was difficult (I.F.4.3, I.F.4.4).

One faculty referred to ‘integration’ in varying contexts (I.F.1.4). He called for integration of humanities in ME. He referred to integrated medical teaching in which different aspects of a topic would be covered by different departments in the same, or closely spaced, sessions. This would ensure that the students get a ‘holistic’ view of the topic, and not a ‘piecemeal’ one. He also called for integration of different systems of Medicine (Allopathy and AYUSH).

### **Set-5 (n=7)**

This set of faculty talked about a ‘mixed’ or a ‘diagonal’ approach instead of going for a vertical or horizontal one (I.F.1.3, I.F.1.7, I.F.3.1). In its initial phase, a program needed dedicated attention, and so, had to be vertical (I.F.1.3). This may consume more resources, but it would be necessary to do so initially (I.F.3.1). Once the program got stabilized, and the problem it aimed at addressing somewhat came under control, it could be integrated with the general health system to bring operational efficiency (I.F.1.3, I.F.3.1). How and when to integrate, should be a part of the plan right from the beginning (I.F.3.1). But even after

integration, the program would have elements of verticality as it would require dedicated people for supervision and monitoring (I.F.1.3, I.F.1.7).

In order to explain the need for integration, a faculty took the case of an elderly person having diabetes and also some mental health issue (I.F.4.7). There were three different national programs to cater to this individual: the one for the Health Care of the Elderly (NPHCE), the one for Mental Health (NMHP) and the one for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS). These programs needed to talk to each other for the sake of that elderly person, but that was not happening (I.F.4.7).

Taking example of NPCDCS, a faculty explained how a new program could 'verticalize' an existing integrated set-up (I.F.1.3). NCD patients were already being seen by the general physicians. But after NPCDCS, they were expected to go to the 'NCD clinic' located in the same compound. On one hand, the general physicians would not be happy referring their patients. And on the other hand, the staff recruited for the NCD clinic would not do any other work even if the Superintendent asked them as they were answerable to their NPCDCS program officer. Just co-locating the NCD clinic in an existing healthcare facility was not 'integration'.

At times, programs would be designed in a vertical fashion to achieve quicker results in order to conform to internationally set timelines. Such programs would badly impact the routine health services. 'What western countries achieved over 100 years, we are expected to achieve in a few years' (I.F.3.2). But then, it would also be inappropriate not to participate in global efforts to get rid of a particular disease. The right thing to do according to the faculty was to increase the resource allocation so that such vertical programs could run, and simultaneously, horizontal strengthening could also happen. He opined that 'as your regular health services strengthen, the need for vertical programs reduce' (I.F.3.2). But the issue was that while resource for vertical programs would come readily, those for strengthening of regular health services would not (I.F.3.2).

Integration, however, may not always be a good approach. 'It was a good idea at that time that Bhore Committee said "ok let us have integrated thing (Clinical and Public Health services)". In the long run, integration did happen but integration gravitated more towards bio-medical side of the things. And Public Health side of the things was left out and suffered'

(I.F.1.12). In order to maintain a balance between the two, the faculty suggested having separate verticals for Clinical and PH services. Though, they needed to closely collaborate (I.F.1.12).

Integration at the level of implementation without taking a realistic look at feasibility could lead to inefficiency. A faculty found it impractical to expect the Medical Officer of a Primary Health Centre to handle everything - clinical, administrative and preventive and promotive (I.F.1.12). Other faculty shared that even the field staff faced similar problems. Every new thing was being dumped on them. 'Loading everything on ASHA is not integration' (I.F.4.7).

Absence of dialogue between different programs made things worse. The program planners would devise recording and reporting mechanisms in silos, leading to unnecessary duplication of work for the field staff (I.F.4.7). The program monitors and supervisors would be singularly concerned about the program that they were currently entrusted with (I.F.1.7, I.F.4.7). 'The TB fellow is coming and saying, "you do this"; MCH fellow is coming and saying, "you do this". The lady (ASHA) is tied down to ten different things' (I.F.4.7). Consequently, even the peripheral staff would function in a fragmented way. 'Integration is when various programs speak to each other' (I.F.4.7).

Further, if the staff was given specific tasks, like screening the population in her area for NCDs, or, to get engaged in a fortnight-long immunization campaign, she would not be able to do the routine work for all other programs. '(She) has a finite amount of time. And there will always be an opportunity cost for any other activity which you latch on to her' (I.F.1.3).

So, both approaches had a role and a set of challenges. The faculty opined that a close thought needs to be given regarding which approach was to be used when and where. There had to be dynamism in the system to switch gears instead of freezing one approach for all times and all activities. 'What this involves is good governance, which is a big problem' (I.F.1.3).

## **Theme VIII: Institutional Delivery**

Till a few decades ago, delivery at home by a *Dai* used to be the norm. The *Dai* would be a lady from the same locality whom the family would know, and trust. She would conduct the delivery using the skills she had learnt over the years by observing the older *Dai*, and would

impart the same to the younger one. In lieu of her service, she would be rewarded in cash and/or kind by the family. The pregnant woman would deliver in a familiar space amid familiar faces. This was a self-sustaining community-based mechanism to manage the process of child birth without any dependence on external agencies.

The government strengthened this mechanism by training and incentivising the *Dai*. The limitation of this mechanism was that if some complications occurred around the process of delivery, the *Dai* might not be able to handle them. This could, at times, be fatal for the mother and/or the baby. To minimize this risk, as the penetration of formal medical facilities and personnel increased, the government shifted its focus to institutional deliveries. However, in the process, it made every pregnant woman dependent on a not-so-friendly medical system. It exposed every lady undergoing delivery to a setting which was not always adequately provided.

When the faculty were asked their opinion on this issue, the responses ranged from seeing home delivery as frankly risky, to being able to recognize the positive things of delivering at home by a *Dai*.

Farthest response	Closest response
<i>They didn't see any advantages of delivering at home by a Dai. They saw this as risky.</i>	<i>They appreciated the advantages of home as a place of delivery and Dai as a birth attendant.</i>

### **Set-1 (n=4)**

The faculty considered home deliveries by *Dai* as risky (I.F.3.6); something that may lead to a lot of mortality (I.F.4.5). One of them, who had also done Diploma in Gynaecology and Obstetrics, said that the *Dai* 'try to make even the complicated (deliveries) to normal...they want to prove that they know better than doctors' (I.F.2.2). On the other hand, institutional deliveries were safe. And the government was providing many enablers for institutional delivery, like the free ambulance service and monetary compensation.

### **Set-2 (n=3)**

A faculty opined that while a section of trained *Dai* might have been doing good work, there were many untrained ones who were contributing to maternal mortality (I.F.1.3). He supported the blanket decision to discourage all types of *Dai* because it would have been



difficult to monitor the practices of each. Another faculty said that, even if trained, the *Dai* could not have managed all the complications (I.F.2.6). The faculty didn't think this affected the livelihood of *Dai* as most of them shifted to other tasks around the process of delivery (I.F.1.3).

On the other hand, there was evidence showing institutional deliveries to be safer. The government was also supporting this through AHSAs and other enablers (I.F.4.2). Moreover, with improvement in socio-economic status, education levels and general awareness, even the women and their families wanted the delivery to happen in a hospital (I.F.4.2). There were quality issues in institutional services, but this was the way to go (I.F.4.2).

### **Set-3 (n=15)**

#### **VIII.3.1 Home Delivery by *Dai***

The faculty considered that home delivery by a *Dai*, and training of *Dai* to do so in a safer way, was an intermediate solution for times when there were issues with availability and accessibility of institutional services (I.F.1.6, I.F.2.3, I.F.3.5, I.F.4.4). This was still needed in areas where these issues persist (I.F.2.3, I.F.2.7, I.F.3.8, I.F.4.1). But this was not generally the situation in most parts of the country now. So, why to promote home delivery when 'any delivery, anytime, can become complicated' (I.F.2.4)?

The faculty acknowledged that many developed countries were encouraging home deliveries, but said that India was not ready for that (I.F.2.8, I.F.4.4, I.F.4.9). When cleanliness of home could be ensured, when the birth attendant would become aware about when to refer, when there would be a well developed ambulance service, and when referral facility would become easily available, only then could one think of this.

A few faculty said that childbirth was a natural thing and it had been happening, for the most part of history, in absence of a trained modern physician (I.F.2.8, I.F.3.8). Similarly, a DoCH faculty, who had conducted a lot of deliveries during her PG, didn't find anything wrong in having delivery at home if basic hygiene was observed (I.F.4.8). But they found institutional delivery to be safer and better. 'People in the village were using bullocks for ploughing, but now tractors have come. Whether bullock was a better option or tractor, that is a different thing. As the world is changing, so we are changing' (I.F.3.8).

A DoCH faculty had studied why tribals, even in the present times, were not coming to hospitals for deliveries. He found reasons like not being able to practice their norms in the hospital, and loss of wages over the period of hospital stay (I.F.3.8). He opined that such issues need to be tackled to so as to ultimately bring the tribals to hospitals.

A DoCM-TSI faculty acknowledged that because of known surroundings and presence of family around at home, one would not feel so anxious (I.F.2.4). But she still found delivering at home to be 'quite scary'. She referred to the concepts of 'birth companion' and 'delivery hut' as a balancing act.

### **VIII.3.2 The idea of Institutional Delivery**

The faculty believed that hospitals provide aseptic conditions and trained people to conduct normal deliveries, and were in a better position to handle complications if they arise (I.F.2.3, I.F.2.8, I.F.3.5). They said there was clear evidence showing that focus on institutional deliveries was leading to reduction in maternal and infant mortality (I.F.1.1, I.F.3.3, I.F.4.1).

The faculty also talked about improved roads and transportation; increased availability of round-the-clock adequately staffed delivery points closer to home; about ASHAs who would accompany the lady; and the free ambulance service run by the government (I.F.1.1, I.F.1.6, I.F.2.5, I.F.2.8, I.F.3.8, I.F.4.4). The people themselves want institutional deliveries (I.F.3.5). 'So, why deny a mother and a child (these) facilities' (I.F.1.6).

### **VIII.3.3 The ground reality of Institutions**

The faculty admitted that decision to shift deliveries to institutions had put a lot of pressure on the system as it was still not prepared to handle this workload (I.F.1.1, .F.3.3, I.F.4.1). This was leading to a lot of quality of care issues (I.F.1.1). A faculty called for need-based referral from primary to secondary and tertiary facilities so as to somewhat manage the situation (I.F.2.4). However, they believed that things were getting better with time (I.F.3.3).

## **Set-4 (n=12)**

### **VIII.4.1 Home Delivery by *Dai***

A DoCH faculty shared having read in a book about *Dais* being able to revive babies by stimulating the placenta (I.F.4.6). A senior DoCM-SPH faculty, recalling his experience with

*Dai*, informed that they were indeed very capable (I.F.1.4). In addition, they used to have good rapport with the community. 'People feel free to contact them, and share the minutest detail with them' (I.F.1.8). Another faculty went on to say that the allegation that 'women delivered by *Dai* have complications' was more an opinion without any evidence-base (I.F.1.9).

A senior DoCM-SPH faculty linked the shift from home delivery by *Dai* to institutes with the overall move towards privatization in the decade of 1990s (I.F.1.2). That was also the time when computer, internet and mobile phones came on the scene, and everything was becoming 'fast'. Going the *Dai* way to lower the mortality was not 'fast'. And so, the *Dai* were 'suddenly abandoned like an illegitimate child' (I.F.1.2). The same international organizations which had pushed for training of *Dai* till then, declared that *Dai* were no more required.

A SNSPH-DoCM faculty saw the decision to shift from home delivery by *Dai* as an example of centralized planning (I.F.3.7). He agreed with all the arguments in favour of institutional deliveries but was concerned that the situation in smaller villages and tribes had not been considered. 'If I am in a tribal village in Melghat in Amravati somewhere, and I want to go to the closest health centre, I will probably have to go 50 kilometers, 60 kilometers. I may not have the means for it. Whereas my traditional health worker is available with me who has been delivering for years together now. And I have more faith there' (I.F.3.7).

The faculty from DoCM-SPH opined that it wasn't wise to abolish a cadre built over decades (I.F.1.9). If some of the *Dais* were bad, they could have been better trained. And technology could have been deployed to monitor them (I.F.1.9). The system should have utilized them in some way instead of completely abandoning them (I.F.1.4).

As is evident, the faculty in this set were not against the 'concept' of home delivery by *Dai*. Delivery was, after all, a 'natural' or a 'physiological' process and had been happening at home since antiquity (I.F.2.1, I.F.3.10, I.F.4.10). The comfort that the lady would feel delivering at home and the moral support which she would get from a *Dai* would not be there in the hospital (I.F.1.10, I.F.2.1). But for different reasons, they didn't find it advisable everywhere. Some of them were concerned about the standard of hygiene in and around rural Indian homes (I.F.4.3, I.F.4.10); others were not confident if *Dai*, despite her honest

intentions, would be able to detect and subsequently act if any complications developed (I.F.2.1, I.F.3.10, I.F.4.10). The developed world didn't have such issues to deal with, and so, it could encourage home deliveries (I.F.4.3, I.F.4.10).

The faculty supported the focus on institutional delivery as it has been able to reduce maternal mortality and morbidity (I.F.1.8). With rising level of education, even the women and their families felt safer in hospitals, and so did the health administrator (I.F.2.1). The government was also promoting institutional deliveries through ASHAs and schemes like *Janani Suraksha Yojna* (I.F.4.6).

#### **VIII.4.2 The ground reality of Institutions**

A faculty said that while it got decided to shift the place of delivery from home, the healthcare facilities were not prepared in terms of infrastructure and human resource to handle this workload. And so, the common people were 'left in the lurch' (I.F.1.2). He accepted that the situation has improved since then, but quality issues still remained. A faculty shared her personal experience of delivering in a government institute. 'Due to so much workload, everybody is stressed out...sometimes I feel that having a delivery at home is far better' (I.F.1.10). Another faculty shared similar feelings while recalling the obstetric violence he had witnessed in the labour room during his medical training (I.F.3.10). The faculty opined that it was because of these quality issues that the mortality rates had not fallen as much as expected despite a focus on institutional deliveries (I.F.4.6).

A more serious issue was the risk of unnecessary caesarean-sections, which was more in private sector institutions but was also there in public-sector (I.F.1.10, I.F.2.1). While the providers had a larger share of the blame to take, at times, even the family would ask for a caesarean-section based on the '*muhurat*' (auspicious time for the birth of the baby) (I.F.1.10).

The faculty were of the opinion that the approach need to vary with context (I.F.1.2, I.F.1.4, I.F.2.1, I.F.4.6). Instead of focussing solely on institutional deliveries, it would be better, in difficult areas, to have trained personnel who know when and where to refer, and having some sort of standby facility to immediately shift complicated cases to the nearest health facility (I.F.3.7). Seeing it as a matter of personal choice, a faculty called for strengthening of both the options (I.F.1.10). As a mid-way solution, a DoCM-TSI faculty proposed promoting

delivery at a facility closer to home (a Primary Health Centre), by a familiar person (an ANM who had been providing care to the woman during ante-natal period) in presence of a birth companion (a *Dai*) (I.F.2.1).

## **Set-5 (n=4)**

### **VIII.5.1 Home Delivery by *Dai***

The faculty acknowledged the advantages of home delivery. It would offer privacy, comfort and the lady would not be worried about her other children (I.F.1.7, I.F.3.1). All this would be missing in a hospital. Moreover, the home was not as infective as the hospital (I.F.3.1).

Two of the faculty had been personally involved in training of *Dai*. They testified that the *Dai* used to have a lot of experience, they used some natural birthing methods and many of them actually performed very well (I.F.1.7, I.F.3.2). More importantly, the *Dai's* word was respected in the community, and she would become 'part and parcel' of the family (I.F.1.7, I.F.3.1). This could be seen even in present times in tribal areas where people don't have any trust or faith in doctors and nurses (I.F.3.1).

The faculty also stated the limitations of the *Dai*. While acknowledging that there might also have been issues in the way they were trained, a faculty recalled reluctance among the *Dai* to change their practices (I.F.3.2). Moreover, maternal mortality statistics were not effective to impress upon them that the danger signs were really dangerous. 'Two hundred (deaths) in one lakh (live births) means two in a thousand, one in 500. If somebody (*Dai*) has conducted 200-300 deliveries, it's possible that none of those women died' (I.F.3.2). While agreeing that some of them did engage in malpractices (use of fundal pressure and uterine stimulants), another faculty said that the cadre was disproportionately defamed by the formal healthcare providers (I.F.1.7).

The faculty didn't think that disowning *Dai* was a good move (I.F.3.1). Instead of killing the cadre absolutely, the *Dais* should have been involved in the process in some way (I.F.1.7).

The faculty considered delivery as a spontaneous process, but said that it was difficult even for a staff nurse to predict and manage complications. So, 'the expectation that a *Dai* would be able to do that was wrong' (I.F.1.7). Thus, they acknowledged the role of institutional deliveries. However, they were concerned about the operationalization of this concept.

### **VIII.5.2 The ground reality of Institutions**

The faculty said that just having a delivery table, a light source and a bed didn't qualify a place to serve as a delivery point (I.F.1.7). It needed to have facility for the lady, and her family, to stay for a few hours before and after the delivery; and should be equipped to immediately transfer the lady in case of any complication. In reality, most of the delivery points didn't fulfil this 'philosophy' of institutional delivery. Even at the bigger centres, the staff would ask the lady presenting with pains to go back unless the delivery was imminent.

The faculty highlighted that focus on institutional deliveries had led to over-medicalization and rise in caesarean-section rates (I.F.3.2). And there was something still worse. 'The dignity of a woman that should be maintained during the process of labour...we have hugely compromised that, and we have made this experience of birthing a miserable one for every woman' (I.F.3.2).

The faculty opined that 'as long as we are able to ensure a safe delivery by a skilled birth attendant, hospital or home should not be a concern' (I.F.3.1). A faculty proposed 'a middle path' where deliveries would be conducted by trained para-medical staff, promoting natural birthing methods; and whenever required, arrangements would be in place to immediately shift the lady to a hospital equipped enough to handle the emergencies in time (I.F.3.2).

### **Theme IX: AYUSH-Folk**

Folk medicine, though informal, is an ancient form of medicine. It has emerged from and been developed by the indigenous communities over the centuries. They exist across the world and are still serving the local communities 'through their full participation', 'at a cost that community can afford' and 'in the spirit of self-reliance'. In addition, there are systems of medicine that originated from or built-up on the Folk medicine, or independently. They could get more formalized in terms of having texts and a teacher-learner method of training. In India, these have come to be identified as AYUSH that includes *Ayurveda*, *Yoga*, *Naturopathy*, *Unani*, *Siddha*, *Homeopathy* and *Sowa-Rigpa*.<sup>7</sup> These systems have a following across different classes of society. Together with Allopathy, these systems represent the plurality in medicine.

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<sup>7</sup> <https://main.ayush.gov.in/about-the-systems>

When asked about their opinions on AYUSH-Folk, the faculty responses ranged from being suspicious and disapproving to being appreciative and curious.

Farthest Response	Closest Response
<i>They didn't believe in AYUSH-Folk systems as these lacked strong scientific evidence.</i>	<i>They valued AYUSH-Folk; could appreciate that these (may) have a scientific basis; and talked about integrated medicine.</i>

### **Set-1 (n=2)**

The two faculty in this set didn't believe in systems other than Allopathy. I.F.2.9's distrust began while working at the Primary Health Centre where she found the AYUSH pharmacist mixing steroids in preparations dispensed to patients. I.F.3.6, on the other hand, thought that the efficacy of AYUSH remedies was not validated through research, as was the case with Allopathic medicines. He opined that the government shouldn't support these till there was evidence. Even I.F.2.9 was not in support of her State's decision to promote a ready-to-drink AYUSH remedy for Dengue as she thought it was leading to Kidney problems.

Interestingly, I.F.3.6 supported the idea of Bridge Course<sup>8</sup>. 'There is nobody to work in the periphery. If, with some training, they can at least tell who needs to be immediately taken to the hospital...they can save some lives.' But he called for proper regulation of the course. 'It should not happen that after doing Bridge Course, they come to the town and open their clinic.'

### **Set-2 (n=6)**

#### **IX.2.1 What do the faculty think about AYUSH-Folk?**

##### **AYUSH Practices**

This set of faculty acknowledged that a lot of people accessed AYUSH systems (I.F.1.1), and that many of the Allopathy doctors also prescribed AYUSH remedies (I.F.4.4). But they personally believed only in Allopathy, because it was evidence-based (I.F.4.9). They said that because they had not studied other systems, they didn't understand those (I.F.1.1). They had concerns about the quality assurance mechanisms of AYUSH medicines, but would let

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<sup>8</sup> Bridge Course refers to a proposed short-term training for AYUSH practitioners and Staff Nurses in primary care and Public Health so as to be placed as mid-level care providers at Sub-centres (<https://pib.gov.in/Pressreleaseshare.aspx?PRID=1526197>).

their patient take those as long as they were also following the Allopathy prescription (I.F.4.4, I.F.4.9). They were open for AYUSH to the extent that '(if) there are good studies showing that they (AYUSH remedies) are more effective, why not give the benefit to the community' (I.F.1.1). Though, they didn't need evidence for *Yoga* because it was more like a physical activity that would also manage the stress (I.F.4.9).

### **AYUSH Practitioners**

One of the faculty showed support for Bridge Course (I.F.4.2). Her logic was that if ANMs and ASHAs were allowed to give some basic Allopathy medicines, and when quacks were doing this without restraint, AYUSH practitioners were in a much better position to do so. Moreover, as many people sought AYUSH services, if these practitioners were allowed to also use some basic Allopathy for common ailments, this would increase the treatment options available to the patient. She found it unreasonable on the part of Allopathy doctors to be opposing Bridge courses when they themselves were not ready to serve in rural areas. Though she was in favour of having checks in place for the pass-outs of Bridge Course, she felt that irrational and unethical behaviour was prevalent even among Allopathy practitioners. However, she didn't think that Bridge Course pass-outs would be readily accepted in educated communities.

### **Folk**

The faculty were not in favour of Folk medicine. 'If an *Ayurvedic* doctor gives Paracetamol to a person with fever, I am ok with it. But if a bone-setter, who is not technically qualified at all, and is going to set a bone...I really don't know' (I.F.4.2). She also recalled having seen babies branded by such practitioners. Unlike Allopathy doctors, the folk practitioners were not 'accountable'. 'If the bone doesn't heal properly, people can go to consumer court and you are in trouble. But that doesn't apply to folk person' (I.F.4.4). The faculty thought that people went to such practitioners only for economic reason.

### **IX.2.2 How do the Faculty engage with AYUSH-Folk?**

Two faculty at DoCM-TSI recalled having AYUSH colleagues at Primary Health Centres where they had earlier worked; though, they didn't have much interaction with them (I.F.2.5, I.F.2.6). While they didn't see any folk healers during those years, they remembered having seen 'quacks'.



A DoCH faculty encouraged her patients having NCDs to do *Yoga* (I.F.4.9). A DoCM-SPH faculty was guiding a doctoral study looking at the effectiveness of an *Ayurvedic* preparation in anaemia through a Randomized Controlled Trial (I.F.1.1).

### **Set-3 (n=7)**

#### **IX.3.1 What do the Faculty think about AYUSH-Folk?**

##### **AYUSH Practices**

The faculty in this set were relatively more open to AYUSH. After all, ‘people are getting cured...’ (I.F.3.8). ‘You cannot cure hundred percent ailments through any one form of medicine’ (I.F.2.7). So, AYUSH remedies may have a ‘supplementary’ role wherever Allopathy didn’t work (I.F.1.8). Another faculty saw AYUSH as ‘a form of community participation’, though he found folk medicine debatable (I.F.2.7). One of them even said that these systems should not be called ‘alternative’ medicine (I.F.3.8).

One faculty had several questions related to these systems: Traditional herbs grow in a specific area and may be useful for the local community. How can they help people living in different environmental conditions? For commercial reasons, people would be growing these herbs outside their original habitat, and even using pesticides. Will they still be effective? And, how can these ancient systems come up with treatment for modern diseases? (I.F.2.8).

##### **AYUSH Practitioners**

A faculty, who had personally benefitted from AYUSH, said that ‘there are few things that we (Allopathy doctors) can do. There are few things others (AYUSH practitioners) are capable of doing’. But he was strictly against cross-practice. ‘That’s quackery by definition’ (I.F.4.11).

Others, taking a utilitarian view, supported deployment of AYUSH practitioners at peripheral facilities because this would fill the gap left by the Allopathy ones (I.F.1.3, I.F.3.8).

##### **Folk**

Based on his experience in a tribal area, a SNSPH-DoCM faculty said that those people had immense faith in their folk healers (I.F.3.7). He cautioned against out-rightly rejecting even dangerous practices like branding of young infants. Instead, one had to be slow and steady.

‘As a generation or two pass, as people start understanding better, as knowledge improves, those practices will stop’. He had also been witness to practices which didn’t appear to be harmful, and so, could be allowed.

Another SNSPH-DoCM recalled having seen patients coming with liver failure during his UG which, his seniors would hypothesise, was because they had consumed hepatotoxic remedies prescribed by their traditional healers (I.F.3.8). Though, he personally was not completely against traditional practices. He stressed on their validation before being allowed. He suggested involving AYUSH people or Botanists in such research. This faculty had got exposed to a few Chinese scholars in a Global Health Course who were doing research on their traditional medicine. ‘If China can do it, why can’t we?’

The faculty also highlighted the need for training of the folk practitioners so as to ensure standardization of their practice. Besides, these practitioners could also be trained in things like testing Blood Sugar. These practitioners were working in remote areas where there was no formal health system; and they enjoyed the trust of people. ‘Can we use that rapport of his?’ (I.F.3.8).

### **IX.3.2 How do the Faculty engage with AYUSH-Folk?**

A faculty recalled having a colleague from Siddha system of medicine while he worked in a Tribal Health Project during his PG (I.F.4.11). They used to refer patients to each other, and had developed mutual respect for each other’s system. However, he couldn’t recollect if those tribals were using any folk medicine.

## **Set-4 (n=11)**

### **IX.4.1 What do the Faculty think about AYUSH-Folk?**

#### **AYUSH Practices**

The faculty in this set were very much in favour of AYUSH, and many of them talked about integrated medicine. This belief was not based on the presence of strong ‘scientific’ evidence in favour of AYUSH. ‘(If) you are able to produce beneficial results, ok fine, I agree that I don’t understand (your system), but it seems to work’ (I.F.4.10).

A faculty explained a fundamental difference between Allopathy and AYUSH. While Allopathy focuses on the disease rather than on the person and has a universal drug of

choice, AYUSH systems try to understand the individual, and then, customize the treatment (I.F.2.2). Another faculty said that Allopathy was good for emergencies and for serious conditions, but it had a lot of side-effects (I.F.4.8). Yet another faculty said that Allopathy didn't have answers for many things, and so, alternatives need to be looked at (I.F.4.10).

The faculty recognized that even AYUSH systems have limitations. So, practitioners of all systems should be open to other systems. 'Ultimately, it is the patient who has to be cured' (I.F.2.2). The approach should be to find the best solution for the patient's problem irrespective of the system of medicine (I.F.1.4, I.F.3.5).

With regards to doctors who have hesitation for AYUSH, a faculty said 'the more you become educated, the more you become fixed in your ideas' (I.F.4.5). Another faculty opined that it was mainly the doctors in private practice who opposed other systems (I.F.3.3). But then, when such opponents get old and realize that Allopathy doesn't have solutions for many of their personal health issues, even they think about alternative systems (I.F.4.5). So, it is not right to call other systems as quackery (I.F.3.5).

Talking about the structural neglect faced by AYUSH systems, a DoCM-SPH faculty shared how little the government was investing in AYUSH. This was one reason why the National Institutes mandated to generate evidence for AYUSH remedies had failed to do so (I.F.1.4). Another faculty from the same department said that, even if weak, there was some research base in AYUSH systems which could be subjected to further experimentation. But there was a resistance for AYUSH research in Allopathy institutions (I.F.1.7).

### **AYUSH Practitioners**

While in support of AYUSH, a faculty opposed the idea of cross-practice (I.F.4.8). She called Bridge Course as a 'short-cut' approach, but still supported it as long as the pass-outs don't 'come to the city and become quacks' (I.F.4.8).

### **Folk**

There was a subset of faculty who believed in AYUSH, but were not supportive of Folk medicine (I.F.1.7, I.F.2.2, I.F.3.3). One of them considered home remedies as 'a part of our culture', but was opposed to Folk medicine (I.F.4.5). They fore-grounded the irrational claims made by folk practitioners and the tragic stories of their wrongdoings (I.F.3.3, I.F.4.5). However, they thought that banning such practitioners would only push things behind the

screen (I.F.2.2). Instead, they need to be sensitized. Given their accessibility, they were useful for the community. But they need to know their limits (I.F.4.5).

Another subset of faculty saw worth in Folk medicine (I.F.4.3, I.F.4.6, I.F.4.8, I.F.4.10). 'Just because I don't understand something doesn't mean there is no value in it' (I.F.4.6). They opined that even if there is no medical evidence, but if they have worked for people, they need to be respected (I.F.4.6, I.F.4.10). Taking example of Cinchona, a faculty said, 'many of the medicines are extracts from plants. So, if you can use the plant itself and get cured, why should you go and buy the hundred rupee tablet' (I.F.4.8). Regarding traditional bone-setters, she said 'even here (in Orthopaedic Department), if your hand gets dislocated, it's like a bone-setting only' (I.F.4.8).

They shared a simple classification system for such practices: probably beneficial, neutral or obviously harmful (I.F.4.3, I.F.4.10). The 'probably beneficial' and the 'neutral' practices should continue. In fact, it would be worthwhile to undertake research in the 'probably beneficial' practices (I.F.4.10). 'If there is evidence of its effectiveness, it will be embraced so much more' (I.F.4.3). And for the 'obviously harmful' practices, 'gently, you need to educate' (I.F.4.10). Even this subset of faculty was against the 'quacks' who did things without knowledge and experience, just to make money.

#### **IX.4.2 How do the Faculty engage with AYUSH-Folk?**

A faculty was himself doing *Pranayam* daily and was finding it beneficial (I.F.1.4). Two faculty said that they were making use of home remedies for simple complains like cough and cold (I.F.4.5, I.F.4.8).

Another faculty informed that he would often call *Yoga* expert to train patients in his field clinic as it was something that took one towards 'physical, mental and spiritual health' (I.F.1.7).

A DoCH faculty shared that a group of Interns had once done their project on utilization of AYUSH facility at the Sub-divisional Hospital (I.F.4.5). During the house-visits in the Rural CHAP, this faculty showed medicinal plants like *Neem* to the students in her group and asked those households if they made use of the same.

### **IX.4.3 What factors shape their outlook towards and engagement with AYUSH-Folk?**

One faculty claimed confidence in *Ayurveda* and Homeopathy because he had been exposed to these systems since childhood (I.F.1.7). With the same logic, indifference towards Folk medicine was attributed to lack of any personal exposure (I.F.1.7). A SNSPH-DoCM faculty gave a 'big yes' for AYUSH because she had been seeing patients getting benefitted by the treatment provided at *Arogyadham* (I.F.3.3).

One faculty found it important to clarify that his belief in AYUSH-Folk practices was not out of any love for the rich cultural heritage of the country. It was based on empirical evidence of their effectiveness.

A faculty opined that the attitude of doctors towards AYUSH-Folk was also shaped by the way they were trained in the MC (I.F.4.3). She gave credit to the discipline of CM for having opened her mind in this regard. A SNSPH-DoCM faculty recalled the words that *Vinobaji* used to say to every medical student - 'practice all pathies, including sympathy and empathy'(I.F.3.5).

### **Set-5 (n=12)**

#### **IX.5.1 What do the Faculty think about AYUSH-Folk?**

##### **AYUSH-Folk Practices**

The faculty in this set believed that every community, everywhere in the world, had the knowledge to keep itself healthy (I.F.2.3, I.F.3.2, I.F.3.10). Their healing practices empowered the people, not disempowered them (I.F.1.9, I.F.3.2). Those practices utilized locally available material and considered food as medicine (I.F.1.9, I.F.2.3). Every plant had medicinal value, and this belief would get reinforced through the culture of including them in religious and social rituals (I.F.1.10). These practices would be common knowledge in every family (I.F.1.10). But this 'treasure' of health, like the traditional knowledge in all other domains, was getting lost (I.F.1.10, I.F.2.4). This was because of the notion of modernity attached to Allopathy which got propagated first through colonization and then through globalization (I.F.1.10, I.F.2.4, I.F.3.10, I.F.4.1), and through 'active' de-legitimization of the 'traditional' (I.F.1.2, I.F.4.1). But still, 'lots and lots of people' followed these practices, and more and more were coming back (I.F.1.2, I.F.1.9, I.F.2.4).

The faculty shared that many of the concepts in Allopathy had been derived from traditional medicine, and that even in the present times, efforts were increasingly being made to isolate compounds from plants and animals traditionally believed to be having medicinal value (I.F.1.6). Moreover, Allopathy was not effective in many chronic conditions, like Asthma and Arthritis, where AYUSH remedies worked well (I.F.1.2, I.F.1.6, I.F.2.1, I.F.2.4). And even Allopathy practitioners were commonly using AYUSH preparations for certain conditions, like in liver disorders (I.F.2.1).

A faculty opined that a 'mature' system should have a comprehensive integrated approach. 'Whether it is a *Yoga* posture, or something in Naturopathy...if there is something that can help me, whichever practitioner I go to should be telling me about it' (I.F.3.2). Another faculty talked about the operational advantage of integration. When people start taking care of minor health conditions on their own, this not only saves their time and money, but also reduces the burden on the formal healthcare facilities which can then deliver better quality care (I.F.1.9).

The faculty acknowledged that AYUSH-Folk may appear 'unscientific' to those trained in Allopathy (I.F.3.2). But there were two issues here. Firstly what appears scientific today may be called unscientific tomorrow. For instance, many Allopathy drugs would be withdrawn after years of recommended usage (I.F.2.4). So, even AYUSH-Folk should be given this benefit of doubt (I.F.3.10). Secondly, it depends on what are the criteria of designating something as 'scientific'. A faculty quoted an AYUSH-Folk person he met in Ladakh. 'We might not have conducted the double-blind RCTs which is an epitome of research for you all in your modern medicine. But then, we have our own experiments through which the results have been demonstrated. We have observed this happening since decades, or centuries' (shared by I.F.3.1). Similar thoughts were shared by I.F.4.1.

This set of faculty also talked about 'evidence', but the intent was to increase the confidence in AYUSH-Folk practices rather than taking it as a pre-condition for acceptance (I.F.1.2, I.F.1.6, I.F.1.9). 'If these claims are scientifically tested, that would be such a boon to everybody' (I.F.1.6). One of them, while acknowledging the frauds that often happened in the name of RCTs, said that it was possible to test alternate remedies in this mode (I.F.1.2).

A faculty shared her dilemma as a decision maker. While she was personally convinced about AYUSH-Folk remedies, she found it difficult to allow it in policy, 'because we are tuned to this evidence-based (thing)' (I.F.2.1). She shared an incident where a researcher proposed to study the effectiveness of an AYUSH remedy for anaemia. In the preliminary lab investigations, a small percentage of mercury was found in the preparation. For this reason, the ethics committee couldn't clear the proposal.

The faculty were not of the opinion that everything in AYUSH-Folk was good (I.F.1.6, I.F.1.9, I.F.2.3, I.F.2.4, I.F.3.1, I.F.3.2, I.F.3.10). They were mindful of the wrong practices and the wrong people ('quacks') in those systems, and said that this bit had to be 'weeded-out'. But they pointed out that even Allopathy was not clean of such malice (I.F.2.4, I.F.3.2, I.F.3.10). So, 'each system needs to introspect how it can improve itself further' (I.F.3.2). Instead of positioning one system against the other, 'what is good should be sustained, and what is bad should to be gradually withdrawn' (I.F.3.10). One of the faculty compared the act of condemning other systems with that of condemning other religions. 'When a person says another religion is bad, my understanding is that he knows neither this religion nor his own' (I.F.2.4). She urged that 'let's not just close our eyes and say "no no no, Allopathy is the best"'. 'It's high time that we make our health systems inclusive' (I.F.2.4).

### **AYUSH-Folk Practitioners**

The faculty saw presence of AYUSH practitioners in such large numbers as an asset, and were in favour of their deployment in a healthcare system which was short of doctors (I.F.1.10, I.F.3.2). However, their views on Bridge Course varied. One faculty saw this as demeaning the other systems. 'Either you give them equal respect and promote them (AYUSH systems). And if you feel that they are useless, then close them (AYUSH Colleges). Why this double-speak?' (I.F.1.10). Another faculty supported the idea of building the capacity of AYUSH practitioners in prescribing some basic Allopathy medicines (I.F.3.2).

A faculty even saw value in people who were actually quacks (I.F.3.2) They might infuse saline and inject antibiotics without much thought. But, in absence of anything else, this might prove to be life-saving for a child suffering from diarrhoea or ARI. He hypothesized that presence of such practitioners might be responsible for the child mortality rates in States like Bihar to be not as high as they deserve given their extreme levels of socio-

economic backwardness. He was not supporting such practices. Instead, he was urging the system to recognize these practitioners, and build their capacities to provide limited and rational primary-level medical care.

### **IX.5.2 How do the Faculty engage with AYUSH-Folk?**

One of the faculty was using AYUSH remedies that could be externally applied for her joint pain rather than ingesting chemicals. She said that while a surgery might ultimately become necessary, she would first prefer a practitioner who could anyhow strengthen the joint (I.F.2.3).

A faculty informed taking classes for UG students on alternative systems of medicine (I.F.4.1). Even if there are no formal sessions, faculty would subtly educate their students in this regard. In one of the clinic-social presentation of a case of Leprosy by a second year PG student at DoCM-SPH, initial use of 'some cream' (non-Allopathy) by the patient for his ulcer was posed as a barrier to seeking treatment. A faculty found it important to comment that though this may not be rational as per Allopathy, it was indeed a treatment seeking behaviour on the part of the patient and shouldn't be called a 'barrier' (I.F.1.2).

This faculty has been doing RCTs, through his PhD students, to establish the value of traditionally recommended diet, exercise and *Yoga* in conditions like Polycystic Ovary Syndrome, urine leakage, uterine prolapse, infertility and osteoarthritis (I.F.1.2).

There was a Homeopathy dispensary co-located at the DoCM-SPH's RHTC where the department was running a NCD clinic. But the possibility of referring patients to this dispensary had not so far been considered.

### **IX.5.3 What factors shape their outlook towards and engagement with AYUSH-Folk?**

A faculty recalled consuming a variety of leaves and different types of bananas for different health issues as a village child. He distinctly remembered consuming a *goli* (a tablet) that his mother used to prepare from a particular leaf which, he believed, improved his memory power. 'It didn't actually cost me anything. The leaf was available in my village, I went and picked, and we ourselves made the *goli*, and we took it' (I.F.1.9). He wished to scientifically



test it someday. Another faculty recalled having been taken to a quack whenever he fell ill as a child because that was the only source of healthcare available in his village (I.F.3.2).

A few faculty had experienced the benefits of AYUSH-Folk remedies in their immediate family (I.F.2.1, I.F.4.1). 'What (the practitioner) asked us to take was all roots, vegetables and other things which we could see ourselves...We (felt) safe to use it because we saw the plant' (I.F.2.1).

One DoCH faculty had seen traditional medicine giving unbelievable results while doing his compulsory service in a tribal area (I.F.4.1). Another faculty from SNSPH-DoCH proactively tried to understand the traditional practices in the tribal area of the Primary Health Centre which he chose to briefly work after graduation (I.F.3.10).

A DoCM-SPH faculty had himself generated a lot of evidence in favour of traditional non-pharmacological remedies (I.F.1.2). But the Allopathy people were not supporting such things. Doctors considered it inferior to the system that they were practicing. Some would hesitate to talk about such interventions even when they personally believed in them. He traced the roots of this '*angrezi maansikta*' (English mentality) to India's Colonial past. He opined that the Macaulay's education policy was strategically targeted to kill the indigenous thought process and establish western intellectual superiority. Referring to the Kegel exercise, he said 'we had *Vajroli Mudra* and *Moolband* for last 2000 years. But it became famous only when Mr. Kegel found it in 1948' (I.F.1.2).

A SNSPH-DoCM faculty informed that the first MC, which started in Calcutta in 1830s, began with training students in both, the traditional as well as the modern systems. But the next Viceroy limited the training to only the modern system. Had the Viceroy not changed the pattern of training, India would have had an integrated system of Medicine from the very beginning. 'So, sometimes, the history decides everything' (I.F.3.2).

Yet another faculty linked the aversion for AYUSH-Folk among doctors to the near total lack of any orientation to these systems in the MC. 'We never see, think or study (about AYUSH-Folk). Then how will the understanding develop?' (I.F.1.10).

'Commercial interest' was also given as a reason behind the aversion for cost-effective traditional remedies (I.F.1.2).

A faculty proposed electives in AYUSH-Folk for MBBS students, and courses similar to the Bridge Course for Allopathy graduates (I.F.3.2). Another faculty, however, felt that the corrective actions need to have a wider scope, starting from the family (I.F.1.10).

## Theme X: Ready to Use Food (RUF)

Alma Ata Declaration had stated promotion of food supply and proper nutrition as one of the essential services and had even linked it with issues of agriculture sector like crop choice and land tenure (WHO-UNICEF 1978). While referring to appropriate technology, the document had stressed on its acceptability in the local culture and use of local resources.

In India, Integrated Child Development Scheme (ICDS) was started in 1975 for early childhood development and care. Providing supplementary nutrition is one of the six services offered under the scheme, apart from providing nutrition and health education to the mothers.<sup>9</sup> This includes hot cooked meal for the children in 3-6 years age group, and take home ration in the form of pre-mixes/ready-to-eat food for those below 3 years of age. Besides, for severely underweight children, additional micronutrient-fortified food and/or energy dense food is provided as take home ration. Proposals to replace hot cooked meal with ready-to-use food (RUF) have been highlighted in Indian media.<sup>10,11</sup>

When the faculty were asked about their opinion on this issue, their response ranged from one of ambivalence, to finding hot cooked meals as ‘appropriate’.

Farthest response	Closest response
<i>They placed freshly cooked food and ready to use food on equal terms by listing their respective advantages and disadvantages.</i>	<i>They appreciated locally prepared freshly cooked food as culturally and environmentally appropriate, and sustainable. They found improving the kitchen by empowering the mother to be still better.</i>

### Set-1 (n=1)

A faculty believed that as RUF was prepared in a central place, one could be sure about its hygiene and nutritional content. ‘Here we are not sure how much water needs to be put in

<sup>9</sup> <https://icds-wcd.nic.in/icds.aspx>

<sup>10</sup> <https://www.downtoearth.org.in/news/icds-gets-packaged-food-for-the-malnourished-4301>

<sup>11</sup> <https://thewire.in/health/icds-hot-meals-children-maneka-gandhi>

*daal*, or what's the amount of *ghee* that needs to be put if you cook freshly' (I.F.1.8). However, a fresh cooked meal would be hot and tasty, and based on the need of the community (I.F.1.8).

### **Set-2 (n=7)**

The faculty said that both, fresh cooked food and RUF, had their pros and cons (I.F.1.6, I.F.4.4). While cooked food could be prepared from locally available ingredients, the person responsible for procurement may compromise on quality and can pilfer (I.F.1.6). Moreover, each child may not get the same amount. RUF could also get pilfered, but a fix amount could be ensured for each child (I.F.1.6).

Some of the faculty had past experience with RUF distribution through *Anganwadi* (I.F.3.7, I.F.4.5). They shared issues of poor acceptability and complaints like diarrhoea among children following RUF consumption. One of them still thought that RUF may be given in parallel to fresh meals, provided it is tasty and safe (I.F.4.5). Another faculty said that, fresh food or RUF, any of the two may work if the mother understands the value of nutrition (I.F.2.1, I.F.4.3). But a more basic problem was that not many children were coming to *Anganwadi* centres now-a-days (I.F.2.1).

A few faculty expressed conditional acceptance of RUF. One of them opined that RUF may be used as a 'supplement' (I.F.2.2). For instance, Iron supplementation may be done using either of the two: fortified chocolates or jaggery-groundnut mix. But it can't replace food as it may not lead to satiety (I.F.2.2). Another faculty said that RUF could also be used in places where it was difficult to arrange firewood and other raw material (I.F.1.6).

### **Set-3 (n=9)**

This set of faculty found RUF suitable for children having severe forms of malnutrition (I.F.2.8, I.F.3.8). But once the child is stable, s/he should be switched to locally cooked food. Another faculty preferred freshly cooked food, but said that if it is not possible because of routine operational challenges or during some calamity, one will have to resort to RUF (I.F.4.1). A SNSPH-DoCM faculty stressed on empowering the mother instead (I.F.3.8).

A subset of faculty found fresh meals to be better than anything else (I.F.2.5, I.F.2.6, I.F.2.7). A faculty said that if government itself introduced packaged food, it would contradict its own message to general public against using packaged food items (I.F.2.6).

One DoCM-TSI faculty said that *Anganwadi* centres were for 'supplementation' of food, and not for its 'substitution'. 'How much does it matter whether it is ready made one or freshly cooked one' (I.F.2.3).

#### **Set-4 (n=14)**

Most of the faculty in this set considered fresh cooked meals to be better than RUF (I.F.1.1, I.F.1.3, I.F.2.4, I.F.2.9, I.F.3.3, I.F.3.10, I.F.4.6). They found cooked food to be culturally appropriate (I.F.1.3), acceptable to the community (I.F.1.3) and sustainable (I.F.3.3). It could be prepared from locally available ingredients that would vary with seasons (I.F.4.6). On the other hand, the faculty had doubts about the content of RUF (I.F.3.3, I.F.4.6). It may have preservatives (I.F.2.4, I.F.2.9), and may get contaminated during packaging and transport (I.F.2.4). There were concerns whether children would be able to digest RUF (I.F.3.3, I.F.4.6, I.F.4.8), and that they might get bored with the same item given every day (I.F.4.6). Moreover, a faculty said, 'it sends a wrong message that you can get good supplementation only from outside food, not from what can be prepared in your kitchen' (I.F.3.10). He gave an example from his home state where the government had once started giving small packets of chocolate-flavoured nutritious powder to children whose weight was in red or yellow zones. Soon, the parents of children in green zone also started demanding the same thinking that these packets were superior to the rice cooked at *Anganwadi* (I.F.3.10).

A faculty acknowledged the challenges in procuring and storing the raw material, and in cooking the meals. She also thought that one could be sure about the quality and nutrient content of RUF. But still, she considered fresh meals to be better (I.F.1.1). But two faculty in this set were deeply concerned about these challenges, so much so, that they doubted if 'the freshly cooked fantastic quality food' could actually happen (I.F.2.4, I.F.4.10). Another faculty considered RUF to be good as a 'supplement' to freshly cooked food (I.F.4.8).

Many faculty said that it would be better to empower the mother to cook nutritious recipe at home (I.F.2.9, I.F.3.3, I.F.3.10, I.F.4.8). This would sustainably improve the diet of not only the child but the entire family.

A senior faculty from DoCM-SPH said that improving the nutritional status of a child required multi-sectoral coordination, which was not happening (I.F.1.4). Taking a step back, another senior faculty from the same department said that the relation between nutrition and growth was not 'mathematical' (I.F.1.2). Growth was multi-factorial, and was not only dependent on what or how much the child was eating (I.F.1.2). With regards to *Anganwadi*, the faculty said that not many children were now coming there because, even in villages, parents were sending them to private play-schools (I.F.1.2). So, the question of fresh meals versus RUF was not a very important one. Any of the two would do as long as it was hygienic and healthy (I.F.1.4). A relatively more important issue was to stop hiding grade-III and grade-IV children, and giving them personal attention (I.F.1.2).

On a different note, a younger faculty from DoCM-SPH found RUF to be a 'hugely contentious issue' having 'several economic underpinnings' and something worth doing a policy analysis on (I.F.1.3). A DoCH faculty referred to the lobbying by RUF manufacturers, and compared it with the tobacco industry (I.F.4.8).

### **Set-5 (n=7)**

The faculty felt that freshly cooked meal could be moulded as per local situation and one could offer a wide variety from the same set of ingredients, which was not possible with RUF (I.F.4.9). It would be culturally acceptable and would incorporate what was appropriate for the local environment (I.F.1.9). With RUF, the food diversity would be lost. 'For example, people living in high altitudes may be already taking food from their ancestral practices which are helpful for maintaining their health. What is the point going there and telling them "eat this, eat that"' (I.F.1.9). Comparing it with promotion of vegetarianism, he saw RUF as one of the several attempts to decimate the local in the name of national. Moreover, RUF would bring-in corporate interests and the associated politics (I.F.1.9). Any intervention based on external resources couldn't be sustainable, and RUF was no different (I.F.1.7, I.F.4.2). So, it could be used as a short-term measure, but not in routine (I.F.1.7).

A few faculty had past experiences with RUF and were convinced that it was not the answer (I.F.3.2, I.F.4.9). Talking specifically about Ready to Use 'Therapeutic' Food, a faculty informed that he was one of signatories on a letter which was sent to Ministry against it (I.F.3.2). Instead, he opined that traditional energy dense foods, that vary from State to

State, should be looked into. Indigenous formulae, like the Hyderabad mix, could also be explored.

The faculty saw cooking of food at *Anganwadi* as an opportunity to train the mothers in preparing a balanced diet (I.F.4.2). Such improvement in the family kitchen would prove to be a long term and sustainable solution (I.F.1.7, I.F.4.9). In fact, this should have been the focus of ICDS. While a certain proportion of families would actually need food supplementation, the general approach should have been to empower the parents regarding how to better feed their child using traditional dietary practices and diet diversity (I.F.3.2). But then, instead of focusing on mothers meeting and home visits, the program has focused on MAM<sup>12</sup> and SAM (I.F.3.2). Even here, the system was under-reporting (I.F.4.9). The faculty accused medical academia for adding to the 'abnormality bias' in the program (I.F.3.2). They would be much more concerned about facility-based management of complicated SAM, and much less about community-based management of children who were at-risk or were normal. And so, they would often support measures like Ready to Use Therapeutic Food (I.F.3.2).

## **Theme XI: Private Sector**

The Alma-Ata document acknowledged that while in some countries all health services might be provided by the government, in other countries, there might be multiple agencies involved. However, the document, in no uncertain terms, positioned health of the people as the responsibility of the government. With respect to healthcare financing, it cautioned developing countries against uncritically accepting the methods followed in the more affluent countries. 'Every country has to evolve its own method, based on its own circumstances and judgement, analyzing the experiences of others in the light of its own political, social and economic context...' (p72-73, WHO-UNICEF 1978).

In India, since pre-independence period, private sector has been a default option for seeking healthcare in absence of an adequate public sector (See Chapter 1). Government policies have also actively promoted the private sector (Baru 1998). Especially after 1990s, the government also started promoting privatization and corporatization of health care, and has

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<sup>12</sup> Moderate Acute Malnutrition

started experimenting with state-funded health insurance. This approach has been criticized on several grounds.

When the faculty were asked about their opinion on this theme, their responses varied widely, ranging from an uncritical appreciation of the private sector to demanding a nationalized healthcare system. Some of them, however, balanced the desirability of strengthening public sector in the long term with need-based engagement with the private sector to meet the immediate healthcare needs of the population.

Farthest response	Closest response
<i>They saw private sector as a synonym for quality, and insurance as a mechanism to improve the access to that quality.</i>	<i>They appreciated the centrality of a strong public healthcare system</i>

### **Set-1 (n=3)**

This set of faculty hailed the private sector for its high quality and comprehensive clinical care. They said that public sector was focussed on PH issues like TB and Leprosy. Because of lack of funds and the red-tape, only limited super-specialty services were available in the government sector. So, it made sense to let private sector grow. ‘It will be cheaper than you going abroad to avail the same facility’ (I.F.2.8). Moreover, the healthcare services of private sector were of much better quality than government hospitals. Similarly, the medicine, devices and equipments manufactured by private companies were of superior quality. They were expensive, but that was because of R&D costs, just like ‘many of the cars are expensive’ (I.F.4.4).

The faculty appreciated the idea of health insurance because many people could not otherwise afford private sector service (I.F.2.6, I.F.2.8, I.F.4.4). ‘Middle class people can (now) approach a corporate hospital. Otherwise, it would be a *dream* for them to go to a corporate hospital’ (I.F.2.6, emphasis added). One of them thought that the costs could be brought down if the influences of private institutions linked to politicians were kept under check (I.F.4.4).

## Set-2 (n=5)

This set of faculty saw the public sector as falling way too short in meeting the healthcare demand (I.F.1.8, I.F.3.7, I.F.4.8). At the same time, a huge proportion of population was using private sector (I.F.3.7, I.F.4.8). So, the two sectors needed to collaborate (I.F.1.8, I.F.2.5, I.F.3.7, I.F.4.8, I.F.4.11).

One faculty saw this collaboration as a way to optimally distribute the workload across the two sectors that would ultimately benefit the patient (I.F.4.11). Another faculty saw this from the angle of quality. He praised the private sector for having 'very good facilities' and 'wonderful hospitals' in comparison to public sector where, despite NRHM, 'a lot of things remain' (I.F.1.8).

The faculty, matter-of-factly, said that the private sector was indeed after money (I.F.3.7, I.F.4.8). With the same practicality they added that, while engaging the private providers, government need to ensure that their commercial interests were not hampered (I.F.3.7, I.F.4.8). As a concession, a faculty proposed corporate social responsibility for these for-profit entities (I.F.4.11).

In reference to health insurance, the DoCH faculty shared the problems of low rates offered by the government and a huge backlog of payment because of which many private providers were pulling out of State-financed insurance scheme (I.F.4.8). Another issue was that government doctors were hesitating to refer patients to empanelled non-government institutions. Irked by this, a faculty asked 'why private entities are seen as demons?' (I.F.4.11). He said that the government doctors should consider the distance and the waiting period while referring the patient instead of looking at whether the empanelled institution was public or private (I.F.4.11). He added that even public facilities were able to generate funds by being empanelled under the State-funded health insurance scheme (I.F.4.11).

With regards to unethical practices in the private sector, a faculty said that 'labelling everybody as bad because one or two did something wrong doesn't make sense' (I.F.3.7). Another faculty opined that such things should not deter engaging with the private sector because they could be tackled through regulations (I.F.1.8). A faculty was confident that the private players would not be able to charge anything over and above the price-cap fixed



under PMJAY (I.F.3.7). He also appreciated the Government's efforts to regulate the drug industry despite its powerful lobbies (I.F.3.7).

Regarding strengthening the public sector, a faculty clarified, 'I am not saying that you don't develop public sector...Nobody stops you from developing those. But till it is developed, we can't leave patients without optimal services' (I.F.1.8).

### **Set-3 (n=12)**

#### **XI.3.1 Rationale for Engagement**

The faculty found it difficult for the government to build its own capacity because of lack of finances and bureaucratic hurdles (I.F.3.3). On the other hand, private sector had a lot of freedom (I.F.3.3). They saw 'need-based' private sector engagement as required in areas, and at levels (tertiary care), where government alone could not satisfy the healthcare needs of the population (I.F.2.9, I.F.3.3, I.F.4.2).

At present, the public sector was utilized only by the poor and the private sector by the rich. A large proportion of the middle class was also accessing private healthcare by somehow managing the expenses. Collaboration with private sector would a) enable even the poor to access the 'five star' hospitals (I.F.3.8); and b) protect those already accessing it against out-of-pocket expenditures (I.F.3.8, I.F.4.5). It would remove the hesitation that people have in approaching private providers, and so, would make it easy to access healthcare (I.F.2.3, I.F.3.8). A DoCH faculty supported collaboration saying that while it was essential to subsidize the cost of healthcare for the poor, the private sector also couldn't run in losses (I.F.4.2). The faculty supported State-funded health insurance as the mechanism of collaboration.

#### **XI.3.2 Problems in engagement**

The faculty shared that knowing that the patient is insured would influence the doctor's clinical decision (I.F.4.3, I.F.4.5). For instance, they might pre-pone an angioplasty which could have waited for a few more months (I.F.4.5); they might do a caesarean-section without giving enough time for delivery to happen normally (I.F.4.3). 'The number of Caesareans has increased in some States in the race to claim that amount' (I.F.4.3). Even PH decisions are not immune to private sector influence. 'When you talk about Rotavirus

(vaccine), everybody is happy...everybody is looking at those kinds of solutions for child health' (I.F.4.6).

One of the faculty understated these risks saying that it depended on the individual. 'There are some, even in the corporate sector, who are doing great work and great service' (I.F.3.5). Another faculty proposed engaging only that part of the private sector which was working on a no-loss-no-profit or some-profit basis, rather than profit-oriented corporate sector (I.F.4.1). One faculty mentioned 'regulations' (I.F.2.9), but others saw the difficulties in implementing them (I.F.3.10, I.F.4.3). One faculty saw 'increasing the standard of public facilities to a private level' as a solution for many issues (I.F.2.2).

Talking about other problems in private sector engagement, a faculty said that this would increase the health expenditure 'a little bit' (I.F.2.3). Another faculty said that the private providers would not worry about the preventive and promotive aspects (I.F.3.10). DoCH faculty raised concern regarding the enormous amount of paper work that government expected from the non-government partners, and about the inordinate delays in clearing the dues (I.F.4.2, I.F.4.5, I.F.4.6).

However, despite these issues, the faculty found private sector engagement as benefitting the people.

## **Set-4 (n=11)**

### **XI.4.1 Problems with private sector**

The faculty shared the irrational and unethical practices prevalent in the private sector (I.F.1.1, I.F.1.7, I.F.1.10, I.F.2.1, I.F.2.7, I.F.4.7). They talked about targets being given to doctors in corporate hospitals, about unnecessary treatments, and about unrestraint profiteering. Consequently, the doctor-patient relationship was increasingly getting worse. A faculty said, 'In today's time, if one falls ill, "who to consult, where to go" is a big question. It feels like those sitting out there are all robbers' (I.F.1.7). Engaging with private sector through insurance mechanisms further enhanced such malpractices (I.F.1.1, I.F.2.7). The faculty called for strict regulations to rein the private sector (I.F.1.6, I.F.1.10) but acknowledged that it was difficult (I.F.1.6, I.F.2.1, I.F.3.6). 'The private sector is not much amenable to regulations. They are having their way' (I.F.1.6). A faculty shared how a

Corporate, which was managing Urban Health Centres under NUHM in a State, refused to send its staff for Measles-Rubella campaign despite orders from the Health Commissioner (I.F.3.6).

A faculty said that ‘if our comprehensive Primary Health Care is good, we can delay the onset of disease’ (I.F.1.1). But this was what got neglected in a system dependent on private sector. Another faculty said, ‘Even if the drain in the same street, where they are practicing, gets blocked...they won’t do anything’ (I.F.3.6). Regarding health insurance, a faculty pointed out that even the State-funded schemes covered only in-patient services and elective surgeries. ‘If I have a stroke or a MI (heart attack), I will get care. But if I have diabetes or hypertension, I have to pay out of pocket’ (I.F.4.9).

The faculty also shared that the mechanism where State pays the private sector for its services to the underprivileged was a costlier way of ensuring healthcare than strengthening public sector (I.F.1.6, I.F.1.10). They rejected the argument that even public sector facilities could reap the benefits of being empanelled under State-funded health insurance (I.F.1.1, I.F.1.10, I.F.4.7). As public hospitals had been chronically under-provided, when given a choice, people invariable preferred private hospitals. And so, the reimbursements were disproportionately going to the private sector. Instead of this strengthening of the private sector from public funds, faculty opined that taxpayer’s money should be used to strengthen public healthcare infrastructure, starting from the primary level (I.F.1.1, I.F.4.9). One of them proposed nationalizing the private sector (I.F.2.7). He said that if a State government could bring all the alcohol shops under a single banner, it could do the same for healthcare facilities also.

#### **XI.4.2 Rationale for Engagement**

When the Researcher said that ‘60-80 percent healthcare is *provided* by private sector’, a faculty objected. He said, ‘I think we should say it the other way. 60-80 percent healthcare is *accessed* in private...people are going to them because government is unable to provide those set of services’ (I.F.3.6). Several faculty in this set were of this opinion that private sector had grown (from village to cities; from primary to tertiary) because the public sector has been chronically inadequate (I.F.1.7, I.F.2.4). ‘Government sector is still

trustworthy...but it lacks comprehensive solutions' (I.F.1.7). 'Significant amount of poverty is due to hospitalization (in private)' (I.F.1.6). And so, there was a need for engagement.

But the faculty stressed on engaging only genuine non-government facilities (I.F.1.1, I.F.4.7). Partnering with private institutes which exist just for profits won't work (I.F.4.7). And, at the same time, the processes of engagement should be kept simple (I.F.1.7).

In the same light, faculty saw State-funded health insurance to be of value (I.F.1.9). It encouraged people to access healthcare in time rather than sitting at home and making things worse (I.F.2.4). And it reduced out-of-pocket expenditure (I.F.1.6, I.F.1.7). But they were concerned that these schemes would often miss the most needy ones (I.F.3.6, I.F.4.7). For this, a faculty proposed covering everybody under State-funded insurance instead of only those who were designated as living below poverty line (BPL) (I.F.2.7).

A faculty considered these as measures for 'immediate management', like giving a therapeutic dose of Vitamin A to a case of night blindness. 'The long-term measure is strengthening the Public Health facilities' (I.F.1.9). And even in short term, too much dependence on private systems was not favoured (I.F.2.1).

The faculty acknowledged that this was not how the healthcare system in the country was going. On asking why there was no opposition from the medical fraternity, a faculty said 'Government sector doctors are allowed to do private practice here...So who is going to oppose' (I.F.2.4). Another one said 'at the end of the day, it is what the PMO wants' (I.F.1.10).

### **Set-5 (n=7)**

The faculty in this set had opinions similar to those in Set-4. But also they explained the context in which private sector develops, and reflected on some of its fundamental issues.

#### **XI.5.1 Context**

A DoCM-SPH faculty explained that the health system in different countries is influenced by their social-political contexts (I.F.1.12). Countries and regions which believe in 'collectivism' do not take health as a commodity. It is considered as a 'basic right' of the people, and an obligation of the State. On the other hand, countries which believe in 'individualism' ('individual initiative, individual freedom, individual competitiveness') leave health, like

everything else, on the free market with a hope that a fair competition will let only the most cost-effective options thrive. With reference to India, another DoCM-SPH faculty talked about the decade of 1960s (I.F.1.2). Recalling the idealism, the leaders, the songs of that decade, he said, 'now everything has changed'. Since early 1990s, when the country's economy got liberalized and expenditure on social sectors got tightened, the focus had completely shifted. So what was happening in health sector was simply a reflection of what was generally going on in the society. Yet another faculty from DoCM-SPH commented on the general acceptance of this concept in the society. 'If we at all are sick, we go out of our homes and seek a nearby doctor, we show him we pay him the money...and we find that a natural phenomena, we don't feel bad about it...(we feel) it is ok to have a system where we go and fend for our own health by paying money' (I.F.1.3).

### **XI.5.2 Fundamental Problems with Private Sector**

The faculty in this set, like those in Set-4, referred to the irrational and unethical practices of different scales and scope in the private sector. These ranged from the international 'experts' who change the threshold values of physical parameters (like Blood Sugar or Blood Pressure) thus increasing the pool of people who can now be classified as 'patients', to the labs that write reports without actually running the tests. 'The situation is very dangerous', a faculty said (I.F.1.2).

The situation was, however, not surprising. A DoCM-SPH faculty explained that health is a 'public good', and given the 'information asymmetry' between the buyer (the patient) and the seller (the healthcare service provider), it should not be left on the vagaries of the market forces (I.F.1.12). A DoCH faculty peeked into the basic psyche of most of the people in private sector. As a businessman, 'I want maximum returns for minimal investment' (I.F.4.10). This 'philosophy' doesn't change just because the investment has been made in healthcare sector. The businessman would still want to maximize profits, and would not think about the welfare of the population. Engaging with private sector, thus, results in 'a lot of treatment (and) a lot of cost' (I.F.4.10).

A DoCM-SPH faculty informed that countries which funded their health system through tax (like UK, Europe, Canada, Australia) produced better health outcomes at lower costs compared to those who go for market type of competition (like North America) (I.F.1.12).

He said there was enough evidence, even from India, to show that investing in the public sector was a more cost-effective way of delivery of healthcare, and that the market approach actually deprived healthcare to a large section of population (I.F.1.12).

A SNSPH-DoCM faculty was not convinced with the logic of utilizing its unused potential as the justification for private sector engagement. He stressed that 'health should be seen as Right of the people'. And 'whenever private sector comes in, it becomes a selective approach. It becomes Health for Some, not for All' (I.F.3.2). He expressed concern over the dichotomised healthcare system where the rich go to the private and the poor go to the public. He opined that 'the quality of services in public sector will be guaranteed only if those who have voice are also the clients' (I.F.3.2). And this could materialize only if the government focus on strengthening public sector and make it universal (instead of targeting).

The faculty acknowledged an enthusiasm for private sector engagement rather than public sector strengthening in the policies and blamed the nexus between the policy makers and the for-profit lobby for this (I.F.3.1). The faculty were certain that whatever the government puts on the policy table, 'because of (their) inherent nature...the private providers are going to win' (I.F.3.2). The same logic explained the difficulty in enforcing regulations (I.F.1.2).

### **XI.5.3 Fundamental Problems with Insurance**

The faculty in this set, like those in Set-4, said that the most-needy may get left out from getting enrolled in the State-funded health insurance. Due to insufficient efforts at making people aware, even the ensured patients may end-up taking treatment from non-empanelled facilities. They may get over-treated because of the 'perverse incentives' created by the insurance, and may be charged more than the price-cap and/or over and above the sum insured ('balance billing'). These were the reasons why the out-of pocket expenditure often doesn't reduce, or even increase, among the insured (I.F.1.3). Consequently, the overall cost of healthcare to the country increase (I.F.1.4, I.F.3.1). And the insurance mechanism disproportionately benefitted the private sector, which was why all the multinational chains of hospitals were looking to open their 'shops' in the country (I.F.1.4). But they also talked about problems more basic than these.

A DoCM-SPH faculty said that, because of ‘market failure’ in health, insurance can’t even be expected to work that well in this sector (I.F.1.3). A DoCH faculty opined that the idea may still be adequate for the West where social determinants were good. ‘Here, when we don’t have road, power and water...only paying for this guy’s treatment in hospitals...is it going to result in health as defined by WHO?’ ‘What about the Primary Health Care - the eight elements and the four principles?’ (I.F.4.10). A faculty informed that *Ayushman Bharat* was largely focussed on the National Health Protection Scheme (PMJAY), and that the concept of Health and Wellness Centre was only a ‘second thought’ (I.F.1.4). Another faculty saw this relative silence of *Ayushman Bharat* on strengthening of Public Health sector as a ‘huge problem’ (I.F.3.2). Even as a concept, a DoCH faculty saw insurance mechanism akin to giving ‘contract’ of a population to a private provider where the responsibility of the State was limited only to making the payment (I.F.4.10). Instead of such ‘coverage’ he was in favour of Universal Health ‘Care’, which he saw possible only through public health system.

#### **XI.5.4 Rationale for Engagement**

The faculty acknowledged the ‘pathetic’ state of government healthcare system in terms of infrastructure, human resource, logistics and even organization of services (I.F.1.2, I.F.1.4, I.F.4.10). To consider that government services alone could take care of healthcare needs, a faculty said, would be like ‘living in a fool’s paradise’ (I.F.1.2). It was a sad reality that a larger proportion of population was going to private sector to access healthcare because public sector was not functioning well (I.F.1.4). So, ‘not engaging with them (private sector) is not an option’ (I.F.3.1).

Given the current situation, faculty said that need-based purchase of services from the private sector was needed (I.F.1.12). But, even in short-term, the Government should not be a puppet in the hands of the professional groups having vested interest, like the IMA (I.F.3.1). The faculty said that it was the responsibility of the technocrats working within the system to guide the policies in favour of those at the margins (I.F.3.1). In medium and long-term, capacity building of the public health system should be the goal (I.F.1.12).

One faculty, however, had a different view (I.F.1.3). He said that after allowing the private sector to grow phenomenally over the decades, it didn’t make sense to shun it now. He proposed dividing the spectrum of services (primary, secondary, tertiary) between the

public and the private, and let the two sectors function within those boundaries. Besides developing the primary and secondary levels further, he advocated for building even the tertiary care in the public sector to an extent that the government had the bargaining power over the private. And he suggested making the State-funded health insurance universal so as to bypass the flaws of targeting, while letting people opt-out if they so want.

## Quantitative Analysis of the Assigned Scores

As mentioned in Chapter 2 and detailed in the previous section of this chapter, each faculty was assigned a score between 1 and 5 for her/his response to each of the eleven themes. The total assigned score of individual faculty was calculated by adding the theme-wise scores. Similarly, the total assigned score of a department was calculated by adding the faculty-wise scores.

As shown in [Table 24](#), the score vary across departments. DoCM-SPH and SNSPH-DoCM are closely followed by DoCH. DoCM-TSI, however, lag by around 15 percentage point from the average. So, there must be something in the way a Department functions that influences how its faculty understands PHC.

**Table 24: Combined Scores assigned to Faculty of the Four Departments for their Understanding of Primary Health Care**

Department	Faculty	Maximum Score	Assigned Score	Percentage
DoCM-SPH	10	550	414	75.3
DoCM-TSI	9	495	265	53.5
SNSPH-DoCM	8	440	318	72.3
DoCH	11	605	407	67.3

Given that there were 11 themes, and the maximum score per theme was 5, the maximum score that a faculty could have been assigned was 55 (11\*5). This, when multiplied by the number of faculty in a department, gives the 'Maximum Score' that a department could have been assigned. 'Assigned Score' is the sum of scores assigned to all faculty of a department for all themes. Percentage was calculated by dividing the assigned score by the maximum score

However, when scores assigned to individual faculty are seen in [Figure 3](#), two observations can be made: a) the understanding of PHC vary widely among the faculty within the same department, and this is true for all departments; and b) the departments having a lower combined score also have certain faculty whose understanding is comparable to that of the faculty in high-scoring departments. Both these observations inform that, irrespective of the



department, there must be some factors and processes acting at individual level that shape one’s understanding of PHC.

**Figure 3: Spread of Individual Scores assigned to Faculty of the Four Departments for their Understanding of Primary Health Care**

	55	54	53	52	51	50	49	48	47	46	45	44	43	42	41	40	39	38	37	36	35	34	33	32	31	30	29	28	27	26	25	24	23	22	21	20	19	
DoCM-SPH	*					*					*	*				*			*		*	*				*												
												*							*																			
DoCM-TSI																*			*					*		*									*		*	
																			*																			
SNSPH-DoCM					*									*						*		*	*	*														
				*																																		
DoCH								*			*				*	*			*	*			*		*	*	*											
																	*	*									*	*										

Maximum score for a faculty for each theme is 5, so maximum possible total score for a faculty is 55; Each asterisk (\*) represents a faculty

When seen across themes (Table 25), it becomes evident that the percentage scores vary widely (Column-2). The responses of faculty to different themes are at different distances from the poles<sup>13</sup> of those themes. The total scores for themes like ‘AYUSH-Folk’ and ‘Understanding of Health’ are closer to the pole in comparison to the total scores for themes like ‘About PHC’ and ‘Terminology’.

Similarly, in Column 3 to 6 (Table 25), the percentage scores of each department are seen to be varying with the theme. So, the same department is closer to the pole for some themes, but not for all. For instance, in case of DoCM-TSI, the understanding of the faculty about ‘AYUSH-Folk’ is closer to the pole as compared to their understanding about ‘Integration’ and ‘Community Participation’.

<sup>13</sup> Based on the Researcher’s interpretation of ‘Primary Health Care’ from Alma-Ata Report and its subsequent analyses, the responses for each theme were arranged in an order. The responses found closest and farthest to the interpretation were taken as the two ‘poles’. The polar responses have been shown at the beginning of every theme in the previous section of this chapter. The same may also be found in Table 14 (Chapter 2).

**Table 25: Percentage Scores Assigned to Different Themes across Four Departments**

Theme	Total	DoCM-SPH	DoCM-TSI	SNSPH-DoCM	DoCH
(1)	(2)	(3)	(4)	(5)	(6)
AYUSH-Folk	73	82	67	75	69
Understanding of Health	72	72	56	78	82
Inter-sectoral Coordination	71	76	51	75	78
Ready to Use Food	70	76	60	75	69
Decentralization	68	76	56	75	65
Integration	67	80	47	70	71
Private Sector	67	84	56	70	60
Community Participation	66	68	49	83	67
Institutional Delivery	65	76	51	70	62
About PHC	63	74	49	63	65
Terminology	56	64	49	63	51

The total score obtained for a theme was calculated by adding the scores assigned to faculty for that theme. This was divided by 190 {38 (total number of faculty)\*5 (maximum score for every theme)} to calculate the percentages shown in Column-2. Similarly, the total score obtained by a department for a theme was calculated by adding the scores assigned to its faculty for that theme. This was divided by the maximum score for that department (number of faculty\*5) to calculate the percentages shown in Column 3 to 6.

If [Table 25](#) is read row-wise, the percentage scores for the same theme are seen varying across departments. So, different departments are at different distances from the pole for every theme. To illustrate, for 'Understanding of Health', the faculty of DoCH are closer to the pole in comparison to other departments. Similarly, for 'Community Participation', the faculty of SNSPH-DoCM are closer to the pole in comparison to other departments.

Even within a department, the understanding of different faculty for the same theme varies widely ([Table 26](#)). For instance, the score assigned to different faculty of DoCM-SPH for their understanding of the issue of 'Ready to Use Food' vary from 1 (i.e. farthest response) to 5 (i.e. closest response). This is true for all themes and for all departments. This, once again, indicates the significance of individual experience and exposures of the faculty irrespective of how their department functions.

And lastly, the understanding of individual faculty across the eleven themes also varies ([Table 27](#)). In fact, for almost half the faculty, the variation was of three or four points. To illustrate, there were four faculty (I.F.1.6, I.F.2.4, I.F.3.6, I.F.4.1) whose scores varied from 1 to 5 across different themes. For instance, I.F.4.1 was assigned 1 for 'Terminology', but 5 for 'Understanding of Health' and for 'AYUSH-Folk'. This indicates that individual experience

and exposures may deepen the faculty’s understanding on certain aspects of PHC, but not on all aspects. This also indicates that many faculty are not actually guided by the ideological thread that runs across different aspects of PHC.

**Table 26: Variation in Score assigned to Different Faculty of a Department for their Understanding of a Particular Theme**

Theme	DoCM-SPH	DoCM-TSI	SNSPH-DoCM	DoCH
Understanding of Health	1 to 5	1 to 4	3 to 5	3 to 5
About PHC	3 to 5	1 to 3	2 to 4	2 to 5
Terminology	2 to 5	1 to 4	2 to 4	1 to 4
Community Participation	2 to 5	1 to 3	2 to 5	2 to 5
AYUSH-Folk	2 to 5	1 to 5	1 to 5	2 to 5
Institutional Delivery	2 to 5	1 to 4	1 to 5	1 to 4
Ready to Use Food	1 to 5	2 to 4	2 to 5	2 to 5
Decentralization	3 to 5	1 to 4	3 to 5	2 to 4
Integration	2 to 5	1 to 4	2 to 5	2 to 5
Inter-sectoral Coordination	3 to 5	1 to 5	3 to 5	3 to 5
Private Sector	2 to 5	1 to 4	2 to 5	1 to 5

The scores assigned to all the faculty of a particular department for a particular theme were looked at to ascertain the maximum and the minimum score. This range of response is shown in each cell of the table.

**Table 27: Variation in Score assigned to Individual Faculty across the Eleven Themes**

Maximum-Minimum Difference	Number of Faculty	Score Range
0	1	NA
1	1	3 - 4
2	18	1 - 3; 2 - 4; 3 - 5
3	14	1 - 4; 2 - 5
4	4	1 - 5

Response of each faculty for each theme was assigned a value from 1 to 5. ‘Maximum-Minimum Difference’ in the table refers to the difference between the maximum and minimum scores assigned to a particular faculty across the set of 11 themes. Number in the cells of second column of the table indicates the number of faculty who had the maximum-minimum difference shown in the corresponding cell of first column. For instance, ‘18’ in the third row indicates that there were 18 faculty whose responses varied by 2 points (the range of response could be 1 to 3, 2 to 4 or 3 to 5).

## Summary

This chapter presented the understanding of the faculty about PHC through qualitative analysis of faculty responses on eleven themes, and through quantitative analysis of the score assigned to those responses. The analysis brings out variations in the understanding across departments, and even among the faculty of the same department. Even the

understanding of same faculty is found to vary across different aspects of PHC. These variations underscore the role played by structural, milieu and individual-level factors and processes. These have been discussed in the next chapter.

# **Chapter 5: Factors and Processes that shape the Understanding of Primary Health Care among the Faculty of Community Medicine**

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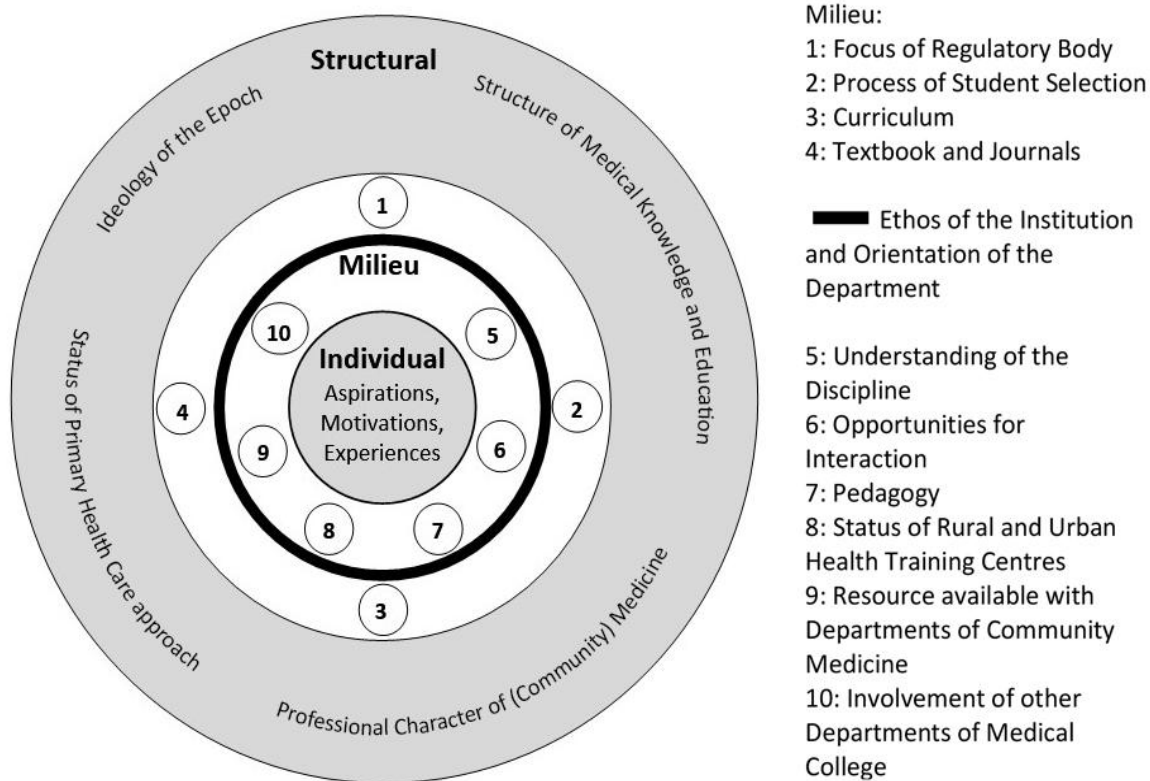
This study began with a conceptualization of the factors and processes that influence the understanding of Primary Health Care (PHC) among the faculty of Community Medicine (CM) (See [Figure 2](#), Chapter 2). They were seen to be operating at three levels: structural, milieu and individual. Structural-level factors are those distal factors which form the overarching context; which may not be readily perceived and may be difficult to act upon, but are real, omnipresent and powerful. Milieu-level factors surround the individuals more proximally and are themselves shaped under the weight of the structural factors. Individual-level factors refer to the socio-economic backgrounds of the individual faculty that forms the soil in which concepts like PHC approach take roots. These factors and processes are all intricately linked, with each one interacting and influencing the rest.

The study findings have led to a more nuanced and deeper understanding of the factors and processes at these three levels. A layer of institutional ethos and departments' orientation has been found to mediate between the structural and individual-level factors and processes ([Figure 4](#)). The operational issues with the departments of CM have been found to be of greater consequence. The individual-level factors have been found to also include the aspirations, motivations and experiences of the individual faculty at various stages of their lives. These, in turn, are influenced by the structural and milieu-level factors through process of socialization and professionalization. Further, components and context-specific content have been added to the ones already envisaged at the beginning. The various influences, as explained by the respondent CM faculty, and as observed and inferred from this study, are discussed in detail in this chapter.

## **I. Structural-level Factors and Processes**

These include: Ideology of the Epoch, Structure of Medical Knowledge and Education, Professional Character of (Community) Medicine, and Status of PHC approach.

**Figure 4: Factors and Processes shaping the Understanding of Primary Health Care among the Faculty of Community Medicine**



## I.1 Ideology of the Epoch

‘Ideology of the Epoch’ refers to the way the society largely thinks and operates in an era. An overarching stress on capital in the present times has led to formation of a societal fabric that supports commodification of everything, from land and water, to education and health. Such a society hails consumption as a positive attribute: the more one consumes, the higher the status. This leads to a race with no end. ‘We have made our lives that way that we want money for everything. And family wants this and family wants that. Keeping the family pressures in mind, you need a job, and you need to bring that much of money’ (I.F.4.8). The society expects individuals to fend for themselves. Those who can’t may be helped through charity, which is considered a valid substitute for social responsibility emanating from a sense of solidarity.

There is an alternate way where every member seeks satisfaction in fulfilling some need of the society; and the society, in turn, looks after the needs and basic comforts of all its members. This is not the dominant ideology of the present epoch, but is indeed the way

several people think. Such marginal social streams always challenge the dominant ideology, temper its advancing edge, and sometimes, may gain enough strength to lead to a paradigm shift. In fact, the PHC approach itself has been one such articulation in the health systems sphere.

The dominant ideology in the society influences individuals directly as well as through their families, professional groups and institutions. Contrasting the idealism of the decade of 1960s with the liberalized-privatized-globalized world since 1990s, a faculty shared that now economic development had become synonymous with development (I.F.1.2). There is dominance of materialist thinking and consumerist culture, and the effects are everywhere to be seen.

### **I.1.1 Medical Practice**

Growth of private sector, because of state's active promotion and a simultaneous neglect of public sector, has led to increasing commercialization of healthcare (I.F.1.2, Baru 1998). Privatization and corporatization, especially after 1990s, have turned healthcare into a profit-making industry (Baru 1998). Technological advancements in Medicine have led to branching out of new specialties and super-specialties from the existing ones. These advancements have also, in parallel, changed the environment of medical practice, making it more competitive. The differences in remuneration, working and living conditions of specialists versus those of generalist, and among those working in private versus public sector, are huge. This influences the career choices a medical student makes (I.F.4.11).

Explaining why clinicians don't act on the other dimensions of health even if they have that understanding, a faculty said, 'It is the world view which is important. What matters more? If it's money that matters more, then they want to have more money. And then they design the strategies, "where will I get more money"' (I.PF.6). So, 'the actions limited to only this discipline will not be helpful in improving the scenario' (I.PF.6).

The doctor-patient relationship has reduced to that between a provider and a consumer (I.F.1.1). 'I pay you, and you deliver me services that I pay you for. You don't deliver, I go to the next person. There is no connect' (I.F.4.7). 'Out of 100 headaches, one may have a brain tumour, 99 won't. But that one that you missed may sue you. Because of that, you will order MRI for all 100 people' (I.F.4.8). Frequent incidents of violence against doctors are

both a manifestation of, and a contributor to, the widening gap in this relationship. With this constant fear of getting abused or sued, remaining 'appropriate' is difficult. Recalling his 85 years old father-in-law who is an Ophthalmologist, a faculty said 'when he saw a patient in those times, they know all about that guy. Which village he is from, where he is coming from, what is his surrounding, what is his circumstance...everything. Because that's the way they were' (I.F.4.10). Those days are history. In absence of that 'connect', going beyond the patient and his/her disease, becomes a tall order.

The society, in general, has accepted individual out-of-pocket payments for healthcare services as normal (I.F.1.3). In fact, those who can pay demand sophisticated care and are no longer content with just the optimum. And some of them even regard this as a measure of their status, and something to flaunt.

### **I.1.2 Public Health**

The focus of government on industrial growth and defence services has increased while the social sectors (health and education) are starving for resources (I.F.4.7, FGD.PH.1). The government allows the sale of tobacco and alcohol, despite their known health hazards, because these things bring-in huge revenue (FGD.PH.1). 'When you talk about Rotavirus (vaccine), everybody is very happy. Pharmaceutical companies immediately want to provide Rotavirus (vaccine)...everybody is looking at those kinds of solutions for child health' (I.F.4.6). Even PH associations are not immune to such influences. A national-level PH conference in 2017 had a dedicated session on newer vaccines for Dengue, Rotavirus and Cholera sponsored by organizations having a direct conflict of interest.

As against something that comes cheap/free, paying is seen as a matter of 'reputation'. Educated and financially capable parents prefer packaged neutraceuticals over routine home-made preparations (I.F.1.11). Even in villages people assume that only those children go to Anganwadi who do not have enough to eat, or whose parents cannot afford private preparatory schools (I.F.1.11).

### **I.1.3 Medical Education**

The number of capitation-fee Medical Colleges (MCs) has been rising, and those under non-government ownership now exceeds number of government MCs (I.F.1.2, MCI 2017). Huge, and cost-insensitive, demand for Medical Education (ME) has brought together politicians,



bureaucrats and businessmen (Qadeer and Nair 2005). This formidable nexus has been successful in its operations despite legislative and judicial interventions (Bajaj 1998b). Many private MCs have been established as business enterprises. 'The purpose is not to be able to reach out to the people' (I.F.4.7). With such institutional ethos, concepts like PHC have little chance.

By going in private hands, ME has become difficult to afford. A faculty did some maths and arrived at an expenditure figure crossing Rupees One Crore by the time the student finishes specialization, if s/he studies at full fee even in an institute like St. John's. And it may be still higher in other non-government institutions. 'A fellow spending 1.5 Crores on medical education...what will he want to do? Will he want to go to a village and serve, or will he want to actually join the closest corporate and try to earn it back?' (I.F.4.7). Many of the students have to take study loans which have to be paid back in time. 'We can't ask them to go in the community and do service' (I.F.4.4). 'Their compulsions are different. So these things (PHC orientation) may or may not make a mark on them' (I.F.4.10).

### **I.1.4 Image of a Doctor**

The popular image of a Doctor in the society is of somebody who sits in a clinic/hospital and treats the sick (I.F.1.1). It is difficult for people to see a 'Doctor' working for health promotion. Many faculty and students shared the difficulty they faced in explaining the meaning of CM to others, especially to their own family members (I.F.4.4). Unless PHC work is acknowledged, well respected in society and is remunerated handsomely, graduates will not be attracted towards it (I.F.2.10).

Another perception in the society is that 'good doctor means a doctor with a higher degree' (I.F.3.8). The care seeking, especially among those classes of society which medical students generally belong to, has shifted from generalist to specialists. 'If you are just an MBBS, the patient doesn't consider you able enough to treat' (FGD.Intern.3). 'How much of the community actually goes to a MBBS doctor? Everybody looks for specialists' (I.F.4.2). So, 'you have to specialize. MD is the least you have to do' (I.F.4.8). 'The system forces you. Even if you want, you cannot (just remain a graduate)' (I.F.3.8). Even the religious nuns coming to St. John's, who would earlier go to serve their Missions after graduation, now want to first specialize (I.F.4.2).

A higher status accorded to specialists by society is evident not just in clinical interaction, but also in social interactions. 'If you are just an MBBS, nobody will respect you...no parent will give you their girl in marriage' (I.F.4.11). Even within the medical fraternity, 'we have degraded it saying that mere MBBS will not work' (I.F.4.11). So, going for specialization after graduating has become a 'social norm' (FGD.Intern.3); 'the need of the hour' (I.F.3.8). It has become a natural course of action, a culture.

### **I.1.5 Family Dynamics**

The Institution/CM department can try to sow the seeds of PHC orientation, but the students need to have a fertile mind for those seeds to sprout. Taking example of Doctors like the Bangs and Amtes, a faculty said, 'these people didn't decide after coming to the Medical College that they would work with the community...the seed was there since long' (I.F.3.2).

This depends a lot on the thought process within the family, and its ways of living day to day life (I.F.3.2, I.F.3.8, I.F.3.10). For instance, being from a family engaged with spirituality would drive the student towards a particular kind of work (I.F.3.10). If the dinner table discussions in the family had often been about the underprivileged, explaining why the poor were in that state rather than blaming or cursing them for their poverty, it develops a different kind of sensitivity in the student (I.F.3.2). If the family is not expecting a 'return on investment', the student may think of serving the needy (I.F.4.2). In contrast, if the family expects the student to be working in some established position, even the thought of being in a small village and empowering the community may not occur to him/her (I.F.3.8).

### **I.1.6 Peer Pressure**

The informal discussions that happen with peers during tea-time while one is in school or college also matter a lot (I.F.3.2). 'Now the trend is towards who earns better...who can settle down faster...That is the trend of the current generation' (I.F.2.2). 'Time is money for the student...after five years, he has to earn his money' (I.F.2.8). Medicine is a long drawn course; by the time a doctor starts earning, his/her school friends from other fields are already far ahead (I.F.1.1). So, 'it is not possible that medical students alone talk about social conscience' (I.F.3.2).

There are similar pressures within the medical fraternity. 'I enjoyed my job (at government Primary Health Centre), and I was very popular there. But, the most important part is this that, like in my friend circle and everywhere, there is a craze of becoming a MD doctor now. So that was one thing that I need to do an MD' (I.F.3.8). And it is not just everybody wanting to specialize, but also to do so as early as possible (I.F.1.6, FGD.Interns.4). 'It's a rat race. You have to finish immediately. If you go for a rural service, you lose two years' (I.F.4.7). And such pressures continue even after specialization.

ME, including CM education, is taking place in this environment. The principles of PHC don't seem obvious and natural in this climate, neither to CM faculties nor to public health (PH) practitioners. 'We can't dissociate our discipline from the overall society' (I.F.1.2).

Though the dominant thinking is what has been outlined above, there are people, families and institutions which do not concur with it. There are individuals who prefer a simple life, without much craving for possessions. There are medical practitioners who are minimalists. And they refuse to enter the race for name, fame or money. There are PH personal who still talk about the basics, like food and water. There are MCs which continue to believe that values are not just theory. There are families which are content that their child has entered a socially relevant profession. There are medical students who find themselves out-of-place, and not under pressure to follow the majority. In fact, a senior faculty shared that the number of youngsters, from medicine as well as from other fields, who are getting disenchanted with the run-of-the-mill, is growing. And this group keeps the alternative thinking, and the hope, alive.

## **I.2 Structure of Medical Knowledge and Education**

Medicine is a discipline that believes in objectivity and emphasizes on tangible evidence. 'Body being a bunch of systems...they break down, and you have to repair them at all costs...that's the philosophy' (I.F.4.10). It searches for physical causes of disease inside individual bodies, and attempts to cure the disease by ameliorating that specific cause.

In practical terms, the purpose of ME is to create doctors who can treat patients; it is not to create doctors who can keep people healthy (I.F.3.10). 'Medical Science gives a very narrow vision to you'; 'if they (medical faculty) tell that only drugs can solve all the problems, that is what the student is going to learn' (I.PF.5). A faculty, sarcastically, said that MBBS 'is not

Bachelor of Health. It is Bachelor of Medicine and Bachelor of Surgery'. 'Most of the world's medical schools prepare doctors not to care for the health of the people but to engage in a medical practice that is blind to anything but disease and the technology for dealing with it' (Mahler 1981).

The concern is for the 'disease', and not for the person as a whole. Secondly, the concern is limited to the 'individual'. 'Doctors come with these two strong biases' (I.F.3.2). So, for instance, 'if you engage doctors to solve the problem of nutrition, they will talk about managing malnutrition. Your whole program will get deviated from what needs to be done for every child...to what should be done for complicated SAM (severe acute malnutrition)' (I.F.3.2). Arole and Arole (1994) write, 'In general, the members of the Indian Administrative Services seem to have a better understanding of the health problems in rural areas than do doctors who are trained in the narrow tradition of curative medicine with emphasis on biomedical technology'.

A representative from the MCI wrote an editorial in Indian Journal of Community Medicine titled 'Innovation in Medical Education towards Primary Health Care' (Jain 1989). He says, 'Unless necessary changes in the clinical training methodology are not introduced, the country...will have an apparent shortage of doctors for primary health care'. While raising a crucial issue, in effect, he equated PHC with primary-level medical care. Frenk et al. (1990), in an attempt to define PHC for medical educators, differentiated it from first level of contact. They also distinguished 'appropriate technology' from 'simplified technology'. But still, they considered PHC as an approach for 'risk anticipation', something that pre-empts health damage and not repair it after it has happened. 'The essence of PHC is the stage of the health-and-disease process at which actions are aimed' (Frenk et al. 1990). They could not stretch beyond preventive medicine.

A pamphlet published by a Doctors-led grassroots NGO defined 'Health for All' as 'scientific treatment free of cost to all citizens' (Bala and Bera 2017). While demanding free hospital care for all who need it is very much required, it is just one component of the larger demand of Health for All. 'If we want to actually work for the betterment of the health of the people, medical approach is not sufficient. It's not the correct approach' (I.F.1.10). Secondly, stressing on 'scientific', focussing only on monetary 'cost', and restricting to 'citizens' is

incompatible with the principles of PHC. Such a concept of health, understanding about the cause of disease and its management does not sync with the PHC approach.

The pioneers of the discipline of CM, and the faculties who have been carrying it forward, have all been a product of the same structure. 'Essentially, they are physicians. So, it is very very difficult to bring them out of this bio-medical field to another level, another paradigm' (I.F.1.12). 'These biases continue even after completing the Community Medicine training...it takes a lot of time' (I.F.3.2). In fact, it may take a lot of time for the individual to even realize that such biases exist. An inherent resistance to comprehensive approaches like PHC may therefore be expected, both at individual and disciplinary level. And it is natural that such resistance then reflects in the formal medical curriculum. Minds with such biases, be it from CM or other medical specialties, are 'unfit' to deal with the needs of normal population (I.F.3.2).

The students, whom the CM faculty are supposed to orient, are also located within the same structure. Irrespective of which clinical textbook they read or which ward they are posted in, they see the patient reduced to a body in which a verifiable cause of disease is to be found and fixed using some technology. So, it is not easy for the PHC approach to make any impact on the thinking of the students unless the overall structure becomes more accommodative.

However, the structure of medical knowledge is not built in bricks and stones that it cannot be expanded or modified. But the market interests, which have historically exploited this structure for personal benefits, ensure a *status quo*. They offer new and newer technologies which not only perpetuate the bio-medical paradigm, but make it more and more intense. The same mechanisms influence the PH paradigm, as exemplified by the almost complete shift in understanding of disease causation from miasma to germ.

### **I.2.1 Skew towards Specialization**

Arole and Arole (1994) writes, '...medical education continues to emphasize training medical graduates in more and more highly specialized areas of medicine. There is little emphasis on addressing the basic health problems of the poor and marginalized people who form more than 50% of our country'. A significant proportion of time during ME is spent in OPD and wards of a tertiary-level hospital where students observe a highly specialized kind of

medicine. They see patients who are in advanced stages of the disease, requiring high-end investigations and being subjected to specialized diagnostic/therapeutic procedures; they witness dramatic events like life being saved and life getting lost. The students see only the end stage of the disease process and not much of what happens in the community (Rao 1985). 'We do take our students out in field. But for how many days...it is 4-5 weeks in a course of five years. Whereas every day, I see a clinician looking at a patient; and a patient looking up to them...' (I.F.4.4). Rajya Sabha (2016) also recognized that exposure to primary and secondary set-ups during medical training is sub-optimal. Even in the class, the faculty would 'praise the student like anything if they are able to tell some uncommon syndrome which they might never see in their lifetime...But then, the same student might not be able to tell or do what is required for a child who is absolutely normal, or a pregnant lady who does not have any complains or complications' (I.F.3.1). So, the students internalize not just bio-medicine, but a highly specialized and technology-intensive form of bio-medicine. This, along with the social factors discussed earlier, drives the students towards specialization. Let alone comprehensive PHC, the students with such mindsets find it difficult to relate to even primary-level medical care (Ekman et al. 2008). 'Who is there now in the country to work as a general practitioner? Your MBBS doctor cannot write a prescription after coming out from the medical college' (I.F.1.4). This value system has influences beyond individual practice.

It's a chicken and egg situation. Knowing that the students will invariably specialize, the ME system has become lax in preparing them to take up primary-level medical responsibilities upfront (I.F.3.3, I.F.4.2). Because of this laxity, the graduates don't feel confident enough to start working and feel the need to specialize (I.F.4.11, FGD.Intern.3, Seal 1966). Faculty shared that UG students are so certain about specializing that they take MBBS as a stepping stone. 'They are not doing MBBS to serve. They are doing MBBS to do an MD and DM' (I.F.4.8). '...the goal of undergraduate medical education should not be to produce a "protospecialist"... Instead, the goal should be to produce a professional who is capable of balancing the skills and values of population-based health care with the capacity to provide high-quality care to treat the most frequent medical conditions' (Frenk et al. 1990). But increasingly, even the PG is becoming a stepping stone for super-specialization. Arole and Arole (1994) say that community needs the services of specialists only rarely. Seal (1966)

suggests that need for specialization should never exceed 20% of the graduate output. But, far more specialists and super-specialists are getting trained than are necessary (Deodhar 2003). Consequently, in order to justify their position, the specialists introduce procedures beyond those which are necessary, thus increasing the cost of care (Editorial 1958b). Thus, specialization often makes healthcare inappropriate and unaffordable. And this has roots in the skewed ME system.

### **1.2.2 Community Medicine is not glamorous**

CM is commonly seen as the flag bearer of PHC. As a discipline, it is considered as 'dry' (I.F.2.5); and not as 'happening' as the clinical disciplines. 'You see a swelling, you examine it and then there is a surgery, and you say this is the tumour that came out...it's more fascinating. Here, it is not like that. It is more abstract' (I.F.2.4). The focus in CM is (should be) more on preventive and promotive work, which takes a long time to bring about a change. It doesn't give that 'immediate gratification' (FGD.PG.3).

Secondly, the change that ultimately comes-by may still not be 'visible' (I.F.3.1). 'It's easy to say I conducted so many cardiac surgeries...But it's difficult to count the number of people who didn't have a heart attack because of some preventive measure which you took' (I.F.4.9). 'In clinical departments, they can *demonstrate* what they are talking about' (I.PF.6, emphasis added). 'When the students go in field, they see just a glimpse. They have not seen what it was earlier, and what has changed since then. It is a cross-section, a snapshot of a movie' (I.F.4.4). This is unlike clinical disciplines where the complete chain of events (from admission to discharge) happens in front of the student.

Thirdly, the change brought by community-level actions can seldom be seen as an improvement in the condition of an individual, nor can it be attributed to individual effort ('I' did this for 'him/her'). 'Pulse Polio started in 1995, and it got eradicated in 2013. The people who started it, they are nowhere around' (FGD.PG.3). Moreover, CM work demands one to 'reach-out' to others (patients, communities, officials) rather than having those others queue at one's doorstep as is the case with clinicians (I.F.1.1). That 'power', which also brings respect, is always a desirable thing (FGD.PG.3).

CM (may) also involve seeing patients. But this would be only for very basic complaints. The discipline doesn't provide scope to exercise sophisticated clinical skills and 'dramatically'

save lives. And those patients would largely be from a lower socio-economic class. So, none of the attributes commonly associated with the medical profession – power to cure, fame and money - find much scope in the discipline. Irrespective of whether a particular ‘department’ of CM is highly respected in its MC or is considered an appendage, these fundamental characteristics of the ‘discipline’ do not change.

The same hold true for CM faculty. Students want to be like that Surgeon who took such fine sutures, or like that Physician who picked the fault in the lab report just from the patient’s history (FGD.PG.3). They see lives being saved when there was little hope. And those who save lives become their heroes. ‘The role model is not somebody who has gone to the village, taking care of thirty thousand population and preventing diseases’ (I.F.1.1). Also, ‘if they see a big car with a professor of medicine, and a roaring practice...they develop their own mindset that I will also become a person like him one day... If they see a poor person of Community Medicine, he has no car, big car, they think that this is a useless specialty’ (I.PF.2).

If the Department of Community Medicine (DoCM) is active, students may appreciate the discipline and its concepts better; though, it still is a difficult choice. ‘They like what they see in Community Health, but they don’t want to do that’ (I.F.4.1). A group of Interns interacted with wanted to specialize in subjects like Surgery, Medicine, Paediatrics, Emergency Medicine, Orthopaedics, Interventional Radiology, or the ‘chilled ones’ like Dermatology or Ophthalmology (FGD.Intern.4). None of them wanted CM/CH. Interestingly, one of them, whose doctor-father had left hospital practice to work with communities, said, ‘I am not averse to working in a community set-up later. But I don’t want to take Community Health as my PG degree. That is pretty clear’ (FGD.Intern.4).

And then, there are DoCMs that fail to instil counter-insights into the UGs regarding what this discipline has to offer them on professional and personal terms. Many-a-times, the situation is no better even for PGs (FGD.PG.3). The problems are somewhat similar for other branches which do not involve a direct contact with patients.

So, CM and its concepts like PHC are not sufficiently appealing to students who have come to become ‘doctors’. A faculty felt that students are not like that when they enter the MC. ‘The first years when they come, they come with very beautiful ideas, very good concepts.



As they transition, it's the college I think that destroys them, and they become very focussed and all super-specialty oriented' (I.PF.3).

### **I.2.3 Status of Community Medicine as a Discipline**

Many faculty thought that there was a hierarchy between CM and the core clinical disciplines. One of them compared this with the *Varna* system of Indian society, with the clinical disciplines being the *Brahmins* (I.PF.5). Another faculty quoted a line written by a senior CM person - "our specialty is a kind of specialty which is viewed by other faculty in *amused tolerance*". '...meaning, people smile, and say, "*theek hai*" ...utter disdain' (I.F.1.2). A faculty shared her experience from PG days while she was posted in the department of Paediatrics. The faculty there found her to be good, both in terms of skills as well as knowledge. 'You know what the AP said? "You seem to be answering well. You could have very well taken MD-General Medicine instead of Community Medicine". It was an insult' (I.PF.3). I.F.4.9 heard similar things from her UG faculty when she opted for CM for PG, as she used to be a 'good student'. 'In our own fraternity, we tend to look down upon our own colleagues. If you are a clinician, you are held in high regards. If you are not a clinician, then...That's where the minds of our young medical graduates get corrupted' (I.F.4.11). A faculty shared that though he was passionate about CM, he wouldn't admit this to his friends as they would judge him. He scored well in PG entrance, but found it 'difficult' to opt CM as only those who were last in the merit would go for it (I.F.3.2). So, he first did PG in Paediatrics, and only later went for DNB in PSM.

Many CM faculty, at least in their initial years, try hard to prove themselves. They soon realize that no matter how hard they try, the bias attached to CM doesn't budge. 'Whether we tell them what we do, or we don't, they don't bring up their opinion on us' (I.PF.3). So, they stop doing that. 'I know who I am. Why should I prove that to this person?' (I.PF.3). Some get exhausted and stop taking that extra effort, because 'anyways, we are getting paid' (shared by I.PF.3). And some of them just don't try, which only strengthen the negative bias for the discipline. Because of the lethargy of such CM faculty, even those from other departments, who understand the value of the discipline, critique it.

A faculty shared what he had once heard from a stranger about CM. 'This specialty is very good, but it has remained confined to books' (quoted by I.F.1.4). Another faculty put it more

bluntly saying, 'You close down Paediatrics...the kids will get into trouble. You close down Surgery...operations will stop. You close down Medicine...OPD will get shut down. What about us? You close down Community Medicine today...will that make any difference to the world?' (I.F.1.2). The answer to this hard-hitting question came in a beautifully way from another faculty who said, 'from mango tree, they get mango. From an apple tree, they get apple. From forest, they don't see the oxygen that it gives' (I.PF.3). 'That's the reason we cut our forests', she added.

### **I.3 Professional Character of (Community) Medicine**

A faculty shared that the Cartesian model of body, one that sees humans as a set of different organs/parts, influenced not only Medicine, but also disciplines like Sociology. 'In some subjects, we have moved ahead. But in Medicine, we are moving slowly' (I.F.1.5). Besides market interests hinted above, there is something else that doesn't let the structure of Medicine and CM change. And that is the element of professionalism attached to this discipline.

Professionalization is a process of setting the boundary and scope of a profession (Matrimianakis et al. 2009). Who can enter the profession, and who cannot; what kind of work is expected from the members of the profession, and what they are not supposed to do; how are the members of the profession supposed to conduct themselves, and what sort of behaviour will not be acceptable - questions like these are answered in a standard manner through the process of professionalization. This boundary-work is desirable because it specifies the expertise, ethics and behaviour one has to demonstrate, persistently, in order to become, and remain, a member of the profession. However, it becomes problematic when the professional boundaries become inflexible and non-porous, and when safeguarding professional identity becomes more important than the larger good of the society. In this regard, Swick (2000) mentions two types of professionalism: 'expert professionalism', which has been constantly rising, and 'social-trustee professionalism' which has been on a parallel decline.

PHC approach espouses a conception of health which goes beyond medical care. It proposes a close engagement with the community and efforts towards empowering them, sometimes by transferring knowledge and skills which fall within the currently defined professional

boundaries. It stresses on the role of other sectors, and so, of other professionals, in attainment of health. These demands may not sync well with narrow professional interests. Professional bodies, including government regulatory bodies, fear that this would depreciate 'the economic and social stability of the profession' (Kapur 1985). Moreover, 'Nexus of these professional bodies and the pharmaceutical and related industries exercise such power so as to induce in the governments a state of inertia' (Kapur 1985).

Cueto (2004) shares that physicians opposed PHC approach saying it was 'anti-intellectual, promoting non-scientific solutions and demanding too many self-sacrifices' as they feared losing 'privileges, prestige and power'. Ramalingaswami (1989) finds the resistance from professional bodies as responsible for the limited success of several other initiatives taken to 'de-westernize' medicine. Opposition of the following by the modern medical fraternity may also be viewed from the lens of professionalization: integration of different systems of medicine; short-term courses to prepare medical assistants; developing cadres of community health workers and nurse practitioners; imparting Life-saving Anaesthetic Skills (LSAS) training and Emergency Obstetric and Newborn Care (EmONC) training to medical graduates (I.F.3.2).

Professional traits, good and bad, are transmitted less through the formal curricula, and more through the hidden curricula (Hafferty and Franks 1994). Students absorb the views and habits of their faculty which influences how they identify themselves and affect their behaviour for rest of their lives (AKF-WHO 1981). For instance, if the UG students are not encouraged to ask questions in the class, and the lecture goes on as a monologue, they grow up to become doctors who behave in the same way with their patients, staff and in the community. At the same time, they become submissive to the authority of generalist administrators. They just don't question. Similarly, if the sessions in PH conferences do not reserve time for audience questions, this reinforces the perception of the power vested in authority. If every speaker in the conference is introduced in terms of how many publications s/he has had, the PG students get the message about what matters.

One trait, which has social origins, but is reinforced through professionalization, is the pervasive superiority complex among doctors. 'As Doctors...we are more egoistic than anybody else' (I.F.3.1). The process begins quite early (I.F.1.5). While choosing subject

stream after class Xth, 'we think doctor, engineer...this is how we grow...then (comes) arts' (I.F.1.13). The science subjects, and later, the medical curriculum are considered as 'hard'. The selection process is highly competitive. Each student, who has made it to a MC, has achieved something which a large majority of people aspire to but do not achieve. It is natural for this to get into the head. This only gets more intense with specialization; even more so if the institutes attended happen to be reputed ones (I.OF.4.1). Secondly, medical training confers the power to cure on the students. This, along with the social status and the economic bonanza, feeds into the complex. In fact, as soon as they get an entry into the MC, the students start getting a special status in their own extended families (I.F.1.5). Thirdly, the curriculum (the formal and the hidden) that the students go through in the MC adds to the superiority complex (I.F.3.2, I.PF.5).

As this happens, 'we alienate ourselves from society' (I.OF.4.1). It hinders a level-headed dialogue with the patients, with non-medical team members, with the community and with other sectors (I.PF.5). 'You think that you know everything' (I.F.1.1). And so, seeking participation of significant others, at best, reduces to just taking their concurrence on one's own ideas. Being primarily doctors, many CM faculty continue to behave in similar fashion.

While this mindset is incongruent with PHC approach directly, there are indirect pathways also. 'We have defined the limits of this knowledge base and set it on a pedestal which other people cannot understand' (I.OF.4.1). This 'mystification' goes against the spirit of PHC. Moreover, 'we create a knowledge base, where people from outside cannot contribute anything' (I.OF.4.1). If any other discipline has to contribute, it has to first get 'medicalized'. Hence, there is 'medical sociology', 'medical anthropology', 'medical humanities'. 'We keep talking about "Medical Education". Do we talk about "Education"? We don't' (I.OF.4.1). Devoid of their 'theoretical rooting', these medicalized social sciences also have limited success in explaining concepts like PHC.

Guarding against entry of personnel with backgrounds other than medicine/CM is another trait that is shaped and reinforced through the conduct of professional associations<sup>1</sup>. Some associations, as a policy, do not allow professionals with other qualifications to become

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<sup>1</sup> The views of CM faculty regarding MPH course, and their comfort level with PH persons having backgrounds other than medicine has been discussed in detail in a later section.

their members. In reference to one such state-level association, a faculty said ‘that association feels that Public Health is a domain of medical specialists’ (I.F.4.1). Another faculty shared the case of a PH faculty who was given membership in national-level association only after waiting for a year, and was still denied the voting rights (I.F.3.11). While some faculty do not support this stand, some think that entry of people from different backgrounds may lead to ‘intellectual clash of ideas’. ‘Currently it's a homogenous group, all are doctors, all are MDs. So, our wavelengths match. The minute you have MPH, or somebody else...their perspective or perception may be different from ours’ (I.F.4.2).

A senior faculty having background other than medicine found the conferences of such associations discriminatory, unlike the international ones (I.F.1.5). They would never invite her to chair sessions or even present a memento. Even medicos from non-CM backgrounds are met with such behaviour. A faculty shared the case of a Paediatrician who had established the CM department of a prestigious PG Institute. He headed it for almost a decade, and then applied for Professorship in the same department. ‘<name of the association> actually went in court against him...a person who is not trained in Community Medicine, how can he become a professor in Community Medicine’ (I.F.3.2).

Even individual faculty display such guarding of the territory. A fresh PG in Paediatrics, having a strong urge to work in CM, wished to join Senior Residency in CM department of a prestigious Institute. When he met the HoD of CM, he was cross-questioned that would a Department of Paediatrics accept a MD-CM person as a Senior Resident. So, there are people who act like ‘custodians’, who have to ‘protect’ and ‘safeguard’ the purity of CM (I.F.3.2). The faculty called this sheer ‘professional arrogance’ (I.F.3.2).

Attachment to clinical work is another trait seen among many CM faculty. ‘If you ask some of the veterans, they would say that you should (practice clinical medicine). The fact that many of the Community Medicine people do not practice clinical medicine subsequently is something that they are to be blamed for, and they should be actually doing it’ (I.F.1.3). Krishnan (2016) informs that in an annual conference of Indian Association of Preventive and Social Medicine held in Udaipur in mid-70s, the issue of nomenclature of the discipline was raised. The choice was between Community ‘Health’ and Community ‘Medicine’; ‘Public Health’ was not even a contender. And the conference went for Community ‘Medicine’.

Nath (1987), in an oration at the annual conference of IAPSM, says, 'It is all very well to say that public health action is also medical care and that public health action has saved many lives...You and I know that, but who else realizes it?' He urges his peers to also practice clinical medicine, equip themselves to be able to interact with the clinicians 'at their own terms', and not to be seen as 'pseudo-doctors'. Similar penchant for 'medicine' was observed by the Researcher at IAPSM's national conference held in 2017 where a genuine attempt was made to redefine the discipline. These are the ways in which the boundaries are set and guarded.

As society cannot fully comprehend the body of knowledge, the profession is granted the right to self regulation (Cruess and Cruess 1997). This makes it difficult for people outside the profession to impress upon the need for changes within the profession. But then, there are faculty who consciously tell their students to remain humble and open (I.F.3.1, I.F.3.4, I.F.4.10, I.OF.4.1). There are clinicians who leave lucrative practices and take-up community oriented experiments. The discipline gets impacted by such individuals and groups within it who espouse principles of a higher collective good. The Alma-Ata Declaration emerged in a context framed by such efforts (Chapter 1).

#### **I.4 Status of Primary Health Care Approach**

The PHC approach, in which the faculties of CM must believe before they could use it in their work, has itself been discredited and attacked. As detailed in Chapter 1, it has been blamed as being primitive and cheap healthcare for the poor (Venediktov 1981). It has been described as anti-intellectual and non-scientific (Cueto 2004). It has even been charged as being a means of social control of poor (Cueto 2004). It has been accused of being ambitious and vague, and so, un-realistic (Wisner 1988).

Given the politico-economic context of those times, within a few months of Alma-Ata Conference, a selective approach to PHC was advanced as an 'interim' strategy (Walsh and Warren 1979). Under this approach, diseases which were responsible for high mortality, and which could be effectively prevented or treated by efficient interventions, were to be selectively targeted. This approach was attractive for donors/international agencies (as it gave quick and tangible outputs), governments (as it didn't question the status quo) and

industry (as it involved technologies). Hence, this was the approach that prevailed, thwarting the dream of a comprehensive PHC system.

In 1993, World Bank proposed to limit the State responsibility to 'essential' health care, practically leaving out secondary and tertiary care to market mechanisms (Bisht 2013). World Health Reports (1999) echoed the World Bank's sentiments and made a plea to recognize the limits of the State (Bisht 2013). In 2008, World Health Organization proposed a new approach in the name of PHC, called 'Universal Health Coverage' (WHO 2008). The current interpretation of this approach is largely limited to insurance-based medical care. Social determinants, which were integral to the PHC approach, have been delegated a supplementary role.

In parallel, there have been individuals and groups who have been resisting the delegitimization of PHC approach. For instance, in the year 2000 (the year by which the goal of 'Health for All' was to be achieved, but by which time the policy environment had only got worse), people from across the world came together in what they called the People's Health Assembly. They adopted the 'People's Charter for Health' and placed comprehensive PHC back on the agenda. A section of PH researchers and faculty are leading members of such civil society organizations and networks. Many outside these relatively small networks also espouse the cause of comprehensive PHC approach in their official capacity wherever they work - within government, or in non-government agencies.

It is because of the efforts of such individuals and groups, supported by a favorable political context, that an initiative like India's National Rural Health Mission gets launched (2005); that WHO sets-up a Commission on Social Determinants of Health and gives call for 'Primary Health Care - Now More Than Ever' (2008); that governments of different countries once again gather for the Global Conference on Primary Health Care and commit to empower individuals and communities (WHO-UNICEF 2018). The work of these individuals and groups may not be able to significantly align the health systems to PHC approach, but it certainly acts as 'brakes' to slow down the pace of the detour (Priya 2018). It is their steadfast belief that has kept the approach alive so as to be periodically harked back on.

Among the respondents in this study too, there were those who scored 1, and those who scored 5 on the different themes around PHC approach. How a faculty understands the

approach is influenced by which thought processes s/he gets exposed to - the ones of belief in the PHC principles, or the ones of skepticism or disbelief.

### **I.4.1 PHC principles in PHC delivery**

While ME and CM education system has the crucial responsibility to orient medical students in PHC approach, the healthcare system, where the students will finally go and work, should also reflect this ethos. Changes in training alone, though necessary, would be meaningless and frustrating if not accompanied by changes in existing culture in the healthcare system (Yesudian n.d.). The manner in which PHC services are planned, organized and delivered, often do not stick to the PHC principles (see Chapter 4 for a thicker description).

**Equity:** The allocation of budget across sectors (health and education versus defence) and across levels of health care (primary versus secondary and tertiary) doesn't follow the principle of equity (I.F.1.4, I.F.3.6, I.F.4.7).

**Comprehensiveness:** The focus on curative and individual-level preventive measures (like vaccines) continues to overshadow the health promotive aspects (I.F.4.6, I.F.4.10).

**Universality:** Health access in remote areas remains an issue (I.F.2.3). Even if such areas have been reached infrastructure-wise, human resource and logistics issues keep them dysfunctional. Marginalized groups suffer even in the heart of cities.

**Self-determination:** There is significant influence of international organizations, development agencies and the industry in the decision making process (I.F.1.7, I.F.4.3). Instead of relying on our own resources and technical personnel to improve the standard of knowledge and to solve our own problems, we are depending on outside help (Seal 1966).

**Self-reliance:** Instead of developing the capacity of the PH system, the health policy has pushed collaborations with private entities (I.F.3.2). And the system, as a whole, fails to acknowledge the capacities of households to manage a significant proportion of their health issues.

**Community Participation:** NRHM's idea of community-based monitoring has been resisted by States. The capacity of community members in VHSNC and RKS has seldom been built, and there are chronic delays in disbursement of untied funds to these bodies (I.F.1.10).



Inter-sectoral Coordination: Except in times of outbreaks, healthcare system largely works in isolation. ICDS and Education are the only two departments with which it regularly interacts.

Integration: Different health programs have been integrated at the level of implementation, but they do not talk to each other at upper levels (I.F.1.7). This approach maintains the verticality in the minds of implementers, and only increases the work of peripheral staff (I.F.2.4, I.F.4.7).

Appropriateness, in technology and otherwise: Despite knowing that only a fraction of the pregnant women would actually need institutional support around delivery, and despite knowing the limitations of the existing healthcare facilities, the system created a culture of institutional deliveries. There is no PH cadre in most of the States, and clinicians are deployed at PH positions. An Anaesthetist would be working as a District Health Officer, an Urologist looking at State's Family Welfare Program and a Neurologist managing the Malaria Control program in a State (I.F.1.4).

Decentralization: Though health is a State subject, the guidelines prepared by the Centre are projected, and also accepted, as binding (I.F.3.6). From Districts to Sub-centres, at every level, targets are given from above (I.F.1.2).

The PHC delivery system, at different levels, is the site for exposure of students and faculty to PHC. If this system itself compromises on the PHC principles, stressing on them in the MC remains hollow. This system is also the future place of work for many students. If these principles are not to be followed there, there is little purpose in developing an understanding about them.

Transfer of resources to PHC without re-orientation of the entire system in PHC will not solve the problem (Tejada 1981, Yesudian n.d.). As doctors tend to adapt to the existing health system, 'the health system will have to be changed first' (Mahler 1981).

## **II. Milieu-level Factors and Processes**

The milieu level includes one set of factors that are closely aligned to the structural: the focus of the regulatory body, the process of student selection, the prescribed curriculum, and the textbooks and journals commonly referred to ([Figure 4](#)). These determinants are

shared by all DoCMs in the country. However, they are mediated through the ethos of the concerned institution and the orientation of the concerned department. There is another set of milieu-level factors that are more closely influenced by the ethos of the institution and the orientation of the department, and so, vary from place to place.

The layer of institutional ethos and department's orientation helps the faculty to negotiate the dominant culture in professional (and personal) domain. As deduced in Chapter 3, DoCM-SPH has a 'Research and Policy' orientation; DoCM-TSI has a 'Public Health Administration' orientation; SNSPH-DoCM has a 'Community Development' orientation; and DoCH has a 'Community Service' orientation. These orientations emanate from, and feed into: how the CM faculty understand the discipline, the opportunities they get to interact with the world outside the MC, the pedagogy they follow; what is the status of the Rural and Urban Health Training Centres, whether or not the DoCMs are provided with adequate resources and how other departments of the MC engage with PHC ([Figure 4](#)). All this influences the way faculty of CM understand the PHC approach.

## **II.1 Focus of Regulatory Body**

ME in India has so far been regulated by the Medical Council of India (MCI). It has been responsible for issuing curriculum, fixing teacher's eligibility and maintaining uniform standards of ME. Besides, it is also responsible for upholding ethics in medical practice (IMC Act, 1956). A report of Department-related Parliamentary Standing Committee on Health and Family Welfare took note of the opacity in functioning of MCI, lack of accountability, failure in discharging its mandated responsibilities and allegations of rampant corruption (Rajya Sabha 2016). Others have criticized this body in harsher terms (Baru and Diwate 2015). A past faculty shared, 'our honorable (past) president of MCI was caught red-handed and then put behind bars...it was a very bad example for the youngsters' (I.PF.2). In absence of a regulator which keeps public interest central to its functioning, the ME and CM can't be expected to be oriented towards PHC.

The MCI prescribes minimum standards related to infrastructure and human resource for the MCs and for each of their departments. A senior faculty shared that while the council would be strict in enforcing the norms for rest of the MC, it would be 'relaxed' when it came to CM (I.F.1.12). Niyogi (1973) also mentions this as being responsible for persistence of

deficiencies in the department. At the same time, another faculty was disturbed with the 'instrumental' way in which MCI's inspections were done. The inspectors would be only concerned about the number of faculty and available infrastructure. They would not at all be interested in the quality that the department was delivering and the difference that it was able to make (I.F.4.7). Similar observations were also made by the Parliamentary Committee (Rajya Sabha 2016).

Ethics are an important component of PHC approach, and the MCI has released a module on ethics for UG ME in 2018. However, despite numerous reports of breach of ethics in practice of medicine in form of over-charging, unnecessary diagnostics and treatment, MCI's ethics committee had blacklisted only 109 doctors over past 45 years (1963-2009) (Rajya Sabha 2016). By a 2016 amendment in the Code of Ethics Regulations, the Council had set free professional association of doctors to endorse medical products (Rajya Sabha 2016). Such things pollute the context in which medical practice and ME happens.

Almost 65% of UG and PG seats are concentrated in southern and western parts of the country. There are more private/trust-owned MCs than government ones. Though the Council is not directly responsible for such skews, it has undoubtedly facilitated them by disproportionately favoring the private sector. It has also remained mute on the wrongdoings of the capitation-fee colleges (Rajya Sabha (2016)). It was surprising that not many CM faculty interviewed for this study referred to these overarching defects that are so obviously an impediment in developing an understanding about PHC.

On 8<sup>th</sup> August 2019, National Medical Commission Act received the assent of the President of India paving the way for replacement of the MCI with a National Medical Commission. An year later, on 25<sup>th</sup> September 2020, the National Medical Commission actually replaced the MCI.

## **II.2 Process of Student Selection**

Admission to UG and PG courses, at present, happens through a national-level eligibility-cum-entrance test (NEET). Earlier, States and non-government Institutes had relative freedom to follow their own selection process. Three out of the four Institutes included in this study had their own entrance exam before NEET. MGIMS had a paper on Gandhian Thought apart the routine Physics, Chemistry and Biology subjects followed by an interview

for UG entrance. Even St. John's had its own process for student selection based on well established technical, social and psychological principles. PGI had its own entrance exam for PG courses. TSI had a State-specific process of selection.

After coming of NEET, the student profile has seen a change at least at DoCM-TSI. A faculty from this department, during informal conversation, shared that 'I could find a housemaid's child in the class earlier. Now, most of them are from cities. Many have at least one of the parents as a doctor or in class-I job'. Even at MGIMS, earlier, students and their families would consider applying because they believed in the ideals of this institute. Now it is one of the many colleges to choose from. Moreover, the Rural Bond Scheme, which was a hallmark of its 'rural' character, had almost completely lost its ground at MGIMS.

Though NEET has brought-up new issues, even the earlier process had limitations. Table 6 (Chapter 2) shows the socio-demographic profile of the CM faculty interviewed for this study. Overall, there were more males than females. Three out of four respondents were from unreserved category, and there were none from Scheduled Caste or Scheduled Tribe. Majority of respondents have had private English medium schooling in urban areas and had at least one graduate parent.

Ramalingaswami (1985) presents the social class of parents of 669 final year medical students from 11 MCs located in different parts of the country. She classified the parents based on their education and annual income, and found that 80% parents belonged to middle, upper middle or upper class, and 20% belonged to low middle class. Duggal (2014, 2018) abstracts Census data to highlight the class and caste character of Doctors. Duggal (2018) informs that as per Census-2011, among persons aged above 15 years with Medical Qualification (Allopathy and AYUSH), 61% were males, 78% were urban and 91% were from social categories other than Scheduled Caste or Scheduled Tribe.

While these data sets don't compare the same set of professionals, they do make one clear point - that the diversity of backgrounds in medical profession and ME is not adequately representative of the society out there. PHC approach is for all ('universal'), but it is more concerned about those who have greater needs ('equity'). If these people are not adequately represented in the MCs, their issues will be seen as 'their' issues. Having

students from rural, or poor urban, areas would sensitize the entire batch about the challenges these areas face (AKF-WHO 1981).

## **II.3 Curriculum**

The UG and PG curriculum of CM, like for all other medical subjects, is issued by the MCI. It is executed through the Health University to which a MC is affiliated. In addition, each MC has a curricular committee which goes into the finer aspects. The Health University, the MC's curriculum committee and the DoCM operate within the broad scope given by the MCI.

### **II.3.1 Undergraduate level**

#### **Content**

The Graduate ME Regulations (MCI 1997) states that 'the training should be able to deliver what is essential for health care in our country'. The first objective of the Medical Graduate Training Program is mentioned as to develop ability to 'recognize "health for all" as a national goal and health right of all citizens...' Other objectives include achieving competence in practice of 'holistic medicine' and promoting 'healthy living'. As one of the Institutional Goals, the regulation mentions that the undergraduate student coming out of a MC should be able to 'appreciate the socio-psychological, cultural, economic and environmental factors affecting health and develop humane attitude towards the patients'. Under CM, the regulation mentions that, at the end of the course, the student should be able to 'enunciate the principles and components of primary health care and the national health policies to achieve the goal of "Health for All"'. Besides an exposure to DoCM in all three phases of the MBBS course (pre-/para-/clinical), that includes classroom activities and short exposure visits, the regulation provides for a two months posting at Primary Health Center(s) during the one-year compulsory internship. The regulation also mentions 'integrated teaching' across departments.

However, the regulation doesn't offer guidance regarding what is essential for health care in the country. Secondly, in the year 2008, following words were added in the regulations: 'training should be able to meet internationally acceptable standards', which might confuse

the educator as to where to look – within or without.<sup>2</sup> Thirdly, it is difficult for concepts like PHC to blend with the clinical mindsets unless linkages are consciously and organically woven into in the curriculum. The regulation doesn't frame spaces to let these linkages manifest themselves. It doesn't operationalize 'integrated teaching', or even defines it. Rajya Sabha (2016) goes to the extent of saying that the MCI has failed to devise a curriculum suited to the needs of the country.

Bhore Committee (Gol 1946) had recommended merging of the curriculum of Diploma of Public Health (DipPH) with that of under-graduate (UG) medical course. 'This was a conscious choice made in the 50s. They said that the needs of India were such that we needed to have Public Health oriented medical students' (I.PF.7). However, it is not clear if the course, which was primarily meant for in-service Medical Officers, was customized for UG medical students. The faculty as well as students interacted with in this study shared that 'sanitary latrine' and 'mosquitoes' are kind-of emblematic of CM, and are difficult to relate to (I.F.1.8, I.F.1.9, FGD.PG.4). 'It is a blunder...to teach environmental sanitation in great details. We have not to turn a medico into a Public Health Engineer/Section Officer/Sanitary Inspector' (Chugh 1983).

Further, on comparing the present day DipPH curriculum of Achutha Menon Centre for Health Science Studies, Thiruvananthapuram (AMCHSS 2017) with the CM curriculum in MCI (1997), several differences are found between the two. CM curriculum includes Epidemiology and Biostatics, and this receives disproportionate attention, but it lacks modules on Philosophy of Research. It focuses on quantitative methods, but neglects qualitative ones. It mentions social factors related to health and disease (like gender and migration) but doesn't emphasize on social science perspectives through which students can make sense of things. Health Policies are included for their historical significance, but policy analysis is kept out. Ethics, PH Legislations and Environmental issues do not receive as much attention. While the structure of India's healthcare system is taught in detail, the alternates being practiced within and outside the country do not find a mention. Information regarding

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<sup>2</sup> Mahler (1981) says, 'Any thoughtful observer of medical schools will be troubled by the regularity with which the educational system of these schools is isolated from the health service systems of the countries concerned. In many countries these schools and faculties are, indeed, the proverbial ivory towers. They prepare their students for certain high, obscure, ill-defined and allegedly international "academic standards" and for dimly perceived requirements of the twenty-first century, largely forgetting or even ignoring the pressing health needs of today's and tomorrow's society.'

contemporary issues like Health Insurance and Public-private Partnership may be delivered, but there is no space kept for debate on their relevance and their goodness-of-fit in Indian context. The politics of health is characteristically absent from the curriculum.

The faculty shared that to work at PHC level, one needed skills in management, administration, communication, planning, decision making and community engagement (I.F.4.5, I.F.4.9). Under 'management', they included logistics and finance and also people's management. Under 'communication', they included the one at inter-personal level and the one with masses; that for health and that which is of general nature. A past faculty informed that, in the West, 'cultural competency' is recognized as a skill to be developed in medical students. 'They will discuss issues on ethnicity, on race, all types of privilege and lack of privilege with their first year medical students' (I.PF.7). These aspects have not so far been included adequately in the curriculum (I.F.1.1, I.F.1.6, I.F.1.9, I.F.3.8, I.F.4.5, I.F.4.9). 'We train them in doing only the clinical work, whereas, when you become a PHC Medical Officer, clinical work is hardly 25% of what you do' (I.F.4.9). One reason for this may be the non-inclusion of people delivering healthcare services in the process of curricular designing (Frenk et al. 1990).

Social sciences have been included in the curriculum only as topics, and not also as an orientation. Moreover, the relative share of social science topics in the curriculum is too little, so they get only that much attention (FGD.PH.1). UGC-ICSSR (1975) had also highlighted that Social Sciences topics constitute only 5-6% of PSM curriculum, which is literally nothing if entire medical curriculum is considered. The report claimed that the discipline, therefore, had little justification to be called Preventive 'and' Social Medicine.

There is a lot of stress on National Health Programs. But the exposure is limited to how these programs are delivered, and not to what goes behind the scene (I.F.1.6). Moreover, the standard treatment protocols prescribed in the national programs are not followed by the clinical departments, which confuse the students (I.PF.2). Programs that have got long wrapped-up, like Guinea Worm Eradication Program, are still taught while the contemporary issues gets neglected (I.F.1.2, I.F.1.8). The students are not able to relate to such content, and do not find it relevant (Saha 1988). A few UG students of a MC had made

a spoof of CM.<sup>3</sup> The disclaimer appearing at the beginning of the video is telling. It reads: 'The subject of "Community Medicine" shown in this video is a real subject in Medical College, in which "Medicine" is silent. Any similarity between this subject and Medicine is only fictional; there is no earthly relation between studying this (subject) and becoming a doctor'.

Though CM teaching spans over three-and-half years, the faculty said there was too much to cover in the given number of hours (I.F.4.2). The curriculum was very cluttered and didn't have 'space' for the students to explore or do something else (I.F.3.2). For the same reason, it would be difficult to accommodate new things (I.F.1.1, I.F.1.6).

### **Phasing and Duration**

Earlier, CM teaching used to be spread across the entire MBBS duration. Since 1997, it ends in the pre-final year. So, there is no CM teaching when 'colourful' subjects like Medicine and Surgery are taught. 'The minute they (UG students) finish Community Medicine and go to Medicine, where the stress is only on examining, eliciting some signs, they won't remember that the patient is a person' (I.F.4.2). There is an opinion within CM fraternity that the subject needs to be assessed at the end of final year, along with other major clinical subjects (anecdotal).

The MCI's guideline provides for brief exposure visits of two hours each. While this duration may be enough for visits within the MC hospital, it is insufficient if the visit is to be made outside the campus, especially those to rural facilities. And in quantitative terms, this is too little when compared to the tertiary-level clinical exposure that the students get in the MC hospital during the four-and-a-half years of UG education.

Earlier, during internship, CM used to have a three months posting. Now it is just two months (I.F.4.8). Of greater concern is the fact that Interns, for most of the time, are made to manage primary-level OPD in this posting. They would rarely accompany the outreach workers to see how they implement the National Health Programs and interact with the community (I.F.2.7).

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<sup>3</sup> <https://youtu.be/evRYvm6M2tI>



## Assessment

As per MCI (1997), CM has to be assessed in the pre-final year. Twenty percent marks are allotted for internal assessment. This covers students' participation and performance in the classroom, field and research activities (if any) over the three-and-an-half years. Assessment for 80% marks happens in the end. 'At the end of the day, what you answer in your theory paper and what you do in your practicals is what matters' (I.F.1.10). So, students get interested in CM only towards the end when they simply mug-up the topics which are important for the exam. 'Rest of the time, they come, hear, and go...the priority is clearing those subjects on which they are going to appear for exams' (I.F.2.10). A past faculty shared her concern about some private MCs which follow unethical routes to ensure a higher pass percentage (I.PF.7).

A faculty informed that she would often tell the students that exams were just part of the process and that, in the end, it is not the marks but something else that would matter (I.F.4.5). But practically, 'assessment always drives learning, and even teaching-learning methods used, and how much time students will give to it' (I.F.3.2). The 'exam-mentality' is not a personal choice (I.F.2.1). 'It cannot be avoided unless the assessment process is changed' (I.F.3.2).

A faculty suggested that assessments shouldn't be just to declare a student as pass or fail. Rather, it should be a process to ensure that competent physicians come out of the system (I.F.4.7). But then, reforms at UG level may not suffice. The problem has roots in the school education system (I.F.1.9). And going downstream, the PG entrance exam is based on a multiple choice question (MCQ) format where the marks obtained decide the branch one gets to specialize in. So, 'the learning moves from talking to a patient, taking a proper history and evaluating the patient, to opening the book and reading the MCQs' (I.F.4.5). To develop an 'understanding' on concepts like PHC in this scenario is a challenge for the faculty.

As per anecdotal evidence, the National Medical Commission is planning to implement a National Exit Test (NEXT) from the year 2022. It will have a theory component which will replace the final year MBBS exam; the practicals will be conducted at the end of internship. Besides leading to award of MBBS degree, it will also serve as the selection process for PG.

### **Are the Regulations restrictive?**

The faculty, in general, found the curriculum to be very accommodative (I.F.1.8, I.PF.2, I.PF.7). It gives a 'long rope to the Medical Colleges' (I.PF.2). 'How you deliver, matters' (I.PF.3). They said that those who find the curriculum restrictive are those who do not want to take the trouble of being innovative (I.PF.2, I.PF.7). The greatest resistance for any attempt to innovate comes from the teaching faculty itself (Luthra 1971). 'The curriculum is never a block' (I.PF.7). Rajya Sabha (2016), however, finds MCI's curriculum to be too centralized.

In this regards, a faculty expressed concerns regarding the culture of 'regulating' and of 'being regulated' that exists in the education system of the country, including in medical education (I.F.3.2). MCI regulations are broad in many respects. And several CM Departments have been innovating within the given framework (I.F.1.4, I.F.1.9, I.F.3.5). But then, many departments and faculty demand 'clear guidelines from above' for anything and everything. 'We keep searching for instructions' (I.F.3.2). They feel that Universities should tell 'what to teach, and even how to teach' (I.F.3.2).

In some respects, however, the faculty do find the regulations to be restrictive. For instance, at MGIMS, a lot regarding Maternal and Child Health happens in field during the Social Service Camp in the first year. But formal classes on this topic would happen only in the third year. 'We have to teach as if the camps do not exist' (I.F.3.2). Moreover, even if a motivated department tweaks the curriculum within the scope of regulations, and/or uses innovative pedagogy, the prescribed assessment methods would still have to be followed like by any other department.

MCI prepares curricular guidelines by forming several task forces comprising of faculty from different MCs (I.F.4.9). So, the process is, to an extent, democratic. But no amount of representation can capture all the diversity. And so, flexibilities are required. Bhole Committee stressed on flexibilities saying 'where reforms have to await agreement among a large number of institutions, the result is usually delay in progress' (GoI 1946, Vol II, page 358).

## **The New Curriculum**

In 2018, the MCI revamped and repackaged the UG curriculum (MCI 2018b). It introduced a Foundation Course, made provision for Early Clinical Exposure and offered Electives in the UG ME. It organized each subject into a list of topics, each topic into a set of competencies and gave suggested teaching-learning and assessment methods. Besides, for each competency, it mentions the subject(s) that need to integrate, in a vertical and/or horizontal framework. The 'content' of the CM curriculum is, however, not much different from the previous one.

The faculty found introduction of Objective Structured Clinical/Practical Examination, i.e. OSCE or OSPE, as encouraging. But they saw operational issues in implementing the competency-based curriculum, especially in busy clinical departments. 'It's lot of work...formative assessment, summative assessment...a lot of work' (I.F.4.11). Moreover, the act of teaching is not adequately stimulating for faculty of clinical branches and is considered a burden and inferior work (AKF-WHO 1981). 'With the current strength and mindsets, I see great challenges' (I.F.4.11).

In 2018, the MCI also introduced a module on Attitude, Ethics and Communication (AETCOM) acknowledging that these aspects had not received due attention in the past (MCI 2018a). The module is based on the fundamental principle that 'changing a person's attitude can change his or her behavior'. The module adopts a hybrid problem-based learning method using case studies and student narratives. This approach would allow student to reflect, discuss and form opinions. The course is spread across the four-and-half years of UG ME.

The AETCOM module has sixteen suggestive case studies. These case studies present scenarios where doctors find themselves in a tough situation because of their own self-image and beliefs; or because of (seemingly) unreasonable expectations of patients or their attendants; or, simply because of the circumstances. For instance, one of the studies presents a patient who is scared of angiography because of some bad past experiences in the family. He asks for an alternate investigation, but this offends the cardiologist. In another study, a lady is diagnosed with cancer. The husband requests the doctor not to disclose the real diagnosis to her. All the scenarios presented in the case studies are real and

bring out the dilemma that doctors have to deal with. But many of these studies present the doctor as a specialist working in an urban private clinical set-up and dealing with an upper middle class patient. The dilemma faced by: a graduate doctor working in a government Primary Health Centre who is pressurized by a *Sarpanch* to appoint a particular person as ASHA; or a senior PH official who is forced to agree on a policy which s/he knows is not in the best interest of the people...these are missing.

The faculty also shared some conceptual and operational problems with the AETCOM module. It gives 'specific' learning objectives. 'I think Humanities require general learning objectives. You need to widen-out people's understanding' (I.OF.1). It stresses on student narratives, but not all students can 'translate their feelings and their ideas into words' (I.OF.1). Even those, who can, may do it best in their native language, not necessarily in English. And as there can be multiple native languages, it makes things difficult for the faculty. It offers limited pedagogical tools and lacks methodologies which go beyond language, like dance, drama, visual arts, photography and film-making. Regarding teaching of ethics, a faculty was concerned that 'the institutional ethos may not be supportive' (I.OF.2). The MC and its hospital may not have functional frameworks to ensure and uphold clinical and research ethics, and so, 'the students will see a gap between what is taught and what is practiced' (I.OF.2). However, some faculty saw the new competency-based curriculum and the AETCOM Module as 'slow progression towards betterment' (I.F.2.3).

### **II.3.2 Postgraduate level**

Lal (2004) points out that the MCI has not standardized any curriculum because of which the training content vary significantly across MCs. He informs that even evaluation procedure is not uniform. The Researcher could access a document titled 'Guidelines for Competency Based Postgraduate Training Program for MD in Community Medicine' on the MCI's website (MCI n.d.). This document specifies competencies, syllabus, teaching learning methods and assessment methods (formative and summative). It also recommends a training schedule and a list of books. However, based on the experience of visiting the four departments, the Researcher found variations in training schedules (see Chapter 3).

A faculty shared that MD curriculum lacked 'theory' (I.F.1.2). By 'theory' he meant that which explains the observed phenomena and not the 'theoretical' approach where one

learns only from books. Instead, the focus is more on information and skills. Moreover, macro-level issues and policy analysis, which feature prominently in the PH courses, are missing in the MD curriculum (I.F.1.3). The politics of health is completely absent (I.F.1.9). 'How do you fight for health rights? All that is not covered in what we do' (I.F.4.6). Some faculty opined that all this do come under the scope of CM, but is not being taught in most places because of operational constraints (I.F.4.9, I.F.4.10). Instead, a lot of time is spent on clinical work. The PG students get some flavour of PH when they read about the development of different National Health Programs and their critiques (I.F.4.9).

A young faculty shared his concern regarding the thesis work during MD. Most departments give only three months to the student to finalize the thesis topic. Fresh out of graduation, into a new environment, this period is too less to think and explore what one wants to work on (I.F.3.10). A senior faculty expressed concerns with the way in which MD thesis were supposed to be assessed. 'The University says you approve or disapprove' (I.F.2.3). She would find a lot of scope for improvement in the submitted thesis, but the system wouldn't allow for that. Not approving the thesis would be an injustice to the student. 'So, we just approve' (I.F.2.3).

Some faculty shared their concerns regarding absence of any field training for PG students other than those who join CM. Some of these PGs only would later take up faculty positions and become Heads of Units and Departments, Deans and Superintendents with whom CM faculty would have to interact. Except Paediatrics to an extent, 'no other department thinks about the mental and social aspects of a disease' (I.F.4.2). After UG, there is no formal reinforcement of this broader understanding (I.F.4.8). 'It's not there in their curriculum' (I.F.4.2). PGs of some departments in some institutions do get posted in the outreach for a while. For instance, PGs of Paediatrics Department at St. John's are posted at CHTC. But their parent department is a very busy one, and it keeps desperately waiting for them to come back and resume 'the work'. For them, it's like 'we are giving you a break' (I.F.4.8).

## **II.4 Textbook and Journals**

Textbooks are the primary source of information and knowledge for the students. For CM, *Park's Textbook of Preventive and Social Medicine* ('Park') is a very popular textbook among the UGs as well as PGs. Faculty would often call it the 'Bible' of CM and would plan their

lecture schedule as per the index of this textbook (O.C.4.2). How this book incorporates the concept of PHC, thus, has an effect on how the students understand it. And as the faculty have grown up reading and teaching it, year after year, it also influences their understanding.

Park (2013) has the concept of PHC explained in less than four pages spread across three chapters with a lot of repetition. Besides the standard definition, it lists the eight components and explains the four principles of PHC – equitable distribution, community participation, inter-sectoral co-ordination and appropriate technology. One of these chapters carries a dedicated section on 'Primary Health Care in India', but it details the structure of primary-level health service delivery at village, Sub-centre, Primary Health Centre and Community Health Centre level. This articulation further strengthens the general impression about PHC being only a level of care rather than being an approach that applies to entire health system. Another chapter states that '(t)he concept of primary health care involves a concerted effort to provide the *rural* population of *developing* countries with at least the *bare minimum* of health services' (emphasis added). This contradicts another chapter which mentions that the approach is applicable to both developing and developed countries, and that the package of services is flexible. Ideally, PHC approach should form the base and should cut-across different health topics, as is demonstrated in reports like ICSSR - ICMR (1980). However, the principles are cocooned in one chapter of the book, and they do not generally reflect elsewhere. It gives an impression that PHC is a historical concept that is worth knowing about, but it need not be invoked while discussing CM in general. Even more worrisome is the fact that, while the discourse on PHC has undergone so many ups and downs as mentioned in Chapter 1, the content on PHC in the book has remained literally unchanged since 1989.

According to Mankad (1991), the book propounds following notions: Ill health is a result of interaction of man and nature, where changes in the latter are beyond our control, and so, the essence of medicine is to help individuals make necessary adjustments; that individual acts are the major reasons for ill-health (like, infants die because mothers don't breastfeed), and so, the object of PSM is to enable students to help individuals alter their lifestyles, without disturbing social institutions and norms; that social and political forces do not significantly affect medicine or health policy; and that society is generally uniformly

cohesive. Mankad (1991) further say that the book serves the purpose of a 'dictionary', but doesn't help students in understanding the dynamics of disease process in society. Gaitonde (2005) critiques the textbook from a gender lens. Some students find it bland. An Intern said, 'It's black and white, with diagrams that lack creativity. Somebody should come-up with a better, more interesting book'.

Referring to the textbooks of disciplines other than CM, Vine (1958) suggests that the preventive and social aspects of diseases need to be incorporated as integral subjects of study, at equal importance with diagnosis, treatment and prognosis. This would help in integrating these doctrines into the thinking of clinicians, and through them, into the students (Vine 1958).

PH/CM journals are another source for the students and faculty to develop their understanding and get new information. They are also a platform for the authors to share their perspectives and work. It's an input-output cycle. What one thinks (input) leads to what s/he writes/says (output). And this output serves as an input for others. Basically, what get published is a reflection, and a re-enforcer, of the popular discourse in the discipline. Journals, thus, play an important role in shaping the mindscape of individual faculty and student.

All the four departments included in the study had subscribed to popular Indian CM/PH journals. However, several faculty admitted that they were not too much into the habit of reading (I.F.2.1, I.F.2.6, I.F.2.8, I.F.3.6, I.F.3.7, I.F.4.1, I.F.4.5, I.PF.3, I.PF.5). They would read journal articles which were being presented by PG students in the Journal Club so as to be able to make comments (I.F.2.9, I.F.4.6, I.F.4.8, I.F.4.9). Besides, they would refer to journals when they themselves were drafting an article (I.F.2.8,). Occasionally, they would read if something very interesting came-up (I.F.3.6), or if there was some update in their specific domain (I.F.4.2, I.F.4.9). But otherwise, there is little time for this activity (I.F.4.6).

From whatever exposure the faculty had to journals, they found them to be addressing the issues of PHC (I.F.2.2, I.F.2.4, I.F.2.5, I.F.3.3, I.F.3.5, I.F.3.7, I.PF.5, I.F.4.6, I.F.4.9).<sup>4</sup> This contentedness contrasts with what literature shows. For instance, Bhatia and Rifkin (2010)

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<sup>4</sup> The concern is regarding the quality of published studies, and their utility in terms of field action (I.F.2.4, I.F.3.3, I.PF.3).

found ‘primary care’ and ‘Primary Health Care’ being used interchangeably in the special eight paper series of Lancet titled ‘Alma-Ata: Rebirth and Revision’ published in 2008. Lewin et al. (2008) did an overview of 20 systematic reviews, each of which has reviewed several primary researches on specific interventions to strengthen health systems. They found that most of the reviews addressed provision of quality care and ways to improve coverage and access. One review focused on interventions to improve the referral system. However, there was little data regarding equity or cost-effectiveness. And there was no review of interventions from Low and Middle Income Countries to explicitly improve inter-sectoral action, de-centralization or community participation (Lewin et al. 2008). So, while every topic may appear to be related to PHC, it may not necessarily incorporate the PHC approach.

## II.5 Understanding of the Discipline

The department is known by different names in different institutes. At PGI, the department is called ‘Department of Community Medicine and School of Public Health’. At TSI, it is called ‘Department of Community Medicine’. At MGIMS, it is known as ‘Dr. Sushila Nayar School of Public Health incorporating Department of Community Medicine’. At St. John’s, it is ‘Department of Community Health’. As shown in [Table 28](#), in almost 75% of MCs, the Department is known as one of ‘Community Medicine’.

**Table 28: Different Names of the Community Medicine Department in Medical Colleges of India (as in the year 2017)**

Name of the Department	n
Community Medicine	355
Preventive and Social Medicine	38
Social and Preventive Medicine	12
Community Medicine (PSM)	13
Community Medicine (SPM)	2
PSM (Community Medicine)	10
SPM (Community Medicine)	3
Community and Family Medicine	6
Community Health	2
Preventive Medicine	1
Humanities and Community Medicine	1
Not found	36
<b>Total</b>	<b>479</b>

*Source:* This information was compiled by visiting the official websites of individual Medical Colleges. The list of Medical Colleges was taken from MCI website. The search was made in the year 2017.



### **II.5.1 History of the term ‘Community Medicine’**

Till the first half of 20<sup>th</sup> Century, the subject was taught as ‘Hygiene and Public Health’ in India. Influenced by the Goodenough Committee in England (1944), the Bhore Committee (GoI 1946) recommended setting-up of a Department of ‘Preventive and Social Medicine’ in each MC. This recommendation was stamped at the ME Conference jointly organized by Ministry of Health and Family Planning and Medical Council of India in the year 1955 (MoH 1955).

In 1972, the Faculty of Community Medicine was established in United Kingdom, jointly under the three Royal Colleges (London, Scotland and Glasgow) so as to prepare ‘community physicians’ for a restructured National Health Service (I.F.1.2, I.F.3.11, Warren 2000). Shortly thereafter, Indian Association of Preventive and Social Medicine and the MCI also endorsed ‘Community Medicine’ as the new nomenclature for the discipline (I.F.3.11, Krishnan 2016). However, unlike in Britain, there was no larger context to the change in name of the discipline (Chugh 1983, Singh 2004). ‘We didn’t have any history...we changed because they (the English people) changed’ (I.F.1.2). ‘But as far as function is concerned, there is no change at all’ (I.F.3.11). Neither was there a change in public healthcare delivery structure, nor in the curriculum taught in the MCs. Deodhar (2003) calls this change of name as an example of ‘empty educational reforms’. Interestingly, the people in England reverted back to ‘Public Health’ in 1990, but ‘Medical Council of India did not bother to do that, nor did our national Association’ (I.F.3.11).

### **II.5.2 How attached are the CM faculty to ‘Medicine’?**

‘Medicine’, meaning curative care, is one of the ways to restore health. PHC approach acknowledges the necessity of ‘medicine’, but doesn’t regard it as sufficient. Being too attached to medicine is an obvious block in developing a comprehensive understanding about PHC.

A general inclination towards ‘medicine’ becomes evident both in the literature and in the faculty responses. Deodhar (2003) writes, ‘It is all right in teaching of public health to restrict to “prevention” and the “groups” of people. But in PSM, one always speaks of “treatment” and deals with “individuals”’. Nath (1987) defines CM as ‘everything that Preventive and Social Medicine was, with the addition of curative care up to, and including

the level of, the first “doctor” intervention’. He further asserts that ‘it must be both recognised and practiced as a clinical specialty’. Krishnan (2016) also speaks of the keenness among CM professionals to emphasize the clinical nature of the discipline. A faculty said, ‘Technically, as per MCI, we are a para-clinical department. But here, they feel that we are a clinical department, because we do a lot of clinical work in our rural centre. So, being a clinical department itself is promoting ourselves’ (I.F.4.2). The work of preventing diseases and not letting them recur was also deemed fit to classify the discipline as ‘clinical’ (I.F.2.4). A PG student said that even PH research would not be purely ‘non-clinical’ as one would still be ‘dealing with the people’ (FGD.PG.4).

However, such labels didn’t bother every faculty. I.F.4.8, for instance, said ‘It doesn’t make a difference to us whether it’s classified as clinical or para-clinical. We do whatever we have to do’ (I.F.4.8). Another faculty saw this sort of classification system - clinical, para-clinical, pre-clinical - as an ‘insult’. ‘All the subjects are taught by the doctors; all the subjects have relevance to health, well-being, sickness, illness, disease of the patients...I wish they do away with this nomenclature’ (I.F.4.11).

Some faculty and PG students interacted with in this study said that the word ‘Medicine’ has been kept in the name of discipline for its glamour quotient (I.F.2.3, I.F.3.11, FGD.PG.3). Because of this ‘Medicine’, ‘the orientation somewhere becomes very clinical...focussing on the curative aspects more’ (I.F.3.1). They didn’t find it suitable because, ‘we are practitioner of health; we are not practitioner of medicine at all’ (I.F.3.11). Referring to the Greek Goddesses symbolizing clinical cure and prevention, a faculty said ‘You are not going to think only about Panacea. You are also going to think about Hygeia’ (I.F.2.3). For these very reasons, the faculty working at the department at St. John’s around 1980s picked ‘Community Health’ as the name. ‘They looked at community health in a holistic way. It wasn’t just about medical care. It was care of the community in other domains as well, one being development - women's development, community development. And therefore, they didn’t want that world 'Medicine', because medicine is more boxed-in’ (I.F.4.6). Even faculty and students from other departments felt ‘Community Health’ to be a more appropriate term (I.F.2.3, I.F.3.11, FGD.PG.3).

Another important question is that how attached are the CM faculty to curative medicine, irrespective of how the discipline is classified or named. Almost all the faculty interacted with in this study saw curative care as an important component of CM. Though, their reasons behind this viewpoint varied.

One way of thinking was that CM personnel were basically doctors, and 'seeing the patients is basic for every doctor' (I.F.2.6). 'If we are not treating patients then whatever (developmental) work we are doing will be a waste' (I.F.4.2). And clinical services actually satisfy a genuine community need. Some faculty saw the purpose of CM teaching to be preparing 'basic doctors' and 'community physicians'. Unless they themselves engaged in clinical services, how would they train the UG and PG students in the same? (This is actually a circular argument).

Several faculty and students, however, saw interaction with individual patient as a starting point<sup>5</sup> for the practice of CM (I.F.1.1, I.F.1.4, I.F.1.6, I.F.1.9, I.F.3.8, I.F.4.10, FGD.PG.3). 'A single patient can inform a lot about Public Health...where our system is failing, where we are not able to reach him, where we missed picking the disease at an earlier stage' (I.F.1.1). Secondly, curative care would give a legitimate entry into the community. Nath (1987) says, 'to get people accept preventive and promotive advice, we must fulfil their role expectations of a doctor and also help them by providing first level curative care'. A faculty said, 'We now feel very free to walk into a village, we have an identity, we can get a group together, we can talk about social determinants in a more authoritative tone' (I.F.4.10). 'I am suffering from fever and you are talking about building up Self-help Groups...that doesn't work. First you treat my disease, and then I will listen to you' (I.F.3.8). However, they agreed that going beyond may not be possible if the clinical work becomes overwhelming.

A few faculty called for a moderation of clinical work in CM, including during PG training (I.F.1.3, I.F.1.8, I.F.2.1). This was because a) MBBS-level knowledge was enough to perform primary-level clinical duties (I.F.2.1); b) this is not the work that PGs aspire to, or would

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<sup>5</sup> Vine (1958) says, 'The sickness is no more than the means of introducing him (medical student) to the host of circumstances which make up the goodness or badness of an environment - social, economic, hygienic and the rest'.

actually, do after finishing the course (I.F.1.3, I.F.2.1) ; and c) 'clinical is not our forte' (I.F.1.8). 'The (CM) discipline is meant to actually serve the health systems' (I.F.1.3).

### **II.5.3 What is the role of CM?**

The role of CM, according to most faculty and student, was to deliver comprehensive healthcare at community level. 'The CM person would see the patient holistically, and would try to relate the disease with patient's environment. He would also look-out for patterns in the complaints with which patients present in the OPD. Based on this, the CM person would take action at community level' (I.F.1.1). It is a specialty which 'identifies the needs of the community, plans to meet those needs, implement those plans, and ensures that those needs are met' (I.PF.3). CM sees the person as a whole, and explores the social determinants of health (I.F.4.8). A faculty used the analogy of 'floor moppers versus tap turners', and that of 'intracellularists versus balloonists' to distinguish between the clinicians and CM professionals (O.C.4.2).

A group of Interns saw CM as a subject that calls for coming out of the hospital and reaching out to people; that brings-in other factors affecting health; that focuses on prevention through measures like health education at community level; that touches upon administration; and that involves research (FGD.Intern.4). A faculty shared the perspective of his PG guide who saw CM as 'a training to make you a good Medical Officer' (shared by I.F.3.10). Interestingly, a non-CM faculty equated CM with PHC when, in reference to this study, he said, 'Studying the understanding of PHC among faculty of Community Medicine is like studying the understanding of Surgery among Surgeons' (I.F.3.9).

To fulfil these roles, teaching and training of CM at DoCM-SPH would include: Family Medicine, Epidemiology, Health Management and Health Promotion (I.F.1.1). Other faculty also put forth a similar composition, with addition of 'administration' at DoCM-TSI (I.F.2.3, I.PF.3).

Another view was that CM was about planning, implementing and evaluating the National Health Programs. 'We should work to improve community health rather than individual health' (I.F.1.8). Diverging further, a faculty said 'there are a whole range of issues, a whole range of problems facing the health system. We need to address those problems, engage with them, find solutions to those problems, test the solutions and give those solutions.

That is the contribution we probably can make' (I.F.1.3). Nath (1987) underscores Epidemiology, supported by Statistics and Research Methodology, as the keystone of CM, something through which CM personnel can demonstrate their expertise to colleagues from other discipline and to the health decision makers. Freyman (1958) opines that DoPSM has to inculcate an appreciation of the importance of social factors in health and disease. This it has to do through teaching behavioural science (understanding the patient beyond his disease), ecology (understanding the man in relation to his environment) and methods of scientific inquiry including statistical methods. All this needs to be done in the classroom, OPD/ward and in the community, directly by PSM people or indirectly by their influence on other faculties (Freyman 1958).

One faculty felt that CM offers an opportunity for 'exploring'. 'The questions you put to yourself regarding "health", Community Medicine is a subject that gives you answers' (I.PF.5). And that, she felt, is because CM is interdisciplinary; it is one subject that breaks free from the narrowness of Medical Science. 'You can connect it with Psychology, you can connect with Anthropology, you can connect with History, Geography...lot of dimensions are there' (I.PF.5). And, it tells that 'you are a part of the community; being a doctor doesn't make you special' (I.PF.5). Rao (1967) similarly highlights the interdisciplinarity inherent to Social Medicine and positions it as the essence of the 'philosophy of medicine'.

#### **II.5.4 How different is 'CM' from other similar disciplines?**

The department at the recently established AIIMS have got 'Family Medicine' (FamMed) added to their name. The faculty considered FamMed as much closer to clinical medicine (I.F.1.1, I.F.1.10, I.F.3.11). Though CM also involved going into the family aspects of a patient, it didn't require as much clinical expertise as did FamMed (I.F.2.3, I.F.2.5, I.F.2.6). CM was about multiple levels of prevention while FamMed was more about secondary prevention, which is diagnosing and treating the sick (I.F.2.4, FGD.PG.3). Unlike CM, FamMed didn't require much research and administration (I.PF.3). In Paterson (2008), following words have been used in relation to FamMed: holistic, accessible, affordable, comprehensive (promotive to palliative), integrated (with tertiary), continuous (not just episodic), 90% of health conditions can be managed at this level, has a defined geographical area, involves mobilizing and educating communities, is aware of the potential of

communities, adopts a 'person-centred' approach. The two disciplines have overlaps, but otherwise, their roles and functions are different (I.F.1.6).

'Public Health' is another term used to describe what CM people do. A large number of CM faculty are members of the Indian Association of 'Public Health'. Some reference books used by PGs and Faculty also carry this name. Faculty regard PH as something dealing with 'policy' and 'planning', 'advocacy', 'administration' and 'management', 'supervision, monitoring and evaluation' at 'health systems' level, and engaging with large scale research involving multiple sectors (I.F.1.1, I.F.1.10, I.F.2.3, I.F.4.5, I.F.4.6, I.F.4.9, I.PF.8). It deals with macro-level issues and distal determinants like 'water and sanitation' (I.F.1.12, I.F.4.9, I.PF.8). To fulfil these roles, the person would be working at District-level and above, and would not be 'delivering' services, clinical or otherwise (I.F.1.1). 'Public Health is more like IAS-kind' (I.F.4.2). However, Krishnan (2016) says that PH can be practiced at 'micro' (community), 'meso' (organizational/district) and 'macro' (state/national/global) levels.

One schema is to arrange these different disciplines along a continuum. 'I think it will start with General Medicine, where you are treating the disease in an individual. Then you have Family Medicine, where you are looking at the family also. Then you have Community Medicine, where you have the individual, the family and the community. The next step on the ladder would be Community Health, where you are looking not only at medicine, but you are also looking at other determinants of health. And the next step would be Public Health, where you are looking at the community as a whole as a denominator, more into policy and planning' (I.F.4.9). Another representation is that of a 'Venn diagram'. 'The little triangle, where they overlap, is the ideal Community Medicine course where you are learning clinical part from Family Medicine; you are learning about preventive medicine, national programs from Community Medicine; and you are learning policy, advocacy, health systems from Public Health' (I.F.4.6). Krishnan (2016) defines FamMed as a combination of micro-level PH and primary- and secondary-level clinical medicine. He defines CM as a combination of meso- and micro-level PH and primary-level clinical medicine, thus acknowledging that macro-level issues (related to policy, legislation etcetera) stands out of the scope of CM.

DoCMs were earlier called Departments of Preventive and Social Medicine or of Social and Preventive Medicine. Even now, some departments are known as that ([Table 28](#)). A national association of CM faculty is named Indian Association of 'Preventive and Social Medicine'. Park's textbook, commonly used by UGs and PGs for CM, also holds the same name. Faculty found it a bit difficult to distinguish PSM or SPM from CM. Some of them found these to be same as the course and career prospects were same (I.F.2.4, I.F.2.5, I.F.2.9). Others opined that the clinical component, which is integral to CM, was absent in PSM (I.F.3.5); that 'individual' was the unit of thinking under PSM, and not community (I.F.2.3). A past faculty said that departments of 'PSM' were largely supposed to only teach (I.PF.8).

Though CM was seen as different from FamMed and PH, there was a general feeling that 'Community Medicine has everything' (I.F.1.1). 'We are actually the overall people, because we are trained in all these aspects' (I.F.2.3). 'A Community Medicine person can wear any hat' (I.F.4.11). This diversity often invites confusion among the faculty and students (Freyman 1958). But then, a past faculty called these as the different facets of the 'diamond' called CM. 'Where we want to polish, what we want to reflect, it's up to us' (I.PF.3).

### **II.5.5 Purpose of CM Teaching-Training**

ME, by design, is technical in nature. 'Humanization' is something missing in it (I.F.1.1). The faculty generally believed that the purpose of CM teaching and training at UG-level is to make students aware and sensitive about the contexts from which the patients come, to inform them about the preventive aspects, and to encourage them to go a 'little beyond' (I.F.4.10). 'The aim of (UG) teaching should not be (to) turn out Public Health specialists, but good practitioners of medicine who are aware of community conditions, their duty towards the community, and responsibility in the national health problems and programs' (Deodhar 2003). A SNSPH-DoCM faculty said, 'we don't really expect to produce staunch Gandhians through this process. But then, what we are attempting is to tickle that sensitivity in their minds' (I.F.3.1). This means making the students realize the importance of talking to the patient for a few extra minutes; to give them a few tips beyond the medicines; to reduce/waive the costs for those who can't afford (I.F.4.4). They felt that if they could make such 'humane' doctors out of the students, the objective would be achieved (I.F.4.2, I.F.4.4).

The faculty acknowledged that the root causes of ill-health were beyond health services for which 'being humane' would not be enough. But to train students to delve into and try to tackle the root causes, alongside medical training, was a tall order. 'That's where the aspirations of Community Medicine have to be moderated' (I.F.4.10). The faculty have accepted that only rarely would a student actually go and work at the community level. So, 'even if they are sitting at a tertiary level, and if they are helping out patients from a rural area sitting there, it's fine' (I.F.4.2).

To learn how to be 'critical' is reserved for PG training (I.F.4.9). But even here, 'we should not trouble them too much with understanding social science, history, history of medicine and how these relationships have come up to this level etcetera. My effort is to improve their behaviour with the clients, especially at the program level. For me, Community Medicine is to work on the programs' (I.F.1.5, a Sociologist!).

As is evident from above discussion, the understanding of the discipline of CM varies across faculty. While some faculty/departments undertake Social-Economic-Political-Cultural-Ecological analysis and work towards long-term PH solutions, others are happy bringing relief to the communities in short and medium term. The former may see the latter as 'reductionist'. And the latter may consider the former as 'sitting up in the Himalayas' (I.PF.8). The problem is that 'we all get trapped in our own thought processes. And the departments and institutions also get trapped into those thought processes' (I.PF.7). What is important is to have dialogue. 'I think it will liberate people...' (I.PF.7). 'There has to be a mature critical engagement' (I.PF.7).

### **II.5.6 Relationship with 'Public Health'**

DoCM-SPH runs a Master of PH (MPH) course which is open to students from diverse backgrounds. The department has a separate set of faculty for this course, some of whom have backgrounds other than medicine. DoCM-TSI has a Diploma in Public Course (DipPH) which is restricted to medical graduates and is managed by the same faculty who teach and train MD-CM students. SNSPH-DoCM and DoCH didn't have such courses at the time of this study. This section is about the views of faculty regarding MPH, and regarding presence of persons other than medicos in the field of PH.



PH used to be a status symbol for Physicians till 19<sup>th</sup> century as it projected them to be above commercial interests (Lasker 1997). Also, there wasn't much in clinical medicine to offer to the patient except bleeding, purging and sending them to hills or sea-side. This changed with the discovery of germ as the Physicians could now cure the ailing patient with antibiotics. Even PH turned to vaccines to prevent people from falling ill, and to other similar technological measures. But as the results of the work of Physicians could be 'seen', their social and economic status increased in comparison to those engaged in PH. With rise of non-communicable diseases, the tide turned a bit in favour of PH as there were no germs here that could be killed. The same keeps happening as and when a new communicable disease emerges (like HIV-AIDS) till the time an effective technical fix is found. So, while the Physicians call PH as a subspecialty of medicine, the PH personnel consider medicine as one of the arms of PH (Milton 1985). The clash is, at times, worse with PH personnel seeing Medicine as full of 'arrogance, self-interest and self-aggrandizement' and Physicians looking at PH as 'a politically corrupted field populated with individuals intellectually incapable of medicine and science' (Brandt and Gardner 2000). While Physicians generally tend to have an upper hand over PH, places where PH people had been more powerful, even they have tried to make the curative medicine subservient to PH. Such a conflict makes integration an impossible affair (Gour 1958).

Schools of PH first started getting established within or in close proximity to Medical Schools in early 20<sup>th</sup> Century in United States. The purpose was to influence medical personnel with PH approaches. In India, All India Institute of Hygiene and Public Health was established in 1932 that offered DipPH courses for doctors, and still does. After Independence, based on the recommendation of Bhore Committee, DipPH course content was merged in UG medical curriculum and Department of Preventive and Social Medicine were established in all MCs. As the scope of PH widened, the need for bringing-in other disciplines was felt. As this was difficult to do within the confines of MCs, the trend of starting Schools of Public Health outside the MCs began (Brandt and Gardner 2000). Centre of Social Medicine and Community Health, at Jawaharlal Nehru University, and School of Health Systems Studies at Tata Institute of Social Sciences were some of the early ones in India. Their number has multiplied since the turn of the century (I.PF.7).

## **How CM faculty see MPH course?**

When every medical graduate is being taught CM, and when hundreds of MDs in CM come out of MCs every year, why is there a need for separate PH courses?

One explanation given was that a significant part of PH work didn't require much medical knowledge (I.F.2.1). Using doctors for such work would be a mis-utilization of their capacity. Moreover, doctors themselves didn't like, nor did they have time, to do things which fell outside their core-competencies (I.F.1.1, I.F.2.1, I.F.3.2). It would also be economically inefficient as training doctors is a costly affair. Another way to say the same thing is that it is costly to employ doctors for jobs that could be done by personnel who are not doctors (I.F.3.2). Hence, there is a need for courses like MPH. No doubt that some faculty saw MPH as a source of cheap PH labour (I.F.4.6), deliberately pushed by international agencies (I.F.2.1).

This explanation, however, puts a question mark on the relevance of MDs in CM. They are all qualified doctors, but have a limited clinical role. So, is specializing in CM a wastage of medical resource? And why are some State governments then sponsoring in-service doctors for PH trainings offered outside MC set-ups? Thus came another explanation which recognized the importance of doctors in PH work but saw the need as too huge to be met alone by the doctors trained in CMs (I.F.3.2). Moreover, CM doctors largely preferred to work as faculty in DoCMs instead of taking administrative posts in the PH system (I.F.4.9). MPH allows in-service doctors to develop PH skills (like administration) in lesser time (I.F.2.1, I.F.4.10). Hence, there is a need for a separate course.

But then, why some CM-trained doctors still go for MPH? And so, there came the third explanation which saw operational and conceptual limitations in CM education. Operational limitations included the inability of the departments to touch upon PH aspects like policy and planning, because there was already a lot to do (I.F.4.8, I.F.4.9, I.F.4.10, I.PF.7). Same topics may be covered in different ways in the two courses. For instance, while Epidemiology, in MPH, would be about multi-variable analysis, meta-analysis, inter-country comparisons and about how to control for confounding; in MD-CM, it would focus on situation analysis, outbreak investigation, prioritizing and planning health services and monitoring programs in a given area (I.F.1.12).

A few faculty acknowledged the conceptual limitations and said that some essential PH perspectives were difficult to develop within the intellectual boundaries of a MC (I.F.3.2). For PH, 'you need to have exhaustive kind of understanding about society, individual, family and all the institutions' (I.F.1.5). So, the option for medicos was either to move out of these boundaries and get trained in a multi-disciplinary environment (I.F.1.12). Or, to collaborate with people from other disciplines who work for PH with perspectives different from their own (I.F.1.4). Both these options necessitated a separate course in PH.

A senior faculty from DoCM-SPH, which runs a MPH course, informed that there would be a lot of 'churning' in the discussions in MPH classes because of the diversity in the backgrounds of the students and faculty. 'They are able to appreciate that bio-medicine is only one part of it, or healthcare is only one part of it. They realize that there is a broader socio-political-economic basis of Public Health, and interventions are required at that level to bring big change in the system, and in the health outcomes rather than having only minor incremental changes' (I.F.1.12). He said he could clearly make out the difference between the two groups during department seminars. While discussing, the CM group would 'always boil down to individual behaviour and top-down actions', while the PH group 'always converging on to the sociological, socio-political approaches to solve the problems of society, emphasis on social justice and social action'(I.F.1.12).

### **How comfortable are CM faculty with non-medicos in PH?**

Many faculty were not comfortable with personnel from backgrounds other than medicine being in the field of PH. One reason was that they didn't consider such people as 'capable' to undertake PH work. 'When a medical person thinks, questions a disease, he knows the anatomy, pathology of it...How can they (persons with MPH qualification) do unless they have a basic foundation' (I.F.2.3). The faculty took the example of departmental statisticians who could do a lot of statistical analyses, find *p*-values, but would fail to interpret them in the given context (I.F.2.3, I.F.4.3). Or, even the economists for that matter who now frame health policies (I.F.4.3). They opined that grasping power of MD-CM was better than those who do MPH (I.F.1.2, I.F.4.2). One faculty went to the extent of questioning if MPH was 'quackery of Community Medicine' (I.F.4.11).

Some faculty didn't have such concerns. "Health" is not controlled just by the medical people. It is not just the role of health people. It is role of lot of people' (I.F.1.9). And so, it requires people from 'all spheres, all disciplines' (I.F.1.4, I.F.3.2, I.F.3.11). Moreover, working with personal from different backgrounds is 'enriching' and 'mutually beneficial' (I.F.1.6); 'it only improves things in the country' (I.F.4.1). 'We should not forget that many of the luminaries in Public Health were not actually trained Public Health people' (I.F.1.6). A faculty having background other than CM shared, 'if you go in Harvard and other PH schools, you will see even the artists are part of PH department' (I.F.1.13). So anybody who is interested in PH, irrespective of whether s/he is a doctor, is welcome (I.F.1.6, I.F.1.8, I.F.1.9).

The second reason why many faculty were not comfortable was because MPH pass-outs were being offered the same job opportunities that MD-CM personnel would fit-in. This was not only true for NGOs but also for international agencies and even State and National Government. 'I will not be comfortable if you put an MPH, non-MBBS MPH as equivalent to somebody who had done MBBS and Community Medicine. That is not acceptable' (I.F.4.11). And as MPH people would be ready to work at a lesser pay, the recruiters would prefer them over MD-CM, thus shrinking their job space (I.F.4.8, I.F.4.9). Despite pushing the demand for a PH Cadre by CM lobby since long, the issue is yet to find resolve. 'You can see in many Medical Colleges, Community Medicine seats are going vacant because of no scope for a job' (I.F.4.6). PGs ask 'What am I going to do after I finish my MD-Community Medicine? Am I going to go back to the same PHC and write the same tablets?' (shared by I.F.2.1). Krishnan (2016) has also referred to such insecurities.

Some faculty didn't have such anxieties. They felt that MD-CM personnel were all qualified doctors who could see patients and prescribe medicines. This differentiated them from other PH people and gave them a unique and incontestable place (I.F.1.2, I.F.1.6, I.F.4.2, I.F.4.4). Krishnan (2016) proposes opening up to non-medical disciplines and be ranked higher to them as a remedy for the low self esteem that CM feels because of being low in the pecking order of clinical disciplines.

Two senior faculty had put the things in perspective. They opined that people from other disciplines could very well compliment the work and expand the scope of CM. The goal of both, CM and PH, was to improve health of the people. 'The problem comes when you

starting considering the two as synonymous' (I.F.1.7). 'They are not representing the same body of knowledge' (I.F.1.12). The two should work collaboratively and find ways to move together. But they should have their autonomy.

By looking at the faculty codes, it becomes evident that most of those from DoCM-SPH find it desirable to have personnel with backgrounds other than medicine in the field of PH. This department conducts a MPH course, has a disciplinary diversity among the faculty, students and staff, and collaborates with researchers from widely varying fields. All of this exposes one to different perspectives and offers opportunity to realize the value of multidisciplinary. SNSPH-DoCM and DoCH also have a few faculty who think this way, but more among them either don't have a clear opinion on this issue or see this as an encroachment on their domain.

The concerns are not recent. Gour (1958) writes, 'Gone are the days when the specialties were nurtured within their boundaries. The artificial partitions have to be lifted up. Our whole aim has to be the welfare of the community, thus of the mankind as a whole. If we doctors do not break open those channels, the non-medical men may do (that) for us and we many have to follow it by law. So let us gird our waists and do the job peacefully, gracefully and amicably'.

## **II.6 Opportunities for Interaction**

A faculty explained that the more diverse the exposure, the deeper the understanding about health and PHC (I.F.4.9). Meeting different kinds of people and getting to know varying perspectives develops the understanding at an accelerated pace as compared to doing the same thing again and again. Deodhar (2003) also emphasizes on DoCMs having linkages with community, health services and other departments. Such interactions also prevent the faculty from developing an 'ivory tower' mentality (Jungalwalla 1958).

### **II.6.1 Interaction with Community**

'Primary health care starts with people and their health problems', says Mahler (1986). It is very important to interact with the people for whom the health system is supposed to work. It is important to understand how they live, what they do, what they feel and what they think. One such interaction happens between the doctor and the patient. It has its own importance. It can be very informative, educative and even transformative. However, to

understand PHC, the interaction with community has to go beyond a clinical set-up; beyond those who are ill and have been able to access the doctor.

SNSPH-DoCM and DoCH had plenty of opportunities for interactions with the community. Though, it was largely managed by the Social Work teams of these departments. DoCM-SPH had presence in field, but it was largely for clinical work or research projects. DoCM-TSI didn't have a community attached to its peripheral centres, which is true for many DoCMs. (This has discussed in greater details in Section II.8 titled 'Status of Rural and Urban Health Training Centres').

### **II.6.2 Interactions with the Government Health System**

It is the government health system that plans, implements, monitors and supervises health programs for the masses. CM faculty have a lot to learn from, and to contribute to, the government health system at different levels (block, district, State) (I.F.1.3). But there are no formal linkages between the Directorate of Public Health (which manages the government healthcare system) and Directorate of Medical Education (which manages the MC departments) (I.F.1.4, Nath 1987, Rajya Sabha 2016). So, the opportunities of interactions have to be created at departmental or individual levels.

DoCM-SPH was extensively involved with the government health system, from local to national level. SNSPH-DoCM was very closely linked to the local and district-level, and some of its faculty were also party to State and National level discussions. DoCH had engagements with the local health system and had some interactions with the government health system at other levels. DoCM-TSI was making progress in this regards. However, the faculty opined that, in general, there was not enough interaction between DoCM faculty and the government healthcare system.

The faculty shared the reasons for this state of affairs. On one hand, the faculty have inertia, or a superiority complex of being from a MC. They fail to realize that 'people will not recognize you by virtue of your position... (but) by the amount of contribution which you will provide to them'; 'you can't do Public Health just by sitting (in the department)' (I.F.1.4). On the other hand, there may be problems from the other side as well. MC faculty are seen as 'outsiders' in the government health system, more so if they belong to a private MC (I.F.1.5, I.F.1.10, I.F.4.4, I.F.4.6, I.F.4.10). Even government officials may have arrogance of being in

authority. Despite being approached by the faculty, they may not invite them in review and update meetings (I.F.2.3). A faculty shared that government health officials had a general resistance for innovative, cross-sectoral ideas. This, he said, may be because a) they are accountable for their decisions and they do not want to take risks, b) they are overworked, or c) they also have been trained as doctors, and so, have that 'attitude' (I.F.3.2).

Even when such interactions happen, the final results are not always encouraging. A faculty recalled tabling a gap analysis report with several clear-cut recommendations to the concerned State-level officials. 'All those issues are still there. Nothing has been rectified...the whole machinery moves so slowly, or not at all, it becomes very difficult for private players like us to make that difference' (I.F.4.6).

### **II.6.3 Interaction with Peers**

#### **Professional Associations**

There are two large national-level associations related to the discipline of CM. Faculty shared that these associations have not been quite active (I.F.3.1, I.F.3.2, I.F.3.11, I.PF.6). They were more about elections and less about giving direction to the discipline (I.F.1.7, I.F.4.7). The problem was also at the level of members of these associations. They would often hold opinions different from that of the association, but not many of them would voice it. 'If we are not raising our concerns, we are equal party to whatever is happening' (I.F.3.1). There are people within the association who think positive, but they are inactive (I.F.3.2, I.F.3.11). The fact that the two associations worked independently, without much synergy, further weakened their position (I.F.3.11). Consequently, unlike, say, Indian Academy of Paediatrics (IAP), or the Federation of Obstetric and Gynaecological Societies of India (FOGSI), these associations were not strong enough to get a voice in policy circles (I.F.1.2, I.F.3.1, I.F.3.2, I.F.3.11). And, often, the associations chose wrong battles to fight (I.F.4.2). For these reasons, the young entrants in the discipline get disillusioned and frustrated with the associations very soon.

Given the current status of these associations, a past faculty opined that other bodies, like the Indian Medical Association (IMA), need to come forward for PH (I.PF.6). This also needs to happen because 'Community Medicine people are not the only people who should be bothering about health of India' (I.PF.6). But associations like IMA have played a very

miserable role (I.F.3.1). 'They work only for the interest of their members...Health of the community is not at all a priority for them' (I.F.3.2).

However, things have been lately changing in CM/PH associations for the better (I.F.1.8). The associations have taken initiatives like attempting to re-define the discipline and coming-up with a textbook (I.F.3.11). State-wise chapters have recently been established in Southern Indian States, and conference venues have also gone in that part of the country. Though there is still a disproportionate focus on publications, they have now started giving space to innovations in teaching and service in their conferences. The younger members are also more active and concerned (I.PF.6). The cohort of like-minded and passionate individuals is growing, and it's a matter of time that their mass becomes critical to the decision making within these associations (I.F.1.1, I.F.3.1).

### **Professional Conferences**

The environment and discussions at discipline-related conferences may have a profound influence on the perceptions that faculties and students develop. They are the conventional platform to facilitate peer-to-peer interactions, sharing experiences and exchanging ideas (I.F.3.3). They may serve as a mechanism to make the faculty learn new things because 'the professor of Community Medicine cannot be taught in a classroom' (I.PF.2). They are one of the ways to keep the faculty motivated (I.PF.2), and provide a platform for networking (I.F.1.10) and meeting friends (I.F.1.3). Conferences which are open to people having backgrounds other than CM give a chance to get exposed to differing perspectives.

The faculty at DoCM-SPH used to attend International, National and State level conferences. Those at SNSPH-DoCM were regular at National and State-level conferences, and occasionally, also those at International level. DoCH faculty preferred State-level conferences as the National ones happened largely in North India, and it would consume a lot of time in travelling. Not many DoCM-TSI faculty were into attending conferences. The PG students everywhere had to attend conferences as they had to mandatorily present posters and papers.

The faculty found the national conferences to be generic in nature. Those who had specific areas of interest preferred domain-specific conferences. They further shared that many participants see conferences as an opportunity for personal glorification, be it as organizers,



speakers or those who judge the papers and posters (I.F.4.8, I.PF.6). And many of them would give more importance to non-academic activities (like sight-seeing, shopping, partying or campaigning for association elections) rather than wanting to share knowledge and build perspectives (I.F.3.6, I.PF.5). In order to accommodate these interests, the organizers would not focus as much on the academic content of the conferences as desired. This scenario is not conducive to any discussion, let alone PHC. Consequently, the deliberations held there would not lead to something substantial (I.F.3.8).

A junior faculty shared an experience from his PG days when his paper was initially selected for poster presentation at a conference. At the insistence of his Guide, he modified the title and did some cosmetic changes in the abstract. And the same paper then got selected for oral presentation in award category! (I.F.3.10). Only a few speakers had something good to share. Otherwise, the faculty shared, 'my own teachers, who have never gone to a Primary Health Centre, were delivering lectures on how those facilities should function' (I.F.3.10). He felt that such experiences are a negative inspiration for the students.

Besides conferences, the younger faculty also resort to forming smaller sharing and discussion groups on social networking applications like Facebook and WhatsApp for a more regular interaction.

The faculty opined that issues of PHC would find a space in the conferences (I.F.2.4, I.F.2.7, I.F.4.6). For instance, there would be papers discussing non-medical determinants of health like women empowerment, sanitation and ASHAs.

#### **II.6.4 Interactions at Policy-level**

Policy making is as much a technical process as it is political in nature, if not more. It is a 'tug-of-war' between competing ideologies and interests, and it is 'power' more than 'reason' that wins (I.F.1.3, I.F.1.12). Virchow said 'the physician is the natural attorney of the poor', and physicians need to play this role at the level of policy as well. While the principles of PHC apply at all levels, other levels will tend to ignore them if these do not reflect in the policy.

A faculty said that the departments should essentially be engaging with the issues of health system and providing evidence-based solutions for the same (I.F.1.3). As detailed in Chapter

3, many faculty at DoCM-SPH were contributing to policy at State and National level. A few faculty from SNSPH-DoCM and DoCH were also attempting to do so. DoCM-TSI was in a very good position to influence the State policy, and was beginning to explore these opportunities. However, generally speaking, the faculty shared that participation of DoCMs in policy making process was minimal.

The faculty acknowledge that 'trying to influence government policy, "translating" what you do into policy' is a worthy endeavour (I.F.4.10). But there are different reasons why they are not able to do so.

### **Faculty/Department issues**

Firstly, the faculty find this a time intensive endeavour (I.F.4.6). 'There is quite a lot of teaching and training load in terms of classes and visits...also run the rural and urban health training centre...' (I.F.4.9). 'You have to follow the teaching schedule, exams and all of that' (I.PF.7). In addition, they are put in many committees at the institutional level (I.F.4.9). So, they are really busy. Besides time, creating models or evidence to influence policy require resources which may not be easy to find. 'The Management will ask you to fulfil teaching responsibilities. That is your primary job' (I.F.4.9). One of the reasons why DoCM-SPH could engage with policy was that it didn't have the pressure of teaching-training UG students (I.F.3.2, I.F.4.3). Moreover, this department had Senior Residents who would shoulder the responsibility of routine activities at peripheral centres, thus setting the faculty free to take-up other work (I.F.3.2).

Secondly, the faculty feel, 'our primary *identity* is as academic members of a Medical College who have a job to do, which is to educate' (I.F.4.10, emphasis added). 'If it's purely a Public Health institute..., offering a MPH degree, you could then really focus on that end of the spectrum' (I.F.4.10). One middle-aged faculty felt that maybe, they'll be able to contribute to policy after they become senior, when they'll have more time and would have gained enough experience (I.F.4.9).

Lastly, neither the MCI's curriculum expects, nor the popular textbook used for the discipline explains, how to critically engage with the policy.<sup>6</sup> This gets compounded by the

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<sup>6</sup> The curriculum and the textbook focus on information about the official approaches and how to implement them [detailed in Section II.2 ('Textbook and Journals') and II.6 ('Curriculum)].

limited exposure to the ground-level situation, and to the concurrent discussions. Consequently, the faculty lack capacity to contribute to policy (I.F.1.2). For the same reason, they are not able to question the program designs and performance reports. This uncritical and conformist attitude naturally seeps through to the students.

### **Issues on the other side**

Firstly, 'it is not that government is always looking for suggestions and ideas' (I.F.4.10). Secondly, the access to policy circles is limited (I.F.1.1). The academia does get represented in the decision making process at State and National level. But, generally, it only the 'big' names, or those stationed in National/State capital who get invited in such meeting. Those working in the field, in different contexts, are left out (I.F.3.2, I.F.3.7). Nath (1987), however, says, 'it is no use bemoaning the fact that we are not consulted. It is in our interest and in the interest of the people who will benefit to establish a close liaison, and therefore, we must make the effort and continue to do so until we succeed'.

The faculty who got such opportunities shared that policy circles are dominated by administrators. 'Some super-IAS would be setting there, who thinks we people are morons. They know everything...' (I.F.1.2). And there are strong influences from external agencies and experts (I.F.1.7). At times, the decisions may not entirely be guided by the public good (I.F.1.6), but there is little one can do. The faculty would have three choices: to concur with the agenda, to keep quiet or to speak-up at the risk of being silenced. The smart ones, the 'yes sir types', go with the first choice (I.F.1.2, I.F.1.7). While returning from such forums, one would often think, 'everything was pre-decided, why did they call us' (I.F.1.2). 'The day this culture develops in India, that you say what you want to say, then probably the discourse would be different' (I.F.1.7).

Actually, it may not be necessary to be physically present in policy discussions to influence the process. The CM faculty may also contribute by generating evidence. However, the policymakers tend to take the brand value of the evidence as a measure of its quality. 'You quote <names of two popular international journals>, and they will be fascinated by that, even if it's trash' (I.F.3.6). And worse, the policy maker may just not value evidence (I.F.1.7, I.F.3.6).

## II.6.5 Interaction with Others

Even beyond the community, government health system, peers and policy-makers, there are people and institutions with whom CM faculty may interact, learn from and collaborate. These may be individuals having backgrounds other than medicine who may lend a new perspective to health issues. These may be organizations working for such groups of people who do not figure anywhere in day to day discourse. Or, these may be informally organized movements for the rights of the people. And these may also be international institutions and organizations which have experience of working in diverse cultural contexts. Such interactions further deepen the understanding of PHC, and allow one to do what may not be possible within the formal structure.

At DoCM-SPH, there were people from diverse backgrounds (like Sociology, Anthropology, Engineering, Law) as faculty, students and project staff. Besides, the faculty had research partnerships with local, national and international institutions which would include professionals as diverse as chemists and mathematicians, depending on the need of the project. SNSPH-DoCM has been interacting with local, national and international NGOs for community-based projects. It also has been, off and on, having short-term student exchange programs with foreign and in-country institutions. DoCH has been receiving funds from international organizations to run its field projects. Besides it collaborates with various NGOs in the city and beyond so as to expose its students to different dimensions of health. St. John's has reserved UG seats for religious sisters who, after finishing their studies, go back and serve in very remote areas. Having such company influences other students as well. A few faculty at DoCM-TSI also had been collaborating with other institutions for research, or doing voluntary medical work in remote areas. There would be one or two such faculty in almost every DoCM.

One interaction which was conspicuous by its absence was with organizations working for the rights of the people, and with health movements. The Researcher could find only a handful of faculty across the four departments who were somewhat in touch with, or even aware about, such organizations and movements. Many faculty had acknowledged that policy makers and program planners would just sit over evidence. But still, they refrained from 'activism' of any kind. At best, they talked about 'advocacy'. A faculty who was aware about such endeavours, but was still not associated with them, cited shortage of time as a

reason. But then, as per a past faculty, 'we are missing the wood for the trees. We are not understanding the deeper dynamics' (I.PF.7).

Another issue was a weak interaction with people working in fields allied to health. For instance, 'how much is Medical Education engaging with, say, ecology? Those are the Primary Health Care issues' (I.PF.7). The Division of Humanities at St. John's facilitates lectures by such speakers under its Citizen-Doctor program. Such initiatives are very much desirable so as to get-out of the echo-chamber.

## **II.7 Pedagogy**

'If you really want to generate interest in a subject, you have to focus on the teaching methods more than the content' (I.F.1.8).

### **II.7.1 Undergraduate level**

#### **Classroom**

The MCI guidelines recommend lectures, seminars, group discussions, tutorials, demonstrations, practicals etcetera as the teaching-learning methods. It also says that didactic lectures should not exceed one-third of the total time allotted to the subject (MCI 1997).

The faculty recalled the UG lectures in their times as 'monotonous' (I.F.1.8, I.F.1.9; I.F.4.3). 'When we were taught epidemiology, we couldn't gather even the a-b-c of epidemiology, what all those jargons meant' (I.F.1.8). So, as students, they would just mug-up things and vomit them out during the exams. Nath (1987) also shared similar issues. 'That is where the problem starts' (I.F.1.9). Some of them also shared that, in their times, the classes would not happen regularly (I.F.4.5), or would be taken by faculty not qualified in CM (I.F.3.2).

Now, LCD projectors have replaced the 'boring' wall-boards and over-head projectors (I.F.1.6). Though, the faculty do not find this sufficient (I.F.2.3). 'They will make a power-point from the textbook, project it, teach and go. What will one learn from this' (I.F.1.10). The teaching is more descriptive: 'this is the age group in which it is very common. This is more common in females, more common in males' (I.F.4.5). These 'packets of information' do not help the students understand the relevance and importance of the discipline.

Moreover, with improved access to e-resources, the 'information' is readily available (I.F.4.4, I.F.4.5). If the same thing is repeated in the classroom, students get bored (I.PF.7).

Mocking the casual approach of some of the faculty towards lectures, a faculty quoted his friend who would say, 'the whole Community Medicine can be summarized in twenty-eight words. Just put "and", "is", "that", "this", and you can take lecture on any topic. Just twenty-eight words, like "appropriate technology", "primary prevention", "secondary prevention", "health worker", "political will"' (shared by I.F.1.2). The critique is equally valid for Social Science jargons like 'privilege of birth', 'social structures', and 'oppression' as was observed in one of the lectures.

A basic sensitization in Social Sciences is necessary to understand PHC. While the curriculum includes Social Science topics, they are mostly taught by CM faculty. These faculty have themselves had an intense exposure to bio-medicine, and have little orientation in Social Sciences. In some departments, these topics are delegated to the Medical Social Workers. But even they may fail to do justice with the topics if they can't link these to health (FGD.PH.1). And some departments may just skip the Social Science topics (FGD.PG.4).

A larger issue is that the faculty are not 'required' to get trained in the science of Education. 'The only profession, where there is no training in teaching required and people still end up teaching, is medicine' (I.F.4.11). 'Pedagogy as a subject is not common, and we expect every doctor to become a teacher by divine intervention!' (Nath 1987). MCI has a network of Nodal Centres (n=10) and Regional Centres (n=22) spread across the country<sup>7</sup>. It runs two faculty development programs through this network: Basic Medical Education Technology and Fellowship in Medical Education (earlier called Advance Course in Medical Education). Foundation for Advancement in International Medical Education and Research (FAIMER), a non-profit organization, has also been active in India in this regards<sup>8</sup>. In addition, as per MCI (1997), every MC should have a ME Unit or a Department for Faculty Development. However, these either do not exist or are found to be inactive (Supe and Burdick 2006, Sood 2008, Ananthkrishnan 2010, Garg and Gupta 2011). So, the teaching capabilities of CM faculty, and medical faculty in general, are basically taken for granted. Deshpande (1982)

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<sup>7</sup> <https://www.mciindia.org/CMS/information-desk/national-faculty-development-programme-new>

<sup>8</sup> <https://www.faimer.org/education/regional.html>

says, 'We have for long assumed that a good student will become a teacher by simply observing another teacher. This has only produced stagnation.'

The faculty included in this study shared that they would: cite examples from their own experiences; relate the theoretical concept with what students would have seen in field; give interesting group-work; narrate short stories; show videos; bring-in light humour to make the lectures interesting. A past faculty shared how the same thing could be described at different levels. "Japanese came and bombed Pearl Harbour", you can see it as that statement alone, as a fact'; 'You can (also) see it as "the Japanese were so silent, they had (developed planes) which were not detected by the radars of the Americans"...That's an insight'; 'or, you can go further and say..."the atom bombing (on Hiroshima and Nagasaki) was triggered by this attack' (I.PF.3). A few faculty, like I.F.1.9, also take feedback from students. But this is not something very common (I.PF.7).

Specifically with respect to PHC, Nath (1987) says, 'Our involvement in the teaching of Primary Health Care seems limited to giving the students definitions and theoretical descriptions'; 'Do we have anything in the curriculum about Community Participation other than a mention of the term? Are the students taught how to enlist such participation, how to make the people active partners in their health care? Do they see us practising it in our field areas?'

Another concern was that, despite being pushed by MCI, integrated teaching rarely happens (I.PF.2). The same topic, in parts, is taken by different departments, which leads to a lot of repetition (I.F.1.2).

At times, faculty themselves underscore the importance of a topic by linking it with exams (O.C.3.3, O.C.4.1, O.C.4.2, O.C.4.3). 'What is there in ASHA's Kit...listen...it's asked in exam' (O.F.3.1). An Intern shared that many faculty begin their lecture saying 'a lot of questions in NEET come from this topic'. Even field activities, like Family Study, are introduced as something which students would have to face in the practical exams (O.F.3.4).

Some faculty, in order to keep the students interested, stress on things like 'Community Medicine is easy', 'it is simple', 'it just needs common sense', or 'it doesn't have difficult terms like other subjects' (O.C.3.3). These are the strengths of CM. But the problem is not

that students find CM difficult. The problem is that they don't find it relatable. At times, faculty's attempt to make things relatable may subtly convey something unintended and undesirable. For instance, while explaining transmission of influenza, a faculty created a scene where a patient is repeatedly coughing on the face of the treating doctor (O.F.3.3). While the students might have been able to identify with this situation, such things reinforce the image of a patient as somebody who is ignorant, careless and irresponsible.

### ***The Culture of Questioning***

Medical students are not encouraged to question. The faculty would either forget to ask the students if they have any questions (O.C.3.1), or do so as a ritual at the end of the session when there is practical no time left (O.C.3.3). But even when the students are encouraged, they still rarely ask questions. One explanation for this is the relatively fixed nature of medical knowledge. The basic medical facts do not change for a long time, and so, there is little scope for questioning (I.F.1.5). Another reason is that 'in Medicine, you have to learn skills; and there is *Guru-Shishya* kind of situation' (I.F.1.5). So, you don't question the authority. Similar behaviour can be seen at professional conferences.

The nature of questions asked by the faculty is another concern. People focus on recall-type things rather than talking at the conceptual level (I.F.1.7). And the answer to the question asked by the faculty has to conform to what is in their mind, otherwise they will not be satisfied (I.F.1.7). This doesn't just happen in classroom. A faculty recalled a senior colleague asking 'how many pages are there in *Park*' to a candidate appearing for a faculty position (I.F.1.2).

### **Field**

Speaking from his own experience during UG, a faculty shared that the concepts and principles of PHC would make little sense if taught only as a theory in the classroom (I.F.4.4). 'No book can replace the community' (I.PF.2). 'Unless you show them Primary Health Care in the field, in the programmatic settings, then only it is going to enter their heads' (I.F.1.8). Another faculty saw field as a 'proof of concept' for what was taught in the class. He compared this with the act of a Physician showing the effect of a drug by actually treating a real patient with it, or a Surgeon actually showing a procedure in the operation theatre (I.F.1.2). He said that proofs for concepts like health promotion were not being shown to the



students in the field. If one wishes, the hospital compound itself provides a lot of opportunities. But, 'we have not taken the charge of campus anywhere' (I.F.1.2).

SNSPH-DoCM and DoCH conducts week-long community orientation programs for their UG students SNSPH-DoCM also uses long-term monthly family follow-ups as a pedagogical tool for its UG students (see Chapter 3). Faculty and PG students informed about a few more DoCMs that conduct similar programs. Such initiatives do touch upon the 'affective' domain of the student. But in quantitative terms, these community exposures are far too less when compared to the tertiary-level clinical exposure that the students get in the MC hospital during the four-and-a-half years of UG education. DoCH faculty shared that, despite having specific initiatives for UG orientation, their students were not getting to see all the field activities of the department (I.F.4.2, I.F.4.9). During UG, classroom activities dominate over exposure to community. 'This is "Knows" and "Knows how", that's all. How it is actually changing their (UG students') attitudes, I don't know' (I.F.4.2).

DoCMs which do not have such innovative programs rely solely on the short two-hour exposure visits to Primary Health Centre, Sub-centre, *Anganwadi* Centre, or to Water/Sewage Treatment Plant, or to the community. Some departments/faculty would meticulously plan these visits (I.F.1.8; I.PF.3). They would orient the junior faculty and field staff on what they are supposed to do; would brief the students about the learning objectives of the visit; would encourage focussed observation in the field; would try to manage the language issues that some students might face; would ask the student after the visit about what they saw in field (de-briefing); and would relate that to PHC. They would help the student make sense of things. They would not give long and information-intensive formats to the students. 'If it's elaborate, they will focus only on the questionnaire because they have to finish it' (I.PF.3). The structured formats obstruct a free flowing conversation with the family members.<sup>9</sup> And often, students are not comfortable with the formats (O.F.3.4, O.F.4.2, O.F.4.5). But such level of preparation is an exception rather than a norm. Consequently, the students see these brief visits as a 'sight-seeing tour', or as an 'outing', or

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<sup>9</sup> Saha (1958) writes that knowing the community through surveys is very informative, but not sufficient. One has to know the attitudes of the community towards health services and the health programmes. One has to study the habits, behaviour and traditions of the community. Vine (1958) writes that the constant use of a paper of questions with its hint of an official record is sometimes enough to diminish the value of the response. Further, he says that the aim of home visitation should be to understand the family and help them, rather than to only elicit information (Vine 1958).

a 'picnic' which doesn't lead to any engagement (I.F.3.8). 'Till you go and teach them inside a Primary Health Centre, inside a Sub-centre, inside a village, and participate in what is going on there, they will not get oriented' (I.F.1.10).

Still worse is the situation at DoCMs which do not step out of the MC campus at all. They teach a concept like PHC 'only in the paper' (I.F.1.10); '...selling the idea through telling' (I.PF.2). The knowledge of students would, thus, not go beyond definitions (I.F.1.6). For instance, they would 'know' what a FGD is and how many members it should ideally have, but they may not have ever 'seen' and 'experienced' it (I.F.1.10). Students are not able to 'see' what contributions can be made through CM, which they are able to appreciate when they are posted in clinical departments (I.F.1.3). 'You want them to become Primary Health Care physicians, or a community doctor. Without exposing them to the community, you can't expect them to become one' (I.F.4.4). Even if some of them ultimately work at the community-level, they would give 'bookish' advice - '...you should be doing this, doing that...eat fruits, eat green-leafy vegetables...' (I.F.1.10). They find themselves ill-equipped, both, in understanding and skills (I.F.1.1; I.F.1.6). They fail to get 'the pulse of the community' (I.F.1.9). In order to develop the understanding among students, 'we (CM faculty) should not only be teaching, but we should be, in real sense, the practitioners of Primary Health Care' (I.F.1.4).

During Internship, students get a two-months posting in CM. On one extreme, there are departments where Interns go the Sub-centre, accompany the ANM in field, attend *Panchayat* meetings and see 'what are the pressing demands of the people...what all projects have they implemented in the village, are they related to health' (I.PF.2). And the Interns are assessed on requisite skills before being given the completion certificate. On the other extreme are the departments which have designated RHTCs and UHTCs only for fulfilling MCI's requirement, otherwise rarely anybody goes there. Most of the departments lie in between these two extremes.

Many departments run General OPD or specific clinics within the MC hospital campus for things like immunization, ante-natal check-ups, fever treatment or dog-bite cases, and they post their Interns in these set-ups. Even when posted at a (government) health facility outside the MC campus, Interns are mostly seeing the patients, often as a replacement for

the regular Medical Officer (I.F.1.9). Involvement in non-medical work is little, and poorly supported (I.F.3.10).

Students at Institutes like St. John's, and to an extent, also at MGIMS are supposed to do two-year rural service at identified centres. But even here, the graduates mostly do primary-level clinical work and are rarely going in the community (I.F.4.2). However, the faculty still felt that working in such settings may be transformative for at least some of the graduates (I.F.1.12, I.F.3.8, I.F.4.4, I.F.4.6, I.F.4.7, I.OF.4.1). Though, such compulsory service was criticized by students and also by some faculty.<sup>10</sup> They said that medicine was already a very long course in comparison to other professional courses (I.F.4.7). Secondly, the conditions in peripheral facilities were not conducive to live and work (I.F.4.7, FGD.Intern.3, FGD.Intern.4). A faculty also said that compulsion may spur corrupt practices (I.PF.3). Thirdly, the element of compulsion will not lead to the desired transformation (I.F.3.8, I.F.4.7, FGD.PH.1)<sup>11</sup>. And lastly, such expectations selectively from doctors, when students of other state-funded institutions [Indian Institutes of Technology (IITs) and Indian Institutes of Management (IIMs)] may even join multi-national companies, were unrealistic (I.F.4.6, I.F.4.7, I.F.4.11). It's as if doctors are being 'punished for doing medicine' (I.F.4.3). Mahajan (1972), however, says that 'medical education and medical services have to be tuned to needs of community and not personal needs of doctor's material gain or his scientific satisfaction'. Chugh (1983) asks 'Is the tax payer getting his due from his investment in the medical education when one looks at the finished product?'

## Research

This is another important pedagogical method to develop an understanding about PHC. All the three departments included in this study, which had UG courses, were focussing on UG research. A faculty shared that her previous department had also instituted a Young

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<sup>10</sup> Even a 1967 survey of 733 medical students at BJ Medical College - Pune found 70% of them to be against compulsory government service (Deodhar 2003).

<sup>11</sup> Talking about a compulsory year of social service ('pasantia') in Latin American countries in 1980s, Yesudian n.d. shares that the student would somehow complete it. Even community would be aware about their low interest levels and would prefer to consult established city-based physicians. This disinterest was because of the gap between what doctors aspired to do after their training at the high technology university hospitals, and what they were expected to do in PHC settings. Moreover, the tenure was too short for development of mutual understanding between the community and the doctor.

Researcher Award to promote UG research (I.F.2.2). But, this is not true for many DoCMs in the country (I.F.1.9, I.F.2.6).

## **II.7.2 Postgraduate level**

### **Classroom**

The MCI guidelines recommend Journal Clubs, Seminars, Case Presentations and Lectures/Discussions for PG students in the department. These activities were observed to be happening regularly in three out of the four departments included in the study. But in many DoCMs in the country, PG is regarded as a 'self-learning' endeavour (I.F.1.3). Classroom lectures are rare. Students have to explore their interests, and find their paths. While this approach may help the students become independent thinking professionals, they miss the opportunity to learn from the experiences of different faculties. And then, the 'self-learning' label is often used as an excuse by some faculties and departments who are either 'sedate', or have other priorities (I.F.1.2).

A faculty pointed out lack of 'de-learning' as a cross-cutting weakness in the pedagogy of CM, and medicine in general. 'Only training, training, training. To de-learn, and then re-learn...listening...these things are not taught to us' (I.F.1.2).

### **Field**

The MCI guidelines recommend posting PG students at Primary Health Centres and Sub-centres for a year, with residential posting at RHTC; posting in the District Health Office for a month; posting in MC hospital for a month (General Medicine, Paediatrics, Obstetrics and Gynaecology); short postings in allied hospital departments (like in the one dealing with Bio-medical Waste) or in field (like during a *mela*, or during an outbreak); and visit to institutions of PH importance (MCI n.d.). These postings were happening in different combinations and for different durations across the four departments included in the study (see Chapter 3).

At DoCM-SPH, there was a year-long posting in the tertiary-level hospital. Except the residential posting at RHTC, majority of PG students' time was spent on providing primary-level clinical care. The same was the case at DoCH, even during the residential posting at CHTC. Student's direct involvement at community-level, for work other than clinical, was limited. This mirrored the extent of involvement of faculty in such work. DoCM-TSI didn't have a RHTC with residential facility. So, the students would go in the morning, provide the

OPD services, and return by the afternoon (I.F.4.7). This was told to be the case with most of the DoCMs in the country. In many departments, the service component is entirely absent, or is in form of certain clinics based in the MC Hospital itself (FDG.PG.4). On the other hand, a few CM departments are overwhelmingly clinical, thus leaving little space for other things (I.F.4.1, FGD.PG.4). Nath (1987) says, 'majority of MD courses do not bother with practical public health practice...we seem to be concentrating on producing "teachers" who are only trained for one job - producing more MDs'.

At DoCM-SPH and DoCH, students were not getting posted in the District Health Office. An issue peculiar to DoCH was that the students would spend most of their field posting at the department's CHTC. As CHTC was not implementing all the National Health Programs, the ground-level experience of students with these programs would be limited (I.F.4.3). Similar problem was told to be present in other reputed departments which have their own Health Centres but have little connect with the government health system (I.F.2.1, I.PF.3).

Faculty's engagement in field-based teaching of PG students was found to be weak across the departments. A young faculty said, 'It is taken for granted that if you join Community Medicine (as a PG), you understand Primary Health Care' (I.F.1.9). This was when many PG students would not have had adequate exposure to rural areas and to the government health system during their UGs. It is more important to make them understand basic things like 'what is the role of ASHA, of VHND, of VHNSC in Primary Health Care', rather than teaching them 'some hi-fi concept that is new and sounds intellectual' (I.F.3.10).

## **Research**

At PG level, research is a mandatory part of the curriculum. However, the research guides have a significant influence on the topics that the students work on. The process should ideally be participatory, but many-a-times, it is not so. While some guides would dictate the process, others would have a laissez-faire attitude (I.F.3.1, FGD.PG.4). In some departments, both students and faculty may be busy with other activities (project-based research, or UG teaching), resulting in weak PG research (FGD.PG.4).

Another concern was 'irrelevance' of the research, either because of repetitive nature of the topics (like 'epidemiology of hypertension') (I.F.1.2, I.F.4.1); or, because of repetition of methods (like KAP surveys) (I.F.1.7, I.F.4.1). Many of the dissertations would be only

descriptive in nature (I.F.3.10). The faculty blamed the guides more than the students for such irrelevance (I.F.1.2). Further, the students are asked to use readymade survey formats rather than being made to learn how to design one (I.F.1.2). Faculty also shared concerns regarding plagiarism in MD thesis at some places (I.F.1.2, I.F.3.10).

A less appreciated issue was an obsession for ‘publication’ (as against ‘research’) among some PG students and younger faculty. Number of publications is a metric of worth in CM. ‘In (job) interviews, they look for how many papers we have’ (I.F.3.10). What is valued, gets done. And in this race for publications, ethics sometimes get compromised. Even some the faculty promote ‘Salami Slicing’<sup>12</sup> so as to bring out as many publications from the thesis as possible (I.F.3.10).

Doubts were raised regarding the ‘competence’ of the new crop of CM personnel. Based on her experience as an examiner, a faculty called the quality as ‘pathetic’ (I.F.1.10). Another faculty was concerned that good talent was getting sucked by international organizations, and faculty jobs were going to ‘anybody and everybody’, thus perpetuating the mediocrity (I.F.1.2).

### **II.7.3 Overarching Issues**

While the pedagogy has a significance of itself, a lot depends on the interest and engagement of the faculty in teaching activity. The kind of experiences and exposures they have had, and the understanding of PHC that they have developed, are crucial to make effective use of different pedagogical methods (I.F.1.1, I.F.1.7). ‘If you are not able to generate the kind of interest that needs to be inculcated in the students in a given specialty, a lot of the onus and responsibility has to be placed on the faculty, the way they teach, the way they themselves get involved in the specialty’ (I.F.1.3). This issue has been raised by several others in past. For instance, see Rao (1985), Saha (1988).

Thereafter, the pedagogy used by the faculty may be limited by issues beyond their control. If the concerned MC does not have a ‘functional’ R/UHTC, or if the concerned DoCM doesn’t have easy access to vehicles to ferry the students in field, or if the faculty-student ratio is low because of faculty shortage or because of large batch size, the individual faculty can do only so much, no matter how interested s/he is.

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<sup>12</sup> ‘Salami slicing’ refers to breaking down one set of data into different parts

Summing-up, a faculty shared that in many DoCMs, teaching is all about ‘a series of boring lectures, a series of mandatory visits, and practicals that have no meaning and application in today's life’ (I.F.4.6). Overall, the teaching is not very inspiring (I.PF.7). However, ‘There is a slow progression towards betterment. I am sure by ten years time, there will be a real change in the way they look at Community Medicine...very sure of it’ (I.F.2.3).

## **II.8 Status of Rural and Urban Health Training Centres**

Interaction with the community, and with the existing healthcare system in the community, is crucial to develop an understanding about PHC. The MCI guidelines require every MC to have one Rural and one Urban Health Training Centre (RHTC and UHTC). The RHTC should also have residential facility for the students. These Centres can be owned by the MC or can be affiliated to government-owned Health Centres. PGI and MGIMS have a RHTC and a UHTC of their own. St. John's has a RHTC of its own (CHTC), and runs an urban facility in collaboration with an NGO. TSI has government-owned centres designated as Rural and Urban HTCs.

While the MCI prescribes the broad norms, it doesn't specify: the nature of activities to be conducted by the department, and the role of faculties, at these centres (I.F.1.12); the population that these centres should cover (I.F.1.12); whether the department should also be ‘responsible’ for the health needs of this population (I.PF.2); and the type, number and space for faculty residences, hostels and classrooms at these centres (I.F.1.12). In absence of such norms, Rural and Urban Health Training Centres have become a ‘nominal thing’ (I.F.1.12). IAPSM, in 2018, had come out with ‘Technical and Operational Guidelines for Rural and Urban Health Training Centres’ which answers many of these questions (IAPSM 2018). But it is unclear if it has been endorsed by the MCI.

RHTCs attached to MCs located in cities may not be actually ‘rural’ in true sense of the word. They might have been designated as RHTCs keeping the feasibility of visits in view. Or, the area might have been rural when the training centre was established but has got urbanized over time, as was the case at DoCM-SPH and DoCH.

When the facilities designated as R/UHTCs are not under the ownership of the MC itself, the coordination between DoCM and the officials responsible for those facilities becomes an additional task. For instance, DoCM-TSI faculty needed a formal ‘permission’ from

concerned government health officials each time they took their UGs to visit R/UHTC. This hinders community orientation (Mahajan 1972).

There were variations in the way the DoCMs were utilizing their R/UHTCs. All four DoCMs would conduct OPDs at their respective centres. In addition, SNSPH-DoCH and DoCH also had a defined community attached to their HTCs. While their PG students and Interns would conduct outreach clinics in these areas, the Social Work team would engage in community mobilization. These communities were also utilized for exposing their UG students. While going in community, the focus of faculty and senior/junior residents at DoCM-SPH was more on research.

While it is mandatory to have Urban and Rural Health Training Centres, the faculty were not sure how far these centres were actually being used by other MCs (I.F.4.3). They shared disparities in terms of frequency of visits, engagement of faculty, engagement of students, and nature of work.

### **II.8.1 Frequency of Visits**

DoCMs which have their own Rural/Urban HTCs centres have some regular activity. They may also have adopted a defined population for health services, as was the case with SNSPH-DoCM and DoCH.

This is followed by departments which occasionally visit these centres to expose the UGs, like they were doing at DoCM-TSI. They also post their Interns and PGs at these centres, but they do not have the responsibility of surrounding community. 'We are Community Medicine people, without any community, with no involvement with the community. So who will give us recognition' (I.F.3.8).

On the other extreme are departments from which anybody would rarely go to the peripheral centres. Several faculty and students, on record or off-record, expressed concerns regarding DoCMs being solely focussed on classroom-based teaching. As a result, 'Community Medicine has remained to be just an academic subject' (FGD.PG.3). In some cases, the Centres may be shown as linked to the department to fulfil the MCI requirement, but the faculty may not even know the names of these centres (I.F.3.10).



## **II.8.2 Engagement of Faculty**

It is usually the junior faculty who accompany the UG students for exposure visits and who are made in-charges of these centres. The senior faculty's engagement with field, and with field-based training, is relatively lesser. Faculty's engagement with field for activities other than teaching-training is even rarer. Faculty/Departments which have field-based research projects or service delivery projects, as was the case at three out of the four departments included in this study, do have more frequent interaction with the peripheral centres. But then, a faculty recalled his PG experience that, at times, people who have not spent a day in a Primary Health Centre would plan field-based interventional studies (I.F.3.10).

## **II.8.3 Engagement of Students**

Departments which have residential facility at RHTCs would make the Interns and PGs stay there for the duration of posting. At other places, the students would simply commute on a daily basis. Faculty shared that, in some DoCMs, the PGs would be going only for one or two hours a day (I.F.3.3), or only occasionally (I.F.3.10). And such PGs go on to become CM faculty. 'What will they talk, or what will they share with their students?' (I.F.3.8). On other hand, departments like SNSPH-DoCM and DoCH organize residential camps at RHTCs even for the UGs.

## **II.8.4 Nature of Work**

The nature of work at these centres vary from supporting the facility-based out-patient care, to running a round-the-clock primary-level clinical facility with regular outreach clinical work, to also engaging with the local community.

SNSPH-DoCM and DoCH had an identified area surrounding their centres which they were engaged with. However, engagement with communities was largely through the department's Social Work team. The CM faculty and students would go in the community for outreach clinics, or visiting specific families or patients, or for outbreak investigations, or for some health education session. Their involvement 'with' community was limited<sup>13</sup>. However, a past faculty justified this saying, 'Some division of responsibility is needed, according to the strengths of each person's ability and their disciplinary background' (I.PF.7). She thought it was fine as long the faculty understand the importance of this work, and

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<sup>13</sup> The monthly Village and Family follow-up activity for UGs at SNSPH-DoCM is an exception in this regards.

‘there is a close and non-hierarchical relationship between the Social Workers and Doctors’ (I.PF.7).

As per the faculty, most of the DoCMs, which do not have RHTCs and UHTCs of their own, are limited to making their Interns and PGs attend OPDs at the affiliated centres. ‘(MCI) says that the department should have a field practice area. So, the department has it...They just visit, and visit for paltry things or small things, or establish a clinic for some minor ailments etcetera’ (I.PF.2). They don’t take responsibility of a community in terms of implementing health programs, or even investigating outbreaks (I.F.1.9). Imparting community perspective to the undergraduates is a very crucial input for improving the health system (perspective of a third person, shared by I.F.3.2). Without community engagement, DoCMs teaching and research lacks an alignment with the local context. Health needs assessment, at best, gets reduced to a set of field assignments. The faculties and student fail to identify the irrelevant aspects of top-down planning and the need to promote a bottom-up approach so fundamental to PHC. Knowing the ‘pulse of the community’ is what gives CM an edge over other disciplines. But then, ‘you can keep a hand on the pulse of the community only if you are visiting the community...How much of this is happening...’ (I.F.1.4). However, the faculty also shared examples of departments like the one at Christian Medical College-Vellore which had, long back, started income-generating activities for community women (I.PF.7).

So, while having RHTCs and UHTCs is necessary, it is not sufficient in itself so as to develop an understanding about PHC. How much, and in what ways, the faculty and students engage with these centres and the community around is what matters. The faculty were of the opinion that things were gradually changing everywhere for the better (I.F.1.4, I.F.1.9, I.F.2.3, I.F.4.5).

## **II.9 Resources available with Departments of Community Medicine**

### **II.9.1 Human Resource**

A full complement of teaching and non-teaching staff is a basic requirement for any department to function smoothly. None of the four departments included in the study reported any shortfall in staff as per the norms laid out MCI. However the faculty pointed out that what MCI prescribes are the ‘minimum’ standards. They found the prescribed faculty-student ratio to be insufficient to provide quality teaching and training (I.F.4.9). The

ratio becomes more inadequate at places where the faculty also have to teach students of other courses like nursing and physiotherapy.

The issue of shortage of medical faculties, including CM faculty, have been raised in literature (Supe and Burdick 2006, Sood 2008, Ananthkrishnan 2010). Deficiency of teachers in MCs may be to the tune of approximately 30 to 35% or even more (Rajya Sabha 2016). A faculty shared that at some places, especially in private MCs but also in government ones, the faculty in DoCM would be on deputation from other MCs, or the faculty not having a background in CM would be teaching (I.F.1.9). In fact, faculty shortage was a serious issue at DoCM-TSI till about two years back. The faculty had to depend on PG students to cover UG syllabus, and taking UGs for field visits was extremely difficulty (I.F.2.4). Consequently, the field exposure of the PGs also gets compromised (I.F.3.10).

Another problem shared by the faculty was adjusting with the increased batch-size. Firstly, there may be a time-lag in fulfilling the MCI's minimum standards related to infrastructure and human resource for the increased batch size. Secondly, the MC may not split the bigger batch into sub-batches for the purpose of lectures and postings. So, despite proportionately increasing the number of faculty, the effective faculty-student ratio in the lecture hall, or during the field visit may continue to be very low. At DoCM-TSI, the faculty were finding it hard to connect with 250 students at once. A faculty said that the lectures had become a formality to complete the course (I.F.2.8). For the same reason, facilitating field visits and UG research had become difficult (I.F.2.1, I.F.2.2, I.F.2.4). To an extent, this was a problem at DoCH also (I.F.4.2, I.F.4.4, I.F.4.9).

A large batch size also leads to some 'softer' issues. The faculty shared that earlier they would know students by name; now, they are just roll numbers (I.F.2.2, I.F.2.4, I.F.2.8, I.F.4.2). 'In this big number, they (students) kind-of get lost in the crowd. Unless they are recognized as individuals, I don't think they are going to recognize patients as individuals' (I.F.2.8).

The more reputed departments have a different kind of problem. They get stretched because of projects, as everybody wants to work with them (I.PF.5).

Shortage of non-teaching staff can similarly restrict different activities of the DoCM (I.F.3.10).

## **II.9.2 Vehicles**

'Vehicle is the most essential "equipment" for Community Medicine Department' (IAPSM 2018). The MCI guidelines mandate every MC to provide adequate transport (both for staff and students) for carrying out field work and teaching and training activities by the DoCM. This was not an issue in three out of the four departments included in the study.

DoCM-TSI was facing problems in arranging vehicles for field visits. Each time, a request had to be made to the Dean's office for allotment of the college bus, which was a tedious process with uncertain results (I.F.2.7, I.F.2.9). A faculty commented, 'Only when you get own vehicle for the department, you can do everything perfectly' (I.F.2.7). And this problem was not limited only to a few DoCMs (I.F.4.9). Mahajan (1972) has also highlighted this problem.

## **II.9.3 Department's Status in the Medical College**

If DoCM has to orient other departments of the MC towards PHC approach and has to seek their co-operation in orienting the student in the same, it has to have a good standing in the college. If it has to influence the UG students, it has to have an impressive face in the MC. Though a status doesn't still guarantee that DoCM will be able to do these things, but it is a basic requirement.

There is no difference in the pay structure, designation and seniority of faculty across the departments. In fact, CM faculty often acquire administrative positions in the MC and its hospital. All the four departments included in the study were engaged in activities at Institutional level (see Chapter 3). DoCH has had a very supportive relationship with the college administration since beginning, and SNSPH-DoCM has historically been a seat of power within MGIMS. But these are exception than the norm. Many of the faculty agreed that, howsoever subtly expressed, there is a status differential between CM and other clinical departments.

The position of the 'discipline' of CM in the hierarchy of medical specialties has been discussed earlier. To an extent, this also affects the status of the 'department' of CM.

Secondly, the department has a specific stereotyped image in the MC. The faculty shared that 'they (other faculty) consider (us) only as a...sanitation work' (I.F.2.9); 'They just see us as a contingency' (I.PF.3). 'Other doctors are looking at Community Medicine with a lens...camps means Community Medicine, dengue means Community Medicine' (I.F.4.5). Often, other departments expect DoCM to 'act' on hygiene issues of the MC campus, but the CM faculty do not have the authority or resources to do so (I.F.2.1). Even if they do so, CM doesn't get any appreciation for keeping things normal most of the times. '(But) when something goes wrong, they know it was because of the non-functioning' (I.PF.3). Thirdly, the faculty in other departments and those acquiring administrative posts in the MC have all, as students, been exposed to a DoCM. Whether good or bad, they carry those same impressions about the department. A past faculty recalled how coldly their Dean had responded to the news of their paper having won first prize at a conference (I.PF.3). Even if a DoCM is now working very dedicatedly, above mentioned factors affects its image in the MC.

The status also has historical roots. Banerji (1973) informs that the personnel who initiated the DoPSMs were not the best of the lot and were called-in from periphery to fill the newly created vacancies in the MCs. Some of them joined just to be able to live in a city and didn't essentially have the motivation and the right kind of attitude (I.F.1.12). As a result they were perceived as outsiders and were not held in high regards by the clinical specialists (Deodhar 2003).

Even now, there are DoCMs which are not adequately active so as to be recognized by other faculty and students. The faculty 'would usually come to the department, have tea, just wait for the day to get over and go' (I.F.3.7). Their engagement in research, in service delivery (clinical or otherwise), with government healthcare system and with communities, beyond the teaching and training requirements, is minimal. They keep themselves isolated even from rest of the Institute. They refrain from taking any responsibility within the MC, like being a part of Research Committee or Bio-medical Waste Management Committee. 'Generally, Community Medicine people live in their own shell. Nobody knows them, nobody values them' (I.F.1.7). 'Instead of becoming the focal points, the Departments tend to build cocoons around themselves' (Deodhar 1989). While this was not true for three of

the four departments included in the study, a few faculty at DoCM-TSI attested the 'cocooning' of the department to an extent (I.F.2.7, I.F.2.9).

'You are valued if you are seen in action' (I.F.3.10). 'If you think you are just going to teach this book and sit, just try to do some research...it's not going to happen' (I.F.2.3). Given that clinical departments are, by design, visible, such attitude of CM departments only worsens their image in the MC (I.PF.5, I.PF.6). 'How will anybody take us seriously? If you don't practice at all, how can you talk about Primary Health Care approach, I don't know' (I.F.4.11). 'And that is what is happening with maximum Medical Colleges' (I.F.3.8).

#### **II.9.4 Intra-departmental Relations**

DoCM consists of Faculty, Medical Social Workers and other non-teaching staff, field staff and students. DoCM-SPH, as a special case, had faculty and students from different disciplines. It is natural for any department to have some amount of inter-personal issues and groupism. But at some places, these become serious enough to hamper department's work. While PHC may talk about 'decentralization', 'integration', 'coordination' and 'participation', the functioning of the department may not reflect these principles.

A faculty cited examples of several CM departments of well known MCs which were not performing up to their potential because of a manipulative or an authoritarian head (I.F.1.2). The manipulative ones keep the department divided by playing dirty politics, and the authoritarian ones do not let new ideas and new thoughts grow<sup>14</sup>. The work-culture in faith-based institutes is relatively better, but this is difficult to replicate (I.F.1.2). Incidentally, at DoCH, there was a provision to rotate the Headship of Department every four years among the Professors.

SNSPH-DoCM had a post for 'Social Scientist'. It had a 'teaching post' for Statistics and Demography, and the person on this post had progressed up to the designation of Associate Professor at the time of this study. At DoCM-SPH, a Sociologist was working as a Professor in the School of Public Health. But this is not generally the case. A person who joins as a Medical Social Worker remains so irrespective of years of service, additional qualifications and research contribution. Designation of a person, and how much respect s/he gets in the

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<sup>14</sup> Dutt (1978) says that we have a culture in which 'interchange of opinions, and suggestions from lower formations are not encouraged, in fact, resented'.

department are two different things. But they have a linkage. A past faculty opined that ‘if you have Sociologists and Statisticians who get struck at Assistant Professor level, then what you are saying is that medical paradigm is central; these other people can help in our understanding, but they can’t question the whole basis of it’ (I.PF.8).

## **II.10 Involvement of Other Departments of Medical College**

A UG student attends several departments during four-and-half years of ME. PHC approach is not just a topic that has to be taught by a particular department. This approach has to reflect in the way different departments conduct themselves on a day to day basis. Only then will the students imbibe it. In reference to preventive medicine, Bhore Committee quotes Dr. Etienne Burnet as saying, ‘The reason why preventive medicine has not, up to the present, become inter-related with clinical studies is that it has been taught largely by public health officials. If the practitioner is to practice preventive medicine, he must be taught that subject by his clinical professor’ (Gol 1946, Vol II, page 356, point 2). The same logic applies for PHC approach. If it is only DoCM which try to develop a more holistic understanding about health and PHC while other departments continue their business as usual, there is little hope (Narayan et al. 1993).

To assess the understanding of faculty of other departments about PHC was beyond the scope of this study. However, the CM faculty were asked about their interactions with other departments, and the challenges they faced in these interactions.

Several faculty said that ‘PHC’ was considered a baby of DoCM, and DoCM alone (I.F.3.8, I.F.4.2, I.F.4.5, I.F.4.11, I.PF.2, I.PF.6). ‘Whenever we talk of Primary Health Care, I do not know from where it comes in our mind that this is the work of Community Medicine people. It is not like that’ (I.F.3.8). Mahajan (1972), Chugh (1983) and several others have also raised similar concerns.

The faculty of other departments, especially the clinicians, lack an orientation in PHC (I.F.4.8). ‘If pressed, they say it is about paramedicals giving simple remedies; the better read say something about the bare foot doctor’ (Nath 1987). ‘They come in the morning, there are a lot of things to be done, they keep doing it, they go home. They don’t necessarily think about all this also. There is no space to think...“hey! hang-on...there are communities...there is wellbeing” and all that. They are so busy in servicing the machine

that the normal, the outside world, doesn't really fit into their scheme of things' (I.F.4.10). 'They just see the organ, and the disease' (I.F.4.8). They are 'concentrating too much on diagnosis and treatment. They are not seeing how this person got the disease, and how can we prevent it. Or, how can we improve the socio-economic status, how can we reduce the cost of the treatment' (I.F.4.2).

A faculty took the example of a patient having diabetes who presents to the endocrinologist with non-specific aches and pains or sleep disturbances (I.F.4.11). The endocrinologist would do everything possible to manage the blood sugar level but he would not refer the patient to a psychiatrist. The ultimate aim is to enable the patient live a healthy and productive life and not to keep his blood sugar under control. 'If that is your objective, please realize that 30-40% of your patients have depression. Without handling that depression, there is no way you can address the problem of patient fully. When you address the depression, his sugar levels will be better controlled, we have scientific evidence for that' (I.F.4.11).

This attitude reflects in their teaching. 'They (other departments) are not linking the national health program for diabetes and hypertension while talking about the disease. So students remember the disease and its treatment, but they forget the primary and primordial prevention' (I.F.4.2). The patient management protocols taught by clinical departments may differ from those given in the guidelines of National Programs (I.F.3.1, I.PF.2). Even 'the examiner won't ask about the socio-economic status of the patient' (I.F.4.2). A compartmentalized curriculum and lack of integrated teaching adds to the problem.

A past faculty informed that DoCMs were supposed to make the faculty of other departments run clinics in the field. 'This Professor (from other department) should understand that the quality of care at <name of a peripheral centre> will have to be different from that at <name of Medical College Hospital>....choices in antibiotics, who do you give, whom do you not give, economic choices, technical choices, generic versus branded...all these have to be different' (I.PF.8). Instead, CM people themselves started running field clinics, with some success in getting specialists on specific days.



DoCM-SPH, SNSPH-DoCM and DoCH conduct specialty clinics at their RHTCs. SNSPH-DoCM also calls clinical specialists to take clinic-social cases and lectures during the ROME Camp. It is mostly the junior doctors who come from those departments for these activities now. They do not look very interested in the social aspects, and, in going to the community. 'Primary Health Care...leave it. That is for Public Health people to do' is what they think (I.F.3.6). Even senior faculty in those departments feel that 'going in field in a time-pass activity' (I.PF.5). Madan (1980), long back, reported similar problems in interaction between DoCM and other clinical departments. Nath (1987) questions the fraternity itself in this regards. 'How many of us have fulfilled our responsibility to educate and inform our colleagues about this (PHC) concept? How then can we complain about not getting enough support...' (Nath 1987).

Many faculty thought that this lack of cooperation was because the clinical departments were already overworked and didn't have time (I.F.3.2, I.F.3.6). A few also said that this was because of lack of mutual respect between departments and professional arrogance (I.F.3.2).

A lesser appreciated issue was that expertise and sophisticated technology gives a sense of power to these other clinical departments. This goes contrary to the PHC approach, which talks about sharing of power, demystification of medicine, using community health volunteers and empowering the communities. So, it is obvious that they would find it difficult to relate to the concept. Though, the same may be true for CM faculty as well.

The past faculty informed that, in order to orient other departments on concepts like PHC, CM faculty were supposed to accompany the specialists in their ward rounds<sup>15</sup>, 'because only then would preventive and social aspects come in the clinical subjects' (I.PF.8). But they didn't ever go to the wards. 'Nowhere have the Preventive and Social Medicine people challenged the clinical medicine' (I.PF.8). This might have been because of the weak status of the discipline, and of the department.

Whatever the reason, when students see their teachers in other department behaving in a particular way, they obviously feel that 'all this is just to pass Community Medicine. It will not be of any use to us in future' (I.F.3.6).

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<sup>15</sup> Editorial (1959) and Seal (1978) makes similar proposition.

Other department may adopt PHC approach if the ethos of the institution is aligned to PHC. 'If institution goes on harping on it, then the departments will willingly start to think in those terms' (I.F.4.10). The importance given to CH work at Christian Medical College-Vellore becomes evident from what an Anaesthesiologist from the institute complained about: 'The rest of us feel we have to apologize for existing' (quoted in Paterson 1993). But generally, 'most institutions are busy running their colleges and hospitals' (I.F.4.10).

### **III. Individual-level Factors and Processes**

The understanding that faculty develop about PHC also depends on their personal backgrounds and early life experiences, the aspirations with which they joined the MC, their experiences during UG and Internship, their work experience as graduates, the motivation with which they joined CM for PG, their experience with the department over those three years, their work experience before becoming faculty, the kind of work they have been engaged with as faculty and other exposures. Many of these factors also operate in case of students whom the faculty are supposed to orient in the PHC approach. 'It doesn't start only once you land-up in Medical College...it starts from the day you are conceived...the kind of books you read, kind of people you interact with...so many things, so many influences...we even forget, but we are influenced by those things' (I.PF.5).

#### **III.1 Early life Experiences**

The environment in which one has spent his/her early formative years shapes one's sensitivity towards issues which are of concern in the PHC approach. A faculty coming from a rural background had seen local plants being routinely used by households for minor ailments (I.F.1.9). Another faculty with similar background could appreciate the role that 'quacks' play in areas where there are no other healthcare providers (I.F.3.2). Yet another faculty shared that, as a child, he used to spend all his vacations in his ancestral village. Every year, while going from the city to that village, he would take a mental note of how things would suddenly change. These visits made him well aware of the advantages of the village life, and its disadvantages. He got to know the problems of the village people and their needs. He could feel how difficult it was to leave one's village and go to a city, and how the village disintegrated when people abandoned it. Because of those exposures, he could now feel one with the village people.

A faculty shared having been exposed to the Leftist ideology prevalent in area where he spent his childhood (I.F.3.2), and another one shared being exposed to the philosophy of *Sarvodaya* movement. These early exposures had deeply influenced their thinking for all times to come and had affected their career choices.

A faculty, who grew-up in a family having spiritual leanings, said, 'My mindset was not even slightly materialistic. It was service oriented' (I.F.3.10). Another faculty recalled having read a book on Ida Scudder<sup>16</sup> while she was in ninth standard (I.F.2.3). This book furthered her deep religious inclinations, her wish to serve the people, and had a strong influence over her career choices. Similarly, a past faculty shared having attended classes on Christian morality in school which had an impact on her thinking (I.PF.3). A senior faculty, not from DoCM, shared during informal conversation that it was *Karuna*, or empathy, that drives one to do such work. 'What emanates from intellect, doesn't go far. It has to flow from the heart.' And when that happens, one doesn't have to force the self to engage with the work; one gets driven into it.

A faculty shared that when he was in ninth standard he lost his grandfather to Stroke. His grandfather was a very independent person till he developed hemiplegia; and suddenly, he became dependent on others for everything. 'That (dependence) was biting him, killing him daily' (I.F.3.1). That was when this faculty decided to get associated with health. It also made him realize the value of preventive health, as he had seen that curative medicine could not help beyond a certain point.

### **III.2 Motivation to join Medicine**

Almost all the faculty shared that anyone who aspires to become a doctor, does so because this profession offers scope to help others in times when they need it most; and it bring a lot of respect in the society. Relieving patients of their immediate suffering is the work they expect to do as doctors. While this is a very noble purpose, it somewhere primes the students to conceive just one of the many kinds of works that are required for attainment of Health for All.

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<sup>16</sup> Ida Scudder was a very compassionate lady physician, and was the person behind setting-up of Christian Medical College, Vellore

### III.3 Experiences during UG

The experience during UG has been transformative for some faculty. One faculty, who did her UG from MGIMS, fondly recalled the Social Service Camp during which they lived in 'conditions mimicking those of villagers'; 'so, you develop a very strong sense of what life is there' (I.F.4.6). And she found the subsequent family follow-up exercise 'wonderful'. 'I was a city girl. I never knew what a village was. I think the kind of empathy that you develop by living in the village and seeing what it is, it's wonderful. That exposure at that age, when your mind is so mouldable, is wonderful' (I.F.4.6). Another faculty, also a UG from MGIMS, recalled *Kiran Clinics* which used to give them ample time to interact with each patient. 'Those conversations would make one understand why patients are not able to reach the hospital on time' (I.F.3.6).

A faculty, who did her UG from Christian Medical College-Vellore, said, 'We went and lived with the villagers, we moved with them, we talked with them, we came to know what it is to live in one room' (I.F.2.3). She was also appreciative of the faculty, across departments, who would be available round-the-clock to serve the patient. So she would literally get shocked when, later in her life, she would see faculty of other MCs doing private practice. Another faculty, a graduate from Kempegowda Institute of Medical Sciences, had witnessed similar dedication from her UG CM faculty. 'I could see that they were emotionally invested in it... the intensity with which the faculty over there counselled a patient about the need for an anti-Rabies vaccine was something that has stuck to me' (I.F.4.9). A senior faculty recalled his CM professor saying that while 80% of population lived in villages, 80% doctors were practicing in urban areas, and that something had to be done about it. 'It had some kind of impact on me' (I.F.4.1). Besides field visits and rural postings, some faculty could participate in research projects and conferences during their UG (I.F.4.1, I.F.4.7, I.F.4.9). A past faculty recalls having been part of a study circle which used to discuss women's issues (I.PF.7).

But for most, the UG experience has not been a good one from a PHC point of view. 'It was more to do with the textbook and the exam' (I.F.4.10). 'All the Community Medicine teaching, I remember, happened in class only' (I.F.4.11). 'It used to be only Park, and some models and some mosquitoes' (I.F.4.2). Concepts like PHC were important topics for the exams, 'not for practice' (I.F.4.2). 'We were very thrilled that we elicited certain signs, we percussed well, we heard crepitations, bronchial breathing...but we didn't see the patient as

a person who came from a particular socio-economic background' (I.F.4.2). The CM lectures would be so uninteresting that they would bunk them (I.F.4.3). Some recalled not having sufficient faculty (I.F.2.2), or qualified faculty (I.F.2.9, I.F.3.2) in the department. So they would be taught by Entomologists or Tutors (I.F.2.9), or by faculty of other disciplines (I.F.3.2).

'We just read about Primary Health Care...we didn't have a discussion or we didn't have an exposure' (I.F.1.9). Some of them recalled having been taken for visits to Primary Health Centres, water-works, sewage treatment plant etcetera. One faculty shared that they were allotted families for repeated visits, but the department was doing it as a formality. There wasn't much 'engagement' (I.F.3.8). Some faculty recalled their UG CM departments as functionally 'non-existent' (I.F.3.2), 'sedate' (I.F.1.3), even 'useless' (I.F.1.7). A PG student referred to his UG DoCM as 'time-pass'. A faculty shared that he had always liked community-related work. But because of the image of the department, he would hesitate to express his liking for the subject in front of his friends (I.F.3.2).

From among these faculty, for some, internship was 'enriching'. 'I did it thoroughly, including one eye-camp...tying the loud speakers to the van, going in the village...did it all' (I.F.4.11). Another faculty had got chance to visit underprivileged areas and quarries during this time (I.F.4.4). A faculty shared that it was during this time that 'I started believing that there is a community, and the approach to the health of the community is different than what work we do in the hospital' (I.F.4.10). Two past faculty (I.PF.7, I.PF.8) and a PG student shared how their thinking got transformed after participating in disaster relief activity during internship. But then, others would have only attended clinics at the peripheral centres, not getting to know 'what exactly this community work is' (I.F.1.9, I.F.4.5). Or, worse, they wouldn't have left the hospital at all (I.F.4.3). A young faculty recalled having done his internship seriously, because 'students there were not much aware about what to do after MBBS, about PG preparations and all'; 'this changed after the coaching institutes opened their branches there' (I.F.2.5).

Irrespective of the quality of UG CM department, a few faculty got meaningful exposure from elsewhere. One faculty shared that he got associated with a NGO working in Melghat

(a tribal region of Maharashtra) during Internship (I.F.3.1).<sup>17</sup> This NGO was basically trying to prevent child deaths in that area during monsoons when small villages would get cut-off from the nearby towns having health facilities. Volunteers from all walks of life (not just doctors), and all ages, would be trained in basic management of neonatal and childhood illnesses (primary treatment, danger signs and referral mechanism), given necessary logistics and deployed in those villages. They would do house-to-house survey, provide primary treatment, and if any child required higher medical attention, they would escort or facilitate the referral. This faculty continued his association with the NGO working in Melghat even during his PG.

Another faculty shared that, during MBBS, he read Dr. Verghese Kurien's *I Too Had A Dream* that talked about the Amul Dairy Cooperative. 'That's how I got introduced to the concept of sustainability'; 'Amul model empowered so many people, and it is still running, even after the founder is no more around' (I.F.3.10). A few Interns shared having been exposed to youth development programs like Nirman<sup>18</sup>.

### **III.4 Work Experience as Graduate**

Most of the faculty at DoCM-TSI had worked at government Primary Health Centres after graduation (Table 8, Chapter 2). Besides, one faculty each from SNSPH-DoCM and DoCH had also worked at such Centres. This experience made them aware about the functioning of, and challenges in, the government health system at the grassroots. 'What one reads in books is entirely different from what we see on ground' (I.F.2.9). One of them shared an incident when a lady was brought to the Primary Health Centre with a retained placenta, and had to be referred to the District Hospital around 80 kilometers far. The family member said, 'I have sold my cattle, and with that money I have come to you. Do whatever you can' (shared by I.F.3.8). The faculty could experience the goodness in people. 'They will be providing food to you, they will be bringing fruits...you are one among them' (I.F.2.6). And some also experienced their rowdiness (I.F.2.1, I.F.2.4). 'Only when you know what is happening at the ground level you can talk about higher things' (I.F.2.1).

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<sup>17</sup> <http://www.maitripune.net/melghat.php>

<sup>18</sup> <https://nirman.mkcl.org/about/info>

The exposure improved their communication and managerial skills (I.F.2.1, I.F.2.4, I.F.4.3). It gave them a context to which they could relate while studying, and teaching, CM (I.F.2.2, I.F.2.4). 'I can straightaway quote examples...I don't have to look into a book to quote an example' (I.F.2.4). It also gave them insights that are of help to this day in their different endeavours. 'I realized that you can learn from somebody who is a nurse, and IEC officer, or anybody who has experience. It's finally a team'; 'My outlook would have been very different if I had not worked in a Primary Health Centre' (I.F.4.3). 'That experience gave me the confidence to manage many things for the rest of my life' (I.F.2.1). 'Had I not worked there for three years or so, my experience of Community Medicine would have been...I would have lacked many things' (I.F.3.8).

Some of the faculty had done rural service as a part of their obligation to their UG Institute. One of them shared that, during this period, he used to see a lot of patients who had sold all their assets (land, bullocks) to feed the greed of the private hospitals spread across the city. This experience made him averse to ever working in private sector. Another experience he recalled was when a newborn baby girl, whom he and his staff could somehow resuscitate after herculean efforts all through the night, was simply abandoned by her family. That was when the issue of 'gender' first struck him (I.F.3.6). Another faculty shared the magical results he had witnessed with folk medicine prevalent in the tribal area where he did his rural service (I.F.4.1). This, and other experiences from that place, has had a lot of influence on the way he teaches medical students now. Another faculty got to do his service in an old Mission set-up that was crumbling under the pressure of growing private sector. The experience of resurrecting that set-up 'gave me a lot of confidence, strength and resolve to be able to look at what more can I do in communities...What I did there helps me strengthen what I am doing today' (I.F.4.7).

Some faculty had also worked in urban private clinical set-ups, out of choice or as a stop-gap till they could secure a PG seat. One of them shared her experience of working with terminally ill Cancer patients. 'They all know that they are going to die, but they don't know when, maybe next week. I used to comfort them...Just go and sit with them, talk with them, and they will talk about their past, how happy they were...that really used to release their tension.' She felt that this experience was helping her in teaching CM. 'When you say all this, the (future) doctors get exposed to such things' (I.F.2.3).

### III.5 Motivation to Specialize in CM

Interest level of the faculty in the discipline of CM is one of the key determinant of their interest in and understanding of PHC. And their interest in this subject at the time of joining PG is a somewhat important marker for this.

In this regards, the faculty can grossly<sup>19</sup> be divided into two groups:

- First group comprise of those who 'chose' CM because they wanted a particular kind of lifestyle for themselves. This group may be further subdivided into two groups:
  - o One includes faculty who wanted work for the underprivileged (I.F.4.2, I.F.4.7); who wanted to go beyond the four walls of the hospital (I.F.1.3, I.F.4.4, I.F.4.9, I.PF.5); who wanted to work with the community (I.F.3.1, I.F.3.2, I.F.3.10, I.F.4.10, I.PF.7); who had realized the limitations of clinical work (I.F.3.1, I.F.3.10); who wanted to serve all kinds of patients (I.F.2.3); or, who were more interested in research (I.F.2.7, I.F.4.3).
  - o Another group includes faculty who wanted a work-life balance, and not a very hectic life with unpredictable schedules (I.F.2.8, I.F.2.9, I.F.4.5, I.F.4.6, I.F.4.8); who saw it as a pathway to join international agencies (I.F.1.10); who wanted a secure city job in a MC (I.F.1.2); who didn't have means to establish a clinical set-up in future (I.F.1.7)
- And second group is of those who 'settled' for CM because it was the best among the available options. They would have seen it as more clinical than other options (I.F.1.1, I.F.3.5); or, it was available as a 'degree' while other options were all 'diploma' (I.F.1.8, I.F.3.6, I.F.4.11); or, they were getting it in a reputed institute (I.F.1.9, I.F.1.10, I.F.4.11); or, it matched with their past work experience (I.F.2.4, I.F.2.6, I.F.3.8).

CM can be very frustrating for those who join it without interest, without understanding what lies ahead. 'If you have chosen (CM) just as an opportunity, you will keep fumbling. If you have chosen it with a purpose, you will enjoy it' (I.PF.3). 'Otherwise, you will keep on repenting throughout your life' (I.F.1.4). Such people are also not good for the discipline, and for the future students (I.F.1.1, I.F.1.4, I.F.1.9, I.F.3.10, I.PF.5, I.PF.6). The faculty who know this, proactively tell their students to go for it only if 'something strikes inside you' (I.F.1.4, I.PF.5).

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<sup>19</sup> This division is for the purpose of understanding. There are always multiple considerations while deciding which branch to specialize in. For instance, a faculty who wants a work-life balance may also want to work for the underprivileged.



### III.5 Experiences during PG

The concept of PHC gets 'somewhat internalized' during the PG (I.F.1.1). A faculty recalled being 'just thrown into' an integrated tribal development project for three months soon after joining PG (I.F.4.11). Besides health, the project had activities on adult education, legal aid, agriculture, water harvesting, and empowerment etcetera. He had close interaction with non-medical people, like one having a background in Business Administration, and also with a Siddha doctor. Initially, he was not sure if that was the kind of work he should be doing as a CM student. But looking back, he finds it a very enriching experience. He also fondly remembered an elderly lady there who used to make him ginger tea every morning (I.F.4.11).

Another faculty said, 'I learnt how to critically analyze, I learnt how to question, I learnt that there can be another opinion about this; I learnt that, ok, this is there in the National program, but this may not be the best way' (I.F.4.9). I.F.3.8 shared that while he was only implementing the National Health Programs during his Primary Health Centre job, it was during PG that he learnt how those programs were made, what their lacunae were and how to evaluate them. He also got a chance to participate in a Global Health Program during PG where he came in touch with people from different countries and different backgrounds. Another faculty recalled having participated in Leprosy Elimination Monitoring Survey and meeting national-level program officers during his PG (I.F.1.8). One faculty, who joined PG after a long period of service in a PHC set-up, enjoyed the theoretical exposure she got during the course (I.F.2.4).

Community-based research during PG may also take one closer to the concept of PHC. Referring to the findings of his PG dissertation, a faculty said 'I concluded that we need to look at this integration also...households which have a patient with respiratory problems have a much higher need to shift from *chulha* to gas' (I.F.3.6).

A faculty, who had done his PG from Christian Medical College-Vellore, shared that the approach of that department in those times was a mixture of a sound primary and secondary level medicine, and a fairly vibrant community outreach program. Besides, 'I think the ethos of the place and the values there also rubbed-off a bit' (I.F.4.10).

Many more faculty shared that they had extensive and rigorous field based training during PG which not only involved managing OPDs but also had a component of community interaction (I.F.1.3, I.F.1.9, I.F.1.10, I.F.3.6). Some of them had not joined CM as a 'choice' (I.F.1.1, I.F.1.18, I.F.3.8, I.F.4.2); and a few even continued preparing for PG entrance during their first year residency (I.F.1.1, I.F.1.8). But such rich exposure made them change their mind. 'I realized that Community Medicine is much much more. Sky is the limit' (I.F.4.2). 'Once I joined, I found that I should have been here only. This is the best subject that I could have joined' (I.F.3.8). The way the department functions, the work culture, the interpersonal relationships...these things matter a lot (I.F.1.8). And the discipline also reveals its worth as one engages with it over time - through readings, teaching, discussion, interactions, field work, research, etcetera. Similarly, Jungalwalla et al. (1967) found that a large majority of PH physicians had 'medical' service as their first choice immediately after their graduation, but were now content with what they were doing.

At the same time, there were several others who didn't have a good experience during PG. Some of them shared that their PG department didn't have adequate number of qualified faculty (I.F.2.3, I.F.2.9, I.F.4.5). One of them told that they would go and attend workshops conducted by DoCMs of another MC so as to learn the basics (I.F.2.9). Others shared that the department was heavily focused on classroom teaching, and that the PG student's time was largely consumed in teaching the UGs (I.F.3.10, I.F.4.5). The visits to the RHTC would be rare (I.F.3.10), or restricted to clinical activity (I.F.3.1). They would go to nearby schools or to some elderly home for health check-ups. 'But again, it was primarily (going) from one "facility" to another "facility"' (I.F.3.1). In the name of 'outreach', they would participate in Pulse Polio Immunization rounds, or attend some routine immunization sessions (I.F.3.1, I.F.4.5). A faculty recalled having tried a survey in the UHTC area. But as the department's Medical Social Worker (MSW) didn't have any rapport with that slum community, the people didn't cooperate much. So, 'in a month or two, even the enthusiastic PGs would give up' (I.F.3.10). They also didn't have good experience doing PG thesis. Either the guide were not capable enough (I.F.3.1, I.F.3.10), or were too prescriptive (I.F.2.3, I.F.3.10, I.F.4.3), or the department had a culture of taking-up only hospital-based topics (I.F.4.5). And once the thesis was submitted, the guide expected them to bring out multiple publications from it. 'So, the culture was like that, and we picked it' (I.F.3.10).

So, 'it also depends on the department that you have joined. That also determines what kind of a Community Medicine person you become' (I.F.4.11).

### **III.6 Motivation to become Faculty**

In-service candidates (have to) return to their parent department after finishing PG. Other candidates have the option of joining international/national agencies or Central/State government services. Some of them start their own NGOs. Occasionally, somebody may decide to work directly with underserved communities. However, joining as a faculty in a DoCM has been the most common career choice for PGs in CM.

Faculty position, in principle, offers diverse opportunities: to provide primary-level clinical services, implement/supervise and monitor government health programs, and get involved with research, besides teaching and training medical students. It comes with the status of working in a MC and being in a secure and reasonably well paying job. In fact, many of the founding faculty of CM joined the department so as to be able to settle in cities (I.F.1.12).

Faculty who have earlier worked in programs or in patient care still miss it (I.F.2.1, I.F.2.3, I.F.2.4). One of them shared how she convinced herself for a faculty job: 'If I teach hundred students, and even ten of them become like me, the impact would be much larger than what I could do alone' (I.F.2.3). Though not many faculty may join with such a purpose, they do feel content when they see their students doing good work after passing out (I.F.4.4, I.PF.2). At the same time, they fondly remember the teachers who shaped their thinking (I.F.1.3, I.F.1.9, I.F.2.9, I.F.3.3, I.F.3.5, I.F.4.1, I.F.4.7, I.F.4.9).

There was a boom in faculty position in CM due to rapid expansion in number of MCs, especially in private sector. However, with a parallel increase in number of PG seats, the supply seems to have overtaken the demand. Other PH jobs, in private as well as government sector, have opened up for medical graduates, and even non-medicos, with a PH qualification. The demand for a PH cadre within Central and State government set-up remains unresolved. So, PG students are bit concerned, and are looking at alternate career options. There was a session kept on 'Emerging Career Opportunities for Public Health Professionals' in a national-level conference held in the year 2017, and it was very well attended. Out of the three panellists in this session, one was from an insurance company, one from a Clinical Trials organization and one from a Vaccine manufacturing firm.

### III.7 Experiences as Faculty

Though MD-CM has a significant component of self-directed learning, 'you evolve fully as an individual only after your MD' (I.F.4.5). Many of those who didn't 'choose' CM, and/or who didn't have a good experience during PG, may develop an interest in the discipline after they join as faculty (I.F.2.9, I.F.3.1, I.F.4.2). 'When now I think about Psychiatry (her first choice), I believe that it's better that I am in this branch...Being in Community Medicine, I am doing the kind of work in mental health which I would not have been able to do had I been in Psychiatry' (I.PF.5). Besides the possibilities in the discipline, the environment, the work culture of the department and the people within also play a very important role (I.F.3.1).

The faculty would learn from others in the department. A faculty gave credit for her ability to link various dimensions of health to the presence of MSWs in the department (I.F.4.2). Yet another faculty shared that he had learnt the skill of entering the community and talking to people from the Social Worker (I.F.4.11). A past faculty recalled how a Sociologist working in the department would explain the community dynamics to them which, as doctors, they would never realize (I.PF.7).

One's understanding may get deeper even by engaging with the students through teaching and training. A past faculty recalled analyzing the road-to-health charts from an *Anganwadi* Centre with a group of Interns. The Interns threw up a finding that 'the child from *dalit* family is not able to move from third degree to second degree, while the one from an upper caste family is able to do that easily' (I.PF.8). While making house-to-house visits 'the Interns found a pattern that "if we first go to *dalit basti* and then go to upper caste, people don't welcome us"' (I.PF.8). Such experiences helped the faculty delve deeper into the social issues like 'caste'.

Interaction with patients is also considered as a way to understand PHC by some faculty. 'When I talk to a patient, I talk about his neighbourhood, his background, migration, affordability...everything' (I.F.1.1). Another faculty shared that 'sometimes when I talk to a patient, and the patient says something, something strikes and my understanding of that topic becomes a little better' (I.F.4.9). A past faculty recalled how the clinic exposed her to the issue of caste. '*Dalit* patients would not even sit on the bench that we had. They would

be sitting outside, under the tree. We are running the clinic inside, we call out their names, nobody is turning up' (I.PF.7).

Field exposure is what the faculty find most educational. '...whatever ideas I get, they come from the field...when I sit with the patient, with the ANM' (I.F.1.1). 'Even now when I go to the field, I try to talk to the people, look at their registers, how they work...that's how you understand' (I.F.1.10). 'That is the best thing which I like...going to the community, and discussing...because only then you learn' (I.F.1.8).

Engaging with the communities exposes the person to the capacities of lay people. A past faculty shared, 'In Mallur co-operative, since the people paid for it (health services), there were instances where they did not agree to some professional things that we proposed...And they agreed to some things which we thought were not so important...So we realized that the leadership of the village can determine policy' (I.PF.8). And it also helps them understand the ground-level dynamics. When the same faculty tried to start a *dalit* co-operative in the village, he was called a naxal. The village leaders were otherwise ready to 'help' the *dalits*, but would not let them organize. Some of the faculty at SNSPH-DoCM had worked in the tribal area of Melghat. The culture of those communities and the remoteness of the area made them realize the importance of folk medicine and traditional *dai* (I.F.3.7, I.F.3.8).

By participating in projects, conferences and training workshops, the faculty get exposed to regional, national and international personalities and institutions. Such exposures give new food for thought and expand one's horizons. A faculty recollected her interaction with students from Maastricht University who visited the department a few years back. 'They told me that home deliveries are very common in Scandinavian countries. They prefer home deliveries. So, I was very surprised' (I.PF.5). Another faculty shared that he had attended some international trainings and had liked their teaching methodology. He used those in his classes, and this was highly appreciated by the students (I.F.1.7).

Community-based research projects take the faculty closer to the ground-level realities. Referring to one such project on household air pollution a faculty shared, 'When we entered these houses, our eyes were tearing, but (those) people were working as routine. And this pollution is four time higher than routine' (I.F.1.13).

Some faculty get a temporary deputation to agencies like WHO (I.F.1.4, I.F.1.12, I.F.3.2). A faculty had worked in RCH projects with the State Government and UNICEF (I.F.2.1). Such experiences enriches one's understanding of PHC not only because they bring one in touch with different people, but also because they force one to get into different shoes, and look at things from a different vantage point. Similarly, involvement in policy research and policy dialogue enriches ones understanding about the macro-level issues and the associated politics (I.F.1.2, I.F.1.3, I.F.1.7). Involvement with planning and programs also makes one aware about the way the administration works (I.F.4.6).

But then, there are others who do only as much as is necessary to retain the job. They either have some non-professional priorities, or they still regret their carrier choice (I.F.1.4). They are a negative inspiration for their colleagues and students. Also, there are faculty who want to do things, but lack network (I.F.1.9). To raise the academic standards of the discipline is an important responsibility of the faculty (Frenk et al. 1990). But even those who are somewhat active may go with the flow, following the fashion of the day. 'HIV/AIDS came...wherever you see, more than half of the departments were doing HIV surveillance, or they were conducting trainings of NACO' (I.F.1.2). 'After 2000, there was a cacophony of MDG. After fifteen years, there is a cacophony of SDG' (I.F.1.2). Or, they are busy discussing less important issues, like which is a better socio-economic classification system (Kuppuswamy versus Prasad), and how to modify it (I.F.1.2). Innovative, original and contextually relevant ideas can't be expected in this scenario.

### **III.8 Experience during Additional Academic Courses**

More than half of the respondents had attained post-MD qualification (s) ([Table 8](#)). A past faculty did a course on 'Liberation Theology' which, she said, gave her a very clear understanding of political economy (I.PF.7). Another faculty, who did her PhD on Health Equity from Maastricht University, shared that she was guided by three people from three different backgrounds: a social scientist, a family physician and a health economist (I.F.1.1). Yet another faculty, who had done Masters in International Health from a foreign University, specifically shared that more than half of her batchmates were non-doctors (I.F.2.1). Such exposure opens one up not only to different disciplines, but also to personnel from different disciplines.

### III.9 Brief Exposures

Brief exposures to a different context can also be very enriching. A faculty recalled a recent visit to a remote part of Jammu and Kashmir where there were no roads, and the only way to travel was to walk. Being a hilly terrain, it exhausted her. 'That time, I realized that we need to do something for these people...These people remain left out. They are really in need of services' (I.F.1.11). Another faculty shared a similar experience on a river island in Assam that had no hospital facility, and no electricity. The boats were available only till 5 pm. In case of any emergency after sun-set, those people would 'just see the person dying' (I.F.2.3). Such exposures give an idea about the level of remoteness that still exists in the country.

Such exposures may also lead one to think about alternative solutions. Recalling his visits to Hemalkasa<sup>20</sup>, the area where Drs. Prakash and Mandatai Amte have been working with the *Madia-Gond* community, a faculty said 'there was nobody to tell them what to do. The approach was totally community-based. They learned from the people what their needs were, what were their requirements, what were their priorities' (I.F.3.5). Another faculty shared about his visit to Ladakh. 'I was surprised by the (traditional) medicine that they use' (I.F.3.1). Some faculty had been part of flood relief activities and found it to be an educative experience (I.F.3.2, I.F.4.7).

### III.10 Other Experiences

A senior faculty shared how she herself had experienced patriarchy (I.F.2.3). Her father controlled everything in her life, personal and professional. She was forced into marrying when she was interested in only serving the rural people. While she was not allowed to specialize in a branch of her choice for a long time, her brother could join Navy against her father's wish. 'He (the brother) was able to stand, whereas I wasn't able to stand. That is the female's social problem, culture problem' (I.F.2.3). With such life experiences, she could personally relate to the problems that women face.

A few faculty were engaged with (I.F.1.5, I.F.1.12, I.PF.7, I.PF.8), or at least in knew of (I.F.3.2, I.PF.5) PH forums like Medico Friend Circle<sup>21</sup> and movements like *Jan Swasthya*

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<sup>20</sup> <https://anandwan.in/hemalkasa.html>

<sup>21</sup> <http://www.mfcindia.org/>

*Abhiyaan*<sup>22</sup>. They acknowledged that such association had helped them develop their critical thinking (I.PF.7).

### III.11 The ‘Other Thing’

Some of the faculty had extra-curricular interests like reading fictions, watching movies, running, cycling, mountaineering etcetera. One of them faculty was doing theatre as the ‘other thing’ (I.F.4.10). He explains in his Tedx Talk<sup>23</sup> that the theatre has helped him become expressive, and to be able to sense others’ expressions; it has inspired him to ‘reach out’, and to understand people; it has trained him in working as teams. All these, he says, are the core in the practice of medicine and PH. While sitting next to poor elderly patients in distant villages, he recalls his theatre director who would say, ‘unless the deaf old lady sitting in the last row understands you, don’t even bother showing up’.

Literature is another source of understanding for some faculty, especially when it is approached at leisure and not specifically for academic gains. While explaining how government, as a knee-jerk reaction to a calamity, abruptly shuts down what people have been so far accessing, without creating an alternative, a faculty referred to a story by Munshi Premchand. ‘...you must have read, *Thakur ka Kuaan*...a woman from Schedule Caste goes to fetch water. *Thakur* wakes-up and the lady is not able to get water. On reaching home, she finds her husband is drinking water from the drain... One has to quench the thirst no, even if the water is dirty. You close the well without providing clean water...this is government’ (I.F.1.2). A past faculty recalled books like ‘*Health By The People*’ which helped shaping her idea of PHC (I.PF.7). However, some of the present faculty do not get time to read. ‘See, right now I have thirty-seven research papers which are pending...Plus, I am managing projects’ (I.F.4.6).

Movies were another source of understanding for some faculty. One of them urged students to watch *Motorcycle Diaries* which is based on the transformative days in the life of Ernesto Che Guvera (I.F.1.12). While talking about the debate on quantitative versus qualitative methods, about the Newtonian and Einsteinian era and about the Chaos Theory, a faculty referred to movies like *Life of Pie* and *Teen Patti* (I.F.1.5). The faculty mentioned *Ki*

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<sup>22</sup> <https://phmindia.org/about-us/>

<sup>23</sup> <https://www.youtube.com/watch?v=ef90Xu2Cplk>



*and Ka* while talking about gender roles, and to a scene from *3 Idiots* to explain how mechanical the physical sciences, including medicine, are (I.F.1.5). Another faculty could relate his experience during Rural Sanitary Latrine Construction Program to *Toilet - Ek Prem Katha* (I.F.1.2). While explaining how traditional medicine got de-legitimized by the colonial powers, he referred to a dialogue from *Sarkar*, '...kill the thinking' (I.F.1.2).

## Summary

This chapter discussed the factors and processes that shape the understanding of PHC among the faculty of CM and influence the extent to which they are able to adopt this approach in their work. The factors and process were seen to be acting at structural, milieu and individual levels. Structure-level factors and processes included Ideology of the Epoch (the way the world thinks, and the contrarians), Structure of Medical Knowledge and Education (dominance of bio-medical orientation), Professional Character of Medicine and CM (which resists change, till a critical mass demands it) and Status of PHC Approach (which itself has remained compromised, but still relevant). Milieu-level factors and processes comprised of the Focus of Regulatory Body (its moral and ethical standing), Process of Student Selection (which has been picking a pool of students that do not adequately represent the diversity in society), Curriculum-related issues, and Textbook and Journals (how they incorporate PHC approach). This level also included following factors that are more closely influenced by the ethos of the concerned institution and the orientation of the concerned department: Understanding of the Discipline (and how it relates to PH), Opportunities available to the faculty for Interactions (with community, government healthcare system, peers, policy process and others), Pedagogy-related issues, the status of Rural and Urban Health Training Centers, the Resources available with the Department of CM and the involvement of other departments of the MC in the endeavors of CM department. Individual-level factors and process consisted of the early-life experiences of individuals, their motivations to join medicine, CM and as faculty in DoCM, their experiences at all these stages, and other exposures. The next chapter attempts to make suggestions regarding how some of these factors and processes may be modified so as to develop a more comprehensive understanding about PHC among the medical faculty and students.

# Chapter 6: Strengthening the Understanding of the PHC Approach and its Implementation

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The understanding of Primary Health Care (PHC) varies across departments, and also across individual faculty within the same department of Community Medicine (Chapter 4). The understanding of same faculty for different aspects of PHC also shows variations. These differences are linked to various structural, milieu and individual-level factors (Chapter 5). This chapter compiles the suggestions given by the faculty respondents regarding how the students and faculty can be better oriented about comprehensive PHC approach. These apply at the level of Central and State Government, Directorate of Health Services and of Medical Education, the Regulatory Body, the Medical College (MC) and its various departments, the Departments of Community Medicine and at the level of individual faculty. 'Reform needs a number of things. Single method will be a problem. We will get exhausted' (I.F.1.9). As many of the suggestions are a repetition of what has been said countless number of times since 1950s but has not been adequately worked upon, the last section of the chapter ponders on the implementation aspects.

## I. Suggestions for Strengthening the Understanding

### I.1 Central and State Government

While the faculty made several suggestions regarding reforms in Medical Education (ME), they also, in parallel, expressed the need to align the PHC delivery system with the PHC principles, and to make it adequate. So as to improve the context for PHC, they called upon the concerned governments to take 'bold decisions' (I.F.3.2). These included the need to increase the health budget and to address the shortage of health human resource.

#### I.1.1 Directorate of Health Services (DHS)

Working at PHC level should be made 'lucrative' (I.F.4.11) and 'glamorous' (I.F.1.1, I.F.1.10) in order to attract and retain medical graduates. The salary has to be made attractive (I.F.4.9), and/or additional perks or incentives need to be offered (I.F.1.1, I.F.1.12,

FGD.PH.1). The job responsibilities have to be redesigned so as to provide ample scope for interesting work (I.F.3.6, I.F.4.9).

A faculty suggested to have formal placement drives in the MCs during final year MBBS, or during internship (I.F.1.12). An assured and well paying job immediately after internship will help getting doctors for the rural health facilities (I.F.1.1, I.F.1.6). Another faculty suggested that bringing in the gate-keeping role for primary care physicians, as is there in United Kingdom under the National Health Service, will improve their status (I.F.1.10).

The career progression pathway has to be pre-defined and followed. A faculty suggested a plan in which a medical graduate will work in a Primary Health Centre as a team with a Public Health (PH) graduate for certain number of years (I.F.1.12). Thereafter, the medical graduate will go on to specialize in Community Medicine (CM), and the PH graduate will go for MPH. The two will again team-up at the Block-level for another few years, and will subsequently escalate to the District and State-level (I.F.1.12).

Enabling working conditions in terms of adequate staff, infrastructure and logistics have to be ensured (I.F.3.6, I.F.4.9). A vehicle, along with adequate provisions for fuel and maintenance, has to be made available for moving in the field; this will also add to their status (I.F.1.1). Comfortable living conditions have to be provided (I.F.3.6). A faculty suggested providing them a bungalow, similar to the one provided to the District Collector (I.F.1.1).<sup>1</sup>

The posting in difficult areas has to be kept on rotation (FGD.PH.1). The difference in policies for contractual and regular staff should be kept to a minimum, and there should be a pre-defined and set pathway for regularization (FGD.PH.1).

A PH cadre has to be created to accommodate CM and PH professionals within the government health system (I.F.1.4, I.F.1.12). Till that time, such professionals have to be given preference over clinicians for positions in program and policy planning (I.F.4.9, FGD.PG.4).

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<sup>1</sup> Industrial townships, and even MCs, located in remote areas provide basic amenities, like housing and Schools, to their staff. There is enough demand for such amenities in every Block, and government may develop them at Block headquarters so as to attract and retain staff in health and other services.

Several of these suggestions have been repeatedly made in the past; for instance, see Jungalwalla et al. (1967), Deodhar (2003) and Dolea (2010).

### **I.1.2 Directorate of Medical Education (DME)**

The faculty suggested that medical graduates should be compulsorily made to work at Primary Health Centres. This will expose them to the real scenarios on ground. Otherwise, 'how will they know what is Primary Health Care?' (I.F.2.2). The faculty suggested similar services for post-graduates and superspecialists as well, though at a level appropriate to their qualification (I.F.3.6, I.F.3.8, I.F.4.8). 'If you do not have that experience, when you start teaching, or practicing, you will not be able to make that connect' (I.F.4.3). This suggestion has been given since long; for instance, see Seal (1966). But the intent behind the suggestion, even when given by PSM/CM faculty, has been limited to filling the vacancies in the periphery. What challenges it poses for the individuals and how to prepare them for the same; what benefits they can expect out of it and how to support and enrich their experience - these aspects have not been adequately looked into.

The element of compulsion, however, has to be handled with care. Firstly, the students have to be sensitized in the MC about the need for engaging with such work, and they have to be oriented and motivated for the same (See Chapter 3 to know how St. John's is doing this). Secondly, they have to be incentivized for taking it up, like by giving preference in selection for PG (I.F.3.8). Thirdly, they have to be given enabling working and living conditions at their place of deployment (I.F.4.7). Fourthly, they have to be supported while they are doing this work. The graduates first have to be posted at Community Health Centres or District Hospital to gain confidence in clinical skills (I.F.4.4). Even at Primary Health Centre, they should first be placed under a senior officer before being asked to manage it independently. MC faculty should periodically visit the peripheral centres to support and encourage the graduates (I.F.4.5).

So, it has to be a multi-pronged approach, with several stakeholders. If such care is not taken, the endeavour may become counterproductive (I.F.4.4, I.F.4.8). It may look like 'bonded labour' (I.F.4.7). The graduates may not own the work and may not acquire those sensitivities and perspectives for which they have been sent to the periphery in the first place (I.F.3.8, I.F.4.4, I.F.4.7). But, given the present-day mind-sets of the student,

compulsory service has to be enforced (I.F.4.4, I.F.4.8). And there should be no escape route, like cash penalties in lieu of not going for service. 'You just have to do it, otherwise you cannot move to the next step' (I.F.4.8). With time, the students will start seeing it as natural. And when the students would know that they will have to compulsorily work in the periphery after graduation, they will also focus more on developing skills required for PHC work rather than on preparing for PG entrance exam (I.F.1.6).

A very important point made by the faculty was regarding the nature of work that the graduates and PGs should be doing during this service. They shouldn't be only seeing patients but should be expected to mix with the community. Only when 'you are with the people, you get to understand what are the things you need to do' (I.F.3.8). 'Once they develop the bond (with people)...Primary Health Care will come automatically' (I.F.3.8). Such exposure will influence their practice for lifetime (I.F.3.6). Another faculty stressed on the importance of having a 'questioning mind', and suggested making research mandatory during such rural service (I.F.2.3). The government doctors should be sensitized by the MCs for this task of mentoring, rather 'nurturing', the young graduates (I.F.4.4).

Few faculties argued for an even wider exercise. They proposed compulsory rural service for all professionals, not just doctors, on the lines of compulsory military service that some countries have instituted (I.F.4.6). After all, it is not just lack of medical services that plagues rural parts of the country. When everybody goes, the proposition will be much more acceptable to medical graduates as well (I.F.4.3).

### **I.1.3 DHS-DME Linkage**

There has to be a close linkage between the DME and DHS (I.F.1.4). It may be built in the domain of teaching-training, research and service. The CM faculty may undertake training of government staff, and DHS officials may be called as guest lecturers in Department of CM (DoCM) (I.F.1.12, I.PF.2). DHS may handover the management of a few of its peripheral centres to the MC. It may accept PG students for postings at District/State-level. Faculty and students of DoCM may support DHS in trainings, annual planning, routine monitoring and supervision, program evaluation, and in times of outbreaks and disasters.

Having such linkages is a 'win-win' for both the Directorates (I.F.1.10, I.F.2.1, I.F.2.3, I.F.2.4, I.F.2.7, I.F.2.10, I.F.4.5, I.PF.3). This would enable PHC orientation: directly, by exposing the

UGs and PGs to the communities and PH system; and indirectly, by engaging the CM faculty in the health system issues. This would also facilitate induction of fresh medical graduates and PGs in government PH services (I.F.4.4). After all, 'the doctors, who are going to come to the Primary Health Centres, are getting produced here. If they (DHS) want some effective work to be done there...they have to make this extension here' (I.F.2.3).

## **I.2 The Regulatory Body**

Upfront, a faculty urged the government to replace the doctor-dominated Medical Council of India with a Public Health Council of India where people from medical as well as other backgrounds would have a say in the functioning (I.F.3.11). Other suggestions were related to curriculum, and selection of students and faculty.

### **I.2.1 Undergraduate Curriculum**

#### **Increase focus on Social Sciences and Humanities**

The faculty opined that students are ethical and sensitive when they enter the MC. 'But they become "realists" by the time they reach internship' (I.OF.4.2). 'In Medical Colleges, we are trained to look at the patient only. We don't look at where the patient comes from, and what circumstances he is in' (I.F.4.3). Going beyond the issue of sensitivity towards patients, a faculty shared that medical teaching and training is very technical, and it creates a 'tubular vision' among the students (I.F.1.1). 'Medicine has become different systems - liver system, cardio-vascular system...not community systems. We don't understand caste, class, gender, feeling good, bad...nothing we can understand. Like a television, you repair it with this drug, that vaccine' (I.PF.8). This is not sufficient for betterment of health of the people (I.F.1.10).

There is a need to sensitize and humanize medical students and to discuss issues like equity and social hierarchy that helps them ascertain the real needs of the country (I.F.1.1). Each one of them 'should be aware about all these social determinants, not just the Paracetamol or the antibiotics or the procedures' (I.F.1.9). Given the fact that diseases have a multi-factorial etiology, and that they cannot be fully understood nor prevented or controlled when removed from the context in which they occur, Seal (1966) calls for 'medicine to be recognized as a social science'.

A faculty from the Division of Humanities at St. John's opined that 'the only way people can relate to other people is when they understand that they too are a part of the society...that, in many ways, self-preservation requires preserving society' (I.OF.4.1). While clinical training provides clinical competence, 'your human competence, your ability to actually relate to society comes, both, from your interactions with patients, and from areas outside' (I.OF.1). So, 'Humanities definitely have a role' (I.OF.4.1). 'Humanities bring humanity' (I.PF.8).

'Unless you bring Social, Economic, Political, Cultural, Ecological (SCPCE) analysis, you can't humanize the doctor' (I.PF.8). 'That's where the Social Sciences come in' (I.PF.7). The past faculty informed that in American ME, students are exposed to sociological concepts like gender and race from the very beginning (I.PF.7). Talking about inequities and the underlying politics, a faculty said, 'I also came to know about this very late in my career. And it was an eye opener. If MBBS students know it from the very beginning, I think it is going to change the mindset' (I.F.1.1). Paterson (1993) also pitches for some education in the political, sociological and economic dimensions to the trainee health-care professionals.

Besides, developing an understanding about overarching macro-level issues would require inputs from other disciplines like Sociology, Anthropology, Law and Economics (I.F.1.6). Referring to the rising incidents of violence against the doctors, a faculty said, 'if I, as a doctor, fail to understand why there is a shortage of doctors, my whole reaction will go into people who have come to receive services from me. But if I understand the reasons, probably, I will start fighting with the system, that give me a b c' (I.F.1.5). So, 'We really need an integrated medical education' (I.F.1.4). Banerji (1969) highlights the need to introduce Sociology, Social/Cultural Anthropology and Social Psychology in UGME and suggests phase-wise plan to do so.

Faculty personally felt that it would have helped if they were taught more of Social Sciences (I.F.4.2, I.F.4.3). They were witness to many hierarchies in their own professional life and were not able to make sense out of it. 'In Community Medicine, we learn few of these things. But that doesn't go, the superiority that you are this this this...' (I.F.1.1). Social Sciences are humbling. For instance, when one reads history and becomes aware of how even the greatest of kings and dynasties ultimately collapsed, 'you understand that you are also a part of that pattern' (I.PF.5).

Regarding the 'practical utility' of such sensitization, a faculty said, 'it's not a mathematical equation that you do A and B will happen. In my opinion, changing the mindset is more important' (I.F.1.2). A faculty having background in Sociology shared her experience of training a group of Medical Officers on Gender (I.F.1.5). For first two days, there was a lot of resistance. The trainees would say 'Madam, what are you trying to teach us? Don't we know what is *streeling - puling* (man - woman)?' The ice somewhat melted on the third day when one of the lady participants shared her personal story of being ignored by her partner. The story was simple, and relatable. It made everybody realize how the needs of women, even in middle-class households, get invisibilized. Some participants took this training very positively. They committed to building toilets in their health facilities. Realizing mobility to be a big issue for women, they said that they would never turn-back a woman from OPD (I.F.1.5). So, Social Sciences work in subtle ways.

What appears as 'resistance' or 'incompetence' for sociological concepts like gender and hierarchy among medicos is actually a sort of 'blind spot'; something which is not presently being talked about. The understanding about these issues will certainly improve if they are included in the curriculum and discussed (I.F.1.3). And this will make them better PHC physicians (I.F.1.1). It is not that only people in medicine require such sensitization. But 'if you are in this profession, you are here to serve, you are here to serve, which is different from other professions' (I.F.1.1).

The faculty from the Division of Humanities at St. John's, however, cautioned that Humanities are often understood in a limited way. Humanities include 'anything that helps us better understand the human conditions' (I.OF.4.1). The attempt should not be to force students to think in a particular way because, by their very nature, the Humanities are plural. 'You want people to have views which are different. You want people to accept those views. You want a setting where these views can all be aired, and where people can debate and discuss these issues, because people feel differently' (I.OF.4.1). Moreover, it requires 'theoretical rooting'... 'the "why" of "what", rather than just...these are set of codes or rules that you follow' (I.OF.4.1). And, Humanities 'cannot just fit in the cracks, wherever suddenly some space or time opens up' (I.OF.4.1).



### **Incorporation of Community Orientation Programs**

Community Orientation Programs, like the ones conducted by SNSPH-DoCM and DoCH, touches upon the 'affective domain' (I.PF.6). They give an opportunity to the students to 'engage' with (not just get 'exposed' to) the challenges that exist at community level (I.F.3.8); 'students can make connections' (I.F.4.3). The faculty recommended formal inclusion of such programs in the curriculum, so that every MC conducts them (I.F.4.3, I.F.4.8). 'If only a few departments are doing this in isolation, this is not going to affect' (I.F.3.2). In fact, one may raise doubts about the effectiveness of such initiatives unless there is a critical mass. 'But if all medical colleges start doing it, there will be a sea change' (I.F.3.2).

### **Block posting at Primary Health Centre**

It is not possible to produce medical graduates who can address primary health care need by training students exclusively in a tertiary care centre. So, instead of just making them visit, they should be posted at Primary Health Centres, Community Health Centres and District Hospitals, not only during internship, but also during UG years (I.F.1.6, I.F.3.2, I.F.3.3, I.F.3.8, I.F.4.2, I.F.4.3). The students should be learning about the preventive aspects and about the health programs instead of only running OPDs (I.F.2.7, I.F.3.6). They should actually 'do' certain things in the village (I.F.4.2).

### **Other Suggestions**

The faculty suggested inclusion of topics on management, administration, attitude, ethics and communication skills in the UG curriculum as they were crucial to work at PHC level (I.F.2.7, I.F.2.8, I.F.4.9). As a move in this direction, the MCI has come out with AETCOM module (MCI 2018a). Further, the faculty suggested focussing on research at UG level so as to develop a research orientation among all types of doctors (I.F.1.9, I.F.4.3). This, in the long run, will reduce the general reluctance for research seen among the government health officials and MC departments (I.F.1.9). The faculty also stressed on developing basic clinical skills among UGs so that they feel confident in practicing independently as graduates, and not depend on specialization (I.F.1.4, I.F.1.6).

## **I.2.2 Postgraduate Curriculum**

### **PG students in CM**

There was a consensus among the faculty that PG students should get primary-level clinical exposure, and so, the DoCMs should take clinical responsibilities. However, such responsibility should not be overwhelming (I.F.1.1, I.F.1.6). The faculty and student should be able to give sufficient time on each patient so as to go beyond the immediate physical complaints (FGD.MD.1). Secondly, the posting in specialty clinical departments of the MC should be shortened (FGD.MD.1). The time saved by moderating the clinical exposure should be used to focus more on the macro-level issues of PH (I.F.1.3).

The faculty stressed on the importance of engagement of PGs with the community. 'They cannot just sit in the department and read the textbooks. This way, they may pass. But tomorrow, will they be able to go out in the community and do something?' (I.F.4.4). Another faculty added that, even if a MC had its own rural centre, exposure within the government set-up was very important (I.F.4.3). The faculty also emphasized on the need for PG students to be posted in the District Health Office or the State's Directorate of PH (I.F.1.6, I.F.4.3).

One exposure that is completely lacking in the MD-CM curriculum is that to health activism. For this, the faculty suggested sending MD students to NGOs working on those lines. This will also clarify to the students that the work of NGOs can go beyond just running programs parallel to the government, or trying to take medical care to the outreach (I.F.4.6).

### **Others PG students**

Discussion on PHC stops with CM in the pre-final UG year. There is a need to develop some mechanism to keep PGs from all disciplines sensitized about this approach (I.F.4.2). A faculty suggested having a chapter about this approach in textbooks of all specialties (I.F.4.11). Secondly, every PG should be posted at primary and secondary levels of care (I.F.3.8, I.PF.8). In this regards, National Medical Commission is planning to start a 3-month 'district residency' for all PG students (anecdotal).

## **I.2.3 Student Selection**

'We have to ensure that medicine is a kind of profession where individuals who take it up, actually take it up for the cause of medicine, and not just to get a degree, become a doctor'

(I.F.4.7). Somehow, besides merit, preference needs to be given to students who come from difficult circumstances and want to do something about it...who have an 'inner motivation' (I.F.4.7). Having only a MCQ-based entrance exam doesn't fulfil that purpose. Institutes like MGIMS and St. Johns have had a more comprehensive selection process which can be looked into.

With regards to specialization, the faculty thought that it should be a mid-career option rather than being offered upfront. 'They need to practice as a general practitioner for some time to get an in-depth understanding of social issues and healthcare issue. They will be better specialists I guess if this intervening period of about five years is there' (I.F.1.12). This is especially true in the case of CM. Candidates who have worked in field realize the importance of this discipline and can relate the theory with their experience (I.F.1.6, I.F.2.4). So, it would be desirable to make work experience mandatory for PG.

## **I.2.4 Faculty Selection**

### **Make field experience mandatory**

Allowing implementers to take the role of educators is a very desirable arrangement. This was common in the initial years of setting-up of the DoPSMs in the country. The Second Institute, and other older government MCs in that State, still have some of its CM faculty from the Directorate of PH. Another option is to allow only those having experience of working in field for certain number of years to become CM faculty. The field provides practical knowledge which can't be gained by 'reading textbooks' or even by 'adopting one Primary Health Centre and doing the services along with regular service' (I.F.2.10). 'So much of the teaching will come out of experience' (I.F.2.4). But for this to be widely adopted, official provisions need to be made by the regulatory body (I.F.2.10).

### **Open CM to faculty from other disciplines**

At present, only MD-CM can work in DoCMs. A faculty stressed on the need for the regulator to allow mobility across disciplinary boundaries. If a Physician, or a Cardio-Thoracic Surgeon or an Ophthalmologist decides to work for community on preventive or promotive aspects, if s/he is trying to understand epidemiology, there should be scope in CM to train her/him, recognize him and absorb him (I.F.3.2). Similarly, there should be

scope for CM people to find a place in departments like Paediatrics, Ophthalmology, Obstetrics & Gynaecology or Psychiatry to work on related community aspects (I.F.3.2).

Moving beyond the medical disciplines, topics related to Social Sciences and Humanities are presently being taken mostly by faculty having CM background.<sup>2</sup> A faculty equated this practice with quackery, as CM faculty were dealing with concepts that they themselves have not been trained in (I.F.1.6). Many faculty and students expressed the desirability of having dedicated personnel trained in respective disciplines, especially Social Scientists (I.F.1.1, I.F.1.6, I.F.1.10, I.F.1.13, I.PF.7, FGD.PG.4). One faculty saw the entry of personnel from other disciplines as something that could reduce the biases<sup>3</sup> inherent in the structure of Medicine (I.F.3.2).

While topics of Social Sciences and Humanities may appear to be 'common sense', it is not so. For instance, a faculty having CM background saw involvement of male partners in Family Planning services as an adequate representation of 'gender issues' in RCH program. Another CM faculty, in his lecture to the UG students, termed 'gender', along with age, as a constitutional factor about which nothing much could be done. In contrast, a faculty having background in Sociology mentioned 'women's health' as the focus of her department in early 1980s, but she quickly corrected herself. 'I shouldn't say women's health, it was maternal health'. Table 18 (Chapter 3) shows the difference between the approach of an Anthropologist towards PH and that of a Paediatrician. So, the understanding varies depending on the faculty backgrounds. 'If a doctor is exposed and trained in those things, they may also develop that. But a Social Scientist is always deeper' (I.PF.7). The faculty, especially at SNSPH-DoCM and DoCH, were highly appreciative of department's Social Scientists and Medical Social Workers (MSWs). Faculty/staff having roots in such disciplines understand the social dynamics, they know how to connect with people, and people accept them as their own (I.F.3.11, I.PF.7, FGD.PG.4). And some faculty shared how they themselves had got enriched by working closely with colleagues from other backgrounds (I.F.1.1, I.F.1.6, I.F.4.11, I.PF.7).

The faculty suggested that till such personnel can join as full-time regular faculty, the department should be allowed to tie-up with relevant institutions or individuals to sensitize

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<sup>2</sup> There is a provision of Medical Social Worker in each DoCM, but this is generally a non-teaching post.

<sup>3</sup> 'Individual bias', 'Abnormality (disease) bias' and 'Linear causality' bias

the students on Social Sciences and Humanities (I.F.1.4, I.F.1.6, I.PF.7). A conference on 'Social Sciences in Professional Education: Agriculture, Engineering, Medicine' was held by ICSSR, way back in 1975. While it asked the Social Scientists already posted in MCs to engage with all the Social Sciences irrespective of their parent discipline, the conference expressed the need to have a full-fledged Department of Social Sciences in every MC (UGC-ICSSR 1975).

However, the faculty gave two points of caution. Firstly, they said that personnel from other backgrounds need to have some understanding of medical aspects (I.F.1.9, I.F.4.2, I.F.4.3). And secondly, they should be in touch with the ground. 'The academic Social Scientists are in a different world, and they use a different language. They have their own nomenclature which is un-understandable to a medical student' (I.PF.7). So, the inclusion of faculty from other disciplines has to be done on practical consideration; there is no point being 'romantic' about them. Similar pointers were given by UGC-ICSSR (1975).

A faculty flagged that the medical faculty and those from backgrounds like Sociology may not gel very well. One may feel 'lost' in the company of the other as the two disciplines are conceptually very different (I.F.1.5). Though, the two should have parity in pay and designation (I.PF.8, UGC-ICSSR 1975).

CM has to be seen differently, and not as a 'typical' medical specialty - both by the CM fraternity and others, including the regulators.

### **I.2.5 Other suggestions for the Regulator**

Despite the MCI having specified the minimum standards for MCs with different intake capacities, faculty expressed large batch-size as a challenge. It is a problem, both for the faculty and the student (I.F.2.8, I.F.4.9). The regulator needs to reconsider approving such a large number of seats for a MC. Instead, MCs with lesser capacity, distributed more equitably, will serve the purpose better.

The faculty stressed that the Rural and Urban Health Training Centres should be under the ownership and management of the MC rather than just be affiliated to it. Only when the MCs are 'responsible' for such centres, will they take it seriously (I.F.1.6, I.PF.2, I.PF.8). That the administration of the field training facility should be in the hands of concerned institute

was one of the recommendations given by the Bhole Committee (Gol 1946). Moreover, every MC should be mandated to take responsibility of a fixed geographical area, not just a peripheral health facility. And the DoCM should cater to the PHC needs in this assigned community (I.F.1.6, I.F.1.10, I.F.1.12, I.PF.2). The faculty went on to say that regulator should make it mandatory for the DoCMs to physically operate entirely from the Rural and Urban Health Training Centres instead of being located in a tertiary-level institution. 'We should have very strong presence in the community rather than commuting' (I.F.1.12). When the students see their teachers working in such setting, they would feel it is feasible to work in remote areas, and would be motivated to do so in future.

As an overarching comment, the faculty said that the standards, guidelines and regulations should not be 'watertight'. There should be enough flexibility and scope for innovations (I.F.3.2).

### **I.3 Institution and other Departments**

The ethos of the institution significantly influences how individual departments, faculty and students behave. 'Till institutions feel the need to do this, till they feel this makes a difference, nothing is going to happen' (I.F.4.7). Though it may not be 'sufficient' to have the ethos aligned to PHC, it is 'necessary'.

The institution should ensure the necessary resources needed to orient students in PHC approach. It should have a functional Rural and an Urban Health Training Centre under its ownership so as to 'demonstrate' PHC concepts in action (I.F.4.10). These Centres should be considered as extensions of the MC (I.F.1.12).<sup>4</sup> However, the facilities and services at RHTC and UHTC should not be very different from the other government run Primary Health Centres so that the UG are prepared for real-life scenarios. Besides, the Institute should make available appropriately sized vehicles for easy movement of faculty and students to these Centres and beyond (I.F.2.7).

It is not possible for DoCMs alone to orient students in PHC (I.F.3.6, I.F.4.2, I.F.4.11, I.PF.5). It is the overall experience of the students in different departments that shape their

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<sup>4</sup> In this regards, Frenk et al. (1990) write: 'First-level facilities must be legitimate educational arenas. For this to happen, such facilities must be improved so that they can become true centers of excellence...they adopt a population base, with risk anticipation, intersectoral coordination, and community participation, so that they fulfill the elements of the PHC paradigm'.

viewpoints (I.PF.5). So, 'first of all, we need to somewhat orient the faculty of other departments' (I.F.3.6). And for this, the institute need to post the faculty in the field, at the Rural and Urban Centres and communities (I.F.3.8). 'When they go there, they have to adjust with the ground reality...And it is learning for them' (I.F.4.5). It can be stressful, but it keeps one grounded (I.PF.7). Several committees and individuals have made similar suggestions in past, like Mathews (1967). Chugh (1983) opines that 'This single step will produce better team leaders (doctors) who in turn will train others...'

The institutions need to nurture a culture of dialogue between departments, not only for teaching, but also for service and research (I.F.4.11). The departments need to thematically align classroom teaching, clinical rotations and field visits. For instance, 'When the UGs are being taught mental health, they are made to visit Psychiatry ward, and are taken in villages to understand the actual condition of people with mental illness, the stigma they face, the support they get from their families. When students see all these dimensions, then probably they will develop a comprehensive understanding' (I.PF.5). This integration will allow the student to look at a topic from different perspectives, will develop a holistic understanding (I.F.1.4, I.F.4.11, I.PF.2), and will 'break the barriers of specialization' (I.F.4.11). A faculty also suggested that the institute should incorporate a 'social diagnosis' section in the proforma for taking clinical history so as to bring those aspects into the case discussion (I.F.4.2).

Besides asking for their academic achievements (publications, orations, memberships, training and workshops attended etcetera), the institute should hold the departments and faculty accountable for their contribution to the community. 'They should be able to answer that how the people and the programs have benefitted because of them' (I.F.1.10).

Students subconsciously pick-up traits from those whom they see, or those who are presented, as role models. Some of the institute's own alumni may have taken a path less travelled, and may be contributing to the society in some meaningful way. The institute need to highlight such inspirational figures (I.F.1.1, I.F.4.7, I.F.4.9).

Fresh graduates lack confidence for independent practice, and need some hand-holding. The Institute should send the faculty to places where such graduates are posted so as to give them technical and emotional support (I.F.4.5).

## **I.4 Department of Community Medicine**

### **I.4.1 Increase the effort**

Teaching is the primary task of a CM department. 'First of all, the academic section, the academic class has to be taken regularly' (I.F.2.6). Thereafter, the CM department should manage Primary Health Centre owned by the institute, and should engage with the surrounding community. 'Without that we can't take our students to field and teach what is community' (I.F.2.9). In order to become good doctors, the students 'have to understand what are the determinants of diseases, and from which community our patient comes from' (I.F.3.3). 'At present, we are offering the student only teaching, means theoretical' (I.F.3.11). The departments should enable 'a lot of practical learning' (I.F.3.3); and, for that, 'community mobilization can be a suitable model' (I.F.3.4). The department should follow, and inculcate in their students, a 'systems approach' for identifying and addressing different issues.

The environment that small children get in the initial few years of their life decides what kind of adults they will become. The same logic applies to medical students. And so, it is important for CM departments to 'engage' (not just 'expose') them with the community, and with the primary and secondary healthcare system, early-on. 'But this cannot happen just by giving instructions that "from next batch onwards, all departments will have to do this"' (I.F.3.2). This would require role modelling, and kindling the passion in the faculty.

In addition, the UG students should also be exposed to the macro-level issues including policy. Otherwise, once they graduate and branch-out into various specialties, it will be practically very difficult to make them aware about the need to engage with the policy process. However, to do so, the department itself has to engage with such issues.

At the same time, the expectation from DoCMs needs to be moderated. Firstly, it is difficult to evaluate its work because the desired outcome may sometimes be only a change in general attitude on the part of student (Freyman 1958). Secondly, while these processes can expose the students to the realities of a section of society which are otherwise invisible, 'each one has a different mindset' (I.F.3.10). So, not all of them may get affected; and not many of them may get attracted to working in primary-level settings, or to CM. 'It's a question of, I think, 'chipping-away'. You chip. With ten percent of them, you may make a



breakthrough' (I.F.4.10). 'We have to teach them an approach which they can use in whichever specialty they are interested in; Public Health is not only about working in villages' (I.F.3.10).

It should not be about numbers. 'Even if one or two committed individuals come and get involved with the discipline or with the field, slowly that critical mass will build' (I.F.3.1). 'At present, students having such mindset feel isolated. When they look around, everybody seems to be behind money, name and fame. So they feel "why should only we do that". If you are able to build a critical mass, such students will have people to look up to. Even if their numbers increase in small counts, it will be of help' (I.F.3.2).

#### **I.4.2 Make students aware about scope in CM**

UG students need to be specifically told regarding what they can expect in CM, and what they cannot (I.F.1.13, FGD.PG.4). 'You might not be treating, not one to one, you (are) treating the society as a whole...Of course, you will get less money. But the satisfaction, what you can do for your society, you can do wonder only through CM...that message need to percolate' (I.F.1.13). 'We have to explain to them that you will be the policy makers in the future...you can prevent many of the diseases in the beginning stage' (I.F.2.6). Such efforts may go a long way in ensuring that reluctant people do not enter the specialty (I.F.1.4). A motivated pool of CM faculty is more likely to orient the future students in PHC approach.

#### **I.4.3 Encourage Interactions**

It is crucial for DoCMs to develop a culture of interactions, both within the department, and with people outside. Interaction helps in deepening individual understanding by exposing one to different perspectives (I.F.4.9). It helps the individuals to get 'out of the well' (I.F.1.7), and make them reflect on their own work (I.PF.2). It may also lead to new partnerships and collaborations (I.F.1.11). And it keeps the faculty and students motivated.

Within DoCMs, there are faculty from diverse age-groups. The belief that maturity comes with age is contestable. Rather, 'It comes with effort' (I.PF.7). Feedback and ideas from students and younger faculty can be very useful and should be taken. The same should be the approach to utilize disciplinary diversity present in the department. PHC principles need a 'mental attitude' which cannot be developed only by teaching in the classroom. It gets inculcated when PHC becomes a 'culture' in the department (I.F.2.3).

The DoCM should interact with other departments of the MC. It should invite clinicians to deliver lectures on how they adopt PHC approach in their practice, and should send its own faculty to discuss the approach in seminars of other departments (I.F.4.11). That the clinicians will not be interested is 'our assumption' (I.F.4.11). A faculty at DoCM-SPH had collaborated with clinical departments to prepare guideline on what can be done for NCDs at primary and secondary-levels. 'And they are very happy to contribute' (I.F.1.4). The DoCMs may encourage some of their MD students to undertake research on how other departments of the MC can incorporate PHC approach in their work. To do this more seriously, CM faculty may be deputed to other departments for a significantly long duration. These faculty may immerse themselves in the daily routines of those departments and try to find ways to mainstream PHC approach in clinical teaching-training and practice. While it is important to do all the good work, it is equally important to 'project' it so as to improve the standing of DoCM within the institute (I.F.2.3, I.F.2.9).

The faculty suggested that DoCMs of different MCs should be open to share and learn from knowledge, experiences and failures of each other (I.F.4.11). The Department should encourage its faculty, students and staff to attend conferences organized by local and national CM/PH associations, and also those of other disciplines (I.F.4.11). Similarly, they should be sharing their perspective in CM/PH journals, and also in journals of other disciplines (I.PF.8).

The Department should also encourage its faculty to engage directly with the community, and not leave this task solely for its social work team. Otherwise, 'our imagination of the "public" may be different to what it really is' (I.PF.7). This will help in meshing the clinical components with the preventive and promotive parts while teaching the students, without sounding 'bookish' (I.F.4.7).

DoCMs need to proactively look out for ways in which they can engage with and help the local PH system on a prolonged and sustained basis (I.F.1.10, I.PF.7). This includes not only the government health structure, but also the non-governmental organizations in the area. This keep the faculty updated with in what is happening around (I.F.4.5). DoCMs also need to explore the possibility of linking-up with other sectors that influence health. 'We are not

the main fighting force. But we have to be a part of the critical thinking and the change process. For that, we have to be proactive' (I.PF.7).

#### **I.4.4 Develop Specialization**

At DoCM-SPH, each faculty had a specific area of work like nutrition, NCD, Health Economics, Health management etcetera. The faculty opined that every DoCM should have such specialized divisions (I.F.1.4, I.F.2.3, I.F.3.10, I.F.4.1). There are so many components in CM that it is not possible for every individual faculty to engage with all (I.F.2.3). Such specialization will allow them to engage with specific issues in greater depth. This will not only bring recognition to the faculty, but also offer better and diverse exposure to the students (I.F.3.10).

### **I.5 Faculty**

#### **I.5.1 Interact and Engage**

While the DoCM has to facilitate, it is ultimately the individual faculty who have to interact and engage with other departments in the MC, with communities, with the local health system and with other sectors. Students want their teachers to speak more from their experiences than from books (I.F.4.5). They should not just teach, but should be 'seen' as doing what they teach (I.F.1.12), be it service delivery or be it research and advocacy. 'If the Community Medicine teachers move out like this, automatically, there is a better standing for yourself in front of students' (I.F.4.5). 'We can confidently tell our students with conviction what we teach' (I.F.4.7). Only then can the faculty be a role model for their students (I.F.3.11). And, very importantly, the faculty should always remain open to new ideas and suggestions rather than taking them as a personal criticism (I.PF.3).

#### **I.5.2 Understand the Learning Process**

Like any teacher, the Medical and CM faculty need to understand the science of education; this is crucial (I.PF.7). The teaching has to be explanatory rather than descriptive (I.F.4.5). The topics have to be made relatable. For instance, the students should see the reason why, if at all, they need to know about the dimensions of RCA latrine (shared by an Intern). New information and concepts have to be pegged on what the students already know and understand (I.F.3.10). At the same time, the subject has to be made 'intellectually challenging' (I.F.3.5).

Field experience can be transformative (I.F.1.12). The concepts taught in the classroom have to be linked to the field realities, and the observations made in the field have to be linked back to the class (I.F.4.4, I.F.4.5, I.PF.2). And it has to be an 'engagement', not just touch-and-go (I.F.3.8). Contextual research is another way to develop the understanding. Using such multiple modalities lead to development of 'parallel thinking' and 'linking thinking' (I.F.1.9).

The faculty should find ways to bring 'visibility' to the CM concepts (I.F.3.1, I.PF.6). For instance, Self-help Groups formed by SNSPH-DoCM and DoCH are 'visible' platforms of community participation. Moreover, the diversity<sup>5</sup> among the students and the range of their life experiences should be used to enable mutual learning (I.F.2.8).

Students have to be encouraged to question (I.OF.4.2); and they should be allowed to make mistakes. 'They may do something which you may think is crap'; 'but it is important for them' (I.F.3.1). And they should be made to think (I.F.2.3, I.F.3.2, I.F.4.9). The faculty should 'provoke them to search for more...increase their curiosity' (I.PF.3). Even the questions asked in the exam shouldn't just require reproduction of information.

The faculty should not try to impose a particular thought process on the students. 'Introduce it, and then leave it. Let them decide for themselves' (I.F.3.1). The faculty should let the students expose themselves to different organizations and communities, to explore and to experiment (I.F.3.2). 'That is important, that is going to help them expand their own horizons, through which their own thinking, their thought process, would become concrete' (I.F.3.1). The faculty should see the students as 'future healers' (I.F.2.8). They should try to preserve, kindle and nurture the sensitivity with which the student entered the MC.

IPHA (1967) states the three traits of a good teacher as being: 'know your subject, like your subject, and like the people you teach'. A very senior faculty, not from CM, shared the finding of an old study that analyzed why the students of one particular school performed brilliantly in life. The researchers found that there was one particular teacher in that school who was behind this. And when the researcher traced and asked that teacher what she did differently to her students, she said 'I loved them'.

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<sup>5</sup> This may include sex, domicile (rural-urban), caste, religion etcetera.

## **I.6 Student**

The most vulnerable and powerless entity in the whole complex is the student. Competition (for entry, for practice), family pressures (to settle, to earn), social status, bank loans...there are too many fronts on which they have to fight. But still, may be, they can do some introspection; may be, they can give the alternative a chance.

Reflecting on the suggestions in general, a faculty said, 'We often leave feasible things, and instead pass big-big generalized statements, which is of no use' (I.F.1.10). However, what appears feasible depends on the level at which one is thinking. So, rather than discarding any suggestion as 'impractical', the level at which it has to be addressed needs to be identified. A very senior in-service PG student, pessimistically or practically, said that 'it is you who need to change. The system doesn't change.' This mindset was countered by a faculty who said 'If we can get the Orbiter on the moon, we can definitely change medical education' (I.PF.7). 'There is no room for cynicism, there is no room for pessimism' (I.F.4.10).

## **II. Need to 'open-up', 'get organized' and 'reach-out'**

Many of the problems identified and the suggestions made by the faculty are not new. A review of policy documents, conference proceedings and faculty publications since mid-1940s reveal that several issues have, more or less, remained the same (see Chapter 1). The country has continued to follow the western system of ME which is urban-biased and cure-oriented. Even among curative care, the focus has remained on specialized technology-dependent care that leaves the medical graduate uninterested and incapable to work in resource-limited primary-level settings. Lack of orientation to PH further limits their utility for the community. There have never been enough incentives for joining practice after graduation, and at the same time, there have been ample opportunities for postgraduation. This has been, in part, because of a neglect of PH over curative care in the general health services. The students, thus, have preferred to specialize rather than first putting to use the knowledge and skills acquired in MBBS. DoCMs, in general, have not been able to escape the charm of clinical. Their linkage with healthcare delivery system has remained weak and the CM faculty have lacked field and research experience. The status of the department has been a chronic concern, and cooperation from other departments of the MC has been sub-optimal.

In response to these repeatedly identified issues, the solutions suggested since long still apply as not much happened in between.

- ME should be contextualized to the needs of the country. It should not alienate students from their own people. MCs should be equitably distributed across rural and urban regions and should incorporate the local problems in their teaching and training. Process of selecting students should have a comprehensive assessment of personality. Candidates, who, socially and culturally, resemble the majority of population to be served, and have an inclination to serve, should be recruited as medical students. They should get need-based support, including financial, during ME.
- Student should be conditioned to appreciate patients as persons, and to recognize their role, and that of others', in the health team. The curriculum and pedagogy should be aligned to enable the students to work at PHC level for the masses. They should be trained to diagnose and treat common diseases with minimum facilities, and to undertake minor surgical and life saving procedures. At the same time, they should also be taught the preventive and promotive aspects; the teaching should demonstrate 'the basic unity of medicine'. The curriculum should include issues of management, personnel, accounts, medical audit etcetera. Social Medicine should be an integral part of ME to give the students a wider outlook and save them from getting reduced to being mere technicians.
- Principles of education science should find application in medical teaching-training. For instance, didactic lectures should give way to small group teaching and discussions. The faculty should be 'fully alive to their social function'. Different department should collaborate for integrated teaching. Teaching on preventive and promotive aspects should be a joint endeavour of all departments.
- DoCMs should broaden in concept to incorporate sociological and ecological outlook, and should extend in operational aspects. CM teaching should permeate the entire curriculum, and should not be treated as a separate discipline with a separate body of knowledge. UG students should be made to visit OPD patients at their homes; observation from these visits should be presented in institute-level conferences/seminars in presence of faculties from different disciplines.

- Management of a few Primary Health Centres should be transferred to the MCs, along with the staff. Residential and teaching facility should be developed at these centres and adequate number of vehicles should be provided. 'Students must be brought to face people and their problems'. CM Faculty should guide the working of these centres and should 'facilitate (student's) contact with his fellowmen, their physical and social environment and their daily life of joys and sorrow...' The Medical Officers of these Health Centres should be given a staff status in the DoCM, and PH officials should be involved in CM teaching and training. Entire internship should be at district, block and Primary Health Centre level with adequate exposure to communities. These postings should be closely supervised, both by the facility in-charge, and by the MC faculty.
- PSM/CM faculty should have clinical as well as field experience. They should develop some expertise so that others respect them. They should engage with the community and with the health system so as to prevent themselves from developing an 'ivory tower' mentality. Within the MC, they should participate in Clinical-pathological conferences and try to stimulate and influence the teaching of other departments.
- There should be mandatory rural postings dovetailed with clear and transparent career progression and with financial and non-financial incentives. Specialty and super-specialty training should be open only to candidates with prior work experiences. The branches and number of seats in such branches should be as per the need of the healthcare system. A PH cadre should be established so as to give PH issues the priority they deserve.

All these suggestions have been made time and again. However, the situation seems to be almost static. A senior faculty said, '...status quo is difficult (to break). It has always been difficult. The change, and social change, is always difficult. So, we have to find ways how to bring about the social change. Ideas are the first starting point. Once there are ideas, and there is a critical mass of people who think those ideas are the correct ones, the second stage comes when those ideas spread, are practiced and produce results, then we get more confidence. And then, this type of change needs a kind of a pressure group which has sufficient force that the status quo people feel the pressure and they feel that it should change' (I.F.1.12).

Ideas are indeed the starting point. But it has become difficult to express one's opinion if it is different from what the majority thinks. A faculty shared his experience when issues like 'violence against doctors', 'Bachelor's course in Rural Medical Service' or 'Bridge Course' were being discussed in his social network. 'I would feel what non-sense is this, but why would I speak...unnecessarily they will jump on me. I keep quiet because there is no scope to convince' (I.F.3.2).

Several of the interviewed faculty showed concerned about privatization - in ME and also in general; about the dominance of technology; about lack of concern for social determinants among the medical personnel, and about other similar issues. A few of them were trying, incessantly, to mould the attitudes of their students in favour of 'the last, the lost and the least'. 'Sometimes, being isolated, we feel that only a few people think like this. It is not so. A large proportion of people want to do something' (I.F.3.2). Several people are experimenting with the alternate, but as they are not networked, their efforts and views are seldom seen as mainstream (I.PF.8). 'We still don't have a critical mass of medical educators who work as a group' (I.PF.7).

There used to be an Indian Association for Advancement of Medical Education. It used to publish a journal by the name Indian Journal of Medical Education, and organize conferences around related issues. For instance, in 1965, it held a conference on 'Medicine and Society' whose central theme was how to mould and adapt educational patterns to the social and cultural needs of the community (Rao 1967). A past faculty shared that the journal doesn't exist and the association is defunct. 'But you need to have an association like that' (I.PF.7).

There are formal networks of medical educators formed by the MCI in the form of institute-level ME Units and regional-level nodal centres. A similar budding network is Academy of Health Professions Educators (AHPE)<sup>6</sup>. But the mandate of these forums is 'to help in medical education "technologies", to develop better educators' (I.F.4.7). They are not as much concerned about the context and orientation of ME. The educators need to come

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<sup>6</sup> <https://ahpe.in/aims-and-objectives/>



together and create a critical mass to reclaim their voice in all matters<sup>7</sup> related to ME, and to build pressure for larger change.

Srivastava Committee (1975), very bluntly, stated that there had been enough discussion on what needs to change (content); but little attention had been paid on who will bring about that change (structure) and how (process). It proposed a 'Medical and Health Education Commission', which did not happen. In 2011, The National Commission for Human Resources for Health Bill was introduced in Rajya Sabha, but even this did not see the light of the day (Rajya Sabha 2016). In 2020, a National Medical Commission has replaced the MCI. The fact, however, remains that such institutions are not always waiting for somebody to come and tell them what needs to change in ME. 'They know it' (I.F.4.7). But, 'it won't come from the top' (I.PF.7) unless there is pressure from below.

The same holds true for PH issues other than ME. Doctors do hold opinions which are different from the dominant view and they do discuss these with each other; but this doesn't happen in an organized way (I.F.4.9). They fail to come together. 'We have not been trained, or probably we don't have that attitude also to raise our voice or mobilize people' (I.F.3.2). 'We can write, we can prepare policy brief, how (else) do we protest' (I.F.1.1). Conversation below exemplifies what faculties perceive as their role.

I.F.1.4: How much is government spending on primary and secondary health care? You visit any Sub-centre and PHC. You see what type of equipments are available there. How many institutions in the country are IPHS compliant?

Researcher: This is a fact which is in the front of the government. Then?

I.F.1.4: Problem is government should think on this. For strengthening Primary Health Care, you have this Health and Wellness Centre. The ANM module for NCDs, which is now used all over the country, is prepared by us. We have prepared the ASHA module for the country. We are now talking about Mid-level Professionals, nurse practitioners...if you see its manual...bridge course which IGNOU is launching...the chapter on NCD is ours. This is the work of institution.

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<sup>7</sup> A faculty said, 'If Medical Educators were to decide on the running of a Medical College, things would be different' (I.F.4.7).

Researcher: But if government is not giving money, how will all that happen Sir?

I.F.1.4: Then it will not happen Sir...

The faculty acknowledged that doctors do unite and speak-out when their professional interests are threatened (I.F.3.2). But it doesn't always happen for issues of public interest, like strengthening of PH sector or re-orienting the ME. The issue is whether those, who are the 'natural attorney of the poor', should accept things hands down? There should be networking between doctors for social causes; and such networks should go beyond medicos (I.F.3.2).

One faculty favoured 'advocacy' over 'activism'. 'You have to push your idea, not "protests" and "*bandh*" and all that. That doesn't make sense. It's momentary' (I.F.4.2). Though these momentary demonstrations also have a value, 'activism' goes beyond them. Another faculty found it desirable for experts to come together and amplify their concerns regarding policy. Though, given the general attitude of indifference among politicians, she had doubts if such activism would work (I.F.4.8). Yet another faculty mistook 'politics' for 'electoral politics' (I.F.4.9). She said that doctors should enter politics if they want to change the situation; but this won't happen because the way politics is practiced in India doesn't suit the dignity of a doctor (I.F.4.9). A past faculty, however, urged the fraternity to realize the dual role it has to play. 'As citizens, we are part of the movement. As professionals we are part of the Public Health system development process' (I.PF.8). These two are 'the Yin and Yang of the new Public Health' (I.PF.8).

There are a set of people who keep a critical eye on the health programs and policy and who mobilize people and opinions towards the larger good. Referring to NRHM, a past faculty said, 'There was a definite role played by the movement in the communitization of public health system. Something similar can happen for re-orientation of medical education' (I.PF.7). But for that to happen, the faculty and the people engaged with health movements have to open-up to each other. If the movements continue to see the faculty as too 'academic' and 'self-interested', and if the faculty continue to view the movements as too 'simplistic' and 'wild', it is the cause that will be the casualty. The key is to engage with each other. 'That dialogue is important' (I.PF.7). And getting such an inclusive and sufficiently

large network in place, which can experiment as well as advocate, is a 'big slow process' (I.PF.7).

In order to understand PHC approach better, the CM fraternity needs to 'open-up' to other disciplines, other professionals and the community. In order to be able to reflect this approach in its work, it needs to 'get organized' and demand what all it takes. The demands have to be made to several stakeholders, including to the members of the fraternity itself. And so as to infuse the PHC approach in the health system, the fraternity has to 'reach-out' to like-minded people. To move beyond the hospital and the disease-frame was the first leap. To move beyond the community and the conventional health frame is the second leap that needs to be taken now.

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## Annexures (Data Collection Tools)

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**Annexure 1**

**Information Sheet for Participating Department**

Title of the Project: Understanding of Primary Health Care among Faculty of Community Medicine in India: A Study of Knowledge, Perceptions and Pedagogy

Principal Investigator: Dr. Mohit P. Gandhi

Supervisor: Prof. Ritu Priya [Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi]

Potential Funding Agency: Not applicable

	Explained in Detail	Subject's Response if any
1. Purpose of the Study: The purpose of the study is to explore the understanding of Primary Health Care (PHC) among the faculty of Community Medicine (CM). The study will also try to explore to what extent do these faculty consider the approach relevant and reflect it in their teaching, research and practice. And finally, the study will attempt to explore the factors and processes that shape the understanding and the extent of application of this approach by the faculty of CM. The purpose is purely academic, and in no way an attempt to evaluate the knowledge or performance of an individual or a department.	[ ]	..... ..... ..... ..... ..... ..... ..... ..... ..... ..... ..... .....
2. Study Procedures: a) Certain basic information about the department will be collected; b) Face-to-face in-depth interview will be conducted with individual faculty in two rounds, each of which may take 30 minutes or more; c) Focus Group Discussion (FGD) would be conducted with six to eight Interns and a similar number of Post-graduate (PG) students [The interviews and FGDs are intended to be audio-recorded, with due consent of the participants]; d) A few sessions of academic activities within department will be observed; e) Around five days will be spent in field; f) Topic review of faculty publications, and of PG theses submitted in the department, will be undertaken.	[ ]	..... ..... ..... ..... ..... ..... ..... ..... ..... ..... ..... .....
3. Risk of the Study: None anticipated	[ ]	.....
4. Benefits from the Study: Satisfaction of contributing to generation of new knowledge, and an opportunity to reflect on	[ ]	..... .....

- the content of the departmental work. ....
5. Complications: None anticipated [ ] .....
6. Compensations: Nil [ ] .....
7. Confidentiality: The audio files, if any, will be permanently deleted after transcription. No personal identifiers will be mentioned in the transcript and other forms of data. The transcripts and other data will be dealt with as per University norms. [ ] .....
8. Rights of Department/Participants: The department, and individual participant, will be free to withdraw, partly or wholly, at any stage of the research. Despite the confidentiality measures illustrated above, participants may refuse for audio-recording. [ ] .....
9. Alternatives to Participation in the Study: Not applicable [ ] .....

**Investigator’s Statement**

I, Dr. Mohit P. Gandhi, have explained to the authority responsible for the Department of Community Medicine in a language she/he understands the purpose of the study, the procedures to be followed in the study and risks and benefits.

\_\_\_\_\_

Name: Dr. Mohit P. Gandhi

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Place: \_\_\_\_\_

\_\_\_\_\_

Name of the witness:

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Place: \_\_\_\_\_



**Annexure 2**

**Institutional Consent Form**

I, \_\_\_\_\_, have been explained the purpose and process, and the advantages and disadvantages, of research titled “Understanding of Primary Health Care among Faculty of Community Medicine in India: A Study of Knowledge, Perceptions and Pedagogy” in which \_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_ is expected to participate. I know that the department can withdraw its participation, partly or wholly, at any stage of the research. I, on behalf of the department, willingly and under no pressure from the researcher, agree to take part in this research which will help acquire knowledge for the benefit of the humankind.

I have been informed that Jawaharlal Nehru University, New Delhi and the researcher (Dr. Mohit P. Gandhi) will take prior consent from concerned authority of abovementioned department before they draw benefits from research based on departmental inputs.

\_\_\_\_\_

Name:

Designation:

Date: \_\_\_ / \_\_\_ / \_\_\_

Place:

\_\_\_\_\_

Witness:

Designation:

Date: \_\_\_ / \_\_\_ / \_\_\_

Place:

\_\_\_\_\_

Researcher: Dr. Mohit

Designation: Researcher

Date: \_\_\_ / \_\_\_ / \_\_\_

Place:



- 6. Compensations: Nil [ ] .....
- 7. Confidentiality: The audio files, if any, will be permanently deleted after transcription. No personal identifiers will be mentioned in the transcript. The transcripts will be dealt with as per University norms. [ ] .....
- 8. Rights of Participants: The participant will be free to refuse answering any question(s). The participant may also modify or withdraw his/her response to one or more question(s) after the interview is over. Despite all the confidentiality measures illustrated above, the participant may refuse for audio-recording. [ ] .....
- 9. Alternatives to Participation in the Study: Not applicable [ ] .....

**Investigator’s Statement**

I, Dr. Mohit P. Gandhi, have explained to the participant in a language she/he understands the purpose of the study, the procedures to be followed in the study and risks and benefits.

\_\_\_\_\_

Name: Dr. Mohit P. Gandhi

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Place: \_\_\_\_\_

\_\_\_\_\_

Name of the witness:

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Place: \_\_\_\_\_

**Annexure 4**

**Consent Form (Interview Participant)**

I, \_\_\_\_\_, have been explained the purpose and process, and the advantages and disadvantages, of research titled “Understanding of Primary Health Care among Faculty of Community Medicine in India: A Study of Knowledge, Perceptions and Pedagogy” in which I am expected to participate. I know that I can refuse to answer, or withdraw/modify my response to, one or more question(s) at any stage of the interview and even after the interview is over. I willingly, under no pressure from the researcher, agree to take part in this research which will help acquire knowledge for the benefit of the humankind.

**I agree / don't agree (*encircle what applies*) for audio-recording of my interaction with the researcher.**

**I agree / don't agree (*encircle what applies*) to quoting my name with any of the ideas or statements shared by me during the process of this research.**

My consent is explicitly not for disclosing any personal information. For disclosing any personal information, further consent should be obtained.

I have been informed that Jawaharlal Nehru University, New Delhi and the researcher (Dr. Mohit P. Gandhi) will take my prior consent before they draw benefits from research based on my inputs.

_____	_____	_____
Name:	Witness:	Researcher: Dr. Mohit
Designation:	Designation:	Designation: Researcher
Date: ___ / ___ / ___	Date: ___ / ___ / ___	Date: ___ / ___ / ___
Place:	Place:	Place:

## Annexure 5

### Interview Schedule (Round 1)

- Greet, tell about yourself and explain the purpose of the research
- Seek permission for audio-recording the interview.

- 1) What changes have you seen in the department since you joined?
  - a) Faculty? Students?
  - b) Approach to the discipline? Values?
- 2) How is this Department different from the others that you have worked in, or know about?
  - a) What led to starting MPH course?
- 3) What kind of research is promoted in the department?
  - a) How are the research areas and topics chosen?
  - b) How is the research used/followed?
- 4) What are the mechanisms of your interaction with people outside the department?

	Research	Training	Field Action	Advocacy
Other MC Departments				
Government (Health)				
Government (Other)				
Other PH people				

- a) What are the challenges?
- 5) How were you exposed to the Primary Health Care (PHC) approach?
- 6) What do you understand by the PHC approach?
  - a) There are several principles of PHC approach. Which do you think are most fundamental ones?
  - b) Which National Health Program you find based closest on the PHC approach?
- 7) Is PHC approach, and the principles you mentioned, relevant in the present times? Feasible?
  - a) What are the challenges in adopting the PHC approach?
- 8) How do you expose your students to the PHC approach?
  - a) What are the challenges? Curriculum?
- 9) Do you see PHC approach reflected in popular PH journals and textbooks?
- 10) Do you see other faculty of CM engaging with the PHC approach in conferences?
- 11) Is there some inherent resistance among CM faculty, or among doctors in general, for PHC approach?
- 12) What needs to be done so that the faculty and the students (UG/PG) get better oriented in the PHC approach?
- 13) Tell something about your journey from the time the thought of becoming a doctor first came into your mind.
  - Thank
  - Ask about contact details of past faculties who may be available for interview
  - Give the Personal Information Sheet
  - Schedule second round of interview

## **Annexure 6**

### **Interview Schedule (Round 2)**

*Greet; Seek permission for audio-recording the interview.*

- 1) W.H.O. has defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. How do you see this definition?
- 2) In 1978, an International Conference held at Alma-Ata declared 'Primary Health Care' as the key approach to Health for All. The approach has itself seen shifts in paradigms from being comprehensive, to becoming selective, and now we have UHC (i.e. Universal Health Coverage). How do you see these shifts?
- 3) We have a long history of vertical programs with specific interventions, be it malaria, family planning or immunization (including pulse polio campaign).
  - a) How, as a country, we decide what to implement?
  - b) How does emphasizing such specific vertically-delivered interventions influence the overall development of public health system?
- 4) It is often said that 'Health for All' can be attained only by going beyond health services. Do you think this is something a) necessary, and b) feasible?
- 5) Communitization is one of the important components of N(R)HM. What role can communities play in the health system?
- 6) De-centralization is often proposed as a tenet of health planning, monitoring and service delivery. Do you think this is something a) necessary, and b) feasible?
- 7) Under NRHM, institutional deliveries were promoted and those conducted at home by dais, even if trained, were discouraged. How do you see this?
- 8) Some states have decided to switch-over from locally cooked food to pre-packaged food for the beneficiaries coming to *Anganwadis*. What are your views on interventions like this?
- 9) For last 10-15 years, AYUSH, and even folk medicine, is receiving increasing support from Government. What are your views on this? And, home remedies?
- 10) Many a times, individuals or their families resist what appears obvious to us as experts (take the case of direct observation of TB treatment, or vaccination). Who do you think should be deciding?
- 11) There is a significant private medical sector in India and a large majority of patients access its services. What are your views on the private sector engagement in health?

- *Thank*

- *Inform that you will be sharing the transcript for confirmation.*

**Annexure 7****Personal Information Sheet****Schooling:**

Level	Type of School (Govt./Pvt./Other)	Medium of Instruction (English/Hindi/Other Regional Language)	Area (Rural/Urban)
Up to 8 <sup>th</sup> Standard			
9 <sup>th</sup> to 12 <sup>th</sup> Standard			
Pre-medical Course (if any)			

**Higher education:**

Degree/Diploma	Name of the Institute
MBBS	
MD (Community Medicine)	
Any other Degree/Diploma:	

**Work Experience:**

Organization/Institute	Designation	Duration

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Caste: Gen / SC / ST / OBC

Father's Highest Education: \_\_\_\_\_ Mother's Highest Education: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_





- 3. Risk of the Study: None anticipated [ ] .....
- 4. Benefits from the Study: Satisfaction of contributing to generation of new knowledge, and an opportunity to reflect on the content of their own work in the department. [ ] .....
- 5. Complications: None anticipated [ ] .....
- 6. Compensations: Nil [ ] .....
- 7. Confidentiality: The audio files, if any, will be permanently deleted after transcription. No personal identifiers will be mentioned in the transcript. The transcripts will be will be dealt with as per University norms. [ ] .....
- 8. Rights of Participants: The group of participants will be free to refuse to discuss any question(s). The group of participants may also modify or withdraw their responses to one or more question(s) after the interview is over. Despite all the confidentiality measures illustrated above, the group of participants may refuse for audio-recording. [ ] .....
- 9. Alternatives to Participation in the Study: Not applicable [ ] .....

**Investigator’s Statement:**

I, Dr. Mohit P. Gandhi, have explained to the participants in a language they understand the purpose of the study, the procedures to be followed in the study and risks and benefits.

\_\_\_\_\_

Name: Dr. Mohit P. Gandhi

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Place: \_\_\_\_\_

\_\_\_\_\_

Name of the witness:

Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Place: \_\_\_\_\_

**Annexure 9**

**Consent Form (FGD Participant)**

I, \_\_\_\_\_, have been explained the purpose and process, and the advantages and disadvantages, of research titled “Understanding of Primary Health Care among Faculty of Community Medicine in India: A Study of Knowledge, Perceptions and Pedagogy” in which I am expected to participate. I know that I can refuse to answer, or withdraw/modify my response to, one or more question(s) at any stage of the Focus Group Discussion (FGD) and even after the FGD is over. I willingly, under no pressure from the researcher, agree to take part in this research which will help acquire knowledge for the benefit of the humankind.

**I agree / don't agree (*encircle what applies*) for audio-recording of the group's interaction with the researcher.**

**I agree / don't agree (*encircle what applies*) to quoting my name with any of the ideas or statements shared by me during the process of this research.**

My consent is explicitly not for disclosing any personal information. For disclosing any personal information, further consent should be obtained.

I have been informed that Jawaharlal Nehru University, New Delhi and the researcher (Dr. Mohit P. Gandhi) will take our prior consent before they draw benefits from research based on my inputs.

\_\_\_\_\_

Name:

Designation:

Date: \_\_\_ / \_\_\_ / \_\_\_

Place:

\_\_\_\_\_

Witness:

Designation:

Date: \_\_\_ / \_\_\_ / \_\_\_

Place:

\_\_\_\_\_

Researcher: Dr. Mohit

Designation: Researcher

Date: \_\_\_ / \_\_\_ / \_\_\_

Place:

## **Annexure 10**

### **Focus Group Discussion Guide**

**[Interns; Junior/Senior Resident; PhD/MPH Student]**

*Greet, tell about yourself and explain the purpose of the research*

*Explain the purpose of audio-recording and seek group's permission for the same*

*Encourage each participant to put forth his/her views. Proactively moderate dominant participants.*

- How has been your experience in the Department of Community Medicine?
- How were you exposed to the Primary Health Care (PHC) approach?
- What do you understand by this approach?
  - o Principles?
- Is this approach relevant in the present context?
  - o What are the challenges?
- Do you have any suggestions for the Department of Community Medicine regarding the way they orient students in PHC approach?

*Note: Inform that you will be sharing the transcript for confirmation.*

## **Annexure 11**

### **Observation Checklist (Classroom)**

Presenter:

Audience:

Type of session:

Topic of the session:

Date:

#### **1. Presenter**

- Well prepared?
- Interactive?
  - Verbal:
    - Asking questions? Are such questions intended to elicit rote information or to provoke critical thinking?
    - Seeking questions?
      - Answering them convincingly?
  - Non-verbal: Moving around, shifting gaze?
- Delivering only information, or also perspectives, counterexamples and examples?
  - Relating the text to context?
- Using teaching aid? Judiciously?

#### **2. Audience**

- Out of those expected how many are present?
- Are students asking questions?
- Do they look interested? Is anything distracting them?

#### **3. Classroom**

- Comfortable and conducive to learning?
- Does the sitting arrangement add to the faculty-student hierarchy?

#### **4. Topic**

- Anything peculiar about the way in which the topic of this session has been handled?
- Is there any scope to handle the topic differently from a PHC perspective?

## **Annexure 12**

### **Observation Checklist (Field)**

Number of faculty (designation-wise):

Number of students:

Batch of students:

Site of Visit:

Date of Visit:

#### 1. Before the visit:

- Is there a specific purpose and plan for the visit?
- Has the plan been prepared with, or communicated to, the site staff?
- Have the students been briefed about purpose and plan of the visit, and about field etiquettes?
- How did the group reach the venue?

#### 2. During the visit:

- Site
    - Is it adequate, in terms of infrastructure, human resources and services, to serve the purpose of the visit?
  - Faculty
    - Asking questions? Are such questions intended to elicit rote information or to provoke critical thinking?
    - Seeking questions?
      - Answering them convincingly?
    - Relating the visit with what is in text, and the larger context?
  - Students
    - Out of those expected, how many students are present?
    - Do students look interested? Is anything distracting them?
    - Are they asking questions? Are they encouraged to do so?
    - How is the visit being documented?
  - Site Staff
    - Are they interested? Asking, seeking and answering questions?
    - Did they make any preparations for the visit?
    - How is their relationship with the faculty? Hierarchical, co-operative or friendly?
  - Activities: What activities happened on the day(s) of visit?
- #### 3. After the visit: Is there any experience sharing session?
- #### 4. In case of community visits:
- Is there a specific purpose of visiting the community?
  - Have the students been briefed about the community and about basic etiquettes that need to be observed while in community?
  - Are students observing the basic etiquettes?
  - Who is accompanying the students?
  - Are students asking questions beyond the specific purpose?
- #### 5. In case of health camps/mobile clinics:

- Who has supplied the logistics (vehicle, drugs, space)? Is it adequate?
  - Are faculty from other disciplines also present?
  - Are patients being referred to the concerned Medical College?
  - Is there an element of community health education?
6. In case of rural posting of interns:
- Is residential accommodation available at the site for interns?
  - Are interns staying at the site?
  - How often do faculties come for on-site supervision of interns?
  - Is residential accommodation available at the site for faculty?
  - Do faculties stay at the site during on-site supervision?
  - Is there any referral linkage between the site and the concerned Medical College?
7. Anything peculiar about the visit?
8. Is there any scope to plan/manage the visit differently from a PHC perspective?

## Annexure 13

### Questionnaire

- Please explain your opinions in sufficient details.
- Please feel free; there is no right or wrong opinion.
- You may call the researcher for any clarification (mobile: <9x3x9x0x8x>)

Type of Respondent: Intern / Junior Resident / MPH Student / Senior Resident / PhD Student

- 1) W.H.O. has defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. How do you see this definition?

*(Blank space)*

- 2) In 1978, an International Conference held at Alma-Ata declared 'Primary Health Care' as the key approach to Health for All. The approach has itself seen shifts in paradigms from being comprehensive, to becoming selective, and now we have UHC (i.e. Universal Health Coverage). How do you see these shifts?

*(Blank space)*

- 3) It is often said that 'Health for All' can be attained only by going beyond health services. Do you think this is something a) necessary, and b) feasible? Please explain.

*(Blank space)*

- 4) We have a long history of vertical programs with specific interventions, be it malaria, family planning or immunization (including pulse polio campaign).

- a) How, as a country, we decide what to implement?

*(Blank space)*

- b) How does emphasizing such specific vertically-delivered interventions influence the overall development of public health system?

*(Blank space)*

- 5) Communitization is one of the important components of N(R)HM. What role do you think can communities play in the health system?

*(Blank space)*

- 6) De-centralization is often proposed as a tenet of health planning, monitoring and service delivery. Do you think this is something a) necessary, and b) feasible? Please explain.

*(Blank space)*

- 7) Many a times, individuals or their families resist what appears obvious to us as experts (take the case of direct observation of TB treatment, or vaccination). Who do you think should be deciding? Please explain.

*(Blank space)*

- 8) For last 10-15 years, AYUSH, and even folk medicine, is receiving increasing support from Government. What are your views on this? And, home remedies?

*(Blank space)*

- 9) There is a significant private medical sector in India and a large majority of patients access its services. What are your views on the private sector engagement in health?

*(Blank space)*

- 10) Under NRHM, institutional deliveries were promoted and those conducted at home by dais, even if trained, were discouraged. How do you see this?

*(Blank space)*

- 11) Some states have decided to switch-over from locally cooked food to pre-packaged food for the beneficiaries coming to *Anganwadis*. What are your views on interventions like this?

*(Blank space)*