

NEWS FROM THE NETWORK: TOWARDS UNITY FOR HEALTH

Position Paper on Community-Based Education for Health Professionals

Editor's note *The section called "News from The Network: TUFH" replaces our previous section called "Reports and Announcements". Below we print the second of several position papers of The Network: TUFH, this one on Community-Based Education for Health Professionals. Unlike other articles in this journal these Network: TUFH position papers are seen as dynamic and ever changing, and thus, not a finished product. Therefore, we also publish a review of this position paper, done by A. Greer. You are welcome to also send us your suggestions.*

Position Paper on Community-Based Education for Health Professionals

Why be concerned about Community-Based Education?

Today's health professionals are inappropriately trained to address the health of the public, particularly the large proportion who are disadvantaged; they are also maldistributed by specialty and geography. Health disparities exist worldwide, but are of crisis proportions in developing countries where the magnitude of health problems far outstrips the available meagre resources. Community-based education has the potential to train service providers, educators and researchers who can assist communities to identify their priority health needs and to implement feasible, affordable and sustainable interventions.

What are the goals?

- The health of communities will be improved measurably.
- Increased numbers of health professionals will pursue careers in community settings, care for the disadvantaged and engage in local social and political processes that impact individual, family and community health.
- Increased numbers of academic institutions will engage with and influence the political and social decision processes of their own communities, measurably improving the health of the public.

What are the rationales?

CBE is just one aspect of a global strategy to achieve “health for all”. Universal access to health ranks among the world’s greatest challenges.

Community-oriented health professionals and academic institutions that adhere to the values of “Toward Unity for Health” (TUFH)—quality, equity, relevance and cost effectiveness—contribute to the goal of “health care for all” through research, education, service and policy development.

The greatest advances in health status derive from improvements in the standard of living, sanitation, housing and occupational safety. Further progress requires social and economic conditions that facilitate healthy personal behaviours and improvements in the organization and accessibility of health care services.

In the developing world, 70% of the population lives in rural areas and over 70% of deaths in children less than 5 years of age are due mainly to five preventable conditions: measles, diarrhoea, acute respiratory infections, malaria and malnutrition. Health professionals contribute not only by providing personal health care to individuals, but also by assisting communities to redirect available resources to prevent these diseases.

Increasing the health workforce only partially addresses the need, as many seek employment in areas (or even other countries) that offers greater financial and social security. However, those who train in community settings may have a higher likelihood of seeking employment in underserved locations.

What’s in a name?

- “Community-oriented” education prepares health professionals to address the priority health needs of a community. The emphasis is on health promotion and disease prevention, the focus on populations. Such training could be situated in community, university, or other settings and augmented by distance learning. When located in a community setting, it is termed “community-based” training.
- “Health professional” education is multidisciplinary, including future physicians, nurses, social workers, therapists, public health officials, etc. “Interdisciplinary” curriculum trains professional students from multiple disciplines together. “Medical education” generally implies the education of physicians.

Why now?

The current crisis demands urgent action to improve access to health, appropriately redistribute the health workforce, and reorient health services toward health promotion and disease prevention and population concerns.

How do we define community?

A community is often defined geographically. We can also define community as a social or political construct that can be influenced by its members, for

example, a region, a hospital, or a professional organization. (Members of a health insurance plan that restricts members from such influence would not be considered a community).

What are the attributes of community-oriented health professionals?

Community-oriented health professionals are adaptive to a variety of settings, demonstrate leadership capacities, and humility. They have the skills and a zest for continuous learning. Whether specialist or generalist, they are advocates for the disadvantaged.

What are the competencies of the community-oriented practitioner?

Competencies include the ability to:

- Engage individual patients across cultural and social boundaries.
- Counsel patients about health promotion and disease prevention.
- Care for full spectrum of health and illness.
- Engage in community and political processes.
- Educate the populace about its health risks and behaviours, appropriate to the specific social context.
- Assist communities to define and prioritize their health needs.
- Use epidemiological skills to assess and track the needs of the community.
- Work in multiple sectors to provide technical and /or material assistance to implement interventions directed at identified health problems.

What are the attributes of the community-oriented academic institutions?

- The institution's mission statement commits to improve the health of its community.
- Community-orientation permeates the entire school, including all departments and all aspects of the curriculum.
- The institution models community engagement and citizenship for its students and faculty, for example, by sponsoring community health programmes.
- Students and faculty engage in community service as policy makers, advocates, coordinators, health managers or health service providers.
- The relationship between the academic institution and the other stakeholders in community health improvement is one of integration rather than domination, mere cooperation or advocacy.
- The institution demonstrates social accountability by publicly disclosing the specific goals of these relationships, and reporting periodically on progress.
- The institution continuously develops new capacities.
- The institution disseminates lessons learned in its efforts to improve the community's health.

- The institution employs teaching techniques, like problem-based learning, which stimulate life-long, self-directed learning for students and community.

What are some examples of community-based learning?

Community-based learning may be in the areas of service, research or education. The following are some examples from the October, 2000 Network conference: “Innovation in Health Professions Education and Community-orientation”, Manama, Bahrain.

- “Family attachment course” – Sudanese students are attached to impoverished families whom they visit periodically over a 3-year period.
- “A Touch of Spice”: teaching Hindi and Urdu to medical students to serve those populations in Leeds, UK.
- Interdisciplinary learning at a time of crisis – teams of students planned, organized and evaluated the effectiveness of a student and faculty convoy to provide flood relief in Sudan.
- The “Community Interaction Unit” is in a community health center setting in Marilia, Brazil, in which to teach medical and nursing students clinical skills and many aspects of health service delivery.
- “Indigenous Media,” a video broadcast training programme at James Cook University in Northern Queensland supporting a network of radio stations for news and cultural resources, run by aboriginal people across North Australia.

What are some of the challenges?

- Avoid unrealistic expectations on the part of students, faculty or community members; define clear roles for each.
- Sustain community-based educational programmes in resource poor settings.
- Engage “community faculty” in the teaching process, including supervision, evaluation and feedback to students.
- Nurture “community faculty”: recognition (e.g., adjunct faculty), access to libraries and other facilities, encouragement to perform research (e.g., co-authorship), career advancement opportunities through access to courses and financial aid.
- Nurture academic faculty: recognition (e.g., promotions, assistance with research, sabbatical time, career advancement, etc.).
- Integrate experiential learning with classroom learning; foster interdisciplinary teaching.
- Maintain community receptiveness over time; avoid community fatigue as they participate in research and education of health professionals.
- Assure meaningful and sustainable benefit from teaching activities and research activities.

- Evaluate the effectiveness of community-based education programmes in the short and long term.
- Influence policy to adopt community-based approaches at central and peripheral levels of the health care delivery system.

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Review of Position Paper on Community-Based Education

“We Need Dedication, Self-Sacrifice and Refining of Leadership”

The committee correctly identifies that health professionals are ‘mal-distributed’ throughout the world, which contributes to the inability of leaders to address public health issues. The scale of the disparity is truly an inverse relationship to health problems and resources. The description presented of community-oriented education for health professionals is valid throughout the Position Paper.

However, the problem requires further examination in determining why such ‘mal-distribution’ and ‘disparity’ exists. Funding resources (including governmental, public, and private) have been expended towards a philosophy of community academic partnerships to advance community-oriented education over the last decade. The key to eradicating the problems of inequity and access to care, lies in the allocation of financial and social security of the health professionals and their individual families. The trained individuals must be dedicated to servant leadership and willing to sacrifice advantages offered by areas that are economically secure.

Community populace, which are disadvantaged and devoid of resources, can scarce afford or extend an offer to health care professionals that provides an opportunity for a stable social, economic practice without subsidy.

Community-oriented education offers health care professionals a basis for the competencies needed for generalized collaborative practice, but does not train the individuals how to adapt to the personal and family development that may differ culturally and economically from that of their legacy environment. In essence, it is dedication, an exercise in self-sacrifice, and a refining of leadership geared towards ethical service that will resolve the ‘mal-distribution’ and ‘disparity’ world-wide.

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