ESCAP'S MOBILE TRAINING SCHEME

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"Traveller, there is no path.
Paths are made by walking."

Antonio Machado

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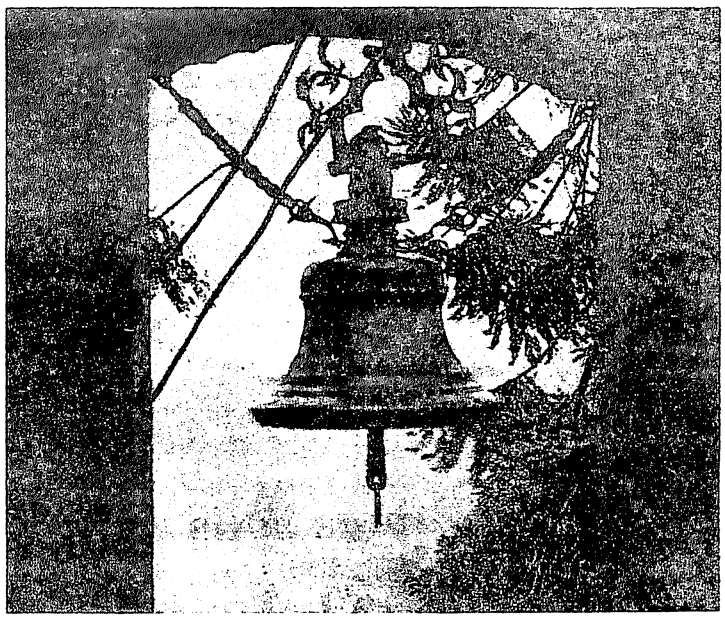

The views on the Mobile Training Scheme expressed in this *Newsletter* are entirely those of the writers and do not necessarily imply the expression of any opinion whatsoever on the part of the United Nations and the Economic and Social Commission for Asia and the Pacific.

Mantras and Medicine for Development

by

David Drucker

The material provided here is drawn from village and health profiles written by trainee supervisors in the Panchayat Women's Programme. The English has been left almost untouched as it was provided by the translator - somehow the use of words and grammar gives a dimension of authenticity which editing might have destroyed.[1]

A word about the process of experiencing the situations from which the material is derived (I deliberately avoid the terminology "collecting the material" for reasons which will become apparent): both the secretaries and the supervisors were placed in the villages for three weeks at a time over a period of four months, with intervals of a week or 10 days between times. Each time the same worker went to the same village. The workers were expected to enter into the life of the villagers and gradually get to know the village problems, wishes, priorities and resources in order to assist in developing village-inspired plans and projects with the active participation of the village panchayat. Each trainee was expected to produce a general description of the village (profile) and gradually add dimensions - agriculture profile, water profile, etc. Eventually a health profile was requested, with some general guidelines given, which consisted of discussing with ordinary people what sicknesses they or their family members had suffered in recent times, to whom they went for what, what treatment they had received and its outcome, where they could meet "health workers" officially recognized or indigenous; the trainees should hear what they had to say about sickness in the village and its treatment, where they had "learned their trade as healers", and so on. There was no interview schedule or questionnaire and the guideline was prepared with the level of sophistication of the trainee in mind and to keep the information-seeking as informal and matter of fact as possible.

The trainers who were involved in the training programme are well-educated, have years of experience and have all lived in Kathmandu for many years. They have taught child care, nutrition, public health and so on. It was of interest to note that, as we began to talk of Jhakri, Lama, Dhamee, etc., the trainers themselves began to relate their own and their own families' dealings with such persons here in the capital city. At times during the discussion they laughed a little embarrassedly but generally told how ailments (some very serious)had been cured which modern doctors either would not or in some cases had tried and failed to cure. Indeed, when the writer's children "fell"sick, a trainer offered the assistance of an indigenous healer (it is clear that despite the Western veneer, the two "cultures" of sickness and treatment reside side by side without much conflict in the mind or certainly in behaviour).

Of particular interest for all those who are eager to formulate questionnaires and train interviewers in this field of primary health care is the further example that surfaced during work with the trainers. A trainee reported that one of the trainees had asked "What will the Ministry do if, when I call on the Jhakri, he secretly makes a cut in my clothes or takes a small piece of my hair?" It was explained to the writer that this expressed the common fear that, if one did not approach the Jhakri respectfully in the Jhakri's professional capacity, he could do one great harm by means of the way described.

Subsequently one trainee reported that on the way back from a Jhakri she had great pain in her legs, found big blue marks around her knees and could not walk for three days.

One worker reported: "When we first approached the rural physicians we were much perturbed for fear that the physicians may harm us. The attitude and language of the physicians was afraid that we had visited the area to oust them from their profession. The rural people are apprehensive of danger, thinking they may be arrested or banished from the locality. So they are not willing to disclose anything."

Another worker explained their solution to such difficulties: "We may flatter them as benevolent social servants of the village. They may be praised as protectors of human life in the rural area, they may be pleased to hear that they have saved the villagers from the trouble of visiting the hospital by trekking for two or three days even for ordinary disease and their attack to the children of the village."

We can say "The people in this village are getting good relief from the local physicians and their treatment - we believe. This is really a very good humanitarian job - is it not?"

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1 Linda Stone (United States Education Foundation) in an informal presentation of her work on "Treatment of illness in rural Nepal" beautifully describes the contrast in verbal forms she found regarding sickness as expressed by the people in the village where she worked and Western verbal forms.

Thus, the Nepali statement was passive, impersonal: "A cut has happened to the hand" as opposed to "I have cut my hand". She says that Western forms talk in military terms: *attacked* by illness, *invaded* by bacteria, and medicine is seen as a counter-attack and implies control and containment of the destructive forces. Nepalis apparently use eating terminology: e.g., heart attack is colloquially "heart eaten", etc., and connected to this terminology is the concept of imbalances in food between sour and sweet, hot and cold, etc., and also the warding-off of evil (devouring?) spirits or propitiating the good ones by offerings of food. In this way, the words (imagery) we use is connected with conceptions and action.

If we hold dialogue with them in this way, respecting them, they are then inclined to open their mouths voluntarily with a little confidence in us. They then will begin to give a good description of their faith in cabalism. Yet another reported the anxiety of those approached and the cheerful reassurances (very premature? prophetic?) which were given. The exchanges were like this:

"Is it that owing to the activity of the rural magicians and physicians the medicines of doctors did not get good sale and popularity? - It is not so? Suggestions are now current that HMG may extend a programme so as to include rural physicians too into a training project.

"If it is so, this is a very good idea. I appreciate it. Can we get a job after we get training?

"It is the concern of the Government. It is not yet decided. Perhaps they may give a lucrative job later on."

The problem of securing "objective" information can therefore be seen to be a particularly difficult one. It will be clear from the quotations used in this paper that there is no claim that the facts and opinions expressed are objective. The language betrays very much the sympathies and biases of the reporters. It matters little; our reporters are somewhat close to the situation they describe and provide us with a subjective dimension that is important also. The purpose of our profiles has not been to establish an unchallengeable thesis, but to begin with an impressionistic account of what is the situation in each village and to see also what stage our trainee village "planner" has reached in his conceptualization of the situation. We hope to take each situation individually and help the trainee to instigate planning from where the village itself is and with the resources it has. Any "unobjective" statements will gradually be improved upon and learned from, and in time nearer "approximations of reality" will be borne in upon us as we witness the success or failure of our planning attempts.

From the planner's eye view in Kathmandu, one constantly sees maps of Nepal scattered with measle-like dots (usually in red) which "cover" the country. Coverage is usually expressed either as a ratio of one to so many of the population, or has a geographical significance.

It is clear to us that this coverage is graphic only. Only in rare situations reported to us do people travel any great distance for health post care there are impediments and barriers through which the people will not pass to use modern medicine. The question is often asked: "How can modern services (of all kinds, not just health) reach out into the villages?" A more meaningful question seems to be: "How can one assist and motivate the people to reach up to the realistic resources which are made available in a way the people want and understand?"

The impediments and barriers are sometimes straightforwardly economic in origin. "How can we eat paper?", the villager asks; he means that he is given a prescription for medicine which is often not available and, if it is, for which he has no money. Living in areas in which subsistence agriculture is the pattern and not having passed, from the barter system to a cash economy it is more meaningful to him that the "indigenous" healer expects (usually does not ask for) offerings of food or sacrifices of he-goats, chickens, ducks, etc. Not only is it possible for the villager to produce these "offerings" but he is not expected to "pay" until he is "cured", unlike the medical practice of paying cash in advance.

It is clear that many village people see sickness not as a discrete condition, but as being related to a series of misfortunes that befall them. Ideas of causation are not often present, certainly not in terms of phenomena such as flies in drinking water, excreta, bacteria, viruses, etc. The cause is not tackled so much as what needs to be done, which evil influence is to be bargained with, or which good influence is to be propitiated. Each requires an offering (usually of food).

The treatment of the sickness, the actual symptoms, seems to be of secondary importance and it is these that the medically trained person might be able to treat.

Thus it is that the indigenous healer appears to understand and be able to deal with two areas of phenomena and has two sets of skills. The first is what might be called demonology and the second is medicine (treatment of signs and symptoms). The modern-trained medical practitioner, according to this view, has only one skill, and that is the lesser one anyway. Permission is commonly necessary from the indigenous healer before the patient or his family will dare approach the modern practitioner.

Although, of course, there are many variations, it would seem that the indigenous healers make some accommodations to modern practice (where it appears and becomes available). What is not clear is whether modern medicine has accommodating practices to make to the indigenous healer and his "devotees" (patients?). For service delivery strategies such a question is crucial. For example, it is reported to us that some school teachers are emphasizing to the children "away with all this superstitious nonsense" in areas where no modern alternatives are actually available and when the school teacher falls sick he is pleased (privately) to receive what attention the indigenous healer can give him.

We have already commented how, even in Kathmandu, sophisticated "modern" people still use the old healers along with the new.[2]

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2 Linda Strong endorses the view that, although to many the idea and effectiveness of modern medicine are accepted, the institutions, physical and social, in which modern medicine is made available are not.

What seems to be required is some kind of set of strategies so that in any given area we can effectively introduce what modern medical technology can offer according to the social and conceptual condition of the community appraoched. Thus, in circumstances where modern resources are scarce or not available, the indigenous healers should be seen as the major (if not only) resource and manpower, and attempts should be made to organize their service as effectively as possible, providing a framework for their co-operation among each other with whatever training or aids can be provided to them. The objective of such a strategy should be to ensure that one minimizes the amount of harm they can do (e.g., cleasing of scythes before cutting umbilical cords, etc.) while gradually maximizing the good. At a later stage, such healers must be constructively involved in creating the conditions within which whatever modern functionary we have the resources to introduce will be positively received in the context of the indigenous healer's welcome and recommendation.

Much later, when truly modern facilities become a possibility (hopefully modified, to meet local conditions; this is as necessary in modern affluent societies as anywhere else), strategies for phasing out the medical involvement of the indigenous healers must be sensitively invented while at the same time his reputation and status as "pastoral" aid and comforter must be left intact so that he can still play a valuable part in his community even though medical matters are now identified as medical and the appropriate care is recognized as being effectively in the hands of the medically trained who have access to specialized modern equipment. Even the most advanced medical facilities and skills must still admit of limitations and uncertainty in the face of human suffering and the human condition. (For example, the matter of death is unavoidable even with modern medicine and the social aspects are usually handled very badly by modern institutions.)

From this position, a case can be made for actively involving all health workers (official or otherwise) in a panchayat to self-survey their problems and needs and, as a formal instrument of the village panchayat, to be specifically involved in village-level planning in both identification of needs and the maximizing of resources in implementation.

We suggest a task group pattern[3].

In producing these "profiles" the trainee has attention drawn by the trainer to a vital aspect of his assignment:

"Inherent in all these profiles is not merely what, but most importantly *who*. Although the information provided by the trainee is important in its own right, its true value is for the teacher to use it for helping the trainee practitioner to plan for planning.

"Village plans and projects must belong to the village people and not be the construct of the trainee or for that matter any *one* else. Therefore, the profiles lead us to go through with the trainee, *who* he might encourage to get to work in exploring problems, the information required, and the steps to programme implementation, etc. for *themselves*. In this sense the *amount* of information a trainee provides in a profile exercise is less important than its quality and *'relevance' relevance* to the task to be performed.

"Indeed, if he brings too much information he may be damaging the potential of the village to do things for itself and *to nurture this potential is the major objective of his role.*

"At this stage the teacher's activity is to make sure that all the appropriate planning steps and human relations activity is systematically, skillfully and sensitively handled and that the principles and theoretical generalizations are made available to the trainee to give him understanding and insight into the - possibly all too farmiliar - daily activity."[4]

This emphasis on "who" leads us to identify those who actually care for the sick, the injured, the pregnant women, etc. It is these persons who probably "know" best what the conditions and situations are in the village regarding what ails people and what resources are actually available and used. Work needs to be done:

1. To make conscious and ready for public use what they "know";

2. To explore whether they are panchayat-spirited enough to work with each other in an organized manner, responsible to the village panchayat;

3. To see whether the *pradhan panch* and the panchayat will actually appoint these persons as a "task group" formally linked to the panchayat structure, possibly chaired or convened by an elected panchayat member;

4. To spell out carefully the role and functions of the "task group" and to see whether appropriate short courses "on the spot" might be provided to the task group for its understanding of this role and function. This training could possibly be provided by the panchayat village scretary, if he is trained appropriately in task group management, and the health aspects are collaboratively and appropriately contributed in such training by the Public Health Service.)

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3 See D. Drucker, "A task group approach", Panchayat Secretaries and Technical Collaboration, MTS, Jhapa, 1975.

4 See D. Drucker, "Village profile as tool for teaching and planning", MTS, Jhapa, 1975.

The role and function of a health task group would include:

(a) Responsibility for considering present conditions and realistic future possibilities ("self-survey" skills would need to be encouraged);

(b) Keeping abreast (with the aid of the secretary) or new resources and programmes as they might affect the village and become available;

(c) Formulation of a village level health plan, to be presented to the village assembly annually;

(d) Organizing itself so as to make the maximum contribution to the realistic implementation of any plan and its innovations, and to report progress quarterly (?);

(e) From time to time, recommending to the *pradhan panch,* should be nominated for special short courses in health provided by the appropriate service agency, the candidate becoming the village "resource" person in the specific areas for which training has been provided (training needs should be part of the health plan proposed by the task group);

(f) Where resources become available from outside - medicine, equipment, personnel, etc. - these should be channelled through the panchayat's task group, which would be responsible for working out how to maximize the input by "preparing the way" and involving itself collaboratively and constructively.

It is to be hoped that successful operation of such task groups would, in time, creatively inform and constructively help the formulation of policy and programme at the district, national and even international levels.

It might well be repeated here that the operation of "task groups" (for each of the many different technical aspects) at the village panchayat level can be expected to offer practical machinery for strengthening the panchayat structure all the way up and will place the Panchayat Ministry in a position to play a major role in relation to the sectoral technical ministries, both at the grassroots level and nationally. In this sense, the task group approach might be a highly practical and fundamentally vitalizing contribution to Nepal's aspirations for development.

Selected Indigenous Teaching Materials

by

Naushir F. Kaikobad

Introduction

Three examples of indigenous teaching materials developed in Afghanistan and Nepal are presented.

Finding the teaching materials

In a way, the production of indigenous teaching material was an exercise in many kinds of learning for the course participants, who had to go through the "vestibule of learning" described by Bertha Reynold in the early classic book on social work teaching. In the initial stages, understandably, there was an acute sense of self-consciousness, hesitancy and resistance to the idea that ongoing and seemingly simple and ordinary incidents could serve as valuable tools for learning-teaching purposes. In the training system where the teacher "covered the topics" based on the lecture notes carefully prepared on the basis of his reading of "fundamental" and "basic" books, the suggestion of using simple situational material did not sound like a "learned" proposition.

If you have to quote an indigenous source you rely on the latest studies by the scholars and their findings. This attitude comes very near to the "banking" concept of education described by Paulo Freire. The banking concept of education relies more on the "stored" or "owned" knowledge of the experts. What is needed for the field practioners and their trainers is the problem-solving educational methodology that breaks the verticle pattern characteristics of "banking" education. Here the teacher is no longer one who teaches, but the teacher and the learners become jointly responsible for a process in which they both grow. Problem-solving education does not dichotomize the activity of the teacher and the learners.

In the venture of scouting indigenous materials, both the trainers and the front-line workers were involved. In a way, there was no dichotomy in the activities of the trainers and the trainees, so far as the efforts to find and test teaching materials suitable for classroom use were concerned in the MTS training programmes.