The Anatomy of My Community Immersion Activities

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ABSTRACT

A good planning of summer immersion activities facilitates accomplishment of learning objectives given a short period of time. As a UPCM RP student, I share how I planned and conducted step-by-step the eight activities in San Gaspar, Salcedo, Ilocos Sur, arriving at successful outcomes, and appreciating my integration in my own community.

Key Words: Community immersion, planning, University of the Philippines

Introduction

For a first year student (LU3, Learning Unit 3) of the University of the Philippines-College of Medicine Regionalization Program (UPCM RP), the summer immersion learning objectives are to: a) know the community (culture, geography, health situation, leaders, NGOs), b) utilize effective interviewing skills, c) conduct an epidemiological survey focusing on health behaviors and health seeking patterns, d) make an initial care plan to assigned family, and e) perform health promotion/wellness activities through health information dissemination. Good planning is required for these learning objectives to be accomplished within a short period of time.

Planning is an active verb with an outcome of preparedness. Planning is a process which involves all of the activities, practices, interactions, relationships and so forth which over the short term or long term are intended to improve the response pattern at times of impact.[1]

This paper reports a series of activities done by myself to fulfill all these learning objectives in one summer immersion period, with the hope of sharing the importance and method of planning for RP students who would cross this similar path.

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Methods

Prior to the immersion activity, I prepared a tentative schedule detailing daily tasks and activities *vis a vis* the learning objectives according to my year level. The place (San Gaspar, Salcedo, Ilocos Sur, Region I) and dates of immersion (12-23 April 2010) and the field preceptor (Dr. Maribeth N. Tudayan, MHO) were identified. The activities were planned, with official and ethical approval from the UPCM RP Committee and the local Municipal Health Unit, and with the informed consent and signed participation from the community participants. The following activities were conducted accordingly: 1) courtesy call and orientation, 2) ocular inspection of the immersion community, 3) training of enumerators for the survey, 3) house-to-house health survey, 5) focus group discussion (FGD) with emphasis on health knowledge, beliefs, and practices, 6) initial care plan to assigned family, 7) public health lectures on diarrhea prevention, hypertension and arthritis, 8) presentation of survey and FGD results to the community. The series of activities done by myself to fulfill the learning objectives were described according to schedule of activity, description of the process, target participants from the institution/community, materials/resources used, significant outcome for the community, and problems encountered and how they were addressed.

Anatomy of My Summer Immersion

1. Courtesy Call and Orientation (12 April 2010)

a. Description of process

As early as semester break in October 2009, information and communication on possible summer immersion had been arranged with the Municipal Health Officer (MHO) Dr. Maribeth N. Tudayan. The summer immersion activity was given legal and ethical approval by the UPCM Regionalization Committee, as well as the MHO Dr. Tudayan.

Formal communications and tentative schedule of immersion activities were forwarded in March 2010. A week before actual immersion, telephone conversation was made to finalize that immersion will take place as scheduled.

During the first day of immersion, I went directly to the municipal rural health unit where Dr. Tudayan held office. Dr. Tudayan warmly welcomed me and gave an overview on the municipality's latest and updated health situation, health

programs, health service delivery system, and working dynamics of health workers. After an overview, I was introduced to the other Rural Health Unit (RHU) staff and was endorsed to the rural health midwife assigned to the immersion site.

b. Target participants from the Rural Health Unit

MHO, Dr. Maribeth N. Tudayan and the RHU employees, with their informed consent.

c. Materials used

Letter of endorsement and camera for documentation.

d. Significant outcome for the student and the community

The student was properly endorsed to the community.

e. Problems encountered

None.

2. Ocular Inspection at the Immersion Community (13 April 2010)

a. Description of process

Upon endorsement of Dr. Tudayan, Mrs. Marniele G.. Contawi (the Rural Sanitary Inspector) replaced Mrs. Gloria S. Rubio (the Rural Health Midwife) to accompany me to the immersion site. Mrs. Rubio was not available due to implementation of *Garantisadong Pambata* (Healthy Children) program at another *barangay* (barrio).

Upon arrival at the immersion site, Mrs. Contawi introduced me to Mrs. Marites C. Budayao, one of the two *Barangay* Health Workers (BHWS). After exchanges of pleasantries, the group proceeded to the residences of Mr. Ernesto G.. Cosning, the *barangay* captain and the other BHW Mrs. Melba C. Padilla, who were not available. Our group then went to see Mr. Diomedes de Guia, a *barangay* councilor, to whom I presented an overview of the objectives and schedule of my immersion activities. I also requested needed materials and aids for the duration of immersion, a request on behalf of the local health workers.

Ocular inspection and meeting with the *barangay* counterparts ended with pleasantries with the BHW and RSI.

b. Target participants from community

RSI Marniela G. Contawi, Rural Health Midwife Gloria S. Rubio, *Barangay* Captain Ernersto G. Cosning, BHWs Maritess C. Budayao and Melba C. Padilla, with their informed consent.

c. Materials/ resources used

Camera for documentation

d. Significant outcome for the community

The community was properly informed about the immersion to be conducted. Thus, necessary preparation and arrangement were done.

e. Problems encountered

None

3. Training of Enumerators for the Survey (14 April 2010)

a. Description of process

For efficient survey activity, I involved the BHWs as additional enumerators.

Survey questionnaires were translated to local vernacular-Ilocano in order to minimize misinterpretation of questions. Leveling of expectations and proper asking/leading of questions were taught during the training, I demonstrated the proper way to conduct the survey and the return demonstration was done by the BHWs. During the feedback, points of improvement as well as techniques on how to generate right answers were highlighted.

b. Target participants from community

BHWs Marites C. Budayao and Melba C. Padilla, with their informed consent.

c. Materials/ resources used

Household survey questionnaire, pens, and camera for documentation

d. Significant outcome for the student and the community

Enumeration was done in an orderly manner.

e. Problems encountered

None

4. House-to-house Health Survey (14-16 April 2010)

a. Description of process

Barangay San Gaspar is a relatively small community with population of 381 distributed in 68 households. Upon request of Dr. Tudayan, I conducted a complete enumeration of all households. However, only 59 households were actually surveyed because 9 households either did not have any credible informant or no household member was present during the house-to-house visit.

After critiquing and a short training, we proceeded to conduct a house-to-house survey. To avoid duplication of household visits and conduct an organized survey, the BHWs sketched a route map. Each enumerator was given a particular route and area of assignment.

After settling in the assigned areas, we went on separate ways and agreed to meet in a particular place and time to consolidate accomplished survey forms.

After a day's work, the BHWs forwarded their output to me. I checked accomplished forms and made sure that all questions were answered. Any questionnaire with incomplete entries was returned to the assigned enumerator for follow-up.

b. Target participants from the community

BHWs Marites C. Budayao and Melba C. Padilla, with their informed consent.

c. Materials/ resources used

Household survey questionnaire, pens, camera for documentation

d. Significant outcome for the student and the community

The community was able to have a glimpse of their health profile and health seeking behaviors. This updated and latest survey result can also be utilized for other academic purposes. The results of the survey are detailed in another paper.[2]

e. Problems encountered and how they were addressed

Complete enumeration was not achieved due to various reasons like: 1) household members were not present during initial survey and follow-up, and 2) members left at home were too young to be respondents. If the same problem occurs during follow-up, it was decided that such households will be excluded.

5. Focus Group Discussion with Emphasis on Health Knowledge, Beliefs, and Practices (15 April 2010)

a. **Description of process**

An FGD (focus group discussion) was organized with household heads and primary healthcare givers as participants. An optimal size of 12-16 participants was targeted and attendees were predetermined by the BHW. I facilitated the FGD and included open-ended questions on health-seeking behaviors, beliefs and practices, which could generate more information compared to a survey.

The FGD session started with the participants identifying the most prevalent health problems existing in the *barangay*. Causes and nature as well as particular beliefs and practices per illness were also probed. Immediate place and reason for consult, services availed, and preferred services were also asked. The FGD ended with a synthesis of the afternoon's session.

b. Target participants from institution/ community

The household heads and primary healthcare givers**,** with their informed consent.

c. Materials/ resources used

FGD guide questions, Manila paper, pens, metacards, camera for documentation

d. Significant outcome for the student and the community

The community was made aware of its people's knowledge, beliefs, and practices on various diseases. The result of the FGD was beneficial in determining programs to be implemented for health improvement of the community. The results of the FGD were as follows:

Health Knowledge

The people of San Gaspar were aware of the common illnesses affecting their *barangay*. Most common illnesses based on their perception were consistent with the top ten causes of morbidity based on rural health unit data. People also had solid and adequate working knowledge on causes, nature, and treatment of these diseases. They identified poor personal hygiene, poor environmental sanitation, poor stress management, genetics, poor dietary habits, and poor healthy lifestyle as possible causes of diseases. Many were knowledgeable on self and home management of diseases, and they were able to elucidate scientific background of such treatment. Information campaign from rural health unit and access to television, radio, and other media were their primary source of information.

Health Beliefs

Inadequate self care, inadequate and improper food intake, and unpredictable climatic changes were the main reasons why people got sick. Beliefs on punishment from wrong doing or punishment from local deities were not mentioned as causes of illness.

Health Practices

Albularyos (traditional medical practitioners) were not a popular choice as healthcare providers in San Gaspar. Consultation with the healthcare provider depended on the severity of illness. Mild illnesses requiring home medication were treated at home. More severe illnesses were brought at the rural health unit or community hospital. The foods allowed and restricted also depended on the type of illness. Information on dietary management of diseases came from information campaign by the RHU, the participants' experiences, and information from their relatives abroad.

e. Problems encountered

None

6. Initial Care Plan for Assigned Family (15-16 April 2010)

a. Description of process

The assigned family (with informed consent) had been predetermined by the field preceptor through the recommendation of the rural health midwife assigned to the *barangay*.

The BHW introduced the family subjects to me. After exchange of pleasantries during the initial encounter, interview on family dynamics was done. The mother acted as sole respondent for this family health interview. Further probing was also conducted and support questions were asked. After completing the initial interview, this first encounter ended up with light refreshment given by the host family.

On the following day, family health care plan was presented and discussed with the mother and health workers. Emphasized during the discussion was the rationale of each recommendation. All queries and clarifications were made, given questions from the family and health workers. The initial family care plan will be the basis for the follow-up care during the next summer immersion.

b. Target participants from institution/ community

The assigned family, with their informed consent

c. Materials/ resources used

Interview guide question, camera for documentation

d. Significant outcome for the student and the family

The family was made aware on how to maintain and improve their existing family health status. The student learned family dynamics and the initial family care plan is the baseline for this family for next follow-up visits. The details of the family care plan are written in another paper.[3]

e. Problems encountered

None

7. Public Health Lecture on Diarrhea Prevention (20 April 2010), Hypertension and Arthritis (21 April 2010)

7.1 Health Lecture on Diarrhea Prevention (20 April 2010)

a. Description of process

Based on the result of the survey, diarrhea was one of the most common illnesses particularly affecting infants and young children. In an effort to address the problem, a lecture on diarrhea prevention was conducted.

Interested children were invited to attend the lecture. Before the lecture proper, fun games were conducted to rouse the children's interest in the activity. Before snacks were served, children were asked to be seated and the lecture started. The contents of the lecture included: proper toilet use, proper food and water storage, proper garbage disposal, and proper hand washing. Visual aids were prepared and lecture was delivered in Ilocano.

Proper hand washing was demonstrated, using the "happy birthday" technique or washing for about 20 seconds,[4] and children were requested to do a return demonstration.

b. Target participants from institution/ community

Children ages 3-12 years old, with their parents' informed consent

c. Materials/resources used

Instructional-education campaign (IEC) materials, basin, towel, soap, metacards, pens, camera for documentation

d. Significant outcome for the community

Children learned proper hand washing. If practiced correctly and regularly, occurrence of diarrhea can be prevented.

e. Problems encountered

None

7.2 Public Health Lecture on Hypertension and Arthritis (21 April 2010)

a. Description of process

Based on the focus group discussion and community health survey, hypertension and arthritis were among the top complaints of adults and elderly.[2] These two illnesses were requested by the FGD participants for discussion. General information and management of hypertension and arthritis from the US Center for Disease Control and Prevention website[5,6] were used in preparation of visual aids. The lecture was delivered in Ilocano.

People interested to listen to the lecture were invited. Aside from general information about the diseases, practical management measures such as dietary interventions and weight loss were emphasized. A lively open forum and testimonials from the participants followed the lecture. The event culminated with light refreshments.

b. Target participants from institution/ community

Interested community members, with their informed consent

c. Materials/ resources used

IEC Materials, metacards, pens, camera for documentation

d. Significant outcome for the community

People were made aware of common signs and symptoms of the diseases as well as how to manage the disease effectively. Some were also cleared of their misconceptions and popular beliefs on hypertension and arthritis.

e. Problems encountered

None

8. Presentation of Survey and FGD Results to the Community (21 April 2010)

a. Description of process

Upon the recommendation of Dr. Tudayan, results of survey and FGD were presented to the *barangay*. Presentation of results was attended by the *Kagawad* (Councilor) for Health, BHWs, assigned Rural Health Midwife, Rural Sanitary Inspector, RHU Public Health Nurse, and community people.

Results were presented and interpreted in relation to the health status of the *barangay*. After the presentation, questions and clarifications followed.

b. Target participants from institution/ community

Barangay Captain, *Kagawad* for Health, *Barangay* Health Workers, Rural Health Midwife, Rural Sanitary Inspector, RHU Public Health Nurse, community people

c. Materials/ resources used

Manila paper, metacards, pens, camera for documentation

d. Significant outcome for the community

Key health stakeholders at *barangay* level were informed of the current health situation of the community, and thus given perspective on what needs to be done to improve community health.

e. Problems encountered

None

Discussion

1. On planning

The anatomy of my summer immersion activities above shows that with good planning, I was able to fulfil my learning objectives within the short period of time. I share this with other students and other people to stress that good planning requires a methodical process that clearly defines the steps that make any activity easy to accomplish. Planning refers to the process of deciding what to do and how to do it. Planning occurs at many levels, from day-to-day decisions made by individuals and families, to complex decisions made by Rural Health Units and governments. Planning is a social activity – it involves people.[7] Successful planning requires effective involvement of the pertinent people within the community, of diverse backgrounds, interests and abilities. Planning facilitates action and thence, change. The planning process should reflect the following principles: comprehensive – all significant options and impacts are considered; efficient – the process should not waste time or money; inclusive – people affected by the plan have opportunities to be involved; informative – results are understood by stakeholders (people affected by a decision); integrated – individual, short-term decisions should support strategic, long-term goals; logical – each step leads to the next; and transparent – everybody involved understands how the process operates.[7]

Summer immersion is a test of planning skills. Good coordination and communication with community partners facilitate successful implementation of immersion activities. Planning enabled me to respond well to unexpected changes during implementation. Though some activities did not proceed as planned, the objectives were still attained due to alternate activities considered prior to conduct of activity. Well planned activities also eliminate unnecessary stress when changes arise. The entire planning process therefore, allows us to have room for adjustment in case initial plans do not materialize.

2. On regionalization

I strongly believe that for an educational institution to be called community-oriented, it needs to expose its students to a real community setting. This immersion experience made me realize the essence of community-oriented medical education. Though it cannot be denied that I still have inadequate medical knowledge, being familiar with dynamics and settings of the community is a good jumpstart for future medical practice considerations. I believe that awakening the students' consciousness on the current health situation in the countryside is a very effective start in fulfilling the vision and mission of the college. Having been exposed to the real community setting ignites a desire in me to help these people, and I hope that this desire will be cultivated in my succeeding years of stay in UPCM. Such experience taught me how to be more compassionate to those who need it most. It also made me think that these people can still realize their dreams and aspirations by having good health. Since health directly involves life, these people should have quality life by having quality health.

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