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Thinking rural health in Santal community in West Bengal: An interprofessional bottom-up approach to rural health

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Abstract

Background: An interprofessional and cross-cultural pedagogical project in community health for students in nursing, social work, anthropology and medicine at the end of the bachelor's

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degree begun in 2014. After a rural context fieldwork in several Santal villages of West Bengal (India), students had to conduct a research project, based on a community-health topic.
Aims: This paper describes how such a pedagogical project, introducing students to ethnographic research, can initiate new ways of thinking for possible future health interventions in rural communities.
Methods: An inductive approach based on ethnography was used during the fieldwork, including observations, interviews, focus groups and local documentation.
Results: Our observations led to the finding that actions in rural health cannot be initiated without: promoting an interprofessional/interdisciplinary perspective and a culture of complexity and reflectivity; considering local populations in transition and not in a fixed homogenous situation; understanding more than imposing; taking into account local disease classification and local pragmatic solutions; considering the dialogue between bio-medicine and therapeutic pluralism; considering local perceptions and practices; considering care itineraries/pathways; and finally being conscious of our apostolic function.
Conclusion: Our interprofessional pedagogical project promotes a bottom-up approach in dialogue with a global health vision.

Keywords
anthropology, community-health services, global health, India, interprofessional education, nursing, primary care, rural health, social work

Introduction

In the context of global health policies promoting care efficiency, facing diversity of situations and people's autonomy, health professionals are increasingly confronted with new kinds of uncertainty that must be taken into account in educational programmes. We propose an interprofessional pedagogical approach allowing students of nursing, medicine, social sciences and social work to study together global health challenges in a rural context characterised by therapeutic pluralism. Through a research project based in several villages of West Bengal, India, the objective of our approach is to share reflective practices and to create, renew or reinforce common theoretical frameworks, based on a fieldwork experience (Rossi and Herzig, 2015). How can such a pedagogical project, introducing students to ethnographic research, initiate new ways of thinking for possible future health interventions in rural communities?

A few words about the context of the study, the Santal community in West Bengal. The Indian government considers the Santal community as belonging to 'scheduled tribes' (Singh, 1997). Santals have specific beliefs, religion, life habits and a rural culture (Bhattacharya K, 2017a, 2017b; Bhattacharya RK, 2017a, 2017b; Bodding, 2001; Carrin, 1986, 2015). Santal villages present a very specific atmosphere, even if surrounded by other communities, rural or urban, and having contacts with them. Santals are found in a number of villages in and around Santiniketan where Rabindranath Tagore founded his University, Visva-Bharati. It is here that the Crafts Council of West Bengal has started a project on documentation of indigenous knowledge. Over a hundred years ago, Tagore too was deeply involved in working among rural communities in the fields of health, agriculture and cultural rejuvenation.

As Hart et al. (2005) mentioned, rurality is difficult to define and its definition could have serious impacts on allocation of resources in which care would be affected as would other areas of civil life and services. In our field of interest, namely healthcare, the question of what could be the best approach is of concern: should the definition be based on density of population, on the distance from urban centres or services, on care deprivation or on cultural dimensions? In the case of West Bengal, rural cultures are also found in urban places (Hart et al., 2005). A simple way to define rurality is through population size: a minimum of 5000 persons or more would constitute an urban centre, which means that population below 5000 would constitute a rural community (Census of India, 2011). Apart from population size within a limited area, there are some features by which rural communities can be identified: similar living standards and livelihood, common identity associated with the village inhabited; usually intimate interactions among members of rural communities; people generally know each other personally. Rural life is strengthened by ties of community. Rural areas miss out on many of the services and facilities of urban areas as well as having limited choice in availing services and it is especially true in the case of healthcare. However, on the flip side, rural communities have a social accommodation of problems, including ill health, in family and community support. Santals have specific rituals for birth, death, marriage and illness and believe in specific deities influencing their lives (Maran Buru as the supreme God, and spirits named Bonga). They also have traditional healers, who use plants and other shamanic techniques. Indian authors (Singh and Badaya, 2014) suggest that providing the entire range of modern health services in rural areas is difficult, and so the call is clearly to take stock of resources at the ground and find ways of strengthening the same through innovation, improvisation and professional help by experts from time to time.

Facing the complexity of this context, it becomes necessary to form an interprofessional team collaborating among themselves so that the ground reality, the needs of the community and assessment of standards of care can be ascertained so as to form a comprehensive picture.

Building a conjoined point of view between anthropologists, social workers, nurses and general practitioners, allows us to:

- break the ice between the community and the team by a better understanding of transcultural practices;
- identify the resources and the ways in which the community accesses them;
- ascertain if the level of care is adequate or if it can be improved;
- work around procedures and systems in innovative and inventive ways;
- be able to guide healthcare professionals to keep in mind social adequacy of therapies/procedures/systems.

Today, rural health is a part of global health, which is also difficult to define. According to Beaglehole and Bonita (2010), global health can be considered as research and action with collaborative and trans-national dimensions for the promotion of health for all. Koplan et al. (2009) underline interdisciplinarity and interprofessionalism, considering population diversity jointly with a high degree of individuality.

Thus, starting from the understanding of rurality and micro- or localised health, we are attempting to understand the macro aspects of global health where health is for all, irrespective of the location of the people all over the world. Making historical analysis of

global health, some authors (Harrison, 2017; Packard, 2016) have observed the application of top-down strategies, ignoring comprehension of local situations, resources and context, before implementing public-health measures.

This particular project asks to keep in mind knowledge of community, the local resources and their use in the forefront together with global health, containing the possibilities of multiple standards of care and service ensuring wellbeing of people as the final backdrop or point of convergence of conjoined efforts of collaborating professionals (Farmer, 2013). Indeed the combination of our approaches allows us to understand complexity when developing a definition of rurality and generating relevant research (Roberts and Wynn-Jones, 2013); if we do not do so, thinking about rural health in an era of globalisation of medical knowledge and practices is nearly impossible.

Our intention was to initiate a pedagogical project taking into account the complexity of rural health, and offering students (end of the bachelor graduation) the opportunity to develop alongside the usual top-down vision, the approach of bottom-up capabilities for the appraisal of health in a rural context (Widmer et al., 2017) and to integrate with their comprehension of social and health situations an intercultural dimension and other practices and ways of thinking. Bringing together different disciplines and professions allows us to bridge the gap between top-down and bottom-up expertise.

Historical background of the project

Dr Patrick Ouvrard (SFTG, Paris), 20 years ago, created a continuing medical education programme for general practitioners, jointly with anthropologists, to address primary healthcare systems in Asia or Africa (Ouvrard and Widmer, 2017). We came in contact with Santal communities during our collaboration with Dr Ouvrard and the Crafts Council of West Bengal (as part of a project of a centre for knowledge of the indigenous communities in Santiniketan). Together with SFTG, Institute of Family Medicine (Faculty of Biology and Medicine) and the Faculty of Social Science and Politics of the University of Lausanne we conducted the first field work study in 2014 among the Santals (Table 1). In 2015 we obtained a pedagogical innovation grant from the University of Lausanne for continuing the project in 2016. The innovation was to create a common optional training for students in medicine and social sciences (Rossi and Herzig, 2015). It was an opportunity to open the project to other professions and to collaborate with an existing training programme.

For 10 years, medical students in Lausanne have to present a community-based medicine research work (IMCO, *l'immersion communautaire* (community immersion)) at the end of the bachelor's degree (Daeppen et al., 2015). In following Swiss medical learning objectives they must investigate a health question not only on a medico-sanitary aspect but also on social, political, juridical and ethical dimensions. Since 2014, nursing students from La Source, School of Nursing Sciences in Lausanne have been integrated in this training with projects in India and China. In 2016, we began our first IMCO field work among Santals with eight students in medicine, nursing and anthropology. Fieldwork trips in 2017 and 2018 were financed by a governmental fund (Canton of Vaud) in the hands of La Source. Local partnership is of course necessary, and we had the opportunity to collaborate with the Social Work Department of the University Visva-Bharati (Santiniketan, India).

Students are introduced to research methods and have to present their work at Visva-Bharati University (where they receive feedback from faculty, students and local community members) and finally at the IMCO Congress in Lausanne (through PowerPoint presentations,

Table 1. The different steps of the project: method and pedagogical process.

Year	Topic	Authors	Presentation	Publication	Funding
November 2014	1. Anthropological and medical exploration of care offer in a context of medical pluralism	V. Simonin (M)	Masterwork	UNIL, Masters	IUMF SSP
June 2016	2. Diabetes type II in Santal tribes	D. Nicolet (A) S. Saha (SW) L. Kampmann (M) J. Friteau (M) L. Fragnière (N)	Visva Bharati + IMCO Congress	*Primary and Hospital Care* (Nicolet et al., 2017)	Pedagogic Innovation Fund Unil
	3. Santal women and birth control	M. Bruttin (A) N. Lama (SW) L. Martin (N) L. Piedavent (M) H. Vautrin (M)		*Primary and Hospital Care* (Bruttin et al., 2017)	
June 2017	Resources available in Santal Tribes. 4. The care of children from 0 to 5 years 5. Elderly care	L. Ducor (M) J. Jutzi (N) L. Lima (A) M. Damiano (M) S.B. Roy (SW) C. Desarzens (A) M. Ducroz (M) S. Menny (N) F. Rhyner (M) S. Mondal (SW)	Visva Bharati + IMCO Congress	Archives of IMCO	Canton de Vaud via Institute and High School la Source
October 2017	Socialization and well-being: insights from the Santals. Santals at the crossroads of tradition and contemporeneity.	Prof. K. Bhattacharya (TSW)	SSP, UNIL and Institut et Haute Ecole la Source. Two meetings 'Health in Santal Tribes'	Website sftg (Bhattacharya K 2017a, 2017b; Bhattacharya RK, 2017a, 2017b)	High School la Source, SSP and SFTG
	Plurality and rural Birbhum. A nuanced understanding. A picture of Reverend Bodding's work on Santal Medicine	Prof. R. K. Bhattacharya (TA)			
April 2018	How to explore health representations and behavior in scheduled tribes in India	D.Widmer (TM) P. Ouvrard (TM) K. Bhattacharya (TSW) R. Bhattacharya (TA) N. Lama (SW) S. Chatelard (TM) M. Baumann (TN) B. Guinchard (TN) I. Rossi (TA)	Workshop, 15th Wonca World Rural Health Conference, New Dehli, 26–29 April 2018	Conference abstracts	D. Widmer P. Ouvrard

(continued)

Table 1. Continued

Year	Topic	Authors	Presentation	Publication	Funding
June 2018	Mental health in Santal tribes 6. Depression 7. Madness	A. Abrecht (M) S.Blanc (A) J. Braun (N) C. Grieumard (M) H. Chevallier (N) O. Gasser (M) M. Micakovic (A) S. Roquelaure (M) S.S. Ghosh (SW) A. Chanda (SW)	Visva Bharati + IMCO Congress	*Primary and Hospital Care* (Abrecht et al., 2019) *Primary and Hospital Care* (Chevalier 2019)	Canton de Vaud via Institute and High School la Source

SSP, UNIL, Social Sciences and Politics Faculty, University of Lausanne; SFTG, Société de Formation Thérapeutique du Généraliste; M, medical student; A, student in anthropology; SW, social work student; N, nurse student; T, teacher (with M, A, SW, N)

abstracts and posters). Nursing students use the fieldwork in their bachelor thesis as a specific analysis integrating their considerations about interprofessional work and nursing concepts. Students in anthropology have to present a fieldwork report for validation of their training.

Method and pedagogical process

With the main objective of this exercise being the understanding of rural health in India, the team selected themes to be investigated within a period of two to three weeks of fieldwork, that is being in the villages and interacting with the villagers, following an ethnographic approach. The themes were to give a shape and form to the enquiry and also explore if such cross-cultural fieldwork could be used as a pedagogic tool. There was no question of clinical intervention or otherwise during this exercise. Rather, during our immersion process at the beginning of the fieldwork, we were alert to the physical condition of people; their customs and rituals, their food habits, occupation and health situation. We worked around a gamut of factors in order to gain insight into questions of health and healthcare of the Santals.

The students of social work introduced the teams to the villagers, identified the key informants and led smaller groups within the villages, visiting households and acting as interpreters.

For the fieldwork, we used an inductive approach largely based on ethnography (Olivier de Sardan, 2008), comprising observations, interviews, focus groups and local documents including images. A literature review was done at the beginning, during and after the work. We promoted a reflective approach. Every evening, a debriefing of the lived experiences and of the work was organised, under the supervision of teachers of each discipline. Students had the possibility to share observations, results of interviews as well as emotions lived within the research contacts with the villagers. All of the students evaluated these exchanges between each other and with their supervisors in a positive way.

Our project included two dimensions:

(1) Provide an innovative interprofessional pedagogical experience. Immersion through fieldwork is an ideal way for students to adopt a comprehensive perspective on observations, and to build a trusting relationship with their teachers, colleagues and the village respondents. Verbatim records of the debriefing sessions were made, with a qualitative analysis of their content to be subject of future publication about this pedagogical experience.
(2) Through fieldwork, build on a bottom-up approach for exploring health perceptions and practices among scheduled tribes in India, as we are convinced that it is the first step before implementing any health programmes. This paper presents the results grounded on our fieldwork; seven different periods of fieldwork were held for three weeks, over four years.

The methodology was discussed with colleagues at the Wonca rural congress in Delhi (Widmer et al., 2018) where it was received positively. Certainly, the bottom-up approach belongs to the culture of primary care more than to some public health approaches. The question for further research is how to bridge the gap between the two approaches, that is top-down and bottom-up.

Table 2 shows the list of villages where we conducted fieldwork. In the villages, the key informants were the chief (*maji haram*), the priest (*naike*) and villagers, selected by a

Table 2. Village populations.

Village name	Total population	Data source
Bergram	1737	Census 2011
Khiruli	1237	Census 2011
Debogram	1155	Census 2011
Ramnagar	1023	Census 2011
Ghosaldanga	345	Sona Murmu, Ghosaldanga
Bandhlodanga	1000	Village people
Pearsonpally	410	Sufal Hemrom, Secretary (Santiniketan Adibasi Kalyan Samity) Balipara
Balipara	520	Sufal Hemrom, Secretary (Santiniketan Adibasi Kalyan Samity) Balipara
Lal Bandh	700	Village people
Sauntal Para	460	Lilpi (Lipi's Ceramic Studio)

snowball sampling. Other informants were traditional healers, accredited social health activists (ASHAs), nurses, pharmacists, doctors (non-official and official such as ayurvedic, homeopathic or allopathic doctors), social workers and teachers. For each of the seven periods of fieldwork, a mean of 20 individual interviews and focus groups were conducted (total around 140) with 31 students. The interview, focus group and observation fieldnotes were the material for the coding process (axial coding allowing to elaborate themes for each research question). This paper takes a step forward using the data from all seven fieldworks to answer a more general question: how could we improve rural health?

Results and discussion

Our project must be considered as the first step of a process for understanding the cultural and healthcare contexts of Santal populations and to appreciate needs, perceptions and practices of the targeted population. This process could initiate new ways of thinking for future health interventions in rural communities. This section aims at giving some insights, considering that actions on rural health cannot be initiated without the following.

Promoting an interprofessional/interdisciplinary perspective

Interdisciplinarity is a collaboration of different academic disciplines (Jacobs and Frickel, 2009). It values different discourses and practices, and opens oneself to other perspectives on a same phenomenon. For example, an anthropologist observed that he related mental illness to traditional institutions of belief, spirit-world, shamanism, ignoring the clinical symptoms manifest in individual cases that could be relevant for nurses and doctors. A social worker concerned with disentangling the strands leading to conditions and situations diagnosed as problematic, gives the metaphor of anchor and buoy, as if clinical and scientific reasoning, orienting healthcare practices, had to find a landmark rooted in real life, relating health actions to the context. For healthcare professionals, discovering an ethnographic approach and grounded theory prevents them from reducing health to care and cure practices, opening to a more complex field including ethics, culture, religion and medical pluralism. As

expressed by a GP, interdisciplinary work opens what medicine always should have been: a holistic approach. For a nurse, this collaboration is also an opportunity for thinking about his/her professional position with modesty and being free of complexes. Here we distinguish interdisciplinarity, that is the academic collaboration, and interprofessionality defined as the collaboration between different healthcare professionals (Samuelson et al., 2012a, 2012b). In western countries with the importance of multimorbidity, this collaboration is particularly important between nurses, homecare organisations, doctors and pharmacists (Widmer et al., 2016). Our fieldwork experience underlines the importance of social workers in the field of health through either the formation of non-governmental organisations or inclusion in governmental programmes such as in the training of ASHAs, having an important role for maternal health education (Bruttin et al., 2017) and facilitating community participation in the health system (Mony et al., 2012). Anthropologists introduce some reflectivity when investigating community's perceptions, practices and resources and observing the consequences of health measures. The question whether to consider medical anthropologists as health professionals or belonging to another discipline was discussed in our group and the answer remained open, even if for some authors (Kleinman and Benson, 2006)), both anthropologists and clinicians believe that experience comes first.

Promoting a culture of complexity

After a difficult, chaotic day in a village with focus groups and interviews, we remember a student of medicine, during the evening debriefing, saying she cannot stand the blurred vision, the uncertainty anymore. At this time, the student was not able to make sense, to find meaning in the patchwork of fieldnotes and impressions. Healthcare professionals define complexity as a state of low certainty (low grade of evidence) and low grade of consensus (Fraser et al., 2001; Widmer et al., 2011): in the case of this student, there were some contradictions between the persons interviewed and also between the interpretation of different professionals. Healthcare professionals usually build evidence on quantitative methods such as randomised controlled trials. These methods are difficult to apply in complex situations: it is mandatory to find other methods to approach evidence, such as qualitative research. This has been undertaken, for example, by different researchers through a global appreciation of ASHA work (Mony and Raju, 2012; Saprii et al., 2015). The culture of complexity implies specific methods to cope with uncertainty and to obtain consensus with community and different health professions. It is mandatory to have a global view including the context. This experience – as said by a GP confronted by the ethnographic method – let us understand how much care professions are focused on specific objectives, putting the context aside. Healthcare professionals tend to focus on a target, as someone using a microscope looks on a cell.

During the fieldwork we named this attitude the 'microscope syndrome'. Working with other professions, we could understand other objectives. As noted by an anthropologist in our group, the complementarity of perspectives of the interprofessional approach helps us constantly redefine our methods and embrace the complexity of health issues in a specific community.

Promoting a culture of reflective thinking/reflectivity

An important moment in becoming a reflective practitioner (Schön, 1983) during our fieldwork was the evening debriefing with students and teachers together: the opportunity

to exchange the facts, narratives and emotions of the day. For example, the perception some students expressed that the villagers could see them in a colonialist position, when the team arrived in the villages in two jeeps. And the answer found was that there could be no pure observation: the first step of fieldwork is a mutual recognition, an exchange between people.

Avoiding rigid categorisation of local populations

Frequently criticised in the field of anthropology, essentialism refers to the act of attributing unchanging and ontological features to other cultures, perceptions and practices. Kleinman and Benson (2006) proposed seeing culture as having multiple variables and not as a homogenous and static content. Santals are not traditional societies fixed in their representations, beliefs and habits indefinitely, but they are also societies in transition in a globalised world confronted with therapeutic pluralism, religious syncretism, that is the blend of different religious systems, or the incorporation of beliefs from other religions in their own – syncretism refers to the mixing of different religious traditions whether as active, ongoing process or as historical fact (Stewart and Shaw, 1994). Therefore, Santal populations share the challenges of modern India.

Understanding more than imposing

In Santal villages we previously observed small huts offered as toilets by a public health programme to counter open defaecation; the toilets were now found to be transformed into storage huts for agricultural tools. A public health programme must not to be imposed in a top-down approach, as observed by Clair et al. (2018) but has to take into account multiple dimensions such as gender, social and cultural issues, and community practices.

Taking into account local disease classification and local pragmatic solutions

A group of students working on depression created the concept of traditional Santal versus bio-medical identification filter. For bio-medicine, depression is identified by symptoms (tiredness, sadness, lack of pleasure, etc.), defining the nosological category by convention, while Santals consider the consequences (not to be able to work or madness).

This emphasis put on functional before categorial conventional diagnosis implies that people are turning to traditional solutions for simple symptoms. It is important to reflect on the indigenous body of knowledge and to develop it instead of changing it in the name of modernisation (Chaudhury, 2008).

Considering the dialogue between bio-medicine and therapeutic pluralism

Santals are not a closed community and, according to the problem, can seek different therapies: traditional, ayurvedic and western medicine (medical pluralism). The rationality of evidence-based medicine (EBM) permitted the efficiency of western medicine. Some voices proposed submitting traditional medicine to EBM and randomised trials (Patwardhan, 2014). Alongside isolating the causal relationship from all confounding factors, we must find the place for a more holistic approach. The examination of the eco-system, the health resources available and the socioeconomic conditions are part of a rational approach to a problem that should not be taken in isolation (Chaudhury, 2008).

Considering local perceptions and practices

We discussed care practices with a Santal man suffering due to a vertebral fracture and a partial legs palsy after a motorcycle accident. Immediately transported to the local hospital after the event, he underwent successful surgery. When he returned to the village, he consulted the *ojha* (local shaman) to know which *Bonga* (spirit) was angry with him. This example illustrates the pluralistic use of different resources for the same problem. We must consider the coexistence of different medical systems: the traditional, complementary and biomedical. This therapeutic pluralism, which has been described in several societies (Broom and Tovey, 2008; Rossi, 1997) is found to participate in the context of rural health.

Another illustration to take into account is the local reality. Some Santals we met had a specific philosophy on life: they were not interested by the future, their logic being centred on coincidences at the present moment, for example for the decoding of the sense of an accident.

'Peace in mind and fun in life' an old man said to us, explaining what was important for him: the present moment. All is good as long as you can go to the fields and do your job. For this reason, it is very difficult to introduce prevention programmes that can only function in anticipating the future.

Considering care itineraries/pathways

There are pathways created by professionals to manage some diseases (Schrijvers et al., 2012) and care plans decided by the patients themselves. In the Santal villages we visited, women largely invested in bio-medicine for contraception and for this, the pathways seemed easy with the important role of the ASHAs.

Sometimes patient's itineraries are not optimal for diseases such as tuberculosis (Yellapa et al., 2017) and the time lost in vacillation between physicians and traditional healers can have important consequences. It is mandatory to have a good knowledge of existing itineraries before implementing a new programme.

Having consciousness of our apostolic function

All health professionals have a certain idea of what is good for the patient or for the community, and of what to do, without taking into account other people's ideas. One GP teacher described this as a 'formatting' and underlined the importance of coming out of the straitjacket of our apostolic posture. A nurse teacher asked for modesty and humility when healthcare professionals believe they are the patient's advocates. The anthropologist Byron Good (1994) qualifies this phenomenon as a 'fundamentalist epistemology' comparing this with religious fundamentalism acting to convince people to change their beliefs for their salvation. Michel Balint (2005) introduces some nuances describing the apostolic function as an important dimension of a carer's identity. With too much apostolic function we don't see the patient's point of view, however without any apostolic function we won't have the desire to care anymore. A well-tempered apostolic function seems the solution.

Limitations

The limitations of this study are related to the two objectives of the project, that is pedagogical: on one side using fieldwork for teaching interprofessional collaboration, and on the other side using fieldwork to create a new approach to health-needs definition in rural areas.

We also observed that Santals can take our expectations into account and this can have an influence on our results.

Another problem is the participation of the villages in the study. We were interested to give feedback and to discuss the results with those concerned. All the results were presented at the University Visva-Bharati with the presence of Indian social-work professionals. Tribe representatives were only two or three well-known persons such as local tribal leaders. Unfortunately, we had no direct feedback from the people interviewed. In order to improve the evaluation of our pedagogical project, the inclusion of feedback from participating communities would be necessary.

Conclusion

For a bottom-up approach to rural health, our intention has been two-fold: to test the efficacy of developing an interprofessional collaboration in healthcare especially when dealing across cultures, and secondly using the fieldwork project as a pedagogical tool in the teaching of medicine, nursing, anthropology and social work engaged in the field of healthcare. This community approach participates in promoting a perspective which includes members of local communities as research partners rather than as objects of inquiry. Indeed, global health cannot be understood without taking into account the dialogue with local community health, in this specific case rural health (Rossi et al., 2015).

Key points for policy, practice and/or research

- Use of a bottom-up approach in dialogue with global health. The necessity to develop observational, qualitative methods to understand local realities to be accepted and recognized before implementing health programs.
- Consciousness of the need for moderating caregiver's apostolic function. Undergraduate students often are very motivated to help and offer their new skills to a patient or a community. An immersion in a different culture helps them to moderate action and reinforce listening and understanding as the first interaction.
- Importance of therapeutic pluralism. As a caregiver, taking time to understand local resources, local medicines, financial means, beliefs and practices, considering evidence-based knowledge as a belief in interaction with others.
- Debriefing as a means to improve reflectivity. After a fieldwork having an exchange of experiences including emotional dimension. It is a key point for interprofessional collaboration
- Interprofessionality to enrich points of view. Complex situations have to be considered from different points of view in order to improve the outcome for a patient or a community.

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The author(s) declared no potential conflict of interest with respect to the research, authorship and/or publication of this article.

Ethics

The fieldwork followed the ethical principles of the IMCO programme of the Faculty of Biology and Medicine, Lausanne and, for the Indian part, the principle of no commercial use of data according to the Craft Council of West Bengal. As student's works are not biomedical research but socio-anthropological investigation they don't belong to the Cantonal medical research commission of Canton de Vaud but directly to the validation process of the IMCO. Each project is presented as a protocol in March and validated by the IMCO feasibility and ethical commission of the Faculty of Biology and Medicine – Lausanne. https://www.unil.ch/ecoledemedecine/files/live/sites/ecoledemedecine/files/shared/Enseignements/Cahiers/2017-2018/B3_6_cahier_module_17-18_v2.pdf

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