Exploring the Implementation of the District Residency Programme for Community Medicine Residents in Kerala

Dr. Jenyz M Mundodan
Assistant Professor in Community Medicine
Govt Medical College Manjeri, Kerala
Kerala University of Health Sciences, Thrissur

Introduction

NMC introduced 3-month District Residency Programme (DRP) for postgraduate residents w.e.f. 2021 admission

To train District Residents (DR) at diverse settings close to the community level; thereby also contribute to services of the District Health System as Speciality resident doctors working as members of the district teams.

Good exposure for residents of Clinical Departments as well as Laboratory based departments – to understand problems and troubleshoot in resource-limited settings at community level

Objectives of DRP are in line with Subject specific objectives of MD Community Medicine programme:

- Exposure to District Health System, involvement in health care services
- Acquaint with planning, implementation, monitoring, and assessment of National Health programmes at the district level
- Orientation to promotive, preventive, curative and rehabilitative services provided under the umbrella of National Health Mission

Community Medicine DRs – "can be trained by District Health System teams within available avenues in coordination with the District Health Officer."

- Lack of clarity unlike other departments

MD Community Medicine course **in Kerala** focuses more on Public Health administration and less on Clinical exposure, as compared to other states

Aim

To explore the experiences and challenges of Community Medicine Junior Residents (JRs) in Kerala about DRP and their suggestions to improve it

Methodology

Study Design : Qualitative Descriptive Study with Exploratory Analysis

Research Paradigm : Constructivist Approach

Theoretical Framework: Experiential Learning Theory

Study Setting : Medical Colleges across Kerala with Postgraduate training in Community Medicine

Study Population : Post graduate residents who have completed three months of DRP in selected districts in Kerala

Data collection :

- Focus Group Discussion (FGD) conducted in three districts (with atleast 5 JR per year) – 2-3 JRs from each College
- In-Depth Interviews (telephonic) from three districts – 2 JR each Medical College

Analysis :Transcription, Manual coding based on recurring ideas

Themes were analysed to identify key patterns

Ethical Considerations: Informed consent was obtained {written for FGD, verbal for telephonic interview

: Study approved by IRB

Results

1. Overall Experience and Expectations of DRP

- All appreciated the experience; interaction with professionals who put Public Health administration into practice
- Very few districts had a prior plan for Community Medicine residents under DRP; in most places a pattern evolved though trial and error.

2. Clinical Exposure

- All JRs provide clinical services at their hospitals (Preventive Clinics, Local OP) or at RHTC and UHTC - outside the DRP
- Some districts, DRs placed in District / Taluk Hospital for 1- 1½ months for Clinical Exposure as well as to learn Hospital Administration
- Most preferred the clinical exposure at their respective MCH; more time needs to be allotted for DMO[H] posting
- Reservations about the *relevance* of certain clinical postings for Community Medicine residents.
- Many attended a 10-day course on palliative care

3. Exposure to Public Health Administration

3.1.Understanding District Health System

- Accompanied DMO/DSO teams for visits to Peripheral Institutions – practical insights into public health administration
- Received a field level SWOT analysis of the running Health Programmes from those implementing it
- Attended District level and Block level conferences.
- Posting under NHM was beneficial – particularly for those who got around 5-7 days
- In districts with adequate numbers, a set of activities have been assigned to DRs (such as analysis of IDSP data)
- All appreciated the exposure, particularly those from private colleges, who had limited experience in outbreak investigations and death audits

3.2. Field level at Peripheral Health Institutions

- Residents from Private colleges had limited experience working with field staff of PHC / CHC.
- JRs of one College adopt a village (ward of Panchayat) as their PG population, in liaison with the ASHA and Health workers. [A model to be emulated by other colleges]
- Residents valued networking with the public health system, from DMO to field-level workers – this was encouraged by their parent departments.

4. Challenges faced during DRP

a. **Support from Health Services Staff** – Staff in a few peripheral centres did not understand what was expected for them

b. **Used as stand-by HR** – Residents were sometimes used to cover for absent medical officers or assigned to telemedicine duties (e-Sanjeevani), often hindering their designated fieldwork or outbreak investigations

c. **Transportation** – Vehicles were frequently unavailable, with residents asked to use personal transport for field visits.

5. Contact with 'Parent' department

- Most DRs routinely reported to their department with updates of posting; very few attended Seminars
- Remaining JRs in some colleges face increased burden of work
- One college completely called off PG academic programmes

6. Duration and Pattern of DRP posting

- Duration of 3 months is adequate
- Clinical posting (if included) should not exceed 1 month

7. Suggestions for Improvement

a) A clear set of SLO, with a detailed plan for 3 months. There must be a small space for flexibility to accommodate district specific issues that may arise at different months of the year.

b) A list of competencies to be achieved can be listed out – to ensure the minimum number of each activity, such as outbreak investigations

c) Orientation for District Level Nodal Officers as well as faculty in-charge – to ensure everyone is on the same page

d) The current system of one-week training at state level (DHS) must be continued and not clubbed to DRP. Options for postings in specialized settings, like Tribal Specialty Hospitals, could be explored.

e) Residents of Private colleges suggested inclusion of week-long posting at a Govt PHC / CHC

Luck factor: "Incidentally, we got to work with the team that visited for a State Level Malaria surveillance"

"Experience at Gender Based Violence centre (***Bhoomika***) at the Government Hospitals was an eye-opener"

Attitude and orientation of the **District Nodal Officer** was probably the single most defining factor

DR utilized as Human Resource to plug gaps in the system. This is a common complaint across different specialties

Conclusions

- Interaction with the District Health System is a unique opportunity for a Postgraduate resident, and this must be properly leveraged through DRP.`
- The shift from earlier pattern of 1 week visit to DMO[H] and related institutions to 2-3 months posting promotes 'learning by doing'
- In most districts, the posting has become mutually beneficial, with the expertise of DRs being utilized by the health system
- While academic sessions were missed, the practical benefits of DRP postings were seen as a worthwhile trade-off.

Way forward

- Interview recent MD graduates (prior to implementation of DRP)
    - their perspective on what they feel they have missed
- Perspective of faculty of Community Medicine and District level Nodal Officers for DRP (Dy DMO)
    - their understanding of the objectives of DRP and the current implementation
- Develop a statewide framework for DRP in community Medicine
    - through Delphi Method followed by a state level Workshop

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