Rural and urban health training centres of medical colleges in India: A prescription for their revamp

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BACKGROUND

Rural health training centres (RHTCs) and urban health training centres (UHTCs) are an integral part of every medical college in India. They are mandatory for obtaining approval from the Medical Council of India (MCI) for opening a new medical college.3,4 These centres provide community-based learning for undergraduate (UG) and postgraduate (PG) students as well as interns, build capacity of the staff and facilitate field research.3 In view of their value for different stakeholders, it is worth reviewing their functioning and outlining their future role.

STATE OF AFFAIRS AND THE WAY AHEAD

Institutional issues

The MCI guidelines stipulate that every medical college should have three primary health centres (PHCs) or RHTCs for training students in community-oriented primary healthcare and rural-based health education.3,4 One of these centres should be located within a distance of 30 km or one hour or less of travel time from the medical college, with arrangements for lodging and boarding for students and interns. The guidelines also state that every medical college should have one UHTC.

The number of PHCs or UHTCs adopted by various medical colleges is not known. Nor is it clear if a medical college should have three RHTCs or can make do with one functional RHTC as is the case with most medical colleges. The requirement for both types of centres is irrespective of the admission capacity of a medical college.3,4

The number of RHTCs and UHTCs for a medical college should be linked to their student intake. This rationalization will result in a larger benefit to the communities in terms of healthcare service delivery. It will also facilitate the teaching–learning process and enhance the potential for research. Accordingly, institutes with intake capacity of around 50 students may have one RHTC, while those with a higher student intake (up to 150 students) should have two RHTCs and the larger institutes should have three RHTCs. Similarly, an additional UHTC should be set up at a medical college with 200–250 students.

The administration of some medical colleges neglect these centres and basic requirements such as vehicular support are perceived as a luxury.5 To address this issue, the dean/principal of the medical college should be made overall in-charge, and the departments of community medicine should be assigned more autonomy to manage the centres. To facilitate inter-departmental coordination, other departments of the medical college should be actively involved. This would help generate ideas for collaborative research and forge liaison with governmental agencies.

Role of RHTCs and UHTCs in teaching–learning

Rural sites are ideal locations for students to understand the broader determinants of health in the context of complex social and economic forces.5 The present MBBS curriculum, however, has limited opportunities for orienting students to rural as well as the urban communities. The Reorientation of Medical Education (ROME) scheme, introduced in 1977 on the suggestion of the Srivastava Committee Report, intended to achieve community-based learning for UG medical students and integration of medical colleges in the healthcare system. However, the scheme was a non-starter, largely due to lack of commitment at all levels, slow progress in the utilization of Central funds and the absence of efforts in restructuring teaching programmes at the college level.6

The failure of the ROME scheme should not come in the way of its restructuring. Good results have been achieved where it is still operational. For instance, a study in a rural medical college showed that the scheme was well accepted by students and recommended its revitalization in all medical colleges as an effective practical approach to teaching the principles and practice of public health.7

The traditional medical curricula lay more emphasis on the acquisition of knowledge than on skill development. The oft-neglected skills that need a thrust during medical education are those in human resource management, ability to lead a healthcare team and provide cost-effective care in rural/non-hospital settings.8 The MCI has expressed in its Vision 2015 document the need to train ‘basic doctors’ who would possess the requisite clinical as well as other relevant skills.8 What better way to hone these skills than in the RHTC and UHTC? The WHO too foresees communities becoming ‘laboratories’ for skill development.10 An appropriate module should be developed to incorporate aspects relevant to such skills and be implemented during the UG course. Students should be separately assessed for these skills on the basis of their RHTC and UHTC postings/visits.

An oft-lamented issue is the reluctance of young doctors to serve in rural areas of India. In a review in North America, a majority of students reported that rural experiences influenced them towards primary care specialties and to consider rural practice. They generally valued the experience and had a high degree of satisfaction.11 Hence, a well-spent time at the RHTC could motivate students to serve in rural areas of India.

The period of internship is critical to develop and refine various skills including clinical skills as well as soft skills like communication; RHTCs and UHTCs seem ideal for this purpose. It has been observed that this period is not effectively used, with students often spending that time in preparing for PG entrance examinations.9 RHTCs and UHTCs can shape the interns during their three months of community posting. The focus should be on improving clinical as well as communication skills, implementing

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small yet focused education projects, being involved in institutions such as the rogi kalyan sanitis, i.e. patient welfare committees and village health, sanitation and nutrition committees (VHSNCs), training of community workers, etc. This should be made part of the formal internship assessment.

PG students of community medicine are more active at these centres. Many of them write their dissertation based on the work related to RHTC and/or UHTC areas. The substantial amount of time they spend there should aim to facilitate their development as complete public health professionals. Postings at these centres should be used by PG students to sharpen their administrative, teaching, clinical and communication skills. They should be given projects related to extension activities in the community. Preparation and presentation of epidemiological, managerial and social case studies should be encouraged and be made part of the overall student assessment.

Delivery of healthcare services
Basic healthcare services provided by RHTCs and UHTCs include outpatient facilities, inpatient care and extension services. These services are expected to be more than those available in PHCs not attached to medical colleges. For example, a medical college can provide multidisciplinary specialist care, though referral from these centres to the parent teaching hospital remains an issue.

The National Rural Health Mission (NRHM) launched in 2005 is a landmark event in the history of healthcare in India. But the NRHM framework has no role for the RHTCs. The National Urban Health Mission (NUHM) initiated in 2013 has provision for urban PHCs across cities and towns. However, it remained silent on using the existing UHTCs attached to medical colleges. The latest National Health Mission (NHM) that subsumes the NRHM and NUHM too has no mention of RHTCs or UHTCs.

There are about 400 medical colleges in India. Assuming a population of 30 000 potentially served by an RHTC and UHTC of every medical college, the total population thus served would be almost 24 million, or about 1.9% of the country’s population! If larger institutions were to have more than one RHTC and UHTC, the served population would be even larger. However, in the absence of formal arrangements, it is unfair to expect accountability on the part of medical colleges in achieving specific health outcomes through these centres.

The NHM should therefore acknowledge the importance of these centres and develop appropriate institutional mechanisms to involve them in the full range of healthcare services across diverse rural and urban communities. This should also include private medical colleges, with whom suitable partnerships should be developed not just for service provision, but also for other activities such as training of healthcare workers.

Referral facilities can be improved with the NHM linkage. Apart from routine visits of specialists, telemedicine facilities can be used to improve patient care, with the medical college functioning as the hub, and the RHTCs and UHTCs acting as satellites.

Efforts are required to promote community involvement in the activities of RHTCs and UHTCs. One way is to set up patient welfare committees at these centres, similar to those in public health institutions. This is also necessary to ensure accountability. Another way is by increasing the involvement of the centres in community-based organizations such as the VHSNCs, which have been outlined in the NRHM Framework of Implementation. Sanitation-related activities such as village cleaning, promotion of toilet construction, solid waste disposal, etc. are examples of key areas for community involvement by the RHTC and UHTC staff. Outcomes of the NHM can be improved by involving NGOs working in those areas.

Community-based research
RHTCs and UHTCs seem ideally placed to carry out diverse community-based research studies. The General Rural Health Survey carried out in 1944 at the Singur Health Centre was the first comprehensive survey of the health and economic conditions of a rural community in India. The research done presently at RHTCs and UHTCs is mainly in the form of students’ dissertations and field-based surveys. The considerable potential for research thus remains unfulfilled.

The unique position of RHTCs and UHTCs offers scope for a wide variety of research, particularly epidemiological research. These centres have immense potential for observational studies, especially cohort studies and intervention studies such as community trials. With the requisite support, they can function as epidemiological stations, and play a crucial role in disease surveillance.

Presently, the reliable sources for health-related data are the Sample Registration System and the National Family Health Survey. RHTCs and UHTCs can complement these initiatives by generating data on a large scale. These centres also hold great promise for sociological research, especially in understanding the social determinants of health. For example, in the ‘engagement studios’ approach of the University of British Columbia, inter-professional teams of students worked with community partners to identify priority community issues and explore potential solutions. Further, it would open the doors for collaborative research with universities and other academic institutions on inter-disciplinary areas.

Lastly, operational research can be done in collaboration with public health departments to evaluate national health programmes.

Developing RHTCs and UHTCs into centres of excellence
In the long run, RHTCs and UHTCs should develop as centres of excellence in public health. They should enable the staff to build capacities in areas such as research, mentorship and healthcare management, and facilitate their career progression.

Collaborations with national and international academic institutions and other agencies should be actively pursued. For instance, the All India Institute of Medical Sciences, New Delhi has tie-ups with several international universities for research and internship opportunities and is also part of an international disease surveillance network.

Going beyond healthcare
RHTCs and UHTCs should strive to go beyond the ambit of healthcare and work on other issues that concern people’s lives, especially the social determinants related to health. They need to proactively work on a range of issues such as education, vocational training and social ills. Some institutes that work with the community in an exemplary way include the Christian Medical College, Vellore and the Mahatma Gandhi Institute of Medical Sciences, Wardha.

At a broader level, mechanisms for intersectoral coordination need to be established to achieve synergies in various health programmes. For instance, liaison should be developed with the education department at appropriate levels to develop activities that will add value to the existing school health programme. Consultations should be done with the people’s representatives and organizations such as self-help groups (SHGs) and farmers’ clubs to evolve
appropriate programmes. Formal mechanisms should be established with local self-governments for better coordination. For instance, multiple government departments may need to be involved for working with SHGs.

**Evaluation of the functioning of RHTCs and UHTCs**
The functioning of RHTCs and UHTCs has not been evaluated comprehensively in terms of teaching/learning, healthcare delivery, community-level activities and research. The innovative models and best practices adopted at these centres should be highlighted. A standardized format should be developed for medical colleges to regularly report on activities at RHTCs and UHTCs to the MCI. This will facilitate centralized compilation and analysis of the data. These centres should be evaluated on the following parameters:

1. Capacity building of students as well as the medical college staff;
2. Benefits to the community measured in terms of health and other related indicators;
3. Research and its application to solve problems of the community;
4. Contribution to programmes and policy-making;
5. Innovations tried out and partnerships fostered;
6. Furthering of the discipline of community medicine.

**CONCLUSION**
RHTCs and UHTCs need to be revamped to assume a more meaningful role in medical education, healthcare delivery and research. It is necessary that all stakeholders come forward and invest their resources to realize the immense potential of these centres.

**REFERENCES**