Mandatory One Year Rural Internship –

Programme Design:

The Medical Council of India has recommended a one year rural internship as part of its efforts to ensure that the medical doctor produced has all the basic skills and attitudes needed for a medical doctor in the Indian context.

The Public Health Sector could also benefit from this to improve its service delivery to the under-served in rural and remote areas of the nation.

However to ensure that these goals are met, we need a well designed programme that would address the possible problems such a scheme would face and plan on how to overcome these so that we get the desired outcomes.

The key challenges are-

a> rational and efficient posting of the medical graduates with no loss of time to them and with maximal utilisation for the public health sector.
b> Ensuring that they are well mentored so that there is a good learning opportunity for them- on both clinical skills and on public health.
c> Ensuring that this gives them a understanding and orientation to public health- defined as taking care of the health of populations.
d> Ensuring that the professional isolation the young provider of care feels, is overcome by networking and peer support using appropriate IT tools.
e> Ensuring that there are proactive measures seen to overcome the social isolation that these young providers would feel and to reduce the cultural gap between providers and the population they serve. These gaps and the sense of isolation acts as a barrier to the development of trust and confidence between community and the public health system.
f> Ensuring that it is economically sustainable, if not an attractive proposition for the graduates to do such an internship.

Programme Design Elements:

1. The first year of internship is in the medical college, the second year is in rural areas. As soon as the student enters the internship programme in the medical college, his or her name , with contact details is forwarded to the Rural Internship Coordination Center at the state and the center. Each state keeps as many graduates as needed for the state- and then gives the rest of the names to the all India pool. The all India pool would distribute surplus graduates from states which have more than their requirements to those states which are deficient- having less students than needed to meet their requirements.
2. During the year of internship- the student shall work for one month at the district hospital, two months at the block hospital and then for 9 months at the primary health centre. The state requirements /ability to absorb interns should be taken as the total number of public health facilities- adding DH, SDH, CHC and PHCs together. This would mean that there would be a slight surplus for most of the year, and some PHCs would have two interns. But it would

also mean that when interns are doing their DH or CHC posting, there is someone available at the PHCs.

3. There would be a limited choice for interns on place of posting- and allocation by counselling based on a merit list. This would be done by the state RICC for the state pool of interns and by the National RICC for those interns in the all India pool. There would be a preference to be posted near their " native places" when interns opt for this.
4. The interns would be paid at the same salary as those entering permanent service *plus* some of the perks/benefits that go along with permanent service in that state.(eg NPA, housing allowance, hardship allowance etc). For those in the all India pool, the salaries and benefits of the first year of permanent service in the all India CHS would apply.
5. Every intern would have an academic mentor from both the medical college and from within the district health system. Mentors are meant to support and encourage learning and be available for problem solving. Mentors would themselves receive simple instructions and some orientation.
6. The role of the mentor is to primarily guide the intern to understand the health of the population, the gaps in health care practices and health seeking behaviours, the specific gaps in service provision and the social determinants at work in the area under the PHC. There should be tools and methods by which he can understand this. Given the fact that in a PHC catering to 30000 population there would be about 30 ASHAs, 6 ANMs, 30 Anganwadi workers and about 20 other medical staff of different types – including MPWs and the PHC staff- there is enough of a team for such an understanding to develop. The important dimension is that the PHC should feel responsible for the health of the population it serves, and not be limited to only the health of those who come to seek curative care in the clinic.
7. Interns would have a log book which would record the work they are doing.
8. Interns would be provided with internet connectivity. Preferably multi-channel, the minimum connectivity that would be assured is a data card and mobile based internet connectivity(and a laptop?). This would be used for skype based programmes and other forms of tele-medicine linkages. These would be used for regular interactions with mentors and supervisors. E-groups would be formed for supporting peer interaction and learning. District level meetings once in two months would also encourage such sharing and help overcome the sense of professional isolation.
9. Interns would be given an organised social welcome when they arrive at the PHC. This would involve the panchayat members, and the village health and sanitation committee members. It would be the responsibility of the rural internship programme coordinator at the block level to identify local patrons of good character who would support the young intern and give them a sense of security and warm welcome. The rural internship programme coordinator also must ensure a good grievance redressal system for them, but the emphasis is on proactive measures to build " a positive practice environment. " International experience shows that this is perhaps one of the most effective tools of retention of skilled professionals in rural areas, and we could learn from this.