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Medical Education With Village Adoption – Social Responsiveness For Rural Health

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Abstract

Rural development is imperative if the gap between rural and urban is to be filled for the betterment of human development, global health, and social justice. The first rural medical institute of India took the bold step of adopting a village with each batch of medical students**.** The village community gets screened for diseases while students get to experience and study ground realities of rural health, whether preventive, curative, promotive, or rehabilitative at the patient's door step. Medical students and clinicians learn to diagnose and go on to treat with low costs to patients. Just prior to their first winter vacation, medical students lived with mentors in their respective villages for two weeks. This stay included batch visits and helped keep track of community illnesses and health literacy and awareness. Merging social accountability, rural remote health, and community-based medical education incorporated the mandate of The Network: TUFH.

Introduction

A lot of the global population lives in villages, and rural development will be critical if the gap between rural and urban and between the 'haves and have not's' is to be filled for better human development, global health, and social justice. The National Rural Health Mission (NRHM) of India [1] envisaged the 'communitization' of public health services, which enabled health service providers and rural communities to have ownership. The process of communitization was expected to help enable universal access to available and affordable quality of health care that was responsive to the needs of the rural masses. While medical institutes strive to improve the quality and relevance of their education, they also need to contribute in improving effective health care delivery of relevant quality care. Through their medical graduates, medical institutes have the responsibility for a greater contribution in improving the health system's performance, keeping in mind the health status of the society at large. The medical institutes are judged for their excellence by their capacity to anticipate the kind of doctors required for the society and global health by constantly evolving health systems for the communities they serve and their capacity to produce such doctors.

Mahatma Gandhi Institute of Medical Sciences, Sewagram, Maharashtra, India, the first rural medical institute in India came into existence in 1969 in the Gandhi centenary year. India now has 542 medical colleges [2]. Decades ago, the then Prime Minister of India suggested that for the rural masses, medical colleges need to be in villages. 'Sewagram', then named 'Segaon', was the

natural choice for the first rural medical college of India as it was Gandhi's 'Karma Bhoomi', or 'real place of work'. Mahatma Gandhi lived in the Gandhi Aashram in Sewagram for many years, which is now one of the country's sacred heritage sites visited by people around the world.

Ex-union health minister, Late Sushila Nayar, physician of Mahatma Gandhi [3], was given the responsibility for the hospital. Keeping in mind the social accountability of all stake holders, Central Government, State Government, and Kasturba Health Society Sewagram, funding was divided amongst them: 50% was invested by the Government of India, 25% by the Government of Maharashtra, and 25% by the Kasturba Health Society, a Non-Government Organization. It is a civil society registered under the Societies Registration Act 1860 [4] in 1964, with Founder President Dr. Sushila Nayar.

There was priority reservation in medical admissions for rural students, girls, and wards of KHS employees in addition to reservations as per the government mandate. Opening medical colleges in village helped many. Rural people could get best of the health care without spending on travel and high fees. Many rural people got employed too. However, for everyone in villages to get screened and other services at their doorstep was not possible. So, the first rural medical institute of the country took another bold step of adopting a village with each new batch of medical students**.** It was a win-win situation for everyone. The whole village community got screened for various diseases and students got to know the ground realities of health problems of rural communities. They encouraged villagers to make the best of the drive. Local government, health, education, maintenance, water, and sanitation were all involved with matching teams of medical institutions. This practice started in 1969 and continues, remaining dynamic with all the changes in technology over the years.

Halfway through the first year, just prior to their first winter vacation, medical students lived with mentors in their respective villages for two weeks. This stay included batch visits and helped keep track of community illnesses and health literacy and awareness. The student's stay is provided by the villagers in their houses, schools, temples, and community halls. Some mentors additionally visit the village every day. All health services are free for the villagers. Formal inauguration and valedictory are held with the participation of villagers, teams, and institution's management with guests (Fig 1).

Figure 1

Students are allotted families. All the family members, whether symptomatic or asymptomatic get screened for vector borne, non-communicable diseases and other disorders. Additionally, those symptomatic are seen by specialists who visit the village in rotation. If people that are asymptomatic are found to have any abnormality, they are also seen by the specialists. Those in need of special care, especially high-tech investigations or surgeries are helped at the medical institute. In the medical institute, diagnostic, therapeutic, and surgical services are free not only during the social service drive of two weeks but also for another two weeks after the culmination of the annual event. Some of the villagers actually living with the treatable disorders due to various reasons get completely cured with no financial burden. The epidemiologists get a lot of research data. Clinicians get a lot of ideas and material for research in addition to satisfaction of treating and learning to treat with minimal resources. They visit the village every month on a fixed day. The whole batch visits and keeps track of the illnesses of the whole community and tries improving health literacy too (Fig 2).

Figure 2

By the time the internship is over, villagers feel a sense of comfort with the institute and use the health services as per their needs, using the institution's various health assurance schemes. Their association with students continues over the years to the extent that when students come back to the campus for silver jubilee celebrations of their batch, they visit their adopted villages as well. The village adoption scheme for each batch of medical students seems doable, feasible, sustainable, and useful for rural health. The merging of social accountability, rural remote health and community based medical education, is also a mandate of The Network: Toward Unity For Health (TUFH). Today, when medical education system is striving for 'Five Star Doctors' [5] who are able to function in the roles of a clinician who understands and provides preventive, promotive, curative, palliative, and holistic care with compassion, a leader and member of the health care team with capabilities to collect analyze, synthesize and communicate health data

appropriately, a communicator with patients, families, colleagues and community, a lifelong learner committed to continuous improvement of skills and knowledge, and a professional, who is committed to excellence, is ethical, responsive, and accountable to patients, community and profession; village adoption in the first year of medical education seems like a good beginning.

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