The objectives and goals of Postgraduate medical education in Community Medicine are to produce competent specialists to manage the teaching departments in the Medical colleges, or to manage health services and national health programmes at various levels or to conduct biomedical research in the discipline of community medicine. It is expected that the specialist so trained will be able to manage effectively the health services at Primary Secondary and tertiary level of care and function as effective leader of health teams engaged in health care, research and training. Much will depend upon the nature and content of training imparted to them during postgraduate period as also on the trainers or teachers. Right now the Medical Council of India which is the regulatory body on medical education, provides broad guidelines on postgraduate medical education regulations (2000) and purposely omits detailed curriculum. As per MCI 2000 regulations the major components of Postgraduate Curriculum Constitutes:

1. Theoretical knowledge
2. Practical and clinical skills (Managerial skills)
3. Thesis skills
4. Attitudes including communication skills
5. Training on research methodology.

The major focus of MCI regulations is on staffing pattern, their qualification and facilities and recognition of institutions for P.G. Courses rather than regulating a standard curriculum.¹

The knowledge and skills gained in the field of social sciences, epidemiology, biostatistics and managerial sciences, ultimately should result into capabilities of becoming a good communicator, a young teacher, planner, researcher with analytical skills, a manager, a leader of health teams and above all mobilizes of resources with mindset of thinking epidemiologically and acting socially in varied situations. The emphasis should shift from "teaching to learning". In order to facilitate learning the trainer should have a plan of what needs to be achieved at the end (learning objectives), what content areas need to be selected for this purpose, what method of training is most appropriate and how to judge whether the learning objectives are attained or not (evaluation).

In the first instance, there is no well defined curriculum worked out, if at all it is there, the methods of acquiring the desired competencies are vague or not at all stated. Therefore, the challenge is to work out a written protocol stating the competencies to be acquired and methods to be adopted to acquire such competencies within a time frame. Only a few institutions in the country have adopted a detailed curriculum of PG studies in Community Medicine in the country. I could lay my hands on curriculum of premier institutes of PGI Chandigarh, AIIMS New Delhi, DNB courses, PGDMCH IGNOU and
NIHFW, respectively. Of late, Universities of Health Sciences have come into existence and hopefully these universities will come out with a detailed uniform curriculum at the national level to be pursued and followed at various levels.

The current situation is that these universities are primarily occupied with conduct of examinations, appointment of examiners for thesis and final university examination apart from awarding degrees. At places Health Sciences Universities have appointed curriculum consultants too, probably to evolve need based, relevant and appropriate curriculum for various disciplines including the discipline of Community Medicine. But so far these curricula have not come out of the shelves.

Prescribing curriculum, its contents and programme of teaching and training is no problem and it appears to be fine on paper and write up but its implementation leaves much to be desired. Since MCI also emphasized "self directed" learning during the whole course of PG study, the PGs are left to themselves in most situations to learn and acquire need based competencies and skills and knowledge and most of which is based on peer's experience and work culture specific to the situation of that place MCI has left it to each discipline and department to evolve a competency and need based well defined curriculum, made available to trainees at the beginning of the programme to enable them to acquire desirable competencies.

**Training Variation - Training Scenario:**

The status of PG training in India as imparted by various institutions/universities varies from institution to institution and from state to state, depending upon the strength of faculty positions as also facilities. The course contents, methods of training and experiences gained through postings and methods of evaluation, nomenclature of theory papers and final evaluation varies from university to university. A vast majority of PG education tends to occur in tertiary care hospitals, where super specialists and unusual diseases is the focus of academic attention, whereas M.C.I. regulations explicitly focus on community needs based education. Students are placed in the community to learn social sciences, basic tools of community diagnosis, epidemiology and biostatistics as well as concern for management, community mobilization/organization and participation apart from logistics, supplies and finance mobilization for primary health care.

One of the basic premises of Community Medicine teaching and training is that most of it should occur in the community and of necessity it should be community based and Community biased. Field practice areas in most situations have not been developed and consequently nor its laboratories and accordingly the mindset of PGs develops in that orientation and environments. Since the training contents, methodologies and exposure varies from place to place the competency and skills acquired also vary from product to product. There is no agreed upon principle of minimum or essential skills to be acquired by the PGs in the course of three years training. MD Degree in Community Medicine attracts graduates who have been denied the opportunities or are placed on low merits in entrance test, with some notable exceptions. Therefore it is a challenge for the teachers of Community Medicine or department to train such candidates.
One institution cannot do all the justice for producing a right kind of product. One has to draw other relevant resources of the institute in the first instance or have to develop linkage with the district/state health authorities to create learning situations for PGs. Sometimes one has to develop linkages with other departments in the neighbouring states or national institutes.

Teachers and faculty in Community Medicine must keep their eyes and ear open to know the strengths and weakness of various Public Health Institutions and Medical Colleges in the country. It must be acknowledged that no one institute or Medical College can offer varied learning experiences, so essential to assimilate for training of postgraduate students and to develop faculty and respective department of community health. Networking of teaching, training programmes, research endeavours and facilities available can provide an opportunity to enhance the training programmes.

Recently results of survey of 103 medical institutions as also our observation of 57 medical colleges showed that activities of public health departments/ institutions in India varied substantially. A few of institutions conducted a number of courses including distance education programmes, did publish a lot of research papers, besides organizing national and international conferences and trained many professionals in public health. However distressingly, around 50% of institutions were not very active in terms of above activities.

PGs from the department of Community Medicine of various institutions in Delhi were quite often seconded to Medical College, Rohtak, for extended period of two weeks, in field practice areas to acquire competence in national health programmes in rural settings as also to develop community contact with PRI's. Quite often the PG's from LHMC, AIIMS, NICD, NIHFW were seconded to field practice areas of Medical College, Rohtak to acquire specific competency related to National Health Programmes. Similarly, trainees of NIPCCD, IGNOU and Regional training centres of NIPCCD, were posted to Medical College, Rohtak field practice area to learn aspects of Integrated Child Development Services in rural areas. Similarly, DGHS of India used M.C. Rohtak as a launching pad for developing preventative initiative against common disabilities (Impact India). faculty and students of national institutes of Delhi derived is such exposure and enriched their training programme. Both Faculty and students of Medical College Patiala, Central Bureau of Health education, Delhi and AIIMS and R.P. Centre of AIIMS had first hand experience of mobile teaching cum service hospitals camps; thus opportunity of C.R. Dass mobile hospital camp was used by neighbouring states quite often.

Postgraduate training in Community Medicine should be far more oriented towards the Community with residents working in direct supervision and in collaboration with one or more interns in the rural areas. He should take responsibility for community in PHC system; this would add on to the credentials of the PG.

Most of the thesis subjects chosen are community based, usually epidemiologic in nature and generally relevant and appropriate to the needs of the community but not necessarily high priority areas. Subjects chosen and studies pursued are focused primarily on the
extent and nature of problem, which are too well known by now. Distressingly management areas are altogether left out or seldom attempted. Thesis subjects pursued may not be the local or state level priority and this fits into the convenience of students or teachers. In most situations thesis is the only research work pursued by the departments. Much more needs to be done in this direction as lot of time goes in this pivotal activity (about one year or more). Teachers have to accept this challenge. Ultimately the thesis should lead on the development of competency and skills in research methodology (sampling, epidemiological design, sources of data, interview techniques, primary and secondary data, management of, data, presentation of data report writing and search for references etc).

The struggle starts the day the PG enters the Department of Community Medicine with high hope or some hope and he starts dreaming and most of their) dream to end up with International agencies, nothing bad about it, but what next? After selection to PG Course, a PG struggles to find out the subject of thesis protocol as he has to submit his plan of thesis within one year of beginning of course. Much depends upon the teachers and guides. PGs themselves are at a loss to find out the appropriate subject) topic; therefore teachers have to select a subject for thesis. Teachers with insufficient experience and maturity, of eight years can seldom find an appropriate subject hence the senior teachers must support and take the lead. The subject of thesis should be based on the teachers experience in that area or preliminary work done in that area in the field or at institution. Accepting PG for MD degree is a big responsibility and it must be discharged with utmost commitment and teachers must work hard to accomplish the task. The only research contribution of a teacher happens to be one or two odd papers out of PGs thesis, which leads to self deception and stagnation. Teachers should continuously pursue one or the other research project in the field. Further the subject should be innovative and relevant to needs of community and high priority at state or national level. PG starts searching and gets trapped to internee and gets aliens' references or all foreign references and misses the work done in India altogether and produces an alien protocol not relevant to our situation. Thesis in its final form either becomes a decorative document of library shelf or student's precious possession, it is seldom shared with district, state or other health institution authorities. In essence the results are never fed back to the programme or shared with community whose lives it affects most critically.

Find evaluation of the PG student is in fact an evaluation of teaching and training faculty of that department as also the learning opportunities provided or marshalled by that institute. It is a great event of mutual learning besides faculty development and feed back.

**Examination system:** System of final evaluation of PGs varies from institution to institution. System of continuous evaluation of student by the department/institution faculty is something of an exception than a rule. Log books in most situations are not maintained by the Postgraduates. In most situations the students are given an episodic family exercise and short cases in the community or in the hospital. Focus of these exercises in most situations are missing or absent, altogether these exercises become an endless process and free for everything and whatever comes to the mind of students.
It is almost a ritual to allocate exercise on statistics and Epidemiology which are highly theoretical and mathematical in nature, far away from real practical situation, and lack application by and large. In some institutions the students are given public health laboratory exercises. Students are grilled during viva voce to test their cognitive domain. Psychomotor and affective domain are seldom evaluated. The experience of over 20 years as Postgraduate examinership reveals that health management exercises, training and communication exercises are almost missing in the final evaluation. It reflects that these are probably not a part of the total curriculum. Performance of students was much better, wherever they were trained in the community and in field practice areas.

It is imperative to carry out PG training in the community to acquire competency in community diagnosis, community needs assessment, health priorities, resource mobilization, training of health teams, work load and work-schedule, evaluation of health programmes etc. Building epidemiological and managerial exercises based on the community based teaching seems to be more rewarding than purely theoretical exercises. Faculty and teachers themselves should take lead in these endeavours to become better guides for students and better teachers of Community Medicine. Continuous follow up of family/families should have positive influence on learning of epidemiologic methods, cohort studies, experimental epidemiology besides descriptive epidemiology.

**Learning skills of epidemiology:** PGs should always think 'epidemiologically and act socially' in varied situations. There cannot be universal application of a method for learning of basic minimum skills of epidemiology, of necessity these need to be diversified in view of local situation. These skills need to be practiced repeatedly to develop perfection. Skills must be practiced in "live situation" of health care delivery system and Integrated Child Development Services, in urban and rural settings respectively. Onus of developing these situations conducive for learning of skills of epidemiology lies with the teachers of PG." It should be accepted that the real epidemiologists are those who practice the science of epidemiology, in our way of thinking these are grass root workers like, anganwadi workers, traditional birth attendants and health workers and the people themselves. In essence these skills are to be acquired in the community itself. Whole of the epidemiology can be learnt in mastering one programme in the field situation and the living example is National Anti Malaria Control programme.

**Following Components of epidemiology can be learnt:**

1. Population under surveillance (At risk population),
2. Planning Surveillance operation to cover whole population.
3. Periodicity of visit-beat programme - Spot maps.
5. Monthly and Annual incidence of fever.
6. Annual Parasitic Infection/incidence rate (API)
7. Infant Parasitic rate.
8. Slide Positivity rate.
12. Mosquito density and infection rate.
13. Entomology in Malaria.
15. Organization of Programme - Laboratory services:
16. Fever outbreak investigations.

This offers extensive ground for learning of descriptive, analytical and experimental or interventional epidemiology provided the PG students assimilate the facts on the ground and in the Community. Likewise RCH programme in field settings offers an opportunity to learn several aspects of epidemiology.

Similarly Epidemiology of non-communicable diseases can best be practiced in ICDS model. Example is nutritional status of young children and prevention of malnutrition through growth monitoring of young children. This offers a unique opportunity to learn descriptive, analytical and interventional epidemiology. Cohort studies and case-control studies done by the students themselves offers a wonderful opportunity to learn epidemiology which I call a best opportunity. Class room teaching of epidemiology and computer learning of epidemiology is no substitute to live situation.

Outbreak investigation by students themselves under the guidance of a teacher is yet another opportunity to contain the epidemic and prevent future occurrence and is best example for participatory and active learning of epidemiology. Recently the PGs were involved in investigation of Dengue fever, outbreak of falciparum malaria and hepatitis to learn epidemiology of public health emergencies.

Coverage evaluation surveys should be a routine exercise given to students in urban or rural settings, to both UG and PG students during Intensified Pulse Polio immunization or as a matter for routine immunization coverage in the district. Campaigns like Family health awareness week, goiter surveys, Intensified Pulse Polio Immunization, health melas offer ready made opportunity to learn multiple things including epidemiology, these should be exploited fully.

Epidemiology of interventions like immunization, Vitamin A prophylaxis, IFA therapy and prophylaxis, deworming, therapeutic and supplementary nutrition, safe water, hand washing, school health education, communication for behaviour change for HIV and AIDS and their impact or effect or else coverage, work up by students under appropriate direction can bring in lot of learning of epidemiology.

Two months training course in epidemiology pursued by NICD Delhi, ICMR Institute of epidemiology at Chennai and DPH training at AIIH and PH Calcutta have played distinct roles to prepare field epidemiologists in the country.
**Learning Demography and Biostatistics and Health information system:** Focus should be on applied demography and biostatistics as it is being used for health programmes and service delivery. Involving students in annual surveys of eligible couples and their updating in urban or rural areas, delineating household and population, age and sex, composition of population, sex ratio, family size, total fertility rate, birth interval, age of marriage, preferences for contraceptive and contraception use rate, profile of acceptors for different methods, open and closed birth interval; segmentation of clients and according priority to clients for contraception, immunization and antenatal care could be stimulating live exercises in the field. Anganwadi set up or subcentre set up could be used to learn crude birth rate, death rate, pregnancy prevalence, contraceptive prevalence rate, as also causes of death amongst young children. Live book for biostatics and demography is an Anganwadi or sub centre in action. According to our rating these are best learning temples for biostatistics and demography. Interaction with people and community on their life styles and pattern of living conditions can further enrich these data. Sampling frame and sampling for coverage evaluation surveys can be best learnt in community setting in the form of project exercise or case studies. Elements of biostatistics can also be picked up from district rapid surveys, facility surveys. NFHS, census data and state and district statistics or statistics of field practice area for better learning of demography, statistics and epidemiology. Unfortunately we are obsessed with class room learning of biostatistics and demography and tend to be data driven than action driven. Programme workers are using their data for action and this is the crux, we have to emphasise and demonstrate how to use data and how to collect data and improve the quality and coverage of services in field situations. Different sources of data collection from the field and their use at local level and sharing of information with community and use of data and information by health managers for decision making needs to be demonstrated to PGs for learning of biostatistics and health information system.

PGs should be involved in preparation of monthly monitoring reports and participate to some extent in maintenance of records of facility and give feed back to the workers and health managers for effecting improvements in the system besides evaluating the performance of worker or a facility in the system of health care. Recently computer compatible system of health information is in vogue but it has not been adopted universally. Similarly PGs should utilize the opportunity of preparing annual morbidity or monthly morbidity return of a facility to capture the prevalent morbidities of a geographical area and use there of for indenting medicine and prevention of disease to reduce disease burden.

Learning life table method of analysis from growth charts and follow up of pregnant women and young children have undoubtedly served as best tools to learn biostatistics and epidemiology.

**Learning of Managerial and Social Sciences Skills:** Teaching and learning of management at PG level has been neglected by and large. Teachers are at loss to deal with this subject and they lack confidence and experience. In the first instance the trainers need to be prepared to enhance the learning of management. Though varieties of self
directed learning modules are available on management (NIHFW, Agha Khan Foundation, IGNOU and RCH Modules) for different categories of functionaries. There is no guarantee that after reading these modules one acquires the competency or skills of management. Best way to learn skills of management is to practice basic elements of management by doing things themselves in live situations of health care delivery system. Admittedly learning whole of management and appropriate skills may be beyond the reach of many but certain major aspects can be learnt.18-20

We have used the live situations wherein PG becomes part of health care delivery system at the level of Primary Health Centre and CHC. He/she participates in planning of outreach sessions on immunization, beneficiaries sub-centre wise, carries supplies to sub centres, monitors session on immunization, injection safety and prepares reports, ensures follow up of immunized for adverse reactions. Besides this, they participate in social mobilization and maintenance of cold chain system apart from surveillance of diseases (AFP).

**Community needs assessment approach:** Under RCH, though a paper tiger, has been used as tool - for PGs to learn community diagnosis and "action plan", at the level of sub centre. It is mandatory in our settings for a PG to take responsibility of a sub-centre for two months to pick up the skills by observing job-responsibilities and jobs performed by health workers, preparation of supervisory check list, monitor the performance through monthly reports, participate in continuing education of workers through sector meetings, use of essential drugs in kit A and B, work load and work schedule of health workers, built in mechanism of supervision, community contact and home visits of workers. Once a month, PGs contact the PRI in a predetermined village on fixed dates to get feedback and consultation with elected leaders and to generate additional resources for health sub centre. PGs help organizing women groups (MSS groups), once a month contact with women groups to build their capacities and give them health responsibilities in their neighbourhood (DD., Depots for IFA. contraceptives and chlorine tablets).

Since PGs are part of health care delivery system they are part of all monthly meetings held at PHC and CHC to learn the problems faced by workers, managers' responsibilities to solve these problems, supportive supervision, planning with consultation of workers, giving feed back to workers and supervisors and their continuing education as also reviewing their performance. Cash book inventories, total budget on salaries, drugs and other contingencies, indent preparation, stock register of medicines for drug inventories and log book maintenance for vehicle are repetitive exercise done by PGs for presentation to medical interns. Total internship training programme is managed by PG and senior resident in the setting of PHC/CHC. In essence PGs learn about the available manpower, their control and supervision, material resources, planning and organization of services for coverage of total population as also their monitoring and evaluation. It is total participatory learning.

PGs become part of UG training and take responsibilities of training of small batches in family studies, organize demonstrations and prepare settings for training under the supervision and guidance of teacher to impact skill based training to UGs in the
Community. Similarly PGs become part of resident Internship training programme in the community setting and follow a well defined competency based curriculum drawn by them for 3 months under the preceptorship of faculty member. Since the PGs are resident with interns and faculty members in the community setting at PHC, the learning is maximum in the areas of community interactions and contacts, health care delivery system and national problems besides continuing education programme of functionaries. Learning methods and educational technologies are practiced in the community with Mahila Swasthya Sangh meetings, school population education programme, PRI, traditional birth attendants, Anganwadi workers, health workers and their supervisor, school teachers and other women groups. In our experience through internship and UG training programme the PGs training has been taken to community settings and it has positive impact on development of right kind of attitudes and value system and leaves an indelible impression on the minds of PGs. Most often the internship training programme is drawn and dovetailed deliberately with the activities of CHC/PHC during a particular month. Having vibrant internship and UGs training programme means creating lot many opportunities and situations for PGs training on sustainable basis. In a way it can be most creative and satisfying experience.

The residents in our situation take the responsibility for a defined community, for the training in management of health team, and perform an important teaching function as well as become role models, giving positive influence to the internship experience. All residents are involved intensively in the management process of primary health care system.

Interaction and involvement of District Programme Officers (Health Services) and District Civil Surgeon/CMO in teaching and training programme provides enrichment of learning of community medicine and enhances the development of faculty of Community Medicine apart from building most relevant PGs' training to learn managerial aspect of health care delivery and national health programmes. The situation of district training teams and regional training centre developed all over the country for integrated skill training under RCH Phase I and basic training/promotional training for workers and supervisors and specialized skill training, can be effectively utilized for PG's training. Exposure to such situations can be most productive for learning of all aspects of RCH (Maternal and Child Health as also national health programmes). Faculty of medical colleges must utilize this opportunity by building good relationship with local CMO/Civil Surgeon and mutual understanding.

In the first phase, the Professor and HOD of Community Medicine should attend all monthly meetings of Civil Surgeon and help district teams as resource person, and expose all PGs to this stream to learn managerial skills. Such an exposure provides an opportunity to learn the most pressing local health problem, which can be chosen as an area of thesis for PGs or could be taken up as a research project for the department. Faculty of Community Medicine could become part of rapid evaluation team undertaking district programme evaluation. The results of evaluation and thesis subjects should be fed back to the system for effecting improvements in the system.
Responsibility of geographical area in urban slums set up or rural field practice area should rest with the department of Community Medicine for delivery of services of national health programme as also rendering reports to Civil Surgeon or Municipal Corporation on standard format. This step further establishes linkage with health service system and promotes learning in real situations and can lead on to development of field epidemiological unit.\textsuperscript{21-26}

**Developing Positive Attitudes-Motivation-Communication Skills:** Motivation and development of positive attitudes comes through role models and it cannot be enthused through sermons. Teachers. Senior residents and Medical officers should become good role models and set high standard for themselves, which is observed by PGs and interns and health teams. Senior residents, PGs and interns are resident in field practice area, in our set up and it gives a positive influence to learning as they lead a corporate life. We all are continuously being judged by people, our health teams, interns and PGs who subsequently talk about us and describe our profile and transmit all these to their fellow colleagues. Teachers leave an indelible impression on the minds of taught. Therefore motivation and developing right attitudes is a challenge to the teacher community, how much they transmit and propagate depends largely on them. Shaping personality of interns and PGs depends on teachers and teachers of Community Medicine have a special role in the institution.

Sustained interaction with community and health workers are the basis of ascertaining their communication needs. Communication needs assessment is seldom undertaken. One needs to organize women groups, PRI groups and communicate with them on regular basis to build mutual trust and platform for communication. Communication material which comes in abundance to PHC has to be used judiciously to communicate the message to targeted groups like MSS, PRI, pregnant and lactating women and adolescent girls and boys in and out of schools. PGs have access to all these materials and should develop the abilities to organize groups along with area health workers and supervisors.\textsuperscript{21.26} Evaluation of communication material and message is a virgin area altogether, PGs could use this opportunity to learn the technique of evaluation of health education efforts.

Our experience of involving PGs for interpersonal communication skills development has paid rich dividends. Anganwadi workers have proved to be best communicators, their communication skills have been imbibed by the PGs and health workers in the area of safe pregnancy, safe delivery, promotion of breast feeding, feeding of young children, immunization, management of illnesses, contraception and promotion of personal hygiene practices. Communication skills and counselling skills are vital to change behaviour to reduce morbidity and mortality in women and children.

**Learning Teaching and Training Skills:** While it is essential for teachers in general education to undergo formal training in education, no such Scenario of Postgraduate Medical Education preparatory facilities are available in training in health. Very often teachers acquire skills by chance than choice.
Teacher is a role model for the student community. Teachers training or training of trainers is critical input to develop right kind of trainers/teachers. Medical education cell is a partial answer to the problem. Transmission and propagation of teaching skills to PGs is a pivotal responsibility of the teacher. IAPSM should take the onerous responsibility to train its members as good teachers.

Most teaching and training skills are acquired by imitation of teachers within the department. At the best these skills are acquired by taking responsibility to conduct some tutorials or demonstration for undergraduates. It has been observed that delegation of batches of UGs to PGs is done without briefing or guidance or without preparing the situation for training and consequently the PGs soon become frustrated. In other words PGs are being just told to take a batch or tutorial. How to conduct a group discussion, organization of demonstration, preparation of lesson plan, educational technologies, teaching methods, use of teaching-training aids and evaluation of lesson plan is seldom taught seriously to PGs. Best way to impart training of teaching skills to PGs is to let them attend the UG class when a senior faculty member teaches such a class, as a model of teaching training. Such a step will compel a teacher to come prepared thoroughly. Microteaching is yet another technique which could be exploited in peer groups or small batches to develop teaching and learning skills under the guidance of a supervisor.

Wherever the postgraduate works in direct supervision and collaboration with medical interns and takes responsibility for internship training programme the pride of teaching and training develops to its full potential and provides the postgraduate the valuable experience to become part of his professional credentials when he becomes a teacher for the undergraduate students. Gradually involving PGs in teaching, training programmes of multipurpose health workers, integrated skill training programmes, Anganwadi workers and traditional birth attendants, team's training and continuing education activities of health teams at the level of PHC/CHC has paid rich dividends. Teaching and training of grass root functionaries (AWW and TBA and Health guides, women groups) is a bigger challenge than training of undergraduates. Training needs assessment, communication needs assessment and managerial training needs assessment can become core content of developing appropriate activities for skill development and important exercise or stimulus for further action. It may be stated that training responsibility is a neglected area and is left to an individual PG to develop himself/herself by trials and errors and just being told. Active thinking techniques are seldom deployed. Medical education cell/department established in the institutions to fulfill obligatory requirement of MCI is a step in the right direction but these have to work very hard to upgrade the teaching and training technologies and skills of faculty.

**Learning skills of research methodology:** The PGs should develop an analytical and critical mind. One way and most common method to inculcate this skill is "thesis" for PGs which is must under MCI Regulations. Apart from thesis, the other methods to develop enquiring mind are teaching and training of undergraduates, Project work, rapid evaluation of health programmes, planning and evaluation of programmes as enunciated under acquisition of managerial skills and epidemiological skills. Departmental research projects also can stimulate learning research methodologies. Peer group learning from
each other through their respective thesis topics and research methodologies adopted. Operational research and action research activities in the delivery of national health programmes imbibes lot of skills of Health System Research in the areas of improving coverage and quality of services. One neglected area of research is cost containment and cost benefit of intervention or the field of health economics, which is the need of the system. Health system research courses organized by the NIHFW provides useful opportunity to develop research capabilities of young faculty. Community itself provides lot of opportunities for learning of research methodologies.

What I have deliberated/said about PG training scenario in the country is not a road map for all the problems, it is indicative of strengths and weaknesses of various models of PGs training in a vast country like India where diversity prevails, available manpower and facilities are bare minimum with enormous challenges. It is suggested that networking of various models of training, case studies, research endeavours, field practice areas and their facilities, special skills available for learning of epidemiology and biostatistics in the country be done and disseminated widely to enable faculty and teachers of community medicine to facilitate training and teaching of PGs. This is essential in view of the NHP 2002 which envisages progressive increase in the PG seats in the disciplines of "Public Health" and "Family Medicine" to reach the stage of 25% of total seats for these disciplines. Training desist to rely totally on computer based community medicine learning for PG's. Modern technologies should be used but should not substitute community model or live situation. Teachers training in core content of community medicine through training of trainers exercises helped by IAPSM or donor agencies are to be encouraged. IAPSM holds pivotal responsibility in this area and it has demonstrated by organizing successful RCH orientation activities for teachers of 57 medical colleges in the country about two years back. The same endeavour should continue with progressive involvement of IAPSM.

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