

Original Article



Evaluation of District Residency Program Among Postgraduates of Hyderabad -A Mixed-Method Study

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Abstract

Background: Evaluation of the District residency program highlights the strengths of the program, which can be reinforced and promoted. It identifies weaknesses or gaps in the program, allowing for targeted improvements to enhance the training experience.

Methods: A mixed method of study was conducted among 88 postgraduates who had completed the DRP and were willing to participate. This approach consisted of a quantitative study method about satisfaction with DRP training, satisfaction with basic amenities rated on a Likert scale, specialty-focused skill training, safety and well-being at the DRP site, and a qualitative method through In-depth interviews covering all three phase-wise subjects.

Results: On quantitative data analysed, we found an 86(97%) response rate, with 36% strongly agreeing that the learning objectives fulfilled, 37% with quality of training, 27% support from parent department, only 22% has an access to safe and decent accommodation, and only 37% satisfied with safety and wellbeing. On qualitative analysis, they found limited skill development, poor infrastructure, lack of basic amenities, safety concerns, and no alignment with the objectives of the program, but found two positive aspects, such as cross-departmental collaboration, teaching, clinical exposure, and research opportunities enhancement.

Conclusion: Less than half of them felt that the objectives were not met. Post-graduates of Phase 3 were benefitted with adding a new dimension to their clinical practice; Phase 1 and 2 have not gained any domains of learning, and concerns about safety issues were raised. However, despite the challenges they faced, students have provided good recommendations for improvement.

Introduction

The District Residency Programme (DRP), mandated by the National Medical Commission (NMC) in the year 2020 in India, requires postgraduate medical students to undertake a three-month rotation in district hospitals.¹ This initiative aims to address the gaps in the health care system and medical education, particularly in rural areas, so that it helps to enhance their understanding of community health needs and service delivery at the grassroots level. Due to the COVID-19 pandemic, this became operational for the first batch in 2021, with a notice issued by the NMC in December 2022 stating that it should be completed before the university exam.²

Strengths, Weaknesses, Opportunities, and Challenges (SWOC) Analysis reports illustrate the strengths of this program, which include enhanced patient exposure for residents, training in diverse healthcare settings close to the community, implementation and monitoring of National Health programs, addressing the human resource shortage at district hospitals, working in resource-limited environments fostering innovative

solutions to community problems, and bridging the gap of specialists in the country. Weaknesses include inadequate orientation of residents to their roles, replacing medical officers' responsibilities at district hospitals, and insufficient equipment and resources at district hospitals, which may not support optimal patient care; there is also the perception of DRP as leisure postings, requiring strict supervision. Opportunities include detailed clinical examinations, which may be helpful in their practical examinations, raising patient awareness about various government schemes, participating actively in research activities, and involvement in community health outreach activities. Challenges may be related to food, transportation, and accommodation; lack of specialists with qualified degrees may make academic learning a bit difficult; missing medical college rotations may lead to losing crucial rare case exposure; there is a lack of subject-oriented training for specialties like radiotherapy and oncology, etc.; and there is a risk of unethical practices.³ Evaluation of this program helps to ensure that it meets established educational and clinical standards, providing

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residents with high-quality training. Curriculum relevance helps to update residents with the latest medical knowledge and practices, ensuring they provide safe and effective patient care, leading to better patient outcomes in the district's healthcare facilities. The short-term goal highlights the strengths of the program, which can be reinforced and promoted, and identifies weaknesses or gaps in the program, allowing for targeted improvements to enhance the training experience. A structured schedule for residents to give feedback on their training experiences can be used to make meaningful changes to improve the quality of patient care, thereby achieving the intermediate goal. The long-term goal is to assess the effectiveness of faculty in teaching and mentoring, leading to professional development opportunities for medical educators through strategic planning and resource management.

Very few states, like Rajasthan, Gujarat, and Maharashtra, have published their findings on early implementation of DRP, with issues being raised as related to their poor satisfaction with infrastructure, basic amenities, and their safety and well-being. There were also positive impact findings with good clinical exposure and research.⁴⁻⁶ There is a dearth of data related to this in Telangana; there is a necessity for comprehensive evaluations of the DRP in Telangana to ensure that the program effectively meets its educational objectives while safeguarding the well-being of its residents. This study aims not only to identify whether the objectives of the DRP are met but also to provide evidence that could directly influence the prioritization and sequencing of educational interventions for residents. Specifically, by determining which foundational skill set - cognitive (such as clinical knowledge and reasoning) or metacognitive (such as self-regulated learning and executive functions) - yields greater educational and clinical returns, this research can guide more effective training strategies. Such findings have the practical potential to optimize resource allocation and curriculum design to maximize resident development and patient care outcomes. Therefore, a comprehensive evaluation of the DRP in Telangana is essential to ensure the program effectively meets its educational goals while safeguarding the well-being of its residents. This study was undertaken with the primary objective of identifying the strengths and weaknesses of the DRP using a mixed-method research approach.

Material and Methods

Study design: Mixed-method study (Quantitative and Qualitative)

A convergent parallel mixed-methods design was utilized with concurrent data collection and integration at the interpretation stage via joint displays. Qualitative findings were utilized to explain quantitative satisfaction ratings through a joint display showing convergence, expansion, or divergence between numerical results and participant experiences.

Study setting: District Hospital, Vanaparathi, Telangana, and ESIC Medical College and Hospital.

Study period: 2 months

Sample size: All postgraduate residents from the 2021 batch (34 residents) and the 2022 batch (54 residents), totalling 88 participants, at District Hospital Vanaparathi were included, constituting a census sampling approach. This comprehensive inclusion ensured coverage of the entire target population, allowing for an inclusive and detailed assessment of the DRP experience across cohorts.

Inclusion Criteria

Those who were willing to participate and who had completed DRP were included.

Exclusion Criteria

Not willing to participate, and those who have not completed the DRP

Ethical clearance was obtained from our institution with IEC NO.F655/09-2024, and the questionnaire was framed on expert advice and pilot tested on 2 students. Participants were briefed on the results following completion of the study.

A predesigned pretested questionnaire was developed by the faculty of the medical education unit of ESIC Medical College and Hospital using guidelines of DRP under Post-Graduate Medical Education Regulations 2023, available reports, and feedback from a pilot survey.² While content validity was established through expert faculty review during development, and pilot testing confirmed clarity and relevance, formal psychometric validation was not performed. Qualitative methodology adhered to the Consolidated criteria for Reporting Qualitative research (COREQ) checklist. Data saturation was assessed by identifying no new themes or codes emerging across consecutive transcripts after the 7th interview, with sampling concluding at n=10. Two researchers independently coded transcripts, and discrepancies were resolved through discussion to a consensus.

The questionnaire was divided into the following sections: baseline demographic information; satisfaction with DRP training; satisfaction with basic amenities during DRP; specialty-focused skill training during DRP; and safety and well-being at the DRP site. These sections were derived from the objectives and guidelines of DRP under Post-Graduate Medical Education Regulations 2023.³ Questions were scored on a five-point Likert scale on an order ranging between Strongly Disagree (1) to Strongly Agree (5) or Never (1) to Always (5) for positive items and reverse order for negative items (three questions). Higher scores indicated a more favorable experience of DRP. Challenges and experiences were evaluated by a qualitative method using in-depth interviews from various postgraduate residents, with two from Phase 1, two from Phase 2, and six from Phase 3. To enhance

the rigor of the study, the questionnaire was validated through expert review and pilot testing to assess clarity and relevance. Additionally, methodological rigor was strengthened by triangulating quantitative survey data with qualitative insights from in-depth interviews across multiple postgraduate phases, ensuring a comprehensive and robust evaluation of the DRP.

Statistical analysis

Data were entered in Microsoft Excel 2019 and analysed. Descriptive statistics such as counts and percentages are provided. And for qualitative data obtained from In-depth interviews, were coded as categories, themes, and verbatim. A summative approach to qualitative content analysis was undertaken by two trained faculty members of community medicine to identify the themes from the text data and infer meaning to the given context.

Results

Out of the total 88, only 86 responded, and after excluding pilot survey students, the results were quoted for 84 only. Among the postgraduate residents, 46 (54.7%) were females, and 38(45.3%) were males. The mean age of our residents was 28.67 ± 2.79 years. In-depth interviews were conducted among Phase 1 which is preclinical (2), Phase 2, which is paraclinical (2), and Phase 3, which is clinical (6) students. The distribution of the students in numbers according to the departments was- Biochemistry(1), Anatomy (1), Physiology(1) from phase 1 (Preclinical); Microbiology(3), Pathology(1), Pharmacology (3) from phase 2(paraclinical); Community Medicine (5), ENT(5), Ophthalmology(8), Obstetrics & Gynecology (2), Pediatrics(3), Orthopedics(7), General medicine(13), General Surgery(9), Psychiatry (3), Dermatology(10), Pulmonology(4) and Anesthesiology(5)from phase 3(clinical).

To identify the students' satisfaction with the learning objectives of the program, a 5-point Likert scale was employed, and the Clinical phase demonstrated the strongest satisfaction (39-59% "Strongly agree" across categories). Paraclinical phase reveals notable neutral responses (43-71%), suggesting room for improvement in motivation, supervision, monitoring, and learning objectives as detailed in [Table 1](#).

On satisfaction with academic learning in the context of the parent department, the Clinical phase showed the highest satisfaction (42-54% "Strongly agree"). Paraclinical trainees report heavy neutral responses (43-57%), particularly for training quality, department support, and faculty guidance, indicating mixed experiences. ([Table 2](#))

On satisfaction with basic amenities presented in [Figure 1](#), the Clinical phase demonstrated the strongest satisfaction (22-61% "Strongly agree" across categories). Paraclinical phase reveals notable neutral responses (57-71%), suggesting improvement in providing safe and decent accommodation.

About 67% of the preclinical phase always felt concerned about safety and well-being, paraclinical had neutral responses towards safety and well-being, and the clinical phase were experiencing stress at work place, as always, among 31% and 39% always felt concerned about safety and wellbeing as detailed in [Figure 2](#).

Focussing on the cognitive domain, only 2(1%) had strongly agreed that they had discussions of the concerned speciality along with access to reading material. In relation to any type of assignments, it was only 10(9%) had been provided with an opportunity by the faculty. With the psychomotor domain, only 22(24%) had been posted at the concerned speciality unit, and 5(6%) learnt specialization skills with good clinical exposure. Whereas with affective domain 13(14%) noted a change in the attitude of patients with their skills being implemented, and 7(8%) also received guidance from the faculty on communication skills.

On qualitative analysis, the current study explores the experiences of postgraduate residents in DRP. Data were collected through in-depth interviews with 10 residents covering all phases. A thematic analysis approach was applied to identify the insights. Based on the objectives, we got 6 categories representing the mismatch between expectations and experiences, learning opportunities, challenges, professional growth, positive aspects, and negative aspects of the program. We had identified the key themes emerging from participants' responses with direct quotes illustrated in [Table 3](#) in detail.

[Table 4](#) presents a joint display linking satisfaction ratings to qualitative themes. While 54% rated training quality positively, themes of "no clinical exposure" reveal that this reflects theoretical exposure rather than skill development. Similarly, 42% supervision satisfaction diverges from reports of "no guidance," indicating superficial oversight. Infrastructure limitations explain moderate fulfillment of learning objectives (36%) and academic participation (38%).

Discussion

DRP mandates postgraduate medical students to undergo training in district hospitals to enhance their clinical skills and understanding of community health needs and healthcare delivery in varied settings. Evaluating the implementation of the DRP at our institute revealed mixed results and critical insights.

Current studies have found that less than half of the postgraduate residents felt that their learning objectives had been met with low-quality subject-specific training without any connection with the parent department, and poor access to hygienic food, water, and accommodation. There were concerns raised about travel, safety, and well-being by the majority. There was a mismatch between their expectations and learning experiences, but still, there were chances of good cross-collaboration between different departments and good chances of acquiring

Table 1. Distribution of Post-graduates to identify whether the learning objectives were met or not, along with satisfaction towards DRP

Phase	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Felt motivated						
Preclinical	0 (0%)	1 (33%)	0 (0%)	1 (33%)	1 (34%)	3
Paraclinical	0 (0%)	3 (43%)	3 (43%)	1 (14%)	0 (0%)	7
Clinical	0 (0%)	20 (27%)	16 (22%)	7 (9%)	31 (42%)	74
Received adequate supportive supervision						
Preclinical	0 (0%)	0 (0%)	1 (33%)	1 (33%)	1 (34%)	3
Paraclinical	0 (0%)	0 (0%)	5 (71%)	2 (29%)	0 (0%)	7
Clinical	0 (0%)	24 (32%)	9 (12%)	8 (11%)	33 (45%)	74
Monitoring the training using logbooks/portfolios/assessments						
Preclinical	0 (0%)	1 (33%)	0 (0%)	1 (33%)	1 (34%)	3
Paraclinical	0 (0%)	0 (0%)	5 (71%)	2 (29%)	0 (0%)	7
Clinical	0 (0%)	22 (30%)	18 (25%)	7 (9%)	27 (36%)	74
Learning objectives fulfilled						
Preclinical	0 (0%)	1 (33%)	1 (33%)	0 (0%)	1 (34%)	3
Paraclinical	0 (0%)	1 (14%)	5 (72%)	1 (14%)	0 (0%)	7
Clinical	0 (0%)	24 (32%)	12 (16%)	9 (13%)	29 (39%)	74
Quality of training						
Preclinical	0 (0%)	1 (33%)	1 (33%)	0 (0%)	1 (34%)	3
Paraclinical	0 (0%)	2 (29%)	4 (57%)	1 (14%)	0 (0%)	7
Clinical	0 (0%)	18 (25%)	9 (12%)	3 (4%)	44 (59%)	74

Table 2. Distribution of post-graduates in relation to satisfaction with academic learning in context to the parent department

Phase	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
The quality of postgraduate training suffered.						
Preclinical	0 (0%)	0 (0%)	0 (0%)	2 (67%)	1 (33%)	3
Paraclinical	0 (0%)	1 (14%)	4 (57%)	1 (14%)	1 (14%)	7
Clinical	0 (0%)	16 (29%)	21 (38%)	8 (15%)	29 (53%)	74
Support from the parent department						
Preclinical	0 (0%)	0 (0%)	0 (0%)	2 (67%)	1 (33%)	3
Paraclinical	0 (0%)	1 (14%)	4 (57%)	2 (29%)	0 (0%)	7
Clinical	0 (0%)	16 (29%)	28 (51%)	7 (13%)	23 (42%)	74
Guidance by faculty/guide						
Preclinical	0 (0%)	0 (0%)	0 (0%)	2 (67%)	1 (33%)	3
Paraclinical	0 (0%)	1 (14%)	4 (57%)	2 (29%)	0 (0%)	7
Clinical	0 (0%)	23 (42%)	14 (25%)	14 (25%)	23 (42%)	74
Remote involvement to participate in academic activities						
Preclinical	0 (0%)	1 (33%)	0 (0%)	1 (33%)	1 (33%)	3
Paraclinical	0 (0%)	0 (0%)	3 (43%)	4 (57%)	0 (0%)	7
Clinical	0 (0%)	21 (38%)	14 (25%)	9 (16%)	30 (54%)	74

clinical and surgical skills in resource-limited settings among the clinical subjects.

Globally similar programs in postgraduate medical education have been implemented to address disparities in healthcare delivery, particularly in rural and underserved areas. In Canada, the Distributed Medical Education (DME) model has demonstrated promising results in addressing

physician shortages in rural areas, improving patient care quality, and fostering interest in long-term rural practice.⁷ However, issues like faculty shortages, resource constraints, and maintaining educational standards in district settings continue to exist.⁸ Research from Canada and Australia shows that district-based training improves residents' clinical skills, decision-making, and confidence in independent practice.⁹ Similarly, on comparative

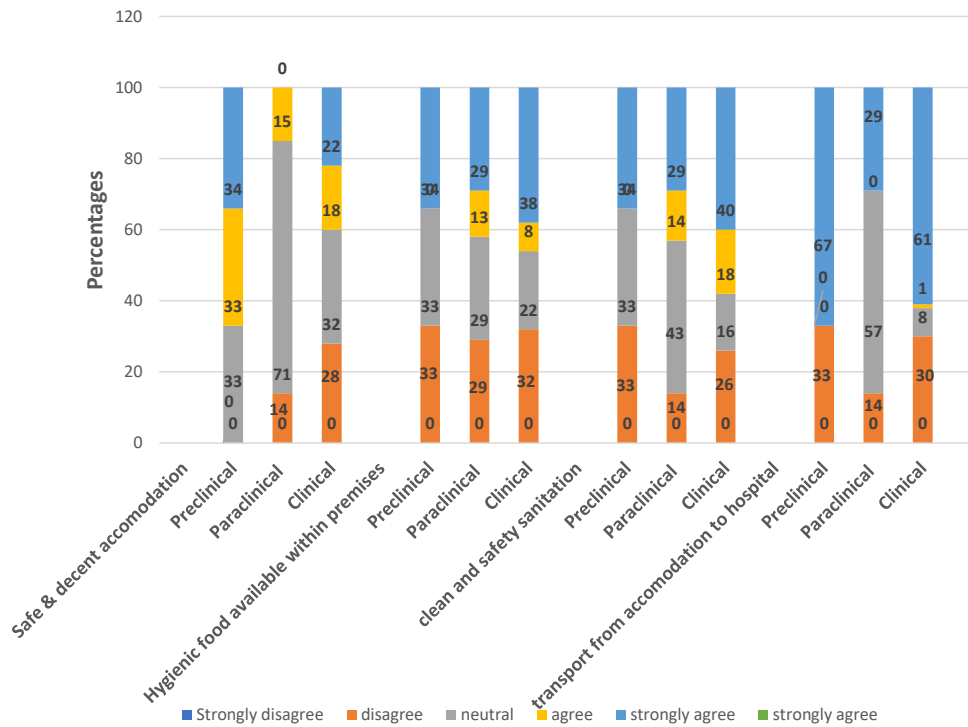


Figure 1. Phase-wise distribution of PGs with satisfaction of basic amenities

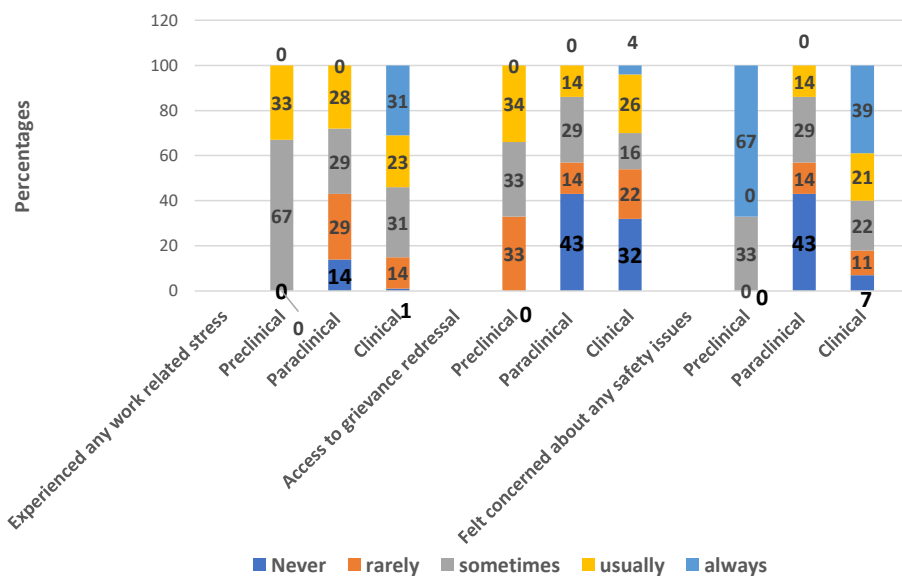


Figure 2. Phase-wise distribution of PGs with satisfaction with safety and well-being

analysis of European residency programs, they found great heterogeneity in terms of surgical competencies achieved by residents in training, with only 45.8% being satisfied or very satisfied.¹⁰

Yoon C.H., in their internal medicine residency training program at Seoul university reported that 62% of them found that the preceptor’s hands-on training in an educational setting was the advantage of implementing CBME in the residency program, and their main concerns included high work overload and lack of manpower.¹¹ Decentralized training models were recommended by

the World Health Organization as a means of bolstering primary healthcare and attaining universal health coverage¹²

In order to close the gap between secondary and tertiary healthcare levels in India, the DRP was mandated by the NMC in 2020. District hospitals are essential teaching facilities where residents handle a variety of clinical issues, frequently in environments with minimal resources. DRP has improved clinical decision-making, procedural abilities, and knowledge of national health systems, according to studies.^{13,14} Residents also have a greater

Table 3. Thematic analysis of in-depth interviews of postgraduate students on the DRP

Categories	Themes	Verbatim
1. Expectations vs. Reality	Mismatch Between Expectations and Experience	"I thought I would be more exposed; it was in a district, but again, the district was in an almost rural area, so I thought more like how district-level functioning of the health system will be there." "We were posted in the medical college... so there was no clinical exposure." "Other than reading, making like giving lectures to the UG students, there was no clinical exposure."
2. Learning Opportunities	Limited Skill Development	"Other than some lecture teaching education field, there is no specific skill that I have acquired from there." "There was no guidance given for us... faculties who were in the concerned department also did not receive that guidance." "Only a lecture was possible because only one person had to take that; there were no other methods."
3. Challenges	Structural and Administrative Deficiencies	"Infrastructure, hostel facility was not good... no security also for the hostel facility." "We were asked to take classes in other subjects like biochemistry, physiology... Which we were not qualified for that." "We had to conduct exams for the first-year university practicals... I was in charge of biochemistry."
	Poor infrastructure and lack of basic amenities	"The mess was unhygienic, and rats were roaming around... There was no proper housing or transportation."
4. Professional Growth	Safety and Comfort Issues	"That building was so far away, so much inside an abandoned area, and there was construction also nearby." "They considered us as wardens since we were there."
	Soft Skills Development	"Got to see snake bite cases and OP Poisoning cases, but no medicines available, and were referred to Mahbubnagar." "It has contributed so much to dealing with students, especially first-year new batch students."
5. Positive Aspects	Missed Opportunities for Research	"My other pharma PG tried to do some research... but there was no IEC committee." "The principal was also not willing to allow us to do some data collection in that."
	Cross-Department Collaboration	"I had an opportunity to work with pharmacology people, micro people, and pathology people." "We discussed common topics and research opportunities that we could do together."
6. Negative aspects	Observation of Resource Management	"With fewer staff, they dumped clinical work on us ." No supervision received in handling medicolegal cases.

Table 4. Integration of Quantitative Satisfaction Ratings and Qualitative Themes

Quantitative Satisfaction (Agree/Strongly Agree)	% Agreement	Qualitative Theme	Integration Insight
Quality of training	54%	"No clinical exposure" "No specific skill acquired"	Expansion: Satisfaction reflects theoretical exposure, not hands-on skills
Received adequate supportive supervision	42%	"No guidance given" "No supervision received"	Divergence: Numerical rating masks absent substantive guidance
Learning objectives fulfilled	36%	"Mismatch expectations vs reality"	Complementarity: Structural barriers explain moderate fulfillment
Remote academic participation	38%	"Poor infrastructure" "Unhygienic mess"	Explanation: Logistics limited engagement despite willingness

comprehension of public health issues, such as managing infectious diseases, maternal and paediatric health, and occupational health risks.¹⁵

Similar to our study, Ankit Raj et al from their study conducted at Rajasthan in early evidence of implementation found that approximately 17% of residents felt that the DRP fulfilled its learning objectives. Over half were never posted with their respective specialty services, hindering specialty-specific skill development. Nearly 60% felt isolated from academic activities and their parent departments during the program. And 80% had safety concerns, and over 75% were dissatisfied with basic amenities like accommodation and sanitation.⁴

Ajeet Kumar Khilnani, on the feedback by postgraduate students of Gujarat on DRP, noted that 89% felt that they received subject-specific training only to some extent, with statistically significant differences among surgical speciality postgraduates compared to medical specialties. About 43% did not feel their skills had been enhanced, 38% did not feel motivated and confident after the posting. There were only half of them were satisfied with the basic amenities during the posting, and they also felt isolated from the parent institute, and 65% students felt

that the duration of DRP posting should be less than 3 months.⁵ Similarly, from the residents' corner, the survey conducted in Maharashtra also found the positive impact of involvement in national health programs, improved their efficiency in surgical/clinical skills, along with negative impacts where most had to deal with challenging accommodation, food issues, and travel issues on their own. They were designed to treat all instances without the need for laboratory testing and with government-approved medications. They felt uncomfortable when they encountered the abusive patients. Particularly for girls, the difficulties included food, sanitation, and security; some also had to deal with linguistic barriers.⁶

This variation of the global and Indian scenario could mainly be due to the difference that high-income countries usually provide better infrastructural support, faculty development programs, and structured curricula for district-based training, whereas, in contrast, India faces systemic challenges related to healthcare infrastructure, inadequate supervision, and resource allocation, impacting the quality of postgraduate training in district hospitals. Faculty availability and quality of teaching in district hospitals remain concerns, with some

residents perceiving district postings as disruptive to their academic training. Moreover, the lack of standardized evaluation metrics poses difficulties in assessing program effectiveness uniformly across different states.

The strength of our study is the mixed methodology being adopted in order to provide critical insights about the program. The results of this study will also help all the stakeholders to optimize DRP implementation so that residents can accomplish learning objectives along with safety and well-being. Furthermore, these findings can guide the design of sequenced educational interventions that prioritize foundational skill development to maximize training effectiveness.

Limitations of our study are the sample size and representation of only one medical college, and this can be modified by implementing multi centric study across various states. Additionally, the potential instructor effect, where differences in faculty teaching styles and engagement may influence resident experiences, was not controlled for and warrants further investigation. The questionnaire, developed by content experts using official guidelines and pilot-tested for clarity, lacked formal psychometric validation, representing a methodological limitation.

Conclusion

This study reveals that less than 50% of respondents felt learning objectives were met, with Phase 3 postgraduate residents benefiting through a new dimension in clinical practice, while Phases 1 and 2 residents saw no domain improvements; challenges included misalignment of program activities with subject objectives and academic isolation. Residents suggested aligning activities with their respective phase objectives, maintaining continuous virtual engagement with parent institutions to prevent isolation, and providing secure accommodations with essential amenities for safety and well-being. The authors opine that implementing these suggestions would significantly boost the DRP's ability to achieve educational goals and improve training experiences, encouraging stakeholders to tailor curricula, foster active mentorship, and allocate resources effectively across all phases.

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Competing Interests

The authors declare no conflict of interest.

Ethical Approval

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