EFFECTIVE WAY TO BOOST PERFORMANCE OF RURAL DOCTORS: A CASE STUDY

Dr. Chandralekha Sen[1], Yashpal Sen[2], Dr. Anoop Shrivastava[3]

[1]Student Dept. of MBA, KITE, Knowledge Village Naradaha, Raipur. C.G.,
[2]Faculty Dept. of ETC, KITE, Knowledge Village Naradaha, Raipur. C.G.
[3]Faculty Dept. of MBA, KITE, Knowledge Village Naradaha, Raipur. C.G.
Email: yashpal.sen@rediffmail.com, anoopoffice@rediffmail.com

ABSTRACT

The importance of addressing considerations of rural doctor welfare so as to boost their performance and retention is wide acknowledged; yet there's very little enquiry on the requirement of rural health professionals. We tend to report findings from a qualitative analysis study in rural Chhattisgarh, involving in-depth interviews with thirty five practitioners and knowledge analysis mistreatment the framework approach. Participants' expressions of their wants encompassed a spread of reforms and enhancements, as well as higher salaries and job security, additional rational posting and promotion procedures, and facility enhancements. Opportunities for need-based skills training and better housing additionally emerged as key need, as did better education, assurance of non-public security, and recognition and appreciation of their services by the administration. Improved investment in rural infrastructure and training, better packages of advantages for rural doctors, and governance reforms to boost the internal responsibility of state health services emerge as recommendations from the study.

1.Introduction

The shortage of medical examiners in rural areas may be a countries drawback, however its effects area unit significantly harsh in developing countries (1,2). In India, shortages of qualified rural health personnel severely constrain the health system's ability to deliver services to rural populations. Government estimates indicate that presently, 18% of primary health centres area unit while not a doctor, regarding 38% don't have a laboratory technician and 16% lack a health pharmacist (3). Specialist medical care doctor's area unit significantly in brief provide within the public sector, with 52% of the sanctioned posts of specialists at sub-district hospitals lying vacant (3). Physician absence in government facilities has additional combined the matter of access to quality care (4).The failures of in public provided health services have additionally resulted within the majority of rural households receiving care from suppliers with very little or no formal qualification, with damage to their health (5,6).

State governments have adopted varied ways to resolve problems with access to quality care within the villages. Lately, attention has been drawn to the importance of the welfare and desires of these serving in rural areas, to raising their expertise, and promoting larger motivation and probability of retention. a global review of approaches to health workforce retention in developing countries multifariously identifies factors such as financial reward, better resources and infrastructure, and opportunities for career development as being instrumental within the retention of medical examiners (7). Many studies have known familial and personal needs, such as secure employment for spouses, education of youngsters and safety issues, as contributively factors towards the accomplishment and retention of doctors in rural observe (8). Ebueh and Joseph Campbell (9) reported that money incentives, higher operating conditions, social support systems and opportunities for career development were all crucial motivators for rural practitioners. Butterworth et al. (10) equally drew attention to the importance of career progression and in-service skilled education opportunities, except for financial advantages. Soft factors, such as a positive and appreciative atmosphere, have additionally been observed to play a task within the effectiveness and retention of

health workers in rural areas (11). Systematic reviews on the topic have highlighted these manifold factors and therefore the advanced interaction between them, and recommend careful thought of essential native and discourse factors to develop appropriate workforce strategies (12,13).

Clearly, a better understanding of rural practitioners' requirements is a basic prerequisite to developing policies to improve the performance and effectiveness of rural health services and aid in health worker retention. Yet, the analysis during this space from India is extremely restricted and there's a big gap in knowledge. This article attempts to address the gap through an exploration of rural doctors' perspectives of their specific requirements while in rural service.

2.Methodology

This qualitative analysis study was conducted within the state of Chhattisgarh. The study had various objectives, targeted on understanding the experiences and selections of rural government doctors. It additionally explored why some doctors stay in rural service. One objective of the study is addressed in this paper is to understand the perspectives of rural doctors in government service with respect to their requirements which, if met, would improve their expertise of rural service.

A groups of two researchers conducted in-depth interviews with rural government practitioners between June and August 2017. All interviews were conducted privately in the participants' respective places of work usually clinics or government offices. It absolutely was usually a challenge to confirm the privacy of participants, since superiors and colleagues often desired to be within the separate area at the time of the interview.

Essential criteria for the choice of study participants were: recognised medical qualification, and service either in a non-remote rural area for more than five years or in a remote rural area (as defined by official government norms) for more than one year. Government records were used to identify all the doctors fulfilling the essential criteria in four districts. Participants for the primary spherical of interviews were known purposefully from the list of eligible practitioners. most variability principles were applied during this choice to confirm illustration of each ladies and men doctors, those trained in allopathic (western or modern) as well as Indian systems of ayurveda medicine and homoeopathy- collectively categorised as AYUSH, in each classes of employment (i.e. regular and written agreement), and across completely different geographical locations among the state (which wouldn't are attainable through random selection), to permit for larger thematic breadth within the responses (14).

Following thirty five interviews in four districts, preliminary listing and analysis of emerging themes unconcealed that no new themes were being generated within the latter interviews and fortification was complete considering principles of information saturation. All thirty five practitioners consented to participation before being interviewed. In-depth interviews were conducted in Hindi.

For organising information from transcripts of interviews, the framework approach of qualitative analysis for applied policy research was applied (16). Framework combines the deductive and inductive approaches of analysis, and involves developing a thematic framework consisting of a priori and emerging thematic codes, followed by application of the thematic framework to the information. The steps within the framework approach as followed by the analysis team area unit are enlisted as follows:

- Familiarisation with information
- Identifying a thematic framework, supported preset objectives, and themes rising from respondent narratives
- Indexing - by applying the thematic framework systematically to the info
- Charting rearranging the info into distilled summaries of views and experiences

- Mapping and interpretation using the charts to locate concepts, phenomena, typologies, and associations between themes.

Practitioners' views of their specific needs while in rural service were extracted from the narrative accounts and classified thematically. Initially, two researchers coded the information one by one using the thematic framework, following that their analyses were compared and revisited to enhance the dependability of interpretations of the information (17). Whereas extracting themes and coding the information, we have a tendency to maintained a stress on extracting underlying implications and meanings that respondents attribute to their experiences, instead of their overtly expressed views and rhetoric.

3.Ethical Precautions

In every case, a signed and witnessed statement of the person taking consent, indicating that s/he had explained the context, purpose, procedures and risks concerned and taken free and informed consent, was provided to the study participant, with a duplicate additionally maintained by the scientist. Information was kept in encrypted format with restricted access. Care has been taken to confirm namelessness of all people quoted during this article.

4.Results

In the study area, the state of Chhattisgarh is located within the central region of India. The state has a district of a 135,191 sq. km. and a population of 25.5 million (18). 44% of the land is forested and is home to tribes that represent one third of the population. The physical inability to confirm outreach services to forested areas, including the poor economic standing of the social group majority, have unnatural efforts to enhance health and health service indicators within the state. Chhattisgarh has associate inadequate health workforce. According to the Bulletin of Rural Health Statistics in India 2005, the doctor-to-population magnitude relation is 1:3100. Government practitioners were usually the only qualified care suppliers within the rural areas that were the setting for the study. The formal non-public care sector was mostly absent, though there have been many unqualified non-public suppliers operational in rural areas. Table1 presents profiles of the 35 participants within the study, on the basis of various characteristics.

Table 1 Profile of study participants

		Selection (n=35)
Sex	Male	30 *(86%)*
	Female	5 *(14%)*
Employment status	Regular	23 *(66%)*
	Contractual	12 *(34%)*
System of medicine	Western or modern (allopathic)	31 *(89%)*
	Indian systems and homoeopathy (AYUSH)	4 *(11%)*
Years of service	1–5	12 *(34%)*
	>5	23 *(66%)*

5.Working in adversity

The practitioners were confronted with a complex range of adverse circumstances and phenomena that influenced their professional and personal lives. Basic working conditions were compromised in several instances, and a number of other respondents rumoured having to alter shortages of water, electricity, house and supplies.

There was an epidemic of gastroenteritis here, everyone was in the same condition and we did not have space. There is no hospital building, and every one this (existing facility) is old-style, like within the monsoons it leaks. When there are several patients, we have problems as to where to keep them, so everything was filled with vomit and faeces. However we have a tendency to treated them. (Allopathic doctor, regular, 24 years in rural and remote areas, male)

Problems in travelling to poorly accessible field outposts were frequently reported. Issues with residential facilities were wide reported, with doctors being forced to require up private accommodation or sleep in poorly maintained or inadequate government facilities. many respondents incurring personal expenses to handle local healthcare needs.

There were also many accounts of doctors, nurses and support workers operating overtime, sharing duties and generally dividing their time across two or more facilities in several locations to overcome personnel shortages. Practitioners routinely experienced late payment of salaries, and inability to get promotions or transfers to different locations.

I have been operating here for sixteen years. If we have to go by government norms then once 5 years of duty in a very tribal area I should have been transferred to a different less remote place, however of these things aren't attainable. I don't want to blame the government but this is a fact that without making a lot of personal efforts, there'll be no transfer. (Allopathic doctor and specialist, written agreement, 16 years in remote areas, male)

Problems of access and communication were significantly marked in moer remote areas. Long separations from families, a typical consequence of being placed in remote and inaccessible areas, were usually a cause of distress. many doctors indicated disturbances in spousal relations and estrangements, sequent to the matter of separation.

We are living 500-600 kms away from our family and relatives. Government gives us 18 days casual leave only (in a year). If something good or bad happens in our family then… if you travel 600 km it will take three days to go and three days to come. And I will stay for at least two to three days. So out of 18 days, 10 days are gone like this. (AYUSH doctor, contractual, six years in remote area, male)

Doctors in written agreement of employment reported a definite set of issues, related to insecurities of employment and a widespread perception of their inferiority in relation to regular doctors. Issues of separation from families were reported more often by written agreement of doctors, who had less choice in selection of their locations, and restricted permissible leave of absence. Clearly, written agreement doctors were affected additional severely by issues of job insecurity and poorly confirming operating and body relationships than doctors in regular employment.

In contract service you can't think much - November will come now, then we will come to know if this service will remain or not. If there is a permanent service then a person thinks about the future also - what will one do or not do. But in a contract job - I have one daughter - you can't plan whether you will have a service or not, or will be able to afford a second child or not. You never know what the future holds. (AYUSH doctor, contractual, two-and-a-half years in remote area, male)

Expressed needs: job and compensation

Remarkably few doctors in regular employment (2/23) expressed dissatisfaction with their current salaries. Among written agreement of doctors, higher pay scales were a often expressed need, with a majority of them claiming that their compensation and therefore the terms of their contracts were unfair. A number of respondents reported how their salaries had not been match the inflation of commodities and services.

They are giving me 25,000 per month, which is nothing. When I joined here, rice was Rs 15 per kg. Now, how can you manage in 25,000? When we used to go to Raipur the fare was Rs 50, today it is Rs 350 and our salary is the same. Our economic condition has been disturbed badly - today if our children fall ill what will we do in Rs 25,000? Salary is not satisfied. (AYUSH doctor, contractual, six years in remote area, male)

Contractual doctors gave prime importance to the peace of mind of a daily job, highlighting the necessity for job security to confirm continuity in rural practice. several of them had joined their current written agreement of positions on the premise of assurance or expectation that the written agreement position would be regenerate to a daily position once a amount of your time. The uncertainties of contract employment were exaggerated within the case of AYUSH doctors, since there aren't any regular jobs earmarked for non-allopathic practitioners. Several respondents highlighted the need for more transparent and rational procedures for promotion and transfer. A number of participants expressed the need for government responsiveness to their preferences for postings, and a clear method for reviewing their preferences.

Expressed needs: skilled support and *training*

Several essential needs for a good rural practice were highlighted by participants, such as well-equipped facilities and improvements in the workplace. Deficient human resources, apart from the problems they create from a planner's perspective, ultimately have a good impact on the work lives of the providers who continue to work in underserved areas. The necessity to handle shortages in personnel by filling existing vacancies was voiced by a majority (31/35) of respondents.

It was stated wide that improving the standard and regularity of medical providers and providing better workplace infrastructure would improve operating conditions and enhance professional satisfaction.

There is shortage of materials, and it is of very bad quality. We get only one-tenth of the required materials for everything. IV fluid – whether I talk to the CMO, the collector, or give in writing – whatever fluid comes lasts only a week… Ladies come and lie down in the labour room – the rubber sheet is never changed. Fifty deliveries take place on the same sheet. For the past 20 years, I keep hearing this – there is no delivery table, no syringe, no stand or drip, no pads or cotton. If we use one suction tube for one child, we should not be using the same for all the delivered babies. If someone is dying of pain, we should not use used syringes. They give 50 gloves for the month, that too unsterilized, and one has to wash it every time and then use it. There are no blood banks. There is just one in the district which has four bottles of blood. If we don't give blood then patients die every day. At CHC level if blood is not given, then many patients will die. Do write all of this down – if something will happen by your writing it, then do write it. (Allopathic doctor and specialist, regular, 20 years in rural and remote areas, male)

When we are do caesarean delivery, most of the items we've got to rearrange (purchase) on our own. As such government is not able to supply all the things to the peripheries like the drugs and equipment there are many things that we have to order personally. (Allopathic doctor and specialist, regular, four years in geographical area, female)

Another key demand across all the respondents was for more training and skill development such as refresher courses, opportunities for specialisation and trainings in relevant areas. Others claimed particular interests and skills, (eye care, infectious diseases, surgery, obstetrics, health administration, etc.) that they wanted to develop additional by means that of training and better education. They felt that this would help to facilitate in a good rural practice.

Many a time, we are in the field and the condition is such that we feel we dont have enough skills. Especially in surgery and obstetrics, we want to treat, but we don't have the authorisation. Thus it should be sensible to get some training. From the beginning, I even have had associate interest in surgery, however though we wish to try and do it, we are unable to, so this is the only thing left. (Allopathic doctor, regular, eighteen years in rural and remote areas, male)

Expressed needs: personal and social support

A need expressed by a majority of participants (25/35) was the availability of quality education for his or her kids. Availability of good faculties in school was frequently cited as a crucial factor about their selections to remain on or leave.

It is the main reason, if a doctor joins here then there is no facility for water and electricity, there are no doctors' quarters, but the biggest problem is that they can't give their children even primary education. *So according to the times, his children will lag behind.. So because of* this, no one desires to *join* here. At block level at least there should be a school for children from there, doctors will go daily to their PHCs. This way, there'll be more doctors for rural service. (Allopathic doctor and specialist, regular, eight years in rural and remote areas, male)

Evidently, personal and social need included both tangible parts such as the supply of education and housing, and also softer aspects such as due recognition of services and even public acclaim.

6.Discussion And Conclusion

No employer will afford to neglect the welfare of its employees, and India's government health services are no exception. Ensuring a health workforce delivering quality services in rural areas needs shut attention to their professional, social and personal needs. The narratives of the rural practitioners demonstrate the varied nature of their needs, that can't be addressed through narrowly conceptualised ways, however necessitate strong and holistic policy reforms, with a definite specialise in their overall well-being. Such a holistic approach should involve tangible reforms within the form of improved resource flows and governance arrangements, but also must consider a soft intervention that can help raise the acceptability of employment in rural health services, in addition as improve the image of state health services among rural communities.

The findings of this study are of a subjective nature however highlighting specific systematic enhancements, which can aid in improving the quality of experiences of the general public health workforce, and ultimately its performance and effectiveness. Firstly, while the necessity for associate absolute increase in pay-scales didn't emerge as a as a strong theme among this selection of respondents (except for contractual doctors), the issue of economic returns cannot be thought of insignificant. However, because of the global literature reflects, it's necessary to balance financial incentives with institutional reforms that that provide other benefits and a contributory working environment (19,20). Such institutional reforms (10) include improved workplace arrangements and resources, needs-specific training and skill development, more rational promotions and transfers, and assurance of job security and personal securities. There's a need for higher operating conditions for medical professionals, including better infrastructure, medicines and instruments. Nurturing doctors' professional interests and ambitions, and stemming the erosion of skilled skills is another crucial step in addressing the needs of providers and strengthening the standard of services.

Also very significantly, doctors, like different public service workers, seek and need accountability and respect from their employers. Rational and clear procedures for placement, transfer, promotion and regularisation of written agreement jobs will all play a task in creating rural government service a more attractive proposition. Finally, the goal of larger retention can be served if authorities were to accord formal recognition and reward for services under difficult conditions to health workers with appropriate credentials and histories of rural service.

Major requirements described by rural doctors

Job and compensation

Assurance of job security (contractual employees)

Better salaries (contractual employees)

Professional support

Improved workplace arrangements and resources

Needs-specific training and skill development

More rational promotions and transfers

Recognition and appreciation of services

Personal support

Good schools for children

Better housing

Assurance of personal security

7.References

[1]. World Health Organization. Not enough here... too many there– Health workforce in India. New Delhi: World Health Organization, Country Office for India; 2007.

[2]. *Census of India, 2011*, Registrar General of India, Government

[3]. Government of India. Bulletin on Rural Health Statistics 2008, Ministry of Health and Family Welfare, Government of India; 2009.

[4]. Hammer J, Aiyar Y, Samji S. Understanding government failure in public health services. *Econ Pol Wkly.* 2007;42(40)**:**4049–58.

[5]. Centre for Medical Competency Assessment and Accreditation.(n.d.) History: Center for Assessment and Accreditation of Medical Practices (RTA). Retrieved July 13, 2017.

[6]. Banerjee A, Deaton A, Duflo E. Health, health care, and economic development: wealth, health, and health services in rural Rajasthan. *Am* 2004;94(2):326–330.

[7]. Willis-Shattuck M, Bidwell P, Thomas S, Wyness L, Blaauw D, Ditlopo P. Motivation and retention of health workers in developing countries: a systematic review. *BMC Health Serv Res.* 2008;8:247. doi: 10.1186/1472-6963-8-247.

[8]. Rourke J. How can medical schools contribute to the education, recruitment and retention of rural physicians in their region? *Bull World Health Organ.* 2010;88(5):395–6. doi: 10.2471/BLT.09.073072.

[9]. Ebueh OM,Campbell PC. Attraction and retention of qualified health workers to rural areas in Nigeria: a case study of four LGAs in Ogun State, Nigeria. *Rural Remote Health.* 2011;11(1):1515. Epub2011 Feb 10.PMID: 21314213.

[10]. Butterworth K, Hayes B, Neupane B. Retention of general practitioners in rural Nepal: a qualitative study. Aust J Rural Health. 2008;16(4):201–6. doi: 10.1111/j.1440-1584.2008.00976.x

[11]. Chhea C, Warren N, Manderson L. Health worker effectiveness and retention in rural Cambodia. *Rural Remote Health.* 2010;10(3):1391. Epub 2010 Jul 29.

[12]. Dieleman M, Zwanikken P, Gerretsen B, Kane S. *Realist review and synthesis of retention studies for health workers in rural and remote areas*. Geneva, Switzerland: WHO; 2011.

[13]. Henderson LN, Tulloch J. Incentives for retaining and motivating health workers in Pacific and Asian countries. *Hum Resour Health.* 2008;6:18. doi: 10.1186/1478-4491-6-18.

[14]. Silverman D. *Qualitative research: theory, method and practice*. London: Sage; 2004.

[15]. Grbich C. *Qualitative research in health? an introduction*. London: Sage; 1999.

[16]. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Burgess RG, Bryman A, (eds). *Analyzing qualitative data*. London and New York: Routledge; 1994: pp.173–94.

[17]. Mays N, Pope C. Quality in qualitative research. In: Pope C, Mays N(eds). *Qualitative research in health care*. London: BMJ Books; 1999:pp.82–102.

[18]. Chhattisgarh Population Census data 2011[cited 2015 Dec 15]. Available from: http://www.census2011.co.in/census/state/chhattisgarh.html

[19]. Mathauer I, Imhoff I. Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Hum Resour Health.* 2006;4:24.

