Why Some Doctors Serve in Rural Areas: A Qualitative Assessment from Chhattisgarh State

REPORT

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PHFI - NHSRC - SHRC Chhattisgarh

'Why Some Doctors Serve in Rural Areas: A Qualitative Assessment from Chhattisgarh State'

Conducted by the **Indian Institute of Public Health, Delhi (IIPHD)**, the **Public Health Foundation of India (PHFI)**, the **National Health Systems Resource Centre (NHSRC)**, and the **State Health Resource Centre (SHRC), Chhattisgarh**

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ABSTRACT

The global problem of the unequal distribution of the health workforce between cities and villages, with its severe consequences for the availability and quality of health services, and on health outcomes in rural and remote geographical areas, is also marked in India. Research into the phenomenon of workforce maldistribution has typically focused on why health workers choose not to stay in rural locations. In this qualitative research study, conducted in Chhattisgarh state in India, we explore the converse – the reasons why some qualified health workers remain and continue to serve in otherwise underserved rural and remote areas. Thirty-seven in-depth interviews were conducted with medical practitioners serving in rural healthcare facilities in eight districts of Chhattisgarh, between June and August 2009. Data were thematically analysed using the "framework" approach for applied qualitative research.

We found that practitioners' initial decisions to join service in rural and remote areas were widely influenced by geographical affinities and familial associations. Once in service, the practitioners confronted complex adverse conditions and circumstances, including poor working and living arrangements, long estrangements from families, and threats to personal security. Their decisions to remain in rural and remote areas over periods of time were driven by varied combinations of factors including geographical affinities, personal values of service, professional interests and ambitions, strong relationships with colleagues and in the case of contractual doctors, the anticipation of obtaining a regular position. A majority of respondents had had a rural upbringing, and emphasized the importance of familiarity and comfort in village environs. For women doctors, the opportunity for both spouses to work and live in the same location distinctly emerged as a positive factor. Specific areas of need identified by respondents included improved workplace arrangements and resources, better housing and schools for their children, training and skill development in areas which reflected community needs, and – in the case of contractual doctors – assurances of job security and better salaries.

This empirical study identifies key, specific complexes of factors at the individual level which act in favour of retention of providers in rural areas. It also highlights the conditions of health workers living in these areas, and their needs. Planners and health authorities can address critical issues of workforce retention by professional education and recruitment policies that attract candidates more likely to serve in rural areas, by enabling and emphasizing the positive phenomena and factors which underlie practitioners' decisions to remain, and by addressing their emerging needs through varied policy actions including improvements in specific aspects of health systems performance and design.

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INTRODUCTION

The global problem of the unequal distribution of the health workforce between cities and villages, with its severe consequences for the availability and quality of health services, and on health outcomes in rural and remote geographical areas, is also marked in India. This study seeks to understand and elaborate the mix of reasons why qualified health workers 'stay on' – why they continue working in underserved areas. In doing so we depart from the convention of exploring the 'negative' phenomenon of resistance to rural placements and migration away from rural areas, and instead focus on the 'positive' outcome (in health planning terms) of qualified health workers continuing to populate and work in rural areas. We focus on medical practitioners in this study. Qualitative research methodology was adopted to address this objective, involving field-based collection of data through in-depth interviews, and thematic analysis of the data. The fieldwork was conducted in eight districts of Chhattisgarh, a state with a significant tribal population of poor economic status and a suboptimal density of qualified health workers

Background

India's Health Workforce Crisis

A health workforce which is adequate in size, skill mix, quality and able to reach all sections of the population is necessary for achieving a high and equitable coverage of health services. Indian census estimates adjusted for educational qualifications reveal that the health worker density (including doctors, nurses and midwives) is approximately 8 per 10,000 population (PHFI 2008), well short of the suggested norm of 25 per 10,000 (WHO 2006). A wide variety of health workers provide services in allopathic and Indian systems of medicine. Alongside the provision of allopathic services, physicians trained in Ayurveda, Yoga, Unani, Sidha and Homeopathy, collectively known as AYUSH, provide health care. Health workers from both systems of medicine are employed by the government funded public sector and the private sector.

The geographic distribution of India's health workforce is disturbing. Most (60%) health workers are present in urban areas where 28% of the population resides (PHFI 2008). This rural bias is consistent across cadres of health workers; 40% of allopathic physicians, nurses and midwifes, AYUSH practitioners and 20% of dentists are present in rural areas. This is reflected in the low health worker density of 11(42) per 10,000 population in rural (urban) areas. Across cadres of health workers the differences are more alarming; the density of doctors per 10,000 population in rural (urban) India is 3 (13), of nurses 2.4 (11.3), of midwifes 0.68 (1.4), of pharmacists 1.3 (4.4) and AYUSH practitioners 1 (3.4). These differences are even more striking for female health workers, particularly female doctors. This geographic imbalance in the health workforce hampers the ability of rural populations to access quality health services.

The majority of health workers in both the private and public sector are present in urban areas. The private sector in India dominates the delivery of curative health services. In both urban and rural areas, the majority (70%) of health workers are employed in the private sector (PHFI 2008). This is consistent across different health worker cadres. Further, over 80 per cent of the qualified private provider market is concentrated in urban areas (WHO 2007). The lack of qualified medical professionals in rural areas has resulted in the majority of rural households receiving care from private providers, many of whom are less than fully qualified (WHO 2007).

The public sector has made considerable efforts to place doctors and a variety of other health workers in rural areas through its vast network of health sub-centres, primary and community health centres in these areas. However, high levels of vacancies in these health facilities due to appointed health workers not taking up posts, absenteeism and dual practice have compromised this effort. This problem is particularly acute for doctors at Primary Health Centres (PHCs) and for specialist doctors at Community Health Centres (CHCs). PHCs serve as the first point of contact for curative services in rural areas and have a critical role in locating basic health services within communities. One study finds that absenteeism among primary care workers in India is as high as 40%, making it is highest in the world (World Bank 2008). These problems contribute to the unreliability of official estimates, and may explain official failures to increase allocations of facilities and beds where they are needed most.

Many reasons have been documented for why health workers typically choose not to work in rural areas. Salary emerges as an important factor of a job and strongly affects the willingness to work in rural areas. (Chomitz 1997; Serneels, Lindelow et al. 2007). In India, starting salaries for allopathic physicians in the public sector is around Rs. 20,000 per month and about half of that for nurses. However, there is little additional incentive given for those who are posted in rural areas. Factors other than salary also play an important role in the preference of urban positions. For example access to training, health care and education for children, promotion opportunities, the availability of electricity, water and housing are all reasons that urban jobs are usually favored (Dussault and Franceschini 2006; Lindelow and Serneels 2006; Serneels, Lindelow et al. 2007). In Pakistan, the absence of equipment and supplies was a major deterrent for accepting a rural post (Zaidi 1986). A study on rural health worker motivation in Vietnam highlighted the importance of appreciation and support from managers and colleagues as well as from the community (Dieleman, Cuong et al. 2003; PHFI & World Bank 2008).

Chhattisgarh State

Chhattisgarh was carved out of the central Indian state of Madhya Pradesh in November 2000. The State has an area of 1,35,191 sq. km. with a population of 21 million (2001 Census). There are 16 districts, 146 blocks, and 20,308 villages in the State. 44% of the land is forested and is home to tribes who constitute one third of the population. The above factors place Chhattisgarh in a unique position. The physical inability to ensure outreach services to forested areas coupled with the poor economic status of the tribal majority have constrained efforts to improve health and health service indicators in the state. Chhattisgarh has a shortage of health workforce;

according to the Bulletin of Rural Health Statistics in India, 2005 the doctor-to-population ratio is 1:3100.

No.	Item	Chhattisgarh	India
1	Total population (Census 2001) (in million)	20.83	1028.61
2	Total Fertility Rate (SRS 2006)	3.4	2.9
3	Infant Mortality Rate (SRS 2007)	61	57
4	Maternal Mortality Ratio (SRS 2001 - 2003)	379	301
5	Sex Ratio (Census 2001)	989	933
6	Schedule caste population (in million)	2.42	166.64
7	Schedule tribe population (in million)	6.62	84.33
8	Female literacy rate (Census 2001) (%)	51.9	53.7

Table 1 Demographic, socio-economic and health profile of Chhattisgarh[1]

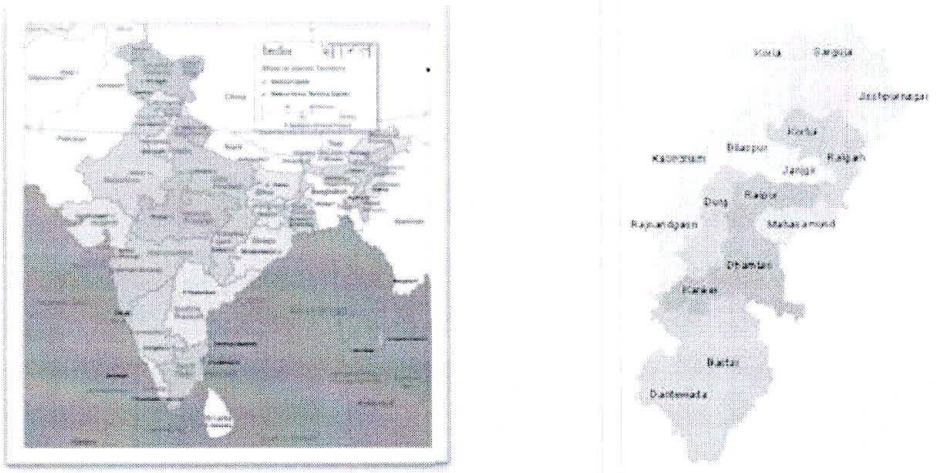


Figure 1 Districts of Chhattisgarh State

[1] Source: http://mohfw.nic.in/NRHM/State%20Files/chhattisgarh.htm. Accessed on 10/9/08

Conceptual Framework

Practitioners' decisions to 'stay on' are complex, and influenced variously by personal factors as well as by their relationships and interactions with the health system, the communities they live and work in, and their patients.

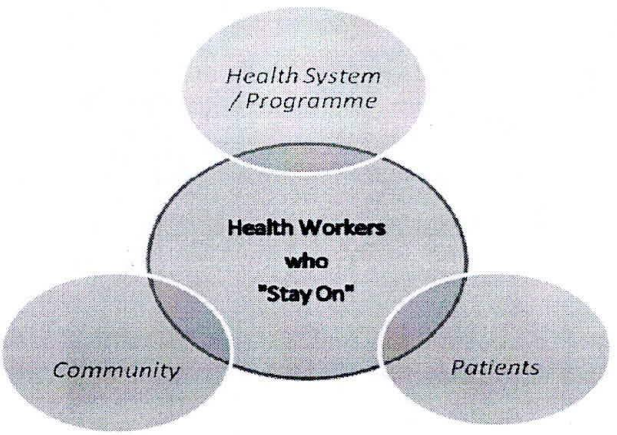


Figure 2 Conceptual Framework

A simple model drawing from Porter and colleagues (2002) was proposed as a conceptual framework to plan the research instruments and for subsequent thematic analysis. The framework is constructed of four overlapping domains, with the main subject of research – the health workers – at the centre. Using this framework, the reasons why practitioners 'stay on' are examined by studying their own personal characteristics, values and forebears, and also their respective interfaces with the health system, with communities, and with their patients.

METHODS

In-depth interviews (Grbich 1999) were conducted with a selection of medical practitioners who have an established record of service in rural areas. The data from these interviews and discussions were analysed using the framework approach for applied qualitative research (Ritchie & Spencer 1994). The data were sorted into emerging thematic categories representing practitioners' experiences, reasons for staying on, and their expressed needs, and are presented.

Selecting Participants

Essential and desirable criteria for the selection of participants were delineated as follows:

Essential:

- Serving in PHC or CHC in a rural area for more than five years
  OR
- Serving in a PHC or CHC in a remote[2] rural area for more than one year

Desirable:

- Allopathic training
- Presence in *remote* rural area for more than 5 years (more than 10 years highly desirable)
- Serving at primary health centre level (as opposed to block level)
- Female

The desirable criteria represented a conscious preference for more highly qualified doctors (their retention in rural areas being more desirable in planning terms), those working in particularly remote areas, and with a greater length of time spent in rural areas (so as to access a richer set of accounts drawn from longer experience), and women doctors.

Respondents were identified purposefully in each district selected for the study, based on information from local facilitators and corroborated by inspecting government records. Care was taken to ensure representation of both sexes, both categories of employment (i.e. regular and contractual) and all geographical locations within the state (8 districts were identified

[2] The criteria for remoteness are drawn from official government classification of PHCs and CHCs, based on the following conditions:

a. Distance from District HQ
b. Forested area
c. Poorly connected by road
d. Extent of habitation
e. Significant security concerns
f. Lack of educational facilities

spread across the Northern, Central and Southern zones of the state) within the state (Silverman 2004). Practitioners meeting 'desirable' criteria were identified preferentially. A total of 37 participants were enlisted for interview.

Fieldwork

A research team from PHFI and SHRC conducted the research over a period of two and a half months from July – September 2009, in eight districts of Chhattisgarh state. Prior to embarking on fieldwork researchers underwent training in qualitative research methodology, including interview technique, framework analysis, and ethical considerations in interviewing and handling data. Topic guides were designed drawing on the different thematic areas depicted in the research framework (see Figure 1), and were used to conduct the in-depth interviews. All interviews were conducted with the verbal consent of respondents. See Annexure for the topic guide and standard form for obtaining verbal consent.

Aspects of interview technique emphasized included developing good rapport and comfort, non-prejudicial and non-preemptive style, avoiding directive or leading questions, inviting narratives of experiences and appropriate probing (Britten 2000). Ethical considerations around taking consent for interviews, ensuring confidentiality of data, respectful communication, attention to social and cultural norms, were also given particular consideration while conducting fieldwork. All 37 respondents identified were interviewed. Interviews were conducted in Hindi and recorded on a digital media device with the permission of the respondents. All recordings were transcribed and translated into English text on a computer word processing programme.

Analysis

Data analysis was conducted side by side with collection of the data. For organizing the textual data from transcripts of interviews, the "framework" approach for applied qualitative research was applied (Ritchie & Spencer 1994). This approach combines inductive and deductive approaches, in that it permits the combination of pre-determined themes, with those emerging from a reading of the data. The steps in the framework approach are enlisted as follows:

- Familiarization with raw data
- Identifying a thematic framework (see annexure), based on pre-determined objectives, and emerging field level issues
- Indexing – by applying the thematic framework systematically to the data.
- Charting – rearranging the data into distilled summaries of views and experiences.
- Mapping and interpretation – using the charts to locate concepts, phenomena, typologies, and associations between themes.

There was an emphasis on extracting underlying implications and meanings which respondents ascribed to their experiences, rather than to overtly stated views and rhetoric. Special attention was paid to notable variations and divergences in perspectives between different respondents.

Two analysts coded the data as per the thematic framework, and their choices in attaching codes to the text were compared and standardized, to improve the reliability of interpretations from the data (Mays and Pope 2000).

Thematically categorized findings are presented which incorporate patterning and variations in responses. We have also extracted remarkable narratives which illustrate specific processes and life experiences of the respondents.

Ethical Precautions

Prior to interviews, respondents were informed of the objectives of the study and how the collected information would be used. Respondents were also informed of the purpose of the study and that the data would be treated in a confidential manner. Verbal consent was obtained for interviews and for recording the interview. All recordings were stored in a lockable container with restricted access. All digital data were handled in computer programmes in encrypted format with restricted access. Care has been taken to ensure anonymity of all individuals cited in this report, by withholding their names and those of towns, villages and institutions which may have led to their identification.

FINDINGS

Field Settings

The study covered 14 CHCs and 23 PHCs located in remote and rural areas across eight districts in the state of Chhattisgarh. All the healthcare centres selected were distant from the district headquarters and poorly connected by any form of public transport. While some of the CHCs were adequately linked by roads, reaching the PHCs was often a problem as they were located deep in the rural interiors usually with unpaved roads. In many cases, the main means of public transport were jeeps, overcrowded with people and owned by individuals residing in the area. Healthcare workers posted in these locations generally rely on their privately owned vehicles and sometimes ambulances (if there is one in the healthcare centre) for travelling to block or district healthcare centres when called for meetings or other work related visits.

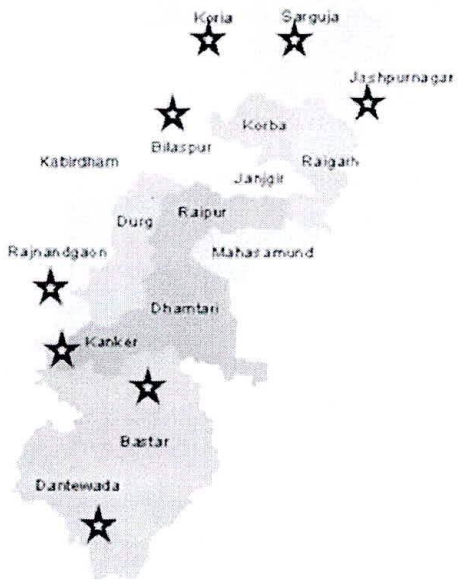
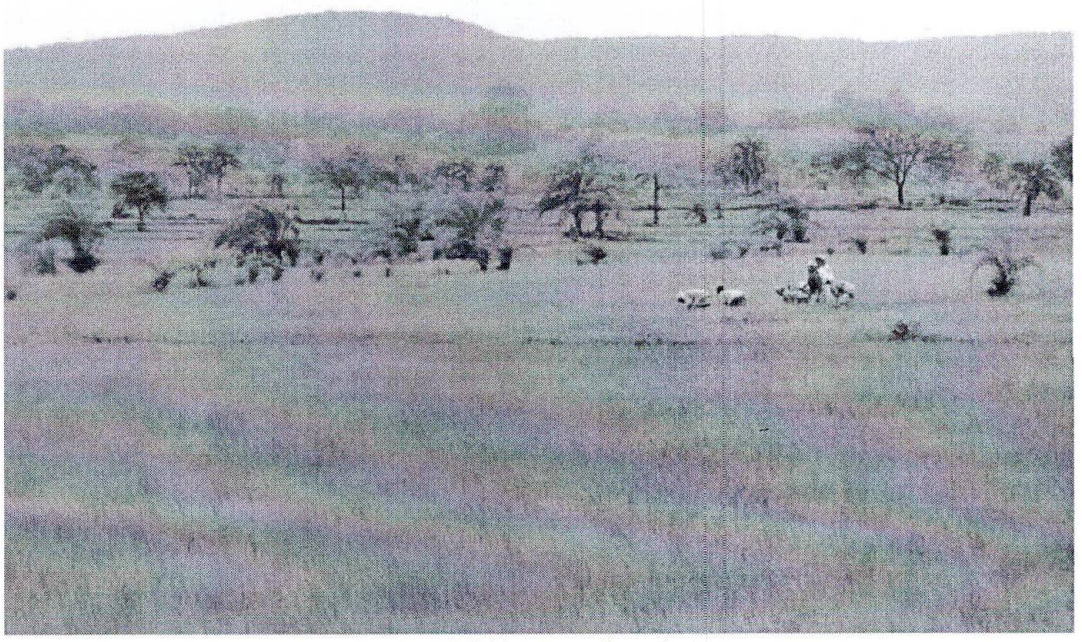


Figure 3 Interviews were conducted in eight districts

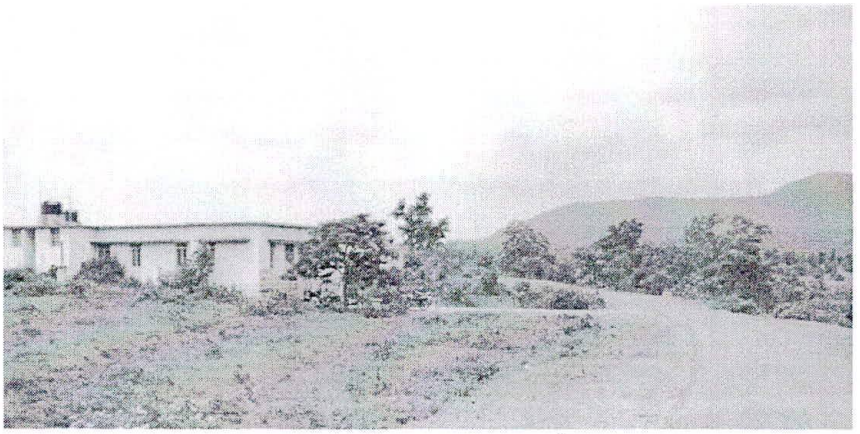
Due to poor road linkages in some places, some PHCs are cut off from the rest of the state during the rainy season causing considerable difficulties for medical supplies, patient referral, and often impede health workers' weekly or daily commutes. Access to fresh produce is also severely limited in these times. Many of the healthcare centres visited lacked basic facilities of water supply, electricity and equipment – this is discussed further in the body of the report. In places where adequate equipment is available, frequent electricity outages prevent its utilization. Bar a few instances, living quarters provided by authorities are in dilapidated condition and in most instances practitioners arrange their own accommodation by renting private houses. Many of the doctors interviewed live alone, compelled by lack of proper housing

and educational facilities for their children, to send their families to towns and cities. Lack of avenues for society and entertainment are apparent in many instances, and feelings of social isolation and loneliness are common. Anxiety and depression were also reported among some practitioners and health workers, coupled with the attendant problems of alcoholism.

The study team had to travel for long hours to reach these locations, through vast stretches of fields and sometimes densely forested areas. The team was accompanied by local health officials or health workers who were well acquainted with the terrain and the location of the healthcare centres. During the visits, the team frequently came across sections of roads which had been destroyed (and recently repaired) by landmines reportedly planted by insurgents, an indicator of the environment of violence and militarization in many parts of the state. For a number of doctors and health care workers posted in areas affected by insurgency, personal safety is a major concern and cause of anxiety. Respondents and study facilitators reported several instances of violent clashes between insurgents, security forces and counter insurgents. In one instance, the team heard of the occurrence of an armed attack resulting in the death of several police officers, a few days after visiting the location. Paradoxically, many parts most affected by strife were also of exceptional scenic beauty, with their lush green landscapes and forest and mountain vistas.

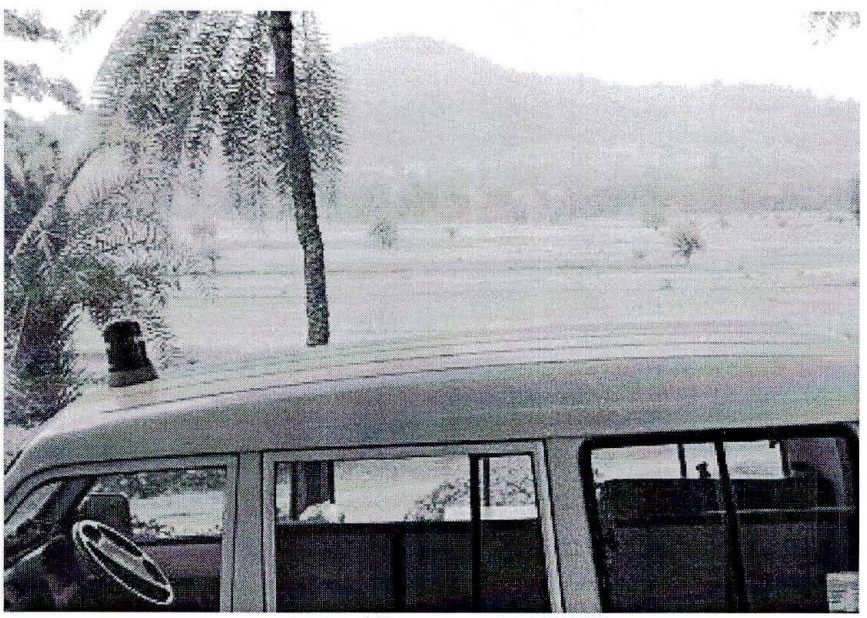


Paddy fields in a southern district



A primary health centre[3]

An unpaved road leading to a PHC



Vista from a community health centre

[3] Photographs are not necessarily of locations where interviews took place

Profile of Respondents

Table 2 profiles the 37 respondents in the study, based on different characteristics. Details of the selection process and parameters, including essential and desirable criteria are described on page 11. The eventual selection is weighted by our preferential identification of allopathic doctors, doctors in remote locations, those with more experience, PHC doctors and women.

Sex[4]	Male	33 *(89%)*
	Female	4 *(11%)*
Employment status	Regular	25 *(68%)*
	Contractual	12 *(32%)*
System of Medicine	Allopathy	31 *(84%)*
	AYUSH	6 *(16%)*
Qualification (degree)	Medical graduate	31 *(84%)*
	Medical postgraduate	6 *(16%)*
Years of service	1 - 5	12 *(32%)*
	6 - 10	9 *(24%)*
	> 10	16 *(43%)*
Workplace	PHC	23 *(62%)*
	CHC	14 *(38%)*

Table 2 Profile of study respondents
(N = 37)

After the study was completed, we undertook an inspection of government records. Chhattisgarh has 1,237 doctors working in rural locations across the state (760 in PHCs and 477 in CHCs). They are profiled in Table 3 below. At the time the interviews were conducted, all AYUSH doctors in the state were engaged on contractual terms.

Sex	Male	988 *(80%)*
	Female	249 *(20%)*
Employment status	Regular	851 *(69%)*
	Contractual	386 *(31%)*
System of Medicine	Allopathy	968 *(78%)*
	AYUSH	269 *(22%)*
Years of service	< 1	231 *(19%)*
	1 - 5	609 *(49%)*
	> 5	397 *(32%)*
Workplace	PHC	760 *(61%)*
	CHC	477 *(39%)*

Table 3 Profile of all rural doctors in Chhattisgarh
(N = 1237)

[4] The preference for respondents with longer durations of service in remote locations conflicted with and limited the number of women doctors in the eventual selection, since very few women doctors fell in this category.

A closer inspection of the records also revealed that 625 medical practitioners in Chhattisgarh corresponded to our essential criteria of a *minimum of five years service in a rural setting* OR *one year's service in a remote setting*. These doctors have also been profiled below, in Table 4.

Sex	Male	526 *(84%)*
	Female	99 *(16%)*
Employment status	Regular	341 *(55%)*
	Contractual	284 *(45%)*
System of Medicine	Allopathy	373 *(60%)*
	AYUSH	252 *(40%)*
Years of service	1 - 5	376 *(60%)*
	> 5	249 *(40%)*
Workplace	PHC	401 *(64%)*
	CHC	224 *(36%)*

Table 4 Profile of all rural doctors in Chhattisgarh corresponding to study essential criteria [5,6]
(N = 625)

At the time of fieldwork, the records revealed that 526 (84%) of these 625 professionals were male, 341 (55%) were regular employees (with the remainder being contractual employees), and 373 (60%) were qualified in allopathic (Western) medicine. All 252 AYUSH-trained physicians were employed on contractual terms, thus forming the majority (89%) of all contractual doctors in the selection universe. Four hundred (64%) of these doctors were employed in primary health centres, and the rest in block-level facilities (community health centres).

[5] These official figures may not reflect actual ground presence of doctors, since they do not account for absenteeism

[6] The profile of study participants (Table 2) varies from that of this listing, since desirable criteria were also applied while selecting respondents (see page 7)

Personal and Professional Antecedents

Upbringing and family background

A significant majority of the doctors in this study had had a rural upbringing (34/37), and a number of them cited humble beginnings and hardship:

> Family background was nothing great from the beginning... straightaway from the bottom we have come to the top *(Allopathic doctor, contractual, 10 years in rural and remote areas, male)*

> We have always stayed in villages and financially also we are not like that that we have been brought up nicely... we have stayed in struggle... *(Allopathic doctor, contractual, 15 years in rural and remote areas, male)*

> I am from a simple and ordinary family. My father was a *patwari* (land records clerk). My education was mostly in remote areas. I did my high school from (name withheld – town well known as insurgent stronghold)- a Naxalite area (even) in 1983 *(Allopathic doctor and specialist, regular, 7 years in rural and remote areas, male)*

At least five respondents identified themselves as being ethnically tribal, and having community affiliations to tribal groups. Some respondents identified themselves as belonging to immigrant communities originally from a neighbouring state. Respondents' parental and ancestral occupations ranged from farming to various forms of government service, and education.

A few (14/37) were born or brought up in the same district or region of their present habitation, whereas in other instances, they were from towns and (usually) villages in other districts of Chhattisgarh (17/37), and occasionally from neighbouring states (6/37). Seventeen of the 37 respondents reported living far away from their parental homes, often able to visit them only infrequently.

Conjugal life

A majority of respondents were married at the time of interview (34/37), often with children. As many as 14 of these 34 respondents reported living apart from their conjugal families. In some of these instances, the spouses and children were located in proximate towns, with opportunities to visit them on weekends or once a month.

> My family is in (a nearby town). My wife is a teacher in the education department. I have a one and a half year old girl in the house. I stay here (in the village) from Monday to Saturday. I go out to the family on Saturday. One day will have to be given to the family. *(Allopathic doctor, regular, 6 years in rural and remote areas, male)*

However some respondents also reported that their spouse and children were located in a distant part of the state or in another state with limited opportunities to meet. Typical reasons for separation included the absence of facilities for children's education in places of work, and employment opportunities for husband and wife in separate locations.

> If I keep them here then his (son's) education will be affected. Where they (wife and son) live is quite far from here. 250-300 km. Sometimes it is 4-5 months before I see them... at times if I get an opportunity then I go more often... *(Allopathic doctor, regular, over 20 years in remote areas, male)*

Of the four female respondents in the selection, three were married - each of them living with their husbands and children - and the fourth was single.

Entering the medical profession

Joining the medical profession emerged as a major life-event for several respondents. The most critical moment in this process, as recounted by respondents, was of gaining admission to a medical college. Entry into a MBBS degree course was widely valued over AYUSH medical degree courses (BAMS, BHMS and others). Some respondents reported repeated attempts to gain admission to the MBBS degree course. One BAMS graduate recounted in detail how he had prepared to commit suicide after failing to achieve the requisite marks for MBBS, but was prevented by his friends and then persuaded to take up the BAMS course.

Respondents were influenced by their siblings and peers studying for pre-medical examinations, and by cultures of academic achievement and aspiration in their respective families and communities.

> I got inspired by my seniors (at school. There were 4-5 of them and I also took the subjects they were doing. I thought that they have also given PMT (pre-medical test), I will also give. This was the thinking. Initially I had not thought of being a doctor and serve the people. I got inspired by the seniors. *(Allopathic doctor, regular, 9 years in remote area, male)*

> During my childhood I did not even know what PMT (pre-medical test) was. When I passed 11th (standard) my friend was filling the form - I asked him what is PMT? They told me that you become a doctor by doing this so even I thought lets fill it up. I had spent some Rs. 10-15 (on the form). And I gave the exam without any preparation, without studying. We were four of us who sat in the exam. Of us, the one who made me fill the form and I cleared it, the other two friends did not. But that friend who cleared PMT failed his first year. Even now when he meets me in (a nearby town)... poor fellow is running a grocery store now. *(Allopathic doctor, regular, 11 years in remote areas, male)*

> When I was studying, at that time there was a lot of craze for the "science" subject in relation to other subjects... whether arts or commerce So in my personal case, the subject that I chose I chose it blindly, thinking that it has a lot of craze, and also... we should say it is respected...so going with this thought I chose science and studied. Straightaway after the first year I was selected in the PMT. *(Allopathic doctor, contractual, 10 years in rural and remote areas, male)*

Parental ambitions for their children were also frequently cited as a determinant for entering medical studies.

> My father wanted me to become an engineer and my mother wanted me to become a doctor... since we were small so we did not think much about becoming a doctor or engineer. In the beginning I prepared myself for engineering only... then my mother said that there is nothing in this....life of an engineer is not as much as that of a doctor...so then I left it and took biology (as an optional subject and pre-medical requirement) and studied and became a doctor *(Allopathic doctor, regular, 11 years in remote areas, male)*

In more than one instance, practitioners recounted critical childhood experiences – sometimes the death or infirmity of a parent from a preventable or treatable cause – which led them to pursue careers in medicine.

> My mother was once bitten here in hand, and once on foot, we tried to get her healed through *jhad-phoonk* (witchcraft) but nothing worked... My father was posted somewhere else. I had to take care of my house, used to look after my mother, used to cook food at home by myself... there was no one else at my place, no uncle-aunty no one it was not a joint family. From that day it came to my mind - I was in class six - that I have to become a doctor. *(Allopathic doctor, regular, 18 years in remote areas, male)*

> My father expired due to malaria. My father was in the irrigation department. He had to go to the field. There was a phone from the home that father is suffering as such. Doctors told me that your father passed away due to malaria... then also I thought that no one should die of malaria. It is a preventable disease. This is the reason I came into this. Otherwise I had chosen administration for myself. *(Allopathic doctor, regular, 6 years in rural and remote areas, male)*

> In my district there is a village...there was this lady...in Chhattisgarhi they said that she had some *chhoot ki bimari* (contagious disease) and she expired... and nobody was ready to pick her up. I used to be really scared whenever anyone died, I would not even come out of my house... but there I picked her up ... this gave me strength.... From then I made a choice for

> but I felt that since I have taken from the government so I return to the government also. Also to the community to which I belong - I have taken from the society so I will have to return it. So to return what I took from the government and society I joined a government job and I am working in the tribal area for my people *(Allopathic doctor and specialist, regular, 8 years in rural and remote areas, male)*

A few respondents indicated that they had joined government jobs in rural areas due to policies linking conduct of rural service with eligibility for or **preferential admission to postgraduate degree courses**.

> I shifted here leaving a private practice worth (Rs.) 30,000 - 40,000. My practice was very good in (a nearby town) and I left that practice to be here. The reason was that with the kids and taking care of the house I could not study. So for this reason only I joined government job that if I am in government then government will get our PG done... this was the motivation. *(AYUSH doctor, contractual, 6 years in remote area, male)*

One respondent recounted the advantages of **greater autonomy** in caring for patients and the ability to utilize his professional skills better as a reason that motivated him to move from a city hospital to a village PHC.

> I left central service and came here... I was there for 3 years. Over there it was like you have to do whatever is set by the government... like paracetamol, brufen (ibuprofen), apart from that you can't do anything else for anybody you just give them some analgesic and send them off, so all this I did not enjoy, so that's why I left it. Here - whatever resources you have, whatever knowledge you have, you can use. You can do a lot for the patient. For that reason I left it and came. *(Allopathic doctor, regular, 18 years in rural and remote areas, male)*

One female practitioner recounted how the proximity of the doctor's home and spouse's place of work, family connections in the health department and her willingness to work in a rural area, each played a role in her decision to take up a position in a remote outpost.

> My proper home is in the colony 25 km from here. After passing the PSC (public services commission examination), I was given this posting. See, no one wants to come here. For the PSC also it is a problem (to find someone) that will come here. The coordinator then, (name of a health official), we also had family relations with them. When the list came out he knew that this PHC is 25 km away and if nobody else, then she will join and go there. If someone else is given then that person will not join. May be they were thinking this because of which I got it. *(Allopathic doctor, regular, 4 years in remote area, female)*

This account epitomizes how **combinations of factors** were frequently responsible for doctors' initial placement and commencement of work in rural primary health systems.

the patient is really ill, if it is a delivery case, then... *(AYUSH doctor, contractual, 3 years in remote areas, male)*

Problems with **residential facilities** were widely reported, with doctors forced to take up private accommodations or live in poorly maintained or inadequate government facilities.

I can't get my family here. There are no facilities. Infrastructure is zero, all other facilities are zero. This is a remote place. It is one's good luck if there is electricity. There is a lot of problem of water. All water sources like tap, borewell are a fail. You have to order water for Rs 10 a litre. Nowadays, because of (a government scheme), since people get rice in Rs 2 per kg, the person who fetches water is also not available. *(Allopathic doctor, regular, 6 years in rural and remote areas, male)*

There are no proper quarters here... you can see the situation yourself... every year I spend at least Rs. 4000 laying polythene (waterproof sheeting to prevent leakage) *(Allopathic doctor, regular, 11 years in remote areas, male)*

There are many of us (doctors) who are living in rented houses... for bathing they are going outside, going to the river... so all this is not right... If you are managing a PHC or hospital, you should stay near the hospital you should have quarters in the premises, a little away from common people *(Allopathic doctor, regular, 18 years in rural and remote areas, male)*

TOILING IN OBSCURITY

Doctors' frustrations from the anonymity of working in remote areas and from the lack of appreciation and recognition of their contributions were expressed eloquently by this Block Medical Officer from an underdeveloped district:

(Doctors) working in good places like AIIMS and Safdarjung (hospitals in Delhi), their work gets highlighted. We learn that some doctor has received Padmashri. I am saying some bitter things. I am working here; if I die in a blast or my hand gets fractured then I am not going to get any Padmashri. We are not getting those garlands, those flowers, or gold medals. We are only serving the patients. If I am satisfied at that level then its fine. Otherwise if I am going to tax my brains by being unsatisfied then nobody is going to lose but me. We understand everything, experience it but cannot say it. Who do we say it to? Would I say all this to the poor tribals who themselves don't understand much. Would I say this to those corrupt administrators? (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

Long **separations from families**, a common consequence of being located in remote and inaccessible areas, were often a cause of distress. Problems of separation from families were reported more frequently by ***contractual doctors***, who had less choice in determining their locations, and limited permitted leave of absence. A few doctors indicated disturbances in spousal relations and estrangements, consequent to the problem of separation.

> The situation is such that mother-father are in (a neighbouring state). Father is 80 years of age and Mother is 75 - we have left them both there and we are sitting here... that's the way my life has turned out. (Investigator: do you miss them?) This you will realize when it happens to you [bitterly]. Day before yesterday my mother fell down [starts crying] and I couldn't go... at the age of 75 what will happen, she doesn't eat anything... [cries harder]... we don't get a leave from work. Only to earn a living, I have left behind my 80 year old father to live in this jungle where no one will live. We don't get leave... we call them, enquire, they tell us "son, I fell down", I say "Mother, take this medicine", and we go off to sleep... so don't ask me about my family [sobs]. *(AYUSH doctor, contractual, 2.5 years in remote area, male)*

> We are living 600-700 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 3 days to go and 3 days to come. And I will stay for at least 2-3 days. So out of 18 days, 10 days are gone like this. *(AYUSH doctor, contractual, 6 years in remote area, male)*

> When sometimes we get a holiday, I go (to visit wife and child in the city) – fewer than once a month, and many times even that is not possible. Because of this yes family relations are a little... they do get a little upset... (They ask) 'what is there, that you are living there so far away?' From my side, I like it here... If we had the schools and everything else was better, then I would have got the family here...but it's like.....my parents made me study and made me a doctor, so our kids should also become something... that is why I have kept them in (the city) *(Allopathic doctor, regular, 11 years in remote areas, male)*

Erosion of professional skills and confidence was a commonly reported problem, as often attributed by respondents to others of their acquaintance, as to themselves. Frequently this was linked to limitations of resources (clinical facilities and equipment) to practice a high standard of medicine, and the lack of opportunity for further academic development.

> Science is moving forward and we are lagging behind... in some emergency if there is some critical disease, I don't know, then I ask another doctor. If he knows then it's OK or else I have to look up books - and books are not here with us. If we had a library, then we could refer to it. Sometimes we

> have to train these people nurses and workers on diseases... so whatever is our knowledge we can only give that much *(AYUSH doctor, contractual, 3 years in remote areas, male)*

> There are no arrangements for X-rays, no arrangement for blood tests. Because of Jeevan Deep (untied funds scheme), there is a table and chair, before this even table chair was not there. We have adapted to this environment - I have forgotten the method of diagnosis of disease here... If there is any reorientation course I would like to do it, and get new fruits of knowledge. But here the situation is such that even what we have done (studied in medical college) has gone. *(AYUSH doctor, contractual, 6 years in remote area, male)*

> We don't have the basic equipment for routine investigation like urea, creatinine, such routine investigations are not possible. If I am not able to properly investigate a patient then how will I be able to give him proper treatment? Once a 30 bed hospital is made there should be an X-ray machine, one sonography, one specialist. All these facilities are not here. We are not able to serve our patients like we want to. *(Allopathic doctor and specialist, contractual, 16 years in remote areas, male)*

Doctors coped with the prospect of declining skills in different ways. While some conceded attrition of knowledge and intellectual fervour, others, conversely, immersed themselves deeply in studious pursuits and accentuated their medical professional identities, to counter isolation and lack of academic exposure.

> I am a doctor so I believe that whatever I have studied I have to maintain that and not let it go or forget. *(Allopathic doctor, contractual, 18 years in remote areas, male)*

Complicating the doctors' concerns around an eroding knowledge base was the problematic **interface with alternative knowledge systems** and perceptions of health that were subscribed to by local populations.

> Many (patients) prefer jhad-phoonk (witchcraft) We tried that this should stop but it was difficult to do so. So we told them that you do jhad-phoonk but take our tablet as well. Many people have adapted to that. They understand that malaria can't be treated with jhad-phoonk only. They keep our medicines as well. *(Allopathic doctor, regular, over 20 years in remote areas, male)*

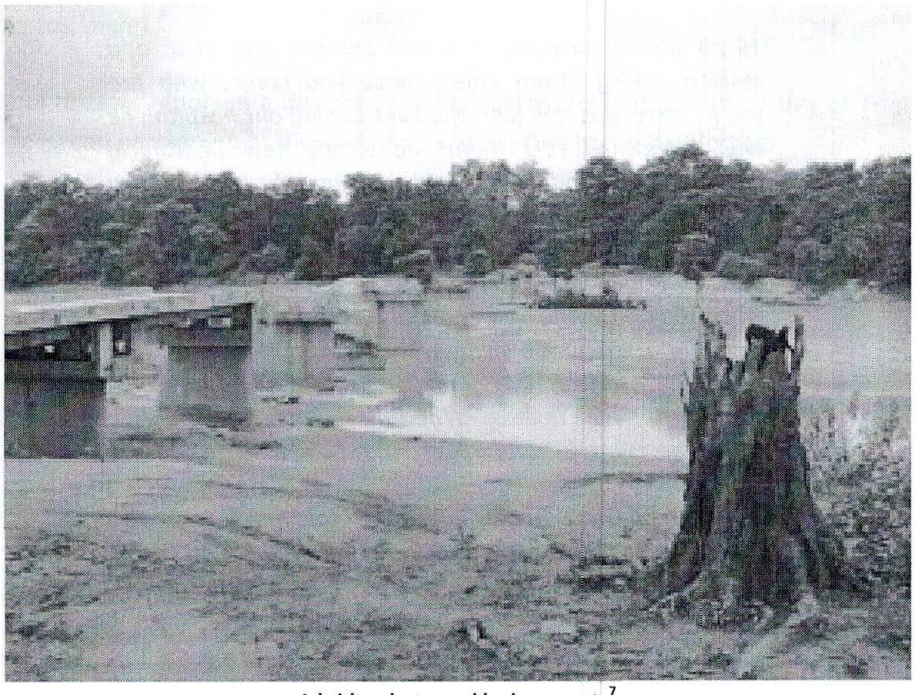
> We keep on calling the meeting of these (traditional healer) people to make them understand. But did not get any result. But they have a hold on the community - if they have a say in the community they will not just let go of it. Also if the people believe in something then they will not just stop

believing in those things all of a sudden. *(Allopathic doctor and specialist, regular, 7 years in rural and remote areas, male)*

For AYUSH qualified doctors in contractual positions, the experience of prescribing allopathic medicines in government clinics was sometimes problematic. Colleagues with allopathic degrees widely did not perceive their competence to be at par, and did not trust them with all aspects of medical management. AYUSH doctors did not have opportunities to pursue or enhance their skills and knowledge in their own systems of medicine.

> Since we are in the (Ayurvedic) profession, we always feel good to give pure Ayurvedic treatment. But you see, in Ayurveda, you do not have medicines for immediate results. The medicines have not been improved. It has happened but not that much. But in Allopathy it is improving rapidly. And we have to (give allopathic treatment) since we have been posted in government facilities. *(AYUSH doctor, contractual, 3 years in remote areas, female)*

The **threat of civil strife** is pervasive in many parts of interior Chhattisgarh. Insurgent groups were widely feared – they were typically referred to in hushed tones as those "from inside" (Hindi: "andar wale", a reference to their dwelling in camps deep inside the forests which cover large tracts of rural Chhattisgarh). However there is also a strong presence of counter-insurgent groups and armed forces of the government in these regions – and these, along with insurgency, represent a collective context of military presence and strife in the lives of villagers, and the insecurities experienced by health personnel.



A bridge destroyed by insurgents[7]

[7] Photographs are not necessarily of locations where interviews took place

> If I think about the children, we have a joint family and their grandparents are there. My children are staying with the grandparents comfortably. I leave them there often. They also study in (the village where the grandparents live). (*Allopathic doctor, regular, 4 years in remote area, female*)

> I had opportunities - I was getting a well-paying job in Delhi, but I did not go. Because I have been staying away from my home, and my folks were saying: 'how many years will you stay away?' So I thought to opt for a nearby place. (I thought) will stay within 100-200 km - at least there will be frequent visits to my place. There are some family problems also so I prefer not to be too far away. *(Allopathic doctor, regular, 2.5 years in rural and remote areas, male)*

Other respondents who did not specifically have forebears in the locations in which they were posted but had had a rural upbringing also cited a preference for rural jobs. **Rural upbringing, familiarity with village life and with associated values** of simplicity and fortitude were the key factors cited in these accounts.

> People from middle class, who are from cities - they don't like it here. We have always stayed in villages and financially also it's not that we have been brought up nicely - we have stayed in struggle. We like it in struggle, there is no problem in that. *(Allopathic doctor, contractual, 15 years in rural and remote areas, male)*

> Why do we want to go to a city? (Because) we feel that there are good facilities, good money and if money is there everything is there. But in village there is no money, but still you can get peace... if you are working for people in villages they will thank you and give you regards from their heart. They will give you more respect. If the person get respect his efficiency and energy increases. *(Allopathic doctor and specialist, regular, 7 years in rural and remote areas, male)*

> My personal feeling is that if you have been born in a village you will not take time in settling down here. But if there is someone born and raised in a city and if asked to live a village then they might not be able to. Those who come from outside, after looking at the environment here, they not be able to adjust. *(Allopathic doctor, contractual, 18 years in remote areas, male)*

> It was already in my heart that I will live in a small place only and work. Because my background was not such, that I would have adjusted in a big place. In very big cities, what they say, the lifestyle, I wouldn't be able to adjust in it. This place was familiar to me, so I felt that it is suitable for me.

> And since then (laughingly) it has continued here. *(Allopathic doctor, contractual, 10 years in rural and remote areas, male)*

> My house is 1 kilometer away... and as far as staying in the village is concerned, I am from a village, I have been born and brought up in the village, and so I do not face a problem. *(Allopathic doctor, regular, 16 years in rural and remote areas, male)*

Some respondents specifically referred to an **ethnic (usually tribal) identity** as being a determinant in their decisions to remain and serve particular communities.

> In my tribal region no other person wants to work so I will only work for my people. People run away from this place – it is a very tribal area, there are a lot of forests. But I am myself a tribal, so (I thought) who will work in our area? We only will have to work in our area *(Allopathic doctor and specialist, regular, 8 years in rural and remote areas, male)*

> I am also an ST (Scheduled Tribe) and I am serving the ST people here, so I find it good *(AYUSH doctor, contractual, 3 years in remote area, male)*

> From the beginning I belong to such a family....now because I am a tribal so I find it fine to work in a tribal area. *(Allopathic doctor, regular, 8 years in remote area, male)*

Ethnic affinities were not only restricted to tribal or caste identity. In at least one instance, a respondent with Bengali parentage indicated that he had preferentially chosen a location which had large Bengali-speaking settlements. In other instances, doctors may not have originally have had a rural upbringing or previous community links in their place of work, but had developed close links and **relationships with the local communities** over time. This sense of belonging to local communities was cited by some as a reason for staying on.

> I liked the place; here it's not like the city life, no fighting and all. Peaceful people live here and if you do a little for them, they treat you like family. They trust you and if they have any problem they come to you saying that you are our elders. *(Allopathic doctor, regular, 11 years in remote areas, male)*

> Once I was transferred, everyone went on a strike, they surrounded the minister, caused a problem. Because the thing is that in remote areas doctors don't want to stay. Now length of my service is getting over. I have settled here. I have spent so many years in this district that now it is difficult for me to go to a different district. In a new place we might know people but who will know us. But in an old place, over here, everybody knows me. Even if a politician goes by more people will know me (laugh) because we are the ones who go for (field work) campaigns – whether it is

The Workplace and the 'System'

The extent of **satisfaction from work** was variable among the doctors. On the one hand, justifiably, most respondents were not entirely satisfied with the support and facilities available to them. Conversely, there was also a widespread expression of being inspired by the unique challenges and ability to influence health outcomes. "I am satisfied 75%, and 25% I am not satisfied because of the facilities, the limitations..." said one contractual doctor. A number of other respondents expressed a strong sense of personal fulfilment from their daily work.

> There was a case of delivery, they had nobody in their home... we send our jeep to her home and got her admitted to hospital and then we referred her, our jeep only took her there... so this happens, then in your heart you get a different kind of satisfaction and peace which you cannot get from any other thing *(Allopathic doctor and specialist, regular, 8 years in rural and remote areas, male)*

> I go with a fully positive attitude. If I take it to be a headache then my work will not happen. I am fond of my work also – I like explaining, talking to the people *(Allopathic doctor, regular, 5 years in rural and remote areas, female)*

> People are happy with my services and I also stay motivated with their response. I have been here for two years now. *(Allopathic doctor, regular, 9 years in remote area, male)*

Interest in the scientific and professional aspects of their work was commonly expressed by respondents (see also boxed item below). One contractual doctor described work in a particularly strife-affected and remote area as being "beautiful and challenging". Many also took an interest in undertaking outreach work, and in implementing national public health programmes in the community. Others claimed particular interests and skills (eye care, infectious diseases, surgery, obstetrics, health administration, etc.) which they wished to develop further by means of training and higher education.

> If you take an interest then the one in front of you will also take interest. I am a doctor so I believe that whatever I have studied I have to maintain that and not let it go or forget... if I keep treating the people and share my medical experiences, whatever I have studied I will remember. I will not forget that topic then. And then when the patient benefits from those medicines then he would be able to develop trust in me as well the medical science that this doctor is good and useful. This is what I think and this is what I had been doing all this time... Prove it to him (the patient) by doing it – that 'you have fever and I am giving you medicine, till evening you will have fever, sleep under a blanket and then you'll feel better'. And then when she (the patient) gets better then she will accept you. If today one

(patient) believes in you, tomorrow there will be 10 and the day after there will be 100. *(Allopathic doctor, contractual, 18 years in remote areas, male)*

The government appointed me, so I stayed here. I stayed and served the people. I went and talked to the people and said that I have been appointed here as doctor. But people said no, we know that there is no treatment, any two tablets are given and we are sent back. So I went door to door in village and I told them 'I am a new doctor - you will get glucose and injections if you need, and you will get admitted in hospital', so this way I convinced the people. A patient welfare association was formed - I worked there with nominal charges of Rs. 2 only and within six months the funds increased several-fold. *(AYUSH doctor, contractual, 6 years in remote area, male)*

I first started health camps in the villages - like till 1, you work in the hospital, then at 2 we leave for the villages. We used to make a plan – when we will go in which village, section wise. In hilly areas my target was more where there was more poor people - so this way, 3 days in week 3-4 times we started doing camps. And during diseases (outbreak) time - extra efforts. Also we used to encourage people to come to the hospital that come you will get medicines and we will give bottle (i.v. fluid) also or whatever things they need, so when we kept doing this, people started having trust. It took a lot of time to do all this *(Allopathic doctor, regular, 18 years in rural and remote areas, male)*

Yes I did camps for cataract - there were more than 100 cases once so I took arranged that the village society would make everything free of cost. We did all the rest - getting the patients, arranging for vehicles, taking care of the patients and all that. *(Allopathic doctor, regular, 24 years in rural and remote areas, male)*

I have treated something like 500 to 700 cases of leprosy. If we get (the patient) in the early stages, it is fine, we treat them, and if he has come to us really late then - if somebody does not have a finger, or a limb - then we donate clothes, shoes, through the Leprosy Mission. So they (the patients) really like us, and say that we are serving them. Those patients remember that if Doctor Sahab was not there we would not have got all this. Earlier doctors have come and gone but we were the ones to pay so much attention to leprosy cases. *(Allopathic doctor, contractual, 18 years in remote areas, male)*

PROFESSIONAL FULFILMENT

While doctors did complain about the erosion of their knowledge and the lack of educational opportunities, yet, scientific interest and professional fulfilment was marked among several of the respondents. The frequently critical nature of illness in poor and underserved areas, and the opportunities to achieve significant medical outcomes was cherished.

> *The life-saving that we have done, like almost when the person was dying - at the brink of death, we have saved them. Many of them - some bike accident cases, malaria, snake bite - you get more satisfaction after giving such service. Basically I am a doctor; I like doctors' work only.* (Allopathic doctor, regular, 28 years in rural and remote areas, male)

> *Like a super specialist is saving life by removing brain tumours, I am working at the same level by treating cerebral malaria, meningitis patients. There is no difference in the work. It would only be my mentality that I am not a super specialist placed in some big place – so I don't have cars and other facilities. Otherwise my motive of serving is being fulfilled here. If there is a patient of diarrhoea and dysentery and the patient is in mortal state, if his life is saved then it has the same value as those in some big place. This is what I believe.* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

Among selected respondents, the ambition to progress to higher positions in the government public health systems was a motivating factor.

> By God's grace if I will do my PG. after that according to the State policy, a government doctor can decide if he wants to go in the administrative field or otherwise - medical. I feel that I will be able to give better service in the administrative team. Either BMO or CMO - one should have knowledge about the programme. The number of national programmes that are running, the epidemics, one should have detailed knowledge. I think I should go in for a BMO in future after I am promoted. I can give a good result as a BMO. *(Allopathic doctor, regular, 6 years in rural and remote areas, male)*

For many doctors, particularly those in the more remote areas, there was no obvious separation between work and home life. Workplaces were also avenues for support and social interaction, and they sharing living quarters, pastimes and preoccupations with co-workers, often adjusting

with equanimity. While there were instances of interpersonal differences, good personal and working **relationships with colleagues** were a source of strength and sustenance.

> I have good relations with all staff members... see if we are good then our staff is good. If I am wrong my staff members will also be wrong. This is such a place that apart from them there is no family - so we share our happiness and sorrows and they share theirs with us. I scold them also if they do something wrong, but I do not scold them in front of the patients. But when patient goes I tell them that they should not have done this. *(AYUSH doctor, contractual, 6 years in remote area, male)*

> I have kept the hospital staff like a family, so whatever work I give to them, they do it. For instance, if I give some other work to the Sister (nurse), she generally does it for me because all of us have to do the work together. Then there are days when I don't have much help, then I do the dressing, I run the OPD, look after the patients as well - I do all work alone... I have told the entire staff that they should work. Everybody do what they are responsible for. Come on time, go on time. I don't say that I am your senior, I am your junior. I am doing my work, you do yours. Everyone works cordially. *(AYUSH doctor, contractual, 2.5 years in remote area, male)*

> There is a (member of) staff who is finishing on 20th of this month. So we are all feeling bad that he is going. You see it is like a family - just 5 staff are there - 2 doctors, RMA, pharmacist and ward boy, so family-style we are attached to each other. We feel like someone from our home is leaving. We are all feeling very bad *(AYUSH doctor, contractual, 3 years in remote areas, male)*

> My working cooperation is fine with all. There are a few who are drinkers - there are always 1-2 people like that. They may not behave very well at times. They do not work without a scolding. Then he works fine. Rest, all is fine. They do whatever I ask them. *(Allopathic doctor, regular, 6 years in rural and remote areas, male)*

The role of **supportive supervisors** and peers was also cited by some in creating a positive working environment at facility level.

> The other senior doctors who are here - they are here from before us - so we keep on discussing with them and take suggestions from them, keep getting support... if in some decision, we are facing some problem with any disease we can consult with the senior doctor. Also for the other things also like we need this or that we keep on consulting... They are helpful, the BMO and CMO cooperate with us fully. *(Allopathic doctor, regular, 2.5 years in rural and remote areas, male)*

> Our BMO is the best - he supports for everything. We immediately call BMO Sahab that Sir this is the problem - so if it is in his hands then he helps immediately...if not then we call the CMO or we contact the sarpanch and rest of the people in the village 30
>
> Our BMO Sahab is a very nice man...its only because of him that I working or else I would have ran away long back *(AYUSH doctor, contractual, 3 years in remote area, male)*

Security and prestige afforded by a government job was reported to be important by some of the respondents, although by some accounts, the prestige associated with govt jobs had waned in recent years.

> This is a government job, so tension, financial tension is less. In private (practice) we had to take tension - the whole day we had to roam about - you had to give door to door service. *(AYUSH doctor, contractual, 3 years in remote areas, male)*
>
> It is government service, so you have stability in life. In a (private) nursing home you cannot have this *(AYUSH doctor, contractual, 3 years in remote areas, female)*
>
> In government we also get other benefits - like we get training for higher studies. We get knowledge, we meet a lot of big doctors - there are benefits *(AYUSH doctor, contractual, 3 years in remote areas, male)*
>
> They (family) are very happy that I am a doctor – if there is some work in which I can help they do come to me, and I feel happy about it. It feels good when somebody in the family is in a high post. *(Allopathic doctor, regular, 11 years in remote areas, male)*
>
> In our time, in 1990, that time there was no such craze for private jobs. Then, government job was considered the best. I had a postgraduate degree, and I got a government job *(Allopathic doctor and specialist, regular, 20 years in rural and remote areas, male)*

Clearly regular jobs were sought after by contractual employees, with these factors in mind, and the anticipation of obtaining a regular job if they continued in service emerged as a significant motivating factor for ***contractual doctors***.

> My Mrs. stays outside, children and all live outside so I think leave it, why bother just for 15000 rupees - this much I can earn there (in private practice in town) also. But because I see some possibilities, so I think that in a year or two I might get regular, then I can get my Mrs here only. We have got assurance - we went on strike and they said "in 2-3 months we

> will do something about you people" Assurance have been given by the CM - he said "close the strike and work" because they were compelled - the rainy season had started and diseases had started to spread *(AYUSH doctor, contractual, 3 years in remote area, male)*

It was an unfortunate observation however that delays and **irregularities in placements and transfers** may also have been an important factor for doctors' continuing to work in their present locations. A number of doctors were dissatisfied with their respective postings, and had sought transfers elsewhere. However they remained where they were, due to unresponsiveness to their requests and their own financial compulsions which prevented them from risking seeking new avenues of work.

> Since you are asking, I will tell that when I had come here I had thought that I will stay for 2 years and then will find something near my house. I had sent in the request last year but they had given me a place further away near (another district). I did not take that and thought that will apply again next year. *(Allopathic doctor, regular, 9 years in remote area, male)*

> After post graduation, twice I have almost left. You could say that I could not leave when I tried to go out but failed... from the past 6 years, 5 years, 7 years I have had a lack of confidence. *(Allopathic doctor and specialist, regular, 25 years in rural and remote areas, male)*

> I thought of taking a transfer earlier. But if a reliever (replacement) will not come then you will not be relieved - that's what they said. And in 2001 I did a transfer - but at that time also they did not get a reliever, so they were not ready to let me go. 2-3 times I gave an application saying relieve me but they did not do so. Then I did not try again. *(Allopathic doctor, regular, 19 years in rural and remote areas, male)*

> I tried, I got a transfer also. But later there was some problem with the reliever, so I did not get relieved from here. He did not come to relieve me, saying that it's a backward area. *(Allopathic doctor, regular, 24 years in rural and remote areas, male)*

> I try every year for a change of posting. Here nobody wants to come. They say, get a reliever. A reliever - from where do I get one? *(Allopathic doctor, regular, 18 years in rural and remote areas, male)*

> The CMO said that in a few months he will bring me to (a nearby city) but then he retired. Then I stopped trying. Now for how many more days would I want to stay here? I have spent 7 years here. At the most I want to stay another year here. *(Allopathic doctor and specialist, regular, 7 years in rural and remote areas, male)*

SUMMARY: THE WORKPLACE AND THE 'SYSTEM'

Work satisfaction was variable among the respondents, with some reporting high levels of personal satisfaction from providing day to day care, and also from advancing public health programmes and strengthening existing services. A number of doctors also pointed to the opportunity for professional growth and fulfilment, in under-resourced areas, in the context of the frequent need for services of a critical and high impact nature. In the absence of other social avenues and separations from families and communities for doctors in remote areas, the strong relations developed with co-workers, peers and supervisors, were important in improving the experience. Notably, since most contractual doctors are placed in remote areas, this finding was more common among them. The security of regular government jobs was a notable motivating factor for contractual doctors. Unresponsive administrative systems also played a role in doctors not being able to achieve transfers to other locations.

Relations with Patients

While most of the doctors reported good relations with local communities, there were also instances of close and extended relationships with particular patients.

> I would like to share my experience with one patient. They showed their child in district hospital - the doctor wrote the medicine 3 days - 4 days, he did not get well, then he brought the child to me. I gave symptomatic medicine to him and the child got fine. He says that district hospital was not able to cure and Doctor Sahab did it. Today also he gets the child to me only. He says Doctor Sahab I will show only to you. So the emotional connection is there *(Allopathic doctor, regular, 4 years in rural and remote areas, male)*

> In leprosy if we got (the patient) in the early stages, it is fine...and if it has come to us really late then...if somebody does not have a finger, or a limb, then we donate clothes, shoes, through the Leprosy Mission. So they (the patients) really like us, and say that we are serving them. Those patients remember that if Doctor 'sahab' was not there 'we would not have got all this'. Earlier doctors have come and gone, but we were the ones to pay so much attention to leprosy cases. So they remember us and after they are cured they respect us. Like even for TB, through the medium of DOTS I have treated a lot of cases. So like even for them there treatment continues from 9 to 12 months. They come and go and keep meeting, and greet us 'namaste'- so a relationship is formed *(Allopathic doctor, contractual, 18 years in remote areas, male)*

> Yes there are many such, they come to me only. If I am not there then they wait for me that when will doctor sahab come... I have been here for 21 years. There was a child with nephrotic syndrome - the kid must be 8-10 years old. Its a very painful life. I saw and diagnosed him. I gave treatment and he used to get OK, and he kept coming to me... now after 11 years he is OK, he has grown into a young man. His father also comes - they take my name, and they refer other people to me also *(Allopathic doctor, regular, 28 years in rural and remote areas, male)*

> There is a woman who was not having menses for a long time, so I prescribed a medicine and now she is having her menses. She is very happy now. Whenever she would have her periods she would come and tell me that "Sir, this month I had my menses". Sometimes she leaves mangoes at my home for the children. So there are such cases - a relationship is established. *(AYUSH doctor, contractual, 2.5 years in remote area, male)*

A community health centre[9]

Some respondents spoke of the importance of adaptability to the different needs of patients in remote areas.

> They don't understand anything so it is our job to make them understand. Now if we explain to them according to their own understanding, only then its OK, if we explain like you would in Raipur then they will not understand anything. So we have to shape ourselves according to their environment. *(Allopathic doctor, regular, 11 years in remote areas, male)*

> People want that if they have come to a doctor so then they don't have the need to go anywhere else... they don't see how much he knows, they want the behaviour of the doctor should be good. If your behaviour is good they give a lot of love... My experience has been very good *(Allopathic doctor, regular, 11 years in remote areas, male)*

> It's a small place. Few people stay here and there is just one doctor - obviously all the patients come here only. Like pregnancy cases - if they have any other ailment they still come to me only. With such patients you form a relationship above the normal 'patient and doctor' *(Allopathic doctor and specialist, regular, 4 years in rural area, female)*

[9] Photographs are not necessarily of locations where interviews took place

SUMMARY: RELATIONSHIPS WITH PATIENTS

A number of doctors spoke of strong relationships with their patients, but there was little indication that these impacted directly on their decisions to remain in rural areas.

What They Need: Improving the Experience

Among ***contractual doctors***, **higher pay-scales** were a frequently expressed need, with a majority of them claiming that their compensation and the terms of their contracts were prohibitive. A number of respondents reported how their salaries had not been increased to match the rising prices of commodities and services.

> They are giving me 15,000 per month which is nothing. When I joined here, rice was Rs 11 per kg. Now, how can you manage in 15,000? 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 15,000? Salary is not good. *(AYUSH doctor, contractual, 6 years in remote area, male)*

> After Chhattisgarh was formed - from Rs. 8000, it straightaway became Rs. 15,000. When it became Rs. 15000/- I was relieved that a good enough pay scale has come. So what if I am on contract basis, it's ok. My work will run smoothly. But as time is passing by, today's position is such that a primary school teacher is earning above 15,000 and we are still working for the same. So now for the family or to maintain the lifestyle, where will you get the money from? So you will have to (do private) practice. But the contract says that no kind of private practice is allowed (laughs). *(Allopathic doctor, contractual, 10 years in rural and remote areas, male)*

> When we started here, we were getting 8000, but now it is 15000. After so many years it is still 15000. In 8000, living was difficult - then it got 15000 and it felt a little good. But with the economic situation now, 15000 is looking equal to that 8000 – it seems there is no difference. And people below us have superseded us - like a worker is getting 20000. So we are feeling a little let down. *(AYUSH doctor, contractual, 3 years in remote areas, male)*

Remarkably few ***regular doctors*** (2/25) expressed dissatisfaction with their current salaries. However, a number of respondents voiced the opinion that greater compensation for doctors working in remote areas would assist in their retention doctors in remote areas.

> Doctors who are working in these remote areas - they are actually doing a favour. We say that "you are a government servant you are not doing any favour" but it's not really like that - if they are living 70 kms inside the jungle then the doctor is very valuable to the people living there – he is doing a favour to the system. And as incentive, if a doctor is living 70 kms away from any place then what can you give? Money - What else can you give? *(Allopathic doctor and specialist, regular, 8 years in rural and remote areas, male)*

> Give the doctors some incentive so that at least they stay here because of the lure. If you do not give that, and say that you have to go to villages - why will that person go? *(Allopathic doctor, regular, 2.5 years in rural and remote areas, male)*

> Salary should be increased according to the village location. Totally interior - salary should be 1 lakh; less interior - 50, 000; city - 30,000. This is very important. *(Allopathic doctor and specialist, regular, 20 years in rural and remote areas, male)*

The **security of a regular job** was also a widely and strongly expressed need among ***contractual doctors***. Many of them had joined their current contractual positions, based on assurances or expectations of conversion to a regular position after a period of time. The uncertainties of contract employment were magnified in the case of AYUSH doctors, since there are no regular jobs earmarked for non-allopathic practitioners.

> I want to see myself progressing but because it is in the hands of God so I don't know if it will happen or not. I feel there can be some progress if we stick here but here, it might also happen that we leave and go. My Mrs stays outside, children and all live outside, so sometimes I think "leave it, just for 15000 rupees..." but because I see some possibilities so I think that in a year or two I might get regular then I can bring my Mrs here. *(AYUSH doctor, contractual, 3 years in remote area, male)*

> I am in an ad hoc job. When I go to the bank for a loan they say you will be turned out after one year so how will you pay back the loan. If you will leave the job and go where will we search for you? By this ad hoc job the government is getting its work done, but our position is getting poorer. *(AYUSH doctor, contractual, 6 years in remote area, male)*

> The foremost thing is that our job is not secure. The sword is hanging - that is the type of job we have. We are under contract and when the allopathic doctors will come then we we will find that we are not needed. So we have no certainty here. Allopathic doctors have a regular post here so it's fine for them *(AYUSH doctor, contractual, 3 years in remote areas, female)*

> 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, 2.5 years in remote area, male)*

"ISSUE A SIMPLE LETTER"

Some ***contractual doctors*** reported having served on contract for an inordinate period of time, reportedly due to loopholes and technicalities which could be have been readily rectified by the exercise of political will by administrators.

> *When I joined on contract, all of MP was one state. The division of Chhattisgarh happened later in 2002, and my position is still contractual. We are giving so much, staying in villages – the government should at least think so much that they make us regular. I have been working for 12 years.* (Allopathic doctor, contractual, 15 years in rural and remote areas, male)

> *I have wished it (getting a regular position) but what can we do about it? It is in the hands of the government. When I joined service I was two years over-age. And now ten years later when another round of selections for regular service is taking place, I am over-age again. So now I have stopped hoping.* (Allopathic doctor, contractual, 10 years in remote areas, male)

> *We joined here when Chhattisgarh was not formed - then this was in Madhya Pradesh. So the Health minister at that time, for (two underdeveloped districts) he introduced a special workforce category. And that is still the case – so we have been here for more than 15 years, but on our record it is written that we are ad hoc. Think about what are going through. On one hand you expect us to serve you and when official loopholes come up then you can't even issue a simple letter.* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

The need for more transparent and **rational procedures for promotion and transfer** were highlighted by several respondents.

> I have been working since 20 years, and so far I have had no promotions at all - I just keep sitting around. Not a single promotion, no increment, no timeline- it's been 20 years. Those who have just finished probation periods have received increments. There are many such cases - there is one who is my 24 years senior, even he has not received any promotion. There is this doctor in (another district) who is 10 years my junior - he has been promoted. Here it has nothing to do with junior or senior. There is no

representation of such grievances - I do it on my own but it's not heard. The review was done last year by the directorate but till date the (administrator) has not been able to get the paper. From here, whatever paper goes to the (administrator) keeps lying in the trash at the directorate. The (administrator) says that he did not receive any such paper and (senior administrator) says that he does not know anything. *(Allopathic doctor and specialist, regular, 20 years in rural and remote areas, male)*

Request the government to make a mechanism for promotion. When I have given service at this level for so long then you should also give opportunity at upper level - at district level *(Allopathic doctor, regular, 28 years in rural and remote areas, male)*

The Government, no matter how many rules it makes, (it) cannot follow. They should say "it's been so many years since his post graduation so he should be settled in district". But they don't do that. I am a specialist for so many years, but still here. I have stayed on here, willy-nilly. *(Allopathic doctor and specialist, regular, 25 years in rural and remote areas, male)*

If a doctor gets posted in a remote area then there is no such policy that that poor person would get transferred after 5 – 10 years. The poor guy keeps aging and continues to stay in the village. Nobody wants to stay there forever. It is like when a boy (young doctor) comes for a job his children are small or he is not married. Then by the time his kids are 4-5 years old he should get transferred because of the children's education. If he is unmarried he can stay anywhere. But when he needs schools and all around then one needs a change of place. The government should have a clear policy. *(Allopathic doctor and specialist, regular, 20 years in rural and remote areas, male)*

I have been working here for 16 years. If we go by government norms then after 5 years of duty in a tribal area I should have been transferred to another less remote place - but all these things are not possible. I don't want to blame the government but this is a fact that without making a lot of personal efforts, there will be no transfer. *(Allopathic doctor and specialist, contractual, 16 years in remote areas, male)*

Deficient human resources, apart from the problems they create from a planner's perspective, have their most immediate impact on the working lives of the providers who continue to work in underserved areas. The need for **addressing shortages in personnel** by filling existing vacancies was voiced by a majority (32/37) of respondents.

See, I should admit her (a patient standing nearby) - she has malaria. She has been treated twice previously. Now if I admit her in the hospital, I might learn that there is a camp or that I have to run to one of the PHCs

(where there are no other allopathic doctors). And there is no staff (nurses) here. This is why I don't admit patients. I keep them in OPD for 2-3 hours when I am sitting, then I ask the patient to come again the next day or day after next, but I can't ask them to stay overnight. *(Allopathic doctor, regular, 11 years in remote areas, male)*

There is X-Ray but the technician is not there so it is not operational... The workload has also increased, with me and (a colleague) what has happened that I have to look after a entire PHC and a CHC. (The colleague) has two PHCs - (names of PHCs). Because of the workload I feel unsure. I think that if I get one helping hand then I will be able to do it. (*Allopathic doctor, regular, 4 years in remote area, female*)

There is one nurse and a ward boy, so it's very difficult to manage with just 2 people. I am one doctor and I am looking after 2 PHCs when there should be 4 (doctors looking after 2 PHCs). I had sent a written request but there has been no posting till now. I have sent it twice... *(Allopathic doctor, regular, 8 years in remote area, male)*

Cleaners are the biggest problem for the hospital - we only had one sweeper. Then from Jeevan Deep Samiti we took a part time sweeper. Even that was not enough - so we have kept him full time now *(Allopathic doctor, regular, 18 years in rural and remote areas, male)*

SHORT-STAFFED AND OVERBURDENED

Existing personnel are overburdened and stand to benefit greatly if vacancies are filled

> *For a population of 70,000 we are just two MBBS doctors. We have to do post mortems, MLCs, OPD, surgery and official work also. We also have to take care of the orders from Delhi, Raipur and (district headquarters). How we manage all these things is something only we can understand. For the sake of humanity - even we are humans - we also have family obligations. We are not able to fulfil our official responsibilities, and our family life is facing difficulties too.* (Allopathic doctor and specialist, contractual, 16 years in remote areas, male)

The need for improving the quality and regularity of **medical supplies** and provision of better **workplace infrastructure** was also stated widely, to improve working conditions and enhance professional satisfaction.

There is shortage of materials, and it is of very bad quality. We get only 1/10th 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. For Janani Suraksha Yojana - it is not as important to increase institutional deliveries as it is to provide facilities in the institution. We need at least 500-600 syringes for 150 deliveries. 200 antibiotics. Ladies come and lie down in labour room - the rubber sheet is never changed. 50 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 4 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)*

OT is not functional, because there is no sterilization apparatus and oxygen cylinders. Secondly there is a problem of electricity here. Without electricity it is difficult to do surgery. If the suction machine does not function, and if there is no proper sterilization, how can we run it? *(Allopathic doctor and specialist, regular, 7 years in rural and remote areas, male)*

When we are doing caesarean section, most of the things we have to arrange 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 which we have to order personally. *(Allopathic doctor and specialist, regular, 4 years in rural area, female)*

In 21 places there is no sub centre - so what should the Sister (ANM) do? Should she open the subcentre at somebody's place? Fix one room for deliveries, with plastic on top? *(Allopathic doctor and specialist, regular, 25 years in rural and remote areas, male)*

Being a BMO I should be getting a vehicle to work on field only then will I be able to cover whole field of 70,000 people - vehicle, diesel, driver, these are petty things that should not need to be said. But, even to do that I have to make lots of efforts and despite those I haven't received them. I have to use my own vehicle and spend on my own petrol and diesel to do field work *(Allopathic doctor and specialist, contractual, 16 years in remote areas, male)*

While many had attempted to raise issues of personnel and material shortages with their supervisors, with varying success, some regarded it to be a futile exercise.

> It is unlikely that someone will join. People come, see the place and go... if I discuss all these things (shortages of staff and materials) with him (the CMO) then it's a waste of time for me as well as him. Therefore I do not do it. The OPD is too heavy for me, I want another doctor, but he himself does not have one, how will he give for me? (*Allopathic doctor, regular, 4 years in remote area, female*)

> Now here we need medicine but don't have it... I did discuss this CMO sahib and he is 'yes, yes, yes', but then later nothing. I mean, you are giving computers everywhere....and there are facilities of mobile phones - if you want to do so much then why don't you give it to me? Medicines don't go waste at my OPD. So there is a problem that I don't have medicines and then what should I say to the patient? *(Allopathic doctor, contractual, 18 years in remote areas, male)*

Greater **opportunity for training and skill development** was another explicitly expressed need of a number of respondents.

> If the government can get the doctors who are posted in the peripheries to polish their skills once in a year or so... A refresher course – we must be given a chance to do something like that. So that even we are benefited and we do not forget whatever we have studied. *(Allopathic doctor and specialist, regular, 4 years in rural area, female)*

> I have to refer out many cases. We should be given a refresher course at least every 2 years, and we should also be given MD (postgraduate degree) training, or at least a diploma. Because we live in remote areas, if they make us into specialists and get us to do MD then the people will be benefit. Cases that we end up referring would then be taken care of. *(Allopathic doctor, regular, 11 years in remote areas, male)*

> Yes, if they train me in orthopedics, (I) will definitely go. They should organize trainings twice a month! (laughs) Also for burn cases – we are not able to manage such cases well. The third is maternal health. We are all male doctors. Initially they do not prefer us - there are some reservations in the community, but when there is a lot of problem then they do not think male or female doctor – this would be most beneficial. *(Allopathic doctor, contractual, 18 years in remote areas, male)*

'MY PATIENTS SHOULD COME TO ME FIRST'

There was a particular demand for **needs-specific clinical skills development** among respondents, in areas which reflected their field experiences, and which would enhance their response to community needs.

> *If I am given more training in handling TB then I will like it because I have seen cases very closely, I have seen patients dying so I feel like I want to be able to do something about it. The biggest thing is that patients don't come here often - they go to (a nearby block headquarters with private doctors). So it hurts – I feel that when I am sitting here then my patients should come to me at least the first time. And I feel that if I was able to tell people more about DOTS and TB care then maybe the condition would not have been such.* (AYUSH doctor, contractual, 2.5 years in remote area, male)

> *Many a time we are in the field and the condition is such that we feel we don't have enough skills. Especially in surgery and obstetrics - we want to treat, but we don't have the authorization. So it would be good to get some training. From the beginning I have had an interest in surgery, but even if we want to do we are unable to - so this is the only thing left* (Allopathic doctor, regular, 18 years in rural and remote areas, male)

The need for **better living and housing arrangements** was commonly reported across all categories of respondents. Costs of repairs in dilapidated housing were often borne personally, and sharing of living quarters was commonplace. Some respondents complained about the indignity of living accommodations which they felt did not befit their professional status.

> Give a few amenities to the doctors. They should make quarters for doctors, not like a primary school master - there are many who are living in rented houses – to bathe, they are going outside to the river. So all this is not right. If you are constructing a PHC somewhere then along with that you should make quarters - a little away from the common people. All these accommodations are not so good – repairs are often needed, and we have to do it ourselves. The government only provides the wall and the roof - if anything has to be improved, we have to do it. *(Allopathic doctor, regular, 18 years in rural and remote areas, male)*

> The second doctor who is here is staying with me, in my quarters. Some work has been done in my quarter, but in his part, nothing much has been done[10] - so he is staying with me only. *(Allopathic doctor, regular, 19 years in rural and remote areas, male)*

> Doctors do not want to come to the village, but why? First thing is that accommodations here are inadequate. For the past 2 ½ years, I was staying in rented quarters - my quarters have just been constructed. If a MBBS doctor is joining here and he sees that if there is no facility for him to live, then how will he feel? I did not have a room to stay in for 3 years. But not everybody would have the same attitude. Because I am raised in a village we do not take time to adjust but if someone from the metros or good city then how will he adjust? *(Allopathic doctor, regular, 2.5 years in rural and remote areas, male)*

> So we have to stay together, have to share. I took this room in the hospital (facility) building only. It is actually a sub-centre building - one room and kitchen. So 3 people live in one room - 2 doctors and one pharmacist. For staying, some better arrangements should definitely be made. *(AYUSH doctor, contractual, 3 years in remote areas, male)*

The need for **quality education for their children** was widely and emphatically cited by respondents (27/37), across all groups and categories. A number of doctors in very remote reported that they were happy to remain primarily because there were good schools in the vicinity. In other instances, those who were otherwise content with rural work reported that better schools were the only reason which would have led them to migrate to cities.

> I want to give my children a good education, so in my circumstances I have to keep them in Raipur. I don't know how many years it will take for a good school to open here. *(Allopathic doctor, regular, 11 years in remote areas, male)*

> 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 that they can't give their children even primary education. So according to the times, his children will lag behind. So because of this nobody wants to join here. At block level at least there should be a school for children - from there, doctors can go daily to their PHCs. This way there will be more doctors for rural service. *(Allopathic doctor and specialist, regular, 8 years in rural and remote areas, male)*

[10] The second doctor's allocated room was in a state of partial destruction, with two walls and part of the roof missing

> There are no schools here – there are government schools but no teachers. Schools are in a bad condition - there is a high school but there is only one teacher - can you imagine from primary to high school only one teacher! *(AYUSH doctor, contractual, 3 years in remote area, male)*

> Because I am a PG in medicine, even I have a desire that, like those children who are going to good schools and have good places to go to from there, similarly our children would also attain a good position. But we are not even able to give our children good education, the most basic thing. *(Allopathic doctor and specialist, contractual, 16 years in remote areas, male)*

> Now for our children education is not possible here. The government should make such a plan where our children can study in a modern school. If they did that, then we would have been tension-free today. And the service we are doing for the government would be done with interest. *(AYUSH doctor, contractual, 6 years in remote area, male)*

Growing concerns in the wake of increasing civil violence and insurgency are summed up in this female doctor's account. The need for **assurance of personal security** is clearly important for doctors in certain violence-afflicted areas.

> Staying here has really become difficult. Day by day, the condition is deteriorating. The Naxalite problem has increased. When I had initially come here it was not that bad. But in last 5-6 months it has got worse. Although they do not trouble us a lot but you never know what trouble we may land up in. That is why I feel that it is better to go from here. They recently burnt a truck near the ANM's house. It is not very safe in the village. We feel afraid. (*Allopathic doctor, regular, 4 years in remote area, female*)

> The posting is fine here. There is no problem as such, there is no real problem from Naxals here, but still if there is a sound of a gunshot, then mind does get disturbed. Especially at night if it seems that there is something happening and someone is approaching, it makes me anxious. *(Allopathic doctor, regular, 16 years in rural and remote areas, male)*

SUMMARY: WHAT THEY NEED

The respondents' expressions of their needs – reflecting perceptions of changes which would improve their experiences of working in rural and remote areas – encompassed a range of reforms and improvements. Better salaries and job security were emphatically stated by contractual doctors, while the entire cross section of doctors emphasized the importance of more rational transfer and promotion procedures, filling of health worker vacancies, and improvements in materials and facilities. More opportunity for needs-based skills training and better housing also found significant mention. Social needs voiced included (most prominently) better schooling for their children, and assurance of personal security.

SUMMARY OF FINDINGS

A synopsis of key observations is presented in Table 5 below.

	MAJOR [11]	*MINOR*[12]
Reasons for Joining	- Geographical and ethnic (tribal) affinities - Personal values of service - Financial compulsions	- Inducements of preferential admission to higher education
Factors Favouring Staying On	- Geographical affinities - Rural upbringing - Ethnic (tribal) affinities - Availability of good schools in the region - Personal values of service - Professional interest and ambition - Strong relationships with colleagues - Anticipation of security of regular job (C) - Opportunity for both spouses to work and live in the same location (F)	- Spiritual and religious leanings - Disinclination for private practice - Financial compulsions - Getting accustomed to rural life - Closeness to parents and family - Familiarity / familiarization with village life - Good relations with local communities - Satisfaction and fulfilment - Good relations with supervisors
Needs Expressed	- Assurance of job security (C) - Improved workplace arrangements and resources - Good schools for children - Better housing - Needs-specific training and skill development	- Better salaries (C) - More rational promotions and transfers - Assurance of personal security

Table 5. Key findings from the study
(C: specific to contractual doctors, F = specific to female doctors)

Practitioners' initial decisions to join service in rural and remote areas were often influenced by **prior familial and community linkages** with the place (district or region) in question. In other instances the decision to join was often automatic or unmeditated – they were simply posted there by the state health administration.

Once in service, doctors not only faced **adverse external circumstances** but also struggle with magnifications of the **generic problems of government health systems**. These conditions evoke a mix of responses among doctors, some revelling in the experience and finding opportunities in the challenge of adversity, and others confronting an eroding knowledge base and decline in professional confidence and capabilities.

The doctors' decisions to remain in rural and remote areas over periods of time were driven by a more complex set of factors reflecting **personal qualities, community linkages** and **systemic factors and influences**. Critically **combinations of reasons** were as important as discrete factors in influencing the decisions of the practitioners to remain. **Life processes**, professional interests

[11] Prominent themes – elicited widely and/or emphatically expressed
[12] Less prominent themes – elicited among or expressed by fewer respondents

and ambitions and relationships built over periods of time influenced the doctors' decisions to stay on.

Respondents' views were also canvassed on what they needed to improve their experiences of working and living in remote and rural areas, which covered a spectrum of potential reforms and improvements around **institutional procedures**, **redressing resource gaps**, and **job safety**.

The professional insecurities of **contractual doctors** set them apart in some respects – both of factors favouring staying on and their stated needs.

STRATEGIC IMPLICATIONS

Of all facets of an effective health service, the presence of health workers is the most fundamental requirement. The successful implementation of health care plans requires close attention, not just to the needs of end-users of care but also to frontline providers of health care, their antecedents, the circumstances in which they live and discharge their duties, the web of interactions which define their roles in health systems and societies, and their interests, aspirations and needs (Sheikh and George 2010).

This qualitative research study explores a phenomenon which should in ideal terms be a *fait accompli* – the presence of health workers in health care facilities – but which in the unfortunate reality of rural health systems, is often rarer than their absence. In its exploration of the work and lives of qualified practitioners who continue to remain in service in remote rural locations of Chhattisgarh state, the study yields findings which are of strategic relevance in Chhattisgarh and Indian health policy contexts, and also contain important global lessons for strategies to retain qualified health workers in rural and remote areas.

Geographical and ethnic affinities, and a rural upbringing, appear to be dominant factors favouring doctors' decisions to join and also to remain in service in rural locations. This finding supports the deployment of policies such as **affirmative action for entry into medical education** for doctors originating from underserved areas, and also potentially for candidates with tribal ethnicity. Another potential strategic direction suggested by this finding is the **decentralization of medical training**: the institution of medical colleges in rural and remote areas, to enable medical aspirants with a rural upbringing to train and join work in their preferred places of residence. Acclimatization to rural life also emerged as an important factor favouring doctors' decisions to remain, which also underscores the importance of rural medical education.

While the need for an absolute increase in pay-scales did not emerge as a strong theme among this selection of respondents, this should not be interpreted to mean that the issue of economic returns is insignificant. The importance of regular remuneration and of attendant benefits to government servants such as **better housing** and **educational opportunities for children** cannot be overstated. Furthermore, a **graded salary scale based on remoteness and difficulty of terrain**, and greater benefits (pensions, housing, free education for children) to doctors serving in difficult areas could be of particular utility, particularly in the context of the war-like circumstances in parts of the state, the implicit risks to personal security and social isolation. Special efforts can be undertaken by the state to assist doctors' spouses in finding employment in the same areas, and in facilitating admission to high quality schools with boarding arrangements for their children. Voluntarily implemented **rotation policies**, with the option of limiting the time spent in a particularly difficult area, may also help to improve uptake of remote postings.

The strong personal values and professional interests evinced by a number of respondents belie the popular myths that doctors remain in rural areas only out of compulsion, and that government service is widely considered inferior to private practice. In spite of significant concerns over the quality of working environments, regular government service was widely regarded by respondents as a stable career option, and a positive opportunity to contribute to the broader social good. Substantive interventions aimed at building on these positive conceptions by **raising the acceptability of employment in rural health services**, as well as the **image of government health services among rural communities** may well serve to attract more new recruits and aid in retention of more qualified workers.

First and foremost, the profile of government health care can be enhanced by providing **better working conditions** for health workers – including better infrastructure, materials and, ironically, more manpower. The presence of adequate numbers of staff in health facilities improves the working experience for those already in station, creating a positive cycle: more manpower improves working conditions which in turn attracts more manpower / aids in retention. **Nurturance of doctors' professional interests and ambitions,** and stemming the erosion of professional skills is another critical step in raising the social profile of government services. **Opportunities to enhance skills and academic exposure in areas which reflect community needs** act to further doctors' professional interests and can reduce problems of intellectual attrition and isolation – doctors particularly emphasised the need for refresher clinical skills training in areas such as emergency and accident care, obstetrics and maternal health, tuberculosis and malaria care. Electronic communication on medical subjects with peers and specialists through video and teleconferencing interfaces has become possible, and could help in countering the professional isolation and skill attrition experienced by rural doctors. The introduction of **postgraduate specialist degrees in rural medicine** and primary care is another intervention that can act to enhance the acceptability and status of rural practice.

Also very significantly, doctors seek accountability and respect from their employers. **Rational and transparent procedures for placement, transfer, promotion and upgradation** from contractual to regular services can all play a role in making rural government service a more attractive proposition. Lastly, cosmetic gestures are not without their pragmatic importance. It is an unfortunate commentary that in some circles, rural postings were regarded as 'punishment postings' or as last resorts for those without the personal connections or entrepreneurial initiative to find work in cities. Far-removed from this image of the unsuccessful outcast, some doctors asserted their own self-perceptions as heroes and frontier soldiers in defence of those most in need. The goal of greater retention may well be served if authorities were to share and promote this perception, and commence to accord **formal recognition and reward for services under difficult conditions** to health workers with appropriate credentials and histories of rural service. Authorities can also assist in building positive and enabling working environments through context specific packages of activities – including supportive supervision, tour programmes, and scientific events. Organized forums and occasions for intermingling with social and professional peers and with local communities can also engender stronger perceptions of appreciation and recognition.

The findings of this study, emerging through a systematic, rigorous, reflexive and well-validated research process, are nevertheless of a subjective nature. While the authors believe that they have significant value in informing strategic directions, they are not intended to represent an immediate blueprint for policy change, (which is necessarily context-specific, subject to the prevailing balance of health sector priorities and to considerations of operational feasibility, political viability and cost). How these findings *can* serve is 1) as an inferential basis for strategic directions which deserve to be field-tested for impact and appropriateness, and 2) to highlight specific systemic enhancements which may aid in improved retention of the qualified public health workforce, locally, nationally and globally. Key potential strategic implications which can be inferred from this study are summarised as follows:

- Establishment of more medical training institutes in rural and remote areas
- Strategies promoting affirmative action for entry into medical education for doctors from underserved areas, and of tribal ethnicity
- Enhanced and assured government employee benefits, notably quality housing and children's education
- Introduction of graded salary scales based on remoteness and difficulty of terrain, and enhanced packages of benefits to doctors serving in difficult areas
- Introduction and implementation of voluntary rotation policies, with the option to limit the amount of time spent in particularly difficult areas
- Stringent implementation of standards for working conditions – including adequacy of infrastructure, materials and manpower
- Augmenting in-service training opportunities to closely reflect community and trainee needs
- Measures to enhance rationality and transparency of procedures for placement, transfer and promotion
- Institution of formal recognition and rewards for services under difficult conditions

Summary: strategic implications

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ANNEXURES

Topic Guide

TOPIC GUIDE

Introduce self and engage respondent

Provide information on the study and objectives, confidentiality and further information as detailed in the consent form

Take informed consent for interview and for recording the interview

Switch on recorder

Commence the interview

TOPICS

1. Educational, professional and social history
2. Context of joining their respective profession
3. Experiences of working in their present location
4. Experiences of working in other locations, if any
5. Social goals and ambitions
6. Professional goals and ambitions

7. Remit of medical duties and activities
8. Types of patients – medical profiles
9. Types of patients – social and economic profiles
10. Interactions with patients, remarkable or long-standing associations if any

11. Familial bonds, experience of geographical distancing from family, if so
12. Community bonds, experience of geographical distancing from community, if so
13. Interactions with community leaders, social movements, political actors

14. Experiences of working arrangements
15. Experiences of remuneration arrangements
16. Interactions with co-workers, supervisors, referral units, other health system actors
17. Experiences of opportunities for personal development / capacity-building
18. Experience of changes and reforms in working arrangements or remuneration, if any
19. Experiences of competing opportunities elsewhere

Obtain / reconfirm the following details

- Full name of respondent _____
- Designation of respondent_____
- Full qualifications _____
- Total duration of experience _____
- Duration of experience in rural / remote rural area _____

Points to remember while conducting interview:

- Take time to build rapport and comfort
- Cover all the topics carefully, as the interview proceeds although not necessarily in sequential order
- Encourage detailed narratives of experiences, probe carefully to encourage - not interrupt - narratives
- Focus on experiences of specific events and phenomena, not on hypothetical or abstract examples
- Encourage respondents to provide explanations of their experiences, rather than opinions which are not linked to specific experiences
- Probe appropriately, introduce new topics naturally in the course of conversation
- Avoid leading questions, do not pre-empt responses
- Always be respectful, adopt a neutral tone and consciously avoid expressing judgment, even if you do not agree with the respondent

Form for Obtaining Consent

Consent Process and Form

Information to be conveyed to the health worker prior to obtaining consent:

We are doing a research study exploring the experiences and circumstances of qualified health workers who have worked for a long time in rural and remote areas.

This study is being conducted by the Public Health Foundation of India, National Health Systems Resource Center of the Ministry of Health and Family Welfare, Government of India and Chhattisgarh State Health Systems Resource Center, Government of Chhattisgarh.

We are hoping to talk with you for about 30 minutes to one hour. Please talk to us freely and frankly and let us know if there are any issues we bring up that you do not want to discuss. At any time, you may terminate an interview or request that interview data be removed from the study.

Your participation in this study, and all records about your participation, remain confidential. All data will be stored in secure locations and available only to study personnel. None of the information obtained will be identified with you, or your place of work.

If you have any questions now I will answer them, and if you have questions later you can contact us

Statement of person administering consent

I have fully explained to _____ the context, purpose, procedures and risks that are involved in the above-described study. I have taken free and informed consent from him/her to participate in the interview, without suggestion or coercion. I have answered all questions to the best of my ability.

_____	_____	_____
Date	Signature (Person Administering Consent)	Name

Witnessed by:

_____	_____
Signature (Witness)	Name

Thematic Framework of Analysis

Superfamily	Code Family	Codename	**Definition:** Segment of text which describes:
BACKGROUND	*Personal antecedents*		
		B_FAM	Personal family history
		B_COM	History of community affinity (ethnic / linguistic / religious)
		B_LOC	Place of upbringing or education
		B_EDU	Personal history of education and qualifications
		B_PROF	Circumstances of entering medical profession
		B_OTHWK	Previous work experience other than in present location
		B_JOIN	Circumstances of joining work in present location
FACTORS	*Factors favouring staying on – personal*		
		F_PERVAL	Personal values with bearing on experience of staying on
		F_ACCUST	Process of getting accustomed to living and working in present location
		F_FAMREL	Relationships with family with bearing on experience of staying on
		F_RELIG	Religious inclinations with bearing on experience of staying on
		F_SPOUSE	Spouse-related factors with bearing on experience of staying on
		F_PP	Opportunity for private practice in present location
	Factors favouring staying on – community		
		F_ETH	Ethnic affinities with bearing on experience of staying on
		F_GEOG	Geographical affinities with bearing on experience of staying on
		F_GOVREL	Relationships with government actors (local self-govt, dist administration, other) with bearing on experience of staying on
		F_POLREL	Relationships with political movements or actors (including insurgent and counterinsurgent groups) with bearing on experience of staying on
		F_COMMREL	Relationships with local communities with bearing on experience of staying on
	Factors favouring staying on – health system		
		F_COLREL	Relationships with workplace colleagues with bearing on experience of staying on
		F_SUPREL	Relationships with supervisors or superiors with bearing on experience of staying on
		F_JOBSEC	Job security as a factor bearing on experience of staying on
		F_WORKVAL	Valuation of work: enjoyment, satisfaction and challenge of work, ideals of professional service or professional identity
		F_COMPUL	Compulsion to remain in present location
		F_PREST	Prestige (of government job, among peers and colleagues, etc.) as a factor bearing on experience of staying on

	Factors favouring staying on – patients		
		F_PATREL	Relationships with patients with bearing on experience of staying on
NEEDS	*Needs which would enhance experience of staying on*		
		N_SALUP	Significance of increase in salary
		N_CHILDED	Significance of educational opportunities for children
		N_ACAD	Significance of opportunities for academic exposure and development
		N_PEER	Significance of opportunities for peer interactions
		N_PERSEC	Significance of better personal security
		N_JOBSEC	Significance of job stability and security (mainly for contractual employees)
		N_PROM	Significance of more rational procedures and policies for promotion
		N_TRANS	Significance of more rational procedures and policies for transfer and placement
		N_STAFF	Significance of correcting shortages of support staff or colleagues
		N_MAT	Significance of correcting shortages of equipment and materials and improving working conditions
		N_HOUS	Significance of better residential arrangements
		N_ACK	Significance of better acknowledgement and recognition of contribution
		N_SUPER	Significance of better supervisory support and guidance
		N_SOC	Significance of improved social life and leisure facilities
NARRATIVES	*Experiential narratives*		
		NAR_CRITEX	Critical experiences which provide an insight into the individual experience of living and working in
		NAR_COP	Experience and mechanisms of coping with personal and circumstantial problems of living and working in the present location

Timeline of Interviews

S. No.	Date	District	Facility in which interview conducted
1	01.07.09	1	CHC
2			PHC
3	02.07.09	2	PHC
4			PHC
5			PHC
6	03.07.09	3	PHC
7			PHC
8			PHC
9	07.08.09	4	CHC
10			PHC
11			CHC
12			CHC
13			CHC
14			CHC
15	08.08.09	5	PHC
16			PHC
17			PHC
18	08.08.09	6	PHC
19			PHC
20			CHC
21			PHC
22	10.08.09	7	PHC
23			PHC
24			PHC
25			PHC
26			CHC
27			CHC
28			CHC
29	12.08.09	8	CHC
30			PHC
31			PHC
32			CHC
33	13.08.09		CHC
34			PHC
35			PHC
36			PHC
37			PHC