Original research

Rural recruitment and retention of health workers across cadres and types of contract in north-east India: a qualitative study

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Abstract

Background Like many other low- and middle-income countries, India faces challenges of recruiting and retaining health workers in rural areas. Efforts have been made to address this through contractual appointment of health workers in rural areas. While this has helped to temporarily bridge the gaps in human resources, the overall impact on the experience of rural services across cadres has yet to be understood. This study sought to identify motivations for, and the challenges of, rural recruitment and retention of nurses, doctors and specialists across types of contract in rural and remote areas in India’s largely rural north-eastern states of Meghalaya and Nagaland.

Methods A qualitative study was undertaken, in which 71 semi-structured interviews were carried out with doctors (n = 32), nurses (n = 28) and specialists (n = 11). In addition, unstructured key informant interviews (n = 11) were undertaken, along with observations at health facilities and review of state policies. Data were analysed using Ritchie and Spencer’s framework method and the World Health Organization’s 2010 framework of factors affecting decisions to relocate to, stay in or leave rural areas.

Results It was found that rural background and community attachment were strongly associated with health workers’ decision to join rural service, regardless of cadre or contract. However, this aspiration was challenged by health-systems factors of poor working and living conditions; low salary and incentives; and lack of professional growth and recognition. Contractual health workers faced unique challenges (lack of pay parity, job insecurity), as did those with permanent positions (irrational postings and political interference).

Conclusion This study establishes that the crisis in recruiting and retaining health workers in rural areas will persist until and unless health systems address the core basic requirements of health workers in rural areas, which are related to health-sector policies. Concerted attention and long-term political commitment to overcome system-level barriers and governance may yield sustainable gains in rural recruitment and retention across cadres and contract types.

Keywords: contractual health workers, health workers, India, permanent health workers, rural recruitment, rural retention

Background

Human resources are a critical component of health systems, and account for approximately 70% of recurrent expenditure in most countries’ health systems.1 The World Health Organization (WHO) has described human resources as a crucial “building block in [a] health systems framework”.2 Despite this, human resources remain a neglected component of health systems in low- and middle-income countries.3 Among these countries, India has been identified as one with significant shortage of qualified health workers.4 Of late, there have been considerable efforts within the country to address the shortage of human resources for health. After the launch of the centrally funded National Rural Health Mission (NRHM) in 2005 (currently known as the National Health Mission [NHM]), state governments have invested in health infrastructure and introduced various policies to attract health workers in rural areas.5–10 Key among these is the contractual appointment of health workers as per NHM norms, to supplement sanctioned state government posts.10 With the inclusion of these health workers, permanent (also called “regular” or “regularized”) and contractual health workers now provide care in India’s health systems, with similar scope of work, but distinct conditions of employment (see Box 1).

Existing studies in India have explored the attitudes of medical students and in-service health workers towards rural service, and the factors at the individual level that act in favour of retention of health workers in rural areas.7,9 Findings from
these studies suggest that rural upbringing, personal values of service, professional interests, co-location with spouses, and availability of education for children are factors at the individual level that influence health-worker retention in rural areas. Poor financial remuneration, lack of good clinical infrastructure in rural areas, and organizational policies and management are some of the key challenges in rural retention of health workers.\textsuperscript{7,9} Finer analysis of motivation, shared and distinct challenges faced by health workers across cadres, and the types of contract in rural and remote areas is often overlooked by studies of human resources in India. The present study seeks to fill this gap in knowledge by understanding the motivations and experiences of health workers across cadres, and the types of contract with respect to rural recruitment and retention.

The study was located in Meghalaya and Nagaland states in north-east India, which are geographically remote, hilly, subject to insurgency on an almost continuous basis, and in many ways disconnected from the rest of India. Meghalaya and Nagaland are predominantly tribal, with about 80% of the population residing in rural areas.\textsuperscript{14,15} Meghalaya in 1972 and Nagaland in 1963 were relatively late entrants as states into the Indian union.\textsuperscript{16,17} have historically had poor economic and development indicators, and have, for many years, been dependent on central/federal government assistance.\textsuperscript{16,17} While some of the health-system challenges – including rural recruitment and retention of health workers – are shared with other states, the unique challenges faced by these states are less well understood.

What is known is that in both states there are large urban– rural differences in the density of health workers.\textsuperscript{8} Neither state has a medical school, but they both sponsor students to enrol in medical colleges across India. Each state has four government midwifery schools; Meghalaya has one government nursing school but Nagaland has no nursing school. Given the larger context, the World Bank initiated a programme to help strengthen health systems, with a focus on the health workers in Meghalaya and Nagaland. This study commenced in 2013 and was carried out at the behest of respective state governments, to better understand the challenges in health human resources for developing strategies to address rural recruitment and retention.

**Methods**

A combination of semi-structured interviews, observations and unstructured interviews were undertaken in Meghalaya and Nagaland. Field-based data collection was carried out between March and May 2014, by a team of three researchers, following approval from the institutional review board of the Public Health Foundation of India.

In each state, one rural/remote and one central district were selected based on state (NHM) categorization criteria of accessibility, in consultation with the authorities of the state health department. Within each district, inclusion of primary- and secondary-level health facilities was ensured; these were mostly primary health centres (n = 9), but community health centres (n = 5), district hospitals (n = 4) and one district maternity and child hospital (n = 1) were also included. In India, primary health centres are the first point of contract with a qualified doctor in rural areas and they provide a range of curative and preventive health care.\textsuperscript{18} According to the Indian Public Health Standards (IPHS), primary health centres are staffed by an allopathic doctor, a doctor from the Indian system of medicine known as an AYUSH (ayurveda, yoga and naturopathy, unani, siddha and homeopathy) doctor, and nurses, along with other paramedical staff. Primary health centres are not equipped to manage clinical complications and refer such cases to secondary-level health facilities. The community health centre is a secondary-level health facility that provides referral and specialist health care.\textsuperscript{19} As per IPHS, a community health centre is meant to be staffed by an allopathic doctor, AYUSH doctor and dentist, as well as specialists (surgeon, physician, obstetrician and gynaecologist, paediatrician, and anaesthetist), nurses and paramedical staff.\textsuperscript{19} The district hospital provides comprehensive secondary health-care services, which include basic specialty services.\textsuperscript{20} In addition to the manpower mentioned for community health centres, as per IPHS, a district hospital should also have the following specialists – ophthalmologist, orthopaedic surgeon, radiologist, pathologist, ear nose and throat specialist, dermatologist, psychiatrist, microbiologist and forensic specialist.\textsuperscript{20} The requirement for health workers varies somewhat, depending on the bed capacity of a district hospital.

In Meghalaya and Nagaland, it was rare to find community health centres with the entire complement of specialists recommended under the IPHS. Further, in all four district hospitals, a shortage of doctors and specialists was noted by participants, and was greater in remote districts. Moreover, unlike other Indian states, district hospitals in Meghalaya do not provide obstetrics and gynaecology services. Therefore, all specialists for maternity and child care were posted in the district maternity and child hospital.
Health workers interviewed, drawn from government registers, were selected based on purposive maximum variation criteria, to ensure a range in type of contract, level of experience and sex, using definitions and criteria applied by the states. They included specialists, allopathic doctors, ayurvedic and homeopathic doctors from the Indian system of medicine, and nursing (including midwifery) cadres. In each cadre, both permanent and contractual health workers (if available) at each facility were interviewed.

At each interview, procedures for informed consent were carried out and, based on their preference, participants gave written or verbal consent. Interviews were audio-recorded and, where permission for this was not given, handwritten notes were taken. Each interview lasted between 30 and 40 minutes. Following the interviews, unlinked transcripts were shared with a professional transcriber, to obtain verbatim transcripts. Data were preliminarily examined and field notes shared by the research team, to determine when saturation was being achieved within a particular cadre or contract type. At that point, no more interviews in that subcategory were undertaken.

Interviews were mostly undertaken in English. In Nagaland, four interviews undertaken mostly or completely in Nagamese were transcribed by a member of the research team who is a native speaker. Data were analysed using Ritchie and Spencer’s framework method of applied policy analysis (1994). Based on the research questions and WHO’s 2010 framework of factors affecting decisions to relocate to, stay in or leave rural and remote areas, a priori codes were encoded in the data. According to this framework, rural recruitment and retention are shaped by six groups of factors – personal origin and values; family and community aspects; working and living conditions; career-related factors; financial aspects; and bounding or mandatory service. These were applied to the study data and emerging codes added, based upon how the a priori codes were elucidated. Finally, codes and quotations were indexed and mapped, and the codes were clustered under themes that could be drawn into a narrative.

Results

Participant profile

A total of 11 specialists, 32 doctors, 25 nurses and 3 auxiliary nurse midwives from public-sector health facilities were interviewed (see Table 1). Out of these, 7 specialists, 18 doctors, 9 nurses and 3 auxiliary nurse midwives were from Nagaland and the remaining 4 specialists, 14 doctors and 16 nurses were from Meghalaya. In addition, a total of 11 key informants (6 in Meghalaya and 5 in Nagaland) were interviewed. Key informants in both states were senior health functionaries in the state and district health departments, and a representative of an international civil society organization in Nagaland. Participants with permanent contracts tended to be older than those with shorter-term contracts. The majority of health workers on short-term contracts reported being employed under an NHM contract, with some others being funded by the state government or health facility.

Motivations for rural service

Table 2 summarizes motivations for rural service for both permanent and contractual doctors and nurses.

Shared motivations

Across all cadres and contract types, there was a desire to serve in rural areas, with a preference to work in one’s own native village or district; rural service allowed workers to serve their own people. Participants also reported seeing family members suffer because of non-availability of doctors and health services in local health facilities. Such experiences influenced their decision to become a doctor or nurse, and also to continue...
Table 2. Motivations of and challenges faced by health workers across cadres and types of contract in rural areas

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<tr>
<th>Factor</th>
<th>Theme</th>
<th>Contractual</th>
<th>Permanent</th>
<th>Distinction by cadre and type of contract</th>
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<td>Allopathic doctors (n = 9)</td>
<td>AYUSH doctors (n = 4)</td>
<td>Nurses and ANMs (n = 9)</td>
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<td>Motivations</td>
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<td>Rural origin</td>
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<td>Spiritual motivations</td>
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<td>Family support-being close to family</td>
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<td>Financial</td>
<td>Hardship allowance</td>
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<td>Career</td>
<td>Few employment options</td>
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<td>Living conditions</td>
<td>Lack of facilities (water, electricity)</td>
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<td>Poor road connectivity and transport</td>
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<td>Lack, poor condition, inadequacy of staff quarters</td>
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<td>Working conditions</td>
<td>Lack or inadequate supply of drugs, medicines, and equipment</td>
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<td>Shortages of health workers – high workload</td>
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<td>Lack of staffing norms</td>
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<td>Insurgency – safety issues</td>
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<td>Financial factors</td>
<td>Lack of pay parity</td>
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<td>Lack of or inadequate hardship allowance</td>
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<td>Professional factors</td>
<td>Lack of career trajectory, and professional isolation</td>
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<td>Poor job security (short contracts)</td>
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<td>Political influence over/irrational logic of promotions, postings and transfers</td>
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<td>Inappropriate norms for service</td>
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<td>Family and community</td>
<td>Lack of educational opportunities for children</td>
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<td>Fitting in with community</td>
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ANM: auxiliary nurse midwife; AYUSH: ayurveda, yoga and naturopathy, unani, siddha and homeopathy.

Note: •• refers to themes suggested first and/or without probing by most or all participants and agreed upon by two or more coders as being highly salient; x refers to themes suggested upon probing by two or more participants. All findings are applicable across both states except where the suffixes (M) or (N) are added; (M) refers to a finding applicable to Meghalaya only; (N) applies only to Nagaland.
working in rural areas. Some doctors and nurses serving in rural primary health centres mentioned that their parents were very encouraging of this career path. Some of the nurses serving in rural areas mentioned that, in addition to taking care of patients, their job enables them to take better care of their family’s health.

My parents did call me, “Why we sent you to become a doctor, because we have very few doctors in X [location withheld to protect participant’s anonymity]. If you don’t give service to the people of your community, then who will give the service? So you come back here”. (permanent doctor, male)

In Nagaland, contractual doctors and permanent nurses spoke of religious/spiritual motivations for service in rural/remote areas. Being a nurse or a doctor was considered to be a form of service to the church. One of the doctors posted in the remotest health facility mentioned “I think like we Christians, we think doctors are just like missionaries. Going to places and reaching people”.

Distinct motivations
It was noted that for permanent doctors in Nagaland, and contractual nurses in Meghalaya across cadres, there were few employment options beyond working in rural areas and this was the reason they were working in rural areas. In the case of contractual health workers, especially nurses, greater financial incentives (i.e. hardship pay) were a motivation.

Challenges to rural service
Table 2 summarizes the challenges of both permanent and contractual doctors and nurses in rural areas.

Shared challenges
Contractual doctors and nurses faced similar challenges as their counterparts in permanent service, in terms of poor working and living conditions.

Lack of pay parity between contractual and permanent health workers was reported by participants across cadres. Contractual nurses reported relatively lower compensation in comparison to permanent nurses. At the time of this study, ayurvedic and homeopathic doctors in Nagaland reported salaries (unrevised since 2011) that were lower than those of the nursing cadres.

Regardless of contract type, safety was a concern among doctors and nurses working in remote areas affected by insurgency. A female doctor working in an insurgency-affected area in Meghalaya mentioned that insurgency groups had demanded money and threatened her colleagues. In Nagaland, while participants did not directly mention insurgency in interviews, interviewers learnt that every 6 months or so, around 20% of their salaries was allocated and diverted for insurgent groups.

Working conditions: The absence of adequate clinical infrastructure, drugs, equipment, diagnostics, ambulances and staff was widely reported as a challenge. Numerous doctors and nurses – regardless of their contract type – mentioned irregularity and inadequacy in the supply of drugs and equipment. A nurse contracted under the NHM in Nagaland reported having to handle bleeding patients with bare hands, in the absence of hand gloves. Among ayurvedic and homeopathic doctors, the lack of medicines and the absence of pharmacists limited their ability to practise their systems of medicine. Another concern raised by doctors was the burden of administrative work, which rested on their shoulders, regardless of the fact that they were not trained for administrative tasks and, further, had to juggle these tasks with providing clinical care in the health facility. Lack of supportive staff further exacerbated this problem.

Professional isolation: Young doctors reported feelings of professional isolation in comparison to their urban counterparts. Some participants expressed the need for mentoring and supportive supervision, in order to improve their performance and productivity.

Distinct challenges faced by contractual health workers
Distinct challenges were seen for contractual workers in the financial and professional domains.

Financial factors: Lack of pay parity between contractual and permanent health workers was reported by participants across cadres. Contractual nurses reported relatively lower compensation in comparison to permanent nurses. At the time of this study, ayurvedic and homeopathic doctors in Nagaland reported salaries (unrevised since 2011) that were lower than those of the nursing cadres.

Allopaths are getting around 45 [thousand rupees] because they are divided under three sector, groups A, B and C [accessible, difficult and most difficult area respectively], whereas ayurvedic and homeopathic [doctors] and dentists, we don’t have any divisions and we are getting less salary than the nurses. General nurse midwives are getting ₹25 000 and we are getting only ₹20 000, whereas the workload here is comparing to allopathy and all, we are equivalent”. (contractual homeopathic doctor, male)

A similar situation was noted for contractual nurses in Meghalaya, where their salary was far below that of their permanent counterparts. Concern about the large disparity in pay for nursing colleagues was raised by a permanent doctor (male), who noted an “almost 50% difference is there for doing the same kind of work”.

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This situation was aggravated by irregular and delayed remuneration and appraisals. At the time of interviews in Nagaland, for instance, these health workers had been waiting 2 months to receive their salaries. Interviewers were informed that sometimes the waiting period is as long as 4 months.

**Professional factors:** The lack of career trajectories was seen by contractual doctors and nurses as a major challenge, and a deterrent factor for continuity in the public sector. Many felt that they held a lower status despite working as much as permanent health workers.

Contractual workers also reported that they had fewer chances of transfers to their choice of location, and limited leave of absence, resulting in prolonged stays in rural and remote areas. This forced married doctors or nurses to live far away from their families, which they also lamented.

In addition, they were frustrated by the short duration of their contracts (between 4 and 6 months). In fact, this was something even permanent doctors and senior nursing staff in Nagaland raised as a challenge, in solidarity with their contracted peers and juniors.

In Meghalaya, doctors expressed their concern over bonding and mandatory rural service. State-sponsored doctors, once educated, were mandated to return to the state and serve 5 years in rural service. Upon their return, because permanent sanctioned posts were not vacant, doctors had no option but to take state contracts. In this arrangement, state-sponsored doctors are recruited as contractual staff in public health facilities and their contract is renewed every 3 months. Under this contract, the state expects doctors to continue working as contractual doctors until the Meghalaya Public Service Commission (MPSC) conducts interviews to transfer them to permanent contracts. At the time of this study, interviewers were informed that the most recent recruitment of doctors by the MPSC had been almost 4 years previously. The irony is that their service as a contractual doctor (even if they had worked for 10 years) would not be counted by the MPSC as years of service for career progression (as would be the case for doctors with permanent contracts). This was deeply demotivating for contractual doctors working in rural service, as their prospects for career progression were actually harmed by taking state contracts. Interviewers found that contractual doctors were keen to complete their mandatory rural service and then leave the public sector, as they felt the odds were, in any case, stacked against them.

Similarly in Nagaland, if contractual doctors were to apply for permanent posts through the Nagaland Public Service Commission, their years of service (including rural service) with the state or NHM would not count as work experience. Regardless of how long they served in a state or NHM contract, they would still begin as an entry-level permanent employee. This situation was grave in Nagaland, given the severe shortages of sanctioned posts in the state. Interviewers learnt that staffing patterns for health facilities were laid down in the late 1960s and 1970s, following which there has been no upgradeation of norms or increase in the number of sanctioned posts for any category of health worker. Interviewers were informed by a key informant that, because of cessation of post creation, the state was unable to absorb all state-sponsored doctors and nurses in permanent posts, even after they expressed a willingness to work in the public sector. There is a lack of connection between the processes of upgrading health facilities and deployment of health workers.

**Distinct challenges faced by permanent health workers**

Distinct challenges were seen for permanent workers in the family and community, financial and professional domains.

**Family and community factors:** The lack of educational opportunities for children in rural areas was explicitly expressed as a challenge to rural service, especially as this cadre was, on average, older than the contractual cadre. Many were staying alone in rural areas and their family was based in a town or state capital for their children’s education. A senior nurse in Nagaland noted that she had three households to maintain—one at her place of posting, another for a daughter in college, and another for the rest of her family. A desire was expressed by participants across cadres for sequencing rural posting earlier in careers.

Many cases were noted where doctors and nurses from the community were given high regard and respect. Participants reported getting along with patients and communities and being supported in campaigns, even honoured during festivals throughout the year. However, if a doctor or nurse was not from the same tribe as the community in the area they were serving, they sometimes faced belligerence by members of the community for reasons including their diagnosis, patients’ recovery, lack of drugs and other factors. A doctor in Meghalaya mentioned that sometimes the community pressurized staff and even destroyed health-facility property.

**Financial factors:** In Meghalaya, permanent doctors were concerned about a sudden and unexplained reduction in the hardship allowances provided by the NHM. On the other hand, permanent doctors in Nagaland lamented the lack of hardship allowance for those practising in rural and remote areas, a provision that did exist for contractual doctors under the NHM.

There is another financial incentive for permanent workers in Nagaland, known as non-practising allowance (NPA), for doctors to not practise in private clinics. A doctor is only eligible for NPA after 2 years in rural service but the implementation and adherence to this policy was inconsistent. A male key informant noted that “those doctors serving in Dimapur and Kohima [urban areas], nearly 80% don’t follow the rule, so those who are practising [there] they benefit more”.

On the other hand, Meghalaya does not provide NPA, but permits doctors in the public sector to engage in private practice. Interviewers found a range of views related to private practice. Doctors in rural areas felt that private practice benefits doctors and specialists residing in urban areas, as urban patients are financially better off. However, some felt that it is morally problematic to draw salary as a public-sector doctor and undertake private practice at the same time. A participant reported that this policy has had negative impacts, as some doctors are referring patients to their own private practice instead of treating them at the health facilities. There was also a group of doctors that reported satisfaction with the current arrangement.

**Professional factors:** Some permanent doctors and key informants questioned the rationale of promotions. They felt that the logic of promotions, postings and transfers was a huge
deterrent factor among permanent specialists and doctors, as it was seen to be either irrational or politically motivated.

The politicians they don’t understand: if the state has a specialist doctor, they should know what you mean by specialist doctor. You cannot expect, you know, our specialist doctor to be posted in a primary health centre because “this is my area, my constituency, my political background so I have to get that”. We have seen in our state that some radiotherapist, who has got nothing to do in primary health centres and community health centres [is] posted in the outpost. (permanent specialist, male)

In both states, specialists were concerned about not having staffing norms for rational deployment of health workers. Some specialists reported working in a primary/community health centre and providing basic health services, owing to non-availability of physical infrastructure, equipment, drugs and supplies.

**Discussion**

Improving the recruitment and retention of health workers in rural areas is a complex policy challenge. This health-systems issue of retaining health workers in rural areas has been studied extensively across countries. The findings in the present study bring out a spectrum of known factors, as well as a few new ones that are critical for recruitment and retention of health workers in rural and remote settings.

The study suggests that serving and representing their community was a specific motivation that brought health workers to rural service. This motivation was high among health workers from rural backgrounds. This confirms findings from other international studies that health workers from a rural background have a high probability of working in rural areas, and underlines WHO’s global policy recommendations for targeted admissions of students from rural backgrounds to medical and nursing schools.

This said, what the present study has revealed is that, once in service, there are challenges that are shared across cadres and contract types, and distinct challenges across contract types that are a function of contractual work itself (i.e. its financial and labour-related structure), as much of it is seen – and indeed experienced – as a temporary or stop-gap measure to bring human resources to rural areas.

It is unfortunate that there are no incentives for contractual health workers to continue in the public sector, although health systems like those in Meghalaya and Nagaland are counting on these workers to deliver health services in rural and remote areas. Understanding the dearth of health workers in rural India, it would be beneficial for the health sector to lay down transparent procedures for pay parity and a clear career path for contractual health workers. On the other hand, a rationalized posting and transfer policy is essential for health workers in permanent service, to improve morale and service delivery.

This is, of course, part of a global trend of contractualization of labour in India: over the period that the NHM has existed, the proportion of contract workers across all industries in the country has grown from 24.8% in 2002/3 to 2004/5 to 33.8% in 2009/10 to 2011/12. On average, this means one in three workers is contractual, allowing “use of contract labour without according them workers’ rights”. The interviewers saw this clearly in the treatment of AYUSH doctors contracted under the NHM, who are paid less than nurses and expected to perform tasks for which they are not trained, in states where these systems of medicine are not even well understood.

The study findings make a strong case that multiple factors influence health workers’ decision to relocate to and stay in rural and remote areas, as well as their job performance, and therefore health systems must consider packaging or bundling strategies for cadres across contracts. Mindful of the challenge, many Indian states (including Meghalaya and Nagaland) have initiated several strategies. This study found that Meghalaya has introduced 5 years of mandatory rural service for state-sponsored medical students after completion of studies. In both Meghalaya and Nagaland, difficult-area or hardship allowances are provided to health workers working in rural and remote areas. However, in Meghalaya, contractual staff are not entitled to these financial incentives. In contrast, Nagaland provides a hardship allowance to some NHM-contracted cadres of health workers, namely allopathic doctors and nurses. It seems that these efforts are fragmented, stop-gap, and often tardy, such that they do not cohere under a strategy or bundle of complementary approaches that are fair across contracts and cadres.

When thinking about interventions and bundling them, the present study suggests that a paradox has to be resolved in these states. At present, the paradox is that while expectations of health workers are the same across cadres (reflected in the nature of their shared challenges), the treatment of these workers is not commensurably the same (reflected in the distinct challenges – especially pecuniary and professional ones). If the health system can resolve the paradox by saying equal expectations means equal treatment, the focus may perhaps initially be placed on distinct challenges, i.e. improving the financial and professional conditions across cadres in response to the limitations this study has raised. Longer term however, the key strategy should be creating permanent contracts and clear trajectories.

Much of this is in the control of the health department, notwithstanding the limitations it faces in terms of budgets, processes and political will. If the health system in each state does not seek to resolve this paradox, and continues to have equal expectations with unequal treatment by cadre, it may choose to prioritize shared challenges so that at least health workers can deliver on what they are expected to do. Long term, however, the split between expectations and treatment may result in further weakening and destabilization of rural retention and job performance.

Finally, in Nagaland and Meghalaya, there is clearly a need for steady improvement in the living and working conditions in rural areas. Social determinants of health, such as road connectivity, telecommunications, housing, water, electricity, access to schooling, and physical safety, affect both the professional and personal lives of health workers, as well as the ability of communities to seek care. Since these improvements cannot be undertaken by the health sector alone, they require central and state government together to engage key stakeholders within and outside the health sector, for broader political, institutional and financial commitment on these determinants.
The study has some limitations. As a qualitative study, it was designed to understand recruitment and retention in rural and remote areas. It was not possible in this study to look at the experiences of allied staff such as pharmacists and laboratory technicians working in rural and remote areas. These practitioners play important roles in the delivery of health service in rural areas, and their needs and experiences are yet to be understood. Another limitation was not being able to look at human resources from the perspective of the patient. Is the receipt of service variable based on cadre or contract? What would patients prefer? Patient perspectives would help triangulate findings and indicate where strategic silences may exist in the interviews of health workers. This may be all the more relevant when considering issues like absenteeism of doctors; this is something to which doctors themselves will never admit and nurses will never report their supervisor’s absenteeism.

Conclusion

This study of motivations and barriers to rural service found that, while the former tend to be uniform across types of health-worker contract, shared and distinct challenges have emerged. Health reform would do well to be guided by these variations and, ideally, to resolve the paradox they present. Concerted attention and long-term political commitment to overcome system-level barriers and governance may yield great gains in rural recruitment and retention, in service of the nation’s path to universal health coverage.

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