Retention of Health Professionals in Rural Health Facilities: Facilitators and Barriers

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Abstract

Human resources for rural health remain insufficient. It is essential to evaluate policies which affect availability and retention of these resources. At Mahatma Gandhi Institute of Medical Sciences, Sewagram, India, we realized that rural families too needed support. Housing and children's education were priorities. Faculty was helped in their academic careers by providing special leave along with other leaves, and funding, while promoting personal growth, continuous professional development and small seed grants for research. Attempts at getting health teams for rural areas persist. Presently, services are provided by staff from base rural institute in rotation. They are provided with travel, stay, meals, and entertainment for free. Attempts at Sewagram continue with failures and successes. Sharing perspectives and information helps.

Introduction

Health workforce is the critical component of any nation's health system. Health workforce availability and accessibility determines the health services, the nation's health, and socioeconomic development. The rural people's health is a critical component of this. Due to various reasons, rural health care has changed but still, resources for rural health remain relatively insufficient. It is essential to reevaluate the health workforce policies to know the facilitators and barriers which affect availability and retention of health workforce. Government policies have attempted to address some of the issues by encouraging network developments and telemedicine, but there continue to persist problems around the world [1].

Many rural communities continue to experience shortages of physicians and the health care in rural regions compares unfavorably to the rest of any nation. Rural communities have long struggled to have access to quality health services. Even in 'first world' countries like America, rural communities lack access to basic health care [2]. While the rapidly evolving health systems present enhanced opportunities to address rural health problems, new threats to the fragile rural health care system prove to be real challenges. Continued policy-relevant research and careful evaluation of the changing nature of health care delivery in rural areas should assist the development of new approaches to support the rural communities and provide high-quality cost-effective services to rural communities. Globally, organizations trying to provide health services to rural communities find it very difficult to get specialists, let alone basic doctors. If they somehow manage, retention is much more difficult. The search for finding ways to retain continues.

It is essential that, to learn from each other and try to find ways which are locally suited and possible, information is shared. Mahatma Gandhi Institute of Medical sciences in Sewagram of Wardha district of Maharashtra province of India is the first medical institute of India. As

it came into existence, it could attract some faculty. Some of those who joined in the first decade have lived their lives in the locality, including the author:

> "When I arrived, the first batch of students were doing house posts, second were doing internships, and the third were in their final year. Actually, misconceptions were also spread those days. I was told by some colleagues in the city that classes were held under the trees and there were dress codes for everyone and so on. There was nothing like that. There was a beautiful campus with proper lecture halls. As such, teaching and learning need proper environments wherever that may be. Everyone dressed the way they wanted. Gandhi's swadeshi, nation's own fabric, vegetarianism, non-alcoholism, and non-violence continued for everyone for physical, mental, and spiritual health."

As the beginning was made, it was realized that families will have to be looked after. Housing was the priority and was provided. Later, faculty were helped in having their own houses (Fig 1) with financial support and loans.

Figure 1

Children's education was also a priority and schools became a necessity. Kindergarten, primary, and senior schools gradually came into existence (Fig 2).

Figure 2

Spouses could also get jobs. Employment was provided to family members in various capacities as per the availability and need. The health assurance scheme, which gave assurance for health services of the family, also attended to health care for employees. With due consent, a small amount was deducted from their salaries for this service. It provided diagnostic as well as therapeutic services. If any employee needed superspecialist services,

they would be provided for as well. A staff club, for various activities, was started with nominal monetary contribution. Through staff club and student cultural activites, sports were arranged and festivals were celebrated where the faculty's families could also gather (Fig 3).

Figure 3

Additionally, a 'cine club' was founded, where students, faculty, and employees, with their families, could gather on a fixed day in a specified lecture hall to watch movies in the evenings. Employees' children had priority reservations in medical admission as per their merit. Beyond personal and familial growth, faculty were also helped in their academic career. In addition to casual leave, earned leave, medical leave, maternity leave, they were given two weeks of special leave to conduct examinations, present or participate in conferences, workshops, etc. Once a year, funding was provided for travel, stay, and registration. This practice continues.

Faculty, residents, students are encouraged to present and share their work experiences. Moreover, faculty are encouraged to attend training programs and learn in and out of the country. While leave without pay is permitted to benefit other regions and countries that have their own need for better and improved health care providers, there are regulations in place for such activities. Consultancy is encouraged, be it local, inter-state, or international, including with the World Health Organization. Personal promotion scheme and system for continuous professional development encourages faculty to have academic development. Small seed grants for research are provided to young faculty to make a beginning of research which could encourage them towards advanced research and projects.

Some faculty have spent all their lives in Sevagram. Their wards completed their education here and have now become faculty. For communities that are more remote and rural, there is still a persistent problem of getting health teams. Melghat is such a center where it has not been possible to get doctors, though other health work force is locally available. In this

region, services are by deputation of staff from the rural institutes in rotation. Travel, stay, meals and entertainment are free (Fig 4).

Figure 4

Doctors and specialists are deputed to provide 24/7 services to rural remote communities. Surgical camps are held as per needs. There is a reasonably equipped health facility. Globally it is being realized that there is an urgent need to scale global action on rural workforce development. World Health Organization-sponsored research suggested eight actions for implementing rural pathways in Lower Middle Income Countries (LMIC) including establishing community needs; policies and partners; selecting health workers; working conditions for recruitment; and retention [2]. Kartika [3] did a review and seven major themes emerged from the included studies: incentives, career and professional development, working conditions, living conditions, personal characteristics, political factors, and culture.

Researchers suggested six broad strategies to address the facilitating factors and barriers for retaining health workforce in rural and remote areas:
1) Provide adequate incentives.
2) Provide CPD for rural and remote health workers.

3) Recruit students from rural background.
4) Improve working conditions.
5) Improve living conditions.
6) Strengthen the role of local government and intersectoral collaboration [4].

By understanding the underlying factors of health workforce retention, key policy-makers can evaluate the policies and develop a range of useful and comprehensive strategies which addressed the roots of its problems. Canada strengthened local community's determination. The community said if more doctors were needed in a community, then they would do it themselves. Northern Ontario School of Medicine (NOSM) helped this wide-flung territory of disparate geography, interests, backgrounds and cultures. It took time and negotiations, ingenuity and faith, hard work and compromise, and – most of all – determination [5]. There is a strong interest in investing in rural pathways to develop and support the rural health workforce and improve health of rural communities worldwide. However, there has been limited consolidation of evidence to know effective actions. Attempts at Sewagram and at other places continue with failures and successes.

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