International Journal of Community Medicine and Public Health
Joshi SC et al. Int J Community Med Public Health. 2018 Jun;5(6):2248-2258
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: http://dx.doi.org/10.18203/2394-6040.ijcmph20181972

Original Research Article

Simple and basic yet vital and essential health services: an exploration of perception of junior health care service providers regarding rural health services in India

Sudhir Chandra Joshi[1]*, Rita Joshi[2]

[1]Department of Community Medicine, [2]Department of Microbiology, R.D. Gardi Medical College, Ujjain, Madhya Pradesh, India

Received: 06 April 2018
Revised: 24 April 2018
Accepted: 26 April 2018

***Correspondence:**
Dr. Sudhir Chandra Joshi,
E-mail: sudhiasia@gmail.com

ABSTRACT

Background: Health services should be scientifically reviewed and researched continuously.. In 2017, at the occasion of completion of seven decades of the India's Independence, a self-funded "doctors' perception study project" was launched. Present paper is an outcome of this project which will soon be followed by similar projects involving other stakeholders of health care as well.
Methods: Fifteen individual face to face in depth interviews (FFIDIs) and ten focus group discussions (FGDs) were conducted during the year 2017 among the junior level health care providers working at a rural health training center. Thematic (content) analysis method was used.
Results: A big gap exists between the concept and its implementation. Several 'people factors' and 'system factors' emerged besides quite a few 'contradictions', 'malpractices' and 'deficiencies'. Perceptions regarding various 'priority domains' for improvement, 'needs' and 'strategies' were also explored. The emphasis was on improving peoples' awareness action and access; staff recruitment, health care facilities and patient referral.
Conclusions: Access barriers are disastrous and devastating for the poor and the disabled. There is a close mutual relation among the various issues. Chaos is being allowed to exist in which there are irrational use of drugs, mushrooming of 'quacks' and diversion of resources from public to private sector. Addressing all the issues requires peoples' awareness and action along with political and administrative vision and will. A different politics is needed. Introspection, internal reforms and more community engagement is expected from the medical community.

Keywords: Rural health services, Primary health care, Community participation, Decentralization, Perception, India

INTRODUCTION

In India, modern medicine and comprehensive-health-care based services were almost non-existent during the colonial era. Immediately after the independence, based on the recommendations of the Bhore Committee, a preliminary health care delivery system for the rural areas was instituted with high priority during the first five year plan (FYP).[1] Since then, decade by decade, with each successive FYP, this system has been evolving. Nevertheless, urban-rural differences and several inequities still exist in a big way. In 2005, in view of these gaps, the National Rural Health Mission (NRHM) was launched.[2,3] Several achievements thereafter have clearly indicated that investment, resources and proper strategies can bring about a big difference within a short time. Although some lacunae have been effectively addressed, several deficiencies and malpractices have been allowed to remain.

Recruitment and retention of qualified health care professionals in the rural areas is one of the major challenging problems leading to a perpetual deficiency. This problem exists all over the world in both resource-poor and resource-rich setups in varying proportions and forms.[4-13] Doctor-population ratio has improved significantly in India during the last seven decades of independence; yet on account of 'urban concentration' of doctors and 'urban dependence', there exist several problems for the rural poor. Government employed doctors manage to perpetually stay in the urban areas, undisturbed for a lifetime. Like the Central Government Health Service (CGHS), there is no definite and exclusive Rural Health Service (RHS). Similarly, there is no system equipped with transportation by design for proper referral to secondary health care from the rural and remote areas; and as yet no arrangements are available in these areas for advanced investigation facilities, emergency surgeries and blood transfusion.

Many such deficiencies - which have been allowed to exist - are compounded by the rampant, permitted malpractices. Financial access barrier is a big problem for common persons, especially troublesome for the poor and the disabled, more so in cases of need of secondary and tertiary care. This problem - while it imposes out of pocket (OOP) expenditures- is escalated by two additional factors- (1) by a special kind of 'absenteeism' - absence from the public sector workplace for private (dual) practice, (2) by corrupt referrals. Thus there are material access barriers enhanced by 'attitudinal barriers' including 'leadership style' too, addressing the latter may involve some price but very little cost. Another type of closely related malpractice occurring universally in India is unregulated irrational use of drugs which has led to problematic drug resistance, on top of which there has been mushrooming of unregulated non-qualified or non-degree-allopathic-practitioners (NDAPs) commonly called 'quacks'.[14] This malpractice is especially rampant in the rural areas taking advantage of lack or absence of doctors combined with 'lenient' administrations, acts and actions and a pluralistic health care delivery system.

In 2017, at the occasion of completion of seven decades of independence of India, a self-funded *"perception study project"* was launched for exploration of *"perception of doctors regarding various changes and challenges in the medical profession with special reference to India."* The domains taken up under this project include various aspects of the health services, the rural health services, medical education and biomedical research. One of the explorations regarding healthcare workplace violence (HCWPV) has recently been published.[15] Present paper is similarly an outcome of the initial research conducted under this project which will be expanded in future in order to cover other stakeholders too. The aims of the present study have been: (1) Understanding the mind of the trainee young doctors and the staff by asking "how do they look at the rural health services of India, its relevance, its current status and its further improvement?" (2) Exploration of their perception about role of health services in (a) improving the sociopolitical system and (b) addressing the social problems and mental health problems (3) Getting feedback about and developing insights into the impact of teaching and training in community medicine.

METHODS

In this qualitative exploration 15 Face to Face In-Depth Interviews (FFIDIs) and 10 Focus Group Discussions (FGDs) were performed, during the year 2017 (January to December) in the Rural Health Training and Demonstration Centre (RHTC) of R.D. Gardi Medical College Ujjain.

The study participants constituted a purposive sample of the junior doctors (interns and post graduate students), their teachers and the paramedical staff members working at the centre. Most of them perform duties for a definite period only or in a rotation. During the study period at an interval of four months, FFIDIs and FGDs were conducted for one month on each Thursday. The junior doctors and faculty members working at the centre on that particular Thursday were interviewed on the basis of their informed voluntary consent. All the interviews were audio recorded and the MP3 sound files were transcribed verbatim**.** For data analysis, thematic (content) analysis method was used.[16] Entire text was first divided into 'meaning units' out of which 'condensed meaning units' (CMUs) were developed.[17,18] As the CMUs were classified, the codes emerged which were independently identified manually by both the authors. The codes were then grouped and classified and thus categories were identified. As the categories converged, the subthemes and subsequently the themes emerged.

RESULTS

In the process of thematic analysis, three themes have emerged (Table 1). Theme 1: Importance and impact: relevance and role of the health services for the rural areas of India; Theme 2: Main challenges problems and issues in implementation; Theme 3: Priority domains, needs and strategies for improvement.

The subthemes and the categories have been presented as Table 1 and further details (the codes, the CMUs and some quotations) as Tables 2 to 4.

Theme 1: Importance and impact: relevance and role of health services for the rural areas of India

This theme has emerged out of two subthemes 1.1 concepts and contribution and 1.2 potential role in community engagement (Table 2).

The rural health services were described as:

"Simple and basic yet vital and essential health services" **FGD_6.**

Table 1: Results at a glance.

	Theme 1: Importance and impact: relevance and role		Theme 2: Main challenges, problems and issues in implementation					Theme 3: Priority domains, needs and strategies for improvement					
Sub themes	**1.1 Concept and contribution**	**1.2 Potential role in community engagement**	**2.1 Preventive services, public health and NHPs***	**2.2 Curative Services : Practices and malpractices**	**2.3 Lack of facility-provisions**	**2.4 Staff recruitment and retention: Attraction and attrition**	**2.5 People factors**	**3.1 Improving community engagement**	**3.2 Improving facility provisions and supportive supervision**	**3.3 Improving the referral system**	**3.4 Improving IEC****	**3.5 Improving recruitment and retention**	**3.6 Improving involvement, motivation and regulation**
Categories	Raison d'être	Role in community development, decentralization and further development of democracy	Positive aspects	Irrational and unregulated use of drugs and mushrooming of quacks	Health care and professional development related	Reluctance toward rural posting	Lack of awareness, sense of responsibility hygiene and sanitation	Community participation & ISC#	Health care and professional development related	Built in transport	Procedure and Equipment	Monetary Incentives	Rural Allopathic Doctors
	Universal access to free of cost quality health care	Role in addressing social problems	Negative aspects	Access barriers for the poor and the disabled	Safety and security related	Reasons for low recruitment and retention	Superstitions and low utilization of health care services	Decentralization (Gram Swarajya##)	Safety and security related	Education and training	Education and training	Extra-Monetary Incentives	Rural Indian System Practitioners
	Impact		Assignments and priorities for public sector rural doctors	Referral realities	Personal-family- and leisure-life related	Wants and vacancies	Lack of initiative and action	Development of democracy (Gram Sabha###)	Personal-family- and leisure-life related	Referral mechanism	IEC mechanism	Separate basic cadre	Health Workers
				Public sector resources in private practice		Promotion chances	Politicians and media			Referral assessment	IEC assessment		Trained Reformed Quacks

*NHP= National Health Programs; **IEC = Information, Education and Communication # ISC= Inter-Sectoral Coordination ##Gram Svarajya = concept of economic and political independence with social cohesiveness ensuring liberty equality and fraternity in each village. ###Gram Sabha = concept of village-assembly or village-parliament, formed by each voter of the village i.e. all members at an equal level politically, though initially they may come from different strata.

Table 2: Theme 1: Importance and impact: relevance and role (subtheme wise categories with some codes, CMUs and quotations).

Subtheme 1.1 Concept and contribution	**Category: Raison d'être** **Nature and scope** simple yet vital and essential services; **Demography** rural predominance; poverty **Geography** distance **Development** (economic benefits addressing problems and leading to development/ develop critical thinking and scientific temperament/ develop the personality) **Disease prevention-** prevention of communicable diseases/ for low disease and death rates/ important for prevention and cure/ disease and death prevention/ prevention and control **Benefits for services** determinant and indicator of health status; less overload; prevent from quacks; outreach and percolation; exposure to ground reality ; indigenous design ; research; local and national interest **If Rural health services were not there** more disease transmission and drug resistance; overload in cities; economic aspects jhadphunk (witchcraft) and superstitions; quacks will exploit more. scarcity of qualified doctors; no health education; there will be no national health programs; there will be high mortality; essential service deprivation (absence of first aid emergency care antenatal care, child birth and immunization services) **Expressions with " but "** very much beneficial but……/ Big program but……/ good initiative but needs to grow fast **Category: Universal access to free of cost quality health care** **Free access** cost factor; place to go for poor and disabled; free of cost public services; basic and comprehensive health services which everyone should be able to get free of cost; very useful [services] provided that doctors and drugs are available free of cost; most of the people cannot afford the cost of medical care whenever they have to go to super specialty hospital or even simple hospital in the city. often access problems for the poor and the disabled at various levels of health care **Category: Impact** ***Disease eradication***: eradication of smallpox, poliomyelitis, leprosy, guinea worm disease. **Disease prevention** reduction in incidence and prevalence rates of many diseases. **Facility expansion** thousands of sub health centers, primary health centers, community health centers **Human resources** thousands of health workers and ASHA workers; improved doctor population and nurse population ratios **Impact of National Health Programs** increased awareness, better nutrition, improved sanitation, impact of free of cost treatment regimes like DOTS and ART
Subtheme 1.2 Potential role in community engagement	***Category: Role in community development, decentralization and further development of democracy*** **Community development and then community participation** peoples' action is needed and unity, harmony too. common people of the villages being involved in the rural health service; approach and role should be convincing and consensus building and not just instruction and voting; convincing, persuading motivating this type of communication is required for community development; not that I am always right and you are always wrong. **Decentralization** 'gram sabha' (village assembly) approach' is better than the prevailing 'commandeering people approach' ; need of decentralization; benefits of decentralization; horizontal versus vertical decentralization current status of decentralization (panchayat raj institutions and village health workers like ASHA etc.) future prospects (gram sabha etc) decentralization is giving the duties the power from a higher level to a lower level it is not like hierarchy; **VHSNCs**; village health sanitation and nutrition committees are being developed; it is a good initiative. **Gram Sabha (Village Parliament)** value system like we respect our national flag this is our socialization and we must respect our institutions so if we respect the 'gram sabha 'as an institution and try to institutionalize gram sabha like the proceedings of any parliament being telecast, the gram sabha proceedings will be directly observed by people around and may be video-graphed and be telecast. **Potential role in interaction and about role models** good leaders can be role models. People have strong faith in good leaders interaction and leadership has the scope of replacing old with the new ideas. health workers can play very important role in changing views and ways, the attitude and ideas of people. Need of group communication skills and working with the communities. **Category: Role in addressing social problems** ***Addressing social problems*:** poverty; lack of awareness and education; population explosion; under-nutrition; insanitary conditions; alcoholism and substance abuse; gender discrimination; the stigma and the discrimination attached to certain diseases etc.

Table 3: Theme 2: Main challenges, problems and issues (subtheme wise categories with some codes and CMUs).

Subtheme 2.1 Preventive services, public health and the national health programs (NHPs)	**Category: Positive aspects** partial success in disease prevention: *in some areas UIP is better than other NHPs; besides, MCH/RCH, Immunization, IEC and in specific diseases disease-surveillance have improved slightly*. **Category: Negative aspects** prevention weak points; impact is there but partial success; local problems and issues are ignored; poor implementation; mostly on paper; fake data; burden of paperwork; target is achieved on paper; good initiative but deficient; poor involvement of doctors in preventive services, public health and NHPs: *this is due to low priority in the health services to health promotion and disease prevention*; inadequate communication: *doctors do not go to sub health centres and there is inadequate interpersonal and group communication in all ; doctors are not motivated enough to be role models and to demonstrate proper methods to field staff in order to improve group communication* inadequate surveillance: *diseases are not being diagnosed accurately and doctors are not documenting and notifying most of the diseases*; **Category: Assignments and priorities for public sector rural doctors** administrative tasks, paper work, attending meetings and court of law several kilometres away and no peer- replacement or peer reliever;
Subtheme 2.2 Curative Services: Practices and malpractices	**Category: Irrational and unregulated use of drugs and mushrooming of quacks** *irrational unregulated use of drugs **;** quacks have mushroomed Quacks: unqualified doctors are called quacks and in Hindi 'jholachaap'* [meaning 'the fake doctor moving around with a bag']. the quacks cannot practice science based rational system of medicine; they do not have the knowledge and skills needed for that; they provide psychological satisfaction sometimes they claim cure of many incurable diseases like cancer**;** they try to influence people by psychological ways creating a religious and cultural effect; they take resort in being god man also; they are jealous with the qualified doctors **;** they misinform people about physical examination methods of the qualified doctors; they would trivialize or criticize negatively saying that just by touching how can one detect the diseases of the patients; they would promote 'mantra tantra jhaad phoonk,'** witchcraft etc. dramatic relief by quacks: dramatic relief by quacks is not a permanent cure and the symptoms will reappear soon definite cure by the qualified doctors only, but people do not understand this; why quacks are allowed to exist? why no one is checking no one is controlling? how the drugs are available to the quacks?* **Category: Access barriers for the poor and the disabled:** little access to the poor and disabled and others who need these services the most; urban dependence; non availability of doctors **;** good and qualified doctors are treating at back foot**;** financial aspects: promise of free of cost health services; nothing is free; OOP#; direct and indirect taxes; **Category: Referral realities** No benefit of referral *referred patients asked to come next day then they do not return; there is urgent need of well educated and well behaved staff paying needed attention; patients have to wander so much without any benefits; then patients forget verbal instructions; cost of referral too much and has to be borne by patients only; delay in attending referred patients; fees for referral too*. Need of written instructions and a record book: *in referrals there is need of clarity about why and where to go? There is also pressing need of regular well trained staff at definite well publicized "referral reception centres" to guide referred patients* **Category: Public sector resources in private practice** private practice of doctors during duty time**;** 'pudia##' treatment; government supply drugs 'sold' through private practice; quack like medical officers.
Subtheme 2.3 Lack of facility-provisions	**Category: Health care and professional development related** dearth of health care facilities too e.g. advanced tests and drugs not available; **Category: Safety and security related** safety and security for self and family. **Category: Personal-family- and leisure-life related** basic needs not being fulfilled (e.g. proper house, safe and adequate water, continuous supply of electricity/energy. [**General Comments importance of facilities**: *important for emergency management and life saving measures; facilities needed to reduce morbidity and mortality, needed to avoid unnecessary referral and for transportation during referral, poor recruitment and retention due to lack of basic facilities*.]
Subtheme 2.4 Staff recruitment and retention: attraction and attrition	**Category: Reluctance toward rural posting** shortage of doctors and staff in public sector's free of cost rural health services; craze for private sector; reluctance for public sector; reluctance for rural posting; urban concentration; migration; **Category: Reasons for low recruitment and retention** reasons for reluctance for rural posting (and poor recruitment and retention of doctors and staff): more security, non interference and privacy in urban areas; lack of basic facilities; goals, habits and lifestyle: *after hard work and high expenditure on medical education earning is the aim ; where to spend money in rural areas? no life there; family life and future of the family is top priority*; demands of profession: *medical profession demands continuous learning, knowledge gets wasted in rural areas*; **Category: Wants and vacancies** lack of specialists at CHCs **Category: Promotion chances** dim promotion chances *doctors and other HCPs are not promoted and the delay is extreme due to various reasons including anticipation of vacancies if doctors from remote rural areas are prompted and posted in towns and cities.*
Subtheme 2.5 People factors	**Category: Lack of awareness, sense of responsibility hygiene and sanitation- lack of awareness** *health awareness is lacking; child-care, antenatal care all need awareness; if mother is educated children will grow, develop and will be educated properly***; sense of responsibility** *do not feel their responsibility for their own health and they are not behaving as responsible persons*; dependence versus independence: *since 15th August 1947 we are independent but day by day our dependence is increasing ; disease-prevention-perception: people want doctors to prevent disease and doctors think that this is peoples' job* ; role stereotypes: *doctors should be available in the hospital only for treatment by drugs only but not in health centres and sub health centres*. **Hygiene and sanitation** poor personal hygiene and hand hygiene; poor food milk and raw vegetable hygiene; delay in consulting a doctor. **Category: Lack of initiative and action- people lack initiative**: *people want facilities but want to remain inactive; people rich and poor as well as government servants lack initiative and action*. **Category: Politicians and media- unfavourable society** *public, politicians and media are unfavourable and hostile*

*'jholachaap' doctors =Unqualified fake doctors commonly called quacks too**mantra tantra jhaad phoonk= ritual superstition and witchcraft and psychological effect based prevailing unofficial 'treatment methods'; #OOP= Out of Pocket Expenditure; ##'pudia= small quantity of powdered tablets or any powder dispensed packed in a small paper, used to conceal the identity of tablets given.

Table 4: Priority domains, needs and strategies (some codes CMUs and quotations).

3. 3 Improving the referral system	3. 4 Improving IEC	3. 5 Improving recruitment and retention	3. 6 Improving involvement, motivation and regulation
Category: Referral Mechanism **Proper system** *patients will have to go through the rural center; cannot go directly to the urban higher center;* **Coordinator** *there must be a coordinator for such cases as serious patients and persons with disability.* **Receiving person** *one person actively referring patients from the rural center and the other person receiving these at the higher center.* **Incentives** *paramedical staff and rural health center should get incentives for referral* **Fixed days for specialist outreach** *team of specialists should visit the rural centers on fixed days* **Screening and referral** *Screening and referral should be done at a large scale after training and involving village level health workers* **Category: Referral Assessment** **Review and feedback needed** *Referrals must be assessed and feedback must be given.*	**Category: IEC Mechanism** **Selecting appropriate channel** *there are limitations related to the posters and hoardings; health camps, lecture cum discussions, dance and drama techniques should be appropriately used.* **Showing videos** *written text might not be very effective; even audio will not be very effective; videos will be very much effective; for example, showing videos about the harmful effects of tobacco, the do's and don'ts during pregnancy, wrong child rearing practices, consequences of wrong household practices.* **Exhibition on wheel** *very useful if an exhibition on wheel passes through the village; an exhibition involving people whom rural people know and trust will be more effective.* **Doctors and Interpersonal / Group Communication** *great if doctors do their counseling task properly; counselors must be appointed to assist doctors.* **Suggestion box** *for two way communication keeping a suggestion box is also important* **Category: IEC Assessment** **Monitoring IEC** *frequent reviews of counseling and IEC are needed.* **(General Comments** *IEC is one of the main pillars of the health system; helpful in tackling troubles too; if anything goes wrong that is properly tackled by communication).*	**Category: Extra- monetary incentives** **More attraction and less attrition** *basic facilities for good personal family and leisure life (good housing; adequate and pure water; 24x7 electricity); health care related adequate advanced provisions; reliever doctors for 8 hour duty (at least 4 doctors for one workplace); shopping and leisure week-off; transport facilities; internet and mobile network facilities; training and future learning opportunities; bright, timely and fair promotion chances; development of Indian Medical Service like the IAS IPS IRS IFS etc.; separate cadre for Rural Health Services, separate administrative cadre and award of IAS to these doctors; recognition of services at state and national levels for rural doctors; promotion in medical education be linked with rural services.* **Facilities knowledge skills salary** *most important among incentives and facility-provisions are: facilities knowledge skills salary, all of these are important* **Category: Monetary incentives** **Questionable effectiveness:** *doctors can't be lured by salary or allowances alone; income in private practice is several times higher than the salary and allowances;* **Monetary incentives for paramedical staff** *government must give monetary incentives for paramedical staff for good work*	**Category: Rural Allopathic Doctors** **CME for rural doctors** *policy of work-opportunity at a higher center then back at the rural center; for continuation, expectation of work with devotion at both type of setup.* **Doctors are role models and responsible** *if doctors disappoint them where can people go? only doctors can involve motivate and regulate paramedical staff* **Category: Health Workers** **They make difference** *motivate the health workers; attitude, knowledge and skills of the health workers make a difference; health worker is not a private doctor; diary must be maintained, they must give report and their knowledge and motivation must be constantly improved.* **Category: Trained reformed quacks** **Screening and referral** *involving the quacks after training and reforming them will strengthen the system, if they provide voluntary screening, referral and public health services; if there will be no antagonism the faith of the general population will increase.* **Convenience:** *if quacks are involved it will be easier for the rural health system staff.* **Caution:** *unqualified practitioners must be banned strictly and be replaced by the trained and 'involved' basic health service providers.* **(General Comments** *public interest first; public should be benefited; devotion will develop good habits**;** proper attitude regarding patients' welfare must be inculcated. one should educate many).*

Potential role of the health services in addressing inequities, harnessing community capacity and developing community participation also covered concepts such as decentralization, participatory democracy at the village level, *'Gram Svarajya'* (concept of economic and political independence with social cohesiveness ensuring liberty equality and fraternity in each village) and *'Gram Sabha'* (concept of village-assembly or village-parliament, formed by each voter of the village i.e. all members at an equal level politically, though initially they may come from different strata) One of the participants said:

"Decentralization this is a thing what we want because one center cannot take care of each and every state and the state cannot take care of each and every village therefore decentralization is needed….will be more beneficial to talk to people in the 'Gram Sabha' because in this body there are many type of people and all of them are voters at an equal level so it is more beneficial to talk to the whole assembly or 'Gram Sabha' rather than talking to a small group of people in the village. Definitely there will be members from each community in this assembly and members from all socio-economic strata" **FFIDI_4.**

Theme 2: Main challenges problems and issues in implementation

Five subthemes have constituted this theme. These are: 2.1 preventive services, public health and the national health programs (NHPs) 2.2 curative services: practices and malpractices 2.3 lack of facility-provisions 2.4 staff recruitment and retention: attraction and attrition 2.5 people factors (Table 3).

The participants talked about a big gap between ideal and envisaged roles and the actual practices. They also described and discussed various ironical malpractices and consequent deficiencies: According to one of the participants

"Present status [of the health services in the rural areas] is not at all satisfactory. The very aim of the rural health services is not being fulfilled. This aim is proper scientific treatment and referral facilities at primary care level [so that patients can be appropriately referred to the secondary care level.] Instead irrational use of drugs is there. Public is also not well aware and they demand unnecessary drugs and injectable. People are now demanding investigations also according to their choice. The facilities given by the government are not being used properly. At many places doctors are not available and where these are available they have established their own private OPD [outpatient department] in their personal clinics where they work during the time of their duty in the government job. The services of the doctors are also hampered by their involvement in the office work. The government-run rural health centers are not functioning according to their capacity. At present there are several quacks and malpractices are very common everywhere" **FFIDI_5.**

Theme 3: Priority domains, needs and strategies for improvement

This last theme is formed by six subthemes: 3.1 improving community engagement 3.2 improving facility provisions and supportive supervision 3.3.improving the referral system 3.4.improving Information Education Communication (IEC) 3.5 improving recruitment and retention 3.6 improving involvement, motivation and regulation (Table 4).

All participants were in favour of increase in the health budget, modernization in the RHS and improvements in the interest of the rural poor and needy. Difference of opinion was found in finer details. For example, a good number of them were pessimistic about effectiveness of monetary incentives in attracting doctors and increasing recruitment and retention and they were against stringent measures for regulation of medical community. Some of them were in favour of monetary incentives provided that these are supplementing the very strict, very stringent regulatory measures; as is evident from the following quotation:

"Very stringent, very strict control is needed on the private practice of the doctors and their tendency to enjoy commission for investigations etc. For this among other things salary should be handsome, allowances should be there and lucrative incentives should also be there for each and every service provider in the health sector. Incentives must be given for example 10 rupees per patient or so additional to the salary so that people are interested in serving more and more patients; and then for any fault or crime the doctors and other staff must be severely punished; if needed should even be jailed. There must be a competition between the public sector and the private sector. The public sector should be the winner in the competition and should be able to set standards for the private sector People's attitude for the doctors and the nurses should be modified making it better. Budget should be increased and on this basis human resources and facilities should be improvised. Educational opportunities, educational leaves and continuing medical education opportunities should be given generously and the doctors and the nurses should not be engaged in useless wasteful bureaucratic activities they resent" **FFIDI_6**.

DISCUSSION

In the present qualitative study, we explored (1) the thinking and feeling of the study participants regarding the ideal role of rural health services (RHS) of India (2) their experiences of actual practices in these services at various health centers and hospitals and (3) their ideas regarding further improvement. The study-participants have pointed out big gaps between various concepts and

their implementation. Several 'people factors' and 'system factors' have emerged. Some 'positive aspects' came up among a plethora of the 'negative aspects' including quite a few 'contradictions', 'malpractices' and consequent 'deficiencies' (Theme 1 and 2). 'Priority domains' and 'needs' were identified and 'strategies' were suggested towards reforms (Theme 3).

Theme 1

Discussions and descriptions initially brought up concept and contribution; importance and impact; relevance and role of rural health services. These revealed that the participants thought and felt that the rural health services were simple and basic yet vital and essential services for the rural poor. There were several expressions ending with "but" followed by silence (Table 2 Subtheme 1.1). RHS were depicted as vital and essential in view of demography and geography, development and disease prevention. Imagination of a situation "if these services were not there" and narration of benefits of RHS also revealed the relevance (Table 2 Subtheme 1.1). 'Beyond medicine' 'potential role' of these services in 'community engagement' also came up (Table 2 Subtheme 1.2) whereby the participants discussed 'a different kind of politics' covering concepts such as decentralization, community participation, '*Gram Svarajya' 'Gram Sabha'* and the potential role of the health services in harnessing community capacity. Related issues of "urban dependence" (for diagnosis and treatment); and "urban concentration" (of doctors and other HCPs) emerged as prominent challenges (Table 3 Subtheme 2.2 and 2.4). The rural communities continue to exist as powerless centers dependent on, dominated by and distanced from urban centers of power. This is in spite of four decades of insistence in international policy on 'centrality of communities' particularly the rural and tribal ones. This insistence is essential for initiation of process of bridging the rural urban gap and in order to take steps against the ineffective 'one size fits all' approach. Under the banner of so called development, which is mostly in the interest of the vested urban interests, several technological, social, political and economic changes in rural environments have damaged rural social cohesiveness. Rebuilding or harnessing community capacity is integral to developing locally responsive health services and is in the interest of communities and governments. Promoting rural social capital maximizes the innate, adaptive, inventive and innovative nature of rural people and leads to empowered communities capable of developing local solutions.[19]

Theme 2

Among the main challenges which have come up in our exploration, an important one is low priority being accorded to disease prevention and health promotion coupled with poor involvement of doctors in preventive medicine and public health. Besides, "for-profit curative services in the public sector" and consequent "access barriers" emerged as associated challenges and issues.

In this context and with reference to various aspects of curative services too (which involved several "malpractices" besides "deficiencies") in the present study we found several 'system factors' and 'people factors' (Table 3 Subtheme 2.1). People and governments are fond of viewing the health services as curative services. Now a day, on account of their growth as well as greed, doctors too are interested in the curative services only (mostly "for-profit"). Doctors' overall public role and community advocacy have weakend over the past 50 years.[20] Recently leading medical associations have called for renewed standards of medical professionalism including stronger public advocacy, a commitment to social justice in healthcare and community engagement.[20] Clinical skills are in high demand and have created a market place for doctors to be fully engaged in.

Health care systems can be influenced by doctors and can influence them. It is interesting to see how the health care systems work "despite apparent consensus" "despite apparent intentions" and "despite apparent decentralization."[19,21,22]

(1) Despite an apparent international consensus on the virtues of disease prevention and health promotion, these approaches have not become as prominent in health policy as hoped, and curative approaches continue to dominate health policy.[21]

(2) Despite apparent intentions of decentralization the final decision-making powers were still held by a person or a small group (found in all the studies in a scoping review).[19]

(3) Despite apparent decentralization, the primary responsibility for primary health care is often left to the weakest tier of government (local governments). Consequently, preference is for secondary and tertiary care services which are governed by higher levels of power and usually located in more attractive (urban) places of posting where salary (or overall income) is also higher and more regular.[22]

In the low and middle income countries, several constraints exist such as low income and lack of facilities, especially in the rural and tribal areas. Several 'pull' and 'push' factors have their role.[11] These global issues must be studied further in the speedily changing contemporary context of India. In view of the findings of present perception study, salary does not appear to be a crucial barrier in recruitment and retention. The attractions and 'addictions' of urban life perhaps play a more important role in urban concentration of doctors. The 'pull' effect of these is strengthened by the 'push' effect of various other factors revealed in our study (Table 3). A focus group study conducted in Germany has also pointed out some

aspects of rural life perceived negatively by medical graduates such as encroachments on privacy and demands exceeding the competence.[7] The most important factor adversely influencing the rural health services which came up in our study are lack of facilities and administrative-social supports.

Involvement of the public sector doctors in administrative tasks (Table 3 Subtheme 2.1) does hamper their services, yet, according to the participants of the present study, in the genesis of the access barriers private (dual) practice seems to play the main role. For-profit-curative services are engaging most of the time of a great majority of the public sector doctors and the field health workers supervised and controlled by them. These services are invaded by irrational use of drugs, use of unqualified rural practitioners as 'agents' and divert time and resources from public sector to the private sector. These malpractices create access barriers for the poor and the disabled (Table 3 Theme 2). A qualitative study has reported that poor people living with disabilities in rural areas experience unique problems in accessing healthcare and there is higher prevalence of disability in the rural compared with the urban areas.[23,24] OOP expenditures for health care are a huge burden and a big challenge for the poor. This is too difficult for the rural and tribal communities to manage and cope with the high costs. Poor families have to borrow money, sell assets and adjust their health care seeking. Families should not be left in situations where they have to choose between health and welfare, between survival of a newborn baby and selling their sheep.[25] In the present study, participants also discussed a variety of other challenges related to the interests of the health care providers such as safety, security, satisfaction, comfort and future prospects. For addressing all these issues, political and administrative vision and will are essentially needed in the absence of which there is disastrous and devastating chaos.

A closely related attitudinal main challenge brought up in our exploration is a special kind of 'absenteeism'. This phenomenon too is widespread in resource poor settings whereby the price of the private (dual) practice of the public sector health care workers is paid by the poor of these nations who form a major portion of the population.[26-29] A qualitative study from Ethiopia has reported that health workers were absent from the public sector while attending to patients in the private sector. There were even cases where health workers referred patients from the public sector to their private practice.[26] Organizational/cultural factors which include health care management's questionable leadership style and cultural expectations[26] also facilitates this special kind of absenteeism wherein neither the public sector health care providers are sick nor their work environment is hostile and they regularly draw their salaries and allowances on the basis of their 'verified attendance'. A good number of main challenges, problems and issues (Theme 2 topics) are additionally permitted, hence perpetuated, by this questionable leadership and administration style. For example, "irrational use of drugs", "mushrooming of quacks" and "referral realities"(Table 3 Subtheme 2.2) which are being allowed to remain in the field of health services of India like heaps of solid waste or pools of hazardous liquid waste in an unclean country. It is thus apparent that all the challenges, problems and issues constituting Theme 2 are closely interrelated. Health care staff recruitment and retention, attraction and attrition issues (Subtheme 2.4) were also found to be closely related to lack of facility-provisions (subtheme 2.3) and people factors (subtheme 2.5).

Shortage of doctors and other HCPs in rural areas- in other words, unbalanced distribution of health personnel between and within countries - continues to be a growing concern globally.[4-13,22] Lack of facilities has emerged as the main barrier to recruitment and retention in the present study, Similar to our findings, in a qualitative study of factors influencing retention of rural healthcare staff in Bangladesh has reported (according to doctors and paramedical staff) poor living conditions (e.g. poor housing facilities and unsafe drinking water); overwhelming workloads with poor safety and insufficient equipment; a lack of opportunities for career development and skill enhancement; insufficient wages and inadequate opportunities for private practice. Other categories in their study brought up lack of fairness in promotion; lack of sufficient authority to undertake disciplinary measures against absenteeism (managers) and need for a national policy on rural retention (policymakers).[30]

Theme 3

Several priority domains, needs and strategies for improvement also came up in the course of our exploration. Most prominent among these were patient referral and staff recruitment and retention. Both need supports from the other four (Table 1 and Table 4) Thus "facility-provision with supportive supervision" is essentially required along with "improved IEC", "involvement, motivation and regulation" as well as "enhanced and better community engagement". Contemporary 'compulsory service programs' do send some doctors in the remote rural areas and the political promise is fulfilled, but the effect is temporary; unless monetary as well as extra monetary incentives are not actually provided, the doctors abandon their places of posting.[10] Hence an appropriate combination of the strategies suggested in our study is important. We recommend that in the process of reforms community participation should be emphasized and prevailing *"commandeering people approach"* should be replaced by *"Gram Sabha (Village Parliament) approach".* A previous study suggested that community efforts to retain doctors etc. should be resorted to. These should include providing social, financial, and accommodation support. Rural communities can and should co-finance and co-manage the rural health services for more human resource attraction and lesser attrition. The rural communities should seek to reform and strengthen governance mechanisms, using both top-down and bottom-up

strategies to improve the remuneration and other supports for staff in rural health services.[22]

In the process of implementation of all the strategies discussed in our exploration the governments, the communities and the medical community all have their roles and responsibilities. Instead of negative 'bossing' and damaging role, the administrators, the politicians and the media should play a positive role. How constructive role of media and published research can positively influence recruitment and retention of doctors, in places where they are needed the most, has been shown by the example of post-disaster-Fukushima. Density of doctors increased in that region after the triple disaster of 2011 (earthquake, tsunami and nuclear accident) and the credit goes not only to the medical community of Japan but also to the media and the research papers too.[31] Let us hope that in other parts of the world too the medical community and the society in general will grow more sensitive to the needs of their respective nations, those of all the weaker and vulnerable groups and of all the difficult terrains.

CONCLUSION

There is a big gap between the concept (declared policy) and actual implementation in the rural health services of India. Several 'system factors' and 'people factors' have led to multiple 'contradictions', 'malpractices' and consequent 'deficiencies'. There is a close mutual relation among the various challenges, problems and issues. Factors such as a meager health budget, corruption and lack of involvement motivation and regulation along with permitted absenteeism from public sector for private (dual) practice are leading to out of pocket expenditures causing access barriers which are disastrous and devastating for the poor and the disabled. A chaos is being allowed to exist. Irrational use of drugs, mushrooming of 'quacks' and diversion of resources from public to private sector are also there. Addressing all the issues requires peoples' awareness and action; political and administrative vision and will. A different politics is needed. Introspection, internal reforms and more community engagement is expected from the medical community. Strategies suggested here are quite likely to make a difference if implemented. Further research is needed, particularly experimental studies on the suggested strategies.

ACKNOWLEDGEMENTS

We would like to thank Medical Director RDGMC Ujjain and all the participants of this study.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. NHP. National Health Portal, India. Bhore committee, 1946. Available at: https://www.nhp.gov.in/bhore-committee-1946_pg. Accessed on 3 March 2018.
2. NHP. National Health Portal, India. The National Health Mission. Available at: https://www.nhp.gov.in/the-national-rural-health-mission_pg. Accessed on 3 March 2018.
3. Prasad AM, Chakraborty G, Yadav SS, Bhatia S. Addressing the social determinants of health through health system strengthening and inter-sectoral convergence: the case of the Indian National Rural Health Mission. Global Health Action. 2013;6:10.
4. World Health Organization. Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. WHO; 2010. Available at: http://www.who.int/hrh/retention/guidelines/en/. Accessed on 3 March 2018.
5. Sundararaman T, Gupta G. Indian approaches to retaining skilled health workers in rural areas. Bulletin World Health Organization. 2011;89(1):73-7.
6. Ramani S, Rao KD, Ryan M, Vujicic M, Berman P. For more than love or money:attitudes of student and in-service health workers towards rural service in India. Human Resources for Health. 2013;11:58.
7. Pohontsch NJ, Hansen H, Schäfer I, Scherer M. General practitioners' perception of being a doctor in urban vs. rural regions in Germany – A focus group study Family Practice; 2017: 1–7.
8. Verma P, Ford JA, Stuart A, Howe A, Everington S, Steel N. A systematic review of strategies to recruit and retain primary care doctors. BMC Health Services Res. 2016;16:126.
9. Dussault G, Franceschini MC. Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce. Human Res Health. 2006;4:12.
10. Frehywot S, Mullan F, Payne PW, Ross H. Compulsory service programmes for recruiting health workers in remote and rural areas:do they work? Bull World Health Organization. 2010;88(5):364-70.
11. Lehmann U, Dieleman M, Martineau T. Staffing remote rural areas in middle- and low-income countries:A literature review of attraction and retention. BMC Health Services Res. 2008;8:19.
12. Ghimire LV. Retaining health manpower in developing countries. Lancet. 2009;374(9686):291.
13. Arora R, Chamnan P, Nitiapinyasakul A, Lertsukprasert S. Retention of doctors in rural health services in Thailand:impact of a national collaborative approach. Rural Remote Health 2017;17:4344.
14. May C, Roth K, Panda P. Non-degree allopathic practitioners as first contact points for acute illness

episodes: insights from a qualitative study in rural northern India. BMC Health Services Res. 2014;14:182.
15. Joshi SC, Joshi R. Doctor becomes a patient: a qualitative study of health care work place violence related perception among junior doctors working in a teaching hospital in India. Int J Community Med Public Health. 2018;5;5:1775-86.
16. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105–12.
17. Joshi SC, Diwan V, Tamhankar AJ, Joshi R, Shah H, Sharma M, et al Qualitative study on perceptions of hand hygiene among hospital staff in a rural teaching hospital in India. J Hosp Infect. 2012;80(4):340-4.
18. Joshi SC, Diwan V, Tamhankar AJ, Joshi R, Shah H, Sharma M, et al. Staff Perception on Biomedical or Health Care Waste Management: A Qualitative Study in a Rural Tertiary Care Hospital in India. Griffiths UK, ed. PLoS ONE. 2015;10(5):e0128383.
19. Kenny A, Hyett N, Sawtell J, Dickson-Swift V, Farmer J, O'Meara P. Community participation in rural health:a scoping review. BMC Health Services Res. 2013;13:64.
20. Crump C, Arniella G, Calman NS. Enhancing community health by improving physician participation. J Comm Med Health Edu. 2016;6(5):470.
21. Atkinson S, Fernandes L, Caprara A, Gideon J. Prevention and promotion in decentralized rural health systems:a comparative study from northeast Brazil. Health Policy Plan. 2005;20(2):69-79.
22. Abimbola S, Olanipekun T, Igbokwe U, Negin J, Jan S, Martiniuk A, et al. How decentralisation influences the retention of primary health care workers in rural Nigeria. Global Health Action. 2015;8:10.3402/gha.v8.26616.
23. Vergunst R, Swartz L, Mji G, MacLachlan M, Mannan H. "You must carry your wheelchair" – barriers to accessing healthcare in a South African rural area. Global Health Action. 2015;8:10.3402/gha.v8.29003.
24. World Report on Disability 2011. Geneva: World Health Organization; 2011. Available from: https://www.ncbi.nlm.nih.gov/books/NBK304079/
25. Husøy OK, Molla SM, Muluken G, Marie MK, Frithof NO, Ingrid M. Selling my sheep to pay for medicines – household priorities and coping strategies in a setting without universal health coverage. BMC Health Services Res. 2018;18:153.
26. Belita A, Mbindyo P, English M. Absenteeism amongst health workers – developing a typology to support empiric work in low-income countries and characterizing reported associations. Human Res Health. 2013;11:34.
27. Kisakye AN, Tweheyo R, Ssengooba F, Pariyo GW, Rutebemberwa E, Kiwanuka SN. Regulatory mechanisms for absenteeism in the health sector:a systematic review of strategies and their implementation. J Healthcare Leadership. 2016;8:81-94.
28. Tweheyo R, Daker-White G, Reed C, Davies L, Kiwanuka S, Stephen Campbell S et al. 'Nobody is after you; it is your initiative to start work':a qualitative study of health workforce absenteeism in rural Uganda. BMJ Glob Health 2017;2:e000455.
29. Ackers L, Ioannou E, Ackers-Johnson J. The impact of delays on maternal and neonatal outcomes in Ugandan public health facilities:the role of absenteeism. Health Policy Planning. 2016;31(9):1152-1161.
30. Darkwa EK, Newman MS, Kawkab M, Chowdhury ME. A qualitative study of factors influencing retention of doctors and nurses at rural healthcare facilities in Bangladesh. BMC Health Services Res. 2015;15:344.
31. Yamamoto K, Ozaki A, Tanimoto T, Leppold C, Kanazawa Y. Solutions to physician undersupply in rural areas: from the experience of rural Fukushima. Rural Remote Health. 2016;16:4031.

Cite this article as: Joshi SC, Joshi R. Simple and basic yet vital and essential health services: an exploration of perception of junior health care service providers regarding rural health services in India. Int J Community Med Public Health 2018;5:2248-58.