CHAPTER- 5
MAJOR FINDINGS, SUGGESTIONS AND CONCLUSION
SECTION 1
MAJOR HR ISSUES IN DISTRIBUTION OF PHYSICIANS, NURSES AND MIDWIVES
5.1.1. INTRODUCTION

After having an analysis and descriptive interpretational previous chapter, this chapter presents the major findings on distribution, attraction and retention of physicians, nurses and mid-wives in rural and remote areas. Section 1 highlights the major findings of HR issues on Distribution, Section 2 highlights major HR issues on Attraction and Section 3 highlights major HR issues on retention and Section 4 provides a preview of the specific findings on Health Sector Reform initiatives and Section 5 presents the major issues in HR Practice related to attraction, distribution and retention of physicians, nurses and mid-wives in rural and remote areas. Thereafter, Section 6 highlights possible options in form of suggestion on the major issues and followed by Section 7 the Conclusion of the study.

5.1.2. MAJOR HR ISSUES IN DISTRIBUTION OF PHYSICIANS, NURSES AND MIDWIVES

5.1.2.1. DISPARITIES IN ESTABLISHMENT OF HEALTH INSTITUTIONS: ISSUE OF HEALTHCARE DELIVERY SYSTEM WHICH LINK DIRECTLY TO HR ISSUES.

Over the last few decades the establishment of health institutions in rural areas of the state are haphazard and not kept pace with adhering to the norms. The state has created 468 numbers of Sub-centres out of which only 286 no. of SCs are functional likewise 119 PHCs were established, whereas functional 24x7 PHC is 29, and functional CHC are 49 numbers, where as functional as FRUs is only one (1). Moreover, the figures of the health institution at the rural areas are different in the central database and the state figures.

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<tr>
<th>Health institution</th>
<th>Central Figure (RHS, 2010)</th>
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<tr>
<td>SC</td>
<td>286</td>
<td>468</td>
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<tr>
<td>PHC</td>
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<td>CHC</td>
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However, the government have attempted the disparities and on the verge of rectification and de-notification of many of the SCs in the rural areas, which were created randomly.

The average population covered by the health institutions district wise has no similarities and the nurses were not followed it ranges from 6064 to 781 population for a Sub-centre in the districts. However, at the state level the figure is 2954 which is better than that of the norms for a SC. While a PHC covers a population from 22048...
to 1590 in the district and the state figure is 11619 which is also a better figure at the state level. Similarly, CHC covered a population from 8822 to 48513 and the state level figure is 28217 which is also a better figure than that of the norms. This trends show that the institution were randomly created without thinking the consequences of human resource requirement and without keeping in mind the Govt. of India norms. It seems the inter district disparities are there in respect of creation of the health institution, which in repulsion create the problem of inadequacy of human resource and inadequacy of importance.

5.1.2.2. THE HUMAN RESOURCE CRISIS IN RURAL AREA: NUMERICAL INADEQUACY OF PHYSICIANS, NURSES AND MID-WIVES

The ramped and unplanned creation of health institution in the state has created a demand of Physicians, nurses and mid-wives. There is huge gaps of demand and supply, placement of Physicians, nurses and mid-wives in the region. Consequently, many rural communities/areas are deprived of the primary health care and desperately need the attention. However, the population norms of establishment of the health institutions does not fit in the state like Aruanchal Pradesh, because the state have lesser population in comparing to the other states in India. The state has the lowest density of population in the country. However, the norms are norms and should be followed by the state. Besides, the in-equities in distribution of Physicians, nurses and mid-wives, there is huge gaps and shortage of these category of health workforce, to cater the maternal and child health needs as well as primary health care in the state. This study found that there are geographical imbalances and shortages of Physicians, nurses and mid-wives. The inequities in the geographic distribution of Physicians, nurses and mid-wives, itself has meant too many rural and remote areas with the shortage of Physicians, nurses and mid-wives.

This is a major reason for Arunachal’s weak health sector performance is due to the crisis in the health workforce. There is a critical shortage of skilled manpower like doctors, nurses and midwives. There are also shortages of personnel trained in concerned disciplines like various specialists, we can say this deals with number and the composition of health workforce, major public health issues. The health systems of the region were characterized by an insufficient number of medical specialists, MBBS doctors, and other professionals such as nurses and mid-wives. Other level of problem is that at many places posts are vacant in wants of appropriate candidate or procedural delays in appointing staff.
Shortage of human resources is a major problem facing Arunachal’s Health sector, where more than 80% of the population lives in rural areas. Most of the districts have the rural population, maximum of the districts are having urban areas only in their District HQ and the rest are comprises of rural areas. Every District is having a district level hospital in its HQ, but these hospitals are also having acute shortage of manpower especially the graduate doctors, PG doctors and staff nurses. Whereas, the availability of ANMs in the state is quite good but this category of workforce is having an artificial crisis. However, under NRHM, doctors, staff nurses and mid-wives are currently recruited on a contractual basis. Among the newly recruited doctors, many of them do not join the service and some numbers leave the job within short span of time.

As per the existing practices, staff nurse are recruited from those having passed out of nursing college and the nursing schools at the state and off-course from outside state. Although, the existing pool are not adequate to fill the vacant posts. Further, new requirements have come up after the launch of central government flagship programmes. There is demand for additional positions under these programmes in many of the district out of their sanctioned posts. The vacancy rates are particularly high for skills that are mostly needed. However, the determination of sanctioned post and vacancies there on, is also not cleared at the district as well as the state level. Most health occupations are highly interdependent when carrying out their tasks. Problems in one professional category may spill over into another. For example, a shortage of nurses resulting from inadequate planning may have adverse effects on the work of doctors.

The shortfall of Physicians, nurses and mid-wives are continues to represent one of the major constraints to the development of health services and access to basic health care in Arunachal Pradesh.

According to the Indian Public Health Standards, the availability of HR is one of the vital prerequisites for competency in the rural health care delivery system in the country. It is also very important where 77% of the population lives in rural and remote areas and poverty is the dominating factors among the population.

Requirement based on the IPHS norms for Physicians, nurses and mid-wives for existence health institution are – 570 midwives with current shortage of 51%, 926 Nurses with current shortage of 70% and 510 Physicians with current shortage of
53%. The shortage of midwives among the districts ranges from 6% to 82%, nurses from 37% to 92% and 1% to 85% of physicians for all the existing health institution.

Similarly, the requirement for rural and remote area is similarly high. We find that the requirement of mid-wives is 714 nos. with current shortfall of 65%, nurses is 747 nos. with current shortfall of 78% and physicians are 545 with current shortage of 66%. The situation is critical in respect of the requirement and the shortfall in rural and remote areas. This is a serious indicator of inadequacy of Physicians, nurses and mid-wives in rural and remote areas in comparison to the urban areas. The requirement is more because of the concentration of more Physicians, nurses and mid-wives in urban areas, which creates inequity in the distribution as well as the shortage of Physicians, nurses and mid-wives.

Therefore, it is found that there is acute shortage of Physicians, nurses and mid-wives in the region and especially in rural and remote areas, while the urban areas have more concentration though there is also have the shortage in some numbers. While, the disparity of distribution of Physicians, nurses and mid-wives in rural and urban co-exists and contributing to the shortage and the huge gaps in the region.

Thus, the poor availability of Physicians, nurses and mid-wives co-exists and creating an imbalance and a problem with debilitating health care delivery system in the region. The shortage of these categories of the health workforce is reaching the crisis proportion and should be the centre of attraction of the government machineries.

5.1.2.3. PRODUCTION ISSUES OF PHYSICIANS, NURSES AND MID-WIVES

Generation of health workers is another issue in the state. It has not been kept pace with the need, especially with the physicians (MBBS) and nurses (GNMs). Absence of adequate training institutes for medical and nursing courses results in low numbers of medics and paramedics produced for the state. There is no medical college in public sector or in private sector for Allopathic disciplines besides a Homeopathy Medical College in private sector. Yearly a fixed numbers of students according to the Govt. Of India quota seats, are placed in various Medical colleges all over India. 32 seats in First nomination 2010 and 34 seats in first nomination 2011 has been allotted to the students for the MBBS course in various Medical Colleges in India (DHTE, 2010 & DHTE, 2011). For the training of nursing personnel, the state runs a lone
Nursing School for ANMs at General Hospital, Pasighat, East Siang District of Arunachal Pradesh. The institute runs training programs on midwifery (ANM) nursing courses. There are no fix numbers of ANM admission seats per year in this ANM School, in the year 2009-10, the number was 70, a year before in 2008-09, it was 47. The variation depends on Government of Arunachal Pradesh continuing changing policy. There exists a chronic and serious shortage of Nurses (GNMs) at present time, as there is no GNM training school in govt. sector in Arunachal Pradesh. A few number of GNMs are produced in GNM School at Ramakrishna Mission Hospital, Itanagar. With this inadequacy in teaching schools, insufficient numbers of professionally trained personnel to compensate the situation.

5.1.2.4. MAL-DISTRIBUTION OF PHYSICIANS, NURSES AND MID-WIVES AMONG THE DISTRICTS: GEOGRAPHIC INEQUITY

Adding to the acute shortage of manpower in the health sector in Arunachal Pradesh, the issues and options for deploying health workforce is always a big deal of concern. Mal-distribution, that is the distribution of health workforce is characterized by urban concentration and rural deficits, but these imbalances are perhaps most disturbing from a district perspective also. Urban/rural imbalance in the distribution of health workers is a problem in the past and present also, and it may be worsening more. There is an over-concentration of qualified health personnel in urban hospitals and urban centres, coupled with shortages in poor neighbourhood districts and rural areas that are not equally distributed, especially to manage change in the health sector.

Health workforce especially the nursing staffs, the physicians are concentrated to the urban hospitals. Doctors and nurses are reluctant to relocate to remote areas and forest locations that offer poor communications with the rest of the main land and few amenities for health professionals and their families. Urban areas in the states are good and convenient to health care professionals for their comparative social, cultural and professional advantages. The Health workforce have been reluctant to work in rural and remote areas in the state, possibly because of little support at these areas, a lack of material resources for them, poor working and living conditions, isolation from professional colleagues and possibly less opportunities for self professionally developed and Silently the education opportunities for their (workforce) children. Moreover, there is a poor distribution of doctors as well as an acute shortage of midwives outside the capital city, particularly in remote areas and sparsely populated communities.
Doctors and nurses are currently recruited on a contractual basis under NRHM, among the newly recruited doctors and nurses do not join the service if they are posted in remote and inaccessible areas in the state and some of them leave the job within short span of time on being regularized or of other reasons. The percentage of such doctors varies from district to district. Furthermore, there is no financial incentive for Working in rural, remote and inaccessible areas, that’s why the problem of geographic mal-distribution of health workers persists.

The majority of skilled health service providers are concentrated in urban areas and the mal-distribution is concern for artificial crisis of health workforce in the rural and inaccessible areas in the state.

The accessibility of Physicians, nurses and mid-wives has been threatened mostly in the rural and remote area of the state. While 77% of the population lives in rural and remote areas, only 63% of physicians, 54% of nurses and 72% of mid-wives are serving in rural and remotes areas of the state. This creates urban and rural imbalance in distribution. The phenomenon of urban skewness and mal-distribution among the districts are there, consequently, many rural and remote areas are in desperate need of the physicians, nurses and mid-wives. Thus, creating inequities in the geographical distribution of physicians, nurses and mid-wives have meant a wide range of rural & remote area are deprived of the primary healthcare at the doorsteps.

In Arunachal Pradesh, the depth of inequities in the distribution of physicians, nurses and mid-wives in urban and rural area is truly a breathtaking. It is also found that the distribution of physicians, nurses and mid-wives is skewed among the districts. It is observed that the physicians, nurses and mid-wives concentrated to the districts which are with good accessibility and communication. The specialist cadre essential for the maternal and child health- Paediatrician, Gynaecologist and Anaesthetist are almost zero in the rural and remote areas and only concentrated to the urban areas. The 449 nos. of physicians are distributed across the health institutions having 1:3079 of doctor population ratio, which is poor than that of the norms. The doctor population ratio among the districts have different and ranges from 1506 to 8972 population per physicians (doctor). It is observed that the concentration of the physicians to the district is asymmetrical and maximum of them are concentrated to the three district with good communication and with more urban and semi urban area and easy rural area accessibility. The distribution of the physicians ranges from 17%
to 1% among the districts, which creates a wide gap in the distribution. The remotest and harder districts have lesser number of physicians.

Similarly, the nurses share the same situation. 390 number of nurses area distributed across the geographical boundary of the state. It is observed that the similar situation like the physicians to nurses. The nurse population ratio is 1:3545 for the state and does not fulfil the norms. The nurses are also concentrated to the same three districts as similar to the physicians. These three districts have good communication and urban areas. The distribution of nurses among the districts ranges from 23% to 1% among the districts. This trend resulted in Nurse Population ratio ranging from 1597 to 9802. It is observed that the nurses are also concentrated to the easy and good districts, whereas the hard and the remotest districts are deprived of the adequacy of the nurses in rural area.

There are 542 numbers of Mid-wives and this category of health workers are to be placed in SCs, which is the lowest and the first contract points to the population. The mid-wives population ratio is 1:2551 in the state, which is also a worst among the ratio norms. The density of min-wives among the districts has the inequities ranging from 1 mid-wive serving 883 to 4722 populations. It is also observed similar to the other two categories – physicians and nurses, that the distribution is also skewed among the district. The district with good communication and urban concentration has the highest mid-wives. The distribution ranges from 12% to 2% of the mid-wives across the districts. The distribution pattern of the mid-wives in the region shares the similar situation as the physicians and nurses have and concentrated to the same three districts.

Thus, we found that there is poor distribution of physicians, nurses and mid-wives, wherein the ratio and percentage of distribution varies across the districts.

5.1.2.5. MAL-DISTRIBUTION OF PHYSICIANS, NURSES AND MID-WIVES IN RURAL AND REMOTE AREAS AMONG THE DISTRICTS

There are 283 numbers of Physicians, 210 numbers of nurses and 390 nos. of mid-wives distributed across the rural and remote areas of the state. This accounted for 32% of physicians, 24% of nurses and 44% of mid-wives in this pool. Physicians outnumbered the nurses, whereas in norms the nurses should outnumber the physicians. Whereas, the nursing cadre in rural area consists of 35% of nurses and 65% of mid-wives.
The total 283 numbers of physicians are distributed among the rural health institutes across districts. The highest numbers are concentrated to the three districts, which have easy to access rural areas from the urban areas. The percentage distribution ranges from 13% to 2%, the deviation exist in the remotest and hardest districts. While the doctor population ratio in the rural areas is 1:3797, which is 74% deviation from the norms and wider that the state ratio of 1:3079. The district ratio ranges from 1:1506 to 1:8972. The better ratio can be observed in the district with smaller populated district followed by the same three districts which have highest numbers of Physicians, nurses and mid-wives and have the good communication and easy access of the rural areas.

Similarly, the distribution of nurses has almost the same picture as of physicians. The 210 numbers of nurses are distributed asymmetrically among the districts. The average rural population serve by the nurses is 5117, which is 90% deviated from the norms. The distribution ranges from 16% to 1% among the districts. The ratio ranges from 2164 to 15039 among the district. The better ratio among the districts is of the three districts. Out of these, two districts are of good communication and easy access of rural areas.

While, it is observed that 390 nos. of mid-wives are distributed asymmetrically among the districts. The distribution pattern ranges from 9% to 2% among the districts. The average rural population served by mid-wives is 2755 against the 2551 of the state, which deviates to 82% of the norms. The mid-wives ratio ranges from 883 to 6332 among the districts. The lowest population districts are having the good ratio among the districts and followed by the good accessible districts.

Thus, we find that there is also poor distribution of Physicians, nurses and mid-wives among the districts in the rural and remote areas.

5.1.2.6. URBAN AND RURAL DISPARITY IN THE DISTRIBUTION OF PHYSICIANS, NURSES AND MID-WIVES IN WITHIN THE DISTRICTS: A CHRONIC PROBLEM

The inequitable distribution of physicians, nurses and mid-wives found between districts. Almost all districts display serious disparities between levels of physicians, nurses and mid-wives between urban and rural areas. Most of the management representatives have a common consensus that the difficulty in distribution of the workforce particularly in the district level. The process of the transfer and posting are a challenging matter in the absence of the residential quarters
and basic amenities at the rural and remote areas. They also pointed out that in the absence of comprehensive HR policy it is very difficult to rationalise the distribution. Overall, the shortage of the staffs is the main challenges in rational distribution of staffs in the rural areas. It is a matter of concern that the urban areas are also running out of the staffs and it is very difficult on their part to get equitable distribution. It is also pointed out that there are many cases of personal and medical reasons in which the management representative cannot force the staffs to be in the remote and rural areas for long durations. It is also sensed from the interview that there is influence of political pressure for the distributional process. However, it is not outspoken by the management representatives.

Thus, the urban-rural disparity in distribution is observed within the districts. The analysis of urban and rural distributional disparity was done in the previous chapter, where the urban and rural areas were also defined in conceptual framework section in chapter of literature review, as being based in a hospital in urban areas especially only the institute in the district headquarter. Urban areas have 37% of physicians in urban areas and 63% in rural areas. The figures ranges from 14% of physicians to 57% of physicians concentrated to the urban health institutions within the districts. The tendency of urban concentration has been observed in the study of distribution of the physicians, out of 16 districts, 8 districts have more than 40% of physicians concentrated to the urban health institutions of the districts, wherein only one health institution is established in almost of the entire districts in the state.

This signals inefficiencies in the distribution of physicians, nurses and midwives. The situation is grimmer in the cases of the nurses. The percentage of urban – rural distribution is 46% and 54% respectively. It is observed the nurses are more concentrated to the urban health institutions. The figures of urban concentration ranges from 79% of nurses to 16% of nurses in the districts. The highest number of concentration of 79% of nurses is in the capital district of the state. There are more than 8 districts having more than 40% of nurses concentrated to the urban health institution within the districts. This creates a huge gap in rural and urban disparities in the distribution of nurses within the districts.

Moreover, the distribution pattern of mid-wives is 28% in urban and 72% in rural areas in the state. However, the urban concentration of the mid-wives is observed within the districts. It ranges from the 59% of urban concentration to 7% of urban concentration. Basically mid-wives are meant for rural areas and meant for
especially the SCs in huge numbers. But huge numbers are concentrated to the urban health institutions. 8 nos. of the districts have more than 20% of mid-wives concentrated to urban areas, creating a havoc situation in the rural areas. The most of the mid-wives are concentrated to the higher health institutions in the urban areas.

Thus, we find a disparity in the distribution of Physicians, nurses and mid-wives in urban –rural areas within the districts. These trends of Physicians, nurses and mid-wives to gravitate in urban health institutions where urban areas have facilities of good communication, accommodation and other basic amenities, this has create a vacuum in rural area and left the primary health care in the mercy of god and this in turn compels the rural mass to seek services to the urban tertiary level health institutes. This situation has also created the patient crowd in the urban level health institutions.

5.1.2.7. DECENTRALISATION OF DISTRIBUTIONAL FUNCTIONS

Decentralisation of HR functions like distribution and deployment of Physicians, nurses and mid-wives had a twin context, in the sense that the function of distribution, deployment of contractual manpower is in the hand of district authority, rather the deployment criteria centralised to state level for regular employees. The second context was the transformation of roles in the health sector in response to crisis in local level only. So, matters relating to the deployment and distribution are a part of district authority as well as the state level authority.

The core HRM practices for the distribution according to the norms are based on recruitment and selection process in the organisation. The recruitment and selection process of physicians, nurses and mid-wives after the initiation of Reproductive and Child Health programme in 1997 and subsequently National Rural Health Mission in 2005 has been concentrated to the contractual manpower and the process is decentralised to the district level since 2010-11. The decentralisation of this process is only for the contractual physicians, nurses and mid-wives. For the recruitment of the permanent employee of this category, the contractual employees are regularised and continued their services as regular employees, the process is basically based on the sanctioned post vacancies and seniority based and the process is undertaken by the Directorate of Health Services headed by the Director of Health Services.

However, decentralization of recruitment and selection process to the district included HR planning, recruitment; transfer and maintenance of human resource have
at the district level only for the contractual physicians, nurses and mid-wives. District authority is now had to play a new role as employers, often without the appropriate technical abilities to do so. The recruitment process under the decentralised arrangement in the district is closely linked to the instruction and financial provision at the state level.

The implementation of the decentralisation policy is only for the contractual manpower in the district. But the appointment and deployment of the permanent physicians, nurses and mid-wives are not comes under the decentralised recruitment and deployment. So, it does not left any room for majority of the recruitment process and deployment. Thus, the recruitment under centralisation, whereby the state level would post permanent physicians, nurses and mid-wives to district may be without taking into consideration the specific needs of each district. Thus districts requiring more physicians, nurses and mid-wives could not get the required number or the willed workforce.

5.1.2.8. OTHER ISSUES
In addition to the above major issues, the other persistent issues remain on eyes. The issues are of data inconsistency on HR deployment, use of the data for planning. In this study it is found that the information on human resource is in consistence among the state and district level, while it is also found that the inconsistency between the divisions of the health department. The official figures are very difficult to match on and come to any conclusive and concrete data on the human resource placement records, especially in the state level. This makes difficulty in estimating and establishment of facts and plan accordingly. The situation is grimmer in the state level taking the HR deployment data in the district level. There is absence of data base related to deployment of physicians, nurses and mid-wives, which could give the planner help.
SECTION 2

MAJOR HR ISSUES IN
ATTRACTION OF PHYSICIANS,
NURSES AND MIDWIVES
5.2.1. MAJOR HR ISSUES IN ATTRACTION OF PHYSICIANS, NURSES AND MIDWIVES

5.2.1.1. COMPULSION OF STAY IN THE RURAL AND REMOTE LOCATION

The study revealed that the workforces who are presently working in the rural and remote areas of the state are either working to finish their minimum rural service tenure for PG courses especially the physicians, or on non-transferable positions like contractual employees or either they in transferred from other urban or rural areas by the Management and political pressure or demand. The cases are different but altogether they are staying at compulsion. It is found that 58% of the workforce is service in rural and remote areas in the compulsion, either they are in hurry to complete minimum rural service tenure or the nature of the position is non-transferable or Management relocations or in political pressure.

When the groups of physicians, nurses and mid-wives are compared separately, 66% out of total physicians, 74% out of contract physicians and 63% out of permanent physicians agreed that they are in compulsion posting. Whereas, the group of nurses have, 49% out of total nurses, 71% out of contract nurses and 30% out of permanent nurses are agreed on the compulsion posting. While, the group of mid-wives have 58% out of total mid-wives, 77% out of contract mid-wives and 27% out of permanent mid-wives have agreed the compulsion.

It is found that the situation is worst in the case of Physicians as more of them are in compulsion. When it is compared of permanent and contract workforce, the situation is worst on the part of the contractual. Secondly, the situation of the mid-wives is also a matter of concern; this group have more percentages of compulsion posting.

The situation of compulsion posting among the workforce is a matter of concern and contributes to a high challenge for attraction and retention in the rural and remote areas. In addition, attracting physicians to rural areas has been a longstanding challenge (Rao, et al, 2009). In this study also we found that the situation is more alarming of the Physicians.

Evidence on compulsory service from the previous studies seems to be unfavourable to the organisation. It seems to be less motivation and less commitment of these workforces and it may result in weak health indicators and low quality in the services. There are unanimous agreements in several studies that the compulsory
positing does attract doctors, nurses and mid-wives to rural areas but there is no guarantee of commitment and improved service in the rural areas. International evidence on compulsory rural service has not been very favourable. Thus, such compulsion was not well received and has not really succeeded in solving the long term problem.

At best, it is seen to address health worker mal-distribution in the short term, but tends to alienate people from the medical profession itself (WHO 2009). A recent review of compulsory education schemes recorded that such schemes rarely got support from health professionals, and health workers rarely continued on the same job after the compulsory stint was over affecting continuity of care (Seble F et al 2010). Many international studies point out that compulsory rural service programmes should be accompanied by support and incentives given to the health personnel (Liaw, et al 2005, Omole, et al 2005). Whereas, in India, compulsory rural service is not well-received by medical students. The level of opposition to this compulsion suggests that implementation is a huge challenge especially with the currently weak governance structures. Further, there exists little evidence of the effectiveness of compulsory rural service initiatives. (Rao & Ramani, 2011). Compulsory rural service schemes (with no incentive attached) may not be the best way to face doctors in rural areas- such schemes have little appeal among doctors and adherence to such schemes has been found to be lacking. The effectiveness of compulsory placement has been assessed by descriptive surveys with inconclusive results (it addresses the short-term mal-distribution, but is criticized for alienating people from the profession, and for the difficulties in administration and enforcement) (Dolea 2009). In the Indian context, linking Post Graduate (PG) programmes to rural service appears to be a particularly influential incentive for attracting doctors to rural posts. There is a strong desire for specialization among doctors after their first degree (MBBS). (Rao, et al 2011).

So, the main element in the attraction of the physicians, nurses and mid-wives in the rural and remote area of Arunachal Pradesh here is compulsion rural postings, and other factors contributes less among these groups of employees. Since, more of them are in compulsion, that may lack in commitment towards work, team working, absenteeism, lack of motivation and so on and so forth, which will create a non performing environment within the system and resulted in to low indicator of health services.
**5.2.1.2. LACK OF CAREER DEVELOPMENT OPPORTUNITY**

Lack of career development opportunities seems to be one of the issues in the attraction of these workforces. With the option of career development opportunity only 23% of physicians, 21% of nurses and 29% mid-wives are attracted to the rural area services in the state. The figures are alarming and it tells us that there is limited scope of career development in the rural service in public health sector. The lack of this component in the public health services in the rural and remote areas keeps the physicians, nurses and mid-wives from the rural areas than that of the urban areas in the state. The missing component of career development along with the promotion opportunities in the rural health service seems to push away the physician, nurses and mid-wives from the rural areas to urban which gives that a potentiality for personal growth in profession, career development and they can be in job hunting if they are in the urban areas in comparing to the rural areas. Career progression and development is always an important point while dealing with the new and young physicians, nurses and mid-wives. Thus, it seems from the selection of the respondents that there is no enough scope of career progression that has attracted them to rural area and for new entrants and it is also revealed that the nurses, mid-wives and especially physicians are reluctant to work in rural areas as opportunities for career development were typically less than in urban areas. So, the study found that the physicians, nurses and mid-wives are at the present posting place at rural and remote areas not for that they have the opportunity to progress.

**5.2.1.3. INACTIVE RECRUITMENT STRATEGY**

Recruitment strategy for the physicians, nurses and mid-wives for rural and remote areas are not attractive and lack strategic recruitment and selection process. It is found that the organisation is not utilizing other means of recruitment advertisement other than that of newspaper advertisement. It seems that the strategy is only to lure the local candidates for the services in the rural areas, whereas to attract it is necessary for a wider circulation of the recruitment notices for a greater pool of potential candidates who are interested for the rural areas services for either reason. The organisation is not utilising the other strategy of recruitments and only relies on days old form of recruitment and selection tactics. There is little information for HR policy for the state or for the district. Absence of appropriate human resources policies, there is always a hindrance in managing people at work. Effective recruitment, selection practices are cohesively depends on the HR policies and in the absence of the same, a
number of difficulties have been highlighted in the interview. The recruitment and selection process in the sector is characterised as traditional way of approach, only newspaper medium is used, no practical test, no scientific selection techniques used and overall there is no written policies that the contractual positions will be regularised if there is any relevant vacancies. The policy of the recruitment approach focused on the same geographic areas where staffs were needed, in the expectation that people would be less likely to want to transfer if they worked close to home. But, unfortunately this not in reality, the findings revealed that the factor for attraction in this study for preference for rural areas home town that is the current health facility is closer to town or Closer to family and friends does have only minimum selection as one of the factor of attraction are 16% for mid-wives, 20% for Physicians and 26% for nurses. Moreover, in the absence of HR Policy in the sector is great hurdle on recruitment and selections procedures. As many research studies concludes that in the absence of the comprehensive state HR Policies the personnel decisions are too often guided by favouritism, political dictates, and nepotism. As it is also seems that recruitment of right people through scientific recruitment and selection process is a significant aspect of HRM. The experience of the yesteryears in this sector in the above context is traumatic. As the "new" employment structure requires new/or modified HRM system to deal with the new organizational types and structure but the researcher could establish the traditional way of acquiring and managing employees are stand till date, there is still existence concept of personnel management rather through the new concept of Human resource management and Human Capital management. The study has revealed that recruitment of physicians, nurses and mid-wives under a decentralised arrangement has only been characterised by complex bureaucratic procedures and political influences and adversely affect the attraction of this workforce of the government service in the rural areas.

5.2.1.4. LACK OF HOSPITAL INFRASTRUCTURE & RESOURCE AVAILABILITY IN RURAL AREA AND POOR WORKING CONDITIONS

The study found that, the attraction factor of availability of equipment, drugs and supplies for the smooth duty discharge of physicians, nurses and mid-wives is very low. It comes to 8% of physicians, 4% of nurses and 3% of mid-wives that are attracted to the rural and remote health care service in the state. It reveals that the hospital infrastructure and resource availability is scares at the rural and remote areas.
While looking at the data of the state public health sector, it is very depressing and from no angle it seems the rural health service an attraction to this workforce. Out of 486 SCs only 286 SCs are functional all together deviated from one or other requirements. Taking 486 SCs at stock, 114 SCs are only with staff quarter, 212 SCs are without proper water supply, 263 SCs does not have electricity. Out of 119 PHCs, only 97 are functional (as per RHS, 2010) in which taking all 119 PHCs in stock, 52 nos. are without Labour room, 108 nos. are without minor operation theatre, 59 nos. have indoor facilities and 53 nos. of PHCs are without electricity. Whereas in the 49 CHCs, 3 nos. does not have labour room, 12 nos. does not have OT rooms, 11 nos. not having laboratories, X-ray machines in only 13 CHCs, only 3 of the CHCs have quarter facilities for specialist for the CHC and none of the CHCs have atleast 30 beds. Overall none of the health facilities are functioning as per IPHS.

The situation of the poor health infrastructure and resource availability in the rural areas is a matter of concern and which is an issues on attraction of physicians, nurses and mid-wives. In the event of lack of equipments, drugs and supplies, it is very hard for a physician, nurse or a mid-wife to discharge their duty adequately, it is just like a soldier without arms in a battlefield. So, this is a very discouraging event for the physicians, nurses and mid-wives to attract towards the rural area services. However, this factor of attraction is not the only which can attract the physicians, nurses and mid-wives by its alone.

While, the above points do have an impact on the working condition by which the attraction of the physicians, nurses and mid-wives could have attraction. The attraction from the improve working condition in the system in rural areas have attracted only 10% mid-wives, 8% nurse and 10% physicians. In the absence of hospital infrastructure and resource availability, it is obvious that the working condition will be poor in nature and have an adverse effect on the attraction of the physicians, nurses and mid-wives. Here in the system in rural areas, the working condition is characterised by poor working conditions and lack of corresponding inputs, which also contribute to the disillusionment of the health workforce. Workforce in the different districts and health institutes in Arunachal Pradesh are facing poor work environment and security at the workplace. Work conditions are characterised by absence of proper facilities at the health centre, ill-equipments, inadequate drugs and supplies, unusual working hours and excess work load, inaccessibility of accommodation, water and electricity etc.
5.2.1.5. LACK OF OTHER CADRES, TEAMWORK AND INTERPERSONAL STAFFS RELATIONSHIP

Teamwork and interpersonal relationship is always a contributing factor for attraction or leaving the job for any jobs positions. It is revealed that 2% of Midwives, 3% of Nurses and 4% of Physicians have selected as one of the factor that attracted to the rural and remote areas service. So, the organisation climate internally is no conducive for the employees. In the absence of adequate cadres in the fields are one of the non-attracting factors in the sector. It is also found in this study that the lack of others cadres, teamwork and interpersonal relationship with Mean of 1.65 has the highest mean among the factors for migration in rural to rural health institutes. Good mixer of cadres is absent in many of the health institutes, as compared to requirement according to RHS, (2010), there was a shortfall of 27 nos. of ANM at SCs taking into consideration of 286 SC in RHS, 2010, whereas, the number of SCs without ANM out of 286 SCs were 56 SCs. There was 140 nos. of shortfall of Nurses in PHC/CHCs. The shortfall Doctors at PHCs were 5 in 2010 with PHCs without doctors were 10 out of 97 PHCs. There was a shortfall of 48 nos. of Obstetricians & Gynecologists in CHCs, 47 nos. of Pediatricians in CHCs. It is also came to know from the interview of the management representative that many of the health posts in the rural area are manned by the less skilled workers like nursing assistant and other semi-skilled or unskilled fourth grade staffs, this because of shortages in nurses and mid-wives or rather they are staying at urban areas. The impact of this mal-distribution on health care delivery in rural areas is profound, at times resulting in primary health care facilities being staffed mostly by other staffs. As per primary data available for this study, there are total no. of sanctioned sub centres are 468, out of which only 301 have existing infrastructure, 222 No. of SCs having only one ANM each, only 33 SCs have 2 nos. each ANMs. 22 nos. of PHCs does not have Medical Officer i.e., the physician. 12 PHCs only have the full strength of 3 staff nurses or 3 ANMs, none of the CHCs except are having full complement of specialists i.e. Gynaecologist, Anaesthetist and Paediatrician.

And it is also revealed in this study that there is no good interpersonal relationship between the permanent employees and the contractual. The contractual are always look down and lack recognition.

So, the lack of good mixer of cadres, team work and interpersonal seems to be an issue and concern in the rural and remote areas.
5.2.1.6. POOR REWARDING, RECOGNIZING AND APPRECIATION OF ACHIEVEMENT IN THE SYSTEM

The reward and recognition for the performance and achievement is not there in the system which could attract the physicians, nurses and mid-wives in the rural area service. The study findings revealed that none of the respondents have attracted to the rural and remote areas due to this reason. There is no distinction of the performer and non-performer and it is known by everybody in the system and outside system in the public health sector in the state. The analysed results indicated that the lowest mean factors with the lowest score. That means the absence of reward and recognition for performance is one of the major issues for attraction of physicians, nurses and mid-wives. It is well know factor in several studies that only the financial incentives could not attract the health workers to the rural and remote areas. Almost all (90%) of studies discussed the importance of financial incentives on health worker motivation. However, it was noted that financial incentives should be integrated with other incentives, particularly with regard to migration where it was concluded that financial incentives alone would not keep health workers from migrating (Shattuck, et al., 2008). The reward and recognition and appreciation of service is a important component of attraction in the rural area service, which is absent in the system in the state.

5.2.1.7. POOR USE OF FINANCIAL (IN TERMS OF SALARY OR INCENTIVES) MEANS OF ATTRACTION

For the attraction of the physicians, nurses and mid-wives for the rural and remote areas services the state does not have any concrete policies and implementation. There are no financial rural incentives for the physicians, nurses and mid-wives, however, there is a provision of hard area allowances under state govt. norms for only for the harder areas but the allowances are so little that it is negligible. The study revealed that none of the respondent has selected this option as one of the reason behind the attraction. It is found that the factors that may motivate the workforce to stay back commonly seem are financial incentives/ rural allowances/performance incentives along with other factors. So forth, the same situational factors may attract the physicians, nurses and mid-wives.

Nevertheless, low salaries were found to be particularly de-motivating as health workers felt that their skills were not valued. Furthermore, they became overworked when taking a second job to supplement their income (Shattuck, et al.,
Likewise the salary is also not competitive; there is no gaps or no difference in the urban posting or rural posting and even more no difference in the salary of performer or non performer.

It is found in this study that the contractual appointments are done majorly to man the rural posts and the salary for the contractual are not competitive in compare to the permanent workforce and associated with a low and stagnant salaries especially for the contractual workforce.

Further, the lack of a linkage between the skills and experience of staff to their remuneration package is absence the system. While, the compensation level of the workforce place in the rural and remote area and the urban areas are paid the same remuneration. The study found no difference in the pay range in the same category of the health workforce, whether being posted in remote rural area or the urban areas of the state. As here one can interpret that the remuneration and financial incentives for rural and remote areas are not competitive than of the urban areas, resulted in non attraction of the rural area services.

Thus, the issue of low remuneration or salary and non existence of the financial incentives, which could in either, attract the physicians, nurses and midwives in rural areas.

5.2.1.8. TRAINING AND SKILL DEVELOPMENT ISSUES

The study revealed that only 19% of the respondents have training and skill development opportunities in their list of attraction. While, the data revealed that only 16% of Physicians, 26% of nurses and 17% of Mid-wives have selected the factors as one of the factors of attraction for rural and remote areas. This seems that this factor has a limited scope of attraction especially to Physicians and the Mid-wives than that of the Nurses, however, the gaps are not wide and can be generalised that the factor have no much contribution for the attraction of this workforce. This creates a vacuum in the efforts of the health sector reform to greatly emphasize in the skill up-gradation and multi-skilling training practices. The non-attraction by this factor could be that the trainings are not given in regular intervals, with right access of the needs of the employees etc. The main issues found in the study is there is no random access of training needs, the planning of training and the execution of the same have a random mismatch in the district and as well as in the state level. The training needs are basically planned according to the services to be provided or it is in the health
institutes, it’s no way access the personal training needs of these workforces that could also enhance their skills in personal fronts and interest. Overall, it is also found that the post evaluation of the training is not done and not in the process and not in implementation at the ground level.

5.2.1.9. LACK OF SUPERVISION IN CERTAIN AREAS

Poor supervision and mentoring is always associated to the public sector. The same situation can be seen in the public health sector in the state. It is found that none of the respondents have attracted due to this factor. That means the factor have no contribution to the attraction of this workforce. It is also highlighted by the management representatives that in the absence of adequate workforce with trained in the matter at the higher level of health institution also contributed to this issue and it is a concern for the management. In reform initiatives the structural changes had taken place but the situation of the supervision could not be changed or improved. While putting light from the management representative interview responses that the supervision services also suffers from the financial constraints, geographical constraints and overall suffers from the skill scarcity that is scarcity of supervisors. The supervision is lack in the upper health institutes than that of SCs, however, whole of the workforce are not getting comprehensive supervision and mentoring.

Thus, this component does not have the weightage in the sector that could attract physicians, nurses and mid-wives at the present scenario.

5.2.1.10. OTHER FINDINGS

5.2.1.10.1. FACTORS THAT ATTRACTED: CURRENT DETERMINANTS OF ATTRACTION AND PLACEMENTS

It is found that the compulsion posting is the major determinant of physicians, nurses and mid-wives in rural and remote areas in the state. The other few factors are career opportunity, health facility is closer to town or family and training and skill development. However, the majority influential factor is Compulsion and it is statistically significant at mean test of 1.5. The study also revealed that the factor that attracted physicians is basically on Compulsion. Beside this factor, other few factors are -Continuing education/higher education Opportunities, Career development opportunity. In the case of nurses also compulsion is the factor, by which they are at the rural and remote areas. Beside the compulsion other few factors are- Current health facility is closer to town or closer to family and friends, Training and skill development Opportunities. In the case of Mid-wives also the have the same factor,
the compulsion. Beside the compulsion, Career development opportunity, Training and skill development Opportunities etc. Compulsion is only the factor which is statistically significant at Mean Test Value=1.5 for all of the three groups.

5.2.1.10.2. RELATIONSHIP OF FACTORS OF ATTRACTION WITH THE DEMOGRAPHIC CHARACTERISTICS

The study revealed the relationship of factors of Attraction and the demographic characteristics of physicians. It is found that there is a relationship between age group of the physicians and attraction factors like availability of equipment, drugs and supplies, Authority, independency and autonomy, Amenities like housing & conveyance provided, Safety at workplace and Current health facility is closer to town or closer to family and friends. Similarly, Family background of the physicians has the relationship to availability of good schools for children nearby town. It is also found that the Marital Status of the physicians has relationship with amenities like housing & conveyance provided; safety at workplace and availability of good schools for children nearby town. Relationship also found of Length of service and availability of equipment, drugs and supplies, Authority, independency and autonomy, Compulsion, Amenities like housing & conveyance provided, Teamwork and Interpersonal staffs relationship, Availability of good schools for children nearby town and Current health facility is closer to town or closer to family and friends. Similarly, it is found that there is a relationship between Nature of Employment of physicians and attraction factors like Availability of equipment, drugs and supplies, Authority, independency and autonomy, Career development opportunity, Amenities like housing, conveyance provided. Wherein, we did not found any relationship between the factors and sex of the physicians.

While analysing the relationship of factors of Attraction and the demographic characteristics of Nurses, it is found that there is a relationship between age group of the nurses and Career development opportunity, Training and skill development Opportunities and Compulsion. No association has been found of marital status and other attraction factors. Similarly, the length of services (group) has the relationship to Career development opportunity, Compulsion, Amenities like housing & conveyance provided and Current health facility is closer to town or closer to family and friends. It is also found that the nature of employment has relationship with Career development opportunity, Compulsion, Flexible working hour with minimal
workload, Amenities like housing & conveyance provided and Current health facility is closer to town or closer to family and friends.

While analysing the relationship of factors of Attraction and the demographic characteristics of Mid-wives, it is found that there is a relationship between age group of the nurses and improved working condition, Availability of equipment, drugs and supplies, Training and skill development Opportunities, Compulsion, Flexible working hour with minimal workload, Amenities like housing & conveyance provided and Teamwork and Interpersonal staffs relationship. Similarly, we found relationship between Marital status of Mid-wives and Amenities like housing & conveyance provided, Availability of good schools for children nearby town, Current health facility is closer to town or closer to family and friends, besides the Compulsion. The length of service has a relationship with the factor of attraction like -Availability of equipment, drugs and supplies, Continuing education/higher education Opportunities, Training and skill development Opportunities, Flexible working hour with minimal workload, Amenities like housing, conveyance provided, Availability of good schools for children nearby town, Current health facility is closer to town or Closer to family and friends, besides the Compulsion. Meanwhile, it is also found that the nature of employment also have relationship with the factors of attraction like Authority, independency and autonomy, Career development opportunity, Continuing education/higher education Opportunities, Flexible working hour with minimal workload, Amenities like housing, conveyance provided, Teamwork and Interpersonal staffs relationship, Current health facility is closer to town or Closer to family and friends, besides the above factor Compulsion also contribute to factor relationship. However, we found no association between Family Background and other attraction factors.

5.2.10.3. FACTORS THAT MAY ATTRACT - CHOICE OF CURRENT PHYSICIANS, NURSES AND MID-WIVES

The few highest percentage selection of the factors are Higher Salary package in compare to urban posting, Conducive working condition, Training and skill development Opportunities, Access to amenities like housing & conveyance, Financial incentives / Rural allowances/ Performance incentives, Safety at workplace, Rotational Posting after completing minimum rural service tenure and Career development opportunities. These factors are statistically significant at Mean Test Value (1.5). While the Mean Test value revealed the following factors significant
factors for Physicians- Training and skill development Opportunities, Access to amenities like housing & conveyance, Career development opportunities, Financial incentives / Rural allowances/ Performance incentives, Rotational Posting after completing minimum rural service tenure, Conducive working condition, Good reward and recognition system, Higher Salary package in compare to urban posting and Continuing education/higher education Opportunities.

While the combination of seven factors are having statistically significant for Nurses: Higher Salary package in compare to urban posting, Conducive working condition Access to amenities like housing & conveyance, Training and skill development Opportunities, Financial incentives / rural allowances/ Performance incentives, Good reward and recognition system and Safety at workplace.

While the combination of ten factors are having statistically significant being found for Mid-wives: Higher Salary package in compare to urban posting, Access to amenities like housing & conveyance, Conducive working condition, Training and skill development Opportunities, Good reward and recognition system, Rotational Posting after completing minimum rural service tenure, Financial incentives / Rural allowances/ Performance incentives, Continuing education/higher education Opportunities, Career development opportunities and Safety at workplace.

While analysing the variance in the choice of the factors that may attract the physicians, nurses and mid-wives, it is found that there is difference in the groups in the view of factors that may attract to the rural and rural areas services. It is found that the physicians may be attracted to the rural and remote area service when they see there is scope of training and skill development, a good working environment, accommodation facilities, incentives and recognition system with a competitive salary that is more than that of urban areas. That meant that the physicians first look at self development by training and development, living condition and to the monetary factors. While, the nurses and mid-wives have attraction of higher salary first, good work environment, accommodation training and development, recognition and Safety at workplace. That meant that the group of nurses and mi-wives are more attracted to financial benefits and then they look after the work and living condition and of course to the Safety at workplace. Thus, it meant that the preferences are not in the same order and the factor cannot be generalised for all the three groups.
SECTION 3
MAJOR HR ISSUES IN RETENTION OF PHYSICIANS, NURSES AND MIDWIVES
5.3.1. MAJOR HR ISSUES IN RETENTION OF PHYSICIANS, NURSES AND MIDWIVES

5.3.1.1. ISSUES OF INTENTION OF INTERNAL MIGRATION AND RETENTION

The study revealed that the factors that hindering the state’s effort to retain physicians, nurses and midwives in rural and remote areas are the migration of these health workforces within the state, very negligible amongst them are intent to search for an alternative employer. The major problem within the board is the problem of rural-urban migrations than that of rural to rural migration or outside migration. The study reveals that only 19% of them want to continue with their present rural posting place. 24% wants to shift to another rural health institute, 51% wants to shift to another urban health institute and 6% wants to shift to another job in some other State/sector in search of an alternative employer. This shows that the physicians, nurses and midwives are eager to shift their current locations. It was also revealed in the attraction findings that more than half of the workforce that is 58.1% of these groups is located in the present rural and remote locations in compulsions and it is obvious that these groups are very eagerly intended to shift their locations.

This is an issue for the group of the physicians that 41.6 % of them intend to migrate to urban area, 24.8% physicians willing to migrate to other rural area and 7.1% Physicians willing to search for an alternative employer. Wherein, 50% of nurses are willing to migrate to urban area, 19.4% nurses willing to migrate to other rural area and only 25.5% wants to retain in the present health institution in rural area and 5.1% nurses intend to search for an alternative employer. Similarly, 59.3% of mid-wives intend to migrate to urban area, 27.6% mid-wives willing to migrate to other rural area and 6.5% nurses intend to migrate in search of new employer.

Similarly, at the other side of the coin which is also an important angle to access the issue of migration that is the nature of the employment of these groups. The finding are 51.3% of contract physicians, nurses and mid-wives are intend to migrate to urban area, whereas, 50% of the permanent physicians, nurses and mid-wives have that intention. So, more of the contractual are intended to migrate.

This study also revealed that the intention of migration of this workforce is related with the level of job satisfaction of these groups of health workforce and propel them to migrate. The variable job satisfaction is significant at p<.001, has an impact on the decision of employees to stay at the present rural place of posting.
While, the study revealed that there is no significant relationship of job satisfaction and parallel migration from one rural area to another rural area. It is also explore that there is a strong relationship of the job satisfaction and urban migration. The variable job satisfaction significant at p<.001, has an impact and predictive power for the decision of employees to urban migration. Job satisfaction also has significant relationship and predictive for migrating in search of an alternative employers.

This intention of migration of physicians, nurses and mid-wives is attributed by several factors within the health system and it’s co-exist external environment. The Factors that contributed for migration of the physicians, nurses and mid-wives as a whole, from the present rural area to other rural area, urban area or to leave the sector have two factors significant that are the Lack of adequate financial incentives / rural allowances/performance incentives and poor working condition.

The Factors contributed for intention of migration of the permanent physicians have the Lack of adequate financial incentives. While, contract physicians have three factors significant that are the Poor salaries, lack of adequate financial incentives and lack of Career development opportunities. For intention of migration of the nurses have two factors, the Lack of adequate financial incentives and Poor working condition. In which, permanent nurses have the Lack of adequate financial incentives / rural allowances/performance incentives. While, contract nurses have two factor that is the Poor salary and Lack of adequate financial incentives.

The Factors contributed for intention of migration of the mid-wives have two factors, the Poor salaries and Poor working condition. In which, permanent mid-wives have two factors that is the Lack of adequate financial incentives and Poor working condition. While, contract mid-wives have two factors that is poor salaries and Poor working condition.

The issue of intention to migrate according to the place of choice is that the highest number of 51% of them is intended to migrate to urban areas. The factors that contribute highest to migration of this workforce to urban areas have two factors, the Poor working condition and Lack of adequate financial incentives. While, factors that contributed to the intention of migration to another rural health institute had the lack of others cadres, teamwork and interpersonal relationship and lack of Autonomy. Similarly, five factors found for migrating outside the state, the Lack of Career development opportunities, Poor salaries, Lack of Job security, Lack of adequate financial incentives and Lack of scope for continuing education/higher education.
The need is to understand the various factors which motivate physicians, nurses and mid-wives to retain themselves in the present rural posting for taking decisions into consideration for planning the financial as well as non-financial incentives, thus, the factors that may motivate the physicians, nurses and mid-wives to retain themselves in the present rural area have the four factors - financial incentives, improved living condition, career development and Good reward and achievement recognition system. For the physicians are financial incentives for rural postings, Improve living conditions, Career development opportunities, improved working condition and Good reward and achievement recognition system. While, contract physicians have six factors, Career development opportunities, Opportunities of continuing education/higher education, financial incentives for rural posting, Improve living conditions, Increase salary by half & Job Security. Similarly, the permanent physicians have five factors, financial incentives for rural posting, Improve living conditions, improved working condition, Career development opportunities and Good reward and achievement recognition system.

The motivational factors that may motivate the nurses have three factors, Financial incentives for rural posting, Improve living conditions and Career development opportunities. While, the contract nurses have five factors, financial incentives for rural posting, improve living conditions, Career development opportunities, Increase salary by half and Job Security are statistically significant. Similarly, the permanent nurses have three factors, financial incentives for rural posting, improve living conditions, Good reward and achievement recognition system.

The factors that may motivate the mid-wives have three factors, financial incentives for rural posting, improve living conditions and Good reward and achievement recognition system. While, the contract mid-wives have six factors, financial incentives for rural posting, improve living conditions, Increase salary by half, Job Security, Good reward and achievement recognition system and Career development opportunities are statistically significant. Similarly, the permanent mid-wives have three factors, financial incentives for rural posting, Improve living conditions (Access to amenities like housing, water, electricity, conveyance and communication) and Good reward and achievement recognition system are statistically significant.
Thus, the issue of migration is a major issue in the sector, more of the workforce wanted to migrate to urban area. So, the major problem within the board is the problem of rural-urban migrations than that of rural to rural migration or outside migration and Job satisfaction as a decision maker theme.

5.3.1.2. ISSUES OF DECLINE AND VARIANCE IN JOB SATISFACTION

In this study finding, in addition to the other issues and concerns, there is a growing dissatisfaction among the physicians, nurses and mid-wives in presently working in the rural and remote areas. The mean of overall scale of job satisfaction of these entire workforce is 2.26 (N=334) in a scale of 1-5, which shows an average low scale of satisfaction. In the group comparison, the Physicians (2.53, N=113), Nurses (2.32, N=98) and Mid-wives (1.98, N=123) means respectively. This shows a lower job satisfaction in the groups this workforce. Low job satisfaction and motivation can lead to non-adherence to guidelines, dangerous practices, or negative attitudes towards patients (Rowe et al, 2005 as cited in Logie et al, 2008). The analysis also shows that the groups of Mid-wives have the lowest scale of job satisfaction, followed by the group of nurses and the physicians. The satisfaction of Physicians are little higher than that of the other two groups and the trend of declining job satisfaction is seen according to the category of employment as the lower groups is having declining job satisfaction. This may be that the lower group are being posted at the lower health institute and they represent a more remote and rural location. The Medical professions like doctor and nurses has been long among the most attractive and satisfied profession in the society, but when it is analysed in the context of rural and remote area services, the results suggests that these group of employees are increasingly dissatisfied with their jobs in rural and remote areas.

It is already explained at the above point of migration and the intention of migration of this workforce is also related with the level of job satisfaction of these groups of health workforce and propels them to migrate. It is one of the determinants of the retention and migration of the physicians, nurses and mid-wives. It is well known that the job satisfaction is effected by the demographic attributes of the employees. It is found statistically significant that there is a positive relationship of job satisfaction with the age, length of service, place of posting and nature of employment. It is found that as higher age employee has higher job satisfaction, higher length of service has higher job satisfaction, employee posted at the higher level of health institute has higher job satisfaction and permanent employees have the
higher job satisfaction than the contractual employees. It is also found the correlation between the marital status and job satisfaction. However, it is found that there is no relationship between family background and job satisfaction of employees in rural setting. Thus, statistically it seems that age, length of service, place of posting and nature of employment has the positive impact on job satisfaction in the rural setting.

While in the group of Physicians, it is found that there is a positive relationship of job satisfaction of physicians with the age, length of service, and nature of employment. No relationship found between family background and job satisfaction of employees in rural setting. While in the group of nurses, it is found that there is a positive relationship of job satisfaction with the age, length of service and nature of employment. While in the group of midwives, it is statistically significant that there is a positive relationship of job satisfaction with the age and nature of employment and the correlation between the lengths of service. No significance found in marital status and family background with job satisfaction. However, in entire group of the workforce the common demographic in context of the nature of employment has a relationship with the job satisfaction or dissatisfaction in rural setting. It is found that Salary and Training & Skill development opportunities are the main contributors to the Job satisfaction in current time of physicians, nurses and midwives altogether in rural and remote area setting.

Thus, there is a growing dissatisfaction among the physicians, nurses and midwives in presently working in the rural and remote areas, more on there is an issue of job satisfaction differentiation between the groups of physicians, nurses and midwives and the job satisfaction if diminishes according the lower category and it also revealed that there is a gap of job satisfaction between the contract workforce and permanent workforce at large. Only the components like Salary and Training & skill development opportunities found to be the main predictors of job satisfaction and no other factors found to significantly contributing to the job satisfaction in these categories of health workforce at the present time in the rural setting.

5.3.1.3. LACK OF ADEQUATE FINANCIAL, RURAL ALLOWANCES AND PERFORMANCE INCENTIVES

As it is mentioned in earlier sections that the Health workforce are reluctant to work in rural and remote areas in the state, possibly because of little support in these areas, a lack of material resources for them, poor working and living conditions, isolation from professional colleagues and possibly less opportunities for self
professionally development. To fuel on this the study found that there is no financial rural incentives for the physicians, nurses and mid-wives; however, there is a provision of hard area allowances under state govt. norms for only for the harder areas but the allowances are so little that it is negligible. Whereas, such allowances for the contractual health workforce are not recorded in this study. The questionnaire survey with the options has not selected by any of the respondents that has contributed their attraction factors or retention factors. It is found that the factors that many motivate the workforce to stay back commonly seem are financial incentives/ rural allowances/performance incentives along with other factors.

In the light of no provision of such incentives for the physicians, nurses and mid-wives for rural area services and the compensation package also is same irrespective of the place of posting. Other non financial incentives such quarters with electricity, water facilities etc. are also not in the system to retain the workforce in those underserved areas.

Moreover, other rewards system linked to performance is also not the system, resulted to the low morale and motivation of the workforce. The below statement was found in the documents of the state govt. but till now there is no sign of such incentives in the field.

“To motivate the manpower located at remote and hard areas will be given incentives. The incentives will be conditional on regular staying and performance based. The incentives will be given through respective RKS at facility level. Detail incentive policies are addressed under NRHM Additionalities”-(Govt. of Arunachal Pradesh, 2009, SPIP 2010-11)

Staff job satisfaction has been affected through rapid change, and the perception of health workers that their compensation levels and working conditions have been negatively obviously affected the motivational level of physicians, nurses and mid-wives.

Thus, it is one of the major issues; a mixer of interventions both financial and non-financial is not in place for retention of human resource. Though, the health need related issues are looked into by the individual states and Govt. of India supports financially. All the states prepare annual plans to include this intervention in human resource issues, but still there are no accounts for these incentives in the field.

Few statements on incentives by the respondents are:

“Furthermore, there is no provision of extra incentives till date for us living in rural area and even did n’t heard about this in my 3-4 years of rural posting”. –A Physician.
“Financial incentives only will not be adequate for us, what do here in rural and remote area….. if we cannot make use of that money in a productive and entertaining way..., no basic amenities like good housing, regular water and electricity supply, good road connectivity is not there” – A Physician.

According to the State Programme Implementation Plan, 2011-12 of all the states, in order to ensure stay of Health workers in difficult rural and remote areas, the states proposed incentive schemes. However, the incentives are yet to be seen materialized, it may be due to financial constraints in the state.

5.3.1.4 ISSUE OF EQUITY IN COMPENSATION:

It is found in this study the public health service is associated with a low and stagnant salaries especially for the contractual workforce. The issue of low remuneration or salary is consistent for the health workforce especially for the contractual employees, the recent pay enhancement corresponding to the Pay Commission recommendation in the state has been only implemented to the regular staffs and it has also created a wide gap in the pay parity of contractual staffs and the regular staffs, but the compensation level was enhanced little to this groups in the year 2011-12, but no how it reaches the level of the regular workforce in the same working conditions and the nature of job.

As here one can interpret that the contractual health workforce in Arunachal Pradesh are underpaid, poorly motivated and very dissatisfied and may have an adverse impact on the health delivery system. Further, the lack of a linkage between the skills and experience of staff to their remuneration package is absence the system. While, the compensation level of the workforce place in the rural and remote area and the urban areas are paid the same remuneration. The study found no difference in the pay range in the same category of the health workforce, whether being posted in remote rural area or the urban areas of the state. Moreover, the workforces that are posted in the urban areas have other options for earning if they will to do so. There are greater opportunities in urban areas for additional incomes to supplement the ever increasing inflation that that of rural and remote areas. This creates a burn out in the rural and remote area physicians, nurses and mid-wives and adversely affects their retention intention. Moreover, as a result of poor compensation, the available workforce such as physicians, specialist, nurses and mid-wives do not want to join the duty and serve in rural areas for longer duration. There is no clear cut policy implementation regarding duration of service in rural areas by these categories of
workforce. Over all it is also mentioned in the earlier point that there is no financial incentive for working in rural, remote areas. Low pay ranges is also a major reason for the sector to face difficulty in attracting and retaining staff along with there are no differences in the compensation packages for serving in urban, rural, inaccessible areas. Thus, the state is failed to use the Salary component as means of retention of physicians, nurses and mid-wives in rural and remote areas. The government has failed to raise the real value of compensation differentiation on the basis of posting to be using it as a retention strategy.

Here, it is also understandable on the part of the government to unable to raise the salaries but the govt. is no doubt capable of being develop a policy implication on different pay structures for the urban and rural with remote areas for retention of the physicians, nurses and mid-wives.

5.3.1.5. DISPARITY IN REGULAR AND CONTRACT WORKFORCE, AFFECTING ADVERSELY IN JOB SATISFACTION AND RETENTION:

We found that contract workforce is more dissatisfied from the job than the permanent workforce. In the group comparison as per the Nature of Employment, the means of contractual employees (1.99, N=154) and permanent (2.50, N=180) respectively. This interprets as the contractual employees have low job satisfaction in comparison to the permanent employees. There is a difference in the job satisfaction between the groups. The mean difference is -0.513 between the contractual and permanent employees.

If we analysed the situation in categorizing the workforce in nature of employment, we found that contract workforce are more dissatisfied than the permanent workforce. 17.5% are highly dissatisfied, 71.4% are dissatisfied, and 5.2% are satisfied in the group of the contracts. While, the permanent employees have 9.6% are highly dissatisfied, 69.8% are dissatisfied, 14.1% are satisfied with only 0.6% are highly satisfied. Thus, permanent employees have the higher job satisfaction than the contractual employees.

The job characteristics of contractual employment are very much responsible for motivating factors to the contractual employee, the factors such as job security, low pay, no benefits and other factors are fuelling the low satisfaction and low motivation in the employees. Contract employees are less satisfied with certain aspects of their jobs, than permanent employees. Contract people are also in job stress from workload and lack of opportunity for career advancement. Contractual
employees receive fewer fringe benefits, have no promotional opportunities, and receive little or no long training opportunities. Therefore, a job with fewer of these characteristics would reduce the person’s job satisfaction.

While exploring to the variance of factors of job satisfaction in between the contractual and permanent physicians, nurses and mid-wives, it is observed the components like salary, job security, career development opportunities, opportunities of continuing education/higher education, Teamwork and Interpersonal staffs relationship and Access to free accommodation (Housing) have the differentiation. While talk about there is differentiation in the compensation package another issue of job security is one of the most significant issues in contractual employments, which may create a greater sense of insecurity in short-term and long-term. Moreover, the work life balance is tough in the context of this contract workforce, who gets only few days of causal leave with no other kinds of paid leave as compare to the permanent employees, the contract employees face the difficulties to maintain the family and work life balance. There is no flexibility for contract employees for leaves to dispose of their family duties. “Juggling between family and contractual is very difficult” - one of contractual employee said while informally discussing the topic.

Financially the compensation is less, when they compared their incomes to those of permanent employees. Contract employee is not eligible for benefits, other employment benefits, pension plans, medical and dental benefits, life insurance, educational reimbursement and training etc. “Even the bank is not providing loan to me as I am a contractual employee” – one of contractual employee said while discussing the topic. Human resource policies define how an employee is treated in the workplace, which is absence in the reform process in the sector. There is an inequity in perception in respect of contractual employees in respect of opportunity within the organisation, with fuelling of no definite path of career advancement and most of them are of younger generation and concern about their career advancement as well. There also an existing of a cold ill treatment of contractual employees by the fellow permanent employees at the work place. This makes contractual employee stress, and affects the working ability of the employee. The more stress comes when under to meet the demands of contract employment. All contract employees (who were informally interviewed including) admitted suffering stress connected to contract employment. “I felt discriminated when I sat with other permanent employees of the
department and when they talk about enhanced pay package and accumulated arrears being paid to them”- one of contractual mid-wife said while discussing the topic.

So, these staff motivation has been affected through rapid change, and the perception of health workers that their compensation levels and working conditions have been negatively affected the satisfaction level converted to low motivational level.

5.3.1.6. POOR WORKING CONDITION:

It has long been known that employees behaviour and attitudes are affected by the nature of the work they do and the environment they do it in. Much experimentation and research have taken place in attempts to discover optimal designs of work and workplaces for maximizing results in organizational improvement and quality of working life. The studies of Kagi (1985) and Surti (1986), confirms the desire of workers for better working conditions. Working conditions in the absence of necessities for human resource in health sector in Arunachal is yet another major issue in this confront. The working condition is characterised by poor working conditions and lack of corresponding inputs, which also contribute to the disillusionment of the health workforce. Workforce in the different districts and health institutes in Arunachal Pradesh are facing poor work environment and security at the workplace.

Work conditions are characterised by absence of proper facilities at the health centre, ill-equipments, inadequate drugs and supplies, unusual working hours and excess work load, inaccessibility of accommodation, water and electricity etc. Work required certain supplies and logistics which are currently inadequate. These supplies and logistics should be made available adequately thus ensuring steady and better service delivery. Added to the ill health infrastructure, absence of proper equipments and proper office infrastructure, there is no proper toilet facilities in maximum of the health facilities especially for the woman workforce, which may adversely affect. Often poor working condition resulted in frustration, low motivation less effectiveness, and sustainability among the workforce especially in woman workforce. Thus, poor working conditions and lack of corresponding inputs also contribute to the disillusionment of the health workforce.

According to Rural Health Statistics (2010), in the state out of 286 SCs only 114 (39.9%) are with quarter facilities, 12 (4.2%) are without regular water supply, 63 (22%) without electricity and out of 97 functioning PHCs, 31 (32%) is without
electricity, 29 (29.9%) without water supply, 11 (11.3%). Out of 48 CHCs, 3 are having residential facility for specialist physicians.

Few statements by the respondents on work condition are:

“We are overburden, not with our clinical practice……there are hardly 5-10 patients in this place daily, which is not a matter of concern for us. But what I am writing about is the managerial and programme management works entrusted upon us. We are technical and clinical persons, but various health programs including the health institutions management are to be look after by us alone with little support of staffs for these works.”-Physician.

“My requirements for works are clinical equipments, adequate medicines and finance. My requirement was of Rs. 4 lakhs but they provided me as little as 50,000/- to 80,000/-. So, how can I work in this situation.”-Physicians.

“We are teaches for patients care- putting IV fluids, injections, medicines, bed and ward management…. But here I have to work for all these including maintaining huge registers daily, preparing reports in many numbers for all health programmes and also management of this health institution.”-Nurse.

“We are performing without adequate supplies and equipments, working condition should be crucial at the work place.”-A Physician respondent.

We can interpret the above statements by the respondents that they are very much involved and concerned about their working environment. They are entangled between the clinical and programme management work at present environment. They also emphasized for adequate supplies, equipments and adequate funding for discharging their duties of rural health care services.

“Urban areas in counterpart are rich living standards and better income opportunities. I can even practice privately after my duty hours, where I can earn a little to support my financial earnings. Overall I am fade up of the less patient load, sometimes it comes to nil. I can’t keep pace with my clinical side… I m forgetting all my learning of practice here… now I am becoming a dak (official letter) runner or above that I am becoming a good clerk. This is the situation where I am becoming isolated from my profession.”

With the above comment of the respondent, it is known that not only the work environment characterized with over burden, which makes an effect on the interest of the respondent. But as a professional they are worried about the patient load in their health institutes in rural area. They can’t keep pace with their clinical side practice in some of the rural areas. So, overburden as well as under-work makes an effect on the situational preference of rural services.

Many medical, technical, and managerial positions in health programs and facilities are needed in a health sector reform environment, and scarce medical personnel are misused for management tasks at various levels. The supply of professional staff is now severely constrained at the leadership and managerial levels.
Shortage of human resource for health with ill-equipped, both technical and managerial workforce at various levels often resulted in duality of roles, overburden and workload to the existing health workforce. Staff shortages have increased the workloads and stress levels, further de-motivating the physicians, nurses and midwives. The formal as well as informal discussion with the staffs for this study shows that the staffs are frustrated for the duality or roles, over burden with the works and the workload, with additional with lack of equipment to discharge their duties.

As many of the technical/ clinical health workforce have to do the managerial, health data information works and other financial management works for which they not appointed. In this situation they have to often discharge a duality of role in the existing system and they have to divide themselves for clinical works and other managerial works, which often have an adverse impact on the discharge to their own duty of primary health care for the mass. Health workers described their workload as being relatively to the data and financial related work and often lead them to work stress. It is the result of new structures, practices, and technologies are imposing a heavy strain on an already weak human resource base in the health sector.

While with the quantitative data findings revealed the factors that may attract physicians, nurses and mid-wives for rural and remote services has the working condition component and followed the percentage of selection of 74%. It is analysed and found that the factors that contributed for intention of migration of the physicians, nurses and mid-wives- from the present rural area to other rural area, urban area or to leave the sector have the factor of Poor working condition after Lack of adequate financial incentives/ rural allowances/performance incentive. The factor of poor working condition and inadequate equipments, drugs and supplies have accounted as top factors for intention of migration among the physicians, nurses and mid-wives.

While the impact of health sector reform on work condition is a matter of concern. They do not agree upon that the reform process has made their work load manageable but rather they think more unmanageable at their level. Thus, it reveals that the workload is more unmanageable to all level due to the reform process. The statement that reform has improved the availability of equipments, drugs and essential supplies for performing the assigned tasks for the respondent’s posted rural health institutes has been agreed in group responses. The group of mid-wives has lowest mean than that of the two other groups. Thus, it seems at the mid-wives do not get adequate equipments, drugs and essential supplies and the reform has failed to
provide them as well, in comparison to the physicians and nurses. Thus, it reveals that the reform has failed to address 360 degrees of these needs too.

5.3.1.7. POOR LIVING CONDITIONS

Poor living condition is directly not comes under an HR issues but it affects the availability of workforce in the rural and remote areas of the state which have lack of road network, hilly terrains, lack of communication, transport, other communication facilities and lack of accommodation facilities, lack of television and radio services and other recreation facilities, lack of effective communication systems like telephones and mobile service at the place of posting resulted in lack of proper living environment. The physicians, nurses and mid-wives have disinclined to rural services, primarily due to absence of accessibility of communication and basic amenities in rural and remote areas. Some of the places are only reachable on foot and more of the rural and remote areas living standards are characterized by poor basic facilities and amenities, for which reluctances in workforce can be seen. RHS, 2010, in the state, out of functional 286 SCs, 95 (33.2%) is without all-weather motor able approach road. Out of 97 functional PHCs, 11 (11.3%) without all-weather motor able approach road, 13 PHCs (13.4%) only with telephone facilities and none of the PHCs having computer access facilities. While, out of 286 SCs only 114 (39.9%) are with quarter facilities, 12 (4.2%) are without regular water supply, 63 (22%) without electricity and out of 97 functioning PHCs, 31 (32%) is without electricity, 29 (29.9%) without water supply, 11 (11.3%). Out of 48 CHCs, 3 are having residential facility for specialist physicians.

Absence of accessibility and basic amenities in rural areas is more emphasized by the respondents in this study. Few statements by the respondents on the accessibility and amenities are:

"Urban areas are good and convenient because they provide us with basic facilities and amenities which are needed for a human being in today’s world. But here posted in rural and inaccessible area, where we are disconnected to outer world due to the natural and topographic reason. This deprived me of basic facilities like good accommodation quarter, electricity, and over all connectivity like regular mobile and internet facilities. This is also having an adverse effect on my preparation of entrance for PG, I do not have internet access which is a basic need for an academics preparing for entrance.”-A Physicians.

“I m an ANM (mid-wife) at Sub centre, but I m attached to a PHC and working for the PHC and visits once a week to the SC area. This is only because of, there is no provision of residential quarter in that health facility and overall being a lady there is always a safety and security issue, so why do I prefer the rural posting…. ” - Nurse.
“Even if we appoint the physicians for rural areas especially specialist cadre, they are more reluctant to join the area, they did not even join the place. This may be because of the reason that the places are deprived of the material resources, poor living standards in the village/rural level and possibly less opportunities for their practice and educational opportunities for their children.”. “They are shows reluctance to work in rural and remote areas in the state (Arunachal Pradesh), often they come to state headquarters for seeking transfer and posting to capital and district headquarters areas....some presents their health issues, family problems and other genuine reasons for to be shifted to the urban areas.”-Key Informant Official.

"We have no quarters for accommodation, good school for our children, so we are staying in a rent house in nearby urban area and daily I have to cover total 40 KMs in Bus to attend my duty, which cost me physically and financially”.- A Nurse respondent.

"I always will look for basic facilities and amenities like housing, water supply, electricity and communication facilities at my preferred work place. These also will include a good school for my child.”-A Physician respondent.

“I am frustrated only because I was not posted to my home village, which is in the same district, I could have been stayed at my own home and attends the duty.”-A Physician.

We can interpret the above statements by the respondents that the doctors and nurse including the mid-wives disinclined to rural services in the state, primarily due to absence of accessibility of communication and basic amenities in rural and remote areas. Thus, living standards are characterized by poor basic facilities and amenities in the area where the health institutes are situated, for which reluctances in workforce can be seen. Moreover, many of the staff prefer to and are allowed to stay in a nearby town from where they commute to their place of work; it is obviously in the absence of basic amenities in the posting place. This means that the health services are not available 24 hours at the health centers as planned. At lower levels health institute, there is no one to provide care at the time of need after duty hours, or when staff is on leave. To add to this, many workers do not go to their place of work regularly. There are also many other interruptions in the regular work such as review meetings, various camps, and trainings. However, the staffs that stay at their place of posting and provide 24 hour service get the same salary as staff that are absent or are available for only three to four hours a day. Other unavoidable situation of staff absenteeism are due to illness of themselves or their family members, some are due to chasing their salaries, allowances, and other bureaucratic tasks at the HQ, etc.

5.3.1.8. LACK OF GOOD MIXER OF CADRES, TEAM WORK AND INTERPERSONAL RELATIONSHIP

Teamwork in health care occurred throughout the 20th century and, more recently, effective inter-professional teamwork has been identified as an appropriate
response to the complex issues in many health care settings. Effective teamwork has been identified as enhancing staff motivation (Wood et al. 1994), including increased job satisfaction and improved mental health (Borrill et al. 2000; Peiro et al. 1992), and improving retention and reducing turnover (Borrill et al. 2001). It is found in this study that the intention of migration of physicians, nurses and mid-wives from a rural area health institute to another rural health institute is propelled mainly by the factor of teamwork and interpersonal relationship in the present place of work. So, the rural to rural migration is mainly due to the factor of absence of teamwork and interpersonal relationship in the workplace.

Good mixer of cadres is absent in many of the health institutes, as compared to requirement according to RHS, (2010), there was a shortfall of 27 nos. of ANM at SCs taking into consideration of 286 SC in RHS, 2010, whereas, the number of SCs without ANM out of 286 SCs were 56 SCs. There was 140 nos. of shortfall of Nurses in PHC/CHCs. The shortfall Doctors at PHCs were 5 in 2010 with PHCs without doctors were 10 out of 97 PHCs. There was a shortfall of 48 nos. of Obstetricians & Gynecologists in CHCs, 47 nos. of Pediatricians in CHCs. It is also came to know from the interview of the management representative that many of the health posts in the rural area are manned by the less skilled workers like nursing assistant and other semi-skilled or unskilled fourth grade staffs, this because of shortages in nurses and mid-wives or rather they are staying at urban areas. The impact of this mal-distribution on health care delivery in rural areas is profound, at times resulting in primary health care facilities being staffed mostly by other staffs. As per primary data available for this study, there are total no. of sanctioned sub centres are 468, out of which only 301 have existing infrastructure, 222 No. of SCs having only one ANM each, only 33 SCs have 2 nos. each ANMs. 22 nos. of PHCs does not have Medical Officer i.e., the physician. 12 PHCs only have the full strength of 3 staff nurses or 3 ANMs, none of the CHCs except are having full complement of specialists i.e. Gynaecologist, Anaesthetist and Paediatrician.

Most of the management representatives have a common consensus that the difficulty in distribution of the workforce particularly in the district level. The process of the transfer and posting are a challenging matter in the absence of the residential quarters and basic amenities at the rural and remote areas. They also pointed out that in the absence of comprehensive HR policy it is very difficult to rationalise the distribution. Overall, the shortage of the staffs is the main challenges in rational
distribution of staffs in the rural areas. It is a matter of concern that the urban areas are also running out of the staffs and it is very difficult on their part to get equitable distribution. It is also pointed out that there are many cases of personal and medical reasons in which the management representative cannot force the staffs to be in the remote and rural areas for long durations. It is also sensed from the interview that there is influence of political pressure for the distributional process. However, it is not outspoken by the management representatives.

So, the lack of good mixer of cadres, team work and interpersonal seems to be an issue and concern in the rural and remote areas.

### 5.3.1.9. LACK OF JOB SECURITY AND CAREER DEVELOPMENT FOR CONTRACTUAL PHYSICIANS, NURSES AND MID-WIVES

Lack of job Security in the health sector for contractual physicians, nurses and mid-wives have adverse effect on the job satisfaction and thereon the motivation to stay and work in rural and remote areas in the state. There is no provision of job security for this group of workforce in the sector. The whole workforce under NRHM is contractual and liable to terminate at any time without assigning any reason with one month prior notice or in lieu one month salary. This is also a factor for low job satisfaction and motivations of contractual health workforce. The service of the employees is renewal every one year on performance based. However, the performance appraisal process is also not effective due to various reasons. Moreover, there is no career path or career development for these employees for which the motivational factor could be high. The study explores the intention of migration of physicians, nurses and mid-wives from the present rural health institute to any other sector or other employer. The exploration of the preset factors from the responses job security option and indicate that this is one of the major issues which propelling the workforce for quite from the state health sector services in rural areas. The views above of the workforce are quite claimed to be of concern in the part of management who expresses fear about the issue. To talk about the issue of intention to migrate in search of other sector and other employer in the same sector, we found five factors significant that are the Lack of Career development opportunities, Poor salaries, Lack of Job security, Lack of adequate financial incentives and Lack of scope for continuing education/higher education. However, in order to give a boost to contractual employment, the state govt. started pulling senior contract physicians,
nurses and mid-wives for permanent vacant posts, but in reality the incumbents have to act upon on.

While, exploring the motivational factors that may motivate the physicians, nurses and mid-wives to retain themselves in the present rural area health institution, the responses of these employees revealed that Career development opportunities and Job Security as one of the factor for retention. While, exploring the motivational factors that may motivate the contract physicians to retain, the responses of these employees revealed factors which include-Career development opportunities and Job Security. In the group of the contract nurses also includes Job Security as one of the motivating factor. In the group of contract mid-wives have also Job Security as one of the motivating factor.

Therefore, the issue of job security and career development is an alarming and major issue in the retention of the contractual physician, nurses and mid-wives in the rural and remote areas in the state.

5.3.1.10. WEAK AND IN-EFFECTIVE PERFORMANCE APPRAISAL SYSTEMS

There are not concrete and effective performance appraisal systems on board. Historically, the permanent physicians, nurses and mid-wives have service book and annual confidential report on the performance conduct of the permanent workforce. However, the system is not effective and does not do anything with the performance in the field and does not have any link with the rewards or incentives upon them. Neither there is any mechanism which can monitor the daily activities undertaken by each workforce, only some clinical services provided are monitored under monthly reports, which is not at all have any connection with rectification of the performance or anything to reward or incentives. While, the contractual part of the workforce are altogether face annual performance appraisal, that is only for the further extension of the contract, which in no way is used effectively for review of the contract. This performance systems on the board is seems only to be the formalities in the nuisance public health environment. However, the performance appraisal of permanent physicians, nurses and mid-wives are used in the service book for pay roll increments, transfers, and other additional determinants in the service life of the incumbents. Discussions with the management representatives expressed doubts about performance appraisal systems and the reports by the concern supervisors that they give the right feedbacks, which could be used for real performance appraisal for any
rewards or any rectification. Moreover, the performance benchmarks were not put in place at the time of initiating the contracts or start of services in the rural areas.

Thus, although the performance appraisal system is placed in the sector but the system is almost defunct and to be very weak. Little evidence exists on their effective use at hospital, district and health facility levels in the state.

5.3.1.11. TOTAL ABSENCE REWARDING AND RECOGNIZING ACHIEVEMENT SYSTEM:
The use of financial incentives as important motivators has been over emphasised in the recent past. However, research in human relations and behaviour sciences has shown that “where as money incentive had not proved effective, psychic rewards worked” (Gellerman, 1963). Later research by Herzberg (1968) & Lawler (1971) confirmed the fact that pay has very little to do with motivation. However, several research studies in India have indicated the positive relationships between pay and employee performance (Dwivedi, 1980). The reward and recognition for the performance and achievement is not there in the system which could boost the satisfaction and motivation to performance in the workforce. The study findings seem that the workforce is dissatisfied with this component in the system. There is no distinction of under performer or good performer in the system. The variable Reward system and recognition have constants or have missing correlations in the responses of the respondents. The analysed results indicated that the lowest mean factors of job satisfaction and retention have one of the factors that are Reward system and recognition system (1.00) which is the lowest scores. That means the absence of reward and recognition for performance is one of the major contributors to the dissatisfaction and migration of the physicians, nurses and midwives. Out of the top 8 factors found that contributed to the intention of the migration to outside the sector, the factor of Achievement not recognized or rewarded with Mean 1.38 can be seen. That means the factor is not in selection for the internal migrations because the respondents know that there is no such provision now and they doubt it could be in future in the system. That’s why who are intended to go out of the system are only selecting this factor as a factor of migration. Therefore, the need is to understand the various factors which motivate physicians, nurses and midwives to retain themselves in the present rural posting. Taking all these factors into consideration, financial as well as non-financial incentives can be planned.
5.3.1.12. LACK OF SUPERVISION IN CERTAIN AREAS

While the analysis of the factors that contributed to stay at the place of posting for more 3-5 years for both contract and permanent physicians, nurses and mid-wives for rural and remote services was done it is found that the selection of improved support, supervision and mentoring with a Mean of 1.17 is only there, which is a lower mean of contribution. That means the factor failed to contribute to the factor of stay back in rural and remote place. It shows that there is a system of poor supervision and support. It is also highlighted by the management representatives that in the absence of adequate workforce with trained in the matter at the higher level of health institution also contributed to this issue and it is a concern for the management. In reform initiatives the structural changes had taken place but the situation of the supervision could not be changed or improved.

However, the statement that reform has made improvement in supportive supervision, management and mentoring form higher authority, has an agreement from the respondents. The physicians have the mean of 3.50, nurses have 3.68 and the mid-wives only 3.76. Thus, the responses revealed that there is an improvement of supervision and mentoring due to the reform process, and the trend is higher to the lower health institutes because the mean of the mid-wives is higher than that of the two other higher groups. While putting light from the management representative interview responses that the supervision services also suffers from the financial constraints, geographical constraints and overall suffers from the skill scarcity that is scarcity of supervisors. The supervision structures starts from very state level to the lowest layer of SCs, the SCs are supervised by the Medical Officers (Physicians) at PHCs or CHCs and these PHCs/CHCs by the district level. The matter is more concern upon lot of higher institutes is without the supervisors and if they are also, they are concern with the clinical abilities and lacks the managerial skills like supervision and monitoring at various levels. The supervision is lack in the upper health institutes than that of SCs, however, whole of the workforce are not getting comprehensive supervision and mentoring. Many staff, particularly those working in the upper health institution in periphery according to the above analysis of Mean factors of all the health groups revealed are deprived of the supervision and mentoring activities. For this reason it can be resulted in lower job satisfaction and retention in rural and remote areas. Ideally, supervision is a formalized HRM instrument to correct shortcomings and to support good practice, on the basis of which recommendations
are provided to help improve individual and facility performance. The weak supervision at all levels may result in lack of availability and accountability of the staff at the working place. The supervision system is placed in the system but it is weak as the supervisors only monitor the work of their subordinates through the reports they submit of the numerical achievements of targets at the end of the month. Moreover, it is also mentioned performance appraisal is also very weak. Appraisal systems in use are basically and practically tend to be based on an assessment of personal characteristics rather than on achievements against agreed-upon work objectives or targets.

5.3.1.13. OTHER MINOR FINDINGS RELATED TO DEMOGRAPHIC ATTRIBUTES

The Medical professions like doctor and nurses has been long among the most attractive and satisfied profession in the society, but when it is analysed in the context of rural and remote area services, the results suggests that these group of employees are increasingly getting dissatisfied with their jobs in rural and remote areas. The analysis shows that the groups of Mid-wives have the lowest scale of job satisfaction, followed by the group of nurses and the physicians, similarly contractual employees have low job satisfaction in comparison to the permanent employees.

We found that there is a positive relationship of job satisfaction with the age, length of service, place of posting and nature of employment. It is significantly found in the study that the higher age of these groups of workforce has higher job satisfaction, higher length of service has higher job satisfaction, and employee posted at the higher level of health institute has higher job satisfaction in rural setting. It is also found about negative relationship between the marital status and job satisfaction. Wherein, it signifies that the more married employees the less satisfaction level in rural setting. And there is no relationship between family background and job satisfaction of employees in rural setting. Thus, there is no effect of family background on job satisfaction of the employees. Only the Salary and Training & Skill development opportunities are the main contributors to the prediction of Job satisfaction in current time of physicians, nurses and mid-wives altogether in rural and remote area setting which is a matter of concern.

It is known from the study that the intention to migrate is having relationship with job satisfaction. Here it is explore the effect of the demographic attributes of the employees on intention to migrate to urban areas. From the study, it is found that
there is no relationship exists between the demographic attributes of age, family background, marital status, nature of employment, and place of posting. Only the length of service is significant and reveals the relationship with the migration to urban areas. And job satisfaction has been statistically significance relationship with the intention of migration to urban area. While analysing separating the positions of the workforce as Physicians, it is found that there is no relationship exists between the demographic attributes of age, Sex, family background, marital status, nature of employment and place of posting and length of service with the intention of migration to urban area. As in the case of Nurses, it is found that there is no relationship exists between the demographic attributes of age, family background, marital status, nature of employment, place of posting and length of service with the intention of migration to urban area. While in Mid-wives, it is found that there is no relationship exists between the demographic attributes of family background, marital status, nature of employment and place of posting with urban migration but found a significant relationship with age and length of service.

Thus, it is found that the demographic factors do contribute to job satisfaction and intention to migrate.
SECTION 4
MAJOR REFORM INITIATIVES
AND ISSUES THEREON
5.4.1. MAJOR REFORM INITIATIVES AND ISSUES THEREON

5.4.1.2. THE RISE OF CONTRACTUAL EMPLOYMENT: ESTABLISHED NEW EMPLOYMENT SYSTEMS AND CONDITIONS OF SERVICE WHICH LINK DIRECTLY TO HR ISSUES.

The vital ingredient in human resource management in health system consists of workforce management, skill mix, workforce performance capacity building and the numerical adequacy. To address the issue of numerical adequacy with cost effectiveness is contracting the human resource. In Arunachal Pradesh along with the country, increasing the number of health worker is a major challenge in improving the health system. The past one decade has seen a growing tendency of contractual employment in the public health sector in the state, toward a fundamental restructuring for addressing the inadequacy issue under reform process. A significant change in placement of human resource has been seen since 2005 in the state.

The task of ensuring the availability of physicians, specialists and nurses to human resource pool by contracting of them is only short-term solution for the inadequacy. One of the greatest drawbacks is possibility of attrition, non-commitment of the employee in compulsion of performance which is very real risk in long run for both employer and employer in the public health sector. In this way, contracting is no better than engaging permanent employee in the sector in long run. The health services are a continuous need of the community and can only be delivered with the adequacy in numbers of the health care provider and supports competitive strategies in long run. Contracting is more likely to be successful only when there is a competitive strategy in long run to convert the contract employment into permanent in a stipulated time period because healthcare sector is highly dependency on key professionals like physicians, nurses and mid-wives. It should also be supported by appropriate policies and guidelines regarding this for the attraction and retention of the healthcare providers. Contract employment is offered for performance under pressure to an employee, which may adversely affect both the employee and employer. It also leads to perceptions of inequity among the co-workers. They also faced a certain degree of uncertainty and change, regardless of their choice. Thus, the permanent employment status should be supported by administrative systems and processes that enable the relationship to operate smoothly in long run. While, the nature of the contract is also not cleared and the basic framework of expectations and obligations are also is not cleared in the system.
Health professional’s choice regarding contract employment, in this study, was conditioned by job security and compensation at par with the permanent employee in the sector. The contract employees were placed in a position of having insecurity and short-terms and conditions of employment of one year. They were forced to choose the contracting job as there is no other options remains within the state. Contract employees are treated differently in the workplace than permanent employees. They faced a certain degree of uncertainty and change, regardless of their choice of being permanent employee. Contract employees have a different attitude to the workplace and their position. Bringing the management perspective contract employees are off-course manageable and cost less to the department but it does not seems long run sustainability and free from HR issues arising out of it.

5.4.1.3. EMERGING ISSUES OF PROFESSIONAL MEDICAL EDUCATION IN ARUNACHAL PRADESH IN REFORM PROCESS

There is existing issues of access, growth and expansion within the agenda of health sector reform in Arunachal Pradesh, which could to some extend helpful in solving the problem of inadequacy of physicians, nurses and mid-wives in the state in long run. Arunachal Pradesh is lagging behind in the field of medical education in comparison to other states of the country. Production of the graduate doctors, nurses and mid-wives in comparison to expanding health infrastructure is becoming a matter of concern and a challenge for the public health sector in the state and its inclusion under agenda of health sector reform is most an issue and a challenge. There is no medical college in govt. sector or private sector for Allopathic disciplines, and it is not adequately addressed by the reform process. It is observed that the aggregate number of seats for medical and para-medical education for the state is not inadequate comparing to the requirement of physicians, nurses and mid-wives especially in the rural and remote areas of the state.

State Public Funding for Medical Colleges, Nursing schools is a matter of concern and it is not widely addressed in the reform process. In the light of resource constraints of the state government, state funding for establishment of Medical Institutes is a matter of concern and challenge. The growth and expansion is only possible with the interventions of central govt. public funding or attracting private funds. The government, which is the major funder of medical education institutes for the state has failed to develop training institutes for medical, nursing, and related professions in the state. This may be subjected to lack of funds. The growth of
potential teaching hospitals for establishment of new medical schools and nursing school in itself is a challenging issue in the reform process. Wherein, in the entire state only two hospitals namely State Hospital, Naharlagun with bed strength of 148 nos. and General Hospital, Pasighat with bed strength of 150 are nearly in shape that can be upgraded to Medical Colleges but proper initiation under the reform process has not been taken up.

5.4.1.4. ISSUES REGARDING DEVELOPMENT OF COMPREHENSIVE HR POLICY IN THE HEALTH SECTOR OF ARUNACHAL PRADESH UNDER REFORM PROCESS

There is no comprehensive HR Policy in Public health sector in Arunachal Pradesh. There are recruitment rules for different category of health workforce. The recruitment and other service conditions for staff in health services of the state government is regulated by the APHS (Arunachal Pradesh Health Service) rules and central recruitment rules are followed. However, there is no specific HR Policy for recruitment, deployment, retention of the physicians, nurses and mid-wives and other health workers especially for remote and rural areas. This issue is not adequately addressed in reform process, the state govt. is preparing a 5 year strategies and policy document for augmentation and maximization of Human Resources as per the management representative, but it is no way would be soon available and its sustainability, as it is well known in the public sector all comes late. And it is also found that the policies regarding recruitment, deployment and retention is much more emphasized on contractual employees only leaving a loose tight on permanent employees.

5.4.1.5. ISSUE OF HR FUNCTIONS DECENTRALIZATION UNDER REFORM PROCESS: CHALLENGES FOR LOCAL CAPACITY

The process of decentralization in the reform process has its own issue. Decentralization of authority, responsibility, and resources for personnel functions is delegated in a decentralized way in reform process to the district level. It is important to achieve effective human resource management and to improve staff performance. However, decentralization itself entails large-scale development of capacity at the local level for health planning, financing, allocation and accounting for resources, and HR management functions including staff recruitment, payroll and allowance documentation, and maintenance of personnel records. The Human Resource
Management functions including recruitment and deployment are decentralized to the districts level.

Though decentralization is used as an ornamental word into the reform process, the actual implementation in the view of low capacity at the lower level is a concern. The new decentralized organizational structures mean that the role of district authority as employer is transferred from state level, but to configure the new structure of decentralized environment there is no provision reform process for HRM system and HRM personnel in the organisation at state or the district level, that to strategically support the initiation. The transfer of human resources functions from State level to district level without a comprehensive design and structure is quite a big challenge for the district administration. Over all in the absence of an appropriate HR policy at state and district level on human resource, is still provide a big deal of challenge for the district authority. The study finds that in the reform process in Arunachal Pradesh, decentralization in many field including HR management issues have been percolated down up-to the district level and to some extend to the health institutes, but there is a need of far greater attention to HR skill deficits. The decentralization has been done in respect of power and resources to the district level and lower level of health administration for HR administration and management. Under this decentralised process, the recruitment is done at the district level, Human Resource planning, and their training needs and to ensure that health facilities had the minimum staffing requirements. In addition, the powers to recruit, exercise disciplinary control, and to remove persons from district service were delegated to the District. Pay determination is heavily centralized at state level and national level, as part of broad based culture as other public sector. Decentralized the local autonomy is facilitating the local preference and to retain the workforce in the district. However, as mentioned earlier to manage the decentralized activities there is shortage of HR management personnel in the district level, which create a challenging environment at this and subsequent level of administration. As to increase the requirement for administrative and managerial staff in the system and likely to associated increase requirement for performance management also.

5.4.1.6. ISSUES OF RECRUITMENT AND SELECTION PROCESS
The reform process more emphasized on the contractual employees and the policies are developed only for the same. The recruitment process adapted in the
reform process is inadequate and lack professionalism. Only newspaper advertisement, walk-in-interviews are utilized and no other options are ever tried to explore to include for better recruitment and selection process in the system of reform. The recruitment and selection processes are often guided by the personal bias and favouritism in the system. After that the appointments are made and no proper performance appraisals are done and many of the physicians, nurses and mid-wives get regularisation. It is also found that the performance appraisal in the system of reform process is not effective and comprehensive.

Most of the management representatives have pointed out for the difficulty in getting physicians, Nurses for the health posts. The management representatives pointed out the crisis is more for the GNMs and then the physicians for rural and remote areas. It is may be due to lower graduates of medicines and nursing candidates. They also revealed that they have many post lying vacant in search of the GNMs (Nurses) and some of them are even personally arranging these cadres for the rural health services. It is also pointed out by the management representatives that in the light of very limited candidates for the posts they have to compromise on the technical expertise and experience of the candidates and have to appoint them for the rural and remote areas which obviously affect the quality of the services in the rural and remote areas.

5.4.1.7. ISSUES IN TRAINING AND DEVELOPMENT SYSTEM UNDER REFORM PROCESS

Skill up-gradation and multi skilling practices are much emphasizes in the sector. Lot of skill up-gradation and multi skilling training are undertaken and the physicians, nurses and mid-wives, but the main issues is there is no random access of training needs, the planning of training and the execution of the same have a random mismatch in the district and as well as in the state level. The training needs are basically planned according to the services to be provided or it is in the health institutes, it’s no way access the personal training needs of these workforces that could also enhance their skills in personal fronts and interest. Overall, it is also found that the post evaluation of the training is not done and not in the process and not in implementation at the ground. The reform process has failed to addressed the access of training needs and post evaluation of the training in the field and in personal front of the employees.
5.4.1.8. ISSUES IN FINANCIAL AND NON-FINANCIAL INTERVENTIONS

The reform process has tried to address the issue of financial and nonfinancial incentive for the rural and remote areas physicians, nurses and mid-wives. But the process had failed to comprehensively plan and execute the same. No adequate emphasized on making use of provision of financial and non-financial incentives for rural and remote area posting and retention is there. Over all the reform process has failed to give emphasizing the compensation equity in the workforce and their differentiation according to the urban and rural posting. Moreover, other rewards system linked to performance is also not the system, resulted to the low morale and motivation of the workforce. The reward and recognition for the performance and achievement is also not there in the system.

5.4.1.9. ISSUES IN INFRASTRUCTURE DEVELOPMENT INITIATIVES INCLUDING ACCOMMODATION FACILITIES AT RURAL AND REMOTE AREAS FOR UNDER REFORM PROCESS

However, the infrastructure development is directly a HR activity, but is no doubt it contribute to HR practice in the organisation, particularly in health sector. Chronically there is inadequacy of residential quarters for workforce at rural and remote areas. For ensuring deploying, attraction and retention of physicians, nurses and especially Mid-wives in rural and remote area, the reform process is emphasizing to develop the residential facilities all over the state, but it has failed to do it with proper planning and wide coverage. However within the limited resources, prioritization is done to provide at-least residential quarters in the health facilities phase-wise. The identification of the health facilities has been done linking the HR availabilities and acceptable infrastructure.

5.4.1.10. THE VIEW OF WORKFORCE ON HEALTH SECTOR REFORM IN ARUNACHAL PRADESH

The exploration of health sector reform process on physicians, nurses and mid-wives has pointed out some of the issues in understanding of health sector reform process and the employees. It is revealed that these three categories have different views on the health sector reform process on Human resource activities. All the employees are quite reserved at human resource policies of the organization, that they are clear about the HR policies of the organization, the mean of the response is only 2.06 in the scale of 5, which can be interpreted that reform has not succeeded to clear presentation of the HR policies (whatever is there exists at present) in the context of
the Physicians, nurses and mid-wives. It seems the physicians are having little understanding of this, but we cannot say all other groups are equally aware of this component. However, the mean of the responses are the lowest we cannot say that the reform process has made human resource policies understandable at all level and contributed to the HR function of the organisation.

All the employees emphasized on that there is no change in the scenario of transparency, fairness and unbiased placement, transfer and promotion. The groups have the view that the reform has failed to make placement, transfer and promotion to transparent, fairer and unbiased.

However, it is found that the physicians and nurses are familiar with their job description clear they agree upon the statement, but not so strongly. Whereas, the mid-wives has no agreement on the statement and may be they are not so clear about the job description of the mid-wives. It is also found that the physicians, nurses and mid-wives do not think that they are getting promotional chances are strong in the light of reform process.

According, the responses of the respondents, the reform process has also failed to make the compensation a competitive one for rural and remote area posting, as the salary structure have no differentiation for urban or rural areas. No groups have agreed upon that the reform process has created the salary structure competitive for the rural area posting. Moreover, the physicians, nurses and mid-wives have the views that the reform has failed to made regular and adequate financial incentives and allowances for physicians, nurses and mid-wives who are posted in remote and rural areas. They also agreed on that there are no increase activities for actual performance appraisals and positive actions on them.

On the front of improvement in working condition at the respondent’s posted health institutes has agreement in group responses, though the mean of the responses is 3.40, quite no so impressive. However, more on the issue, we can say that the lower levels of the health care delivery system where the Mid-wives are largely posted are deviated of improving the working conditions.

The workforce has agreed that reform has increased the training and skill development opportunities for the respondent’s posted rural health institutes, but the group of physicians has little lower mean than that of the two other groups. Thus, it seems at the physicians do not get more chance for training and development opportunities in comparison to the nurses and mid-wives. Thus, it reveals that the
reform has failed to address the need of training and development in equal manner to all the groups of the employees.

While on the front that reform has improved the availability of equipments, drugs and essential supplies for performing the assigned tasks for the respondent’s posted rural health institutes has been agreed in group responses, though the mean of the responses is 3.35. The group of mid-wives has lowest mean than that of the two other groups. Thus, it seems at the mid-wives do not get adequate equipments, drugs and essential supplies and the reform has failed to provide them as well, in comparison to the physicians and nurses. Thus, it reveals that the reform has failed to address of these needs too. Reform has also failed to improved the mix of cadres in respondent’s posted rural health institutes and has made the work load unmanageable. The disagreement increases at the lower level of the groups. Thus, it reveals that the workloads are more unmanageable to all level due to the reform process.

Reform has made improvement in supportive supervision, management and mentoring form higher authority. It is also found that, there is an improvement in housing and other amenities at the workplace of the physicians that is at the higher level of health institute rather in the lower health institute where the nurses and mid-wives are posted.

In overall, the physicians, nurses and mid-wives, concludes that the reform process has failed or has not succeeded for making rural health care services an attraction for the potential physicians and nurses to work in rural and remote area. And it is also revealed in overall that the reform process failed to give attention to the HR front rather giving attention to the other components of reform process in the state.
SECTION 5
MAJOR ISSUES IN HR PRACTICE RELATED TO ATTRACTION, DISTRIBUTION AND RETENTION OF PHYSICIANS, NURSES AND MID-WIVES
5.5.1. MAJOR ISSUES IN HR PRACTICE FOR ATTRACTION, DISTRIBUTION AND RETENTION OF PHYSICIANS, NURSES AND MID-WIVES

5.5.1.1. INTRODUCTION

In addressing the three dimensions of HR Practice for Attraction, distribution (deployment) and retention of physicians, nurses and mid-wives, the researcher could establish that the HRM system and practice in the organisation is mere personnel management functions rather a strategic human resource management approach in a reform environment. In this study researcher could established that the HR practices for attraction, distribution and retention are to an extent not utilized optimally to improve organizational performance and to retain the physicians, nurses and mid-wives. The study found that the HRM practice for Attraction, distribution (deployment) and retention of physicians, nurse and midwives in rural and remote areas is not a comprehensive one and its design, the platform is weak. It is found that from the policies to implementation, there is no concrete and strategic management is followed.

The major findings may be outlined as - There is inadequate Human resource capacity as there is no dedicated HRM staffs, department and the staffs handling the HR activities are having limited experience in the organisation; Annual HR plans exists but it is an exhaustive process in the organisation, but it is not further evaluated for effectiveness; Comprehensive HRD policy in Arunachal Pradesh is very weak; Employee data such as number of staff, location, skill, education, gender, age, year of hire, and the salary level are maintained manually and partially at the district level; performance appraisal system is in place, it is done periodically at the interval of one year, but it does not include the work plans of individual employees and performance objectives jointly developed with the staff, it is rather a traditional singular downward appraisal; skill up-gradation training is an integral part of the programme, however, there is little space for induction trainings and further training and development of employee is a concern with follow up of training. Further, Key ways to motivate employees are also inadequate in the system. Nor was there recognition of the importance of employee empowerment as a powerful mean of developing a service-oriented culture.
5.5.1.2. ISSUES IN POLICIES FOR HR PLANNING, RECRUITMENT (ATTRACTING), PLACEMENT, TRANSFER AND PROMOTION

There is no comprehensive HR Policy in Public health sector in Arunachal Pradesh. There are recruitment rules for different category of health workforce. The recruitment and other service conditions for staff in health services of the state government is regulated by the APHS (Arunachal Pradesh Health Service) rules. The regular doctors and specialist cadre comes under the purview of service rule of APHS. However, there is no specific HR Policy for contractual physicians, nurses and midwives and other health workers.

Absence of appropriate and concrete human resources policies on deployment, there is always a hindrance in managing people at work as the entire district agreed to this. However, the state Govt. is preparing a 5 year strategies and policy document for augmentation and maximization of Human Resources. This includes sustainable HRD and policy reform from restructuring/ rationalization of HR deployment. The vibrant HR policy includes terms of recruitment / filling up of vacancies, rationalising posting, specific tenure of posting, career progression and incentives. The policy is focussing on improving maternal and child health indicators through posting of required manpower for maximising performance at identified functional facilities.

In order to ensure rational deployment of contractual physicians, nurses and mid-wives, recruitment is done at district level and appointments are made for specific health centres without provision of transfer. For the regular groups of employees the intra-district transfer and posting are handled by the District Medical Officer and inter-districts transfer is handled by the Director of Health Services. However, the system is not so transparent and lack in proper implementation. Most of the management representatives have a common consensus that the difficulty in distribution of the workforce particularly in the district level. The process of the transfer and posting are a challenging matter in the absence of the residential quarters and basic amenities at the rural and remote areas. They also pointed out that in the absence of comprehensive HR policy it is very difficult to rationalise the distribution. Overall, the shortage of the staffs is the main challenges in rational distribution of staffs in the rural areas. It is a matter of concern that the urban areas are also running out of the staffs and it is very difficult on their part to get equitable distribution. It is also pointed out that there are many cases of personal and medical reasons in which the management representative cannot force the staffs to be in the remote and rural
areas for long durations. It is also sensed from the interview that there is influence of political pressure for the distributional process. However, it is not outspoken by the management representatives.

5.5.1.3. ISSUES IN HR PLANNING, RECRUITMENT AND SELECTION PROCESS

Research Observation shows that accurate information systems on staffing trends and conditions are not in place. There is no tradition of research on workforce issues in the state. HR planning for contractual employees is theoretically based on decentralized system, however, in the absence of proper information, and trends of staffing makes HR planning more exhaustive and difficult. While, the HR planning in permanent physicians, nurses and midwives are done by the Health Directorate and based on vacancies and annual operating plans. It is also found lack of extensive coordination among the two divisions regarding HR planning. The sector does not have a formal mechanism in place to undertake manpower planning on a continuous basis except the Annual Action Plans. Planning exercise in the department of health is primarily focused on creation of new infrastructure/institutions.

Decentralization of recruitment and selection process to the district is often undertaken without the appropriate technical abilities to do so. There are no staffs specifically to develop and implement HRM system in the organisation. District and state level offices do not have staff adequately trained in personnel administration, nor do they have simple or robust systems for managing personnel affairs. HR management structures and systems at the district level are weak; District offices are inadequately staffed and are poorly resourced. There are staffs generally meant for other services are engaged to look after the HRM activities in the organisation at state and district level. But these sections of staffs are having limited experience related to this field such as personnel recruitment, management or have other functions in the organisation as well as HRM functions. Over all they are at the level of only to maintain basic procedures and record keeping functions, which cannot be comparable to the full functions of HRM system in the organisation. The recruitment process under the decentralised arrangement in the district is closely linked to the instruction and financial provision at the state level. The implementation of the decentralisation policy is only for the contractual manpower in the district. Whereas, the appointment and deployment of the permanent physicians, nurses and mid-wives are not comes
under the decentralised recruitment and deployment. So, it does not left any room for majority of the recruitment process and deployment.

Utilization of various recruitment sources is under-utilised only newspaper advertising is the source. The recruitment advertisement for the contractual vacancies is only undertaken for this kind of process in the districts. The recruitment advertisement for permanent positions is placed in the newspaper and office board by the Directorate of Health Services. However, the internal source of recruitment is widely used, whenever a sanctioned regular post is vacant. This process of recruitment of internal candidates for regular posts supports career development opportunities for internal contractual employees.

The selection processes is based on Walk-in-interview across the districts for contractual employees and for permanent employees it is found the contractual physicians, nurses and mid-wives are taken up to fill the vacancies.

Thus, the recruitment and selection process of the employee in the state public health system is a traditional approach and lack the professional forefront in this process, and the newspaper advertisement, walk-in-interview, written-test with panel interview as the dominant tools in use.

5.5.1.4. ISSUES IN HR PRACTICE FOR PLACEMENT, TRANSFER AND PROMOTION

The deployment of contractual physicians, nurses and mid-wives are done according to the recruitments are done for the particular vacancies for the specific health institution. However, the deployments are interchange able on mutual consent of the employees or the management decisions at the district level. The deployment of the regular cadre employee is done according to the requirement of the district and the district medical officer looks the matter and depends on the physical infrastructure and basic amenities in the health institution. The common minimum tenures are not followed along with the time bound promotions are not practices for several reasons to these categories of staff.

5.5.1.5. ISSUES IN HR PRACTICE FOR RETENTION - FINANCIAL NON-FINANCIAL INTERVENTIONS

There is no use of provision of financial and non-financial incentives for rural and remote area posting and retention. In the light of no provision of such incentives for the physicians, nurses and mid-wives for rural area services and the compensation package also is same irrespective of the place of posting. Other non financial
incentives such quarters with electricity, water facilities etc. are also not in the system to retain the workforce in those underserved areas. Moreover, other rewards system linked to performance is also not the system, resulted to the low morale and motivation of the workforce. The reward and recognition for the performance and achievement is also not there in the system.

5.5.1.6. ISSUES IN HR PRACTICE FOR RETENTION - TRAINING AND DEVELOPMENT

Skill up-gradation and multi skilling practices are much emphasized in the sector. Lot of skill up-gradation and multi skilling training are undertaken and the physicians, nurses and mid-wives are satisfied with the process and most of the workforce are attracted and retain themselves due to this factor in the sector. But the issues is there is no random access of training needs, the planning of training and the execution of the same have a random mismatch in the district and as well as in the state level. The training needs are basically planned according to the services in the health institutes and likely to starting of the services, it’s no way access the personal training needs of these workforces that could also enhance their skills in personal fronts and interest. Overall, it is also found that the post evaluation of the training is not done and not in the process and not in implementation at the ground. The trainings are undertaken only the sake of performance in the training activities, but the real evaluation of the trainings is not done. The trainings are once done, the achievement of the training achieved and no further plans for evaluation. Expensive and important skill-up-gradation trainings are given to these groups especially to the physicians, but the matching of posting place and their performance after the training is not accessed. This creates a gap in the training skilled acquired and utilisation for the benefit of the organisation, society and self development of these workforces.

The multi-skill trainings & capacity building of the workforce are emphasized on physicians, nurses & mid-wives from the rural and remote area. Multi-skilling training is randomly given to a concentrated workforce and makes them jack of all trade, master of nothing. There are many cases the research could establish that a single physician is trained in many skills which makes him confused and specialized in nothing and it does not helped in their self development.
SECTION 6
SUGGESTION
5.6.1. Introduction

This section of the chapter puts lights on the broad suggestions on the issue of distribution, attraction and retention of Physicians, nurses and mid-wives. It is found in the study that most of the workforce is on compulsion to stay at the rural and remote areas and these workforces have low level of satisfaction and resulted in low commitment and motivation towards the service. The contributions of other factors for attraction are very less and seems that the sector has not given due importance and tried to improve the other bricks of the wall. Most of the workforce is intended to migrate to urban or to other sector, it is more of the environmental issues and organisational issues more than that of the personal issues at the current time. The factors that can attract and motivate them to stay at the rural and remote areas have been found in this study. The factors like salary in comparison to the urban areas, conducive working condition, training and development opportunities, accommodation, financial incentives/rural allowances, rotational postings, safety at the workplace and career development opportunity. While, the following factors have been found for the retention of these workforces: financial incentives, improved living condition, career development, good reward and recognition system. These factors for attraction and retention seem to be a blend of financial & non-financial benefits. The distributional issues have an impact on the shortage of staffs in rural and remote areas with mal-distribution. The HR practices having many loop holes and the reform process have failed grossly to take the train on the track smoothly. The situation of the Rural Public Health Sector in Arunachal Pradesh is “Like riding a tiger, not knowing how to get off without being eaten”-(Cappelli, et al, 2011). While the suggestion should be “50 miles to a gallon” (Cappelli, et al, 2011).

Based on the research findings, retention strategies need to include creating a more positive work environment for rural availability of physicians, nurses and mid-wives. To fill the gap of mal-distribution, recruitment and retention in rural community in the state is dependent on the perception of the workforce's non-monetary and monetary needs. A blend of interventions into professional fulfilment, financial remuneration and lifestyle needs are to be taken into consideration while making policies or plans. There should be a strategic planning to address the three fulfilments of manpower. Recruiting and selecting the right people with making conducive working environment will help greatly with retention in rural areas.
Professional fulfilments include the need of adequate supplies, equipments and fund. Conducive working condition at the work place with a good mixture of other cadres at the posting place is the some requirements. Due to highly regulated environment in which health sector operates, professional training needs, career development and opportunity for continuous education of the workforce must be kept into account for attraction and retention of the workforce and their interest on the job and the organisation. Training and multi-skilling will also facilitate the production issues and professional needs, advancement of the workforce and willingness to continue their works in the rural sector. The respondents put light on the workload also; the workload is unlikely due to other management works of a health institution, which can be minimized by posting of clerical or managerial cadres in health institutes. Rotational posting of the physicians and nurses are to be taken into consideration, to increase exposure to rural conditions and overstaying of one staff in rural areas. One of the factors that we saw in this study is compensation, benefits and incentives needs, which will enhance attraction and retention of workforce in rural areas. Likewise, the planners must now recognize the importance of non-monetary incentives and recognition, special award; career path of the workforce along with the incentives for rural posting. This study suggests giving importance to the lifestyle needs of the workforce in today's time for retention. The development of rural infrastructure of basic facilities and amenities is great need of the time. For example housing, water supply, electricity and third party's work for development of communication and other facilities in rural areas should be given emphasize on long run. Policies and retention strategies needs to consider rural manpower family lives. Retention strategies should also include recreation and education opportunities for workforce's children.

Factors affecting rural recruitment and retention are complex and inter-linked; hence a package of interventions is likely to work better than any incentive in isolation. So keeping the points above, the following broad suggestion is presented for this study.
5.6.2. BROAD SUGGESTION

5.6.2.1. EMPHASIZE ON RURAL HEALTH INSTITUTE AND PRODUCTION ISSUE

Building strong institutions for education is essential to secure the numbers and qualities of health workers required by the health system (WHO, 2006). Creation of medical and nursing schools for enhanced seats for medical and nursing studies should be ensured. It should be emphasized that the establishment of the institution in rural areas, so to create a pool of workforce for rural areas. The options for task-shifting can also be put into the system. The MBBS physicians can be replaced by a Registered Medical Practitioner (which is adopted by the State of Assam and other state in India), State can undertake experimentation in medical education by introducing 3 ½ year course of Bachelor of Rural Medicine and Surgery to fill the deficiency of physicians in villages. However, one arguments can be that, 3 ½ course would produce poor quality doctors. Other in favor argument would be full duration of MBBS course is not necessary for educating the public about health, hygiene and treating preliminary ailments in village level. Likewise the inadequacy of nurses can be filled up by the Mid-wives after getting adequate Nurse training and the vacant post of Mid-wives can be filled up after the training of the eligible Village Health worker with education and experience. This will ensure the creation of rural health workers pool to minimize the gap in the inadequacy.

5.6.2.2. ENHANCING CAPACITY OF MEDICAL EDUCATION THROUGH PUBLIC-PRIVATE PARTNERSHIP

Access of Medical Education by prospective students within the state is a great challenge at this time. There is a need of widening of access of medical education within the state. The state is on the process to setup one Medical college with upgrading one of its hospitals in recent time. It is important here to consider that, in a study by Hall (Hall, 1998) shows that a 10% rise in the number of students registering with medical schools will produce only a 2% increase in the supply of doctors after 10 years. So, the requirement of aspirations and capacities of the increased number of potential students and to meet up the requirement of physicians seems difficult with establishing only one Medical College in the state. A healthy Public/Private partnership can do much in this regard. The state should explore the PPP models to establishment of more Medical colleges in the state. However, it should be based on
accountability and evidence based regulations by both the medical council and the state. The issue of fees and seats should be monitored by the government. Moreover, the areas which are not capable of attracting private funds should be supported sufficiently well from public funds.

5.6.2.3. STRENGTHENING HRM POLICYMAKING, PLANNING AND SYSTEMS – THE REFORM PRIORITIES SHOULD BE!

Getting HR policy ‘right’ in order to create a well motivated, appropriately skilled and deployed workforce needs to be at the core of any sustainable solution to health system performance (Dussault & Diallo et al. 2003). The HR policy should be comprehensive and should be completed at the earliest to guide the whole process of HR system in the sector. The policy should include all the component of the HR system in an organization so that it will guide the system to implement in all level, particularly in a decentralized environment. Better distribution of personnel by categories and places is still a challenge for the health sector in Arunachal Pradesh; maximum number of health workforce is concentrated to urban and easily accessible areas counterpart to the rural and remote areas. Interpreting this issue, suggestion could be to formulate a human resource policy to the deployment and incentives for attracting the human resource in the needy and remote places.

5.6.2.4. ROBUST RECRUITMENT, SELECTION AND DEPLOYMENT PROCESS

Investment in employee begins with recruiting process and selection process should be revived and extensive use of different sources of recruitment should be used. Recruitment and selection processes should be based on an objective system to eliminate bias and discrimination. The use of newspaper advertisement should be continued along with the use of other medium like internet, advertisement in regional papers or on national papers etc. to search a wide range of pool for the vacant posts. The selection process should not be bracketed to walk-in-interview only, it should comprises of written test, interviews and professional practical test along with a understanding of the candidate’s will to work in rural and remote areas. Side to it the decentralization of the recruitment should be strengthen in terms of ability to do so. The new recruiters or the existing physicians, nurses and mid-wives should be properly deployed based on the needs of each part of the state and the district and job
descriptions. New graduates from training institutions should be promptly absorbed to avoid frustration and consequent brain drain, but the eligibility and recruitment norms should be followed.

5.6.2.5. FINANCIAL INCENTIVES INCLUDING THE SALARY COMPONENT

Direct financial incentives to practice in rural areas may encourage rural practice, especially in developed countries, but reports from developing countries are not positive (Smith, 2010). In the study it is found that the workforce are more trends to financial incentives and salary differentiation than that of urban areas and salary hikes in the context of the contractual, while talking about the attraction and retention of the workforce. There is a need of development and implementation of financial incentives for rural and remote area posting, it should be plan and adequate budget provision should be there. Side by side, it is high time to make a differentiation in the salary structure of the urban posting and rural posting, featured by higher in rural and lower in urban areas. Along with these interventions, there is a need of enhancing the salary of contractual physicians, nurses and mid-wives, so that their salary could match the permanent workforce salary structure. The incentive system should be competitive that could be accepted by the Physicians, nurses and mid-wives. The incentive should be placed according to the category of the post and categorization of place of posting.

5.6.2.6. REWARD AND RECOGNITION PROGRAMS

Irene (1997), advises not to force and manipulate staff to accept rural posting after their will. Financial incentives are generally ineffective when used alone (Smith, 2010). Many international studies point out that compulsory rural service programmes should be accompanied by support and incentives given to the health personnel (Liaw ST et al 2005, Omole O et al 2005). It is well known compulsion alone cannot work and a mechanism of differential rewards, appreciation and recognition programme should be developed within the system. It is also suggested to differentiate the performers and non-performers, which is a missing component presently in the system. This will motivate the performers to perform more and the non-performer will kick start.
5.6.2.7. **FOCUS ON CAREER DEVELOPMENT OPPORTUNITIES AND JOB SECURITY**

Equitable distribution of health professionals and their retention is in turn related to the prospects of career progression and the incentive packages associated with the posts (Martinez & Martineau, 2002). Every individual whether working at the lower level or higher level needs growth in professional life. Thus, the career development opportunities can attract and retain workforce in job. In this study also it is found that the respondents are looking for the career develop path while attracting and retention is concern in rural and remote area. Therefore, the career path should be pre-defined and strict to rules and regulation, and the implementation should be fair and un-biased and strictly be based on merit and then seniority based. The policies on career development should be revived and make strong career path which can attract physicians, nurses and mid-wives in rural and remote areas. The career path especially of contractual are to be given emphasized at present along with the job security issue of the contractual. There should be clear written policies for providing permanent positions to the contractual. It is also suggested that the minimum period of contractual service should be 3-5 years not 1 year of at present. It will improve the sustainability of contract positions.

5.6.2.8. **IMPROVING LIVING CONDITION**

It is found in this study that the living conditions are likely to be important in determining health workers’ decisions to move to and remain in underserved areas. The importance of living condition is seems to be higher in ensuring the physicians, nurses and mid-wives in the rural and remote areas. The living condition including the housing, electricity, water supply and transport & communication does not directly relate to the HR activities. Though, the issues have a greater impact on HR attraction, deploying and retaining in the rural and remote areas. Most of the respondents emphasized on improve living condition for attracting and retention factors. Thus, the doable point is infrastructure development for proper accommodation facilities, provision of electricity (where electricity is not possible Solar could be the option) and provision of water supply should be ensured. However, the other components are not directly in the hand of the sector but it can be solved with the convergence with the other departments and local governance, thus improving the living conditions.
5.6.2.9. IMPROVE WORKING CONDITIONS

To attract and retain the workforce in rural areas, it is necessary to improve the working conditions in the health institutions. It starts with it can be done with the provision of equipments, drugs and supplies and other working conditions like other basic amenities in the workplace and overall the safety of the workforce should be the priority. The function of the health facilities should be improved by adequate provision of work related items.

5.6.2.10. INTENSIVE TRAINING AND SKILL DEVELOPMENT WITH POST EVALUATION

Training should be designed to help employees not only their positions but is should be altogether have a benefit to the professional traits also that means they should take personal benefits also from the training. The training and skill development should include inductions and refreshing training as well. The post evaluation of training at the field level should be started and support the workplace to increase their performance.

5.6.2.11. EMPHASIZE ON SUPERVISION AND MENTORING

‘We believe a great supervisor is actually an excellent coach, not just a boss – Dr. Reddy’s Lab. (Chapelli, 2011). It is suggested that to strengthen up the supervision and mentoring activities of the Physicians, Nurses and Mid-wives, especially the new comers. The mentoring and supervision should not be just fault taking out of their works but to mentor and guide them. This will create conducive environment between the employees and management and it will give a boost in the job satisfaction of the workforce and will contribute to motivation to continue in the rural and remote area service.

5.6.2.12. REGULATING WORKLOAD AND INCENTIVES

Minimizing the workload in a flick is not possible in the inadequacy of workforce. However, it is suggested that the duty hours should be fixed for every groups and individual in a manner that it do not adversely affect the mental stability of an already frustrated groups of employees. The overtime facilities should be provisioned to boost their morale. The technical workforce should not be waste for management and clerical works. The posting of clerical and managerial cadres should be ensured.
5.6.2.13. ROTATIONAL POSTING

The option for rotational posting and follow up of minimum rural area posting may be ensured. The minimum tenure of the posting should be ensuring with the fairness and without any bias. The transfer and posting should not be influenced by the favoritism and political influences. The minimum tenure of 3 years for rural service may be extended to 5 years, but it should be strictly followed by rotational posting to urban areas.

5.6.2.14. STRENGTHEN PERFORMANCE APPRAISAL

The system of performance appraisal should be further strengthen and make it meaningful. No performance appraisal should be done in merely to complete the formalities; rather it should be based on the reality and actual facts. It should be used regularly to enhance the performances of the workforce. The performance appraisal should be used for the reward and recognition program and the incentive programs. Much of the challenge in health reform involves shifting incentives to improve productivity, quality, and performance (Forgia,2005). Good performance should be linked to incentives and the system should be based on objective criteria to avoid favouritism.

5.6.2.15. CONSISTENCY OF DATA ON WORKFORCE

To ensure that the right health worker is in the right place with the right skills, managers need accurate HRH data for HR planning from beginning to work together to develop a HRIS that tracks health professionals from training until they leave the workforce. HRH planning in the absence of reliable data is not optimally possible, therefore, there is a need of reliable database i.e., more comprehensive data on other categories of health workers, which is absence in the current position. The HR data should be maintain properly with the detail of the workforce and their service tenure in a place. It should be computerized and the consistency of data for every sections of the department should use the same HR data to plan and execute. By this the proper distribution of the physicians, nurses and mid-wives can be possible and the minimum tenures can be managed.
SECTION 7
CONCLUSION
5.7.1. CONCLUSION

This study has attempted to document the gravity and complexity of the HR issues in Public Health Sector in ensuring attraction, deployment and retention of the Physicians, Nurses and Mid-wives along with the contribution of Health Sector Reform in this HR issues along with HR Practice in Reform Process in the health sector in Arunachal Pradesh.

Adequate human resources for health (HRH) are a key requirement for reaching health goals, the study found that, the shortages of physicians, nurses and mid-wives are an ongoing problem in the public health sector in Arunachal Pradesh. One of the most enduring characteristics of the rural health landscape is the uneven distribution and relative shortage of health care professionals (Hart, 2002). To fuel on this part the urban-rural disparities in distribution of this workforce is there, with an intention of migrating is more and the trend is to migrate to urban areas. There is low job satisfaction in the workforce in the current job at rural and remote areas. It is contributed by many of the factors including financial and non-financial benefits. Attraction and retention of physicians, nurses and mid-wives in remote and rural areas are determined by many factors including financial incentive, career development opportunities, recognition etc. But, the factor of compulsion is the main factor of stock in rural and remote areas, and rest of the factors have less contribution, and the financial benefits along with non-financial benefits seems to be migrating factors. The attraction, deployment and retention of physicians, nurses and mid-wives in rural and remote areas are a real challenge and a difficult situation, and affected by several factors ranging from organisational factors to external environmental factors and to personal factors. However, the personal factors have less affect on the situation. The massive poor living conditions in the rural and remotes areas, poor working condition in health institutes, poor career development opportunities with lack of financial benefits are some of the factors that contribute to the reluctances of the physicians, nurses and mid-wives to serve the rural and remote areas in the state. The sector has nothing to offer presently, to attract and retain and to distribute rationally this workforce, which in result deteriorating the situation in the rural and remote areas. Moreover, the reform process is doing less for the HRM perspectives and the HR practices are not effective enough to solve the problems in the state.
This study shows that a blend of interventions is needed to improvised the situation. Nevertheless, the implementation of financial as well as non-financial interventions are to be ensured for improving the situation of Physicians, nurses and mid-wives in rural and remote areas.

Thus, it is clear that many factors affect the rational distribution, attraction and retention of Physicians, nurses and mid-wives in the rural and remote area ranging from environment issues, organisation issues as well as the personal issues, along with the production issues, the facilities and basic amenities along with financial incentives are determinant of manpower in rural areas of the state. It is also known that to solve these HR issues, no individual interventions are not adequate, it need a pyramid of interventions to ensure the minimization of the issues.

Moreover, a blend of initiatives is needed to address the problems of distribution, attraction and retention of manpower in the state, there is a need of continue focus and commitment on the part of government and as well as the political will to solve the problem. In conclusion, efforts to strengthen health sector must address the HR issues and a good Human Resource Management and a far sight in HR requirements are needed.