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# Action Intervention to Provide Health Care Services to the Rural Poor in India

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**Abstract:** *The study undertaken by Centre for Multi-disciplinary Development Research (CMDR) and sponsored by United Nations Development Programme (UNDP) India had a focus of understanding the effects of macro economic reforms on the health sector of India with a special reference to the states of Maharashtra, Karnataka and Orissa. Apart from analyzing various theoretical aspects of Micro Impact of Macro Policies (MIMAP) on health sector, an attempt was made to examine the issue of people's participation in the provision of health care. This was done especially in the background of lack of effective health care provision through the PHC network in the majority of the Indian states. As a result in a village in the state of Karnataka in the Indian union, the People's health clinic was started which got initial doses of inputs from the project funds as seed money. People of the village also contributed both in kind and cash. A medical doctor and a nurse were supported from the project funds and select medicines and other equipments were also provided. The concept of user charges was also tried out to see whether the community members are willing and able to pay for the health care services. The results were quite encouraging and on account of proper motivation and pragmatic support such experiments could be sustained in the long run. The external support though required at the initial stages need to be withdrawn slowly. Thus it is important to put people around such developmental activities rather than putting developmental activities around the people.*

**Keywords:** Health for All, Health Care, Community Participation, User Fees

## Introduction

As India is a signatory to the Alma Ata declaration, we were required to achieve the goal of Health for All (HFA) by 2000 A.D. It is obvious that we have not been able to achieve this goal. The goal distance as enumerated in the health policy document for various indicators still needs to be achieved. In the wake of economic reforms, there seems to be a compression of budgetary resources in general, which has reduced the share of resources for the social sector in general and more so for the health sector. Few research studies have documented this in the Indian context. Shrinking resources have their impact on the health delivery system.

As part of Centre for Multi-disciplinary Development Research (CMDR)'s study, we collected the household level information in the three selected states of Maharashtra, Orissa and Karnataka through the help of structured questionnaire. We tried to elicit information regarding the socio-economic status of households, morbidity and nutritional profiles, utilization pattern and the risk factors affecting the health status of the population. Along with this we also tried to collect the

qualitative information on the perceived status of the community with regard to the health delivery system especially in the reforms period. The results from the data indicate that, the delivery of health services through public institutions have developed certain bottlenecks, which have resulted in lower levels of utilization by the community. Secondly, the aspirations of the community with regard to the public health care institutions are many and the present set-up is unable to meet the growing demand. Such a situation might have been created due to inadequacy with regard to manpower supplied as well as other inputs at the Primary Health Centre (PHC) level.

Our data also reveals that, private practitioners are exploiting the community under the nose of public health care institutions. Sometimes as public health personnel are not available in the villages, the private practitioners (who are usually quacks) charge heavy fees to the patients. Poor people who do not have any options are forced to visit such private clinics. But at the same time we cannot afford to pass on the blame to the public system, which is trying honestly to cope up with the increased responsibilities on the one had and declining budgetary support on the other.

**A Brief Scan of Interventions with Private Partners in Health Care Delivery**

About 6 million urban slum dwellers had little access to primary health care services and could not afford private care. The governments of India and Andhra Pradesh received assistance from the World Bank to establish the Andhra Pradesh Urban Slum Health Care Project (2000-02). Afterwards, the state government continued the project with its own funds.

The Commissioner of Family Welfare (CFW) contracts with Non Governmental Organization (NGO) and provides an annual budget of Rs.3 10,000 that covers salaries, operational expenses, equipment, furniture and pharmaceuticals in addition to NGO training. The NGO hires five providers and three support staff. It provides basic Reproductive and Child Health (RCH) preventive care (antenatal care, immunization, vitamin A, birth spacing, reproductive tract infections, and sexually transmitted infections); services for childhood diseases (e.g., acute respiratory infection, diarrhea, measles); referrals (for high-risk pregnancies, newborns, emergencies); and outreach. (World Bank 2004, Andhra Pradesh Commissioner of Family Welfare)

In the state of Karnataka to take over and operate the Primary Health Centers (PHCs), the government provides the building and all of its equipment, furniture, and supplies. A charitable trust manages the Primary Health Centers (PHCs). The Government also pays 75 percent of staff salaries (the trust is responsible for the remaining 25 percent) and provides Rs.75,000 annually for medications. The trust receives the facilities and uses its own funds for whatever is needed, including renovation, equipment, furniture, and beds.

The Karuna Trust hires all staff, provides training as needed, and handles procurement. The staff consists of one physician, one laboratory technician, one nurse, two auxiliary nurse-midwives, two clerks, and an administrator, all of whom are on one-year contracts. The center also supervises about 20 community workers (World Bank 2003).

In Bihar a hospital has established partnerships with the government to provide immunizations and to host and manage an HIV/AIDS voluntary counseling and testing (VCT) center; tuberculosis directly observed treatment, short-course center; and a leprosy detection and treatment center. In each case, the government has provided drugs and laboratory reagents. The hospital receives no subsidies from the government for the operation of the Community Health Center (CHC) or for its services to the poor. This is a very limited partnership (80 percent private, 20 percent public).

Community Based Distribution (CBD) volunteers were recruited, given one-year contracts, and paid by local village health committees to distribute free and branded (i.e., socially marketed)

contraceptives and other RCH products door-to-door in their communities. They will also provide family planning counseling, enroll pregnant women in antenatal care, enroll children for immunization, organize community activities, work with the auxiliary nurse-midwife, conduct group health education discussions, attend to certain child illness (e.g., diarrhea), and refer clients for Intrauterine Device ( IUDs) and sterilization. The CBD volunteers will travel to nearby towns to pick up contraceptives and other supplies. In return, the CBD volunteers will receive a monthly stipend of Rs.400, plus Rs.50 for each sterilization and Rs.20 for each IUD referral (World Bank 2004, Janani Project 2004).

**Rationale for Our Intervention**

In the background of the above discussion, we need to evolve new mechanism of health care delivery which would strengthen the public health delivery system and also supplement it to reduce the burden on the public system. Community involvement and participation in the provision of health care services is not a new idea altogether. We can note that there are innumerable experiences both within and outside India, which have demonstrated that community participation is a effective resource in the provision of health care services.

Need for such a participation in the present day context arises firstly due to inadequate manpower at the PHC level, which seems to be over burdened. The medical officer at the PHC is finding it hard to manage his time due to his pre-occupancies in 14 programmes / schemes. Thus patients find it difficult to find him whenever they visit the PHC. One may ask for additional doctor at the PHC, but in view of changing budgetary allocations, it may not be feasible to do so.

Secondly, we also now observe that many state governments are willing to experiment innovative methods to improve the situation with regard to the health delivery system. Recently the government of Karnataka has announced the introduction of Rogi Kalyan Samiti (RKS) based on the experiment of Madhya Pradesh. It needs to be noted here that RKS is quite a novel idea in managing the public health institutions. But the Rogi Kalyan Samiti of Madhya Pradesh (A state of India) does not go below the level of Community Health Centres (CHCs), by which it means that it is meant to cater to the referral care rather than primary care. But, we need to experiment new methods of strengthening the public health delivery system even at the primary health level also.

Based on the lessons of an experiment in Karnataka with regard to the participation of NGOs in the delivery of health care services (Report of Deccan Herald –English Daily- dated 4th May 14, 2002) the Central government has made changes in the health policy document 2002. The policy document clearly encourages NGO participation in the delivery of health services through public outlets.

In this background CMDR tried to evolve an intervention package to supplement and strengthen the public health delivery system. The broad objectives of this package are,

- Community should actively participate in the provision of health care services
- Delivery of health care services should be more community friendly
- Try to inject built in mechanisms in the package to make it sustainable, after the initial doses of supplements

The intervention package is outlined as below.

- CMDR would create Primary Health Management Group (PHMG) in the adopted village where a PHC is also located.
- Formation of PHMG would be through the active participation of DHO and other programme officers, village Panchayat, CMDR and other NGOs and corporate bodies in the region
- PHMG would be registered as an NGO
- Initially CMDR would bear the salary costs of additional man power supplied

**Composition of Primary Health Management Group (PHMG)**

- ✓ All households in the village
- ✓ Panchayat members
- ✓ District Health Officer (DHO) and other programme officers when CMDR actually tried to operationalize PHMG. It was not possible to include DHO and his staff due to their non-co-operation for the whole experiment.
- ✓ School teachers of the village
- ✓ Youth associations of the village
- ✓ Women's Associations of the village
- ✓ Corporate bodies in the region
- ✓ CMDR

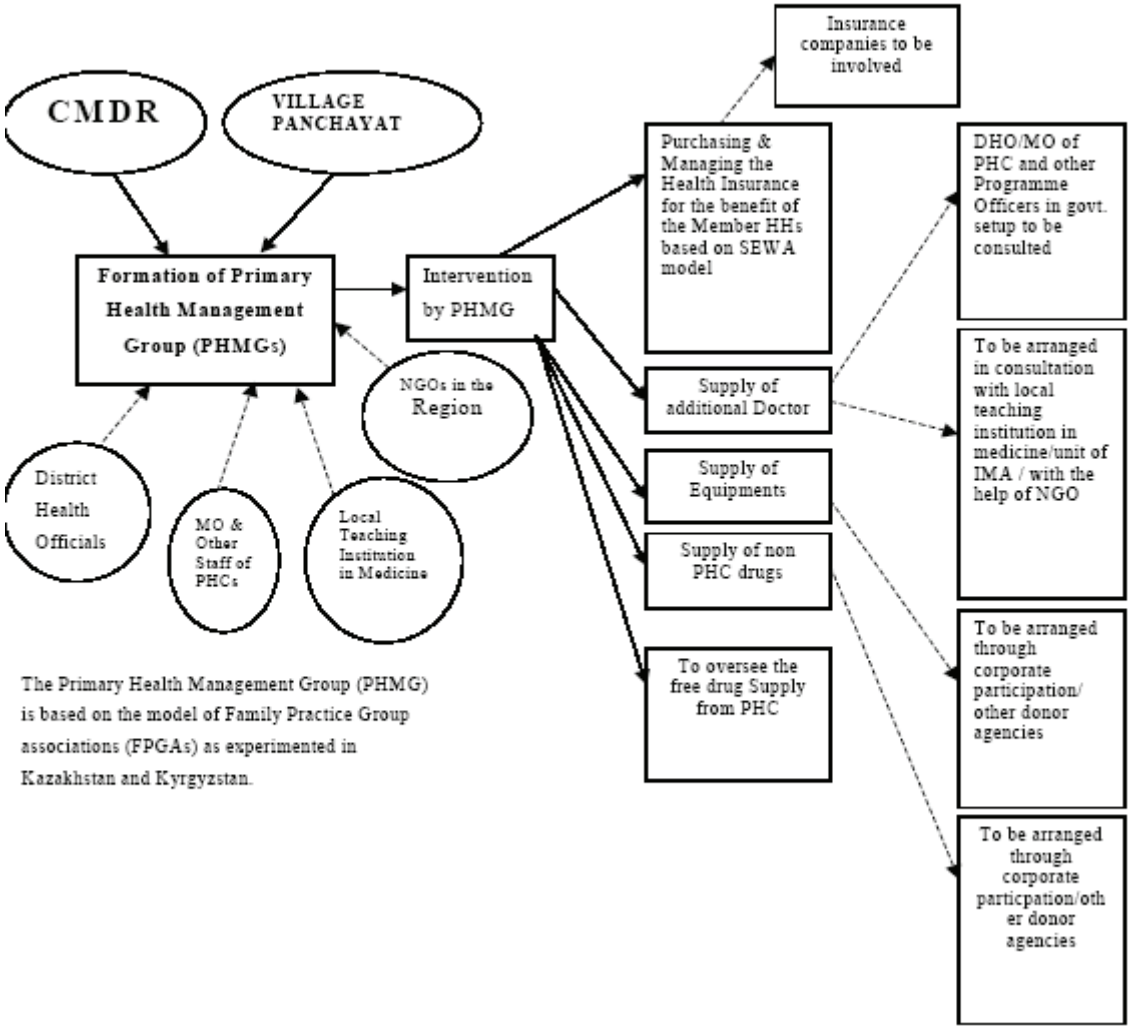
**Responsibilities of Primary Health Management Group (PHMG)**

- Providing M.B.B.S. Doctor to the PHMG clinic
- Providing health cards to the HHs to retain the medical history of the members
- Providing telephone facility and logistical support to the members to avail referral care
- Inviting specialized doctors to the village for the benefit of the villagers
- Organizing eye check up and treatment camps through the help of donors
- Educating the members with regard to preventive health care
- Working out the feasibility of providing health insurance to the members to avail referral care
- Collaborating with charitable hospitals to avail the referral care
- Collecting the user fees from the patients and managing the PHMG clinic on a sustainable basis

In the course of intervention, we had to hold series of meetings and Focus Group Discussions (FGDs) in different villages of the district. In a village, in which we attempted to create the PHMG at the outset provided us some useful lessons. We conducted a baseline survey to know the socio-economic information, morbidity profile, care seeking behavior and the cost of treatment. We also tried to understand the willingness of the community to pay for the services provided by proposed clinic. Though initially some young members of the community evinced interest in the whole affair, gradually the euphoria subsided. When we started holding FGDs with various sections of the community, we started realizing the ground realities. The elders in the village had no interest to promote such experiment wherein they were required to pay for the health services. One issue that came to the forefront in this village is that, the village was quite

nearer to the urban center. The people in the village had an easy and quick access to the health care institutions in the urban center, which probably acted as de-motivating factor towards arousing interest of the community to participate in such an experiment.

The following chart would depict the formation of PHMG and its responsibilities.




The Primary Health Management Group (PHMG) is based on the model of Family Practice Group associations (FPGAs) as experimented in Kazakhstan and Kyrgyzstan.

By this time, we had also initiated the process of bringing the District Health Officer (DHO) into the experiment. Initial discussions were held with DHO and other programme officers of the district connected with various schemes of the health sector. The interest shown by the DHO and his team was really encouraging. He very much supported the idea of making the community responsible for shouldering the responsibility of providing the primary health care services on their own. The prototype of action intervention was explained to him and his team. He also suggested that, since health happens to be a Panchayat subject it would be better to involve the Zilla Panchayat set up in the whole experiment. Such a move would also facilitate to involve the Panchayati Raj Institutions (PRIs) in overseeing the effective delivery of health care services. With this idea in mind, we arranged a much bigger meeting involving Chief Executive Officer (CEO) of the District Panchayat, Officials of Health Department. The discussion of the meeting focused on the modalities of community involvement, user charges to be levied at the clinic of the PHMG

and partnership between PHMG and PHC in the village. Partnership envisaged in this context was to depute additional doctor and nurse to the PHC through the institution of PHMG. These additional doctor and nurse would be functioning in the premises of PHC. The community would get the benefit of this additional manpower by paying user fees. One issue which came up for discussion during such a meeting was that, if a patient gets treated by the Government doctor in the PHC and not by the PHMG doctor, whether he or she is required to pay the user fees or not. If this were so, no body would opt for the PHMG doctor for the simple reason of paying the user fees. Hence it was decided in the meeting to collect the user fees from all patients who would visit the PHC irrespective of the doctor that they consult. Thus user fee turned out to be an entry fee into the PHC. The District Health Officer gave his approval for this in the meeting. Chief Executive Officer of the Zilla Panchayat (ZP) also endorsed this. He was of the opinion that, since PRIs are also involved in the experiment, there should not be any problem in collecting the user fees.

When the action intervention started taking some definite shape with these developments, we intensified the efforts to choose a village where such a experiment would take place. In this context, we started listing those villages in the district where PHCs are located and also such PHCs where either one Doctor or no doctor is functioning. In Uppin Betageri, there was only one doctor at the PHC and the community in that village as well as other villages covered by that PHC felt that there is a need of one more Doctor. Though, two posts of Doctors were sanctioned, only one Doctor was functioning. With this clue, we thought of choosing this village for the intervention. We approached the Panchayat and conducted the FGD. In the Focus Group Discussion the members of the village showed interest and were keen to participate in the action intervention. But the kind of things, which were shaping at the back of our activity were really indicative of the nature of support from government officials. The District Health Officer was quietly recruiting new doctors to the PHC of this particular village. Initially one doctor was appointed and gradually even the third doctor was installed in the PHC though there was no provision for the third doctor. With this sort of staffing at the PHC, the mood of the villagers changed very fast and they thought that it would be futile to participate in an experiment wherein they themselves should shoulder the responsibility of running the clinic after the intervention support is over. They were very happy to have three doctors next to their doors in the PHC and our efforts to enthuse them did not yield results in the desired manner. The DHO considering our experiment to be a competitor and damaging for his reputation as public servant was successful in foiling our experiment in this particular village. The fact that came out from this experience was that, though the public health officials were appreciating the kind of intervention that CMDR was trying to experiment, in actual practice they were not very keen to support it. They were not ready to accept the fact that public health delivery system is not effective in providing health services to the people.

In a village that we chose after this kind of experience was willing to participate in our action experiment. We had discussions with the members of the Gram Panchayat of this village. They were happy about the fact that the PHC in their village would get an additional doctor and a nurse. The CEO of the ZP was prepared to extend his help for the experiment and he even directed DHO to actively support this experiment. As a matter of caution, we had similar discussions in a different village also. This was being to keep the second village as the alternative option if again our attempt was aborted here also. One more intention of doing so was to see whether we could do such experiment in the second village without involving PHC set up. The joint meeting of ZP, District Health Officials, members of respective villages and CMDR team

was held to discuss the modalities of intervention. The people of both villages welcomed the idea of joining hands with PHC and to have additional staff in the premises of PHC. They were willing to pay for obtaining services from the PHC. During the course of meeting the District Health Officer openly stated that he would permit the additional doctor and nurse to use the premises of the PHC and the new doctor would be required to function as per the existing government framework. But very soon, in almost a weeks time we learnt that DHO had a different story to narrate. He said, he would require the permission from his higher ups in Bangalore and if only and only if he gets the approval from them, he would be in a position to handover the portion of the PHC to the new staff recruited under the experiment. This was breaking news for the team of CMDR as well for the village that was ready to participate in the experiment. The villagers were not very happy over this kind of development. They were also not very keen on doing such an exercise without involving the PHC. The office bearers of the Gram Panchayat opined that, the villagers had not necessary mental make up nor the capacity to participate in such experiment in which public set up is not participating. One member felt that the drugs and other supplies to be supplied for the peoples' clinic would be misused by certain sections of the society and people may start suspecting any transaction by the office bearers of the PHMG. Thus, the fate of the first village of the two selected met a phase of dropping out from the experiment.

In the stand by village, which we had selected as a matter of caution, we tried to experiment our prototype of action intervention. One advantage of this particular village was that, it had a good background of community participation in the drinking water supply scheme. The government of Netherlands had initiated a rural drinking water and sanitation scheme in the state of Karnataka, which tried to create the infrastructure for the drinking water supply with about 15 per cent of the cost of the project to be borne by the community. The expiry of the project phase, the created infrastructure would be handed over to the community itself for maintaining and operating the services on sustainable basis. This village by the name Morab, was managing the scheme of water supply successfully. It has the facility to treat the water before supplying and couple of water tanks were constructed to store the water to be supplied to the community. If a household wishes to own a tap in their own home, it has to pay higher user fee than the household, which gets the water through community tap. In any case community had to pay for the drinking water. The scheme was handed over to the Gram Panchayat and it has been running the show successfully for past 7 to 8 years. We considered this as the best positive factor in favor of enthusing community in shouldering the responsibility of providing health care services also along with the water supply and sanitation facilities. At the outset we informed the villagers that, we are trying our best to get the nod from the higher ups of the health department in Bangalore to initiate the experiment in this village with the effective participation of PHC set up. But if we don't get the permission, the community has to be ready to experiment on their own. As expected the government machinery did not respond at all to our various requests to have discussions with them regarding the modalities of our proposed action intervention. More than a month was just wasted in waiting for the official response. We felt that nothing would move forward in this regard. Finally we made up our mind to go ahead without joining hands with the PHC set up.

Village people also got convinced about the non cooperation of the government machinery and they also expressed the desire to experiment the action intervention. When we had decided to move forward, we actually planned the details of the experiment with the Gram Sabha members as well as other prominent members of the community. The suggestion, which came out during such meetings, was that, there is a need to place the details of the experiment before the general public of the village in a open meeting which is known as Gram Sabha or Village Meet. CMDR

team attended the such a meeting in the village and the details of the action intervention were explained to the people. To our surprise the health related matters were taken up at the outset of the meeting and people expressed a desire to have a doctor at the PHC. They made this request because the post of doctor had remained vacant for many years without a regular person taking charge of it. There were many adhoc arrangements, which never fulfilled the requirements of the PHC. Incidentally, the District Health Officer made one more adhoc posting for the vacancy of doctor, and the concerned doctor had come on the day of meeting to convince the people that government has done something to their village by sending the doctor. When the doctor informed the people that he had taken the charge of Medical Officer of PHC for the past one month or so, the people couldn't not believe it. They asked the office bearers of the Panchayat and other people as to whether they noticed the presence of this doctor at the PHC at any time. It only meant that the doctor had taken charge only on paper and had no time to visit the PHC to deliver the services. This event actually benefited us to a great extent. Our turn to present the details of the action intervention was next and hence people were very eager to learn about our experiment. We explained the details of the experiment. The idea of formation of PHMG and establishing a clinic by it in the village appealed to the people. There was a unanimous agreement for this idea. When we also explained about the introduction of user fees at the clinic there was no opposition to such an idea, in fact people were in favor of this, because getting a M.B.B.S. doctor for their village involves certain expenditure was the message from their discussion. The village meet finally gave a unanimous YES for our experiment. After this meet, we intensified our efforts to the formation of PHMG. A series of meetings were held with Gram Panchayat members and other village leaders, social activists, women organizations and youth associations. Our intention was to involve the Panchayat set up in the organization of PHMG on an official basis. This would try to encourage the process of decentralization in the provision and management of health care services But the opinion of the office bearers of the Panchayat was that, the decentralized set up has been reeling under the effects of "Red Tape" and hence it would not be proper to bring PHMG also under the a system which has got spoiled on account of many socio-political factors. We considered their argument and finally decided to keep PHMG out of the decentralized set up, but we got some of the Panchayat members as the members of PHMG also.

Thus the formation of PHMG took place in the village. The members of PHMG included, few members of decentralized set up, school teachers, representatives of women organizations, other prominent members of the community and of course CMDR was also a member of this group. The doctor and nurse were appointed for the clinic. We were able to search a experienced M.B.B.S. doctor. The doctor had several years of practice in rural areas. We had a series of meetings to complete the modalities of opening the clinic in the village. A bank account was opened in the village in the name of PHMG and three people were authorized to operate the account. The doctor of the clinic, the president of the PHMG and the president of the Gram Panchayat were to manage the financial matters of the PHMG. In any case, CMDR had taken the responsibility of shouldering the doctor's and nurse's salary, supply of medicines and 50 per cent of the rent for the premises of the clinic. CMDR had intimated to the PHMG members that such financial support from CMDR would be for a period of six months only. After the expiry of such period, the PHMG will have to take up the responsibility of running the PHMG clinic on its own. A suitable place in the in village was chosen to start the clinic. The members of PHMG named the clinic as Samudaya Arogya Kendra (SAK- Community Health Center). Before the inauguration of the clinic, CMDR supplied the minimum of equipments and other small requirements of the SAK. Following table shows the kind of materials supplied and their value.

**Table 1: Assets given to the Samudaya Arogya Kendra (SAK)**

| Type of assets | Value of Assets (Rs) |
|---|---|
| Medical Instruments | 8825.50 |
| Furniture | 4242.00 |
| Other materials | 1055.00 |
| Total | 14122.50 |

The clinic was opened on the 19th of September 2002. PHMG had agreed to collect the user fees from the patients visiting the clinic. An examination of the patient followed by giving minimum tablets and other medicine would require the patient to pay Rs. 5/-, and if the patient receives an injection, the user fee would be Rs. 10/-. From day one onwards the patients showed interest to visit the clinic. The mood on the opening day in the village was quite euphoric and people and the members of the PHMG were feeling contented because they were instrumental in bringing a M.B.B.S. doctor to the village. They had put up a small board for the clinic with the working hours of the clinic mentioned on it. The clinic was to function from 9 a.m. to 5p.m.

The clinic started functioning, and the staff of CMDR used to visit the village to give publicity to the clinic in the village. They also used the occasion to understand the views of the patients regarding the services offered by the PHMG clinic as well as the PHC which was also situated in the village. The following table shows the month wise income and expenditure of the PHMG clinic.

**Table 2: Income and Expenditure of PHMG**

| Month/Year | Receipts of PHMG Clinic (Rs.) | | | | | |
|---|---|---|---|---|---|---|
| | Patients @ Rs. 5 | | Patients @ Rs. 10 | | Total No. of Patients | Total Amount (Rs) |
| | No. of Patients | Amount (Rs) | No. of Patients | Amount (Rs) | | |
| September 2002 | 28 | 140 | 96 | 960 | 124 | 1100 |
| October 2002 | 140 | 700 | 439 | 4390 | 579 | 5090 |
| November 2002 | 145 | 725 | 431 | 4310 | 576 | 5035 |
| December 2002 | 79 | 395 | 355 | 3550 | 434 | 3945 |
| January 2003 | 135 | 675 | 380 | 3800 | 515 | 4475 |
| February 2003 | 179 | 895 | 299 | 2990 | 478 | 3885 |
| March 2003 | 554 | 2770 | 0 * | 0 * | 554 | 2770 |
| **Total** | **1260** | **6300** | **2000** | **20000** | **3260** | **26300** |

* Note: In view of the non-availability of breakup of patients, we have included all under Rs.5 category

The receipts of the clinic for the period from September 2002 to March 2003 shows that, a total of 3280 patients visited the clinic generating an income of Rs. 26300. Certainly this amounts to be a quite significant sum for the PHMG of Morab. But at the same time, we also need to look at the expenditure to run the clinic. CMDR was paying Rs. 10,000 as salary to the doctor plus Rs.

3000 as the allowances. Nurse used to get Rs. 5000 as the salary and Rs. 680 as the allowances. Apart from this CMDR had also spent on the non-recurring items like, equipments and furniture for the clinic and recurring expenditure on medicines was also made. This is shown in the below mentioned table.

**Table 3: Recurring Expenses of the Clinic (Rs.)**

| Month/Year | Expenditure on Salary | | Expenditure on Medicines | Total Expenditure |
|---|---|---|---|---|
| | Doctor | Nurse | | |
| September 2002 | 5200 | 5676 | 6943 | 17819 |
| October 2002 | 13000 | 5676 | 1390 | 20066 |
| November 2002 | 13000 | 5676 | .-- | 18676 |
| December 2002 | 13000 | 5676 | 2783 | 21459 |
| January 2003 | 13000 | 5702 | .-- | 18702 |
| February 2003 | 8000 | 5624 | .-- | 13624 |
| March 2003 | 13000 | 5676 | .-- | 18676 |
| Total | 78200 | 39706 | 11116 | 129022 |

The average income per patient and average expenditure per patient would give us the overall scenario of the finances of the clinic. It would also give us the gap that exists with the present user fee structure as well as compensation structure for the staff employed. The following table gives us the average income and expenditure per patient.

**Table 4: Per Patient Income and Expenditure (Rs)**

| Month/Year | Income / Patient | Expenditure / Patient | Difference |
|---|---|---|---|
| 1 | 2 | 3 | 4 (Col 2 -Col 3) |
| October 2002 | 8.8 | 34.7 | -25.9 |
| November 2002 | 8.7 | 32.4 | -23.7 |
| December 2002 | 9.1 | 49.4 | -40.4 |
| January 2003 | 8.7 | 36.3 | -27.6 |
| February 2003 | 8.1 | 28.5 | -20.4 |
| March 2003 | 5 | 33.7 | -28.7 |
| Total | 8.1 | 39.6 | -31.5 |

The average income per patient varies between Rs. 5 to about Rs. 8 whereas the average expenditure is between Rs. 28 to Rs 40. This only means that the cost of providing medical care services is quite burdensome and if the community is made to shoulder this kind of responsibility, it may not be feasible for it to do so. What could be the alternatives before us to deal with a situation like this? If one considers the task of increasing the user fees, the community may not support it. Even if some segment of the community supports it, it may severely affect the equity aspects of the services rendered by the clinic, leaving out the poorer segments in the cold. In such a situation, the best thing would be to reduce the operating costs of the clinic. In order to do so, we should reduce the salary of the doctor and consider the reduction of other manpower support. In this particular experiment it was found that, as the clinic was catering to the needs of the community with regard to the treatment of common diseases and injuries, the services of the

nurse was not considered to be very essential. The clinic had no facilities to provide the MCH services, which also made the nurse less useful for the clinic. The premise of the clinic was rented at the rate of Rs 600 per month. There was a scope to shift the clinic to cheaper premises to save on the costs. The various permutations and combinations of the viability aspects of the clinic showed that, at least 35 to 40 patients must visit the clinic and it must generate an income of Rs. 7000 to 7500 per month. Out of this the clinic must find a doctor who is willing to serve for Rs. 5000 per month. Rest of the amount could be utilized for the purchase of medicines and payment of rent and the salary of the helper with of course some minimum savings for the PHMG. We were planning the withdrawal of the intervention by CMDR with this kind of situation created for the PHMG. Under such circumstances the take over of the clinic by the PHMG would be quite smooth and sustainable.

**Views of the Community about the Clinic**

When the clinic started functioning in the village, the news started spreading slowly within the village as well as to the neighboring villages. Thanks to the efforts of the CMDR field team which was instrumental in canvassing the opening up of the clinic as well as services rendered by it for the benefit of the community. The doctor of the clinic was also so effective in rendering the services as required by the community and his interpersonal skills also helped in gaining confidence of the community. As promoters of the clinic, CMDR was keen to know how the community was trying to evaluate the clinic vis-à-vis the PHC that was also functioning in the village. Exit interviews, discussions with the people and patients were conducted at regular intervals to elicit the information.

Young and old, male and female rich and poor were the kind of patients who visited the PHMG clinic. Usually the time of visit of the patients was more in the morning hours (between 10 a.m. to 1.30 p.m.) and in the evenings i.e. around 5 p.m. or at the time of closure of the working hours. The immediate response to the services of the clinic by the community was quite positive and it was mainly due to absence of a M.B.B.S. doctor in the village, for the past several years. Most of the quacks who did function in the village were not very impressive. The doctor at the PHC who was a M.B.B.S. was not available for most of the time

People said that the location of the clinic was in a convenient place as it was placed in the center place of the village. Space within the clinic was quite large, both for the patients to wait in queue and for the doctor to examine the patients. Doctor of the clinic, according to the patients who visited him was receptive and was humane in his approach while treating the patients. The views of the patients about the clinic are summarized as below.

- Need for the doctor to stay in the clinic during night time also
- Patients felt that the user fee of Rs. 10 and Rs. 5 was affordable for the members of the community
- Quality of the services rendered was satisfactory to the patients
- Patients preferred the services of PHMG clinic due to poor quality of services rendered by the PHC
- People expressed the need to include the maternity services in the clinic
- The ultra poor expressed a desire to get free services from the clinic
- Need was also expressed to have special health check up camps

- It was also brought out from our survey that more publicity for the clinic need to be provided in some areas of the village as well as the surrounding villages

Starting the clinic by the PHMG had good and positive impact on the functioning of the PHC located in the village. For the past several years PHC was functioning without any doctor. As the PHMG clinic started providing good service regularly, it started creating ripples around. The sleeping governmental set up woke up and started responding in a reactive way to the initiatives of the peoples' clinic. The DHO came out of his routine way of functioning and tried to save his face against the *'Patient Friendly'* services of the peoples' clinic. Where there was no doctor for years in the PHC, we could see a doctor visiting the PHC everyday. Even the holidays witnessed a doctor at the PHC, which was a rare seen in the village. The PHC also geared up its activities and started visiting the households of the village and started providing services at the doorsteps. This kind of rush of blood attitude put the villagers in confusion. They slowly started thinking that, there was no need to continue with the PHMG clinic as things are quite satisfactory at the PHC. Though this viewpoint came out from some people, the cool headed discussion was fruitful in understanding the situation in a much better way. The villagers could understand the tricks of the PHC set up and were convinced that the things at PHC have improved only because of the CMDR experiment. They were also quite sure that if the experiment is over and the PHMG clinic is closed, there is every possibility that the PHC would revert back to its defunct stage. So people were cautious enough to safe guard the interest of the community by continuing to support CMDR led action intervention.

The views of the community and the support extended by the villagers really enthused us because we had sensed the urge in the community to carry on with the experiment even after the withdrawal of CMDR. As mentioned earlier in the discussion, we were busy in identifying a less expensive doctor to be posted in the clinic, so that the finances of the clinic would be managed favorably to suit the limits of the PHMG. When we finally found a doctor who was ready to work for Rs. 5000 per month, CMDR handed over the clinic to the PHMG by withdrawing the staff earlier recruited. Thus from the seventh month of its inception, the peoples' clinic started functioning in the village as peoples' own initiative.

The experiment has brought out the fact that there is a potential in the community to participate in experiments wherein peoples participation is involved. In matters related to health, the need to participate by the community is still more acute and villagers are looking for helping hands from the world outside for initial doses of supplements. The felt needs of the community show that even the working hours of PHC are not in tune with the peoples' needs. The clinic of their own is certainly a boon to them. Our experiment supported the community clinic for just six months. The community felt that the experiment needs to be extended by about a year or so. They opined like this because, in order to encourage the community to shoulder the responsibility of running the clinic some time period is required. The people were also not able to contribute seed money on account of drought situation for the past couple of years. Capacity building in the community and getting a clear vision of sustaining such experiments on long-term basis also are time-consuming factors. A long-term experiment would certainly be more beneficial to evaluate the sustainability aspect. Nevertheless the community has now taken change of the clinic and the health services are reaching the people in a smooth manner.

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# Computerization of Rural and Community in Southern Ghana: Clients' Perception

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**Abstract:** *Adoption of new technology plays a fundamental role in the development process as via financial institutions. However, more often than not financial institutions have focused on the technological solution or the savings that technology can generate for their businesses without considering the needs of the customers. Sampling 53 clients from 10 computerized RCBs in southern Ghana, clients' perceptions before and after computerization were analyzed using paired sample t-test. Results indicate that all existing products have been computerized but no new product has been introduced. In general delivery of bank services have improved but clients perceive that waiting time and state of bank workers at the front and back offices have not improved significantly. the paper proposes that new product such as micro insurance, weather insurance and micro home loans be introduced. It is recommended that the computerization project must be extended to all RCBs and new products such as electronic and mobile banking, micro-insurance for small entrepreneurs, weather insurance and housing products are introduced.*

**Keywords:** Computerization, RCBs, perception, microfinance

## Introduction

Since 1976, the concept of rural banking has evolved through many stages of successes and failures with increasing number of clientele across the corners of Ghana. With competition[1] from the traditional commercial banks, the rural banks face a challenge in serving their clients most of them are small-scale entrepreneurs. The introduction of the National Payments System (NPS) also means that Rural and Community Banks (RCBs) must change from manual system of operation to computerized system, which involves networking. Computerization is when the activities of the banking system are provided via the use of computers and networking facilities. Computerized activities include withdrawals, deposits, account opening, checking of balances, and the provision of electronic products. At the retail, level banks offer Automated Teller Machine (ATM) and other debit card services. Telephone and Internet banking services are available but their use is not widespread among RCBs in Ghana. In this direction the ARB Apex Bank, United Nations Development Programme (UNDP), Millennium Development Authority (MiDA) and the Bank of Ghana (BoG) have taken the bold step to assist in the computerization of some RCBs on pilot basis which will be extended to all banks in the future. In the original project plan, a satellite was to be connected with Very Small Aperture Terminal (VSAT) which will be linking Bank of Ghana, ARB Apex bank, the regional offices of the apex bank, and six other centres including Ho, Hohoe, Koforidua, Cape Coast, Wa and Tamale. The rationale is that there is growing consensus that computerization of banks improve the efficiency in service delivery, reduces transaction cost for clients and makes them more competitive. It is also asserted that computerization enables banks to break the barrier of serving low-income market[2]. Computers have the ability to

[1] In Ghana all commercial banks are computerized with several products including electronic banking, online accounts, and international money transfer. This is serving as a competition against the RCBs.
[2] Graham et al MicroSave Briefing Note No. 47: www.microsave.org

process large amounts of data at high speed and with a high degree of accuracy. The use of computers also makes information more reliable, up-to-date and consequently improves the quality of decision-making. The use of computers, is expected, will make banks better integrate their plans and will enable quicker response to change and development. It is therefore desirable to investigate the extent of computer technology being used by these deposit money rural banks for customer and bank level services. More so, it is desirable to know the perceptions of the customers about the computerized customer and bank level services. This is because more often than not financial institutions have focused on the technological solution or the savings that technology can generate for their businesses without considering the needs of the customers.

**Research Problem**

Rural people and small-scale entrepreneurs do not only need savings and credit but innovative products such as money transfer, quick services, and other online transactions. The expectation is that with computerization of RCBs clients will enjoy an extension of bank services beyond the traditional working hours and reduced interest charges. At the initial stages of the computerization of RCBs, an assessment is important in order to justify the extension of the projects to the rest of the banks. It is important to know which type of customer services and bank level services are provided by different types of these rural and community banks vis-à-vis clients' needs. It is also important to know the type of banking operations in these deposit money banks where computer technology is currently being used. This will enable us to identify the areas of banking operations where computer technology is required, so that the efforts of financiers will be concentrated on these areas. The computerization of RCBs which started on pilot basis is about 50% complete. The projects have been funded by development partners like UNDP and funds from the Millennium Challenge Account (MCA) managed by Millennium Development Authority (MiDA). However, some RCBs recognizing the importance computerization funded the project themselves. Currently electronic merge (eMerge) licenses have been acquired for 4 ARB offices (Kumasi, Takoradi, Sunyani and Bolgatanga) and 43 local area networks have also been established for 42 rural banks and the ARB apex head office. Further 50 rural banks have been provided with 2 servers, 5 personal computers and 3 printers each to boost the computerization project. As at now electronic merge licenses have been acquired for each of the 124 rural banks. Even though much has been done by the financiers of the project, there is much more to be accomplished. The extension of the computerization project therefore calls for an appraisal of the pilot project. This study will provide some evidence for justifying the continuity of the project or otherwise and the future direction of computerization of RCBs in terms of product development and innovation. Section two of the paper reviews related literature, hypotheses to be tested and the activities of RCBs in Ghana. Section three discusses the methodology that was adopted in the study. Section four presents results and discussion of the survey. Conclusion, challenges and policy implications are addressed in section five.

**Theoretical and Empirical Perspectives**

Adoption of new technology plays a fundamental role in the development process as well via financial institutions. One of the most popular theories of computer technology usage is the Unified Theory of Acceptance and Use of Technology (UTAUT) developed by Vankatesh, Morris, Davis and Davis (2003). The theory explains the user intentions to use information system and subsequent change in behaviour. Among the factors that influence usage intention and behavior