THE DANISH INSTITUTE FOR HUMAN RIGHTS

THE RIGHT TO SERVICES AND POVERTY

A CASE STUDY FROM THE VOLTA REGION IN GHANA

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THE RIGHT TO SERVICES AND POVERTY

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ABBREVIATIONS

CHPS	Community Health Posts
CHRJA	Commission on Human Rights and Administrative Justice
DDF	District Development Fund
DHS	Demographic and Health Surveys
FOAT	Functional and Organizational Assessment Tool
GoG	Government of Ghana
HRBA	Human rights-based approach
JHS	Junior High School
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MPI	Global Multidimensional Poverty Index
NHIS	National Health Insurance Scheme
OPHI	The Oxford Poverty and Human Development Initiative
ROHEO	Royal Health Organization
RSGGP	The Right to Services and Good Governance Program
SHS	Senior High School

EXECUTIVE SUMMARY

The report examines how poor and non-poor households gain access to services in Ghana in the areas of water, sanitation, education, and health. The study compares a village in Jasikan District of the Volta Region, where the Government of Ghana and Danida have made an effort to improve water and sanitation services, with a village in the contiguous Biakoye District in the same region that has not received targeted support. Jasikan District was eligible for special support because of its results in the performance assessment under the Ghana Decentralization Support Program which targets resources and development assistance at well-performing districts.

The study aims to throw light on how poor and non-poor groups benefit from services and service improvements. Are human rights-based approaches effective in redressing imbalances of access to services by its focus on vulnerable groups and on non-discrimination and equality? Does the rights focus enable community members to lay claim to their human rights?

Field work was undertaken during January 2015 as a result of cooperation between Institute of Statistical, Economic and Social Research, University of Ghana and the Danish Institute for Human Rights.

The community studied in Jasikan District which received targeted support from the government and Danida had generally better services. This was the case in terms of sanitation where services of the *poor* in Jasikan were better compared to the sanitation services of the *non-poor* in Biakoye. A statistically significant difference in under-five malnourishment in favour of Jasikan was also found. Moreover, the incidence of malnourishment was almost three times as high in the community in Biakoye District as in the Jasikan community. Differences in water supply, education and health services were not as pronounced though Jasikan performed better on many of these indicators.

There were no statistically significant differences between poor and non-poor households across the districts in terms of water supply. Regarding sanitation, more poor households were forced to rely on unimproved sanitation supply compared to the non-poor. Poverty is thus an important factor in determining access to sanitation. Gaps also existed between poorer households and their wealthier counterparts on some education indicators. More children in poor households were out of school, for instance.

The health indicators followed a similar trend of significant and important differences between poor and non-poor households, to the disadvantage of poor households. In terms of deaths of children aged 6-15 years and under-five years, differences between poor and non-poor households are very marked with significantly less child mortality among the non-poor households.

Generally, the data indicate that poor households are less inclined to make complaints compared to their non-poor fellow households. Across the communities, significant distinctions of complaints behavior prevail regarding primary education, with the non-poor more likely to make complaints. Within the communities in the less favored Biakoye, the non-poor are significantly more apt to forward complaints compared to the poor with respect to water, sanitation and health. A human rights-based approach which is partly premised on the capability of the rights-holders to make complaints must therefore balance the general support for communities with targeted support for poorer households. Service provision in water, sanitation, education and health entails general approaches, but the design of such approaches may require that particular attention is paid to vulnerable and poorer groups.

The study provides localized case material of two communities in two different, but contiguous districts. The efforts of Danida to support the enhancement of the right to services reached one district, but not the other. Thus, Danida may have tended to reinforce a policy of differentiation which already prevailed under the Government of Ghana decentralization and performance incentivizing policies. In terms of poverty reduction it is likely that, where operational locally, the human rights-based approach contributed in making access to water, sanitation, education and health services more equitable. A final finding from the study is that even when a human rights-based approach is implemented, targeting of the poor households is paramount.

CHAPTER 1

1 INTRODUCTION

This study seeks to identify how poor and non-poor households gain access to services in Ghana in the areas of water, sanitation, education, and health. The research will focus on how rights-based approaches may contribute to facilitating access and to empowering poorer populations to make rights claims for these services.

The study compares a village in the Jasikan District of the Volta Region where the Government of Ghana (GoG) and Danida have made an effort to improve water and sanitation services with a village in the contiguous Biakoye District in the same region that has not received targeted support. Jasikan District was eligible for special support because of its results in the performance assessment under the Ghana Decentralization Support Program which targets resources and development assistance at well-performing districts. A more detailed description of the performance criteria is undertaken below.[1]
The services in focus in this report are health, education, water and sanitation services. The analytical problems of the study are: ***How do poorer groups benefit from services and service improvements? Are human rights-based approaches effective in redressing imbalances of access to services and community members able to lay claim to these rights? Can tensions be identified between the effort to support well performing districts and the poverty reduction?***

Danida has engaged in matters of service delivery and human rights and decentralization in Ghana since 2009. The Good Governance and Human Rights Program, Phase II (2009-2013) supported independent justice institutions, specifically the judicial system and the Commission on Human Rights and Administrative Justice (CHRJA). The program, in

[1] See GoG. Ministry of Local Government and Rural Development. *Functional and Organizational Assessment Tool (FOAT). Operational Manual.* 2010, 3: Management and Organization, Transparency, Openness and Accountability, Planning System, Human Resources Management, Relationship with sub-structures, Financial Management and Auditing, Fiscal Capacity, Procurement, environmental Sanitation Management. Altogether 100 points were allocated according to these criteria.

cooperation with the European Union and other donors, also encouraged demand-led governance through its support to civil society organizations.

From 2009 to 2013, Danida also channelled support through a second project: Local Service Delivery and Good Governance. This program funded key institutions implementing the process of decentralization through the District Development Facility. These investments were in the water, sanitation and feeder roads sectors and were allocated to districts according to performance criteria developed by the Ministry of Local Government and Rural Development.[2]

For the period 2014 to 2018, GoG and Danida have devised an exit strategy for the above two programs under the heading: The Right to Services and Good Governance Program (RSGGP). The program is aligned with Denmark's Country Policy paper 2014-2018 and with Denmark's strategy for development cooperation: The Right to a Better Life. The program is also aligned and harmonised with GoG priorities and systems.

The program supports local service delivery in a sector wide approach. It also supports decentralized governance and citizen participation by encouraging support for advocacy and collaboration between civil society organizations and decentralized governance institutions. A support type that was also used during the period 2009-13.[3]

The study will not examine how duty-bearers under the district administer their support and it will not seek to measure the impact of specific performance measures. Rather it will examine how different categories of rights-holders use services or are excluded from them, and the ways in which they channel grievances. The point of view taken, therefore, is that of the rights-holders; human rights-based approaches and access to services are therefore studied from the point of view of different categories of rural dwellers including the poorer groups.

[2] The performance criteria relate to professional planning performance of the district or municipality, to follow-up actions, and to planned activity implementation. Values such as professionalism, effectiveness, efficiency, accountability, transparency, and client focus are part of the service delivery standards. See Local Government Service, 2016. *Performance Contract between Metropolitan, Municipal, and District Chief Executive and Metropolitan, Municipal, District Coordinating Director.*

[3] GoG, Danida, 2013. *Right to Services and Good Governance Programme. RSGGP.* Danida, 2-8.

2 POVERTY IN GHANA

Considering the availability of poverty data—including updated data from Living Standards Surveys, UNICEF MICS data (Multiple Indicator Cluster Survey), and the USAID DHS (Demographic and Health Surveys) - poverty in Ghana is not a subject that has attracted much attention in terms of empirical research. There are only few recent scholarly studies on poverty and health and nutrition[4] and on agricultural development and poverty.[5] With respect to poverty and human rights, the most comprehensive study is the UNDP's 2007 *Human Development Report,* which we use as a reference for comparative interpretation of the results of this study.[6] Also relevant is a study by Aberese, Anyidoho, and Crawford (2013) on local development rights-based approaches in Northern Ghana.[7] Otherwise, the scientific literature that relates poverty to rights in Ghana is scant. We return to issue of rights in the next section.

[4] See Jacob Novignon, Justice Nonvignon, Richar Mussa and Levison Chiwaula, 2012. Health and Vulnerability to Poverty in Ghana: Evidence from the Ghana Living Standards Survey Round. *Health Economic Review* 2: 11. Ellen van de Poel, Ahmad Reza Hosseinpoor, Caroline Jehu-Appiah, Jeanette Vega and Niko Spreybroeck, 2007. Malnutrition and the disproportional burden on the poor: the case of Ghana, *International Journal for Equity in Health* 6: 21.

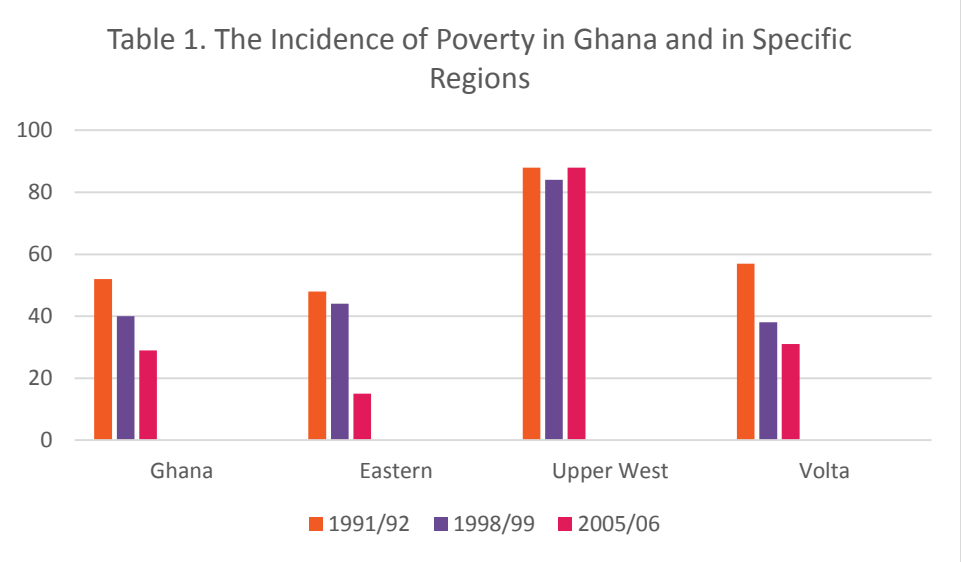
[5] Samuel Benin, Tewodaj Mogues, Godssway Cudjoe, and Josée Randriamamonjy, 2012. Public Expenditures and Agricultural Productivity Growth in Ghana. In: Tewodaj Mogues and Samuel Benin (eds.): *Public Expenditures fopr Agricultural and Rural Development in Africa.* London, Routledge, 109-153. See also Joseph Abazaami, 2013. *Synergies for Wealth Creation and Poverty reduction through Agriculture in Ghana. The Role of Non-governmental Organisations.* Dortmund, Technische Universität.

[6] UNDP Ghana, 2007. *The Ghana Human Development Report 2007. Towards a More Inclusive Society.* Accra.

[7] Matilda Aberese Ako, Nana Akua Anyidoho, and Gordon Crawford, 2013. NGOs, rights-Based Approaches and the Potential for Progressive Development in Local Contexts: Constraints and Challenges in Northern Ghana. *Journal of Development Practice,* vol. 5, 1.

2.1 TRENDS IN POVERTY AND RIGHT TO SERVICES

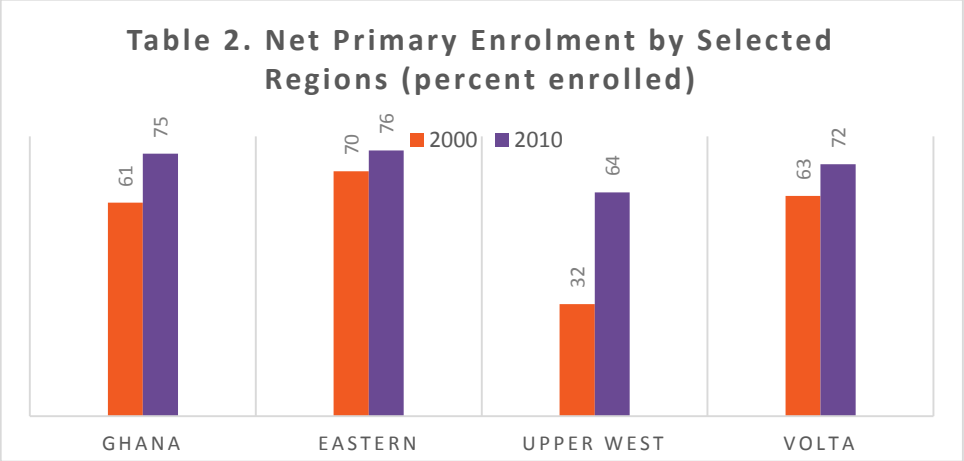
The incidence of poverty over time in Ghana generally and in the regions is illustrated in table 1. These data measures poverty based on consumption.



Source: The Ghana Living Standards Survey up to fifth round, quoted in UNDP 2007, 25.

Table 1 shows a decline in the incidence of in Ghana from 52% at the beginning of the 1990s to 29% in 2005/06. In three of the Northern regions: Upper West (shown here), Northern and Upper East, poverty did not decline, but remained roughly on level with rates in the early 1990s. The Upper West region had the highest incidence of poverty with 88% of the population being classified as poor. In comparison the Eastern region has had a tremendous fall in poverty from a level of 44% in 1998/99 to one of 15% in 2005/06. The Ghana UNDP report attributes this to the social initiatives on cassava, pineapples, and oil palms.[8] With respect to the Volta region, the region where the districts and villages selected for this study are located, poverty incidence fell from 57% in 1991/92 to 31% in 2005/06 (Ibid 25).

[8] UNDP 2007, 25.



Source: Ghana Statistical Service, 2013: 2010 Population and Housing Census Report. *Millennium Development Goals in Ghana*, 19.

Right to education trends. Table 2 depicts the net primary enrolment in 2000 and 2010 for selected regions. Primary school enrolment is a Millennium Development Goal (MDG) indicator, but is also considered by OHCHR an indicator by which to measure education rights.[9] All regions are marked by increasing levels of enrolment into primary schools; in the poorest region, the Upper West, the level of enrolment doubled in the course of the decade, reflecting efforts to fulfil the Millennium Development Goals. Despite this progress, the Upper West remains at a lower level compared to the rest.[10] In the Eastern Region, the increase was small, but the initial level was highest at 70% in 2000. In the Volta Region, the levels 2000 and 2010 were close to the general rates for the country. The gender distribution of enrolment figures did not change much over the decade from 2000 to 2010: the average for Ghana being 0.95 females to males in 2010 and 0.96 in 2000. For the Upper West Region the ratio remained at 0.95, while for the Volta Region, it decreased from 0.96 in 2000 to 0.93 in 2010. The tendency is that the regions with the highest number of urban population are also the ones that experience declines in female participation in primary education.[11]

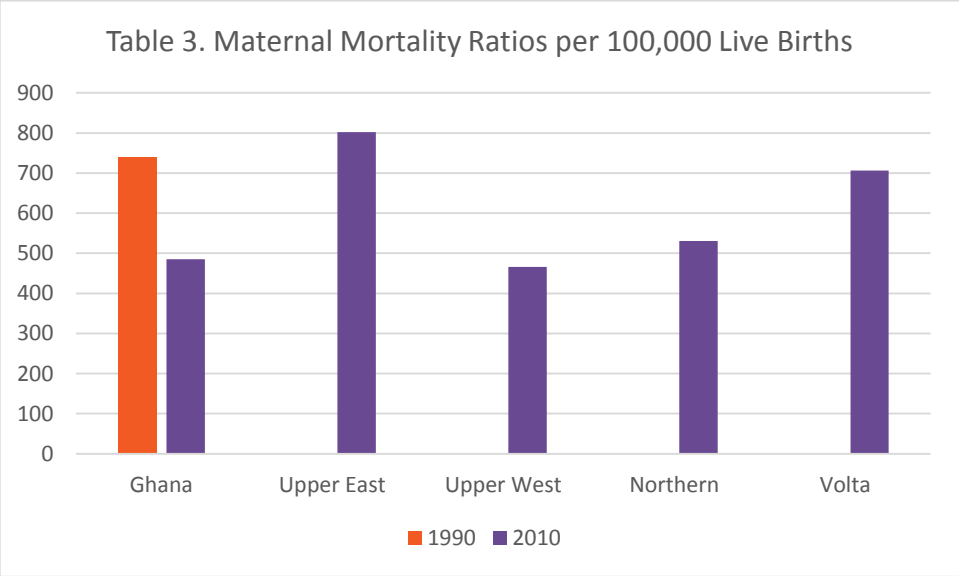
Right to health trends. Concerning the right to health, we shall only depict one MDG indicator that illustrates the health rights, i.e. the development in the maternal mortality

[9] OHCHR 2012, *Human Rights Indicators. A Guide to Measurement and Implementation.* Geneva, UNHCR, 93.

[10] Were the Upper East Region to be included, the marked increase compared to the 2000 level would be roughly similar to that of the Upper West Region, but the former level of enrolment during 2010 is similar to that of the Volta Region, i.e. an increase in the Upper East from 37% to 72%. The poorest region in terms of primary school enrolment is the Northern Region: 32% during 2000 compared to 58% during 2010.

[11] See UNDP, 2007, 76. Quoted supra note 4.

ratio. Other health indicators could be used such as infant or under five mortality ratios, but for brevity, we shall restrict ourselves to one indicator.



Source: Ghana Statistical Service, 2013: 2010 Population and Housing Census Report, 35-36.

The MDG goal was to reduce maternal mortality by 75% between 1990 and 2015. While regional data are not available for 1990, table 3 makes it clear that Ghana is far from realizing this goal. While the 1990 all Ghana level was 740 maternal deaths per 100,000 live births, the 2010 figure for Ghana is 485, i.e. a reduction rate of less than half. Table 3 also illustrates that regions such as Upper East and Volta are still manifesting maternal mortality ratios comparable to the all Ghana level in 1990. Measured by this indicator, fulfilment of the right to health is still generally wanting all over Ghana, but especially in the Eastern parts of the country.

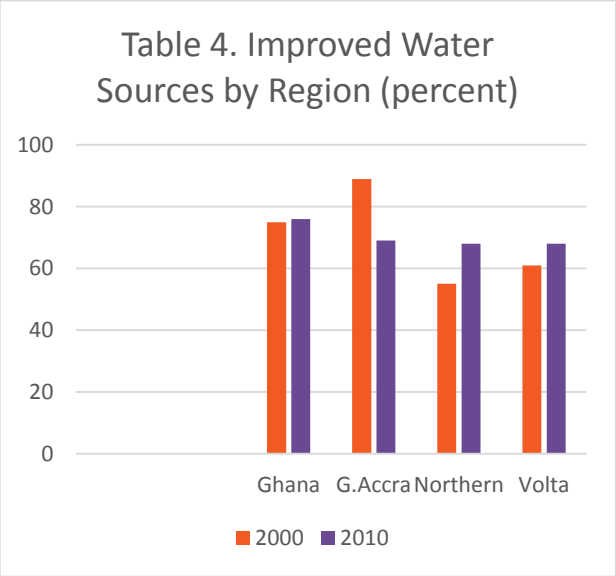
Right to water and sanitation trends. The predominantly positive change in improved water supply by region is shown in table 4. Improved water sources include piped water, public tap, borehole or pump, protected well, protected spring or rainwater.[12]

The decline in the use of improved water sources for Greater Accra illustrates that fact that urban Ghana experienced a decline generally between 2000 and 2010. In contrast, the trend in the Northern and Volta regions is positive as far as improved water sources are concerned as indicated in table 4. The effort to create access to improved water has

[12] Improved water sources do not include vendor-provided water, bottled water, tanker trucks or unprotected wells or springs. See Ghana Statistical Service, 2013, supra table 2, 42.

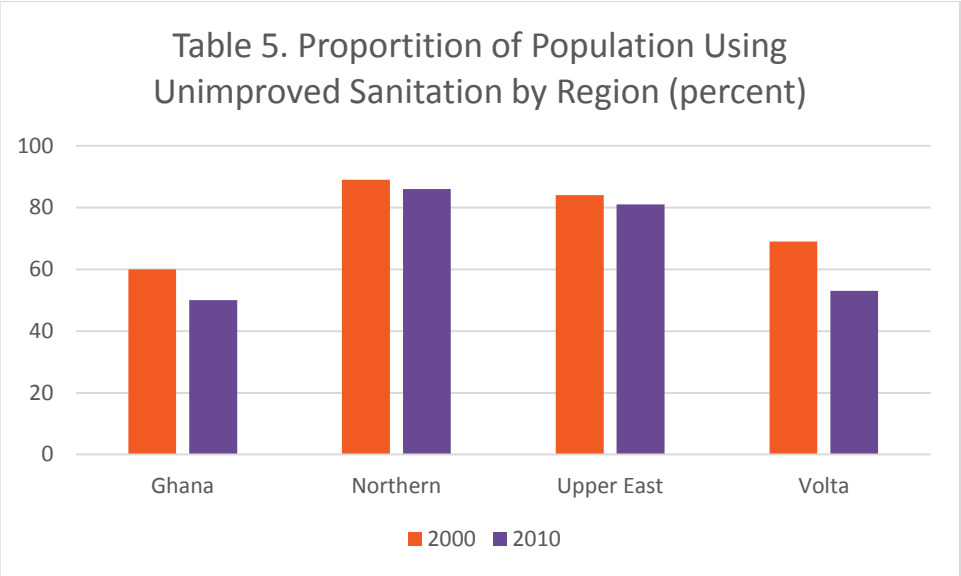
mainly taken place in the rural and more disadvantaged regions in terms of improved water supply.

The data on improved sanitation can be found in table 5. Improved sanitation is defined according to the UN MDG definition, i.e. improved sanitation refers to facilities that separates human excreta hygienically from human, animal and insect contact. Facilities such as sewers or septic tanks, pour flush latrines and simple pit or ventilated improved latrines are assumed to be adequate provided that they are not public (Ghana Statistical Services 2013, 45). Pit latrines without slab or open pit, buckets and open bush defecation are considered unimproved (Ibid. 78).



Sources: UNDP, 2007. *Ghana Human development Report*. 45-46. Ghana Statistical Service, 2013. 2010 Population and Housing Census Report. *Millennium Development Goals in Ghana.* 77 and 41-44.

Table 5, using data from 2010, indicated that Ghana was not likely to reach the MDG target of the 58% share of population with access to improved sanitation by 2015. The table also shows noticeable regional disparities in terms of sanitation. Nationally, the share of population using unimproved facilities fell from 60% to 50%, while the target was 42% by 2015. In the Volta Region, unimproved use fell from 69% to 53%, whereas in the Northern and Upper East regions the decrease of unimproved use was very modest.



Source: Ghana Statistical Service, 2013. 2010 Population and Housing Census Report. *Millennium Development Goals in Ghana.* 78.

3 METHODS

In the section below, we briefly describe the study design and methodology. More substantially, we shall outline the method of measuring poverty and of classifying households according to poverty categories.

3.1 SELECTION OF DISTRICTS AND VILLAGES

Under the Local Service Delivery and Governance Program, Danida supported five regions in rural roads, water and sanitation: Volta, Central Eastern, Greater Accra and Northern. Since 2012, support for water and sanitation has been disbursed through the District Development Fund (DDF). The Volta Region was selected because Danida had previously provided assistance for both water, sanitation and rural roads in this region. However, not all districts in the region were able to meet the district performance criteria that would make them eligible for Danida support.[13] In the Volta Region, therefore, it was possible to

[13] See GoG, Danida, 2012, *LSDGP Local Service Delivery and Governance Programme. 2011 Annual Progress Report.* National Programme Secretariat, Local Government Service Secretariat. – A copy of the districts supported under the rural roads program and the water and sanitation program was provided by the Danish Embassy in Accra.

compare villages in districts that had been supported by water and sanitation services to villages that had not received any such support.

The two villages selected for study were therefore located in two different districts. In Jasikan District, Kudze village was selected because it had received support for water and sanitation under the GoG/Danida Local Service Delivery and Governance Program. The village had also received support via the Danida civil society support for advocacy and participation of citizens. Takrabe village in Biakoye District was selected as a community not receiving targeted district support. Kudze was located 15-20 minutes on a good road from Jasikan town, and Takrabe was located about 30 minutes from Jasikan town on a mostly rough, dusty and winding gravel road.

3.2 QUANTITATIVE DATA

The questionnaire is attached to this report as Annex 1. The study employed a quantitative approach as we were concerned with describing access to services of larger groups classified as poor or non-poor. We were also keen to obtain information of complaints made by different categories of citizens rather than with in depth understandings of the processes under which such complaints were made, treated and resolved.

Altogether 46 households selected were interviewed in Kudze and 39 households in Takrabe. The interviews were undertaken by one of the researchers and four research assistants. Households were selected randomly by walking along four different transects in the villages. Respondents were interviewed in their homes, with each interview lasting about 30 minutes. The survey was undertaken from 23 to 31 January 2015.

3.3 THE METHOD OF MEASURING POVERTY IN THE STUDY

In classifying households, a methodology devised under the Oxford Poverty and Human Development Initiative (OPHI), the so-called Global Multidimensional Poverty Index (MPI) developed by Alkire, Conconi, Seth and Vaz in 2010, which is itself based on methods developed by Alkire, Foster and Santos.[14] MPI data are now available for more than 100 countries accounting for 78% of the world population 2014.

The MPI was developed in cooperation with the team behind the Human Development Report to measure overlapping and simultaneous dimensions of deprivations. Like the

[14] See Sabina Alkire, Adriana Conconi and Suman Seth, 2014. *Multidimensional Poverty Index 2014: Brief Methodological Note and Results.* Available at www.ophi.org.uk/multidimensional-poverty-index. Sabina Alkire and James Foster, 2011. Counting and Multidimensional Poverty Measurement. *Journal of Public Economics,* 95 (7-8), 476-487.

Human Development Index, it measures indicators across three dimensions: health, education and living standards. The effort to develop a multidimensional poverty index was partly inspired by basic needs thinking. Household incomes or expenditures are not part of the measurement.[15]

MPI includes the 10 indicators presented in table 1:

Table 6. The dimensions, Indicators Deprivation Cutoffs, and Weights of the MPI

Dimensions of poverty	Indicator	Deprived if..	Weight
Education	Years of schooling	No household (HH) member has completed five years of schooling	1/6
	Child school attendance	Any school age child is not attending school up to class 8	1/6
Health	Child mortality	Any child has dies in the family	1/6
	Nutrition	Any adult of child for whom there is nutritional information is malnourished	1/6
Living standard	Electricity	The HH has no electricity	1/18
	Improved sanitation	The HH sanitation facility is not improved (according to MDG guidelines), or it is improved, but shared with other HH	1/18
	Improved drinking water	The HH does not have access to improved drinking water (according to MDG guidelines) or safe drinking water is more than a 30-minute walk from home, roundtrip	1/18
	Flooring	The HH has a dirt, sand or dung floor	1/18
	Cooking fuel	The HH cooks with dung, wood or charcoal	1/18
	Asset ownership	The HH does not own more than one radio, TV, telephone, bike, motorbike or refrigerator and does not own a car or truck	1/18

Source: Sabina Alkire and Gisela Robles, 2015. *Multidimensional Poverty Index 2015: brief Methodological Note and Results.*

The questionnaire used in our survey in the Volta Region in Ghana (Annex 1) is slightly adapted to Ghanaian educational systems concerning primary school years and years of schooling. Concerning question six in table 1 under Living standards, the household was considered deprived if it did not own more than one of either radio, TV, mobile phone, or bicycle, or if it did not own either a refrigerator, or a motorbike, car or truck.

[15] Kai-yuen Tsui, 2002. Multidimensional Poverty Indices. *Social Choice and Welfare* 19:69-93.

The MPI index is not formulated in human rights terms explicitly, but the affinity with education, health, water and sanitation access and human rights exist and throw more light on actual human rights situation and poverty than for instance income measures of poverty.

3.4 THE MULTIDIMENSIONAL POVERTY INDEX COMPARED IN THE GHANAIAN CONTEXT

The measurements in Ghana under the Multidimensional Poverty Index have been compared to more conventional poverty measures. The MPI headcount estimate of poverty was at 30.4% of the population for Ghana during 2011, whereas the poverty rate measured at 1.25 USD/day was at 28.6% and the poverty rate according to the national poverty line was 24.2%.Thus for Ghana the MPI estimates poverty at a marginally higher level than other measures, though this trend may not hold in other countries. In the Democratic Republic of Congo and Liberia, for instance, MPI estimates the prevalence of poverty at lower levels than the USD 1.25/day level. [16]

4 THE HUMAN RIGHTS-BASED APPROACH

The human rights-based approach (HRBA) describes a range of development[17] approaches that are all normatively based on human rights while operationally directed towards human rights implementation. Some approaches, such as Danida's[18], focus on the human rights principles of non-discrimination, participation, transparency and accountability as the main tools of implementing the approach, while other international and national NGOs have a selective focus on particular human rights standards such as the right to health, education, or the right not to be subject to torture or ill-treatment. A common feature of HRBA is the effort to spur rights-holders (citizens and people residing in the

[16] See Oxford Poverty and Human Development Initiative, 2015. "Ghana Country Briefing", Multidimensional Poverty Index Data Bank. OPHI, University of Oxford, January. Available at http://www.ophi.org.uk/multidimensional-poverty-index/mpi-2014-2015/mpi-country-briefings/.

[17] HRBA has been mostly applied in development contexts, but national actors like national human rights commissions or institutions in non-developing countries have also been inspired by the concept.

[18] See Danida's development strategy, 2012. *The Right to a Better Life.* Available at http://um.dk/da/~/media/UM/English-site/Documents/Danida/Goals/Strategy/The%20Right%20to%20a%20Better%20Life%20Strategy%20for%20Denmarks%20Development%20Cooperation.jpg.

state) to claim their rights and to prompt duty-bearers (primarily, the state) to live up to their human rights obligations. HRBA will often combine a legal approach with broader processes of mobilizing and empowering rights-holders and of raising the responsiveness of duty-bears. HRBA work is therefore also associated with activism and with efforts to create a collaborative space between rights-holders and duty-bearers.[19]

In Ghana, Anyidoho (2009) recorded the ways in which Ghanaian CSOs responded to the rights-based paradigm. In 2009 when she conducted interviews, the consensus among CSO actors was that HRBA was gaining popularity, but there were only a few groups who considered themselves rights-based organizations. In some organizations the approach generated resistance or conflict, while other welcomed it as a means to gain legitimacy. Generally, the tensions over the approach reflected some reservation towards mainstream (international) interpretation of human rights that some actors saw as conflicting with local interpretations.[20]

4.1 GOVERNMENT OF GHANA AND THE DANIDA PROGRAM ON RIGHT TO SERVICES IN THE STUDY VILLAGES

The Government of Ghana and Danida Local Service Delivery and Governance Programme implemented the sub-component Rural Water and Sanitation component in five regions between 2009 and 2013. Up to 2011 the programme was implemented in collaboration with the Community Water and Sanitation Agency and Environmental Health and Sanitation Directorate, while from 2012 onwards funding was channelled through the District Development fund in an effort to deepen decentralization.

Under the Good Governance and Human Rights Programme, Danida supported efforts to enhance people's rights to participate in their own development. This happened partly via civil society support through STAR Ghana. STAR Ghana is a multi-donor pooled funding mechanism with 150 affiliated civil society organizations (2013). The three objectives of STAR Ghana are: a. Increased citizens' actions at all levels of governance to claim rights; b. increased collaboration between CSOs and targeted independent government institutions to ensure accountability, transparency and responsiveness in delivery of social

[19] See Hans-Otto Sano and Maija Mustaniemi-Laakso (eds.) 'Human rights-based change and the institutionalisation of economic and social rights'. *Nordic Journal of Human Rights* 32(4), 2014, pp.287-290. See also Bård A. Andreassen and Stephen P. Marks (eds.), 2010. *Development as a Human Rights. Legal, Political and Economic Dimensions.* Intersentia 2nd edition. Also Sam Hickey and Diana Mitlin (eds.), 2009. *Rights-Based Approaches to Development. Exploring the Potential and Pitfalls.* Kumarian Press.

[20] See Nana Akua Anyidoho, 2009. *Review of Rights discourses – Ghana.* Human Rights, Power, and Civic Action Research Project, Universities of Oslo, Leeds and Ghana. Mimeo, pp. 27-30. Available at http://www.polis.leeds.ac.uk/assets/files/research/research-projects/anyidoho-review-rights-discourses-march09.pdf.

services, and c. coordinated CSO actions at all levels of governance to influence policy making and implementation at all levels of governance. During 2014 the two previous programmes of Danida, the Local Service Delivery and Governance Programme and the Good Governance and Human Rights Programme, were combined under an exit strategy 2014-2019 labelled The Right to Services and Good Governance Programme.[21]

Volta Region was supported under these programmes as regards water and sanitation and concerning CSO support. [22] In the sections below, we shall seek to trace the impact of these programmes, but doing so from the point of view of the citizens and their access to services in two villages.

5 FIELD VILLAGES

The field work was conducted during the last week of January 2015 in Kudze and Takrebe in the Jasikan District of the Volta Region.

5.1 KUDZE[23]

In selecting Kudze village, we were looking for a village that had benefitted from the water and sanitation support and which was characterized by closeness to the district centre. The village is located about 15-20 minutes car drive from Jasikan town on a tarmacked road that is approximately three miles or five kilometers. According to the 2010 Census, the population was 915 with a total number of households reaching 247 with an average number of people at 3.7/household – a little less than the district average at 4.2

[21] See Government of Ghana and Danida, 2013. *Right top Services and Good Governance Programme RSGGP,* 17.

[22] Danida support was also provided for public works, but we shall not treat this here. See Government of Ghana, Danida, 2012. *Local Service Delivery and Governance Programme. 2011 Annual Progress Report.* Courtesy of Royal Danish Embassy, Accra. Also, Government of Ghana, Danida, 2013. *Local Service Delivery and Governance Programme. 2012 Annual Progress Report.* Royal Danish Embassy, Accra.

[23] There are some variations in how the village is spelled: In the Ghana Statistical Service report from Jasikan District, the village is called Kudze, while the way the name is pronounced is Kudje. We shall use Kudze here as this was the most common local way of spelling the village name. See Ghana Statistical Service, Canadian Cida, and Danida, 2014. *2010 Population and Housing Census. District Analytical Report. Jasikan District.* Available at http://www.statsghana.gov.gh/docfiles/2010_District_Report/Volta/Jasikan.pdf.

people/household. [24] The village stretches along the tarmacked road on both sides for about 1.5 kilometres.

The research team introduced the study to the *mankrado* or village chief, a retired school teacher, who welcomed the work. When he understood that we were working on the right to services, he expressed concerns over the poor quality of education, health and sanitation as well as inadequate water supply. With respect to education, he said there was no pre-basic education; poor educational infrastructure and inadequate number of teachers. He said only two nurses served the village at the clinic, which lacked medicine; patients therefore had to travel to the Jasikan or Wrawra District Hospitals to access better services. He also lamented the youth's apathy towards sanitation. According to him the only public toilet in the village was situated at its outskirt, which created an inconvenient for those who do not live close to the facility. Many residents used the bushes to meet nature's call. There was also no refuse dumpsite in the village. According to the elder, four boreholes served the village, however one of the boreholes was not functioning at the time of the survey.

Following our meeting with the *mankrado*, we visited the clinic. According to the two of the nurses with whom we spoke, the clinic was established by the NGO, Royal Health Organization (ROHEO) and Star Ghana. These two organizations introduced the Patients' Charter, with which they educate and empower people to demand their rights with respect to healthcare. "The charter has put them (health workers) on their toes and has created awareness on the part of the patients", one nurse said. The nurses reiterated some of the issues raised by the *mankrado,* including lack of medicines and poor infrastructure.

The services provided by the Kudze Health Post are family planning, school visits, check-ups for children, home visits, weighing and immunization of babies, general health education, preliminary pregnancy tests, and first aid. Payments are, however, made for consultations, on average 5 cedis[25] per head. Most village residents are registered under the National Health Insurance Scheme (NHIS). It is not applicable to the Health Post, however because it is not adequately resourced to meet the demands under NHIS. Concerning the availability of drugs at the health post, the nurses were expecting that a supply would be delivered soon after the interviews.

[24] See Ibid. Ghana Statistical Service, Jasikan 2014, at 73 and 24.
[25] The exchange rate at the time of the fieldwork was $1 = 3.2 Ghana cedis.

5.2 TAKRABE

Takrabe is also called Takrabe Bowiri. It is located on a bumpy and hilly gravel road a little more than half an hour's drive south-west of Jasikan. Takrabe is located in the Biakoye District. The 2010 Census report from Biakoye does simply not mention Takrabe although it is a distinct settlement cluster. According to satellite imagery, there are more than one hundred households in the settlement which are located on both sides of the gravel road.[26]

A representative of the *mankrado* of Takrabe outlined some of the challenges facing the village including inadequate water supply caused by one of two boreholes being defunct; inadequate teaching staff; poor educational infrastructure, lack of library and generally poor educational standards. He said the village clinic which was built through communal labor lacked adequate health personnel; however a Community Health Posts (CHPS) compound was being established in the village. He lamented the absence of proper refuse dumpsites and public toilets. According to him, many of the residents used pit latrines, which had become breeding places for spitting cobras. This situation he said had caused most of them to use the bushes instead. He related a frightening incident in where one of such cobras spat into the eyes of his little daughter.

5.3 SOCIAL DIVISIONS IN KUDZE AND TAKRABE

Table 7 shows how MPI categories of sample households are distributed in the two villages. While the proportion (43%) of non-poor is the same in the two villages, Takrabe is marked by more households in the poor and severely categories. While in Kudze, there are no sample households living in severe poverty, 10 % of the Takrabe households are severely poor. A higher percentage of households are also poor in Takrabe—30% compared to 24% in Kudze.

Table 7. Kudze and Takrabe Poverty Categories According to MPI Divisions. No. of Households and Percentage Share

Location	Severely Poor	Poor	Vulnerable to poverty	Non-Poor
Kudze (N=46)	0 (0%)	11 (24%)	15 (33%)	20 (43%)
Takrabe (N=40)	4 (10%)	12 (30%)	7 (18%)	17 (43%)
Both Villages (N=86)	4 (5%)	23 (27%)	22 (26%)	37 (43%)

Source: Household surveys January 2015.

[26] The explanation why the Census records do not include this settlement may be that the satellite data for the location is placed a couple of kilometres from the actual settlement in the forest, and not on the road.

Table 8 reports the average age, numbers of female headed households, and average household size for the two broad categories, poor and non-poor according to MPI classifications. The reason why these broad categories are employed is because of the relatively small sample size when measured according to the four MPI categories.

Table 8. Broad Socio-Demographic Distinctions Between Poor and Non-Poor Households in the Two Villages			
	Age	Female-Headed HH	Size of Household
Poor (N=49; 57%)	45.4	26.5%	6.5
Non-poor (N=37; 43%)	47.4	21.6%	5.5

Source: Household surveys January 2015

In the sample, the share of female-headed households and the average household size were higher among the poor (table 8). A distinction between the two villages not reported in table 8 is that the average age of the heads of households is about 10 years older in Kudze compared to Takrabe. The proximity to Jasikan and better economic opportunities may facilitate migration of younger household members out of the rural community.

In the analysis below on access to and use of services, the purpose is to provide evidence on from the questions posed in the two villages concerning two issues: are distinctions evident between respectively the poor and the non-poor households in their access and use of services, and in their perceptions of improvements and problems, and in their propensity to complain about the services in question? In what way are these distinctions reproduced in the two villages? We test for the statistical significance of the sample averages in order to provide evidence of statistically robust differences, but the data of the non-significant statistics are included in the tables below as there may be patterns of differential access and use of services, and of complaints, that can be of interest to the wider audience.

6 WATER ACCESS AND IMPROVEMENTS

The analysis of water services is structured according to access to drinking water sources, household perceptions of improvements in supply, and whether and to whom households have complained about water supply. Finally, household heads have also considered whether corruption prevails in regulating access to or payment for water.

6.1 GENERAL

Table 9 illustrates access to the water, payment for water, perceptions of improvements in water supply sources, perceptions of corruption (actual bribes paid for water services), and propensity to complain among the poor and non-poor groups across the two villages. About 90% of the poor households indicated that boreholes and tube-wells were their households' main source of supply of drinking water. For the non-poor households, 93% had a borehole/tube-well as their main source of supply. Nearly 30% among the poor households had to make 30 minutes or more per round trip for water; among the non-poor households, the proportion was 15.5%. Most households paid for their water, however, the non-poor pay for a higher share of their consumption.

Table 9. Water Supply Sources in Both Villages, Payments, Improvements, Complaints, and Corruption

Category	Water supply source	Payment for water	Improvements	Complaints	Corruption
Poor (N=49)	Borehole 88.9% Unprotc. 3.7% Supply 30 min+ 29.6%	Paid most of supply 85.2%	Yes 29.6% Own effort 0.0% Colct effort 50.0% Vilg aut 50.0% Dist aut 62.5%	Yes 22.2% Because of Vilg aut. 66.7% Dist aut. 33.3% Com.memb 0.0%	Bribe for water service 0%
Non-poor (N=37)	Borehole 93.2% Unprotc. 5.1% Supply 30 min+ 15.5%	Paid most of supply 89.8%	Yes 29.3% Own effort 5.9% Colct effort 35.3% Vilg aut 52.9% Dist aut 47.1%	Yes 32.8% Because of Vilg aut. 42.1% Dist aut. 31.6% Com.memb 10.5%	Bribe for water service 0%

A little less than 30% of the households in both groups consider that improvements in water supply have occurred. While a minority attribute improvements to their individual efforts, a substantial share in the two groups attributed improvements to collective efforts. Among the poor, the efforts of district authorities prevails as the most significant cause of improvements, while the non-poor attribute improvements to village authorities mainly, and to district authorities as a secondary cause.

Almost a third of the non-poor households have made complaints about water supply, while a little less than a quarter of households among the poor have. According to our data, complaints are mainly made to village authorities, especially among the poor

households. Corruption (in terms of bribes for water services) does not occur according to the household members.

In summary, most households procure water from paid and improved water sources, with the more economically advantaged having possibly better access. The latter difference is, however, not statistically significant. Most households are ready to pay for water, again possibly with a bias in favour of the non-poor. A finding is that the non-poor exhibit a stronger propensity to make complaints. However, this finding is not statistically significant at the general level comprising data from both villages. While two thirds of households among the two groups do not perceive significant improvements in water supply, only a small minority, especially among the poor, is apt to forward complaints. This may indicate that those who most need to claim rights to services may be less willing or capacitated to do so[27] and that efforts at empowerment among poorer households have to be stronger. Finally, a reassuring feature is that corruption does not prevail in water services.

How are these trends represented in the individual villages? Again, we use the broad categories of respectively poor and non-poor households in order not to operate with very small and statistically unrepresentative groups.

6.2 KUDZE

In Kudze almost all households obtain water from the boreholes/tubewells in the village and pay for their water (table 10). Only 1 household among the poor fetch water from an unprotected source as the main point of provision. A little less than half of the households in both groups consider that improvements in water supply have occurred. Almost one fifth of the poor and the non-poor households have made complaints about water supply. According to our data, complaints are mainly made to village authorities. Generally in Kudze, there are no marked differences between poor and non-poor households with respect to water supply sources and the other parameters of table 10. Corruption does not occur with respect to water supply according to the household interviews in Kudze.

Table 10. Water Supply Sources in Kudze, Payments, Improvements, Complaints, and Corruption

Category	Water supply source	Payment for water	Improvements	Complaints	Corruption
Poor (N=26)	Borehole 96.2% Unprotc. 3.8%	Paid most of supply 96.2%	Yes 48.0%	Yes 19.2%	Bribe for water service 0%

[27] Ako, Anyidoho & Crawford, 2012.

	Supply 30 min+ 3.8%				
Non-poor (N=20)	Borehole 100.0% Unprotc. 0.0% Supply 30 min+ 0.0%	Paid most of supply 95.0%	Yes 45.0%	Yes 20.0%	Bribe for water service 0%

In summary, almost all households procure water from paid and improved water sources. A reassuring feature is that corruption does not prevail in water services.

6.3 TAKRABE

Table 11 illustrates access to the water, payment for water, perceptions of improvements in water supply sources, perceptions of corruption (actual bribe payment for water services), and propensity to complain among the poor and non-poor groups in Takrabe.

In Takrabe most households obtain water from the boreholes/tubewells in the village and pay for their water. However, the distinction between poor and non-poor households is more pronounced in Takrabe compared to Kudze. More than one fifth of the poor households in Takrabe obtain water from unprotected sources according to our data. More than 40% of the poor households have 30 minutes or more per round trip to fetch water. Almost one third of the non-poor households in Takrabe have a similar long distance to water sources.

The propensity to make complaints about water is markedly different when the poor (13%) are compared to the non-poor households (71% nearly) in Takrabe. This finding is statistically significant. Most complaints are directed to district and village authorities. Corruption does not occur with respect to water supply according to the household interviews in Takrabe.

Table 11. Water Supply Sources in Takrabe, Payments, Improvements, Complaints, and Corruption

Category	Water supply source	Payment for water	Improvements	Complaints	Corruption
Poor (N=22)	Borehole 78.3% Unprotc. 21.7% Supply	Paid most of supply 78.3%	Yes 4.3%	Yes 13.0%**	Bribe for water service 0%

	30 min+ 41.4%				
Non-poor (N=17)	Borehole 97.5% Unprotc. 5.6% Supply 29.4% 30 min+	Paid most of supply 88.2%	Yes 12.0%	Yes 70.6%**	Bribe for water service 0%

Note: Figures marked with one asterisk indicates statistical significance at 0.1, while two asterisks indicate significance at 0.05.

In summary, more households in Takrabe procure water from unsafe sources especially among the poor households. A substantial proportion among the poor, though, appear to prefer the borehole and thus pay for their water. Apart from the costs of water, the price of access to safe water is the long distances that more than 40% households in Takrabe have to walk to get clean water. Even among the non-poor households, long distances prevail among nearly one third of the households. The data from Takrabe on complaints reveal that poor households very infrequently make complaints (13%) compared to the non-poor (71%). The capability to make one's voice heard on relevant issues is strongly related to poverty and socio-economic position. It is not possible to assume that just informing villagers on their rights will create processes of stronger voice or empowerment. In a village like Takrabe which has not been favoured by any recent efforts to improve access to water, the poorer groups are mostly silent concerning their predicament of long distance and unsafe water.

Generally, while the data from Kudze indicate use of improved water supply services at a level above the 65% average for the Volta region in 2010 (see table 4), the data for Takrabe indicate a somewhat higher than average Volta region use of improved water sources, but this has to be qualified by the fact that a substantial share of householders have long distance to walk to collect water.

7 SANITATION ACCESS AND IMPROVEMENTS

The section on sanitation access is structured according to the same outline as the analysis of access to water. We shall examine household sanitation use, whether there are perceptions on improvements, and whether and to whom households have complained

about the sanitation situation. Corruption in the supply of improved sanitation is also examined.

7.1 GENERAL

Table 12 provides information on the categories of sanitation in use and on perceptions of improvements. The table also records whether householders have complained, whom they see as responsible for inadequacy, and whether bribes were paid.

Table 12. Sanitation Supply Sources in Both Villages, Improvements, Complaints, and Corruption

Category	Sanitation supply source	Improvements	Complaints	Corruption
Poor	Pit latrine ventilated: 11.1%* Pit latrine With slab: 44.4%* No facility, Bush: 44.5%*	Yes 30.8%** Own eft 25.0% Colct eft 37.5% Vilg aut 12.5% Dist aut 50.0%	Yes 14.8% Because of Vilg aut. 50.0% Dist aut. 50.%	Bribe sanitation services 0%
Non-poor	Pit latrine ventilated: 28.8%* Pit latrine With slab: 44.1%* No facility, Bush: 23.7%* Other: 3.4%*	Yes 46.6%** Own eft 22.2% Colct eft 37.0% Vilg aut 40.7% Dist aut 29.6%	Yes 31.0% Because of Vilg aut. 66.7% Dist aut. 47.1%	Bribe for sanitation services 1.7%

Note: Figures marked with one asterisk indicates statistical significance at 0.1, while two asterisks indicate significance at 0.05 or below.

About 45% of poor households interviewed in the two villages rely on bush or unimproved facilities, while the corresponding share of unimproved sanitation among the non-poor is 24%. Distinctions also prevail concerning perceptions of improvement in sanitation; 31% of the poor reported improvements compared to about 47% for the non-poor. This finding is significant. The perceived sources of the improvements were similar among poor and non-poor households in the two villages; however, while the non-poor attributed positive change to both district and village authorities, the poor accorded village authorities a lesser role. As in the case of water provision, a bigger proportion of non-poor households

complained sanitation supply compared to the poor. However, this finding could not be confirmed as statistically significant. One household had paid a bribe.

7.2 KUDZE

Table 13. Sanitation Supply Sources in Kudze, Improvements, Complaints, and Corruption

Category	Sanitation supply source	Improvements	Complaints	Corruption
Poor (N=26)	Pit latrine ventilated: 27.0%** Pit latrine With slab: 50.0%** No facility, Bush: 25.0%** Other: 0.04%**	Yes 35.2%** Own eft 0.04% Colct eft 11.5% Vilg aut 15.4% Dist aut 19.2%	Yes 19.2% Because of Vilg aut. 15.4% Dist aut. 11.5%	Bribe sanitation services 0%
Non-poor (N=20)	Pit latrine ventilated: 65.0%** Pit latrine With slab: 25.0%** No facility, Bush: 10.0%** Other: 0.05%**	Yes 80.0%** Own eft 15.0% Colct eft 35.0% Vilg aut 35.0% Dist aut 25.0%	Yes 33.0% Because of Vilg aut. 15.0% Dist aut. 0.05%	Bribe for sanitation services 0.05%

The distinctions between poor and non-poor households in Kudze with respect to sanitation is marked statistically significant. While 25% of the poor households use non-improved sanitation facilities, nearly 90% of the non-poor households benefit from improved facilities, and only 10% from non-improved sanitation, i.e. two households. With respect to the poor households, the data only in part confirm the statement of the *mankrado* "that many patronize the bush". As much as 80% of the non-poor households reported improvements in the sanitation situation in their village, while 35% of the poor households saw improvements. These perceptions can be related to district support for the construction of public sanitation. Most improvements are related to efforts of village or district authorities. Typically the non-poor attributed improvements also to own efforts, while the poor households did not seem to have resources for own improvements.

The poor households attributed improvements more to the efforts of district authorities, while the opposite was true of the non-poor. Collective efforts seemed to be more important for the non-poor, but they attributed improvements in sanitation to both village and district authorities as well.

In terms of complaints, the pattern from the water sector is also found with respect to sanitation. While on third of the non-poor households made complaints, only 20% of poor households did so. However, this finding was not statistically significant. One non-poor household complained about corruption in provision of sanitation services. The household head had had to pay 5 cedis in order not to be arrested for improper handling of household refuse.

7.3 TAKRABE

The pattern appearing from the Takrabe data is more negative regarding sanitation services as the data demonstrate worse sanitation services compared to Kudze. The data also indicate much more modest interpretations of improvements, both among the poor and the non-poor households. As in Kudze, the non-poor households in Takrabe exhibit a greater propensity to make complaints over sanitation; that is to say, those who suffer most from inadequate sanitation complain the least.

Table 14. Sanitation Supply Sources in Takrabe, Improvements, Complaints, and Corruption

Category	Sanitation supply source	Improvements	Complaints	Corruption
Poor (N=23)	Pit latrine ventilated: 0.0% Pit latrine With slab: 43.5% No facility, Bush: 56.5% Other: 0.0%	Yes 21.7% Own eft 0.09% Colct eft 0.04% Vilg aut 0.00% Dist aut 19.2%	Yes 17.4%* Because of Vilg aut. 15.4% Dist aut. 0.09%	Bribe sanitation services 0%
Non-poor (N=17)	Pit latrine ventilated: 0.0% Pit latrine With slab: 64.7% No facility, Bush: 35.3% Other: 0.05%	Yes 29.4% Own eft 17.6% Colct eft 11.8% Vilg aut 0.06% Dist aut 25.0%	Yes 47.1%* Because of Vilg aut. 15.0% Dist aut. 0.00%	Bribe for sanitation services 0%

8 EDUCATION

8.1 GENERAL

The analysis of education was based on household members' completion of primary class 6, junior high school (JHS), senior high school (SHS), and post-secondary education. It also measured the proportion of school-aged children in each household who were not in school. Table 15 summarises the results in this category, showing both proportions and means, as well as the results of tests of significance, using the Pearson's chi-squared and t-tests. The results are interpreted at 0.1 and 0.05 levels of significance. (Figures marked with one asterisk indicate statistical significance at 0.1, while two asterisks indicate significance at 0.05).

Table 15. Educational attainment by type of household

Indicators	*Poor*	*Non-poor*	*P-value*
Any HH members completed class 6? ('yes' responses)	78 % (21)	100 % (59)	0.001**
If yes: Number of HH members completed class 6 (mean)	3.15	3.41	0.637
Any HH members completed JSS? ('yes' responses)	74 % (20)	85 % (50)	0.238
If yes: Number of HH members completed JSS (mean)	2.42	2.64	0.628
Any HH members completed SSS? ('yes' responses)	33 % (9)	44% (26)	0.347
If yes: Number of HH members completed SSS (mean)	1.63	1.69	0.900
Any HH members completed post-SS? ('yes' responses)	11 % (3)	24 % (14)	0.173
If yes: Number of HH members completed post-SS (mean)	1.000	1.643	0.448
Any school-aged children not attending school? ('yes' responses)	28 % (5)	2 % (1)	0.006**

Number of children not attending school (mean across all households)	0.28	0.02	0.033**

Table 15 shows that all household members in non-poor households had completed Primary 6 compared to 78% of poor households, representing a significant difference between the two categories of households. Poor households on average also had a statistically significant higher number of children out of school than non-poor households. However, for types of households, school completion for members tended to decrease at higher levels of education.

On all other indicators shown in table 15 while non-poor household recorded better absolute numbers, the differences were not significant.

Table 16 summarises the results of comparative analyses on education for Kudze and Takrabe.

Table 16. Educational attainment by community

Indicators	*Kudze*	*Takrabe*	*P-value*
Any HH members completed class 6? ('yes' responses)	94 % (43)	93 % (37)	1.000
If yes: Number of HH members completed class 6 (mean)	3.7	3.0	0.176
Any HH members completed JSS? ('yes' responses)	85 % (39)	76% (31)	0.387
If yes: Number of HH members completed JHS (mean)	2.8	2.4	0.312
Any HH members completed SSS? ('yes' responses)	44 % (20)	38 % (15)	0.574
If yes: Number of HH members completed SSS (mean)	1.84	1.47	0.410
Any HH members completed post-SS? ('yes' responses)	24 % (11)	15% (6)	0.301
If yes: Number of HH members completed post-SS (mean)	1.82	1.00	0.108
Any school-aged children not attending school? ('yes' responses)	4 % (1)	14 % (5)	0.219
Number of children not attending school (mean across all households)	0.14	0.04	0.138

The vast majority of members in both Kudze (94%) and Takrabe (93%) households completed Primary 6; an average of 3.7 and 3.0 people per household respectively. The completion rates in both villages reduced as children proceed up the educational level, but there was no significant difference between Kudze and Takrabe in terms of completion at each level.

8.2 SUPPLY OF SERVICES

The analyses in this section are based on responses to questions on payment, improvement and complaints in service delivery of primary education. Comparisons are drawn between poor and non-poor and the two study communities.

Across the two villages, about two-thirds of poor and non-poor households said primary education in the 2013/2014 academic year was free (table 17).

Table 17. Supply of primary education services by type of household

Indicators	*Poor*	*Non-poor*	*P-value*
Is primary education free? ('yes' responses)	60 % (9)	64 % (28)	0.801
Is primary education paid? ('yes' responses)	60 % (9)	46 % (20)	0.330
Extent of problems (mean)	1.53	1.81	0.05**
Improvement? ('yes' responses)	60% (12)	44% (21)	0.222
If yes, improvements due to:			
Parents	33% (4)	24% (5)	0.690
Village authorities	83% (10)	57% (12)	0.249
District authorities	50% (6)	62% (13)	0.506
Other explanations	2% (3)	26% (5)	1.000

With regards to the extent of problems encountered with primary education, there was a statistically significant difference between the households at a 0.05 significance level. In general, poor households reported fewer problems with primary education than the non-poor.

Sixty percent of respondents in poor households reported having seen improvement in primary education in the last five years. Less than half (44%) of non-poor households observed an improvement in that same period, though this did not present a significant difference between the two types of households.

Respondents in both poor and non-poor households credited the improvement in primary education service delivery mainly to village and district authorities, with no significant difference in the frequencies at which these authorities were cited.

Comparing village (table 19), significantly more households in Takrabe (61%) than in Kudze (39%) reported paying for primary education. Households in both Kudze and Takrabe had 'some' problems with education service delivery. However, Takrabe reported a slightly higher average, representing a statistical different.

Households in Takrabe were more likely (86%) to credit village authorities for the improvement in education service delivery than those in Kudze (53%).

Table 18: Payment and improvement in primary education by community

Indicators	*Kudze*	*Takrabe*	*P-value*
Is primary education free?	65 % (20)	61 % (17)	0.763
Is primary education paid?	39 % (12)	61 % (17)	0.091*
Extent of problems (mean)	0.00	0.08	0.005**
Improvement? (Yes)	50% (19)	47 % (14)	0.785
If yes, improvements due to:			
Parents	32 % (6)	21 % (3)	0.698
Village authorities	53 % (10)	86 % (12)	0.067*
District authorities	63 % (12)	50% (7)	0.450
Other explanations	29 % (5)	21% (3)	0.698

8.3 COMPLAINTS ABOUT EDUCATION SERVICE DELIVERY

From the analysis displayed in table 18, more than twice the number of non-poor households (46%) had complained about educational service delivery in the previous year than had poor households (21%), representing a significant difference in rates of complaints. There was no significant differences in the targets of complaints between poor and non-poor households; both categories of households made complaints mostly to school authorities.

Table 19. Complaints about quality of primary education delivery by type of household			
	Poor	*Non-poor*	*P-value*
Complained? ('yes' responses)	21 % (5)	46% (23)	0.057*
If yes, to whom?			
School management	60% (3)	74 % (17)	0.606
Village authorities	40% (2)	57% (13)	0.639
District authorities	60% (3)	26% (6)	0.290
Other parents	40% (2)	22% (5)	0.574

Households in Takrabe were more likely to complain than households in Kudze (table 20). There was a statistical difference between households in Kudze (86%) and Takrabe (21%) in terms of the percentages which complained to village authorities.

There appears to be some disconnect between the sources to which households attributed improvements in primary education and the institutions to whom they directed complaints. Takrabe residents were most likely to credit village authorities for the improvement in education service delivery (table 19), but directed most of their complaints to the school management (table 20). Similarly, residents in Kudze largely credited district authorities for the improvement in education service delivery (table 19) but the majority directed their complaints to village authorities.

Table 20: Complaints about education service delivery by community			
	Kudze	Takrabe	*P-value*
Complained? (Yes)	35% (14)	41% (14)	0.004**
If yes, to whom?			

School management	64% (9)	79% (11)	0.678
Village authorities	86 % (12)	21% (3)	0.001**
District authorities	36% (5)	29% (4)	1.000
Other parents	36% (5)	14% (2)	0.385

9 HEALTH

Analysis for this section focuses on child mortality and undernourishment in MPI poor and non- poor households.

9.1 MORTALITY AND UNDERNOURISHMENT

Table 21 shows that more poor households (42%) reported the death of a child aged 6-15years than non-poor households (14%). There was also a significant different between the proportion of poor households that had malnourished children under-five years (57%) and those in non-poor households (8%).

Table 21: Child mortality and under-5 malnourishment by type of household			
	Poor	*Non-poor*	*P-value*
Any children 6-15 died in family? (yes)	42% (11)	14% (7)	0.006**
Any children below 5 malnourished? (yes)	57% (12)	8% (3)	0.000**
If yes, how can you tell?			
Low weight	75% (9)	33% (1)	0.242
Small height	25% (3)	33% (1)	1.000
Not enough food during hungry season	0% (0)	0% (0)	-
Not enough food all year	0 % (0)	0% (0)	-

9.2 SOURCES OF HEALTH SERVICES

Table 22 shows that both poor and non-poor households reported that household members sought health care overwhelmingly at clinics/hospitals and health posts. There was a significant difference between poor and non-poor households only in terms of use of chemist shops, both as a source of healthcare, and a source used in the last year. It also appear that non-poor households are more likely to seek health services from varied sources, which may be an indication of their ability to pay for health services, even those not covered by the National Health Insurance Scheme.

Table 22: Sources of health services by type of household

	Poor	*Non-poor*	*P-value*
Where do HH members go with health issues?			
Chemist shop	22% (6)	46% (27)	0.037*
Clinic/health post in village	89% (24)	76% (45)	0.173
Town clinic/hospital	100% (27)	97 % (57)	1.000
Local healer/herbalist	33% (9)	49 % (29)	0.170
Faith healers	33% (9)	36 % (21)	0.838
Traditional Birth Attendants	0% (0)	5% (3)	0.549
Health facilities visited last year:			
Chemist shop	26% (7)	46% (27)	0.081*
Clinic/health post in village	59% (16)	58 % (34)	0.887
Town clinic/hospital	93% (25)	86 % (51)	0.495
Local healer/herbalist	26% (7)	44% (26)	0.108
Faith healers	22% (6)	25 % (15)	0.748
Traditional Birth Attendants	0% (0)	2 % (1)	1.000

Table 23 shows a statistical difference that poor households experienced significantly fewer problems than non-poor households.

A majority of both poor (75%) and non-poor (73%) households reported having seen some improvement in health service delivery. Perhaps because of the perceived improvement, only a few members from both poor (19%) and non-poor (21%) complained about the quality of health service delivery. The few complaints there were focused on service

delivery at clinic or health post in village, followed by the town clinics or hospitals. There were no differences in the rates of complaints by household type.

Many respondents in both poor and non-poor households targeted village authorities with their complaints.

Table 23: Improvement, problems and complaints in health service delivery by type of household

	Poor	*Non-poor*	*P-value*
Extent of problems (mean)	1.19	1.54	0.03 **
Improvement? (Yes)	75% (18)	73 % (37)	0.823
Complained? (Yes)	19 % (5)	21% (12)	0.816
If yes, complained about:			
Chemist shop	0% (0)	8 % (1)	1.000
Clinic/health post in village	60 % (3)	92 % (11)	0.191
Town clinic/hospital	60 % (3)	25 % (3)	0.280
Local healer/herbalist	0 % (0)	8 % (1)	1.000
Faith healers	0 % (0)	0% (0)	-
Traditional Birth Attendant	0% (0)	0% (0)	-
If yes, complained to:			
Clinic/health post/hospital management	40 % (2)	33% (4)	1.000
Village authorities	60% (3)	67 % (8)	1.000
District authorities	20% (1)	25% (3)	1.000
Fellow community members	40 % (2)	17 % (2)	0.538

This section presents a comparative analysis of Kudze and Takrabe which is based on the health indicators discussed in the preceding section.

Table 24 shows that significantly more households in Takrabe (38%) than in Kudze (14%) had children under five years who were malnourished. In both communities, many households reported having identified malnourishment mainly by the low weight of the children (75% for Kudze and Takrabe 64%).

Table 24: Child Mortality and under-5 malnourishment by community

Indicators	*Kudze*	*Takrabe*	*P-value*

Any children 6-15 died in family? (yes)	28 % (11)	19% (7)	0.410
Any children below 5 malnourished? (yes)	14 % (4)	38 % (11)	0.043**
If yes, how can you tell?			
Low weight	75 % (3)	64 % (7)	1.000
Small height	50 % (2)	18% (2)	0.516
Not enough food during hungry season	0 % (0)	0 % (0)	-
Not enough food all year	0% (0)	0% (0)	-

9.3 SOURCES OF HEALTH SERVICES

Table 25 summarises the findings on sources from which respondents from Kudze and Takrabe seek health services. Generally, households in both communities patronised the services of modern health facilities more than other sources; the majority of households in both communities sought health services from a clinic or a hospital in the nearest large town. Takrabe residents were significantly more likely to use the health post in their own village, while Kudze residents used faith healers more often than Takrabe residents.

In terms of reported use over the past year, Kudze residents used chemist shops more than Takrabe residents, and the reverse was true for use of village health posts.

Table 25: Sources of health services by community

Indicators	*Kudze*	*Takrabe*	*P-value*
Where do HH members go with health issues?			
Chemist shop	46 % (21)	30% (12)	0.137
Clinic/health post in village	67 % (31)	95 % (38)	0.001**
Town clinic/hospital	96 % (44)	100 % (40)	0.497
Local healer/herbalist	41 % (19)	48 % (19)	0.564
Faith healers	44 % (20)	25 % (10)	0.073*
Traditional Birth Attendants	4 % (2)	3 % (1)	1.000
Health facilities visited last year:			
Chemist shop	50 % (23)	28 % (11)	0.033**
Clinic/health post in village	44 % (20)	75 % (30)	0.003**

Town clinic/hospital	87 % (40)	90 % (36)	0.745
Local healer/herbalist	39 % (18)	38 % (15)	0.877
Faith healers	28 % (13)	20% (8)	0.374
Traditional Birth Attendants	2 % (1)	0 % (0)	1.000

9.4 IMPROVEMENTS AND COMPLAINTS IN HEALTH SERVICE DELIVERY

There is was an observed difference between households in the two communities in regards to health service delivery; households in Kudze reported having had fewer problems than Takrabe.

There was no difference on the other indicators. The majority of households in both Kudze (71%) and Takrabe (77%) reported improvements in formal health service delivery within the last five years. Consequently, only a few respondents from the two communities (Kudze, 24% and Takrabe, 15%) had complained about the quality of health service delivery.

Most complaints were related to service from the village health posts, which may be a function of the extent of use (see table 25). Notably, many (91%) households in Kudze who complained about the quality of health service delivery cited the in-village health post, which might explain they had used it their health posts significantly less than Takrabe residents had used theirs (see table 25).

Table 26: Improvement in and complaints about health service by community

	Kudze	*Takrabe*	*P-value*
Extent of the problem	0.30	0.08	0.030**
Improvement? (Yes)	71% (29)	77% (26)	0.576
Complained? (Yes)	24% (11)	15% (6)	0.297
If yes, complained about:			
Chemist shop	9% (1)	0% (0)	1.000
Clinic/health post in village	91 % (10)	67% (4)	0.515
Town clinic/hospital	36 % (4)	33% (2)	1.000
Local healer/herbalist	9 % (1)	0 % (0)	1.000

Faith healers	0% (0)	0.% (0)	-
Traditional birth attendants	0% (0)	0 % (0)	-
If yes, complained to:			
Clinic/health post/hospital management	46 % (5)	17 % (1)	0.333
Village authorities	82 % (9)	33 % (2)	0.109
District authorities	18 % (2)	33% (2)	0.584
Fellow community members	36. % (4)	0% (0)	0.237

In summary, patronage of formal health facilities in Kudze and Takrabe is high. This might be due to the availability of the facilities and the subsidies under the National Health Insurance scheme. This notwithstanding, one can observe that a number of respondents visit informal health service delivery outlets. It is not clear whether this is linked to satisfaction or whether it is an instance of 'healer shopping'—that is the use of multiple sources of treatment for a single illness, and in particular the use of both biomedicine and 'traditional' methods—which is identified as the predominant approach to health on the African continent.[28]

10 CONCLUSIONS

This report has examined access to services of poor respectively non-poor groups in two villages in Volta region in eastern Ghana. One of the villages, Takrabe, is located in Biakoye District a relatively poor district not benefitting from performance related support, while the neighbouring other village, Kudze, in the more well-to-do Jasikan District was supported not only under local government incentives funding but also by Danida.

[28] See Ama de-Graft Aikins, A. (2005). Healer shopping in Africa: new evidence from a rural-urban qualitative study of Ghanaian diabetes experiences. BMJ 2005; 331:737. Available at http://www.bmj.com/content/331/7519/737.

10.1 THE EXTENT OF DIFFERENCE BETWEEN THE TWO VILLAGES

There are no statistically significant differences between Kudze and Takrabe in terms of water supply and services. The differences between Kudze and Takrabe are more obvious in sanitation supply services than in any other service area studied. A bigger percentage of both the poor and the non-poor in Takrabe (56% and 35%, respectively) used the bush than for Kudze (25% and 10%, respectively). The difference is so wide that the poor in Kudze appear to be better off than the non-poor in Takrabe in terms of sanitation. The implication is that interventions in sanitation services should be community-focused rather than determined by poverty levels.

In general, there is little difference between the two communities in terms of education and health although it does appear that Kudze performs slightly better on both health and education indicators. More people pay for education in Takrabe compared to Kudze. Except for the indicator on payment for education and concerning the extent of the problems where Takrabe households report more problems on primary education, there is no statistical difference between the two communities on the other educational indicators. There is, however, a significant difference between the two communities on under-five malnourishment, with Kudze performing better than Takrabe. Again, there is difference between households in Takrabe and Kudze in terms of sources from which they seek health service; households in Takrabe are more likely to access health care at a clinic/health post in the village, while Kudze residents were more likely to visit a chemist shop.

10.2 THE EXTENT OF GAPS BETWEEN THE POOR AND THE NON-POOR WITHIN THE VILLAGES. WHAT SERVICES ARE MOST UNEQUAL?

There were no clear differences between poor and non-poor households in terms of water supply and services, except in the extent of complaints (discussed in the next session). In terms of sanitation, the difference between poor and non-poor households was is in regard to supply and perceptions of improvements and was only observed in the Kudze sample. In Kudze, non-poor households are more likely to use ventilated pit latrines than poor households, and poor households tend to use the bush. Perhaps not surprisingly, more non-poor households in the village reported improvement in sanitation supply. In general, it is clear that poverty is an important factor in the sources of sanitation supply a household would use. However, an encouraging finding from the data is that poverty does not preclude people from complaining about the service, as we discuss later. This means that if the poor are educated on their rights, they could demand these rights and consequently see some improvements.

There is a gap between relatively poorer households and their wealthier counterparts on some education indicators. More children in non-poor households completed primary education compared to their poorer counterparts; conversely, more school going children in poorer households were out of school. This suggests that gaps which are identified in terms of education are household-based rather than community-based and any intervention in these areas must target poorer households.

The health indicators follow a similar trend where the differences exist more between the poor and non-poor households instead of between communities. Table 21 presents statistically significant differences between households in terms of death of children aged 6-15 years and children under-five years. Although both poor and non-poor households sought health care overwhelmingly at clinics/hospitals and health posts, non-poor households did so from multiple sources. This could be an indication that of households choose to exercise their access to a range of health care sources if they have the financial resources.

Overall, Takrabe has comparatively poorer services than Kudze with respect to sanitation, health conditions of children under five and, to an extent, education. The village with the biggest proportion of poor households was also the one where rights to services were less well protected.

10.3 DISTINCTIONS IN TERMS OF COMPLAINTS BEHAVIOUR WITHIN AND BETWEEN THE VILLAGES

Generally, our data indicate that poor households are less inclined to make complaints compared to their non-poor fellow households. This is evident from Table 27 which summarizes our findings on complaints behaviour from the previous analysis. The last two columns of the table indicate the marked distinctions between respectively poor- and non-poor households with respect to making complaints. With respect to education, the finding is statistically robust (p-value at 0.06). Concerning health services, the complaints behaviour is broadly similar among poor- and non-poor households, whereas distinctions are evident with respect to water and sanitation.

Table 27 also provides an overview over complaints behaviour in the two villages. There are statistically significant differences between complaints forwarded by the poor and the non-poor in Takrabe, with the exception on the right to health. The poor are systematically less likely to make complaints compared to the non-poor regarding water, sanitation, and primary education. In Kudze, a relatively larger proportion of the poor make complaints compared to the non-poor with respect to health. This may be explained by the efforts of ROHEO to introduce Patient's Charter in Kudze. This observation would need more qualitative research to be substantiated. For all other services, the data

indicate a similar pattern as in Takrabe with the non-poor complaining more than the poor. However, none of findings in Kudze are statistically significant as the differences in complaints behaviour in this village are not that big.

Table 27. Complaints over Services between Kudze and Takrabe and between the Poor and the Non-Poor

	Kudze	Takrabe	Poor	Non-Poor
Water	Poor: 19.2% Non-Poor: 20.0%	Poor 13.0%** Non-Poor 70.6%**	22.2%	32.8%
Sanitation	Poor: 19.2% Non-Poor: 33%	Poor: 17.4* Non-Poor: 47.1*	14.8%	31.0%
Primary Education	Poor: 36.4% Non-Poor: 33.0%	Poor: 21.1%** Non-Poor: 68.8%**	21.0%*	46.0%*
Health	Poor: 32.0% Non-Poor: 15%	Poor: 13.0% Non-Poor: 17.6%	19.0%	21.0%

What does this mean? First, it is important that improved services in Kudze might have implied a levelling of the playing field with respect to water and sanitation, education and health. In Takrabe, access to improved services are generally poorer. This might be the reason why such high percentages of the non-poor are recorded to make complaints in Takrabe compared to Kudze.

Second, the data also reveal that complaint behaviour is likely to be differentiated between the poor and the non-poor households in the sense that the poor are more reluctant or less active in forwarding complaints.

An important implication of this is that human rights-based work which also centres on the ability of rights-holders to make complaints must take into account that social differentiation may prevent particular groups from making a straightforward effort to claim their rights. Human rights-based work should integrate methods of targeting in this sense.

10.4 THE EFFECTIVENESS OF HRBA IN THE WAY IT WAS APPLIED IN VOLTA REGION ACCORDING TO THESE TWO CASES

The effectiveness of a human rights-based approach as it has been applied as a result of Danida support is localized to particular districts. In our two case villages, Danida support has been given to the village which was also favoured by the government under the FOAT criteria. I.e. in the localized form in which it has been applied in the Volta Region, human rights-based support did not seek to redress distinctions between districts and communities which already favoured communities which in our cases also proved to be

the more affluent ones. The HRBA support did not serve to ameliorate already existing distinctions under the governance performance scheme of the FOAT criteria. In terms of poverty reduction, the analysis provides indicative evidence that, where operational locally, the human rights-based approach contributed in making access to sanitation, education, and health services more equitable with the result that an indicator such as under five malnourishment was significantly more positive in the community which had benefitted from human rights-based support. The analysis does not, however, rule out the possibility that the results obtained in Kudze could have been achieved by other strategies than a human rights-based approach.

The analysis also showed that targeting of the poor is generally warranted even when applying a human rights-based approach. The poor are served with less optimal services in sanitation, education and health compared to the non-poor. Furthermore, the analysis shows that the poor a less apt to make complaints compared to the non-poor. Rights-holders demanding their rights cannot be taken for granted, even given levels of awareness-raising about rights.

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ANNEXES

Annex 1

[Office use: ID# _____]

GHANA RIGHT TO SERVICES AND GOOD GOVERNANCE

Household Questionnaire

A Meta data

A1 Date: _____/_____/2015
(Day/Month/Year)

A2 Enumerator's name: _____

B Location

B1 District: _____

B2 Town/village name: _____

C Personal Information: Head of Household

C1 Age: _____years

C2 Sex: Male (1) _____ Female (2) _____

C3 Total number of people living in household in 2014: _____
… of which:

C3a ____ Number of children aged 0-5 years

C3b ____ Number of males aged 6-17 years

C3c ____ Number of females aged 6-17 years

C3d ____ Number of males 18 years and above

C3e ____ Number of females 18 years and above

C4 How many years have you lived in this community? _____

C5a Where did you live before? _____(district)

C5b _____(region)

D Multidimensional Poverty Index

D1 Multidimensional Poverty Index: Education indicators

D1a Have any household members completed primary class 6?

Yes (1)_____ No (0)_____

D1aI If yes, how many? _____

D1b Have any household members completed Junior Secondary School/Middle School?

Yes (1)_____ No (0)_____ No answer, not applicable (99) _____

D1bI If yes, how many? _____

D1c Have any household members completed Senior Secondary School/O Level/A Level?

Yes (1)_____ No (0)_____ No answer, not applicable (99) _____

D1cI If yes, how many? _____

D1d Have any household members completed a post-secondary school degree, diploma or certificate (e.g. university, agric college, training college, polytechnic, etc.)

Yes (1)_____ No (0)____ No answer, not applicable (99) _____

D1dI If yes, how many? _____

D1e Are there any children between 6 and 15 years in the household ***not*** attending school?

Yes (1)_____ No (0)_____ No answer, not applicable (99) _____

D1eI If yes, how many? _____

D2 Multidimensional Poverty Index: Health indicators

D2a Have any children (0 to 15 years) died in the family?

Yes (1)_____ No (0)_____ NA/Don't know (99)_____

D2b Are any children below 5 years malnourished?

Yes (1)_____ No (0)_____ NA/Don't know (99)_____

D2c If yes, how can you tell they are malnourished? (tick off one or more options)

D2c_1 Low weight in children _____

D2c_2 Small height _____

D2c_3 Not enough food during hungry season_____

D2c_4 Not enough food all year _____

D3 Multidimensional Poverty Index: Living standards

D3a Does the household have electricity?
Yes (1)_____ No (0)_____

D3b Does the household have a dirt, sand or dung floor?
Yes (1)_____ No (0) _____

D3c Does the household cook with dung, wood or charcoal?
Yes (1)_____ No (0)_____

D3cI If No _____, what other energy sources _____

D3d Does the household own…

D3dII More than one TV?
Yes (1) _____ No (0) _____

D3dIII More than one mobile phone?
Yes (1) _____ No (0) _____

D3dIV More than one bicycle?
Yes (1) _____ No (0) _____

D3dV More than one motorbike?
Yes (1) _____ No (0) _____

D3dVI Does the household own a refrigerator?
Yes (1) _____ No (0) _____

D3dVII Does the household own a car or truck?
Yes (1) _____ No (0) _____

E Status questions beyond MPI

E1 Are you a member of an association? Yes (1) _____ No (0)_____

E1I In case of yes, what organization? _____
_____
_____

F Supply of services

F1 Primary education

F1a Where did your children go to primary school during the 2013/2014 academic year?

Location: _____ NA (99)_____

(town/village) _____

_____

F1b Did you pay for their schooling during the academic year 2013/2014?

Free (1) _____ Paid (2)_____ NA (99)_____

F1bI If paid, how much: _____ cedis

F1c In your opinion, what is the extent of problems that your household has encountered with respect to primary education?

Many (3)_____ Some (2)_____ Few (1)_____ None (0)_____ NA (99)_____

F1d In your opinion, have you seen an improvement in primary education the last five years?

Yes (1)_____ No (0)_____ NA (99)_____

If yes…:

F1dI What kind of improvement? _____

_____

F1dII Are improvements due to efforts of: ***(tick one or more options)***

F1dII_1 Parents_____

F1dII_2 Village authorities _____

F1dII_3 District authorities _____

F1dII_4 Other explanations _____

F1e Have you or another member of your household complained to someone about the quality of primary education service during the last three years?

Yes (1)_____ No (0)_____ NA (99)_____

F1eI If yes: To whom did you complain? ***(tick one or more options)***

F1dI_1 School management_____

F1dI_2 Village authorities _____

F1dI_3 District authorities _____

F1dI_4 Other parents _____

F2 Health

F2a Where do you go when household members have health issues? ***(tick one or more options)***

F2a_1 Chemist shop

F2a_2 Clinic/health post in village _____

F2a_3 Town clinic/hospital _____

F2a_4 Local healer/herbalist _____

F2a_5 Faith healers (church, mallam, spiritualist)_____

F2a_6 Traditional birth attendants_____

F2b During 2014, which health facilities did household members visit and what did you pay? ***(tick one or more options;*** *and provide amounts)*

F2bI_1 Chemist F2bII_1 paid how much? _____

F2bI_2 Clinic/health post in village _____ F2bII_1 paid how much? _____

F2bI_3 Town clinic/hospital _____ F2bII_2 paid how much? _____

F2bI_4 Local healer/herbalist_____ F2bII_3 paid how much? _____

F2bI_5 Faith healers (church, spiritualist)_____ F2bII_3 paid how much? _____

F2bI_6 Traditional birth attendants_____ F2bII_3 paid how much? _____

F2c In your opinion, what is the extent of problems your household has had with respect to health services?

Many (3)_____ Some (2)_____ Few (1)_____ None (0)_____ NA (99)_____

F2d Have you seen an improvement in formal health services in the last five years?

Yes (1)_____ No (0)_____ Don't know (3) _____ NA (99)_____

F2e Have you or any member of your household complained to someone about the quality of health services during the last three years?

Yes (1)_____ No (0)_____ NA (99)_____

F2eI If yes: What did you complain about? ***(tick one or more options)***

F2eI_1 Chemist
F2eI_2 Clinic/health post/hospital management ___
F2eI_3 Hospital/clinic in town _____
F2eI_4 Local healer/herbalist_____
F2eI_5 Faith healers (church, spiritualist)_____
F2eI_6 Traditional birth attendants_____

F2eII If yes: To whom did you complain? ***(tick one or more options)***

F1dII_1 Clinic/health post/hospital management___
F1dII_2 Village authorities _____
F1dII_2 District authorities _____

F1dII_3 Fellow community members _____

F3 Sanitation supply

F3a What kind of toilet facility did members of the household usually use in 2014?

(*pick ONE option ONLY*)

Flush /Pour flush:

Flush to piped sewer (1) _____

Flush to septic tank (2) _____

Flush to pit latrine (3)_____

Flush to unknown place (4) _____

Pit latrine:

Ventilated (5)_____

Pit latrine with slab (6)_____

Composting toilet (7)_____

Bucket (8)_____

Hanging toilet (9)_____

No facility, bush, field (10) _____

Other (11) _____

F3aI If other, specify _____

F3b In your opinion, what is the extent of problems your household has had with respect to sanitation services?

Many (3)_____ Some (2)_____ Few (1)_____ None (0)_____ NA (99)_____

F3c In your opinion, have you seen an improvement in sanitation services of the household the last five years?

Yes (1)_____ No (0)_____

If yes…:

F3cI What were the reasons for improvements? (tick off one or more options)

F3cI_1 Your own efforts in the household _____

F3cI_2 Collective action of community members___

F3cI _3 Village authorities _____

F3cI _4 District authorities _____

F3cII Please specify the improvements: _____

_____

F3d Have you or another member of your household complained about the quality of sanitation services during the last three years?

Yes (1)_____ No (0)_____

If yes:

F3dI What did you or other household members complain about?

(tick off one or more options)

F3dI _1 Inadequate attention by village authorities _

F3dI _2 Inadequate attention by district authorities_

F3dβ If yes: To whom did you complain? (tick off one or more options)

F3dII_1 Village authorities _____

F3dII_2 District authorities _____

F4 Water supply

F4a What is the **main** source of drinking water for members of your household? (*pick one option only*)

Piped water:

Piped water into dwelling (1) ___

Piped into compound, yard or plot (2) ___

Piped to neighbor (3) ___

Public tap/standpipe (4) _____

Borehole/tube well(5) ____

Dug well:

Protected well (6) _____
Unprotected well (7) _____

Water from spring:

Protected spring (8) ____
Unprotected spring (9) _____
Rain water collection (10) _____
Tanker-truck (11) ____
Cart with tank/drum (12) ____
Surface water (river, stream, dam, lake, pond, canal, irrigation channel) (13) _____
Bottled or sachet water (14) ____

F4b Is safe drinking water more than 30 minutes away (roundtrip)?

Yes (1)_____ No, no closer (0) _____

F4c Did you pay for water during 2014?

No, I did not pay for water (0) _____
Yes I paid for most of my supply (1)_____
Yes, I paid for about half of my supply (2) _____
Yes, I paid for less than half of the supply (3) _____

F4cI: In case of payment, how much would you estimate that the household has paid for water, on average, *per week* in 2014?

_____ cedis

F4d In your opinion, what is the extent of problems your household has had with respect to water supply services?

Many (3)_____ Some (2)_____ Few (1)_____ None (0)_____ NA (99)_____

F4e In your opinion, have you seen an improvement in household's water supply services the last five years?

Yes (1)_____ No (0)_____

If yes…:

F4eI What were the reasons for improvements? (tick off one or more options)

F4eI _1 Your own efforts in the household _____
F4eI_2 Collective efforts of community members__

F4eI _3 Village authorities _____
F4eI _4 District authorities _____

F4eII Please specify the improvements:_____
_____

F4f Have you or another member of your household complained about the quality of water supply services during the last three years?
Yes (1)_____ No (0)_____
If yes:

F4fI What did you or other household members complain about? ***(tick one or more options)***

F4fI_1 Inadequate effort by village authorities____
F4fI_2 Inadequate effort by district authorities____
F4fI_2 Inadequate effort by community members_

F4fII If yes: To whom did you complain? ***(tick one or more options)***

F4fII_1 Village authorities _____
F4fII_2 District authorities _____
F4fII_3 Fellow community members _____

F5 Corruption and the supply of services

F5a Last year (2014), did you or any member of your household pay any bribes in relation to education?
Yes (1)_____ No (0)_____
If yes:
F5ai In order to obtain what: _____
F5aii Monetary amounts, total in 2014 (estimate): _____

F5b: Last year (2014), did you or any member of your household pay any other contributions in order to obtain something in relation to education? (gifts, crops, cattle and poultry, sexual favours)
Yes (1)_____ No (0)_____
If yes:
F5bi In order to obtain what: _____
F5bii Please specify contribution:_____

F5c: Last year (2014), did you or any member of your household pay any bribes in relation to health services?

Yes (1)_____ No (0)_____

If yes:

F5ci In order to obtain what: _____

F5cii Monetary amounts, total in 2014 (estimate):

_____

F5d: Last year (2014), did you or any member of your household pay other contributions in order to obtain something in relation to health services? (Gifts, crops, cattle and poultry, sexual favours)

Yes (1)_____ No (0)_____

If yes:

F5di In order to obtain what:_____

F5dii Please specify contribution:_____

F5e: Last year (2014), did you or any member of your household pay any bribes in relation to sanitation services?

Yes (1)_____ No (0)_____

If yes:

F5ei In order to obtain what: _____

F5eii Monetary amounts, total in 2014 (estimate):_____

F5f: Last year (2014), did you or any member of your household pay other contributions in order to obtain something in relation to sanitation services? (Gifts, crops, cattle and poultry, sexual favours)

Yes (1)_____ No (0)_____

If yes:

F5fi In order to obtain what: _____

F5fii Please specify contribution:_____

F5g: In the year 2014, did you or any member of your household pay any bribes in relation to water services?

Yes (1)_____ No (0)_____

If yes:

F5gi In order to obtain what: _____

F5gii Monetary amounts, total in 2014 (estimate): _____

F5h: In the year 2014, did you or any member of your household pay other contributions in order to obtain something in relation to water services? (Gifts, crops, cattle and poultry, sexual favours)

Yes (1)_____ No (0)_____

If yes:

F5hi In order to obtain what: _____

F5hii Please specify contribution: _____

F5i In the year 2014, did you or any member of your household pay any bribes in relation to law enforcement?

Yes (1)_____ No (0)_____

If yes:

F5ii In order to obtain what: _____

F5iii Monetary amounts, total in 2014 (estimate): _____

F5j: In the year 2014, did you or any member of your household pay other contributions in order to obtain something in relation to law enforcement? (Gifts, crops, cattle and poultry, sexual favours)

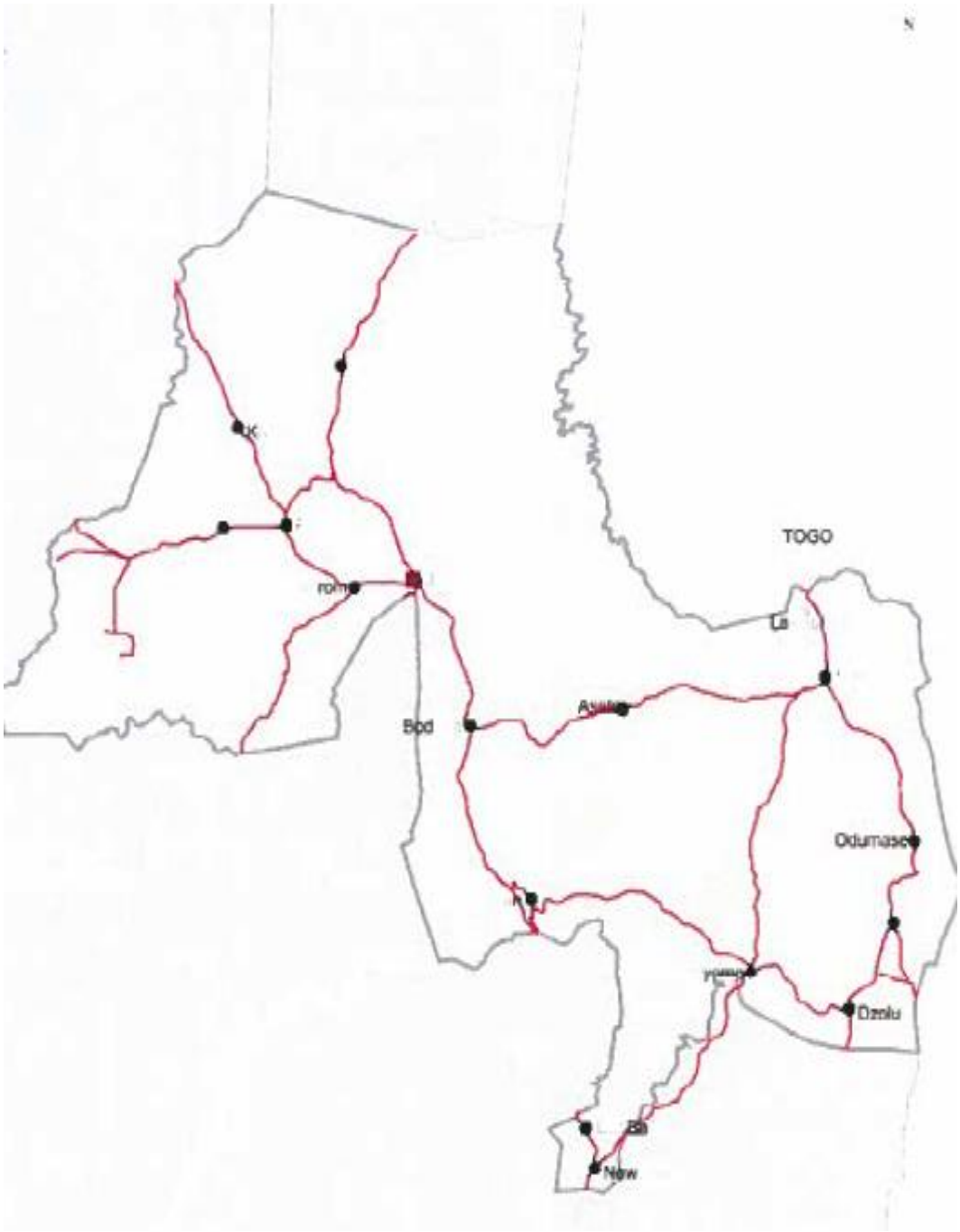
Yes (1)_____ No (0)_____

If yes:

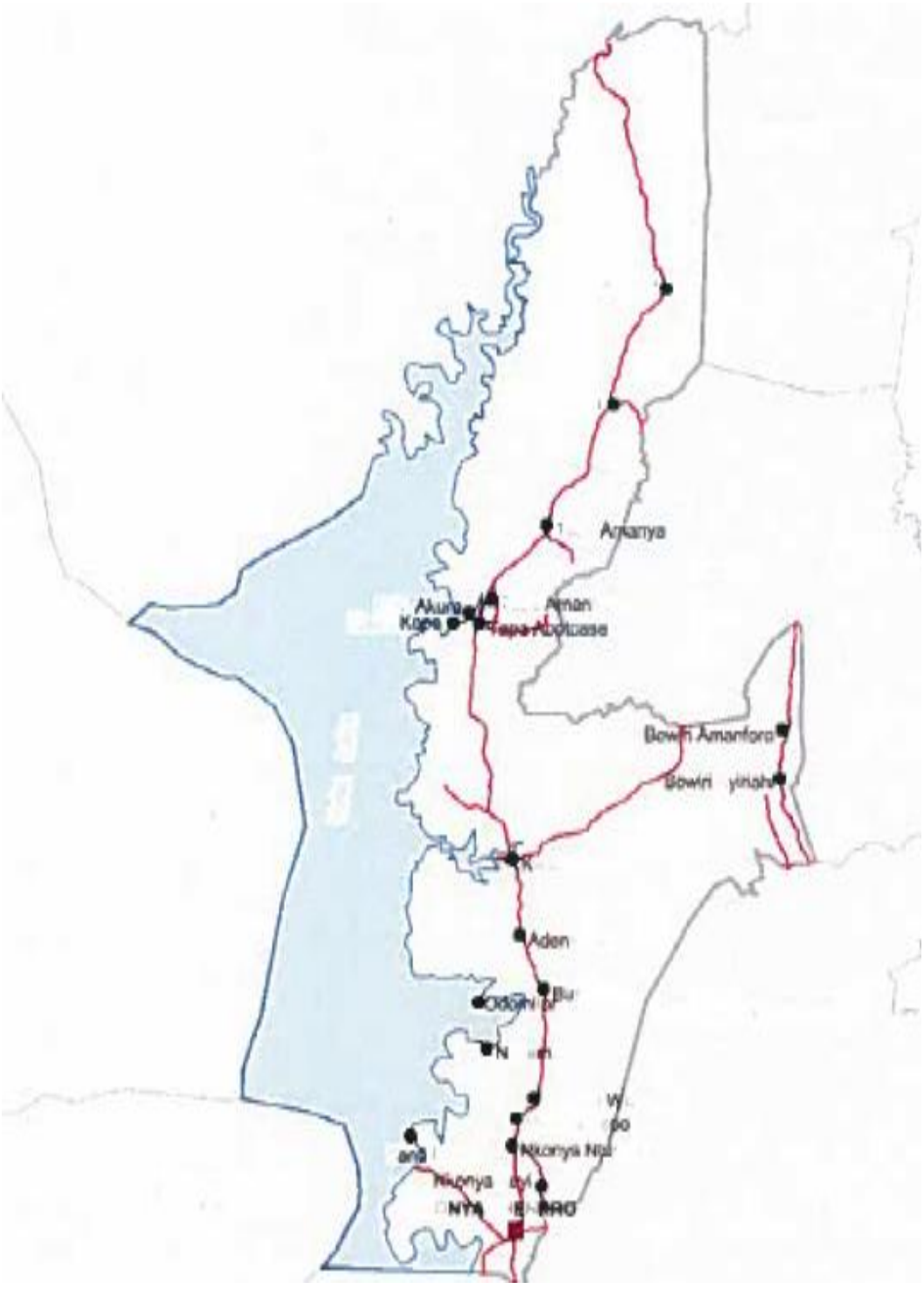
F5ji In order to obtain what: _____

F5jii Please specify contribution: _____

Annex 2 District Maps of Jasikan



Annex 3 District Map of Biakoye

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