

Reality Check Approach: Baseline Study

EXTERNAL IMPACT EVALUATION OF THE
MILLENNIUM VILLAGES PROJECT,
NORTHERN GHANA

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Results in development



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Acronyms

CHPS	Community-Based Health Planning and Services
DFID	UK Department for International Development
FHH	Focal Household
F/HHH	Focal and Host Households
HHH	Host Households
INGO	International Non-Governmental Organisation
JHS	Junior High School
MiDA	Millennium Development Authority
MOFA	Ministry of Food and Agriculture
MVP	Millennium Villages Project
NGO	Non-Governmental Organisation
PDA	Participatory Development Associates Ltd.
PRA	Participatory Rural Appraisal
PTA	Parent-Teacher Association
RCA	Reality Check Approach
SADA	Savannah Accelerated Development Authority
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
TZ	Tuozaafi (a thick cooked porridge of maize and water)

1. Introduction

This report presents the main findings of the baseline Reality Check Approach (RCA) that was conducted in February and March 2013 as part of the qualitative element of the Independent Impact Evaluation of the Millennium Villages Project (MVP). The Independent Evaluation has been commissioned by the UK Department for International Development (DFID).

The study was undertaken by a team of 10 Ghanaian researchers under the guidance of an international team leader, who also undertook some field research directly. Three specially trained translators supported the non-Mampruli and Buili speakers. Overall management of the team and logistical arrangements were made by Participatory Development Associates Ltd (PDA).

The report summarises field debriefings gathered during the fieldwork and will form the basis to an open access database that will be available following the mid-term evaluation. The findings are intended to provide insights into the attitudes, opinions, and behaviours of families living in poverty in the MVP and non-MVP ‘control’ villages selected. Therefore, the findings are expected to complement the participatory rural appraisal (PRA) study and findings from the quantitative surveys.

2. Methodology

2.1 Reality Check Approach

The Reality Check Approach (RCA) extends the tradition of listening studies and beneficiary assessments by combining elements of these approaches through living with people, usually those directly experiencing poverty. It could be likened to 'light touch' participant observation. Participant observation involves entering the lives of research subjects and both participating in and observing their normal everyday activities. It usually entails extensive and detailed research into behaviour, understanding people's perceptions, and their actions over long periods of time. The RCA is similar in that it requires participation in everyday life within people's own environment, but differs by being comparatively quick and emphasising informal, relaxed, and insightful conversations rather than observing behaviour and the complexities of relationships.

Important characteristics of the RCA include:

- **Living with** rather than visiting; thereby meeting the family in their own environment, understanding family dynamics, how days and nights are spent, etc.
- **Conversations** rather than interviews; there is no note taking thereby putting people at ease and on an equal footing with the outsider
- **Learning** rather than finding out; suspending judgement, letting people who experience poverty define the agenda and what is important
- **Household-centred**; interacting with families rather than users, communities, and groups
- **Experiential** in that the researcher takes part in daily activities such as collecting water, cooking, cultivation, accompanying household members to school and the market, etc.
- **Inclusion** of all household members
- **Private space** rather than public space disclosure to emphasise normal, ordinary lives
- **Multiple realities** rather than public consensus to gathering diversity of opinion, including 'smaller voices'
- **Ordinary interaction** with front line service providers; accompanying host household members in their interactions with local service providers and meeting service providers as they go about their usual routines
- **Cross-sectoral**; although each RCA may have a special focus, the enquiry is situated within the context of everyday life rather than simply looking at one aspect of people's lives
- **Longitudinal** change by understanding how change happens over time

This approach was used as a part of the qualitative mix of approaches in the baseline study. Training and orientation was provided in December 2012 to a team of Ghanaians who mostly live and work in northern Ghana and are fluent in the languages used in the study area. The training took place over five days and

included a two-night immersion living with families in the Millennium Villages Project (MVP) villages.¹ This served as a training opportunity and as a means to pilot and test the RCA for the first time in Ghana.

Figures 1 and 2. Informal conversations between RCA researchers and MVP community members



The emphasis on informal conversations (Figures 1 and 2) and observation allowed for openness and insights into the difference between what people say and what they do. The RCA team found the families they stayed with to be very accepting, quickly relaxed, and at ease in talking openly. The RCA team members engaged with all members of the family as well as neighbours (focal households [FHH]) in conversations. They accompanied them to fields, markets, health visits, water collection, firewood collection, and assisted with household chores in order to minimise disruption in their daily routine as well as to ensure the most relaxed conditions for conversations. The RCA team members also interacted with local power holders (Chiefs, Unit Committee members, and Assembly members) as well as local service providers (health workers, traditional birth attendants, spiritual healers, mill operators, school teachers, religious leaders, shop and market stall owners, community volunteers, and Parent-Teacher Association [PTA] Chairs) through informal conversations.

Each RCA team member left behind a selection of household goods (rice, sugar, salt, oil, matches, crayons, torches, and batteries) for each family with whom they stayed with upon leaving as compensation for any costs incurred by hosting the researcher. Timing was an important consideration so that families did not feel that they were expected to provide better food for the RCA members or that they were being paid for their participation. Each team member kept discrete field notes by never writing in front of people with whom they were conversing. These formed the basis of detailed debriefing sessions held with each sub-team immediately after finishing each round of the study. A final whole team workshop was undertaken over two days to reflect on the findings and identify commonalities and differences across villages and households.

2.2 Selection of locations

The six RCA study villages were selected from a longer list negotiated with Savannah Accelerated Development Authority (SADA) MVP headquarters and in consultation with the research team undertaking the Participatory Rural Appraisal (PRA) study so that the two studies would not overlap.² Two of these six villages were designated 'controls' by the SADA MVP where MVP interventions would not be directed. Both of these were selected from the list of 'controls' used in the quantitative study: one designated as 'near' (i.e. close to an MVP location and where spill-over effects are anticipated) and the other was selected from the 'far away' category. The villages are not named in this report in order to protect the identity, anonymity, and confidentiality of participants in what is intended to be a longitudinal study. The controls are not noted in the following table in

¹ Families visited during the pilot RCA study in December 2012 were not used in the baseline study during February and March 2013.

² One location partially overlaps in that the RCA selected a sub-community of a larger community selected by the PRA study. This may provide useful opportunities for triangulation in the two further phases of the evaluation.

order to maintain unbiasedness within the research team. Only the team leader and two other members of the team are aware of which locations are controls.

Table 1: Locations of study villages

VILLAGE CODE	LOCATION	LANGUAGE	REMOTENESS	ETHNIC MIX
A1	Mamprusi	Mampruli	1 hour drive to nearest town Poor access to transport except on market day	2/3 Muslim, 1/3 Christian. Traditionally Mampruli but now mixed with Buili (including mixed marriages). Small population of Fulani (settled 9 years ago).
A3	Mamprusi	Mampruli	4 hour drive or 2.5 hour motorbike/river crossing trip to nearest town	Mampruli speakers. 80% Muslim, 15% traditionalist and 5% Christian. Very small Fulani community on the outskirts.
B1	Builsa	Buili	35 minute drive on good road to nearest town but poor access to transport	All Buili speakers except Fulani (settled 14 years ago). Mix of traditionalists, Muslim and Christian.
B2a	Builsa	Buili	2.5 hour walk to nearest town	Buili speakers. Mostly traditionalists with 25% Christians. No Muslims.
B2b	Builsa	Buili	Few minutes from thriving market and transport access to a variety of small towns	Mostly Builsa comprised of traditionalists and some Christians. Few Muslims.
B3	Builsa	Buili	30 minutes from major town with good transport access	Buili speaking. Mostly traditionalists with a few Muslims and Christians. Two communities of Fulani.

2.3 Selection of households

Members of the RCA team who had participated in the RCA training and pilot in December 2012 selected households using the following criteria in consultation with ordinary people in the villages selected:

- Poorer households
- Different generations living in the house including, where possible, school-age children
- Be at least 10 minutes walk from each other
- Households at the centre of the village as well as the periphery

- Have a number of close neighbours to enable interaction with them

The advance teams entered villages independently either on foot or by motorbike to keep the process ‘low key.’ They met with the chiefs or sub-chiefs³ first and explained the purpose of the RCA study in great detail to ensure that they understood that the researchers needed to stay with poorer families and should not be afforded guest status. This latter requirement was emphasised to get closer to the ‘reality’ of people’s lives and also to minimise the burden associated with having outsiders stay in their homes. Only when this was clear did the team accept assistance in finding suitable households. Other people in the community were consulted as the advance team walked through the village. This remained a negotiated process so that no imposition of inappropriate households could be made by village power holders.

By using local knowledge, the selection of poorer households was facilitated. The households in fact all belong to the categories determined by the PRA study as ‘poor’ and ‘very poor’ (especially widows or persons with disabilities), i.e. using locally generated criteria for determining poverty. More than 50% of the RCA study households had at least one person with a disability and four households were widows or widowers.

2.4 Timing

The RCA study was conducted in two parts with two teams as described in the following table:

Table 2: Timing of the RCA study

Dates	Team A	Team B
24 February – 2 March 2013	Location A1	Location B1
3-7 March 2013		Location B2a
		Location B2b
17-24 March 2013	Location A3	Location B3

Each RCA team member spent a minimum of four nights with their host families, returning early on the final morning for a day and a half of debriefing.

2.5 Limitations

There were some problems with the selection of households in B2a and B2b as the criteria to stay with families was not adhered to and some of the household heads (HHH) were destitute people living on their own or in twos. There were also some misunderstandings among the neighbours that they had been selected because they needed help. However, the RCA team members managed to contain these misunderstandings and, where possible, spent considerable time with neighbours (FHH) to compensate for the limited people in their own HHH. In subsequent rounds of the RCA, the neighbours will be included as proxy HHH even though the RCA team members will continue to stay with the original HHH.

As the season was very hot and dry, the team found that HHH members were less engaged during the middle of the day than they had been during the pilot in December. This meant that some conversations were less fruitful than anticipated although early mornings and late evenings proved to be good opportunities for more interactive conversations.

Three of the RCA team members required translators. All translators received RCA training, which minimised problems during the immersion process. They were particularly vigilant in ensuring that they provided a translation service for both the researcher and the HHH members. Nevertheless, hosting two people and the inherent difficulties of translation like missing some important ‘side talk’ may have limited the possibilities for

³ Small gifts of kola nut were exchanged “he who brings kola brings life”.

interaction. This situation was limited to only four of the 20 households and we anticipate that it will be less of a limitation during subsequent phases of the RCA study in 2014/15 and 2017.

2.6 Context

Whilst all the villages are considered poor, they vary in terms of manifestations and degrees of poverty. Following the fieldwork, team members were asked to rank the villages in terms of poverty (Table 3), which served as universally accepted rankings based on the criteria considered relevant.

Table 3: Poverty ranking of villages

Village	Criteria								
Ranking (poorest last)	Economic activities	Education	Access to water	Population size in relation to resources	Physical accessibility	Access to health services	Active market/ Commercial centre	Electricity	Social capital (bridging)
B3	Commercial farming (beans), fishing for sale, grinding mill. HH own large numbers of livestock	New school with facilities	Boreholes and dam	Good-small population for resources (800)	Close to six markets and excellent road network	Health clinic and good access for referral	Well linked	Solar panels and grid links planned	Well linked
B2a	Irrigated land enabling surplus for sale (especially vegetables)	Choices of school	Boreholes	Modest population (900)	Near town	Health clinic 2 km away	Large market accessible	None	Fair
A1	Subsistence farming	Primary and JHS	Boreholes	Very high growth potential problems	Transport to town available	No health clinic	Small market in village, access to others	Few solar panels only	World Vision used to work here
B1	Subsistence but increasingly beans for sale	Nearest primary 2 km	Boreholes inadequate	Modest (800)	Motorkings and donkey carts to larger market	Health clinic 2 km away	No market but a few 'shops' selling drugs, fuel etc.	Few solar panels	People come in to buy beans
B2b	Subsistence. Low livestock ownership. No grain mills	Chronic absence of teachers	Only 3 boreholes for a population of over 1000	Large (1000)	No transport based in village	No health clinic	No provisions available in village. No businesses	Only one solar panel	Low
A3	Subsistence	Very poor	Waterhole and one borehole-mostly collect from over 1 hour away	Growing and high population	Bikes only Very remote	No health clinic	None	Four solar panels	Very rare visits from outsiders

Table 4 provides some data on the state of village assets as described by people living in poverty and observed first hand by the RCA team.

Table 4: Village Assets (March 2013)

Village code (listed in descending order from least poor to poorest)	Primary School	Junior High School (JHS)	Health Clinic/providers	Market	Local government
B3	<p>Newly constructed Government Primary School including new toilets.</p> <p>Good teacher accommodation.</p> <p>Solar lighting, own borehole (but dry some periods of year).</p> <p>Furniture in all classrooms but some in poor condition.</p> <p>x13 teachers (but only x3 are full govt. teachers, rest are volunteers, temporary or youth employment teachers).</p> <p>School feeding programme.</p> <p>PTA inactive.</p>	<p>JHS newly constructed.</p> <p>Computer facilities.</p> <p>x3 teachers.</p>	<p>Health post comprising consulting room, store and pharmacy. Nurses' accommodation for x3 nurses, recently re-occupied having been empty. People complain that "<i>nurse often not there (especially at weekends).</i>" House to house visits. Motorbike recently delivered.</p> <p>Very low numbers use the clinic.</p> <p>Community health volunteers (x3) just started.</p>	<p>No formal market, some informal stalls in village centre.</p>	<p>Chief does not live in community.</p> <p>Good connections with national and local government.</p>
B2a	<p>Primary school KG-P6, about 260 students, x10 teachers (x4 are volunteer or temporarily employed) but no teachers for KG1 and 2. Very high teacher absenteeism.</p> <p>8 classrooms, x2 teachers office, x2 borehole – one is</p>	<p>No JHS.</p>	<p>Earlier plans to have health centre here never materialised.</p>	<p>No market.</p>	<p>Sub-chief respected for dispute resolution.</p> <p>Assemblyman rarely visits. In fact many said they did not even know who was their Assembly representative.</p>

	<p>solar powered to a poly-tank recently installed but already needing maintenance. Solar power in classrooms and solar powered streetlight. Have sufficient furniture.</p> <p>No teachers' houses.</p> <p>School feeding programme.</p> <p>PTA not functioning- parents worried they will be asked for contributions so stay away.</p>				
A1	<p>Government Primary School with six classrooms but not all used (shortage of teachers). No furniture in KG, limited furniture in other classes <i>"children sit on the floor."</i> Rainwater tank only and was empty at RCA time so used borehole nearby. Toilets old and unused. New teachers quarters.</p> <p>x1 government teacher and x4 volunteer teachers. People say <i>'teachers often absent or leave early.'</i></p> <p>Often short of basics such as paper: <i>"children write on the floor then."</i></p> <p>School feeding programme.</p> <p>PTA in name only- parents called to school when</p>	<p>Three class JHS with x2 teachers. Desks and benches.</p> <p>Solar light in one classroom.</p>	<p>No health clinic though <i>"one has been promised."</i></p>	<p>Small weekly market with no permanent structures.</p> <p>Some small shops.</p>	<p>Chief since the 1980s, active in dispute resolution.</p> <p>Assemblyman holds three village meetings per year to provide information (not consult).</p> <p>People feel <i>"not told things."</i></p>

	teachers need to inform them of something.				
B1	<p>Government Primary School which recently expanded to Class 5.</p> <p>Three classrooms (P1 and 2 share, P3 and 4 share) No classroom for KG.</p> <p>Solar lighting. No borehole. No toilets.</p> <p>x6 teachers appointed but only one in evidence during RCA. People complain about teacher absenteeism.</p> <p>School feeding programme but no kitchen (PTA has started to make foundations).</p> <p>Active PTA.</p>	No JHS.	<p>CHPS nearby, functioning for last 5 years. It is very basic and comprises a single consulting room.</p> <p>x2 male nurses (one temporary intern arrived the week of the RCA). Nurses complain of irregular supply of medicines and people say services are very poor although since the new nurses arrived in January some improvements noted e.g. always a nurse on duty, more drugs, <i>“good because they are friendly and I feel at ease.”</i></p> <p>Home visits being made. x3 community health volunteers meeting people where they gather e.g. borehole and promote vitamin and immunisation.</p>	No market.	<p>Chief died two years ago and acting Chief does not live in community.</p> <p>People do not feel involved in community decisions and do not know what is going on.</p> <p>Assembly representative rarely visits but runs the school feeding programme by proxy.</p>
B2b	<p>Government primary school comprising one new block (with new borehole & toilets) and one old classroom block <i>“falling down.... When it rains it is unusable so children crowd into new block.”</i> Furniture in all classes but much in poor condition. No</p>	Three class JHS (closed during RCA).	<p>Health Clinic comprising consulting room, ward and nurses residence. No water at the centre. Serious shortage of drugs.</p> <p>20 staff (including x3 youth employment nurses).</p>	Cement structures for daily market and small stores.	<p>Acting Chief.</p> <p>Unit Committee not active: <i>“do not know what they are doing.”</i></p> <p>Feel Assembly Member does very little for the community.</p>

	<p>electricity.</p> <p>15 teachers but absenteeism noted by community <i>“involved in their own businesses... as long as they have lesson plans then that is all the supervisors are interested in.”</i></p> <p>2 shifts.</p> <p>No school feeding programme.</p> <p>Relatively active PTA.</p>		<p>20-80 patients per day (seasonal differences).</p> <p>Home visits.</p> <p><i>“Sometimes they are good and other times they have no medicine and only give paracetamol.”</i></p>		
A3	<p>Government Primary school in very poor condition, formerly NGO run. Furniture in very poor condition. Some classrooms without furniture. All dirty on visit. Abandoned new block. Unused teachers’ quarters built by community.</p> <p>4 teachers allocated (x2 are youth employment teachers) but all absent during RCA: <i>“they do not come for weeks at a time.”</i></p> <p>No school feeding programme.</p> <p>PTA <i>“not active.”</i></p>	No JHS.	<p>Construction of health centre abandoned.</p> <p>Mobile community based health worker whom people think is <i>“enlightened”</i> provides primary health care.</p>	No market.	<p>Acting Chief.</p> <p>Unit Committee meets all the outsiders and does not consult with community.</p> <p><i>“Do not trust Assemblyman.”</i></p>

2.7 Agriculture

Summary baseline:

- HHH are farmers cultivating less than five acres (three HHH comprised of elderly persons living off neighbours’ and relatives’ charity).

- HHH felt farming was increasingly costly, hard work, and risky but their upbringing and lack of education prevented them doing anything else. HHH say they cannot make a profit nowadays and supplement their farming with a range of off-farm activities.
- There are no reliable agricultural advisory services and HHH rely on their own experience, word of mouth, and suggestions of commercial agriculture inputs of shopkeepers on the use of insecticides, fertilisers, and new seed varieties.
- The increasingly unpredictable climate is confusing and concerning to HHH engaged in farming.
- Bambara beans are becoming the crop of choice with relatively good profitability.
- With the exception of the Fulani households, the HHH keep very small numbers of livestock (chickens, guinea fowl, and goats) primarily to be used as easily liquefiable assets and are not for consumption. The HHH are predominantly cashless and these small animals represent their savings.

Figure 3. Plentiful crop yields in some areas



All the HHH are primarily farmers (or in the case of widows, their husbands were farmers). Most are subsistence farmers or have small surpluses to sell. They farm between one to five acres of land though the accuracy of their estimates is queried. They grow maize, millet, rice, sorghum, groundnuts, and beans. Beans are becoming the crop of choice⁴ as these are most profitable, particularly if one has land near the river. In the rainy season, some HHH are able to grow vegetables such as okra, tomatoes, onions, and chillies. In village B2b, they have had access to a large irrigated area for more than 40 years and those who were allocated plots there have been able to make a good profit (Figure 3). However, since road access has deteriorated as a result of floods, the international non-governmental organisation (INGO) that used to support them with inputs and markets has withdrawn. Additionally, cheaper produce available from Burkina Faso means their former profits are now in jeopardy.

People in A1 and A3 made it clear that all members of the household (men, women, and youth) involved in farming get their own share of the harvest, which they can sell for their own needs when they want to. Women in A1 indicated that they buy soap, seasonings, and occasional tinned foods from the sale of 'their' part of the harvest. If there is any cash left over they will buy clothes and skin and hair products.

Many shared that they were fed up with farming, but it was all they knew how to do. They felt it was hard work, increasingly costly, and risky (e.g. "you can lose your investment too easily," (woman, A1) or "only those farming on a large scale make a profit these days," (man, B2b). Some want to increase productivity because "it is the

⁴ Mostly Bambara beans but also, in some areas, chameleon tail beans, which we were told have come from Burkina Faso (e.g. B1). People said they are relatively easy to grow (less demanding for weeding compared to rice) and they have low losses. They previously grew watermelon and rice near rivers but are switching to beans).

only hope we have in life as we have no other means of survival,” (HHH, A1) while others are philosophical, “you are born into it. Without education you cannot do anything else but farming,” (man, B3). Similarly, HHH in village B1 lamented that farming was their only option as they were not educated. Others have reduced the amount of land farmed because it is hard and less productive. Generally, these small farmers said they could not make profits and were often forced to sell at low prices during times of need.

Yields

HHH told us that the climate was less predictable than in the past. The dry seasons are lasting longer and the onset of rains is delayed so the main growing season has contracted. “Rains do not come the way they are supposed to. When I was young they came in late March now they come in May or June and stop by September,” (man, B2b). “Sometimes the rains start, we plant and then they stop and the seedlings dry up... other times the rains are very heavy and they wash away the crop,” (woman, A1). Flooding badly affected crops last year, especially maize and millet (e.g. in B1 and B3) whilst drought affected B1.

The decreasing soil fertility is of concern to Focal and Host Households (F/HHH) and the following is a typical sentiment in most villages: “Only the rich will be able to continue farming because they can afford fertiliser,” (man, A1).

The Fulani are widely blamed for crop losses, especially the beans grown near riverbanks that people claim are trampled by cattle being taken to the water.

Inputs

In general, F/HHH complained that the cost of inputs continues to rise and many attribute their low yields to the fact that they cannot afford the needed inputs. HHH complained that government coupons for fertiliser are not available to them because of corruption and they are forced to buy at the open market rate. Typical of other comments, one HHH head said, “if you are not related to a politician then you don’t get,” (village, B2a). People in villages near the border claimed that subsidised fertiliser is being smuggled out to neighbouring countries.

Insect damage can be quite high as one HHH explained they could not afford multiple doses of insecticide. “I hope for heavy rain to wash caterpillars off,” (man, B2b) was a typical comment on the lack of money to buy insecticides. HHH go to agricultural supplies shops in towns, explain the symptoms, and then buy whatever is recommended. However, “sometimes it does not work – the insects hide underground and attack the plants in the evenings,” (woman, A1), and “when we apply the medicine it seems to destroy the whole crop,” (man, A3). The HHH told us that if they complain to the shopkeeper he is not interested and is “even happy that it has not worked because they we have to buy more,” (man, A3). Some people purchase insecticides in town to sell in the village.

The RCA HHH rely mostly on manual labour since their land is too small for tractors and they cannot afford the rental (around 30-40 cedis per acre). They operate a reciprocal labour arrangement where labour is short in the household or pay for labour with shares of the harvest. People feel the old reciprocal system is breaking down and nowadays labourers demand drinks, food, and sometimes clothes making it difficult for the poor to afford their input. Some complained that their harvest is delayed or has yet to be transported to their homes due to a lack of labour force.

Loans for tractor use and other inputs are skewed in favour of larger farmers with collateral and bank accounts. For example, the Millennium Development Authority (MiDA) provided loans in village A1 in March 2012, but required group members who were ‘middle sized farmers’ to open bank accounts and pay a fixed 15% interest rate. None of our F/HHH were able to afford this. “We poor never get,” (man, B2a). Small loans are arranged between neighbours and relatives to purchase inputs. Typically, these are for 30-80 cedis where repayment is equivalent to a bag of maize (valued at 50 cedis) or to bag of beans (valued at 150 cedis), respectively.

In several of the study villages, we heard the same, but independently reported, concerns about the SADA programme last year (2012). Farmers were encouraged to form groups with the intention that each member

would be provided maize seeds and fertilisers to be repaid with bags of harvested maize at the end of the growing season. However, the inputs came far too late and the harvests were very poor. HHH involved said they do not have enough surpluses to pay back the loan. SADA has now suggested that they pay in cash (122 cedis) but families who experienced poor harvests and have few other income earning possibilities find this impossible to do. In some cases, both husband and wife were given seeds and fertiliser so their debt is 244 cedis. People complained that the cost of inputs received was closer to 70 cedis. In village A1, two of the three HHH had very bad experiences and the FHH were also bitter and would not participate in the programme again. They indicated that the promise of inputs last year had diverted them from seeking out loans⁵ and purchasing inputs in time, but that they would not take the same risk this year. In B3, people described a similar situation and one HHH told us, “I would rather go to prison than pay with the few bags of maize I have at home.” While the RCA team was in the villages, SADA officials came to persuade the group members to repay in cash but “we cannot afford to.”

Another scheme for larger farmers (also attributed to SADA) involved a registration fee and then the free use of tractors, but the tractors were located too far away and the group members were forced to rent tractors locally at the usual rate of 40 cedis per acre. Several people talked about “people from outside coming to the village to offer loans,” but never came back, leaving them very suspicious (A1 and B1). In one case, people were asked to form groups and contribute 8 cedis, but the organisation never came back: “outside people come to deceive us, get what they want and nobody can trace them,” (woman, A1). In one control village, it was noted that people came last year and promised seeds and fertiliser at the same time as the SADA programme but then never returned. However, they have heard from other villages that the scheme did not work well and so “people are running away from forming groups now... If they came back we would not be interested,” (man).

In the other control village, a similar programme had been running for the last two years. Despite the stated intention that the groups should be poor farmers, we were told that “only friends and relatives of the Unit Committee member got inputs and they were not even poor.” The harvest was poor here too and “people came to take photographs of the crop” and it was decided that each group member had to pay 20 cedis instead of the required bags of maize. This example illustrates how difficult it will be to claim attribution to the MVP intervention since a similar scheme is operating in the control villages, albeit with different (and in this case better) conditions.

None of the villages receive agricultural extension advice and instead rely on word of mouth and information from agricultural input shopkeepers. In village A3, farmers explained that they work out the right doses for insecticides by trial and error, copying the one that worked best the next time. In village B3, they have been promised that a SADA agricultural officer will visit but they have not seen him yet. They spoke disparagingly about previous Ministry of Food and Agriculture (MOFA) programmes: “Agriculture people do the work in the office, they do their farming on paper and say everything will work but we know it will not work in reality,” (man, B3). In B1 and B2a, people remember “some big meetings in the past” concerning crop management but these were very rare.

⁵ HHH shared that this is very difficult as many moneylenders only give loans to family members. To secure an informal loan usually takes some time and many personal visits.

Storage

Figures 4 and 5. Food storage



There were no community seed storage facilities in any of the study villages although there appear to be plans to convert an old building into a seed storage facility in village B3. Crops are mostly stored inside the home. Those stored for sowing the following season are tied up in bags or bottles (Figure 5) with a tablet of insecticide, contained in used weed killer or insecticide tins. For maize, cobs are hung up from the rafters (Figure 4), often in the kitchen area. In some HHH, there seemed to be much insect activity in the stored maize and millet with ants and weevils present during the night. Some families store their harvest on *gbong* (special ledges on the roof of their houses). There are a number of superstitions around storage that persist such as, “if you store produce in the early morning on an empty stomach, it will store well,” (woman, B1).

Perishable produce such as tomatoes are sold immediately but chillies are dried and can be quite profitable.

Livestock

With the exception of the Fulani families included in the study, the RCA study families had only goats and poultry (chickens and guinea fowl). Where families owned goats, the numbers were modest (between two to three).⁶ All livestock is kept for ready cash purposes or sacrifices and are not eaten by the family.

The Fulani, on the other hand, primarily rear cattle but like the farmers they too are increasingly disenchanted with this occupation: “Come rain or shine we always have to look after the animals, watch they do not stray, there is never any holiday,” (Fulani herdsman, B1). Another noted that, “if there was any other opportunity of employment with a steady income we would opt for it.” Younger men indicated that they had aspirations to work in town.

There are very few vets and only those in village B3 talked about getting routine vaccinations for goats and chickens, mainly because two vets reside nearby. HHH only take the ‘good chickens’ for vaccination as it costs 40 or 50 pesewas depending if they take them to the vet or he makes a home visit. In other villages, the costs of vaccinations are considered too high and people doubt the efficacy (e.g. “vaccines don’t work,” (man, B2a), “my goats were healthy before the vet injected them and then they all died,” (woman, B2a). There is also suspicion that vets are only interested in making money. Since the livestock is primarily regarded as a form of a savings bank, further costs are minimised and vaccination is avoided. Only the Fulani families are really conscientious about vaccinating their cattle (as confirmed through discussions with the vet “others see livestock as a pastime and leave them to providence”) and take trouble to prepare them and call the vet regularly.

⁶ One HHH (A3) had tried to rear goats but all 25 died so now only has a couple for ready cash purposes.

There are concerns in some villages about the rise in livestock theft (especially B2a and B3⁷).

Off-farm occupations

A number of the HHH supplement their farming with non-farm activities, the most common being seasonal work in the dry season. People explained that this used to be unnecessary but since farming has become so expensive some family members have to seek farm or portering work in the south to supplement their incomes.

Figure 6. Charcoal burning



Charcoal burning is also common (five of the 20 HHH were involved in this) but demand is said to be dwindling (Figure 6). In B3, fishing and growing beans are considered lucrative and people have sufficient profits to purchase motorbikes.

Some women collect fruits such as mangoes or other forest products such as shea nuts (*dawadawa*) to sell. In two HHH, the women make masa and kosi to sell in the mornings at the roadside. Another wife buys and sells local gin (*Kpeteshi*). Another wife buys and sells yam and the second wife in the same family sells sugar, chips, and porridge. Other HHH weave ropes from waste materials or local vegetation whilst in one HHH the family makes mats, baskets, and twine, which they exchange for manual labour.

There was little evidence of remittances and relatives who had left home were said to be “busy with supporting their own families,” (old man, A1) or had left home with no trace. Where remittances were sent, they were occasional and small, generally in the form of gifts rather than a source of income.

Some elderly HHH received weekly cash transfers from a non-governmental organisation (NGO), but since the project has stopped these payments have discontinued. The same NGO had begun (and then stopped) a number of projects with the elderly, such as sewing bags for export, and asset transfer programmes, such as providing goats and chickens. One HHH had received four goats and eight chickens, but all but one goat had died. This has had kids but the woman is concerned about the increase in livestock theft. A new programme has begun in B2a that provides the elderly with monthly pensions.

⁷ These are the least remote villages and so may provide easier opportunities for unrecognised people to enter the village as well as easier transport access.

2.8 Health

Summary baseline:

- Three (of six) villages had Community-Based Health Planning and Services (CHPS) or Health Centres but opening times were unclear, medicine supplies erratic, and services limited. New staff recently in post in all three
- Preference for self-prescribed medicines or traditional health providers because they are more convenient and cheaper than seeking health services from government health centres. F/HHH only consider formal health services if an ailment is 'serious'
- All but one HHH had mosquito nets, but only 25% use them during the hot season
- Preference for home births. Confusion about costs of institutional delivery and apparent 'informal payments.' They were regarded as only necessary if 'at risk'
- Only in one village is the practise of feeding colostrum to newborn babies common
- Most mothers give babies under six months water and introduce solids by three months
- Very little interest in family planning. Strong social norm is to have as many children as possible and spacing out pregnancies subjects the couple to ridicule. Some women seek injections secretly but most endorse the idea of having many children
- Poor diet of staple (usually tuozaafi [TZ]) and leafy soup with occasional beans and dried fish eaten once or twice each day

Box 1: Course of action for coping with illness

"The HHH daughter-in-law arrived with her twins aged about nine months and her young son aged about 18 months. She came especially to stay because one of the twins was very ill with diarrhoea and losing weight and she did not know what to do. The older people immediately suggested the baby should be bathed in river water that is sacred and given an herbal enema. Some bark was gathered by the grandfather and boiled into a tea coloured liquid, which was then used as an enema while still hot. Later in the day, they went to the nearby medicine shop and bought amoxicillin suspension and administered this to the sickly twin and the well one ('need to treat the same'). That night I tried to sleep next to the family but was woken regularly as the twin continued to vomit and have diarrhoea. The next morning the mother said the baby was getting better and everyone attributed it to the herbal enema."

Field notes, village A1

Health seeking behaviour

Most of the families claimed to have very good health and few needed to seek medical attention in the last few years. In the most remote village (A3) people said they felt "God had blessed us with good health because we live in such a remote place." Most families said they adopt a 'wait and see' approach to their illnesses. If they do not get better, many indicated they will then consult traditional health providers and make spiritual sacrifices

before buying medicines from the market or going to government health centres. The most common ailments are headaches, unspecified ‘body aches,’ and stomach problems (including diarrhoea, especially in the rainy season), which families regularly self-medicate with Paracetamol and Flagyl. Box 1 describes a typical decision making path for dealing with an illness. Only when illnesses are considered ‘critical’ or persist⁸ do families attend the Health Centres. At this stage, they often circumvent the intermediary Health Centre and go directly to the District Hospital, knowing that they will probably get referred there anyway. Not only does visiting the Health Centre cost money (transport and drugs⁹) but it also entails long waiting times, especially on market days when people take advantage of their regular trip to market to consult on their health.

Health facilities

Our HHH had had very little experience of government health services since they had either never been or rarely visited health centres. Those that had been felt that they were often shouted at by staff and felt embarrassed and awkward about the way they looked. Several commented that going was a waste of time as the Health Centre never had the necessary medicines anyway. They also said that there were usually long queues and the nurse provided each patient very little time and “were quick to write out the prescription,” (man, A3).

Table 5. Views on the nearest Government Health Facilities

Village code	Nearest Government facilities	Views of these facilities
A1	No clinic in village. Health Centre 1 hour away.	Rarely use because of distance. Rely on traditional medicine and drugs bought from seller in village and picked up on market day.
A3	Health clinic construction abandoned.	People say they are ‘ <i>blessed with good health</i> ’ and rarely go to Health Centres. Rely on traditional medicine and the Unit Chair who keeps a limited range of medicines.
B1	Very basic one room CHPS which on-refers serious cases to the District Hospital.	People say service very poor but optimistic since new staff arrived but they do not speak Buili. Irregular supply of medicines and not clear when open.
B2a	Abandoned semi-derelict Health post. Nearest health Centre 2.5 hour walk.	Only use the Health Centre if ailment serious. Very busy on market days so use medicine shops in town.
B2b	Health Centre with limited residential facilities and 20 staff.	Serious shortage of drugs. No water at the Health Centre so nurses collect. About 50-80 patients seen per day in rainy season, 20 in the dry season.
B3	CHPS some 30 minutes walk from sector.	Recently re-opened after many years abandonment. Very low numbers use. People say they often come and no staff there and, if there, there are no drugs.

⁸ People said they are never told by nurses what is wrong with them; they are only given medicines.

⁹ Hiring motorbike or ‘motorking.’

⁹ People complain that even with Health Insurance if the Health Centre does not have stocks of the prescribed drug they have to buy from outside.

Community-based health providers

In Village A3, the Unit Committee Chair maintains a medicine box (Figure 7) and has received some training from the Health Centre some years ago. After selling the medicines, he gets replenishment and a commission for selling. Since the sub-chief in B3 has started to keep a medicine box, families here are beginning to turn to him. He is one of three male community volunteers trained by SADA in 2012. Paid monthly, they have been provided with bicycles and make house-to-house visits, which we observed. None of the other villages had a similar scheme, but private entrepreneurs in some villages were buying common medicines and family planning materials in town and selling them from little shops or market stalls in the villages. Staff of one of the Health Clinics has recently resumed making house-to-house visits.

Figure 7. Medicine box



Health insurance

Despite the apparent low cost of health insurance, most¹⁰ of our F/HHH have either never taken out insurance or have let it expire. “I don’t bother because I am never sick,” (woman, B2b) or “we do not have insurance as there is no need” (Fulani young men, B1). For some, even one cedi¹¹ is prohibitive (e.g. the elderly widow living on her own is waiting on infrequent visits from her daughter-in-law to get this done). A few families who have experienced a number of ailments and the benefits of insurance have their entire families covered but this was very rare among the F/HHH we interacted with. For example, one elderly man had a health scare last year and noted, “if not for this (insurance) I would not be living right now” and is very keen to keep his family’s insurance up-to-date.

Some families told us that they were healthy and thus did not need health insurance, but nevertheless took it out for their children on their own initiative (A3). Others said they felt that, “the scheme is a cheat because you might never fall sick,” (woman, B3). Several told us that they felt that with health insurance “you do not get proper treatment...they will only give you Paracetamol,” (man, B3) or “have to pay for drugs anyway as they do not have them in stock.”

Use of mosquito nets

All but one of the RCA HHH had mosquito nets, which had been provided by a variety of different organisations (some had received them from more than one organisation). The numbers distributed varied from one to seven per family and did not always seem to relate to the number of members living in the household (e.g. in village B3, one family had three for a family of four but another had only one for a family of five; the Fulani family in B1 had so many nets that some had not been unpacked yet).

¹⁰ Only 5 of 20 HHH had health insurance and one was for the children only.

¹¹ There was much confusion about the actual costs of the initial health insurance card, renewal, and how long it was valid for. People were either confused about or not aware that the costs were subsidised or free for some groups. This was further confused in some areas where three-month insurance had been issued over the election period and people had not realised that this was so short lived. In village B2a people said they felt “fooled” as they had not realised the insurance they were given was only for three months: “Leaders fool us and take us for granted.”

Figure 8. Mosquito net at HHH

Of the 20 HHH, only five used mosquito nets during our stay. It was exceedingly hot at night and most families slept outside. They said they only use them in the rainy season or “when the mosquitoes are many and become a nuisance.” It was considered too much trouble to string them up outside and since the mosquitoes do not disturb their sleep it is felt to be unnecessary. The issue of disturbed sleep was the only motivating factor for using nets and none of our F/HHH connected the use with protection against malaria. One family (B1) refuses to use the black mosquito net they were given since after the first night they all suffered from itching. Another (B2a) said that they did not use the nets all year because they were worried it would get spoilt and they were not sure when they might get a replacement.

Maternal health

Antenatal clinics are held in most villages each month, although in A3 they complain that they have stopped since the last election and in B2b it had “not happened for about 10 years.”¹² A team member observed the session in A1 and all the women with young children we spoke to felt obliged to come. A volunteer went house-to-house to remind them to come and there were at least 40 mothers in attendance. Two health workers were present and weighed all the babies and completed the record books kept by the mothers, but did not provide any training. After asking what the nurses told a mother who had returned from the sessions, the mother replied, “they told us to get there earlier and clean the place before they come,” “Nothing else?” “Nothing else.” None of the women who shared their babies’ record with us knew what it meant.¹³

There is a strong preference for home deliveries with traditional birth attendants (TBAs) if they can be contacted in time.¹⁴ As pointed out in the PRA study, TBAs are highly regarded in the community. The reasons for the preference include trust, less cost, they come quickly (day or night), they know the family, and the mother can stay at home. Discussions with TBAs themselves and the F/HHH suggests that they had faced very few problems. For example, one male TBA said that in 15 years he had only had to refer mothers three times to Health Centres. On these occasions, they commissioned motorbikes to convey them to town (two hours away) and in all cases mothers and babies survived. He delivers as many as two babies per day with the help of two others in the community who have received training from Ghana Health and know how to cut the umbilical cord safely. Of the thousands he has delivered only three have died.

In village B3, the TBAs have been officially told to stop assisting at births and mothers threatened that they will be charged 20 cedis by the Health Clinic if they do not comply. One of our HHH was a former TBA who had

¹² When the now abandoned health post was first built.

¹³ The booklet is in English and they could not explain the pictures.

¹⁴ Three HHH mothers told us they had given birth on their own because it was at night or the TBA came late.

received training but has stopped working and is not interested in the ‘meagre’ incentives to bring mothers to the clinic.

A minority have a preference for institutional birth based on personal experience. One young mother (B2b) said, “I think it is best, it feels safe and they take proper care; they prepare tea for you afterwards.” Another mother (B1) had experienced complications and was referred to Fumbisi Hospital and since then says she will always use the Health Centre “where blood is available if I need [it].” On the whole, the idea of an institutional birth is only considered if the mother is told she is at risk and they then go to the health centre a week before the due date. Mothers said that although the delivery was free they had to provide Giesha soap (and detol) to each of the nurses for their personal use, “I thought it was for the baby but the nurses took it for themselves,” (mother, B2b). Some mothers were not aware that delivery was free in government hospitals and others said “nothing is free, people pay cash,” (FHH women, B2b) and others thought it was only free if you had health insurance.

“This is the first thing they tell you when you give birth at the clinic,” says a mother (A1) about feeding the baby colostrum. Another (mother, B2b) said they prescribe it like ‘a medicine’ but although this is well known it is not well practised. “We express this out but if you go to the clinic they will tell you not to do it,” another mother (A1) explained, “I was told to but did not want to. It is dirty.” So she, like many others we spoke with, gives water to the baby until the “clean milk comes through.” Another mother said the first milk has “worms in it so we throw it away” (mother, B1). In A3, a team member observed a new mother painfully expressing the colostrum with shea butter. The mother explained it was ‘dirty’ and buried it. It was clear in conversations that because they knew the nurses and health workers would scold them, they did not tell them they threw the colostrum away or that they gave them water in the first few days. However, a very few had different experiences to share; one HHH mother (B2b) said she provided colostrum and breastfed her two children and pointed out that her first daughter of 10 years is ‘fat’ and healthy as a result. In village B3, where there has been an active health worker for many years, the HHH said they do give colostrum, “it is not true it has worms in it- my child will be stronger,” (young woman, B3) and “nurses tell mothers to do this... it is now common whereas in my day we used black ants to prove the milk was still bad and then gave mothers boiled herbs to purify the milk,” (old woman, B3). Her daughter-in-law added, it will help the “child to fight diseases.”

Few mothers practise exclusive breastfeeding for the first six months. Many said that babies must take additional water, particularly in hot weather (e.g. “if we walk to the farm in the hot wind the baby will be thirsty,” [mother, B3]). Some have heard exclusive breastfeeding messages on the radio but do not agree: “You can’t deny that living (bodies) needs water,” (older woman, B2a). Although we observed very young babies being given porridge, mothers told us that they usually start giving this and flour water from about three months: “The baby will be hungry by then and the breast milk is not enough,” (mother, B1). The Fulani families told us they have traditionally practised exclusive breastfeeding for the first three to four months, provide the colostrum, and will continue breastfeeding for up to three years. They said they never give babies water as it gives them stomach cramps.

Diet and nutrition

The diets of all the HHH families were poor, comprised of TZ with leafy¹⁵ soup and/or beans, occasionally supplemented with small amounts of dried fish (Figure 9). A few took rice perhaps once or twice per week, cooking it with seasoning, chilli, beans, and dried fish. Some families ate uncooked millet in water on some days. The HHH mostly cooked once per day, usually in the afternoon or early evening and ate leftovers in the morning, if at all. The households did not eat meat and it was explained that meat was only eaten at festivals, funerals, or possibly if a guest visits. Depending on the proximity of the river, some households ate fish or sun-dried or smoked it for consumption in the rainy season. In village B1, the children collected frogs to add to the soup (Figure 10). There were few set times for eating and the RCA teams mostly observed people eating when they were hungry and not together as a family. They never ate more than twice per day and mostly once per

¹⁵ Often okra or baobab.

day, though the timing of this meal varied a lot. This means that the food was prepared and often stood around for hours before consumption. Only the Fulani families took milk each day, often mashed with TZ, as well as milky tea each morning. Fruits were foraged occasionally by children and adults on the way to collect water or charcoal.

Figures 9 and 10. Soups eaten at HHH; Children collecting frogs



Water and sanitation

None¹⁶ of the HHH had toilets nor did they use communal toilets.¹⁷ Women rose early in the morning and defecated in the nearby bush. Children and men defecated at all times of the day usually in the bush but sometimes more openly. In villages A3 and B3, defecation was near the house and pigs and dogs were actively encouraged to eat the faeces. In other villages, people said it was “better to defecate out in the open, tomorrow the pigs and dogs will eat and clean up,” (woman, B2b). The faeces of babies were generally gathered up in a cloth and thrown outside the house, the cloths were piled up awaiting washing and the spot where the toddler had defecated cursorily washed down. In some HHH we observed older children defecating inside the compound. Very few ventilated pit latrines were observed in the study villages and there was little evidence of use (Figure 12). Toilets at schools, which in some villages were the only ones, were little used as children preferred outside.

¹⁶ One family (B2b) is currently digging a pit to install a latrine from experience of the son who has returned from working outside.

¹⁷ In village B1, the public toilet is referred to as the Chief’s Palace toilet and they do not use it, but also because it is an enclosed space and smelly. One team member resided close by and never saw it being used in the entire four-day stay.

Figure 11. Unused latrine



Urination was either in the bathroom or in the open. All HHH had very simple bathing areas, some with only half walls and little privacy. Because they were used for urination these invariably smelt bad and drainage comprised shallow and short mud ditches, which spilt out onto the paths outside the house. In some houses water lay stagnant.

Water sources

All HHH had access¹⁸ to water from wells or boreholes. Some preferred wells, if available, as they complained that the water smelt bad or tasted ‘salty’ from boreholes (“it makes the TZ and porridge taste bad,” (woman, A1). The Fulani families preferred the stream as the “water is sweeter” and they drink this when accompanying the cattle to drink.

Some boreholes are broken or in bad condition and these have either been abandoned or the community is trying (unsuccessfully) to raise money house-to-house for repair (e.g. villages B1, B2b, A3, and B3). Most of the HHH do not face too many problems getting water, but in village A3 only one of the three boreholes installed by World Vision is still working so there are very long waiting times, “by the time you get water others have finished cooking,” (woman at borehole, Box 2). In village B3, people complained that they have been paying 50 pesewas per week for what they assumed was a maintenance fund for the borehole but when the pump broke down they have been asked for a further two cedis. One of the RCA HHH said they could not pay this and have been banned from using the pump. She now walks 40 minutes to the dam and collects water from there. Sometimes this is dry so, as observed one night of our stay, she slept by the dam to collect water early next morning.

Box 2. Problems with water access

There were three boreholes, all of which were installed in 2004, but only one works. People do not know to whom to report the broken one and the elders closed down one of the others because women were fighting over the access to water. It now takes a very long time to collect water and many prefer to walk to the waterhole, which is about three miles away, to avoid the queues.

Field notes, village A3

¹⁸ The maximum distance to reach water was one hour’s walk (village B2b) because a nearer borehole was not working and people who had collected money to repair it from villagers has absconded with the money. One of the HHH boys collects two gallons on his bike every morning before going to school. The HHH take measures to conserve the little water they have.

The wells yielded water, which was usually very murky. However, this water was usually preferred because of the taste. Borehole water was often used for washing and to give to livestock (or to provide the RCA team because it was assumed we would not like the look of the well water). Children used dirty cups, rusty cans, and calabash which had been left lying on the ground to drink from. These had often been used by animals, too.

Hygiene

Hand washing or wiping was more often observed after eating rather than before. Cleanliness varied considerably. The Fulani families washed hands before every meal. Many families left the dirty or in-use cooking pots and utensils lying around on the ground all day and chickens and goats pecked and licked these.

Most household members bathed at least once per day with cold water either in the bathroom or outside. Some members of the family, especially the elderly, did not wash at all during our four days with them. Most members of the families rarely changed clothes. Both these behaviours were dictated by desire to conserve water. A few members of the families used chew sticks to clean their teeth but no brushing was observed, although some toothbrushes were stashed away in roof thatch.

Village B3 was conspicuously cleaner than all the others, the only place where soap was used in the HHH, where bathing was regular, and where there was less standing rubbish (especially plastic bags) in the public areas of the community. There has been a health worker at the CHPS for some years and she has been active in visiting households and providing talks on hygiene and sanitation at the school or the community square. This was the only community where rubbish was collected up and burned routinely.

Generally, there was little knowledge of good hygiene practises and disease prevention. Some HHH had heard messages on the radio and younger members of the family had some understanding of the risks of HIV/AIDS. In villages B1 and B3, nurses from the CHPS had made home visits and conducted meetings at the boreholes or in the village square. In village B2b where there is a Health Centre, health workers make occasional unannounced home visits to discuss 'hygiene.' There is no such programme in the villages without Health Centres.

Family planning

"We do not listen to what the health workers are saying as we are not interested in hearing," (woman, A3). There is strong social norm in both of the Mamprusi villages (A1 and A3) to produce as many children as possible. "My mother has four and I want to overtake her by having at least seven or eight," (mother, A3). "My brother has six sets of twins and two other children. That is fourteen. I want to be like him," (young mother, A1). "I have 27 children," said an older man in village A1, who had plans to continue. Even the Chief of village A1 was delighted at the prospect of increasing the size of the village by several hundred before our next RCA visit.

Apparently health workers came to village A1 two weeks before our study and tried to talk about family planning to the men of the village, but they refused to listen and sent them out of the village ("God wants them to give birth to as many as they can"). Women explained that if the mother does not keep producing babies the neighbours jibe and tease, suggesting the husband is impotent or she is barren. However, once "the eldest son is married then the husband and wife stop sleeping together; to have a baby then is not right and people will call you names," (older woman, A1). In the Buili communities, there was also a sense that "God will decide the number and we will take" (woman, B3). Besides, "you can die at any time, better to give birth to as many children as possible first," (woman, B3). Several mothers told us they "enjoy giving birth to many children." Furthermore, as the Fulani men explained, "children are a gift of God; you might block an important person coming into the world," (men, B1).

Men told us that women do not like them to use condoms as they fear them getting left inside. Some men told us they reuse condoms after washing. But our conversations indicated that there is poor access to condoms and disposal problems in the villages indicated that condoms are rarely used. Only in village B3, where community health volunteers are publicising the fact that they have condoms available, was there any sense of uptake and

this was primarily by young men who were concerned about sexually transmitted diseases (STDs) and HIV/AIDS rather than unwanted pregnancies. The health volunteers shared they are concerned that they cannot motivate married couples.

None of our HHH women said they were taking the contraceptive pill. Women said they had heard you could die from it, become infertile, and that taking it “affects your health.” Some said it made you fat and pointed out the nurses who were promoting it as proof. However, the injection was preferred because it can be done discretely and without husbands knowing, (“the nurses do it for us in the clinic in secret,” (women, B2b) and nurses at Health Centres confirmed this subterfuge. One woman (A3) had kept it secret but then became very ill (“heavy heartbeat and shivering, pains in the thigh.. I thought I was going to die”) and blames the injection and tells others not to use it.

One HHH father said that contraception was a good thing as school fees are very costly (B3) and another said, “if you give birth to many you cannot afford school,” (B2b). But these views were very much in the minority.

Lifestyle

In three of the HHH, there were members of the household with serious drink problems where they got drunk on a daily basis. Others, including youth, drank less frequently and in particular the small alcohol sachets which could be drunk discretely. There were many empty sachets littering villages. Smoking was prevalent among the Fulani young men in B1 and A1 and mostly older men (and some women) in some other F/HHH. In one HHH the mother was a regular smoker.

2.8 Education

Summary baseline:

- Education (at least to standard six) valued by parents and children
- Teacher shortages in all villages but B3
- Teacher absenteeism complaints in all villages but B3
- Student absenteeism high in all (even in B3 as self-earning opportunities lure children to meet consumerism wants). Self-agency decisions to avoid school dominate; most parents oppose children dropping out. Reasons given by children are mostly ‘falling behind,’ corporal punishment, opportunities to earn for themselves and/or leave home
- School feeding programmes in four out of six villages. Students go for the programme even where no teachers are teaching (A3 and B1) and we noted high motivation to attend school in B2b without a feeding programme
- High drop out after primary school because of costs of Junior High School (JHS) and will only invest if the child shows potential; children are often old for grade and ready for employment/marriage/want to leave home

Very few of the parents in our H/FHH had received any education but they were nevertheless motivated to send their children to school at least to standard six and beyond where possible. The RCA team observed parents hurrying their children to get ready for school and relieving them of chores so that they were not late in the mornings and could study in the evenings. “If you can read and write you will not be tricked,” (grandfather, B2a), “without school you cannot mix with some people,” (mother, A1) and “even if I have to sell my last goods I will make sure my child goes to school,” (father, B2b) captures the rationale and motivation of other parents to send their children to school.

“A time will come when you will not even get a job as a cleaner without a certificate,” (JHS boy, 18 years old) and many parents are concerned that farming is becoming increasingly difficult. “It is better they get a job,”

(father, B2a) was typical of many parents' sentiments in those villages where there had been examples of people leaving and getting better jobs. Children too were quite motivated at primary level and this age group often told the team members that they wanted to be teachers, nurses, and doctors and serve their villages when they grew up. However, it was evident that if the JHS was some distance from the village, only those 'gifted' or 'school type' children would continue. Parents make clear choices between their children and will invest in those with potential (have a 'calling'), mostly irrespective of their gender¹⁹ but withdraw support for those they consider 'lazy' or 'struggling' or 'who refuse to go' and expect them to contribute to the family subsistence farming or seek waged work outside the community. Going to JHS incurs costs; uniforms and additional exercise books contribute to households accommodating the students and (if no JHS in vicinity) travel costs. In cashless societies as these villages mostly are, these costs are difficult to meet. Even if there is a JHS in the village, terminal exams have to be taken in central examination centres, which is considered costly for families living in poverty.

The motivation for schooling is frustrated by the lack of teachers and teacher absenteeism. In five of the six villages, teacher absenteeism was mentioned by parents as a problem. The only village where this was not mentioned was the one near town, which has a full range of teachers (B3). Children from the other villages told us that they often go to school and there are no classes, "we go to school but only to play as the teachers are not there," (six-year-old girl, B1). Parents feel that the best teachers do not stay in the village schools ("teaching in villages is not effective compared to town," (mother, B2a) and our observations revealed that trained teachers comprised of less than one-third of the teaching staff in the study sites. Parents were frustrated that even where there were teachers' houses, they did not stay in them, "making poor excuses that there is no electricity or water is not available." The main reason cited for teacher absenteeism was long and difficult road journeys, exacerbated in the rainy season, but also parents complained that teachers were engaged in their own businesses. The presence of housing for teachers did not solve these problems.

The low teacher-student contact hours, the lack of trained teachers, and the lack of textbooks are the main reasons families feel that education attainment is low. Basic materials such as pens and paper are lacking and we observed children writing directly on the floor in class in order to practise their writing skills.

Regular school attendance is a problem in most of the schools except the one nearest the town (B3, though even here the lure of lucrative work in cultivating beans and fishing leads to seasonal absenteeism). Children exercise a high level of self-agency regarding their attendance at school. Parents complained to us that they tried to motivate them but they would not go.²⁰ It was clear that some parents were not aware that their children were playing truant (leaving home in uniform but not actually going to school). The children themselves, though often shy to explain this, indicated that the main reasons for non-attendance were that they did not understand the lessons or were frightened of corporal punishment. We observed much evidence of corporal punishment suggesting that this was not just used as "an acceptable excuse" to garner sympathy from mothers, in particular, but a reality. Children in village A1, for example, we observed running to school in the early morning and after mid-morning break were clearly in panic and breathlessly told us that they would be caned if they were late. We observed teachers slapping children in classrooms and in recreation breaks and boys being made to kneel on the hot ground in full sun as a punishment for 'fighting.' An HHH with two sons aged nine and 12 explained that the younger one only went to school once for three days and refuses to return after a beating by the teacher, while the older brother rushed off each morning without eating breakfast and still buttoning his shirt on the way in order to avoid the morning "caning if I am late for numbers."²¹

¹⁹ Very rarely we heard sentiments suggesting that it was a "waste of money" to educate girls "because they move away and stay with someone else, get pregnant and drop school... so better to invest in boys."

²⁰ One HHH mother was so upset that she had not been able to persuade her two children to continue in school she would stop eating when discussing it with the RCA team member.

²¹ (Father, b2a) there were also some conversations in B2b that educated children will turn against their parents and the investment in their education will be lost.

Discussions with teachers and observations of classes at different times of the day indicated that girls outnumber boys in primary classes. Interactions with children suggest that this is because boys are (i) more likely to suffer punishment and become-de-motivated; and (ii) are eager to engage in paid labour or earning for themselves²² as soon as they are physically strong enough, not so much to supplement the family income or because they are expected to but to pay for their own snacks, clothes and, with time, mobile phones, and phone credit. During the dry season many young people move in search of employment, often portering in large urban markets.

Mothers, in particular, sometimes collude with their children's decisions not to attend school. For example one HHH mother (B1) bought her sons fishing nets and chided the older son for taking the younger one to school as "it is too far and he will get ill walking in the sun." Some children complain they get bullied or teased on the way to school and mothers keep them home.

However, post-primary the situation changes with boys outnumbering girls. We were told the factors are many but include the problem girls face in travelling and finding accommodation where they are enrolled in JHS as well as the fact that large numbers of girls graduating at primary level are already in their mid to late teens and choose to raise families or migrate for work rather than continue to JHS. A daughter of one of the HHH in A1 said she missed school for several years and when she returned she suffered daily teasing because she was so much older than the others in the class. "She wept every day – teachers came to the house to try to persuade her to ignore the teasing. She could not and packed her bag one day and fled to Kumasi for work in the market."

School feeding programmes were operating in most of the schools. Teachers told us that the food attracts children in the lower classes (kindergarten and standard one and two), but has 'little pulling power' at higher classes. Teachers in B2a said that children will come to school "with their bowls but without pencils." We observed under-school aged children waiting all morning with their older siblings to receive the midday meal. In two villages (B1 and B2a), although the teachers are frequently absent, children were still going to school just for the lunch. Typical of others, one parent commented on the pointlessness of this incentive programme, "why provide food if there are no teachers?" In others (A1 and B2a) people think the school feeding should be stopped as portions are too small and the cooks are accused of siphoning off the supplies. Cooks told us that the pay for cooking was very low.

We heard in several locations that the distribution of uniforms was inadequate, "there are never enough." In B2b, only nine children out of nearly 500 received free uniforms in 2012. In B2a all the uniforms provided in 2012 were small sizes and were only enough for about 10% of those needing new uniforms. One of our HHH daughters (nine years old, B1) refuses to go to school because her uniform is too big for her. Teachers are said to make the decisions about who gets uniforms using regular attendance, the poor state of current uniforms, and orphaned status as the criteria. In one village (B2a), parents were asked to make a contribution towards the uniforms and warned that the charge would double if not paid within three months. Parents questioned this as they knew the uniforms were supposed to be free and were told the money was "for the school." Distribution of exercise books is considered widely as inadequate. In two places, World Vision used to provide uniforms, exercise books, and shoes for needy students but this has ceased this year.

The school resources vary enormously among the study villages. The worst is the primary school in village A3 (the village ranked most poor) where teachers "do not come for weeks at a time," (PTA Chair). There are supposed to be two government trained teachers and two youth employment teachers. The former live long

²² E.g. in B3 where fishing is lucrative, boys are attracted into this. Older boys told us they want to buy motorbikes. The nearby market has many opportunities for income earning and both boys and girls are attracted to this.

distances from the school²³ and the contracts of the latter have recently expired so throughout the four-day stay of the RCA team there were no teachers present although the classrooms were open and some students came daily. Typical of the frustration expressed in the village, one of our HHH families explained that their second daughter stopped going to school after standard five because the teachers were never there, “even when they came, by the time I got home I had forgotten what they taught me,” and the third daughter says she always comes home when the teachers are not there, “there is no point... I want to go away to be a head porter.” The friend of her twin brother explained he stopped school because he was caned often and says, “what’s the point? I don’t need school if I am going to be a farmer.” Only the youngest daughter (nine years old) is still keen to go. She is in class one and has to sit on a branch for lessons because there are no chairs and says “the teachers don’t teach properly.”

In contrast, the best school is in village B3 (the village ranked least poor). The primary school has 12 teachers making a teacher pupil ratio of 1:34. Because this school is easily accessible all the teachers live nearby and absenteeism is minimal. The school has new premises and resources including an almost daily feeding programme for all primary school children sponsored by the government feeding programme and the World Food Programme, as well as provision of free exercise books and uniforms. There is a fully staffed JHS beside the primary. Nevertheless, several of our F/HHH children have dropped out after primary school against their parents’ wishes. Some girls wanted to leave home and become pregnant rather than continue schooling.

2.9 Infrastructure

Baseline summary:

- Lighting in HHH homes is exclusively with torches, cooking is done by firewood or charcoal
- Rural roads to the villages are potholed and often impassable in rainy season but everyone believes maintenance is the sole responsibility of government
- New forms of transport in the last two years; motorkings and increasing ownership of Chinese manufactured motorbikes are making transportation easier
- 50% HHH have their own mobile phones and others largely have access to those of neighbours
- 50% HHH have radios and listen exclusively to local radio stations and mostly music

Power

All HHH use torches rather than kerosene lamps. Kerosene is problematic to purchase and is considered unsafe and troublesome so the cheap Chinese torches are preferred. Several people made similar comments to this one, “one cedi of kerosene will last for two nights while an 80 pesewas battery will last at least a month and often six weeks,” (woman, B2a). One of our HHH has a single solar panel but this has been purchased primarily as an income source as he charges people’s mobile phones for a small fee. A few solar panels were observed in villages. In B2a there are solar streetlights, which were located “close to someone powerful... I don’t dream of getting one,” (man, B2a). Poles for mains electricity have been delivered in village B2b and B3 in 2012 but sceptical inhabitants think this was simply an election ruse and do not expect the electrification programme to proceed.

All but one of the HHH use firewood all year round for cooking. This is sometimes supplemented by dried millet stalks and charcoal. In the rainy season HHH may switch to using charcoal. HHH often go to neighbours to get fire as they do not keep (cannot afford) matches. None of the HHH know about or use improved stoves.

²³ One has a 1.5-hour motorbike ride.

Roads and transport

The two villages near urban centres (B2a and B3) have relatively good roads which are part gravelled. Village B2b is adjacent to a small thriving market centre which holds regular markets three days per week and has good road access to larger towns. All the other villages are accessed by red mud roads which are dusty and potholed and difficult to pass in places, especially in the rainy season. In all villages people indicated that maintenance of the roads was the government's responsibility and did not undertake any community initiatives to fill potholes. Motorkings have appeared in the last two years and are providing much needed transport solutions. Access to Chinese manufactured motorbikes, which are relatively affordable (equivalent to seven bags of harvested beans²⁴), has meant that increasing numbers of men have these, which has freed the bicycles for children and women to use.

Table 6. Transport available

Locations	Motorkings	Trucks (market day)	Other
B3 (peri-urban)	Many	Yes	Many motorbikes
B2a (peri-urban)	Comes from town	No	Very few motorbikes
B2b (near thriving market)	Many	No	Many forms of transport including buses, minibuses
B1 (35 mins by transport)	1	Yes	Some motorbikes
A1 (50 mins by transport)	2	Yes	Some motorbikes
A3 (most remote)	No	No	Only bikes

Telephones

More than 50% of the HHH had mobile phones and three of these had more than one phone. These were mostly owned by young men. Server access was intermittent. Although mostly used for calling friends and relatives and listening to music, some told us that it had “added something important to their lives.... We can find out the price we should get for our produce,” (farmer, B2b). In village B2b, there is an established system whereby buyers contact the broker in the village and explain the quantity and rate they are willing to pay. The broker then texts this to the farmers and they are in turn able to respond if they want to. The Fulani, especially the young men, in B1 had many phones and used them for playing music, calling friends, contacting the vet and cattle dealers, and obtaining salt cake. Everywhere people charge their phones in the market (50 pesewas) or at the homes of villagers who have solar panels. Those who do not own mobiles usually can have access to ones owned by neighbours.

Radio

50% of the HHH had radios which were mostly owned and controlled by men in the household. They are mostly tuned in to local stations (Radio Walewale or Radio Builsa) to listen to music, but news programmes were also listened to in some HHH. Some HHH indicated that they had heard health messages on the radio, especially ones related to HIV/AIDS.

2.10 Other Organisations

Very little NGO support has been provided for any of the study villages and what was there has largely terminated recently (B2b and A1 being examples of recent exits). Local village churches and mosques, with the exception of B2a, are only concerned with religious services and do not have welfare programmes. F/HHH mention examples of people from outside coming and promising support, notably loans and inputs but not returning. SADA was mentioned by name in A1, B2a, and B3, otherwise government interventions were referred to as “people from outside.”

²⁴ About USD 700.

Table 7. Reported organisations and projects in study villages

Village	Other organisations	Current projects
A1	World Vision 15 years support to school, TBA training, water and sanitation, etc., but finished 2012	None
B1	None	None
B2a	Mission – actively run by minister and his wife for past 8 years	Ongoing education and welfare
B2b	Technoserve (INGO) 5-year project to help farmers groups with inputs, marketing, and storage but closed	None
A3	World Vision but left 'long ago'	
B3	'Presby' Community based rehabilitation programme of the Presbyterian Church of Ghana World Food Programme (school feeding) Ameer Waheed Water for Life-installation of boreholes	Projects for the elderly WFP continuing school feeding None

2.11 Local Governance

All eligible HHH voted in the last national elections (December 2012) despite the long queues. There was cynicism in most villages shared about the way in which projects were started in 2012 and have stopped since the election (e.g. electricity poles abandoned, school building construction halted, short-term health insurance provided).

There was much frustration vented regarding Assembly Members who are “not trusted,” “not transparent,” and “never give us feedback.” Some have never seen the Assembly member and do not know their name (e.g. in B2a people said “we don’t have an Assemblyman because if we did we would know him”). Others said they rarely visit and live in town.

The Unit Committee was also often criticised as not being very active (e.g. “we voted for them but do now know what they are doing” (man, B2b). But mostly the HHH felt marginalised from community decision-making and felt they had very little voice.

Chiefs and sub-chiefs are respected and are most active in solving local disputes. Three villages are awaiting appointment of new chiefs following the death of the previous incumbent, and one has an absent chief whom they distrust since he is “being made rich by the Fulani...and we want them to go,” (B3). They are regarded as a link between the community and external people as they all go through the chiefs.

It was very apparent that there is a strong correlation between connectedness to power holders outside the village and the level of development of the village. Table 3 shows this clearly in terms of bridging social capital.²⁵ All villages seemed to have a PTA but their role and effectiveness varied considerably. In B1, it was claimed that the PTA works well and is currently constructing a new kitchen for the school funded by parental contributions, and in B2b, they have organised the installation of speed bumps to control the traffic around the school. In B2a, parents are afraid to attend because they cannot afford the contributions requested. In A1 the PTA only meets when the schoolteachers request it in order to convey important messages to parents. In A3 the PTA has a

²⁵ Details of these connections are not included here as they may compromise the confidentiality of the villages.

chairperson but people do not come to meetings because they are worried that if they raise their concerns about teacher absenteeism, it may be used against them and women say they are too busy to attend. In B3, the PTA exists but it not very active and our F/HHH were not really sure of its role or activities.