Paper prepared for the conference, "Democratic Deficits: Addressing the Challenges to Sustainability and Consolidation Around the World"
Sponsored by RTI International and the Latin American Program of the Woodrow Wilson Center
September 18, 2007
Washington, DC

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Are You Being Served?
Popular Satisfaction with Health and Education Services in Africa

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Are you being served? This inquiry always greets the well-heeled customers in the fictional department store in the classic British television comedy series. But it is rarely asked of the ordinary men and women who consume basic public services in Africa. This paper seeks to remedy the situation.

The 2004 *World Development Report* frames the debate. Its authors seek to "put poor people at the center of service provision: by enabling them to monitor and discipline service providers, by amplifying their voice in policy making, and by strengthening incentives for providers to serve the poor" (World Bank 2004, p.1). We already possess an extensive narrative testimonies of poor people's demands for socioeconomic development (Narayan 2000, Narayan et al. 2001, Institute for Policy Alternatives 2005). We also have macro-level evidence from India that responsive governance – the public sector analogue of customer service – depends on the free flow of information in the context of electoral competition (Besley and Burgess 2002, Keefer and Khemani 2003 and 2004). Yet research from the same perspective in Latin America suggests that democratic elections and public spending alone are insufficient to guarantee high quality social services or equitable service delivery (Nelson, 2005, Kauffman and Nelson 2005, World Bank 2004, 36).

This paper builds on these foundations by exploring the determinants of public satisfaction (or dissatisfaction) with health and education services in Africa. I select these basic services because of their intimate links to economic growth and human welfare. And, I show at the end that factors like the users' poverty status and their experiences with service providers have implications for satisfaction with the regime of democracy.

Research Questions

The following research questions guide the study:

- How important are basic social services among Africans' development priorities?
- How satisfied are Africans with government performance in the health and education sectors?
- For users, which aspects of service delivery matter more: quantity or quality?
- If quality matters, which aspects of users' experiences with service providers are decisive?
- Does official corruption always undermine popular satisfaction with services?
- Is there an linkage from satisfaction with service delivery to satisfaction with democracy?

The paper proceeds in three parts: contextual, descriptive, and analytic.

Part One describes the context of service delivery. It begins by asking whether (and where) concerns about health and education appear on a "popular development agenda." It also probes "who should provide?" and "who should pay?"

Part Two conceives and measures the main dependent and independent variables. The object of explanation – popular satisfaction with service provision – is measured in alternate ways. We then theorize that service satisfaction will be determined principally by users' perception of the quality of services rendered. Various measures of service quality – ranging from the general ease of access to services, to specific encounters with maladministration and corruption – are reviewed for both health and education sectors.

Part Three is analytical, testing a full range of prospective determinants of service satisfaction in multivariate models. We find that "user-friendliness" in service access is essential, especially to poorer clients. But the low quality of daily service provision undermines client contentment. And corruption has unexpectedly mixed effects. The analysis ends by demonstrating that public satisfaction with basic social services is also part of the instrumental calculus that Africans employ to arrive at judgments about new regimes of electoral democracy.

Data Source

Data are drawn from the Afrobarometer, a comparative series of public attitude surveys on democracy, governance, markets and living conditions.[1] The series is based on randomly selected national probability samples ranging in size from 1200 to 3600 respondents per country and representing cross-sections of adult citizens aged 18 years or older. Samples are selected from the best available census frames and yield a margin of sampling error of no more than plus or minus 3 percentage points at a 95 percent confidence level. All interviews are conducted face-to-face by trained fieldworkers in the language of the respondent's choice. Response rates average above 80 percent. Because a standard questionnaire is used with identical or functionally equivalent items, comparisons of results are possible across countries and over time.

Analysis is based mainly on Round 3 of the Afrobarometer, which covers 18 African countries during March 2005 to February 2006. Recent coverage includes 12 anglophone, four francophone and 2 lusophone countries.[2] Because survey research is most feasible in open societies, the Afrobarometer over-represents stable democracies, although some unstable and undemocratic countries – such as Uganda and Zimbabwe – are included. While the survey results can be generalized to people who live in Africa's new multiparty electoral regimes, they should not be taken, without due caution, to refer to all Africans.

Part One

The Popular Development Agenda

Given difficult life circumstances, Africans demand health and education services. But what priority do they attach to various felt needs? The best way to find out is to ask ordinary people, as with the following Afrobarometer question: "In your opinion, what are the most important problems facing this country that the government should address?" Respondents are encouraged to offer up to three answers. Overall, the distribution of answers can be regarded as a popular agenda for development.

Table 1 shows the top ten problems identified by over 25,000 respondents in Afrobarometer Round 3 surveys in 18 African countries circa 2005.[3] Unemployment is the biggest concern, being mentioned by 39 percent of all respondents. Problems of economic livelihood dominate the list; in priority order, these are unemployment, food shortage, poverty, transport infrastructure, agricultural production and marketing, and the management of the national economy. Together, economic problems account for two thirds of the top ten items, suggesting that Africans conceive of development primarily as a matter economic survival or material advancement.

Social development has a lower profile on the popular development agenda, though health care, especially for malaria and HIV/AIDS, is the second most frequently cited problem, mentioned by 30 percent of respondents. Education (ranked fifth) and household water supply (ranked sixth) round out the list of frequently mentioned social service priorities.

Unless crime and insecurity are classified as political problems, there are no issues of good governance on the popular development agenda. Not shown in Table 1 is the fact that official corruption ranks eleventh, suggesting that, unlike international aid agencies, ordinary people attach limited importance to this obstacle to development: just 8 percent ever mention it.

Table 1: The Popular Development Agenda,
18 African Countries, 2005

Most Important Problems	Percent of Responses	Percent of Respondents
Unemployment	13	39
Health	10	30
Food Shortage	8	25
Poverty	8	24
Education	7	22
Water	6	20
Transport Infrastructure	5	16
Agriculture	4	13
Management of the Economy	4	11
Crime and Insecurity	4	11

Source: Afrobarometer Round 3 (N of responses = 69,095).

Total in last column exceeds 100 percent due to multiple responses.

In other respects, however, the popular agenda converges with official development priorities. Mass preferences are broadly consistent, for example, with the United Nations' Millenium Development Goals to "eradicate extreme poverty and hunger," "reduce child mortality," "improve maternal health," and "achieve universal primary education" (United Nations 2006).

How has this popular development agenda evolved over time? Several trends are evident when selected results are compared from three rounds of Afrobarometer data, 2000 to 2005 (see Figure 3).[4] First, unemployment is the top preoccupation at every moment, reflecting the central role that cash income plays in individual and household welfare. Moreover, popular concern about joblessness is rising, from one in three Africans in 2000, to four in ten by 2005. Second, food shortages are the fastest growing problem, with the proportion mentioning hunger more than tripling between 2000 and 2005, a period when drought hit East and Southern Africa. Third, access to health care is always the leading social problem, rising by a significant 10 percentage points and being mentioned by more than a quarter of all persons interviewed in 2005, an upsurge that coincides with the acceleration of deaths related to HIV/AIDS.

Mass Policy Preferences

How will demands for health and education be addressed? Whom do Africans hold responsible for providing these basic social services? Is it the state, the private sector, or the individual?

We find strong evidence of popular support for state intervention. Asked in 2000, "Who is responsible for providing schools and clinics?" a majority of 59 percent across 11 countries said

"the government" (See Figure 5). Only 4 percent chose "private companies" or "individuals," but some 28 percent were willing to countenance "a combination of these providers."

Thus, public opinion clearly holds that the national government has an obligation to provide education and health care for all. This position is not inconsistent with the international policy consensus that "no country has achieved significant improvement in child mortality and primary education without government involvement."(World Bank, 2004, p.11).

But who should pay? African governments have taken a range of policy stances with regard to financing basic social services. Whereas the governments of Malawi, Uganda, Kenya, Tanzania, Zambia and Cameroon have introduced free universal primary education (UPE), governments in countries like Ethiopia and South Africa, among others, continue to require payments for tuition (Development Committee 2001, Boyle et al. 2002, Bentaouet-Kattan and Burnett 2004, Stasavage 2005). Moreover, even where education is ostensibly free, parents may still have to cover uniform, book, exam, or activity fees. And parents also support community schools in the rural regions of countries – like Chad, Togo and Mali – where the state has been unable to deliver public education.

African governments have adopted a similar gamut of financing policies in the health sector (WHO 2004, Thiede et al. 2004). At one extreme, South Africa's extensive health care system provides free primary care at public clinics for anyone who is uninsured. By contrast, patients in countries like Benin pay for consultations with medical personnel and cover up to two thirds of total costs through out-of-pocket payments (Wadee et al. 2003, Dieninger and Mpuga 2005).

The bold introduction of universal free access to social services invariably involves a massive expansion in the number of users and a concomitant decline in service quality. Over three rounds of surveys, the Afrobarometer has asked citizens to weigh the pros and cons of this trade-off. For example, is it better "to have free education for our children, even if the quality of education is low?" Or is it better "to raise educational standards, even if we have to pay school fees?" One might predict that poor populations with limited previous access to schooling would be enticed by the prospect of gratis provision and would discount the issue of educational quality. But, most Africans we have interviewed have always shown commitment to high educational standards, even if fee payments are required. But the majority preferring this policy has declined over time – from 62 percent circa 2000, to 60 percent circa 2002, to 53 percent circa 2005 (see Figure 6) – perhaps as people have come to appreciate the equalizing benefits of primary school provision to the poor.

As might be expected, support for a policy of tuition fees is highest in countries where people are accustomed to paying for education, as in Ghana (74 percent in 2005), Mali (69 percent) and South Africa (67 percent). By contrast, a majority of people prefers universal free education in those countries wherever this policy prevails: for example in Tanzania (56 percent), Zambia (55 percent) and Kenya (51 percent). It is noticeable, however, that mass endorsement free education is lukewarm in the latter group of countries. And Uganda constitutes an intriguing exception: despite the availability of free primary education since 1996, a barely changing minimum of 55 percent of Ugandans – whether in 1999, 2002 or 2005 – has repeatedly sided with a policy of school fees and high educational standards. Because primary school enrolment doubled in five years, Ugandans are perhaps weighing the costs of overcrowded classrooms, low academic achievement, and rising dropout rates (World Bank 2002).

Part Two

Within this context, we now address the central research question: what explains popular satisfaction with health and education services? Our thesis is that the people arrive at evaluations of government performance through a learning process: popular satisfaction (or dissatisfaction) is shaped by individual experiences with access to services.

Popular Service Satisfaction

In this paper, we measure popular service satisfaction with survey responses to questions about "How well or badly would you say the current government is handling the following matters, or haven't you heard enough to say?" The relevant sub-items are "improving basic health services" and "addressing educational needs."[5]

Average results for across 18 countries are given in Figure 9. Wide variations in positive popular evaluations suggest that Africans can readily distinguish among policy domains and arrive at separate and divergent judgments about each. With this indicator, a sharp differentiation emerges between social and economic sectors, as does a somewhat more cautious mood overall.

In the social sectors – health, education, crime and domestic water supply – people consider that governments are performing well rather than badly. Two-thirds or more approve of government performance in the education and health sectors (67 and 74 percent respectively). It is notable that, government performance on every social service is seen to exceed the Afrobarometer mean (46 percent) for all policy domains.

Oddly, given the spreading ravages of AIDS deaths, people seem to be especially pleased with government performance at combating HIV/AIDS. This result (70 percent approval) may be skewed, however, by psychological denial among respondents (just one-third admit that they know anyone who has died of AIDS), popular ignorance about policy programs (7 percent "don't know" how well government is doing), or the influence within the sample of the large numbers of interviews conducted in West African states (where infection rates – and therefore the salience of the AIDS issue – remain relatively low).

A contrasting picture emerges in the economic policy sectors (see Figure 9). The Africans we consulted were evenly split on the management of the national economy: 48 percent thought that governments were doing well, 48 percent badly. Otherwise, with reference to all other economic policies – from controlling corruption to closing income gaps – more people scored governments as doing badly rather than well. Moreover, performance at all economic tasks was evaluated as falling below the Afrobarometer average for government performance. At the extreme, only about one quarter of respondents gave a positive rating to African governments' performance at inflation control, job creation, and closing the gap between rich and poor.

In addition, the gap in popular satisfaction with government performance between social and economic sectors is widening over time. As Figure 10 shows, satisfaction with education services was 29 points higher in 2000 than satisfaction with income redistribution. But by 2005, this difference had grown to a gap of 44 percentage points.

In sum, while people are reasonably satisfied with social sector policy performance, they are increasingly disturbed that their governments have made little progress at addressing challenges of economic management.

But it is still necessary to probe the sources of the unexpectedly high levels of popular satisfaction with government performance in health and education. Perhaps some elements within the national population – say poor, rural people – are easily satisfied with low quality performance. We test this hypothesis with a simple statistical model that regresses policy satisfaction on a standard array of demographic predictors. As shown in Table 2, we get some confirmatory results. It is true that living in a rural habitat induces people to be more satisfied with health and education policies. And older people are more tolerant of existing levels of performance in the education sector.

On the other hand, education improves people's knowledge of policy outcomes, raises expectations for service quality, and therefore is negative for policy satisfaction.

Moreover, poverty pulls even more strongly in the same direction: poorer people are decidedly less likely to approve of policy performance in both social sectors. The Afrobarometer employs a lived poverty index to measure poverty that is based on an individual's experience with shortages of basic human needs (Afrobarometer 2003). Since the index includes "medicines or medical treatment" and "school expenses for your children," it is hardly surprising that people who are deprived of these needs also feel that the government is underperforming in these domains. So, among demographic considerations, poverty will probably always be a strong (negative) influence on satisfaction, a proposition that we will test further.

Table 2: Demographic Sources of Service Satisfaction
Health and Education Sectors, 2005

	Satisfaction with Health Sector Performance		Satisfaction with Education Sector Performance	
	B (S.E)	**Beta (sig.)**	**B (S.E)**	**Beta (sig.)**
Constant	2.860 (.041)		2.731 (.042)	
Gender (Female)	-.015 (.012)	-.009 (.216)	.004 (.013)	.002 (.729)
Habitat (Rural)	.077 (.013)	**.042** (.000)	.109 (.014)	**.058** (.000)
Age	.001 (.000)	.009 (.214)	.003 (.000)	**.045** (.000)
Education	-.019 (.003)	**-.043** (.000)	-.014 (.004)	**-.030** (.000)
Poverty	-.199 (.007)	**-.213** (.000)	-.153 (.007)	**-.161** (.000)

Cell entries in bold identify statistically significant relationships.

"How well or badly would you say the current government is handling the following matters?"

In the analysis that follows, we employ three versions of the dependent variable: "satisfaction with health services," "satisfaction with education services," and "overall satisfaction with basic social services," which is an average construct of both (health and education) indicators. The construct is permissible because the first two variables are highly correlated.[6] Stated differently, the people who are satisfied with education services tend to also be satisfied with education services, and vice versa.

But what are the main determinants of popular service satisfaction? In the sections below, we define, measure and describe various the structure and processes of service access.

Accessibility of Services: Infrastructure

One possible source of public satisfaction is the physical proximity of service infrastructure in the towns and villages where people live. After all, the prospect of gaining access to a social service would seem to start from the convenient availability of a nearby service outlet (World Bank 2004, 22). The Afrobarometer measures service infrastructure in a distinctive way. Apart from interviews with randomly selected individuals, the surveys include contextual observations by interviewers and supervisors for every primary sampling unit. Among other things, the field teams record the presence or absence of post offices, police stations, electrical grids, and – with relevance to the present inquiry – primary schools and health clinics.

As measured by this method, Figure 11 shows the percentages of adults in 2005 living in a locality with a primary school or health clinic in each of 18 African countries. According to our field observations, countries like Senegal, Benin, South Africa and Uganda have a more physically accessible social service infrastructure than countries like Namibia, Botswana, Zimbabwe and Lesotho.[7] The density of service infrastructure is everywhere greater for schools than clinics. More than three quarters of adults live in areas with access to a local primary school compared to less than half who possess ready access to a local health clinic (on average, 76 percent versus 42 percent).

Accessibility of Services: User-Friendliness

Quite apart from proximity, the accessibility of services depends upon the organizational feature of "user-friendliness." From a user's perspective, a service may be simple, transparent and inclusive or it may be formal, complex and exclusionary. For poor or illiterate people, especially if they feel they lack the skills and status to engage with the agencies of a bureaucratic state, the approachability of the service transaction may be a prime consideration.

In short, do would-be clients find health and education services in Africa easy or difficult to use? The relevant survey questions are direct: "In your experience, how easy or difficult is it to obtain the following services: A place in a primary school for a child? How about medical treatment at a nearby clinic? Or do you never try to get these services from the government?"

Figure 12 suggests that people find it easier to get a child into school than to get medical attention. Whereas, in 2005, 66 percent reported that it is easy to gain access a basic educational service, some 56 percent said the same about a basic medical service. But we reconfirm that, for both services, more people report a positive level of approachability than a negative one. And we note that the main difference between sectors lies in the proportions that find it "very easy" to obtain the service (20 percent for education versus 13 percent for health).

Service Experiences: Education

We now further disassemble the general concept of service accessibility by probing specific aspects of the service experience as seen from a user's perspective. Which obstacles – of service availability, quality, and cost – arise most frequently? For education, the survey asked**,** "Have you encountered any of these problems with your local public schools during the past 12 months?" A list of seven problems was then read out, ranging from "overcrowded classrooms" to "demands for illegal payments."[8]

Figure 13 compares the reported frequency of problems arising with education services. In this case, we count only those persons who have had contact with primary schools during the previous 12 months.

Because popular demand for education exceeds the supply of school facilities, overcrowded classrooms are the most common specific problem, reported by 57 percent of users. This problem arises significantly more often for Africans in countries with universal free primary education,[9] but classroom overcrowding is widespread too in Benin and Nigeria. The related problem of shortages of textbooks and other classroom supplies arises with similar frequency (56 percent). A stunning 95 percent of Zimbabweans report textbook shortages, which reflects the desperate scarcity of foreign exchange in that country and the virtual collapse of routine functions within the Ministry of Education.

Is public schooling "too expensive?" Are users "unable to pay?" In the litany of user problems, the costs of primary schooling actually assume somewhat low priority. Fewer than half of all respondents say that the expense of required fees inhibits them from sending children to school. In this instance, the provision of UPE hardly makes a difference: in 2005, over 80 percent of Zambians still complain about school fees, as do about half of Kenyans, Malawians and Ugandans. Only in Tanzania, where, fewer than one third of adults see financial obstacles to school access does free education have a large positive effect in reducing the problem of fees. Presumably, in the other UPE countries, parents still face a bevy of unofficial charges and expenses.

Finally, about one quarter of users (26 percent) say they confront demands for illegal payments from teachers or school administrators. These may range from bribes in return for school placement to side-payments for private lessons. Such corruption reportedly hardly ever happens in Botswana and Lesotho (so say under 10 percent), but it is said to be common in Namibia (over 40 percent) and rife in Nigeria (over 60 percent). Interestingly, educators are slightly but significantly more likely to report facing demands for bribes in countries with UPE than in countries without this policy.[10] Perhaps because teachers and administrators feel overstretched by the influx of waves of new pupils, they are more likely to feel justified in seeking illicit rents.

Service Experiences: Health Care

A parallel set of questions was asked about health care: "Have you encountered any of these problems with your local public clinic or hospital during the past 12 months?" A list of seven problems was offered, ranging from "long waiting times" to "demands for illegal payments."[11]

Figure 14 breaks down the recent experiences of persons who attempted to use clinics and hospitals. On average, slightly more users report a specific problem with health services (51 percent) than with education services (48 percent, see Figure 13).

This discrepancy is most evident in relation to overcrowded facilities, where three quarters (73 percent) of clinic users complain about "long waiting times" (compared to 53 percent who see "overcrowded classrooms" in schools). By a clear margin, delays in delivery at the point of service are the biggest problem. On any given day, urban hospitals are typically unable to accommodate all patients; long lines of applicants regularly assemble outside rural clinics; and, too often, some people are turned away at the end of the day without consultation or treatment. Relative to effective levels of client demand, health services are in even shorter supply than education services.[12]

Two-thirds of health care clients also report shortages of medicines and other medical supplies. Once again, users confront supply deficits with greater frequency in the health sector (66 percent) than in the education sector (where 56 percent see shortages of textbooks, see Figure 13). Regardless of whether a sound health infrastructure has been built, local clinics may lack the basic commodities needed for routine preventative care. Over 80 percent of Kenyans, Ugandans, Zambians and Zimbabweans express concern about the under-provisioning of health care facilities.

Across all countries, however, health service problems are significantly more common in rural than urban areas. Waiting times are longer at rural clinics in part because of the sparser coverage of health infrastructure in remote areas; medicines are less readily available at clinics due partly to long supply lines from the capital city; and doctors are more often absent, in part because professionals are reluctant to serve at distant outposts. In the only exception to this general tendency, clients claim that medical staff – nurses, technicians, and clerks – are more likely to treat them rudely and without due respect at urban hospitals and clinics.

Across the health and education sectors, equal proportions of survey respondents say they receive corrupt proposals from service providers (that is, about one-quarter). Once again, citizens of Botswana and Lesotho report the fewest attempts at such extortion by health workers (under 5 percent). The South African health system also scores well in terms of the reported probity of its front-line officials. But Uganda now displaces Nigeria as the country where demands for bribes are reportedly most common: in 2005, almost half of all adults who use health services in Uganda say they faced a request for an illegal payment from a health care worker in the previous 12 months (48 percent). Again, in Uganda and elsewhere, demands for bribes tend to be more common at rural clinics, perhaps because Ministry officials find it difficult to supervise field staff in outlying areas.

Corruption

Popular encounters with official corruption are expected to corrode service satisfaction. As a key component of bad governance, the multifaceted concept of corruption is worth measuring from various angles.

On perceptions of the prevalence of graft, the Afrobarometer asks, "how many of the following people do you think are involved in corruption: (a) teachers and school administrators (b) health workers?" This question taps the popular reputation of service providers quite independently of whether an individual respondent has ever been directly approached for a bribe. In absolute terms, health and education workers in Africa have yet to win reputations for complete honesty. On average, 20 percent of the Africans we interviewed perceive that "most" or "almost all" health workers are corrupt. The equivalent figure for teachers and school administrators is 16 percent. In relative terms, however, these estimates are lower than for any other category of public official, especially customs agents (35 percent) and the police (43 percent).

On citizen behavior, the Afrobarometer asks whether, during the past year, individuals actually "had to pay a bribe, give a gift, or do a favor to a government official in order to: (a) get a child into school or (b) get medicine or medical attention from a health worker?" These questions emphasize the distinction between being asked for a bribe and actually paying one.

A gulf exists between perceptions of corruption and the act of handing over a bribe. Some six in ten citizens think that at least "some" public officials are corrupt (62 percent). Yet only one in ten reports that they made any type of extra-legal side-payment to obtain a service during the

previous year (10 percent). As such, people either over-estimate the extent to which corruption pervades their society, or they under-report their own involvement in the socially disapproved act of paying a bribe. Or, most likely, both these biases are present in the data. As such, the real level of illegal exchanges of public goods for private gain probably lies somewhere between these extreme estimates.

Importantly, illicit payments are reportedly almost twice as common for health care than for schooling (13 versus 7 percent), a result that confirms a relationship between the scarcity of a service and the likelihood that it will be traded on a parallel market.

Part Three

This explanatory section of the paper aims at a comprehensive multivariate explanation of popular satisfaction with public services in a cross-section of Africa's new democracies.

Explaining Service Satisfaction

Regardless of the way that satisfaction is measured – with health services, with education services, or with both – the regression models in Table 3 tell a similar story. The strongest and most statistically significant relationships are highlighted in bold in the table and their explanatory power is ranked in parentheses.[13]

The most important consideration – consistently ranked first – is the **accessibility of services**. Across both health and education – and for these social services generally – what matters most is whether clients consider services to be "easy to use" or, on other words, "user-friendly." This quality captures whether citizens regard public services as being open to all types of clientele and as being uncomplicated to operate. It is a quality pertinent to low income, non-literate, peasant populations who seek to draw social services from the agencies of a bureaucratic state. They wish to avoid formal entanglements in administrative red tape and interactions with officials whom they feel to be socially distant. If ordinary people can get a child into school or receive primary health care with a minimum of such hassles, they are likely to be satisfied with service delivery.

It is important to note that this subjective element of service accessibility is much more critical than the objective one. As Table 3 shows, physical infrastructure – whether there is a school or clinic in the locality – remains largely unimportant to service satisfaction. For social services generally, the scope of infrastructure has absolutely no effect on satisfaction (beta = .000!) And a nearby school is actually negative (though statistically insignificant) for satisfaction, which again suggests that, for parents with school-age children, the quality of educational services trumps mere quantity.

The relative superiority of subjective over objective criteria raises a challenge for government ministries responsible for health and education in Africa. Success at service delivery is not simply a matter of building more clinics and schools. Instead, it requires an organizational commitment to an ethic of customer service by which the client comes to feel that his or her needs are being considered and addressed.

The second most important consideration for service satisfaction is the position of the user in the **social structure**. Several dimensions of social identity are relevant, including gender, habitat, education and, especially, poverty.

The poverty status of users remains the key social consideration. The connection of poverty to service (dis)satisfaction is at least three times as strong as the average for other societal influences. And poverty's impact is consistent for both health and education services, and therefore for these social services together. Notably, the impact is negative. The poorer a person, the less likely is he or she to be satisfied with government performance at social delivery. This strong effect persists even after the physical proximity and the user-friendliness of services – among other factors yet to be discussed – are taken into account.

Table 3: Sources of Service Satisfaction, 18 African Countries, 2005

	EDUCATION SERVICES	HEALTH SERVICES	BOTH SERVICES
Constant	*2.766***	*2.662***	*2.621***
Social Structure			
Gender (female)	-.008	-.018*	-.016*
Habitat (rural)	.037***	.033***	.033***
Education	-.027**	-.032***	-.030***
Poverty	**-.098*** (2)**	**-.103*** (2)**	**-.100*** (3)**
Service Accessibility			
School in locality	-.013		.013
Clinic in locality		.033***	.000
Ease of access to education	**.129*** (1)**		.061***
Ease of access to health care		**.178*** (1)**	**.159*** (1)**
Service Experiences			
Fees too expensive	-.045***	**-.070*** (4)**	
Shortages of supplies	-.048***	-.049***	
Poor quality of teaching /treatment	**-.090*** (3)**	-.046***	
Absent staff	.007	-.039***	
Overcrowded facilities	-.016	.028**	
Substandard facilities	-.012	-.034***	
Service experiences (education)			-.079***
Service experiences (health)			**-.108*** (2)**
Corruption			
Demands for bribes	-.030***	.016	
Perception of corruption	**-.080*** (4)**	**-.101*** (3)**	**-.092*** (4)**
Experience of corruption	.008	.016*	.040***
Adjusted R square	**.091**	**.126**	**.133**

The regression method is Ordinary Least Squares (OLS)
Cell entries are standardized regression coefficients (beta)
The strongest and most significant relationships are in **bold**
(Explanatory ranks are in parentheses)
Constants are unstandardized regression coefficients (B)
Significance: ***p =<.001, **p =<.01, *p =<.05

This robust result indicates that existing services embody an anti-poor bias, at least in the opinion of the poor themselves. To the extent that poverty is more prevalent in the rural areas of Africa (as it is in *every* Afrobarometer country), this bias in accessibility is offset and obscured by the apparent willingness of rural residents to accept lower quality services. This combination of facts

suggests that, given a goal to boost popular satisfaction with service delivery, African governments would be well advised to design pro-poor health and education policies and to direct these services initially to urban populations.

Service experiences – that is, the quality of users' encounters with providers – are also part of a complete explanation.

For education services, only three out of six experiences seemingly matter. Leading the way is the poor quality of teaching, which may arise from the rapid introduction of UPE without enough qualified teachers. Shortages of textbooks (and related school supplies) and the expense of fees (including residual or ancillary charges even under UPE) also significantly depress popular satisfaction with primary education.

By contrast, every user experience is relevant to the popular evaluation of health services. Among all problem areas, the cost of services ("fees too expensive") is the principal source of dissatisfaction, markedly lowering popular approval. This outcome is consistent with the slower pace of "de-liberalization" (that is, removal of user fees) in the health sector as compared to the education sector in Africa. As expected, all other experiences – from shortages of medicines to substandard facilities ("dirty clinics") – also remain negative and significant for mass satisfaction.

But we discover an interesting anomaly: even though users of health services cite overcrowded facilities ("long waiting times") as their most frequent problem (see Figure 14), this experience has an unexpectedly positive effect on satisfaction. In other words, would-be patients are apparently willing to overlook the inconvenience of lengthy queues, or even of being turned away from a hospital or clinic and being told return at another time. Users value health care so highly that they have resigned themselves to putting up with overcrowding as an unavoidable cost of accessing this scarce service.

Finally, what is the impact of **corruption**? Table 3 indicates that general perceptions of official corruption (that is, the popular wisdom that "all" or "most" service workers are dishonest) have predictably strong, consistent, and negative effects on service satisfaction. Whether with reference the health or education sectors, or both, such perceptions are deeply corrosive to public confidence in service institutions. And it does not matter whether these perceptions are accurate or not; the mere popular belief that officialdom is an arena of corruption is enough to drive down mass satisfaction.

Table 3 also shows that, if people encounter demands for bribes from teachers and school officials, their satisfaction with educational services drops by a significant margin. In other words, the impact of actually encountering a bribery attempt from a school official, while small, has an additional negative effect. But this relationship does not hold for health services, which raises questions about whether there are distinctive consequences to concrete experiences with bribery across the two service sectors.

The results for experience with corruption certainly suggest so. Recall that this concept is measured by the frequency with which *users actually* "pay a bribe, give a gift, or do a favor to a government official." When users themselves engage in corruption, their satisfaction with social services *rises* rather than falls. This positive effect may be miniscule and insignificant for education, and small but significant for health, but it is larger and clearly significant for both services combined.

This result is unexpected and counter-intuitive. Why would the payment of a bribe, in a context where corruption is generally associated with service failure, lead users to feel more satisfied with service delivery? One possible interpretation is that bribe paying opens the door to services that are otherwise scarce and inaccessible. Supporting statistical evidence can be found in the larger positive effects for health services (which are very scarce) than for educational services (which are less scarce). And positive effects are largest for *simultaneous* access to *both* sets of scarce services, a combination that is presumably harder to attain than access to either service alone.

Substantively, this suggests that corruption is a double-edged sword that cuts both ways. When ordinary people think that officials or other users are benefiting unduly from the corrupt service distribution, they feel dissatisfied. When, however, they occasionally make a side-payment themselves in order to gain preferential access to a scarce service, their satisfaction rises. The acquisition of the service, by fair means or foul, is the decisive factor.

The implications are far-reaching. Theoretically, we are reminded that official corruption is not an attribute of political elites alone. It is a dyadic relationship that involves both a bribe-giver and bribe taker. As such, ordinary citizens, as users of social services may sometimes be complicit in corrupt relationships. Moreover, such encounters do not have universally negative impacts on their satisfaction with government performance. Practically, the participation of some citizens in bribery greatly increases the challenge of rooting out corruption. If the problem has social foundations, it cannot be counteracted by punishment of state officials alone. A solution to the problem requires that governments enforce the broad and equitable distribution of valued social services so that citizens have fewer incentives to seek preferential access by illicit means.

Implications for Democracy

Does service satisfaction play a role in the consolidation of new democracies in Africa? After all, many scholars believe that, unless elected governments are able to widely deliver the benefits of socioeconomic development, citizens – notably poorer Africans – will lose confidence in democracy (Przeworski 1991, Inglehart and Welzel 2005).

As a means of exploring these extended ramifications, we employ a standard indicator that asks, "how satisfied are you with the way democracy works in (this country)?"

As a first step, it is worth noting that satisfaction with democracy is quite well predicted by a model with the same structure as satisfaction with social services (See Table 4, Model 1). The leading (negative) factor is now a summary measure of service experiences, but ease of service access remains positive and significant. Both poverty and perceptions of corruption are consistently negative, and carry much the same weight as before. Even the experience of corruption ("paying a bribe") is positive and significant for satisfaction with democracy just as it is for satisfaction with health and education services combined.

In other words, Africans seem to use similar processes of reasoning in evaluating *both* service delivery *and* democracy. One possible calculus is that people use their felt satisfaction with social services to inform their evaluations of the political regime writ large.

But the model has a glaring weakness. It explains only a limited amount of variance: just 9 percent for education services, 13 percent for health services, and only slightly more for both services (See table 3). And it explains even less variance in satisfaction with democracy, just 7 percent (see Table 4, model 1).

Table 4: Sources of Satisfaction with Democracy, 18 African Countries, 2005

	SATISFACTION WITH DEMOCRACY	
	Model 1	**Model 2**
Constant	*2.791***	*.734***
Social Structure		
Gender (female)	-.038***	-.022**
Habitat (rural)	.041***	.022**
Education	-.078***	-.040***
Poverty	**-.132*** (2)**	**-.064*** (4)**
Service Accessibility		
School in locality	.021*	
Clinic in locality	.031***	
Ease of access to education	.040***	
Ease of access to health care	.044***	
Service Experiences (combined)	**-.138*** (1)**	
Corruption		
Demands for bribes (education)	.008	
Demands for bribes (health)	.042***	
Perception of corruption	**-.066*** (3)**	
Experience of corruption	.040***	
Performance Evaluations		
Political Performance		**.298*** (1)**
Economic Performance		**.268*** (2)**
Social Service Satisfaction		**.086*** (3)**
Adjusted R square	**.066**	**.280**

The regression method is Ordinary Least Squares (OLS)
Cell entries are standardized regression coefficients (beta)
The strongest and most significant relationships are in **bold**
(Explanatory ranks are in parentheses)
Constants are unstandardized regression coefficients (B)
Significance: ***p =<.001, **p =<.01, *p =<.05

The model is therefore underspecified. Apparently, social and political satisfactions are also driven by other, unmeasured factors. What might these be? Based on earlier Afrobarometer research, we propose that satisfaction with democracy is driven by core instrumental considerations, such as the performance of the economy and polity (Bratton, Mattes and Gyimah-Boadi, 2005, Chs. 9 and 11). Economic performance is represented by an index of "how well" citizens regard the government's handling of a range of economic policies, namely "managing the economy," "creating jobs," "controlling inflation," and "narrowing gaps between the rich and the poor." Political performance is measured by a simple indicator: to what degree do citizens think that the country's last presidential or legislative election was "free and fair"?

But our task is to determine whether government performance at *social service* delivery has implications for satisfaction with democracy. Hence we now treat our composite measure of satisfaction with both health and education services – formerly a dependent variable – as an independent variable. It is entered alongside political and economic performance as a predictor in Table 4, Model 2.

By adding performance evaluations to the standard battery of demographic predictors, we arrive at a much more powerful result. Model 2 explains 28 percent of the variance in satisfaction with democracy. To be sure, public estimates of the quality of elections and the government's capacity at economic management are the driving forces in the explanation. But, importantly, *satisfaction with basic social services also contributes to building a mass constituency for democracy*. Indeed, the positive effect of service satisfaction more than offsets the negative effect of poverty. In this regard, we can expect targeted, pro-poor social service policies will have a particularly salubrious effect on the survival and consolidation of new democracies.

Political and Policy Implications

By way of conclusion, this last section draws out political and policy implications.

- Africans now attach higher value to health care services than to education. Yet health services are in scarcer supply than educational services. Democratic governments that seek reelection in Africa would do well to attend to these expressed needs and popular priorities.

- Responsiveness matters. People judge the quality of basic social services principally in terms of user-friendliness of service agencies. Governments, especially those in electoral democracies, can gain political and development capital by aligning services to users' needs and organizing delivery in open and accessible forms.

- Users frequently encounter specific problems with different service providers. Ministries of education should give priority to raising the quality of teachers and instruction, especially in the context of UPE. Ministries of health should apply most effort to reducing (but never eliminating) the cost of primary services, if only for the poor.

- Some forms of corruption can also have perverse effects. At the margins, users who pay bribes gain increased access to services access and thereby express more service satisfaction. Anti-corruption initiatives are required at the point of service and for local society as well as the political class.

- Corruption corrodes. But popular perceptions of corruption have more influence on service satisfaction than first-hand experiences. Thus, to counteract misinformation and establish grounds for accountability, rules and procedures for equitable service delivery should be made transparent and widely publicized.

All told, the delivery of basic education and health care in Africa would benefit from a healthy dose of customer service. But, in rural health clinics as much as in high-end department stores, customers are served principally when they pay. If public responsiveness is to be achieved in Africa, then users must make some contribution, however nominal, to the cost of service provision. And our research shows that most people are not averse to paying for high quality services, especially in education. Some, especially in health, are even willing to make illegal payments.

At the same time, the open exchange of information and democratic electoral contests can inject additional measures of disciplinary control over public officials. Only when real political and economic resources are at stake are citizens likely to succeed in bending social services to their needs.

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Endnotes

[1] The Afrobarometer is a joint enterprise of the Institute for Democracy in South Africa (Idasa), the Center for Democratic Governance in Ghana (CDD), and Michigan State University (MSU).

[2] Benin, Botswana, Cape Verde, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mali, Mozambique, Namibia, Nigeria, Senegal, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

[3] Surveys in South Africa and Namibia were conducted in early 2006.

[4] For this trend analysis, the sample is restricted to the original 12 countries covered by the Afrobarometer since these are the only cases for which we have three observations over time.

[5] In both cases, responses are scored on a four-point scale from "very badly" to "fairly badly" to "fairly well" to "very well." The full scale is used for all inferential statistics, with "don't know" and "haven't heard enough" treated as missing data. For descriptive purposes, we commonly collapse the "very" and "fairly" categories together to create a simple two point scale of "badly" and well." For descriptive statistics, we calculate and report frequencies inclusive of "don't know" and "haven't heard enough."

[6] Pearson's $r = .606$, $p<.001$.

[7] We concede, however, that variations across countries in the size of primary sampling units and in the quality of field observations make these data less than completely reliable and comparable. They are best treated as estimates rather than definitive data points.

[8] All were scored on the same four-point scale from "never" through "once or twice" and "a few times" and "often." Descriptive statistics are calculated against a base that excludes those who "don't know" or who had had "no experience with public schools in the past 12 months." To avoid losing cases, the latter respondents were assigned the mean value for the distribution on each sub-item when calculating all inferential statistics.

[9] 66 percent versus 54 percent: Pearson's $r = .153$, $p<.001$

[10] Pearson's $r = .046$, $p<.001$.

[11] See endnote 11 (check).

[12] This general finding holds for 15 of the 18 countries in the Afrobarometer. The only exceptions, where overcrowding isrportedly more common in schools than clinics, are Benin, Madagascar and Mali.

[13] Explanatory rank is derived from the relative size of the standardized OLS regression coefficient (beta).