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DISTRICT ASSEMBLIES AND PROVISION OF SOCIAL SERVICES IN GHANA. INTERROGATING EDUCATIONAL AND HEALTH CARE INFRASTRUCTURE AND SERVICES IN BEKWAI MUNICIPALITY

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ABSTRACT: *This study assesses District Assemblies' contributions towards the provision of educational and health care infrastructure and services in the Bekwai Municipality. Questionnaires were administered to one hundred (100) households and fifty (50) Assembly Members while in-depth interviews were conducted with the Municipal Directors of Education and Health Services as well as the Planning and Chief Executive Officers. The chi-square test statistics were employed in the inferential analysis. It was found out that activities of the Assembly have expanded education and health infrastructure. This was seen in the consistent increase in providing more school facilities and renovating dilapidated ones as well as providing health facilities and CHPS compounds in remote areas to provide basic health services. Despite these achievements, for more than three decades into the implementation of the decentralisation policy, there still exist inequalities in the provision of education and health infrastructure and services in most communities in Bekwai Municipal. In order to improve equality in access to education and health services within the context of decentralisation, the study recommends: the provision of health and educational facilities should be fully supervised by the respective departments at the sub-national level; the provision of health and educational infrastructure must go through proper identification through to the operational stages to ensure adequate stakeholders participation and the capacity of the assembly in providing health and educational infrastructure and services should be enhanced.*

KEYWORDS: Decentralisation, District Assemblies, Education, Health.

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INTRODUCTION

In the early 1950s, the development activities of most countries were controlled by the central government. Guiding and controlling the economy was done by central planning and administration because most nations were coming out of the colonial rule era (Cheema and Rondinelli, 1983). However, by the end of the 1960s and 1970s, central planning could not achieve these goals in most developing countries, where economic growth continued to be low and even in areas where growth rates were high, only a small group usually benefited from the increased national production (World Bank, 1975). There were growing concerns among scholars about the most basic principles of development theory which would bring the benefits of growth to the large numbers of the poor in developing nations (Kumi-Kyereme, 2005). Decentralisation became a significant strategy in the 1970s and 1980s because governments in less developed countries wanted to create a more equitable distribution of economic growth to meet the basic needs of the poor (USAID, 1979; Kumi-Kyereme, 2005; Boateng, 2017). Also, there were general concerns for the practice of decentralisation because of problems associated with providing social services for the increased population and therefore various governments in the world began to share responsibilities for service provision and management.

In the light of providing social services for the increased population, decentralisation formed a key element in the public sector reform agendas in many countries in the 1980s and 1990s. Various governments implemented decentralisation programmes across the globe, including countries in Europe, South America and Africa among others. In West Africa, almost every country has had a decentralisation programme (Crawford, 2003).

For the past three decades, governments in Ghana have instituted some measures in decentralisation to encourage power-sharing, proper resource distribution, promote capacity building at the district level, provision of feedback, reduction of rural-urban movement and overdependence on central government (Asante, 2000). The Local Government Act, 2016, Act 936 and the National Development Planning (Systems) Act, 1994, Act 480 established the assemblies as the main local institutions responsible for the total development of districts in the country. The power to make, implement and monitor development plans has been bequeathed to the assemblies. The assemblies, therefore, have the responsibility to mobilise and utilise resources available for local development (Republic of Ghana, 1993). Since the assemblies are charged with the socio-economic development of the rural communities, they have the onerous responsibility of coming out with plans and programmes towards the provision of social services such as education and health.

However, the impact of the assembly's policies on the provision of basic education and health infrastructure and services in Bekwai municipality has not been largely examined.

In the area of education, though there has been an expansion in the classroom blocks, school furniture and teacher accommodation in the municipality, about 35 percent of basic schools run a shift scheme (BMA, 2017). About 35 percent and 31 percent of basic school infrastructure (classroom blocks) require minor and major renovations respectively (Bekwai Municipal Education Office, 2017). Additionally, about 45 percent of the basic school teachers are untrained and 76.8 percent of the pre-school teachers are untrained while there is a decline in enrolment in primary schools in the study area. This has affected effective teaching and learning in the municipality (BMA, 2017) and therefore, there is the need to largely examine this situation.

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In the area of primary health care, little research has been done to explain maternal and infant mortality rates which continue to rise despite progress in a number of health care programmes in Bekwai municipal. This is attributed to inadequate health facilities in most of the communities in the municipality (BMA, 2017). Though the municipality has fourteen (14) health facilities (Bekwai Municipal Health Directorate, 2017) ranging from health posts to hospitals, these facilities are unevenly distributed. The available health facilities are more concentrated in the urban and peri-urban areas making accessibility very difficult for the rural folks. Moreover, patients travel long distances to seek health care (only 29 percent of the people in the municipality live within 10 km of health care facility) and in areas where they exist, patients spend long hours seeking the most basic health care. This, however, results in congestion at the health centres and inadequate health care provision in the municipality (Bekwai Municipal Health Directorate, 2017). It is, therefore, imperative for the study to investigate the contributions of District Assemblies in the provision of education and health infrastructure and services using Bekwai municipality as a case study.

REVIEW OF RELATED LITERATURE

The concept of decentralisation has no single definition. Rondinelli (1981) defines decentralisation as the transfer of central government responsibility of the planning, decision-making, public functions management to lower-level agencies. Smith (1985) sees decentralisation as the transfer of administrative responsibility from the centre to the local authority. Decentralisation over the years has been practised because it was associated with providing social services for the increased population and therefore, various governments in the world began to share responsibilities for service provision and management (Boateng, 2017).

That notwithstanding, Rondinelli et al. (1983) note that decentralisation seldom, if ever, lived up to its promise. Shah et al. (2004) concur in a review of 56 studies published since the late 1990s, chronicling that decentralisation in some cases improved, and in others worsened, service delivery, corruption and growth across a large range of countries.

Various researches conducted have shown that decentralisation can help to promote expansion in educational facilities and services. In Uttar Pradesh, India, decentralisation was observed to have resulted in the expansion of primary schools. In 1982, 98 schools were established in Agra District, while an average of seven schools per year was recorded in the previous years (Sanwal, 1987). In Latin America, the educational policies of some countries expanded the provision of educational services. The enrolment rates for both basic schools and secondary schools rose from 68 percent in 1970 to 84 percent in 1987 (Cassusus, 1990). Like many other Latin American countries, Argentina undertook devolution to provinces as part of a broader structural reform, first devolving responsibility for pre-schools and primary schools, and then undertaking the same reform for secondary schools making them largely responsible for the textbook selection and teaching methods. Also, Faguet and Sánchez (2008) use changes in enrolment rates in state schools as the measure of student achievement in order to evaluate the impact of decentralisation on service delivery in Colombia. They analyse the impact of phased decentralisation reform in the country, which not only left local governments responsible for the provision of public services but also provided them with increased fiscal powers to fulfil this responsibility. Habibi et al. (2003) report the empirical relationship between fiscal

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decentralisation and the ratio of students enrolled in schools per 1000 primary students. Using Argentine data from 1970-1994, the authors find that their measure of decentralisation has a positive and significant association with their measure of education output. Yilmaz (2011) is similarly positive about decentralisation, and support his arguments with analysis conducted on a unique data set collected from 183 randomly selected villages in 5 purposively chosen districts in Pakistan. The author revealed in Pakistan that the provision of education increased dramatically after the introduction of the decentralisation reform.

Similarly, Faguet et al (2020) report in Ethiopia that decentralisation did indeed improve public education sector performance. Specifically, decentralisation to regional and woreda (district) governments led to higher school enrolment rates (NER). Clark (2009) observed that schools that opt out of the centralized educational regime – in effect decentralizing themselves – enjoy large increases in student achievement. Barankay and Lockwood (2007) find that greater decentralisation of education to Swiss cantons is associated with higher educational attainment, especially for boys. And Faguet and Sánchez (2014) also indicated that decentralisation improved enrolment rates in public schools and access of the poor to public health services in Colombia. In Ghana, Kumi-Kyereme (2005) stated that decentralisation has provided several social projects such as school facilities, health centres, water supply, market structures, roads as well as putting strategies in place to maintain such facilities.

However, it has been observed that a decentralisation programme does not always lead to expansion in the provision of educational facilities. Mwira (1990) investigated Harambee Schools in Kenya and found out that the proliferation of such schools during the 1970s and 1980s brought about inter-district inequalities in Kenyan education. Such schools were seen to be of low quality in areas of input (teacher) and output with 13 percent reaching minimum standard as compared to about 80 percent of the central government schools. The practice of decentralisation in Uganda in the 1980s where local councils were provided with needed resources for expansion of education infrastructure could not help to expand educational facilities (Francis and James, 2003). In Tanzania, local governments were inclined to the provision of infrastructure projects in the country. For instance, the provision of primary school infrastructure was within the capacity of local-level decision-making. But there were considerable problems such as funds for those projects, educational resources like books and teachers' remunerations among other things (Therkildsen, 2000). Inchauste (2009) examines the relationship between changes in education allocations, and children not attending school and un-enrolled children in Bolivia and reports that increases in education transfers were associated with a decrease in children not attending school in the 1999-2002 period, but an increase in unenrolled children in 2002-2005. The impact of education spending in both periods, and on other intermediate education indicators, is not significant. In Ghana, Korboe (1994); Norton et al., (1995) and Boateng (2017) concluded that providing quality education through the decentralisation programme has reduced. They explained that though the provision of physical structures has increased, the training of more teachers to reduce high teacher-pupil ratios in the villages declined. Kyei (2000), therefore, argued that improving the quality of education in Ghana becomes more efficient when the government (DAs) expands the provision of reading materials, training and employing more teachers, other resources needed as well as rural poor access to them.

In the area of health, Conn et al. (1996) observed that the decentralisation programme which started in the late 1970s and continued throughout the 1980s initially had potential benefits such as encouraging equitable health care provision and speeding up development programmes

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and health care coverage nationally. In Papua New Guinea, decentralisation through the devolution process promoted coordination among health professionals rather than being isolated actors as was the case for the centralised system (Smith, 1997). Accordingly, it expanded access to health care and improved the health of the population, reducing infant, children and maternal mortality and increasing life expectancy (Reilly, 1989). According to Gish et al. (1988), decentralisation of public expenditure in Indonesia expanded health services between 1969 and 1983. The Posyandu (community-based integrated health post, concerned with child survival) was largely provided throughout the country. Gonzalez-Block (1989) studied the effect of decentralisation on equity in health care provision in Mexico by comparing decentralisation in one state with a more centralised provision of health care in another state. In effect, there was an increase in overall service provision in the former whereas, in the latter, the policy of service distribution led to inequity. Faguet et al (2020) report in Ethiopia that decentralisation did indeed health sector performance. Specifically, decentralisation to regional and woreda (district) governments led to improved provision of antenatal care (ANC) to women. Atnafu (2017) similarly finds out in two woredas in the Benshangul Gumuz region in Ethiopia that decentralisation improved health infrastructure due to improved community participation.

Yet, decentralisation practises are not always seen as bringing about better health care provision. Bloom & Xingyuan (1997) observed from China that after the introduction of the programme in health care provision, the hospitals were involved in a competition to acquire advanced technology for more business opportunities. The effect was that cost of health care provision increased which made the poor household spend about 60 percent of their annual income only on average hospital admission. Atnafu (2017) reported that decentralisation improved health infrastructure due to improved community participation in Ethiopia, but a shortage of qualified manpower and weak community participation in other activities held back local progress. Collins (1989) also argues that decentralisation does not guarantee that service delivery will be more responsive to local health needs because local elite groups promote their own interests as central level officials and politicians. Similarly, Collins *et al.* (2000) point out that decentralisation does not necessarily lead to greater equity but can promote increased inequality. He stressed that experiences from Brazil indicate an increase in inequality due to the practice of decentralisation leading to rural and semi-urban areas with poor coverage of health facilities.

Finally, it is worth noting that the distance to the health facility, cost of transport and the type of ailment determine access to health care services across the globe. Oppong and Hodgson (1994) conducted a study in the Suhum district in Ghana and observed that people from surrounding villages in the district did not travel about 10 kilometres or more to seek early medical care. This

METHODOLOGY

Research Design

The research used a case study design with a mixed-methods approach. The case study design is a logical inquiry into an event or a set of related events intended to describe and explain the phenomenon of interest. It is argued that the case study method can be considered as a process

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of investigation aimed at studying the fact of a particular case from all angles. According to Creswell (2014), a case study enables researchers to pay attention to a particular issue within a specific setting through an extensive in-depth data collection employing multiple sources such as observations, interviews, documents review, and participant observation among others. Kumar (2014) explains that in a case study design, the "case" you select becomes the basis of a thorough, holistic and in-depth exploration of the aspect(s) that you want to find out about. It is an approach in which a particular instance or a few carefully selected cases are studied intensively. It is a very useful design when exploring an area where little is known or where you want to have a holistic understanding of the situation, phenomenon, episode, site, group or community. Though you can use a single method, the use of multiple methods to collect data is an important aspect of a case study, namely in-depth interviewing, obtaining information from secondary records, gathering data through observations, collecting information through focus groups and group interviews (Kumar, 2014). It is seen as very objective and replicable which enables researchers to better understand how district assemblies have contributed to the provision of educational and health infrastructure and services in Ghana. A case study design opens the way for more discoveries and gives the researcher an opportunity of studying the role of district assemblies in the provision of educational and health infrastructure and services in Bekwai municipal.

The researcher, however, is aware of some of the associated problems or limitations attached to the use of case study design. For instance, the design identifies and uses investigator related challenges such as those relating to care, skill, age and physical appearance. Again, there are problems related to the nature and type of case under investigation. One major shortcoming of the case study research is seen in the difficulty of generalising findings because of the limitation of its scope to a particular area. That notwithstanding, Denscombe (2007) agreed with the view that generalisation is possible if the situations are similar and the details are sufficient and appropriate. The researcher was, therefore, prepared adequately, for instance in respect to physical appearance on the field in the presence of the respondents.

Sample and Sampling Technique

A total sample size of one hundred and fifty-five was used in the study. This was made up of five (5) officials (heads of Education, Science and Sports and Municipal Health Management Departments, Municipal Planning Officer, Coordinating Director and the Chief Executive Officer), fifty (50) Assembly members and one hundred (100) community members from the study areas to solicit their views on the provision of education and health infrastructure and services in the Municipality.

Systematic sampling techniques and simple random sampling methods were used for questionnaire administration. A systematic sampling technique was adopted in the selection of houses in the study communities. In a situation where there was more than one household in a selected house, a simple random sampling method was employed to select one household head and also community elders at the community level. The simple random sampling method was used because it gave everybody an equal chance of selection and therefore, avoided the likelihood of bias (Opoku, 2002). Furthermore, since every subject has an equal chance of being selected, any extraneous variables to be controlled would be randomly distributed among the various groups in the sample. Again, the researcher realised that improper sampling could lead to difficulties in data analysis and making wrong inferences. As such, the simple random sampling technique was employed because it assisted the researcher to avoid such difficulties.

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The non-probability sampling technique employed was purposive sampling which was used to select communities from the urban / Area councils and the two (2) decentralised departments. Five communities (Kokofu, Bekwai, Ahwiren, Bogyawe and Abodom) were purposively selected based on their development levels. Communities' level of development was determined by the availability of basic services such as health, education water, electricity as well as road networks. This method helped to select communities that enhanced the collection of important and accurate information from residents and the key departmental heads who contribute to implementing the decentralisation process and provision of education and health services.

Data Collection Methods

Data collected were entirely from primary and secondary sources. Primary sources included a collection of data from household heads, community elders and Assembly Members on the contributions of the assembly in providing education and health care infrastructure and services. Secondary sources were extracted from documents and archives which included appropriate and relevant journals, documented policies of rural development, assembly's annual reports, seminar and workshop documents and relevant documents on decentralisation and provision of education and health services. Internet sources relevant to the research were given due attention and recognition.

In the study, data was collected using questionnaires and structured interviews. Structured interviews were conducted with relevant decentralised departments to solicit their views on the level of stakeholder's involvement in the provision of health and education, and the number of health and educational infrastructure provided through the use of interview schedule. Questionnaires were administered among the local people (household heads and community elders) and Assembly Members to solicit their views on the provision of education and health infrastructure and services in the municipality. Both closed and open questions were asked. The questionnaire was carefully structured and designed according to the objectives of the study. Some questions were explained to respondents who found it difficult to understand them. This was done without influencing their responses in any way to avoid the likelihood of bias and to make the findings of the study credible.

Data Analysis

Data was analysed using quantitative and qualitative methods. Data collected were edited, coded and analysed using the Statistical Package for Social Scientists (SPSS v 21.0) and Excel Descriptive Statistics was used to summarise and display the findings of the study.

A qualitative technique involving descriptive analysis was used to analyse the information derived from the key informants. Wherever possible, interview transcripts and direct quotations have been used to enrich the presentation of results and contextualise the discussions.

Quantitatively, a chi-square test statistic (X^2) was used to find out the contributions of the Assembly and improvement in basic education and health infrastructure in the municipality. The chi-square test of statistical significance is a series of mathematical formulas which compare the actual observed frequencies of some phenomenon with the expected frequencies to find out if there are no relationships at all between the two variables in a larger population (Diener-West, 2008). The chi-square test compared the actual results against the null hypothesis and assesses whether the actual results are different enough to overcome a certain

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probability due to sampling error. The asymptotic significance obtained is less than or equal to the significance level (0.05), then there is statistical significance, thus an improvement in basic education and health infrastructure in the municipality.

RESULTS AND DISCUSSION

The Assembly and Provision of Educational Infrastructure and Services

Indicators used to assess the contributions of the assembly to the provision of education infrastructure and services included availability of schools, availability of teachers, total enrolment rate and school performance.

To be able to clearly identify the contributions of the assembly to the education sector, it was important to first identify the number of educational facilities in the municipality. Table 1 shows the trend in the provision of classroom blocks at the basic level in the municipality from 2009 to 2019.

Table 1 Number of Schools

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Number of schools	233	235	237	243	240	241	247	255	255	261	263

Source: GSS, 2018

As a result of conscious efforts made by the assembly and other stakeholders to make education accessible, the total number of classroom blocks constructed increased during the period under study. In 2010, total classroom blocks constructed were two which increased to five (5) in 2012 as shown in Table 1. The study revealed that the number of schools added each year kept increasing throughout the period under study, except in 2013 when the total number of schools reduced to 240. Also, as part of the Assembly's efforts towards improving educational infrastructure, the Assembly constructed over eighty (80) new schools for the basic schools and renovated over forty-seven (47) schools from 2002 to 2013. This shows an improvement in the provision of educational infrastructure in the municipality.

According to the Municipal Education Director, the construction and location of most educational facilities in the municipality have been "spot on", thus the areas that actually needed them were the ones that had them. This was attributed to the information gathered from some assembly members from a few zonal/area councils that were relatively functioning in Dadease, Kokofu and Bekwai. Similarly, Sanwal (1987) observed in Uttar Pradesh, India that decentralisation has resulted in the expansion of primary schools where, in 1982, 98 schools were established in Agra District, while an average of seven schools per year was recorded the previous years. Also, Yilmaz (2011) revealed in Pakistan that the provision of education increased dramatically after the introduction of the decentralisation reform.

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Though the study revealed an improvement in the provision of educational infrastructure in the municipality, some communities had inadequate teachers to ensure effective teaching and learning. The data is presented from 2009 to 2019.

Table 2 Number of Basic School Teachers

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Teachers	1,602	1,630	1,748	1,933	2,055	2,095	2,072	2,138	2,255	2,361	2,463

Source: GSS, 2018

The total number of basic school teachers increased from 1,602 in 2009 to 1,748 in 2011 as shown Table 2. It was observed that the number of teachers each year increased throughout the period under study, except in 2015 when the total number of teachers reduced to 2,072. The main reason according to the Municipal Director of Education was that teachers posted to such communities stayed less than a year and left; they stated lack of basic social amenities in the communities as the main contributing factor as indicated by Mwira (1990), Korboe (1994) and Norton et al., (1995) noted that though the provision of educational structures has increased, training of more teachers to reduce high teacher-pupil ratios in the study areas declined.

The Assembly and community members undertook various initiatives to attract and retain teachers in addition to the infrastructure development in the communities. For example, in the Abodom community, teachers posted to the community have had free accommodation and a free plot of land for farming in order to feel motivated to stay in the communities and ensure effective teaching and learning. However, the teacher vacates the plot of land when going on transfer or when he/she decides to leave the community. One beneficiary had this to say;

> *"……. I was posted here in 2012 and had benefited from free accommodation and a plot of land. I have a small farm on the plot given which support me in diverse ways. It has really supported me"* (Field Survey: August 2019).

The situation was not different at the Ahwiren community where some teachers posted there have now become committed members of the community. During the time of the survey, some had spent more than seven years though they never thought of staying for that long. One resident teacher indicated that he has spent six years and had been awarded the plot of land, on which he had started constructing a two-bedroom house. He stressed that he has now become part of the community. Therkildsen (2000) revealed in Tanzania that, before the allocation of teachers in the districts, most district officers considered the availability of suitable housing and work situations of spouses in order to retain teachers posted to certain communities in districts. This initiative by these communities could be considered by other communities in the municipality so as to help retain teachers to promote effective teaching and learning.

In Ghana, the Education Act of 1961, Act 87, was passed to make education compulsory for every child of school-going age (Kumi-Kyereme, 2005; Boateng, 2017). The 1992 constitution also makes provision for free and compulsory education for all children of school-going age. In spite of these, there are some challenges with enrolment in the municipality.

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Table 3 Basic School Enrolment

Year	Number of Students
2009	36,563
2010	37,454
2011	38,551
2012	38,743
2013	39,157
2014	40,064
2015	41,311
2016	40,541
2017	41,255
2018	42,361
2019	41,463

Source: GSS, 2018; BMA, 2019

The study revealed that total enrolment rates in the basic schools increased from 2010 to 2015 (Table 3). Total enrolment, however, fell during the year 2016 (40,541) but started rising again in 2017 and reduced in 2019. It was revealed that despite improvement in the provision of education infrastructure, total enrolments were on the rise till they fell in 2016 and 2019 as indicated in Table 3. The Assembly members indicated that the main contributing factors were inadequate teachers in some communities and financial difficulties on the part of some parents since most of them are farmers. This supports Kyei's (2000) view that, in Ghana, many children of school-going age were not in school because of their parents' inability to bear the cost of education despite the government's "Free Compulsory Universal Basic Education policy". According to a parent, getting a child to school is not free because it includes the cost of uniforms, books, furniture, development fees and providing in-kind services for the construction and maintenance of primary schools which become difficult for some parents to pay. On the contrary, Faguet et al (2020) report in Ethiopia that decentralisation did indeed improve public education sector performance by specifically leading to higher school enrolment rates (NER). And Faguet and Sánchez (2014) also indicated that decentralisation improves enrolment rates in public schools in Colombia. There is, therefore, the need to improve enrolment rates of basic schools in Ghana through operation decentralisation (District Assemblies).

The study further sought to find improvement in the provision of basic school infrastructure in relation to the schools' performance in the municipality. It was realised that the overall performances of pupils in schools have been positive as indicated by the comparative analysis of the pass rate in the Basic Education Certificate Examination (BECE) from 2010 to 2016.

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Table 4 Basic School Performance

Year	English Pass percentage	Science Pass percentage	Mathematics Pass percentage	Social Studies Pass percentage	Overall Pass percentage
2009	60.2	68.9	78.6	65.6	85.0
2010	67.0	70.1	86.0	67.7	78.1
2011	46.8	61.9	78.6	65.8	80.2
2012	65.5	80.2	82.3	69.5	81.3
2013	49.7	66.5	74.1	55.0	84.6
2014	84.9	83.3	86.6	79.4	85.9
2015	72.4	75.6	81.0	72.4	75.4
2016	76.8	82.7	74.5	76.0	77.5

Source: GSS, 2018; BMA, 2019

Within this time period, the academic performance of students has not been stable as it kept on rising and falling. In 2010, the pass mark rate was 78.1 percent and increased to 80.2 percent in 2011 as shown by table 4. The 2014 pass rate of students in the BECE was the highest (85.9 percent) but fell in 2015 from which the performance rate started to rise again during the period. It was revealed that the overall performance increase in the BECE was attributed to the availability of school infrastructure, provision of textbooks and improvements in the mode of delivery though it faces the issue of inadequate teachers as remarked by the Municipal Director of education. He indicated the assembly has ensured that communities without school infrastructure were provided with them and that teachers posted to remote areas were given an extra allowance for accepting postings to such areas. According to the municipal planning officer, an increase in school performance was because the projects embarked on in the various communities have reflected the needs of the people. One opinion leader at Ahwiren stated that improvement in school performance was attributed to an increase in the provision of school infrastructure in the municipality. In effect, the study found out that improvement in school performance was a result of an increase in the provision of schools in various communities as well as retention policies for teachers by the Assembly and communities in the municipality. This confirms studies by Barankay and Lockwood (2007) that greater decentralisation of education to Swiss cantons is associated with higher educational attainment, especially for boys and Clark (2009) that, schools that opt out of the centralized educational regime enjoy large increases in student achievement. Generally, there was a consensus within the study communities that the activities of the assembly have improved educational infrastructure and services in the municipality.

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To support the argument statistically, a chi-square test statistic was employed to test if there is no significant relationship between contributions of the assembly and improvement in the provision of basic education infrastructure and services in the municipality. The contribution of the assembly was considered as the independent variable while the dependent variable was an improvement in the provision of basic education infrastructure in the municipality.

Table 5 Test of Hypothesis on Educational Infrastructure and Services

Attribute	Contributions of the Assembly and provision of basic education infrastructure and services
Chi-square a, b	9.447
df	1
Asymp. Sig.	.002

0 cells (.0%) have expected frequencies less than 5. minimum expected cell frequency is 80.5

Field Survey: August 2019.

The statistical significance value of 0.002 as shown in Table 5 was less than the significance level set (0.05). It can, therefore, be implied that, statistically, the contributions of the assembly have impacted positively on providing basic education infrastructure and services in the municipality which support the general views of respondents that the role of District Assembly (Bekwai municipal) has significantly improved the provision of basic education in the district.

The Assembly and Provision of Health Infrastructure and Services

Availability of health facilities, availability of health workers, and equity in the spatial distribution of health facilities were the indicators used to assess the contributions of the assembly in the provision of health infrastructure and services.

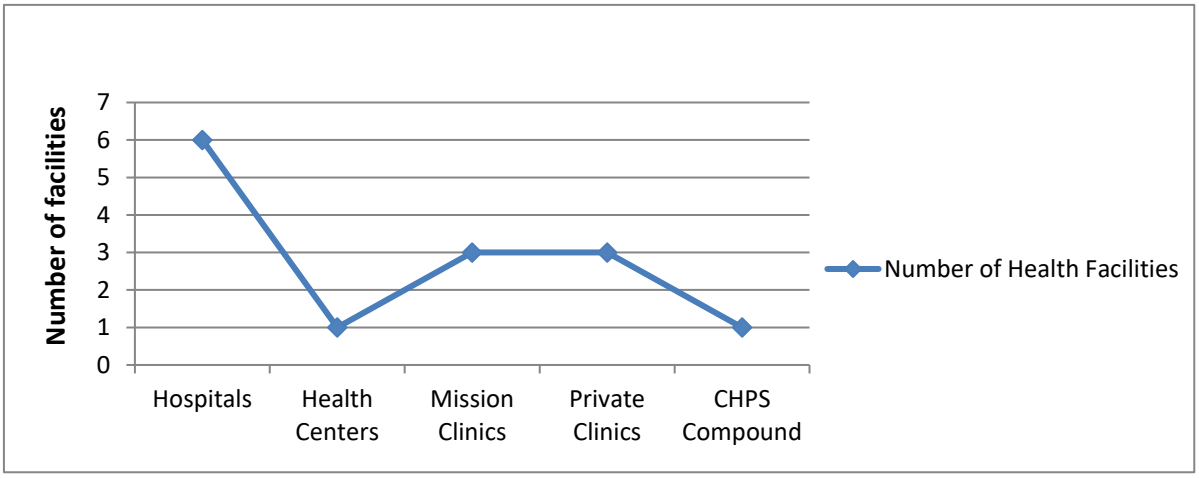

Figure 1 Number of Health Facilities

Source: Municipal Health Management Team (December 2019)

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The number of orthodox health facilities (public and private) available in the municipality was analysed. The Municipal health system follows a three-tier service delivery system that is from the community (community clinic) through the Sub-municipal to the Municipal level. It was realised that the municipality has fourteen (14) health facilities, including six (6) hospitals, one (1) health centre, three (3) mission health facilities, three (3) private clinics and one (1) community-initiated clinic (Figure 1). Four out of the 14 health facilities are state-owned while the remaining are private/mission owned. The Bekwai hospital which serves as the highest health service centre in the municipality requires massive upgrading to be able to attend to referred cases.

The study revealed that providing health care services has not been impressive as compared with the educational sector in the municipality. According to the Municipal Health Director, the assembly in collaboration with the MHMT and the communities have embarked on the provision of CHPS compounds in remote areas to provide basic health service for people living in and around such areas. He, however, disclosed that the project has been unsuccessful because of limited community involvement, lack of accommodation for staff and electricity to power these facilities. The absence of functional CHPS compounds in the municipality has not helped to improve health care provision. This contradicts Gish *et al.* (1988) findings that decentralisation in Indonesia expanded the provision of health services between 1969 and 1983. For example, the Posyandu (community-based integrated health post, mostly concerned with child survival) was largely provided throughout the country.

It is worth noting that the municipality staff strength increased tremendously in 2017 compared to 2016, 2015 and 2014 with 1008 against 834, 732 and 704 respectively. However, the number of Medical Officers declined from 17 in 2011 to 15 in 2012 and 13 in 2015 to 11 in 2017. The number of General Nurses increased in 2017 by 206 compared to 2016, 2015 and 2014. The number of Midwives also continue to increase from 46 in 2014 to 92 in 2017 which is good for safe health care delivery and also a reduction in the Maternal Mortality rate in the Municipality. The Municipal Health Directorate should therefore put in place measures to address the menace of decline in Medical Officers year-on-year.

Table 6 Number of Health Workers

CATEGORY	2009	2010	2011	2012	2013	2014	2015	2016	2017
Director	1	1	1	1	1	1	1	1	1
Medical Officers	16	17	17	15	16	16	13	12	11
General Nurses	68	70	85	123	134	134	142	157	206
Health Assistants	99	101	103	104	107	107	105	141	163
Midwives	12	14	23	40	46	46	50	67	92
Physician Assistants	12	13	15	17	18	18	21	17	22
Nurse Anesthetist	2	3	5	6	6	6	7	8	11
Support Staff	276	286	293	291	301	301	315	342	361

Source: Bekwai Municipal Health Service, 2017.

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However, the municipality had a doctor-patient ratio of 1: 8,027 and a nurse-patient ratio of 1:544 in 2017 (MHS, 2017) which is considered woefully inadequate. The uneven geographical distribution and difficulty in attracting personnel to man the established facilities compound the problem.

In the distribution of medical officers and other medical personnel, there is a glaring bias in favour of the large or urban centres, especially the municipal capital-Bekwai. Thus, most of them are located in urban communities making it difficult for the rural communities to access quality health care. Also, the few ones that are posted prefer the facilities in the urban centres to the rural areas. The distribution of professional nurses and midwives follows a similar pattern. Similarly, Stock (1986) observed that in the Kano State of Nigeria, Kano with only 10 percent of the population had 85 percent of the medical officers. The implication is that the concentration of medical facilities and personnel in urban areas has affected the quality of life of the rural population in the municipality as observed in their high death rate, high infant mortality and low life expectancy at birth as reported by Ghana Statistical Service and Macro International (1999) and Kumi-Kyereme (2005). Thus, providing health facilities and distributing health personnel have not helped in improving the provision of primary health care delivery in the municipality. Therefore, the assembly, as a way of ensuring adequate health care delivery, would have to invest in the welfare conditions of health workers in the municipality in order to retain them for their services when posted there.

It was further described that a common phenomenon in the municipality is the spatial imbalance in the distribution of health facilities. Health facilities are concentrated in the major towns in the municipal whereas some areas lack such facilities. Generally, communities in the southwestern part have no health facilities (figure 2). It is worth noting that Abodom, Bogyawe and Ahwiren study communities have no health facilities and therefore have to resort to nearby communities where such facilities exist, indicating a clear imbalance in the distribution of health facilities in the district.

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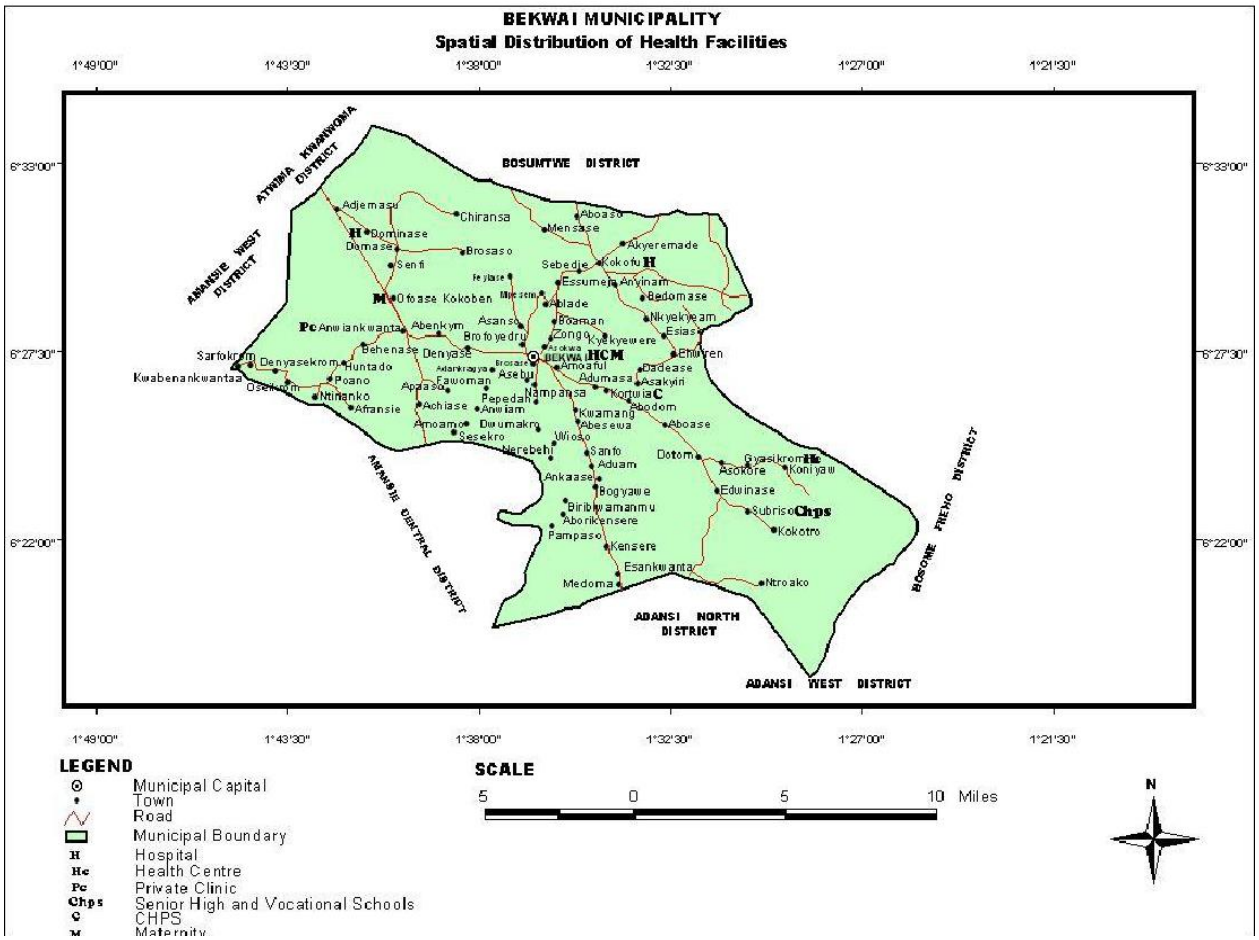

Figure 2 Spatial Distribution of Health Facilities in Bekwai Municipal

Source: Bekwai Municipal Assembly, 2017.

Therefore, the study suggests that the expansion of health facilities under the assembly concept does not tend to be equitably distributed. This confirms Collins *et al.* (2000) view that decentralisation does not necessarily lead to greater equity but can also contribute to an increase in inequality. This perhaps is due to the fact that the decision about allocation of health facilities resides with the central planning team with the district management team only responsible for implementing such policies.

Again, the study revealed that the distance from a client's abode to a medical institution was a crucial variable influencing the decision to go for early medical care as indicated by WHO (1996). Though the nature of ailment and the facilities available sometimes warrant people to travel more kilometres to seek medical care, it was realised that people in the municipality rarely wished to travel 10 kilometres or more to seek medical care. The reasons given were high transportation cost and becoming weaker upon getting to the facility which worsens your ailment. Similarly, Oppong and Hodgson (1994) observed that people from surrounding

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villages in Suhum District in Ghana did not travel about 10 kilometres or more to seek early medical care.

A chi-square test statistic was employed to test if there is no significant relationship between contributions of the assembly and improvement in the provision of health care infrastructure and services in the municipality.

Table 8 Test of Hypothesis on Health Infrastructure and Services

Attribute	Contributions of the Assembly and provision of health infrastructure and services
Chi-square a, b	3.822
df	1
Asymp. Sig.	.149

0 cells (.0%) have expected frequencies less than 5. minimum expected cell frequency is 80.5

Field Survey: August 2019.

The statistical significance value of 0.149 as shown in Table 2 was less than the significance level set (0.05). This indicates that statistically, there is no significant relationship between the contributions of the assembly and improvement in the provision of health care infrastructure and services in the municipality. It can therefore be deduced that providing free access to health care is one of the ways of helping the poor out of poverty and that the assembly has to ensure the provision of health services achieve its intended benefits to help the citizenry. The assembly together with the health ministry and the government needs to establish more health facilities to improve health care facilities in the municipality. In the area of manpower, however, there was no evidence of measures adopted by the assembly to complement government efforts. Nonetheless, the assembly has constructed a number of bungalows for health professionals in the municipality.

CONCLUSION

The implementation of decentralisation policy is to promote grassroots participation in the formulation of plans and providing basic infrastructure and services that enhance the quality of life of members in the community. For effective implementation of the decentralisation policy, DAs are designated as planning authorities charged with the responsibility of all development activities at the local level.

Generally, there was a consensus within the communities that the contributions of the assembly have expanded the provision of education infrastructure in the municipality. It was, however, discovered that capitation grants and school feeding programmes have also contributed to improvement in the educational sector. Again, even though the assembly is not responsible for the recruitment of teachers, they have, together with the communities, put certain measures in place to attract and retain them. Although basic education is free, parents are supposed to bear the cost of school uniforms and other fees approved by school authorities. This, to an extent, has affected enrolment and performance in the municipality.

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RECOMMENDATIONS

These recommendations were made to improve the Assembly system and the provision of education and health infrastructure at the local level.

- The Assembly should strengthen the capacities of the unit committees and the zonal councils in terms of training and logistics for effective participation in decision-making, management and monitoring of infrastructure provision.
- The Assembly should meaningfully involve the School Management Committees and Community Health Committees at the local level who oversee the implementation of education and health issues in the communities in the planning and the provision of health and educational infrastructure in the municipality.
- The provision of health and educational infrastructure must go through proper identification through to the operational stages to ensure adequate stakeholders' participation. This will make the infrastructure so provided, useful and functional.
- The provision of health and educational facilities should be fully supervised by the respective departments at the sub-national level. All funds from central government and donor agencies meant for the provision of health and educational infrastructure at the district level should be channelled through the Assembly.

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