Working Paper No. 65

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

by Michael Bratton

A comparative series of national public attitude surveys on democracy, markets and civil society in Africa.

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AFROBAROMETER WORKING PAPERS

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January 2007

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AFROBAROMETER WORKING PAPERS

Editors: Michael Bratton, E. Gyimah-Boadi, and Robert Mattes

Managing Editor: Carolyn Logan

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

Abstract

This article explores the determinants of public satisfaction (or dissatisfaction) with health and education services in Africa. Among prospective explanations, we consider the users' poverty, their general perceptions of service accessibility, and their specific experiences with service providers. We find that user-friendliness of services is essential, especially to poorer clients. But daily encounters including with substandard teaching and the costs of clinic fees tend to depress public approval, not only of services, but also of democracy. Finally, corruption has unexpectedly mixed effects: perceptions that officials are corrupt decreases citizen satisfaction; but the act of paying a bribe increases it.

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

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. Few systematic details are known about mass opinion regarding public services in Africa's burgeoning cities or vast rural hinterlands. We have the impression that, in an era of state retrenchment, such services are usually scarce and substandard and are rarely infused with an ethic of customer service. But more analysis is required about the strengths and weaknesses of the public delivery systems for health and education services in Africa, especially as seen through the eyes of users. Do Africans think they are being served?

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 record of poor people's demands for socioeconomic development, albeit mainly in the form of narrative testimonies (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 shift the lens of analysis to the micro level in order to systematically analyze service satisfaction from a user's perspective. Among prospective explanations, we consider the users' poverty status, their general perceptions of service accessibility, and their specific experiences with service providers.

Research Questions

The following research questions guide the study:

- How important are basic social services among the development priorities of ordinary Africans?
- 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 onward 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 summarizing the health and educational status of African populations as reported by respondents themselves. We then ask whether (and where) concerns about health and education appear on a "popular development agenda." Third, we probe levels of citizen knowledge about these policies and ask, "who should provide?" and "who should pay?" Special attention is given to felt needs to support and finance the fight against HIV/AIDS.

Part Two conceives and measures the main dependent and independent variables for this study. 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 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 (sometimes less) 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.

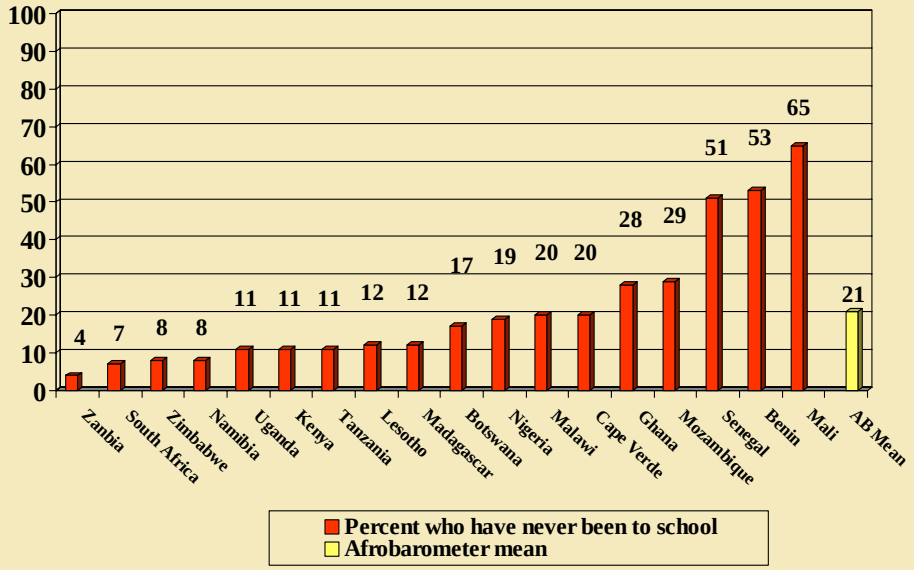
Part One

Education and Health in Africa

It is hardly necessary to assert the need for education and health services in sub-Saharan Africa, the world's poorest and most underserved continent. But, to provide context, we offer a few self-reported social indicators of educational and health status derived from Afrobarometer surveys. Beyond reinforcing commonplace assumptions about low quality of life, these indicators help to pinpoint the specific social groups that most urgently need particular services.

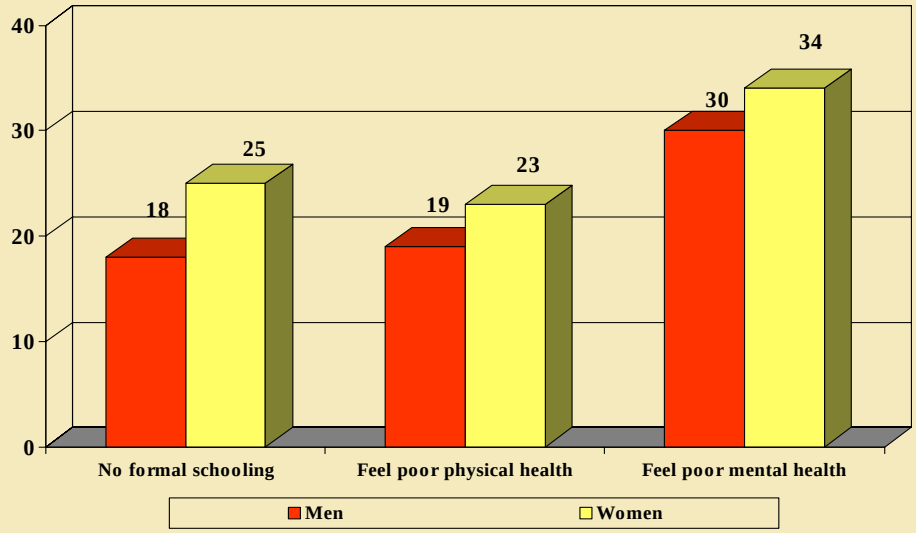
Take education. Across 18 countries in Afrobarometer Round 3, some 21 percent of adult Africans aged 18 years or older report no formal education. This average figure includes 4 percent who have received Koranic education only. But there are major cross-regional and cross-national variations (See Figure 1). Southern Africans are relatively well educated, with fewer than 10 percent reporting no schooling in South Africa, Namibia, Zambia and Zimbabwe. By contrast, a majority of adults in some West African countries say they have never been to school: 51 percent in Senegal, 53 percent in Benin, and 65 percent in Mali. These educational deficits are concentrated especially among women, who are disadvantaged in access to both religious as well as secular schools (see Figure 2). In Mali, for example, some 71 percent of adult females report no formal schooling.

Figure 1: Populations Without Formal Education[1], 18 African Countries, 2005



[1] Defined as secular education; excludes Koranic schools.
Entries are self-reported educational attainment in response to the question, "What is the highest level of education you have completed?"
Source: Afrobarometer Round 3 (N = 25,397).

Figure 2: Educational and Health Status:
African Adults, 18 countries, 2005



Percentage saying "many times" or "always" during the past month:

"How often as your physical health reduced the amount of work you normally do inside or outside your home?"
"How often have you been so worried or anxious that you have felt tired, worn out, or exhausted?"

Turning to health, the Afrobarometer asks respondents to assess their own physical and mental condition during the month preceding the interview. "Has your physical health reduced the amount of work you normally do inside or outside your home?" and "Have you been so worried or anxious that you have felt tired, worn out, or exhausted?" Almost one quarter indicate poor physical health on a regular basis, that is "many times" or "always" (23 percent). And almost one third say they feel poor mental health (32 percent). On average, for both medical complaints, women are about four percentage points more likely than men to so report. The self-assessed ill health of women is particularly marked in Uganda and Zimbabwe, perhaps in part because these countries contain zones of violent political conflict.

The Popular Development Agenda

Given difficult life circumstances, Africans demand health and education services. But what priority do they attach to various felt needs, both between health and education and between these social needs and other economic or political preferences? 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, with results reported as the percentage mentioning any given problem. Overall, the distribution of problems seen to require government attention 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. Education (ranked fifth) and household water supply (ranked sixth) round out the list of frequently mentioned social service priorities. The desire for well-run clinics and schools and for clean household water supplies continues to preoccupy many Africans, averaging 30 percent for health care.

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 Responses
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).

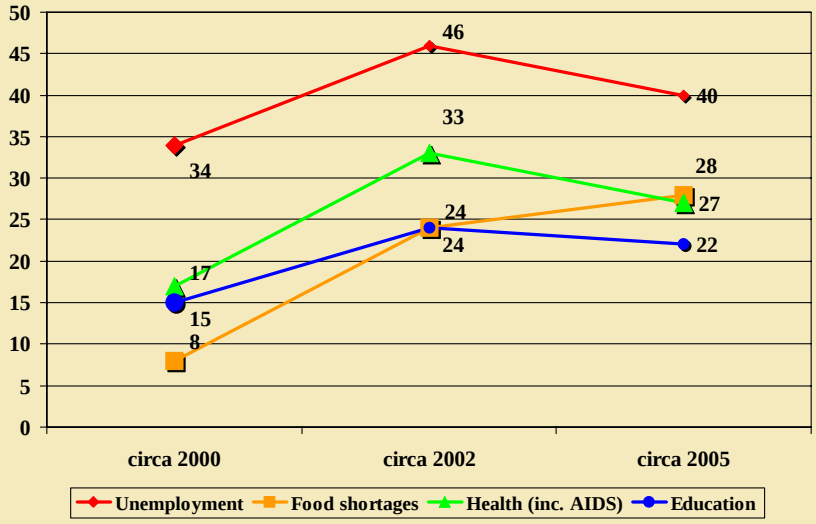
Total in last column exceeds 100 percent due to multiple responses.

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. This upsurge coincides with the acceleration of deaths related to HIV/AIDS, especially in the Southern Africa region.

Figure 3: Trends in the Popular Development Agenda:
Most Important Problems, 12 African Countries, 2000-2005



Percentage of respondents who mention this problem.

"In your opinion, what are the most important problems facing this country that government should address?" (Accept up to three answers).

As an aside, it is worth noting that HIV/AIDS, as a priority distinct from general health problems, so far has had a small impact on the popular development agenda. In the 12 countries for which we have three observations over time, only 9 percent of respondents mentioned AIDS in 2005, up from 3 percent in 1999, but down from 11 percent in 2002. Instead, people give priority to unemployment and poverty. This preference ordering is far from irrational if people face immediate daily problems of earning an income or feeding a family. Viewed from this perspective, AIDS – a largely invisible killer, whose effects are encountered at a distant future date – may seem like a less pressing concern.

Indeed, an inverse relationship is evident between poverty and perceiving AIDS as a priority. At the individual level, people who suffer higher levels of lived poverty (measured in terms of shortages of basic human needs) are less likely to cite AIDS as a priority problem.[5] And at the societal level, the poorer the country (measured as GNI per capita), the less likely is its population as a whole to collectively rank AIDS as an important issue.[6] Instead, protection from AIDS has to stand in line behind attention to other, more basic human needs.

Finally, in every round of survey observations, the economic issue of unemployment and social issue of health care both regularly trump popular concerns about education. This result has important implications. It casts doubt on the older wisdom that Africans regard investment in education as the best way to pull themselves out of poverty. Instead, people have learned that a school certificate or university degree is no longer an automatic passport to a well-paid job. Instead of seeking academic qualifications, individuals and households now apparently prefer to

pursue opportunities to generate cash income, including through private enterprise in the informal sector. And they seem to have concluded, in the era of the AIDS pandemic, that a family's prospects are better served by ensuring the health, ahead of the education, of its members.

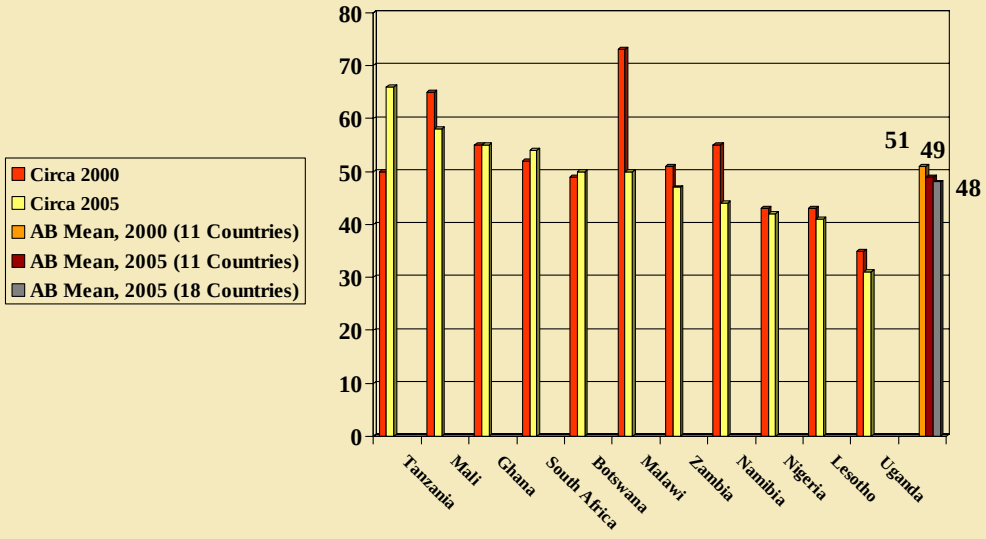
But, as Table 1 and Figure 3 show, education and (especially) health remain leading social priorities. And, despite the growing relative salience of health care in the popular mindset, more Africans are concerned about solving problems with education in 2005 than in 2000. Thus, both these social sectors remain central to the popular development agenda.

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 start by asking whether people perceive themselves as autonomous agents, responsible for their own personal and family advancement or whether, in order to achieve welfare, they prefer to look to assistance from the state. The Africans we interviewed circa 2005 were split down the middle on this issue: whereas 48 percent opted for self-reliance, an identical proportion placed the onus on government. This even-handed distribution represents a slight decline in expressed personal responsibility from 2000. In the 11 countries for which we have two observations over the period, the size of the self-reliant group shrank by 2 points from 51 percent (see Figure 4).[7] At the country level, expressed personal responsibility dropped by meaningful amounts in Malawi, Mali, and Namibia, though it rose in Tanzania.

Figure 4: Expressed Personal Responsibility:
Trends Over time, 12 African Countries, 2005

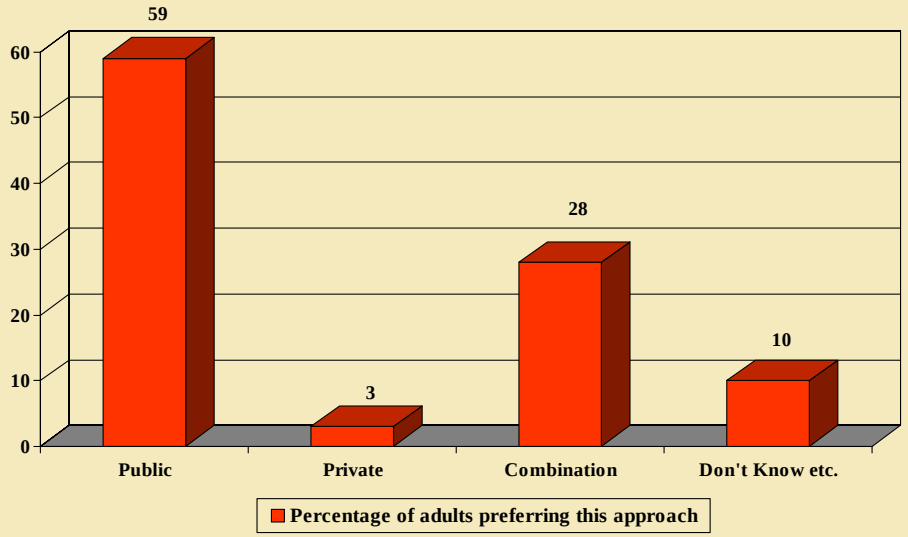


Please choose A or B:
A. People should look after themselves and be responsible for their own success in life.
B. The government should bear the main responsibility for ensuring the wellbeing of people.
Figures are the percentages who choose A, the self-reliant option.

When specific reference is made to health and education services, we find even stronger 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." Some 10 percent "didn't know" where they stood on the important question of public versus private sector responsibility for health and education services.

Figure 5: Preferred Provider of Health and Education Services,
11 African Countries, 2000



I am going to read out a list of things that are important for the development of our country. In your opinion, who is responsible for providing (schools and clinics)? The government, private businesses, or the people themselves? Or some combination of these providers?

The sentiment for state provision is widespread: majorities of citizens prefer public to private services in 10 of 12 countries. The only exceptions are Tanzania and Malawi, where almost half the adult populace stood ready to experiment with mixed public and private approaches. We suspect that these unusually liberal sentiments reflect mass disenchantment with the poor performance of government ministries in these countries, the availability of alternative providers like traditional healers and non-governmental organizations, and nostalgia among older people for the days when missionaries provided most social services. In most places in Africa, however, 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).

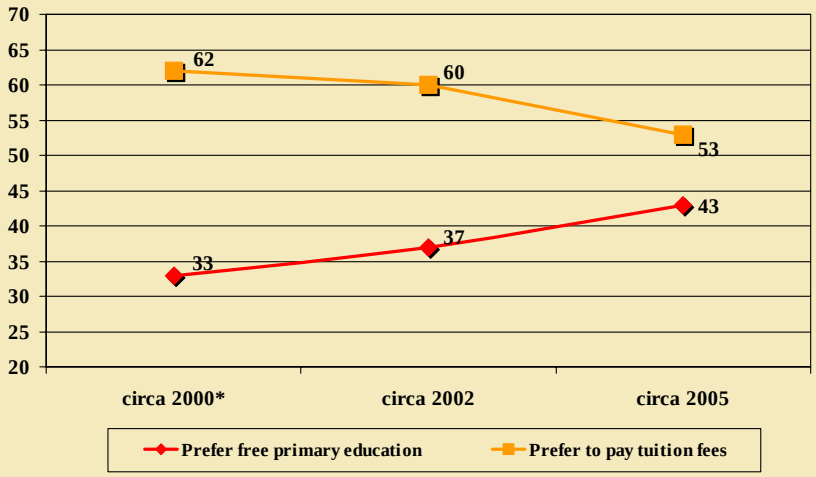
But who should pay? African governments have taken a range of policy stances with regard to financing basic social services. Whereas the governments of Malawi, Uganda, Kenya, Tanzania, Zambia and Cameroon have introduced free universal primary education (UPE), governments in countries like Ethiopia and 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).

African citizens are reasonably well informed about basic health and education policies. Some 73 percent can correctly state whether their government has a policy to provide free universal primary education, that is, "parents do not have to pay school fees." And some 62 percent can do the same for health policies, namely whether there are "fees for (clinic) visits or medicine." Our data suggest that popular knowledge is higher in the education than health sector in part because, in any given year, more people make use of schools than of clinics. And, not surprisingly, people in countries with free universal services are more likely to be knowledgeable about the prevailing policy regime.

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.

Figure 6: Trends in Education Policy Preferences,
12 African Countries, 2000-2005



Please choose A or B:
A. It is better to have free education for our children, even if the quality of education is low
B. It is better to raise educational standards, even if we have to pay school fees

* In 2000, the question for Southern African countries referred to clinic fees

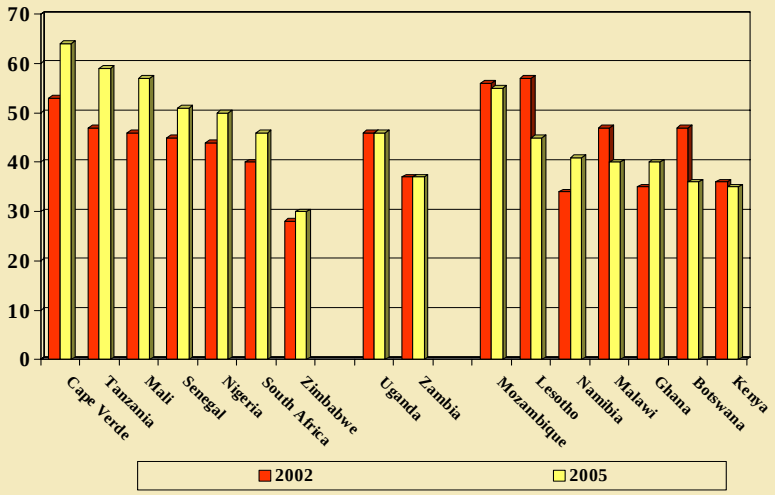
As might be expected, support for a policy of tuition fees is highest in countries where people are accustomed to paying for education, as in Ghana (74 percent in 2005), Mali (69 percent) and South Africa (67 percent). By contrast, a majority of people prefers universal free education in those countries 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).

With reference to AIDS policy, we posed another trade-off. Should the government "devote many more resources to combating AIDS, even if this means that less money is spent on things like education"? Or, because "there are many other problems facing this country besides AIDS," should the government "keep its focus on solving other problems"? In 2005, the Africans we interviewed were of two minds: 46 percent favored more AIDS spending, whereas 47 percent placed budget priorities elsewhere. This result nevertheless represents a change from 2002, when there more people resisted giving priority to AIDS spending (44 versus 48 percent, a small but significant difference).

Ironically, in some of the countries hardest hit by the pandemic, popular support for anti-AIDS spending is low (for example in Zimbabwe at 30 percent) (see Figure 7). In others, low levels of support are declining over time (for example, from 47 to 36 percent over three years in Botswana). By contrast, where death rates remain low and public awareness of the threat is still in its infancy, citizens will countenance increased anti-AIDS spending. In Cape Verde, for

instance, where the government launched an AIDS information campaign in 2004, support rose from 53 to 64 percent between 2002 and 2005.

Figure 7: Support for Anti-AIDS Spending:
Trends for 16 African countries, 2002-2005



Please choose A or B:
A. The government should devote many more resources to combating AIDS, even if this means that less money is spent on things like education"
B. There are many other problems facing this country besides AIDS; even if people are dying in large numbers, the government should keep its focus on solving other problems"

As such, the data present a mixed picture. In some parts of the continent, citizens are suffering from "AIDS fatigue" and yearn to reallocate budgetary resources away from AIDS to other pressing development needs. But there is also trace evidence – gradually over time, in some new places, and as a result of public education – of growing popular support for pushing the fight against AIDS up the policy agenda.

Part Two

Within this context, we now address the central research question: what explains popular satisfaction with health and education services? To prepare an answer, this part of the paper is concerned with the conceptualization and measurement of the moving parts of an explanatory model. 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.

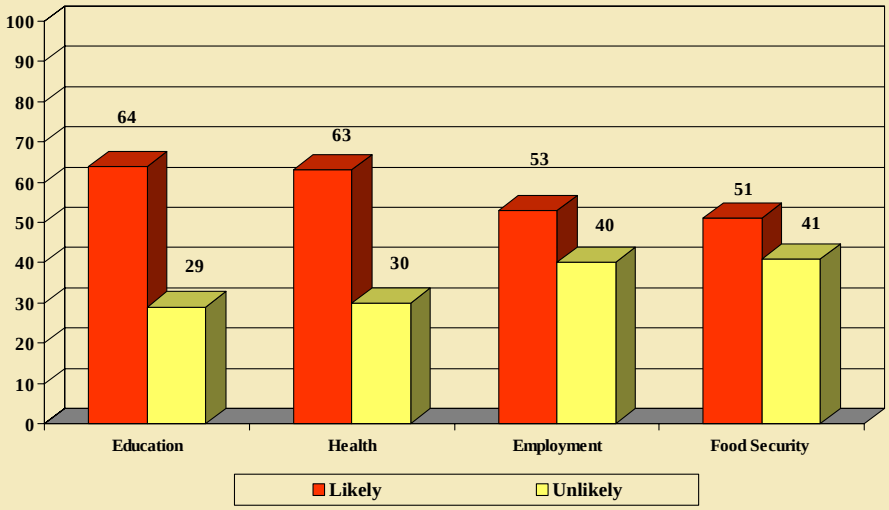
Popular Confidence in State Capacity

As a first step, we want to know whether ordinary people have confidence that their governments can deliver solutions to the development problems that they have identified, including those in health and education. We asked, "Taking the problem you mentioned first, how likely is it that the government will solve this problem within the next few years?"

As Figure 8 shows, people are hopeful that state provision will be effective. Almost two-thirds are optimistic about outcomes for education and health over the next few years (64 and 63 percent

respectively). They are somewhat less sanguine about economic challenges. Only about half think that African governments will be able to generate jobs or guarantee food security (53 and 51 percent respectively). But, in fairness, it must be noted that more people are optimistic than pessimistic about government's future performance at key economic tasks. They apparently still expect some degree of economic salvation from a state-led development strategy.

Figure 8: Likelihood the Government Will Solve Problems:
Popular Estimates, 18 African Countries, 2005



Percentage who mention this problem as their first response.
(N = 1090 for education, N = 1392 for health, N = 4852 for employment, N= 2630 for food security)

"Taking the problem you mentioned first, how likely is it that the government will solve this problem within the next few years?"

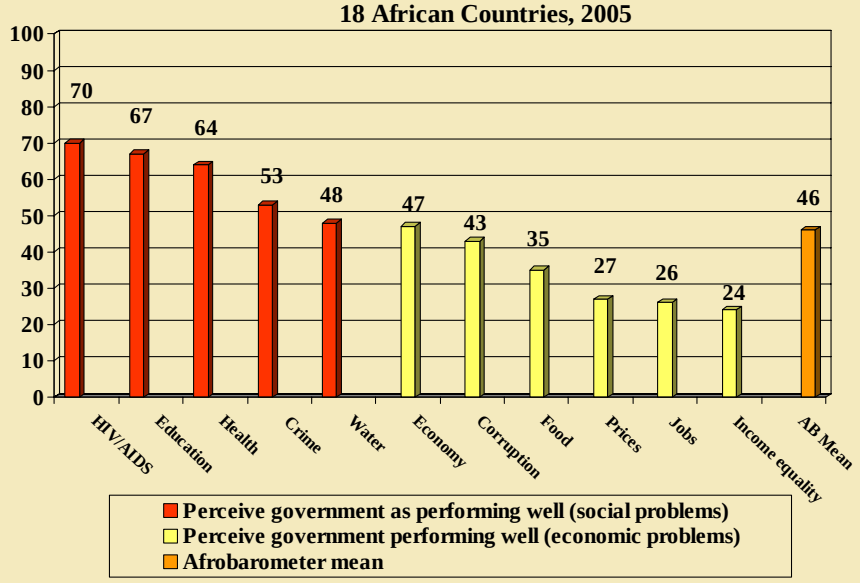
Popular confidence in the developmental capacity of African states is puzzling and requires interpretation. It runs against the grain of the prevalent trend of state decline on the continent (Rotberg 2004), the incompleteness and partiality of African efforts at economic reform (van de Walle 2003), and the low rankings of many African governments on world tables of good governance (Kauffmann, Kraay and Mastruzzi 2006). Perhaps mass optimism is due to the hypothetical nature of the survey question about prospective performance, which may encourage wishful thinking. Hence we turn to a more concrete, retrospective indicator: satisfaction with actual government performance.

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."[8]

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.

Figure 9: Satisfaction with Government Performance, 18 African Countries, 2005



Percentage of respondents who think government is performing well or very well in this service sector.

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

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.

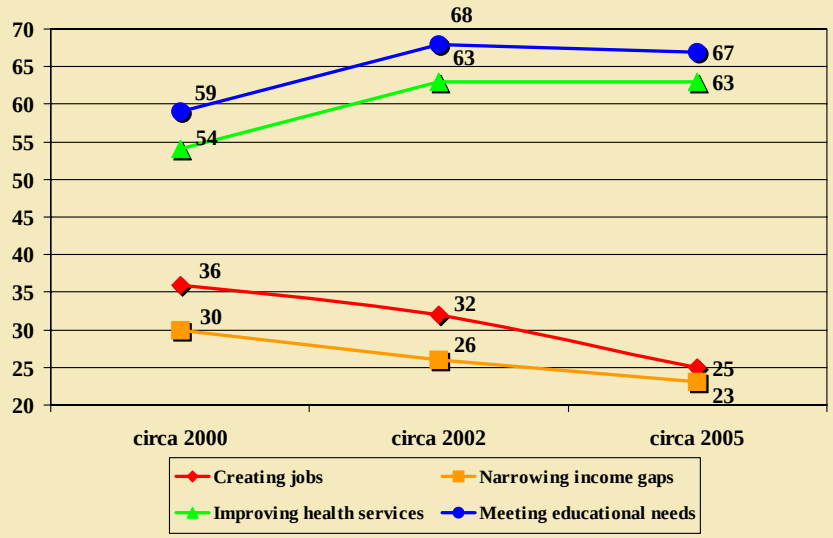
Oddly, given the spreading ravages of AIDS deaths, people seem to be especially pleased with government performance at combating HIV/AIDS. This result (70 percent approval) may be skewed, however, by psychological denial among respondents (just one-third admit that they know anyone who has died of AIDS), 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.

Figure 10: Trends in Satisfaction with Government Performance, 2000-2005



Percentage of respondents (in 12 African countries)
who think government is performing well or very well in this policy sector.

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

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.[9] 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 the various structure and processes of service access.

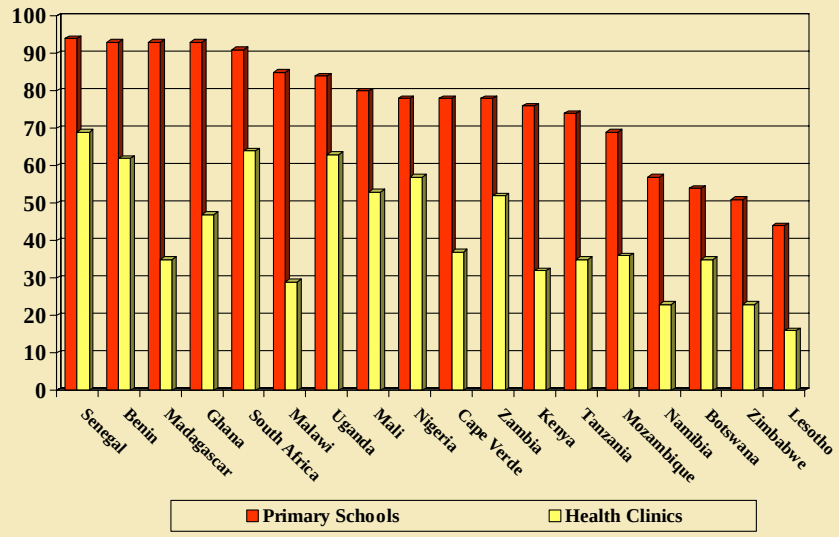
Accessibility of Services: Infrastructure

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.[10] 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).

Figure 11: The Availability of Service Infrastructure:
18 African countries, 2005



Percent of adults living in a locality with a primary school or health clinic.
Based on interviewer observations, confirmed by field team supervisors.

At face value, the wider availability of school facilities (as compared to clinics) could plausibly help explain why people seem to be more satisfied with educational than health services. Let us be clear: we are not claiming that physical accessibility is tantamount to service delivery. Much also depends on the administrative procedures, staff and supplies, and server-client relations that characterize the service delivery process. But the geographic proximity of service infrastructure may be hypothesized as a necessary – but far from sufficient – condition for popular service satisfaction. Thus, if only as a starting point for conceptualizing access to services, physical infrastructure deserves consideration in any multivariate account.

Accessibility of Services: User-Friendliness

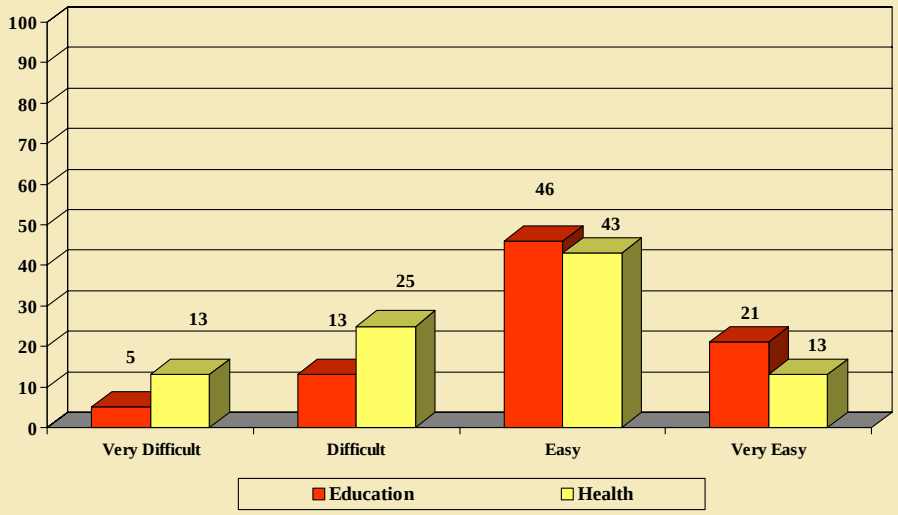
A more promising approach highlights the interaction between service agencies and their clientele. Quite apart from proximity, the accessibility of services depends upon the organizational feature of "user-friendliness." From a user's perspective, a service may be simple, transparent and inclusive or 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).

Figure 12: Ease of Access to Education and Health Services:
Popular Estimates, 18 African Countries, 2005



"In your experience, how easy or difficult is it to obtain the following services:
A place in a primary school for a child? Medical treatment at a nearby clinic?
Or do you never try to get these services from government?"

It is noteworthy that the same people who complain that one service is difficult to use also say the same thing about the other service. In other words, there is a strong correlation between the perceived user-friendliness of health and education services.[11] This result suggests that some people are doubly advantaged by gaining easy access to both services, but that others are doubly deprived: they encounter difficulty with all service transactions. As the analysis proceeds, we will wish to explore whether marginalization from services is concentrated among the urban poor, whom we have already found are less satisfied than other Africans with government performance.

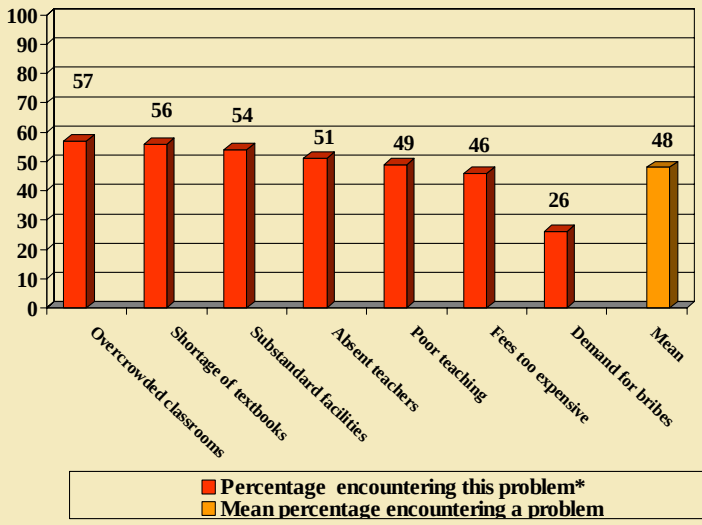
It is possible that ease of access and proximity of service outlets are also related. After all, a nearby facility may seem more approachable than a distant one. We confirm this connection for health services, though the relationship is not strong.[12] We find no linkage for education services, however. Even if people do not possess a primary school in their neighborhood, they are able to easily get their children into school somewhere else. Both of these findings suggest that physical proximity (an objective criterion) and ease of use (a subjective judgment) are largely independent dimensions of service accessibility. Each should be measured separately and both should be included in any multivariate explanation of service satisfaction.

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."[13]

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.

Figure 13: Experience with Education Services,
Specific Problems Encountered, 18 African Countries, 2005



"Have you encountered any of these problems with your local public schools during the past 12 months?"
* Excludes those who say they don't know or have no recent experience with a public school.

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,[14] 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.

About half of all African users register objections to a trio of core issues: substandard school buildings and facilities (54 percent), absent teachers (51 percent), and the low quality of instruction (49 percent). Compared to other Africans, Zimbabweans are especially concerned about absenteeism as the declining value of wages drives teachers to moonlight at second jobs. And Nigerians find run-down school facilities and poor teaching standards to be particularly

widespread and objectionable problems. For their part, Zambians are more worried than anyone else about *all three* of these problems (*averaging* 86 percent).

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.[15] 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.

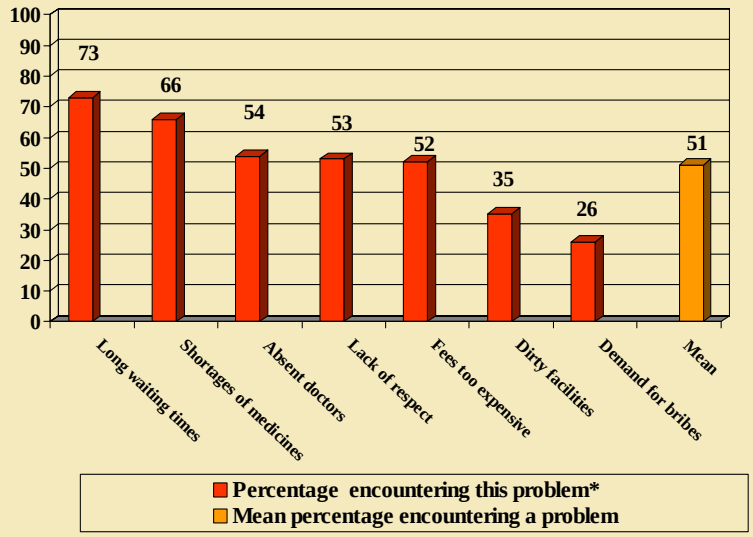
For the record, it is worth noting that specific problems of access to education form a composite whole.[16] In other words, people who perceive one obstacle in gaining access to education are likely to see other obstacles too. We expect an average index of this factor – which we label as "service experiences (education)" – to predict popular satisfaction with education services. But, in order to tease out the relative influence of specific problems encountered, each will first be entered separately in the explanatory models that follow.

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."[17]

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).

Figure 14: Experience with Health Services,
Specific Problems Encountered, 18 African Countries, 2005



"Have you encountered any of these problems with your local public clinic or hospital during the past 12 months?"
* Excludes those who say they don't know or have no recent experience with a public medical facility.

AFRO BAROMETER

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.[18]

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.

About half of all users of health services also find fault with a trio of common problems: doctors who absent themselves from work (54 percent), staff who behave disrespectfully toward patients (53 percent), and the high cost of consultations or medicines (52 percent). Since, on average, African publics are split on these issues, we can approach these problems from a positive angle. The data show that complaints are *least* common about absent doctors in Cape Verde, about disrespectful staff in Mali, and about clinic fees in Botswana.

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.

Finally, few Africans say they encounter substandard ("dirty") health facilities or demands from health care workers for illegal payments ("bribes"). These are minority opinions, held by 35 and 26 percent respectively.

But, 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, 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.

As in the education sector, specific experiences of health access cohere into a single reliable factor.[19] This convergence enables us to derive an average index called "service experiences (health)." Moreover, we notice a marked coincidence between "service experiences (education)" and "service experiences (health)."[20] On these grounds, we also build a meta-index of "service experiences (combined)," which we employ in analysis below.[21]

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. We have already established the frequency with which health workers and school officials reportedly ask for bribes. We now probe popular perceptions of the general prevalence of official corruption in the health and education sectors, as well as the likelihood that citizens will respond to demands for bribes by actually making illegal payments. Together, these perceptions and practices provide a fuller picture of the phenomenon of corruption that should assist in discerning its expected negative effects on service satisfaction.

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.

For the purposes of analysis, therefore, we will be interested to know whether corruption has larger effects on satisfaction with health than education services. We will also want to explore whether perceptions or experiences of corruption have the bigger impact on service satisfaction. And we will wish to confirm that such effects always run in the expected, negative direction.

Part Three

This explanatory section of the paper addresses several such issues. The goal is a comprehensive multivariate explanation of popular satisfaction with public services. As discussed, the object of study is represented by alternative versions of the dependent variable, namely satisfaction with education services, satisfaction with health services, and an average index of both services. The proposed explanatory factors are the independent variables surveyed in the previous section under the rubrics of social structure, service access, service experiences, and corruption.

Explaining Service Satisfaction

What are the sources, then, of public satisfaction (and dissatisfaction) with service delivery in a cross-section of Africa's newly democratized regimes?

The regression models in Table 3 tell a similar story regardless of the way that satisfaction is measured. The strongest and most statistically significant relationships are highlighted in bold in the table and their explanatory power is ranked in parentheses.[22]

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." This feature – earlier termed "user-friendliness" – captures whether citizens regard public services as being open to all types of clientele and as being uncomplicated to operate. These attributes are 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 only exception to this general rule concerns health clinics. The proximity of a primary care facility in the locality remains positive and significant for satisfaction even when all other relevant considerations are held constant. As such, and in contrast to the effect of primary schools, service satisfaction with health care still depends to (an admittedly minor) degree on the provision of a widespread network of clinics.

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.

Women are slightly less likely to approve of the quality of social services, especially in the health sector. More work is required to understand whether their concerns center on services for maternal, child, or infant care, or to women's health care generally. Other things being equal, rural dwellers remain more readily satisfied than urbanites. By contrast and as before, education continues to depress satisfaction with all types of services, perhaps because, with learning and knowledge, personal standards of service evaluation tend to rise.

The poverty status of users, however, 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. With reference to social services in general, experiences in the health sector actually supersede poverty in explaining service satisfaction. But, precisely because

specific encounters have differential effects in the two sectors, results are presented separately for education and health.

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. Notably, however, parents of school-going children seem willing to tolerate absent teachers, overcrowded classrooms, and substandard school facilities, at least as far as their expressed satisfaction with educational services is concerned.[23]

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") – 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 to 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 (as distinct from loose perceptions of corruption) 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

One also wonders whether service satisfaction plays 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). To be sure, 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, the same groups of 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.

Policy Implications

By way of conclusion, this last section rehearses the results of this study and draws out political and policy implications. Framing the analysis are the following discoveries:

- The Africans we interviewed in 18 of Africa's open societies attach higher value to health care services than to education. Yet health services are in scarcer supply than educational services. Governments that seek reelection in Africa would do well to attend to these expressed needs and popular priorities when allocating budgets and other resources to basic social services.

- About two-thirds of Afrobarometer respondents are satisfied with the delivery of basic health and education services. And these high levels of satisfaction have recently risen. As such, governments apparently stand to gain easy approval for even marginal improvements in the quality of basic services, especially from rural dwellers.

- Despite the introduction of free primary education in many countries, more people prefer high educational standards to guarantees of universal access. While the majority that holds this view is sinking over time, opportunities remain to improve quality rather than mere quantity in education.

- The physical proximity of schools and clinics to users' places of residence has little effect on popular satisfaction with basic services. With the exception of rural clinics, the expansion of service infrastructure is not necessary and is unlikely to yield much in the way of positive benefits.

Using popular service satisfaction as a criterion of evaluation, the main results and lessons are as follows.

- Responsiveness matters most. 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 formats.

- Users frequently encounter problems with service providers that point to specific policy measures. 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 topmost effort to reducing (but never eliminating) the cost of primary services, if only for the poorest users.

- Not surprisingly, poor people enjoy less access to services, and feel less service satisfaction, than the relatively well-to-do. Poor people require not only affordable social

services, but specially targeted programs, for example to the health care needs of poor women.

- 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.

- 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 for local society as well as the political class. Penalties for the illegal purchase of favors must be enforced at the point of service through users' groups, community courts and local law enforcement.

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] The relationship is substantively weak, but statistically significant: Pearson's r = -.084, p <.001

[6] The relationship is substantively very strong and, even despite a small sample size (n = 18 countries), also statistically significant: Pearson's r = -.912, p<.001. Note, however that this result embodies a regional effect, with AIDS cited as a priority much more frequently in (richer) Southern African countries than in (poorer) West African countries.

[7] Note: This small change could be due to sampling error alone. The question was not asked in Zimbabwe in 2005.

[8] 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."

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

[10] 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.

[11] Pearson's r = .403, p<.001

[12] Pearson's r = .045, p<.001.

[13] 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.

[14] 66 percent versus 54 percent: Pearson's r = .153, p<.001

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

[16] Factor analysis (principal components, no rotation) produces one factor that accounts for 50 percent of variance. It is reliable at Alpha = .832.

[17] See endnote 11 (check).

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

[19] Factor analysis (principal components, no rotation) produces one factor that accounts for 49 percent of variance. It is reliable at Alpha = .825.

[20] Pearson's r = .552, p<.001.

[21] Factor analysis (principal components, no rotation) produces one factor that accounts for 39 percent of variance. It is reliable at Alpha = .875.

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

[23] The reader may wonder whether the general effect of "Service Accessibility" (notably "user-friendliness") is suppressing the specific effects of "Service Experiences." To test for this possibility, the model was rerun for Educational Services with all "Service Accessibility" variables removed. This formula did not (a) change the rank order of explanatory variables, except to increase the prominence of explanations based on corruption (b) the magnitude of specific effects does not markedly increase (e.g the coefficient for poor teaching goes up from .090 to only .093) or (c) turn insignificant experiences into statistically significant ones. At the same time the explanatory power of the overall model was reduced (from 9.1 percent of variance explained to 7.7). I therefore conclude that both general "Service Accessibility" and "Service Experiences" are largely independent and that both must be included in any comprehensive model.

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