The Social Sciences 5 (5): 440-445, 2010
ISSN: 1818-5800

Deprivations Among Children in Ghana: Evidence from the 2006 Multiple Indicator Cluster Survey

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Abstract: Very little is documented in the literature regarding direct measurement of child poverty and disparity in the Ghanaian context. The present study examines the extent and distribution of severe deprivation and absolute poverty among children in the country using the 2006 Ghana Multiple Indicator Cluster Survey as data source. The findings show that children experience severe and less severe deprivation more in sanitation than any other indicator of child deprivation (38.5 and 29.4%, respectively) followed by education, shelter and information. Almost 30% of children suffer from lack of toilet facilities, the most frequent case of any deprivation in the country. Male and female children are likely to experience at least two severe deprivations than one. The proportion of children experiencing any deprivations is generally high for both boys and girls outstanding disparities also emerge when ethnicity, religion, region and type of place of residence are examined. In all the seven severe deprivations, rural dwellers are worse off than their urban counterparts. This underscores the need for more balanced provision of social amenities between the urban and rural areas. It is important to raise national awareness on poor sanitation and its effects on the health and development of children.

Key words: Children, severe deprivations, poverty, underscores, poor sanitation, Ghana

INTRODUCTION

Emerging democracies in Africa are increasingly focusing on poverty reduction programmes as a strategy to socio-economic development. Generally, poverty reduction programmes that have been implemented in African countries have multiple objectives. In Ghana, the Poverty Reduction Strategy is premised on the goal of the government to transform the economy to achieve growth, accelerated poverty reduction and the protection of the vulnerable and excluded within a decentralised, democratic environment. This suggests that the government sees poverty as one key factor that negatively affects the nation's socio-economic progress.

Ghana in its drive to fight poverty embarked on a national strategy, Ghana Poverty Reduction Strategy (GPRS I), from 2002-2005 and is currently implementing the policies and objectives as outlined in the Growth and Poverty Reduction Strategy II (GPRS II), 2006-2009. Poverty is defined in the GPRS I as unacceptable physiological and social deprivation that is caused or aggravated by a wide range of factors. These include the lack of capacity of the poor to influence social processes through lack of education, vocational skills, entrepreneurial abilities, poor health and poor myths that give rise to anti-social behaviour, among others (Government of Ghana and UNFPA, 2003).

Child poverty has various dimensions that are yet to receive much needed attention in the literature. The consequences of poverty among children include non-pursuit of formal education and incidence of school drop-out, child labour migration and trafficking. These are developments thattend to foreclose the socio-economic progress of children. Poverty reduction strategies such as Ghana's seek to tackle child poverty within the wider context of human development that recognizes child wellbeing as the cornerstone for human resource development that eventually leads to human development.

At the international level, human development has been pursued within the framework of the Millennium Development Goals (MDGs), the eight time-bound development goals set at the 2000 United Nations summit. Of the eight MDGs, four directly affect the growth and development of children and the other four do so indirectly. The four that have direct effects on children's welfare by extension their poverty levels are the eradication of extreme poverty and hunger; achieving universal primary education; reducing child mortality and combating HIV/AIDS, malaria and other diseases. The

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other four goals that may have indirect impact on children are promoting gender equality and empowering women; improving maternal health; ensuring environmental sustainability and developing global partnership for development.

The poverty situation of children therefore, cuts across all eight MDGs to which Ghana, as a country is a signatory to and has been attempting to implement. Poverty among children manifests itself in a number of ways, including the deprivations they suffer with respect to food, health, sanitation, water, education and information. Indeed, these have been indicators employed as single or composite measurements for development since the paradigm shift in development from economic development to human development by United Nations Development Programme (UNDP, 2000).

According to a study commissioned by UNICEF and adopted in the literature (UNICEF, 2009; Magadi and Middleton, 2007; Gordon *et al*., 2003), absolute poverty is a condition characterized by severe deprivation of the seven basic human needs (food, safe drinking water, sanitation facilities, health, shelter, education and information). A child is living in absolute poverty if he or she suffers from multiple deprivations-two or more severe deprivations of basic human need. This approach aims to denote circumstances in which children are so severely deprived that their health, well-being and long-term development is endangered.

Very little or nothing is documented, however in the literature regarding direct measurement of child poverty and disparity in the Ghanaian context. The present study, therefore examines the extent and distribution of severe deprivation and absolute poverty among children in the country.

It is expected that the study will provide baseline information for possible policy intervention on child welfare issues in Ghana. A further objective of the study is to contribute to knowledge in this area of research.

MATERIALS AND METHODS

The study used the 2006 Ghana Multiple Indicator Cluster Survey (MICS) as data source. The MICS methodology was developed by UNICEF to support governments and other partners in measuring progress for children and women towards the internationally agreed set of goals from the 1990 World Summit for Children. At least 50 countries, including Ghana have participated in the three round of data collection conducted first in 1995 and then in 2000 and 2005. In Ghana, the first survey was conducted by the Ministry of Health with technical assistance from the Ghana Statistical Service (GSS) while the third was undertaken by the GSS in collaboration with the Ministry of Health, UNICEF, Ghana and Macro International.

In addition to assessing progress, MICS data can be used for setting the baseline for further research and for monitoring programmes. The MICS questionnaire has been designed as a series of modules that allow countries to adapt the survey to suit their individual data needs.

One of the primary objectives of the 2006, MICS in Ghana was to provide up to date information for assessing the situation of children. A representative probability sample of 6,302 households was selected nationwide for the 2006 MICS. The sample covered the population residing in households in the country. The list of Enumeration Areas (EAs) from the 2006 Ghana Living Standard Survey (GLSS5) served as a frame for the MICS sample. The frame was first stratified into the 10 administrative regions in the country then into urban and rural EAs.

The sample was designed in a manner to provide estimates on a large number of indicators on the situation of children and women at the national level, for each of the 10 regions in Ghana, as well as for separate urban and rural areas.

The 2006 MICS used a two-stage stratified sample design. Of the 6,302 households listed, 6,264 were found to be occupied and interviews were completed for 5,939 households which represent 95% response rate. A total of 6,240 women (age 15-49) and 1,909 eligible men (age 15-49) from every 3rd household were identified for the individual interviews. Interviews were successfully completed for 5,891 women and 1,743 men, yielding a response rate of 94 and 91%, respectively.

In addition, 3,545 children under age 5 were listed in the household listing. Of these, questionnaires were completed for 3,466 which correspond to a response rate of 98%. Overall, response rates of 90, 93 and 87% were calculated for the women's, children under 5 years and selected men's interviews, respectively. Details of the 2006 MICS sampling procedure are presented elsewhere by Ghana Statistical Service (GSS, 2007).

The instrument for the survey was made up of household, women, men and under 5 questionnaires. Data covering the household and under-five questionnaires mainly were employed for the present study. Since very little is known about the income or consumption needs of children and how these may vary by age, sex and location,

the most commonly used poverty measures are inappropriate for estimating child poverty (UNDP, 2000). Young children, for instance have low food requirements but numerous other basic needs that require expenditure.

In Ghana and other developing countries whether a child lives in poverty does not only depend on family income but also on access to public goods and services such as a safe water supply, roads and health care education. Thus, child poverty is measured best using outcome indicators (that is data that reflect the impact of both low family income and inadequate service provision on children) rather than indirect measures based on arbitrary thresholds for income or consumption.

RESULTS AND DISCUSSION

Table 1 shows the proportion of children experiencing severe and less severe deprivations with respect to health, sanitation, water, information and food education. Children experience severe and less severe deprivation more in sanitation than any other indicator of child deprivation (38.5 and 29.4%, respectively) followed by education, shelter and information.

Almost 30% of children suffer from lack of toilet facilities, the most frequent case of any deprivation in the country while 58% of them suffer from deprivation of toilet and education 68% suffer from deprivation of toilet and education shelter.

Table 2 shown the determinants of severe child deprivations in Ghana. Both male and female children are likely to experience at least two severe deprivations than one. Similarly, at least two severe deprivations than one dominate when household size, education and sex of the head of the household region of residence are examined. As should be expected, children living in households where the heads have no formal education and who belong to the lowest wealth index quintiles (or poorest) are substantially more likely to suffer at least two severe deprivations than their counterparts resident in households where the heads have secondary + education and are rich (60 versus 16 for education 76 versus 21% for wealth index quintiles).

The proportion of children experiencing any deprivations is generally high for both boys and girls outstanding disparities also emerge when ethnicity, religion, region and type of place of residence are examined. For example, the probability that children will experience any deprivations is much higher among the Mole/Dagbane, Grusi Gruma ethnic groups than among their Akan counterparts.

The former ethnic groups are concentrated in the three northern regions of Ghana. The phenomenon is even more pronounced when one looks at region of residence. It is noteworthy that the three northern regions (northern, upper east, upper west) are the most deprived in the country; the poorest and with highest percentages of population in rural areas. Children living in these areas are therefore more likely than others to experience deprivations and poverty.

The prevalence of seven severe deprivations, shown in Table 3, indicates that northern and upper east regions are the hardest hit in terms of deprivations in shelter sanitation, water, information and food.

The greatest proportion of deprivation in education is experienced in the three northern regions whereas Volta Region has the highest proportion of health deprivation

Table 1: Child poverty as multiple deprivations (2006 Ghana MICS Data)

Characteristics	Number of children in relevant age cohort (estimates in 1,000s)	Of which experiencing severe deprivation (%)	Of which experiencing less severe deprivation (%)
(a) Incidence of deprivation			
Shelter	12,742	18.9	9.9
Sanitation	12,742	38.5	29.4
Water	2,742	14.0	8.7
Information	26,329	12.6	25.1
Food	26,329	2.4	3.4
Education	4,506	20.2**	28.9
Health	5,939	0.7	3.0
Total			
(b) The incidence of the most frequent combinations of deprivations			
The most frequent case of any deprivation*	12,742	38.5	29.4 (no toilet facility)
Two most frequent combinations*	17,248	58.7	58.3 (toilet+education)
Two second most frequent combinations*	25,484	32.9	18.6 (shelter+water)
Three most frequent combinations*	17,248	77.6	67.7 (toilet+educ+shelter)
Three second most frequent combinations*	26,329	29.2	37.2 (water+Info+food)

Computed from 2006 MICS ** Currently not in school in the preceding year (2004-2005). Index of severe deprivation is calculated by summing the seven deprivations and dividing by 7 = 83.6 Index of less severe deprivation is calculated by summing the seven deprivations and dividing by 7 = 78.4

Table 2: Correlates of severe child deprivations by Background Characteristics, 2006 MICS

Characteristics	At least one severe deprivation	At least two severe deprivation
Male (age)		
1	13.8	18.5
2	18.2	25.8
3	26.0	30.7
4	15.4	20.2
5	11.7	16.7
Female (age)		
1	13.2	20.9
2	8.6	20.9
3	311.9	12.6
4	412.8	13.0
5	511.6	19.8
Household size		
<3	7.1	16.9
3-4 members	11.8	18.3
5-6 members	13.5	18.1
7+	11.4	17.2
Education of the head of the household		
None	38.2	59.5
Primary	27.3	30.7
Middle/JSS	14.3	18.3
Secondary+	12.4	15.9
Sex of the head of the household		
Male	15.4	18.3
Female	5.6	15.5
Wealth index quintiles		
Q1 (poorest)	47.5	75.9
Q2	30.6	43.3
Q3	16.5	18.2
Q4	11.4	17.5
Q5	19.6	20.5
Ethnicity		
Akan	9.0	15.4
Ga/Dangme	11.9	19.6
Ewe	23.6	24.7
Guan	27.4	27.9
Gruma	31.4	45.7
Mole/Dagbane	43.5	74.3
Grusi	34.2	50.9
Other	37.7	55.7
Religion		
Catholic	26.8	33.4
Protestant	13.0	17.2
Pentecostal	16.4	19.0
Moslem	34.0	51.8
Traditional	50.3	83.1
Spiritualist	20.0	20.7
No religion	27.3	30.3
Other	12.3	24.2
Region		
Western	15.5	17.7
Central	10.4	16.7
Greater Accra	8.3	21.1
Volta	34.7	44.5
Eastern	6.7	15.0
Ashanti	3.1	11.6
Brong Ahafo	7.7	19.2
Northern	44.1	72.6
Upper East	48.0	84.3
Upper West	46.4	81.4
Residence		
Urban	11.3	16.7
Rural	33.9	48.9

Table 3: Prevalence of seven severe deprivations by region and residence

Deprivations	Shelter	Sanitation	Water*	Information**	Food***	Education''''	Health''''''
Region	2,485.0	9,430.0	2,223.0	6,617.0	302.0	2,195.0	707.0
Western	2.2	3.6	12.2	7.5	5.5	75.8	18.4
Central	1.6	3.5	2.6	7.0	4.6	80.2	38.2
Greater Accra	6.0	2.8	6.8	5.6	2.7	55.8	25.6
Volta	6.3	6.9	19.2	9.2	8.1	69.9	44.3
Eastern	4.2	1.7	4.8	7.0	9.1	77.5	23.8
Ashanti	6.8	1.2	9.1	10.4	6.8	70.8	16.8
Brong Ahafo	2.2	1.5	6.1	5.5	4.9	81.7	35.0
Northern	27.0	28.9	13.2	20.2	12.4	86.5	32.3
Upper East	29.9	28.5	23.3	16.9	12.4	89.1	17.4
Upper West	13.8	21.4	2.7	10.7	6.0	90.2	13.5
Residence							
Urban	22.9	11.0	25.0	24.4	3.4	63.4	22.4
Rural	77.1	89.0	75.0	75.6	9.6	84.2	28.8

The 2006 MICS raw data. Note: * Unsafe water ** Measured by no radio *** % below -3 sd (Stunted) '''' 100%-net primary school completion rate ''''' Did not vaccinate against all childhood diseases (children aged 12-23 months)

(44.3%), followed by Central Region (38.2%) Brong Ahafo Region (35%). It is remarkable that the attention being paid to the northern regions in terms of vaccination against childhood killer diseases is having some impacts as Upper East and Upper West regions are among the regions with the lowest health deprivation in the country (GSS *et al*., 2003, 2009).

In all the seven severe deprivations, rural dwellers are worse off than their urban counterparts. This underscores the need for more balanced provision of social amenities between the urban and rural areas. The past few decades have seen some provision of electricity and educational facilities for rural areas. While sustaining this approach to bridging rural-urban living conditions, policies on sanitation and shelter that address increasing rural access will need further attention.

A study that attempts to address the poverty situation of children in Ghana is of relevance in many respects. So far, all attempts to examine poverty in the country have targeted the general population without specifically looking at what happens to children. The current study undertook an analysis of the 2006 Multiple Indicator Cluster Surveys (MICS) dataset to explicate child poverty in Ghana.

Poverty affects all categories of the population. Children in particular are more vulnerable in a situation of high poverty incidence. This is because by their tender ages, children are often not in a position to take decisions that could alleviate their poverty and therefore, depending on the decisions that are taken by their parents, older siblings, care-givers and other family members they may escape or live continuously in poverty.

Most vulnerable groups are also poor, many suffering from extreme poverty. From a human rights perspective, poverty is now seen more and more as the deprivation of capabilities rather than merely as lowness of incomes.

The preceding findings suggest that the incidence of severe deprivation is by far more pronounced with respect to sanitation than in the other basic human needs in the country. Diarrhoea, a sanitation-related disease is one of the major causes of child morbidity and mortality in Ghana. One in 5 children had diarrhoea in the 2 weeks preceding the 2008 GDHS (GSS *et al*., 2009). Exposure to diarrhoea-causing agents is frequently related to the use of contaminated water as well as to unhygienic practices in food preparation and disposal of excreta. It is therefore important to raise national awareness on poor sanitation and its effects on the health and development of the children.

To this end, it is crucial for the government to formulate a comprehensive national sanitation policy with a view to ensuring effective sanitation delivery for the attainment of the Millennium Development Goals on sanitation in Ghana. Quality of sanitation and water sources is related to quality of housing. Access to improved sanitation in particular is more likely to be realised when policies and regulations regarding housing are implemented more effectively in Ghana and the expected benefits are substantial. According to a PRB and Child Trends (2002) study, safe water supply and effective means of sanitary disposal are two key factors in disease prevention.

CONCLUSION

Their study found out that the incidence of diarrhoea can be reduced by 22% and deaths due to diarrhoea by 65% when safe water and effective means of sanitary disposal are available to households that raise young children. A study by Badasu (2009) on the effect of housing facility on nutritional and health status of under-fives in Accra also indicates that children in

households that have no toilet facility are four times more likely to be wasted than their counterparts in households that have. As children resident in households where the heads are not educated, poor or living in the northern part of the country are more likely to be severely deprived, the importance of formal education for all cannot be over-emphasized.

Higher education undoubtedly brings a wide range of personal, financial other lifelong benefits to the recipient. Higher levels of education correspond to lower levels of unemployment and poverty since higher education can significantly increase incomes and the rate of economic growth.

RECOMMENDATIONS

The government should continue to encourage increased participation and completion of higher education to improve the lives of children and the society to which they belong. Ghana can also realize the demographic dividend that some Asian countries are benefiting from when such investments are made in the children population of the country. The northern part of the country should be targeted for special interventions (such as citing of multinational industries and public universities, tertiary admission concessions and scholarships to children up to university level) designed in order to improve the socio-economic development of that part of Ghana.

Finally, sustained efforts should be made to implement child related policies and programmes to ensure that Ghanaian children receive the best possible care in life to guarantee their survival in a knowledge-based world. This will go a long way toward eliminating child poverty and disparities in the Ghanaian context.

REFERENCES

Badasu, D.M., 2009. Urban housing and child nutritional and health status in Accra. Proceedings of the 3rd Annual Colloquium on National Identity and Development in Ghana, Nov. 12- 13, University of Ghana Faculty of Social Studies, J.H. Nketia Conference Hall at the Institute of African Studies, University of Ghana.

GSS, 2007. Monitoring the Situation of Children and Women: Findings from the Ghana Multiple Indicator Cluster Survey 2006. GSS, Accra.

GSS, Health Research Unit, Ministry of Health and ORC Macro, 2003. Ghana Service Provision Assessment Survey 2002. GSS and ORC Macro, Calverton, Maryland.

GSS, GHS and ICF Macro, 2009. Ghana Demographic and Health Survey 2008. GSS, GHS and ICF Macro, Accra, Ghana.

Gordon, D., S. Nandy, C. Pantazis, S. Pemberton and P. Townsend, 2003. Child Poverty in the Developing World. British Library Cataloguing in Publication Data, http://www.nscb.gov.ph/poverty/TCPovStat/reading_materials/rioXG/Social%20Exclusion/ChildPov_PP.pdf

Government of Ghana and UNFPA, 2003. State of Ghana Population Report 2003: Population, Poverty and Development. UNFPA/Government of Ghana, Accra

Magadi, M.A and S. Middleton, 2007. Severe child poverty in the UK. Save the Children, http://www.savethechildren.org.uk/en/docs/sevchildpovuk.pdf

PRB and Child Trends, 2002. Kids Count. PRB., Washington, DC.

UNDP, 2000. Human Development Report. Oxford University Press, Oxford.

UNICEF, 2009. The Global Study on Child Poverty and Disparities. UNICEF., http://unicefglobalstudy.blogspot.com/