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COMPLIANCE WITH NATIONAL HEALTH INSURANCE REGISTRATION CONDITIONALITY IN LEAP BENEFICIARY HOUSEHOLDS IN YILO KROBO

BY

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DECLARATION

I, FELIX KWAKU LOGAH do hereby declare that, except where due acknowledgement of references and ideas have been cited in the text, this dissertation is the result of my research at the Institute of Statistical, Social and Economic Research (ISSER) of the University of Ghana.

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DEDICATION

I dedicate this work to the Holy Spirit.

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LIST OF ACRONYMS

ADB	Asian Development Bank
APWDW	Assistance Programme for Widowed and Destitute Women
AIDS	Human Immune Deficiency Syndrome
CABAs	Children Affected by AIDS
CLIC	Community LEAP Implementation Committee
DSW	Department of Social Welfare
DFID	Department for International Development
DNHIS	District National Health Insurance Scheme
FA	Familias en Accion Programme
FCUBE	Free Compulsory Universal Basic Education
GDP	Gross Domestic Product
GLSS	Ghana Living Standards Survey
GOG	Government of Ghana
GPRS	Growth and Poverty Reduction Strategy
GSS	Ghana Statistical Service
HIPC	Highly Indebted Poor Country

HIV	Human Immune Deficiency Virus
ILO	International Labour Organization
LDC	Less Developed Countries
LEAP	Livelihood Empowerment Against Poverty
MDAs	Ministries Departments and Agencies
MDGs	Millennium Development Goals
MESW	Ministry of Employment and Social Welfare
MGCSP	Ministry Of Gender, Children and Social Protection (MGCSP)
MMYE	Ministry of Manpower, Youth and Employment
MOE	Ministry of Education
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
NDPC	National Development Planning Commission
NFBS	National Family Benefit Scheme
NSPS	National Social Protection Strategy
OECD	Organization for Economic Cooperation and Development

OVC Orphan and Vulnerable Children

PAMSCAD Programme of Action to Mitigate the Social Cost of Adjustment Programme

PATH Programme of Advancement through Health and Education

PRAF Programmea de asignacion Familia

PETI Programmea Erradicacao do Trabalho Infantil

RPS Red de Proteccion Social

SPSS Statistical Package for the Social Sciences

WFCL Worst Forms of Child Labour

YKD MHIS Yilo Krobo District Mutual Health Insurance Scheme

YKD MTDP Yilo Krobo District Medium Term Development Plan

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ABSTRACT

The Livelihood Empowerment Against Poverty (LEAP) programme is a social protection measure that employs conditional cash transfer as a means of investing in human development to benefit the poor. LEAP includes conditionalities, which are intended to encourage poor households to prioritize the human capital development of the beneficiaries. This study examined compliance with the conditionality that LEAP beneficiary households have to register with the National Health Insurance Scheme (NHIS). The study involved primary data collection with 62 respondents in four communities of the Yilo Krobo District. The data was subjected to regression analysis to determine the relationship between NHIS compliance among low income (extremely poor) households and the size of household, age of household head and education of household head (independent). NHIS registration compliance was the dependent variable. Results from Pearson Correlation analysis showed that there exist no significant correlation between NHIS compliance and age of household head, and education of household head. However, there existed a positive relationship between size of household and NHIS enrolment compliance.

CHAPTER ONE

INTRODUCTION

1.0 Background

Ghana has made significant progress in poverty reduction, improvement in economic development, good governance and many other sectors of the economy. Poverty levels in Ghana declined impressively from 51.7 per cent in 1990 to 28.5 per cent in 2005/6 (GSS, 2008). However, this poverty reduction and development has not spread evenly across the country. Some areas such as the northern parts of the country, and rural regions, consistently remain poorer than the rest of the country (GSS, 2008; Sultan and Schrofer, 2008). The relatively high poverty level is accompanied by a relatively high inequality level as indicated.

To address the issue of inequality in the country, the government of Ghana has introduced several social protection programmes that target the very poor in the society to help minimize the burden of poverty. This has a direct link with the first of the Millennium Development Goals, which aims at eradicating extreme poverty and hunger. One of such interventions is a Conditional Cash Transfer programme dubbed the Livelihood Empowerment against Poverty (LEAP) programme, which was introduced in 2008.

Beyond the relief aspect of cash transfers it is argued that they also tend to stimulate investment and consumption of goods and services, which promote local markets and benefits whole communities (Help Age International, 2006). Thus, in addition to the vital social contributions, cash transfers support critical economic objectives. Evidence has shown that many of the world's advanced economies like the United Kingdom and the United States of America, as well as the fastest growing economies such as those of Brazil, Mexico and South Africa over the

past several decades have built social protection into their policies at different stages, because of its potential for increasing productivity through healthy and adequately prepared human capital. It also creates stable domestic demand for goods and services (Asia Development Bank, 2003; Samson et al, 2006; UNICEF, 2009, pp.12). The consensus among development practitioners is that making health care affordable is essential to achieve this goal.

LEAP like most social cash transfer programmes in Africa borrows heavily from Brazil's Bolsa Familia programme. It is important however, to note that LEAP is part of an overarching Social Protection Framework in Ghana. It was incorporated into Ghana's Medium-Term Development Framework in 2003. The Department of Social Welfare (DSW), under the coordination of the erstwhile Ministry of Employment and Social Welfare (MESW) is the main implementing agency for the Programme. LEAP has both conditional and unconditional social cash transfer components. Special attention is given to the following categories of vulnerable people: subsistence farmers and fisher folk; elderly poor 65 years or older with no productive capacity and assistance; care givers grant scheme for orphan and vulnerable children, particularly those affected by HIV/AIDS, and children with severe disabilities; caregivers' grants for incapacitated/extremely poor persons living with HIV/AIDS (PLWHAs), and social grants for pregnant women and lactating mothers with HIV/AIDS (see MYYE, 2007).

To ensure the full benefit of the social assistance LEAP, beneficiary households are expected to be linked to existing social protection interventions such as the Free Compulsory Basic Education (FCUBE) and the National Health Insurance Scheme (NHIS) among others. The beneficiary households of the LEAP are required to comply with the following conditionalities of the grant as appropriate:

- Enrol and retain all school going age children in the household in public basic schools
- All household members should be registered under the NHIS
- All new born babies must be registered with the Births and Deaths Registry within five (5) months of birth; attend post natal clinics; and complete the Expanded Programme on Immunization (EPI)
- Household heads must ensure that no child in the household is trafficked or engaged in any activities constituting the Worst Forms of Child Labour (WFCL) (MMYE, 2007).

The focus on NHIS registration as a conditionality for accessing LEAP is to encourage members of extremely poor households to access good health care. This study investigates the level of compliance with the NHIS registration conditionality under the LEAP programme among different households.

1.1 Problem Statement

Governments tend to use fee exemptions and vouchers to support the poor to obtain health care. Exemptions are granted to vulnerable groups for defined services such as free prenatal care, immunization and treatment for chronic diseases (Huntington, 2009). In addition, fee waivers are granted to some individuals to help eradicate certain diseases such as Tuberculosis, HIV/AIDS and Buruli Ulcer in the case of Ghana. These waivers may represent quite substantial charges, even though they may only account for a minority of interactions with the health care system (World Bank, 2001; Devereux et. al., 2004; NDCP, 2009).

Social transfers aim at accelerating significant reduction in extreme poverty, and to boost inclusive growth and human capital development. Reducing morbidity and mortality is vital to

the success of poverty reduction, making access to health care a critical element in social protection. With the introduction of the NHIS the poor and vulnerable only benefit from the exemption if they register. That is the conditionality in the LEAP cash transfer.

The practice of subsidizing health care goes back a long way in Ghana. In 1957 on the attainment of independence, the existing charges in government health facilities in Ghana were waived leaving a minimal level of user fees, as specified in the Hospital Fees Decree, 1969 (Nyonator and Kutzin, 1999). This law was later amended as Hospital Fees Act, 1971. The introduction of the Structural Adjustment Programme (SAP), however, changed the orientation of Government about social services delivery to public goods; an orientation based on market principles, and therefore, on partial cost recovery. This was reflected in reduced expenditure on health services.

In mid 1980s through to 1995, the Government (Ministry of Health – MOH) expenditure on health fell from 11.1% to 6.9 % (Nyonator and Kutzin, 1999). MOH tried to broaden the fees charged to include consultation, laboratory and other diagnostic procedures, medical, surgical and dental services, medical examinations and hospital accommodation. The poor potentially lost out on access to healthcare. Findings from a study conducted on the effect of the health sector reform component of the SAPs in Ghana revealed the negative consequences it had on the poor's access to health services (Asenso-Okyere et al. 1997; 1998; Nyonator and Kutzin, 1999).

After the launch of the Millennium Development Goals (MDGs) and Ghana's adoption of the Highly Indebted Poor Country (HIPC) status, social market ideas filtered into development

planning. A major change is the recognition of social protection especially for vulnerable people as a state responsibility. Ghana recognized that healthcare inequalities had become severe by the end of the1990s and early part of 2000, and that to have sound quality human capital, there was the need for quality health for all its citizens. To this end, the government made some commitments and begun a number of measures in the new development policy frameworks – Ghana Poverty Reduction Strategy (GPRS I: 2003 – 2005 and GPRS II; 2006 – 2009). The National Health Insurance Act, 2003 (Act 650) is one of the major pro-poor policies promulgated leading to the implementation of a National Health Insurance Scheme (NHIS) to relief the needy. As it is the intention of this research is to study the state of compliance with the NHIS in LEAP programme the research questions below are raised.

1.2 Research Question

The study was informed by the research questions below:

- What is the state of compliance with NHIS?
- What are the conditions that facilitate or inhibit registration with the NHIS for beneficiaries of LEAP?
- What are households' understandings of the health insurance registration conditionality in the LEAP programme?

1.3 Objectives

Based on the research questions above, the study addresses three major objectives:

- To ascertain LEAP beneficiary households' timing of registration with the NHIS by socio-economic characteristics.

- To find out the influence of the NHIS registration conditionality on households' access to health facilities and their well-being.
- To examine the interpretation given to LEAP conditionality by the beneficiaries and how this affects their registration.

Empirical evidence has shown that cash transfers tied to conditionality targeted at the poor can yield good results (Samson et al, 2006 pp.87), when they are used as developmental measures rather than punitive instruments. For example, payment tied to compliance with health and education conditionality helps to break intergenerational poverty transmission. It has also been noted that poor households have imperfect information on the benefits of school and health. This makes them resort to child labour and earnings from child labour are regarded as more important than potential higher lifetime earnings (Cassidy, 2010). For example, the secretary of the Department of Social Welfare (DSW) in Philippines, Corazon Juliano-Soliman (2011), indicated in his presentation to members of the Senate Oversight Committee on Public Expenditures that the DSW's Conditional Cash Transfer programme had recorded close to full beneficiary compliance. He indicated that 96% of beneficiaries sent their children below age five for monthly check ups at the government health centres and compliance of households with school going age children was at 96.8%. Attaching health conditionality to LEAP grant is a reflection of government's commitment to increasing access to health care and improving human capabilities as well as enhancing health seeking behaviour in extremely poor households (Coady, 2002).

1.4 National Health Insurance Scheme of Ghana

Ghana, recognizing the importance of healthcare for the quality of her human capital, under the new development policy framework - Ghana Poverty Reduction Strategy (GPRS I: 2003 - 2005), made a number of commitments and initiated a number of measures to minimize the healthcare inequalities in the system. One major pro-poor policy introduced was the promulgation of a National Health Insurance Act, NHIA Act 2003 (Act 650) and implementation of a National Health Insurance Scheme (NHIS) that would replace the "Cash and Carry System" – a pay-as-you-go health service introduced under the SAP as part of the reforms in the 1980s.

The NHIS was aimed at eliminating the financial barrier to healthcare posed by the "Cash and Carry System" by limiting out-of-pocket cash payment at the point of service delivery. The move is believed to enhance access to, and improve delivery of quality healthcare services to every Ghanaian.

1.5 Registration Procedure for NHIS Clients

There are two main categories of the NHIS membership; formal and informal categories. The formal members are the Social Security and National Insurance Trust (SSNIT) contributors and the Exempt Categories. The Informal category is the rest of the citizenry who do not fall within the above categories. To register at the office level the client goes to the Public Relation Section to ascertain his/her category and then fill a form for registration, from there to accounts section to pay the appropriate fees (premium and/or processing fees). The Formal and Exempt category (except the indigents and pregnant women) only pay a processing fee and not the premium. Indigents and pregnant women do not pay any fees. The Informal Category pays both the premium and processing fee. A receipt to acknowledge payments of the prescribed fees is

handed over to the client or must be demanded for as evidence of payments. A picture is taken of the client. The newly registered client especially the informal category will then have to observe three (3) months waiting period, within this period an identity card of membership should be issued. However, pregnant women do not observe any waiting period. The exempt category that pay only processing fees include SSNIT pensioners, persons aged 70 years and above, persons less than 18 years and LEAP beneficiaries. Registration can also be done through an agent or collector for the scheme (Yilo Krobo District Medium Term Development, 2010).

1.6 Renewal of Membership for the NHIS Clients

Renewal of Membership for the NHIS must be done on or before expiration of the policy to enable the clients enjoy continuous benefit under the scheme. Renewal at the office level client goes to the public relation section of the NHIS at Somanya to fill a form for renewal of membership. He/she then moves to an accounts section to pay for both the premium amount (where applicable) and/or re-activation fees. He/she is issued a receipt of renewal and a sticker is pasted at the back of the NHIS membership ID card to indicate active membership. The receipt and ID card must always be kept together in case a client finds him/her self at a facility not connected to the ICT platform of the NHIA [Yilo Krobo District Medium Term Development Plan (YKD MTDP), 2010].

The NHIS operation in Yilo Krobo District was faced with some challenges at the onset, including (i) difficulties in organizing community durbars since community members normally do not attend community durbars, (ii) inability of prospective clients to pay premium, (iii)unauthorized fees charged by some providers, (iv) hostile attitude of some providers towards insured patients (clients), (v) delay in the release of government subsidy to service providers of

NHIS and reinsurance, (vi) inadequate logistics and others (Yilo Krobo District Mutual Health Insurance Office, 2009).

1.7 Significance of the Study

Conditional Cash Transfer programmes are intended to empower eligible households, assist them provide for their basic necessities, and enhance their access to existing social services and other poverty reduction interventions (NSPS, 2007). This is essential for tackling the inter-generational cycle of poverty. However, the available research on the compliance with the conditionalities, especially registration with the health insurance scheme is inadequate in the case of LEAP in Ghana (NSPS, 2007). This research seeks to add to the existing knowledge on compliance with the conditionalities in social cash transfers. The study also suggests recommendations for the implementation of the LEAP for better results.

1.8 Organization of the Study

The study report has been organized into five chapters. Chapter one provides an introduction to the entire study giving the background of the study, problem statement, research questions and objectives, notes on the NHIS in Ghana and the significance of the study. It also provides how this study report is organised.

The rest of the chapters are organized as follows: chapter two reviews literature on the theme and presents the conceptual framework employed in the research. Chapter three presents the research methodology employed and a profile of the study area, the Yilo Krobo District of Ghana. Chapter four discusses the results of the survey. Finally, chapter five deals with the summary of major findings, recommendations and conclusions.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter consists of a review of relevant literature and a conceptual framework that centres this study in the broader research of compliance with conditionalities in conditional cash transfers and social protection. The review focuses on the concept of social protection conditional cash transfers (CCT) globally, beneficiaries' compliance to CCT conditions, social protection policies in Ghana**,** Ghana's Livelihood Empowerment Against Poverty and how this study relates to them.

2.1 Social Protection

Samson et al. (2006) have described social protection as involving a set of formal and informal mechanisms directed towards providing social assistance and capacity enhancement to the vulnerable and excluded in society. In broad terms, such measures cover extremely poor individuals, households and communities, including those who need special care but lack access to basic social services and social insurance to protect themselves from the risks and consequences of livelihood shocks, social inequities, social exclusion and denial of rights. Devereux & Sabates-Wheeler (2007) also define social protection as all initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of socially excluded and marginalized people. According to the Ghana National Social Protection Strategy (2007, pg 1), social protection thus includes the "strengthening of social cohesion, human development, livelihoods and protection of rights and entitlements" beyond simple income support.

Similarly, Conway et al. (2000) defines social protection as public actions and inactions taken as remedies to levels of vulnerability, risks, and deprivation. The International Labour Organisation (ILO) divides those public actions into three general categories: social insurance, labour market regulation and social assistance (ILO, 2001). Social insurance includes contributory schemes designed to protect workers and their households against life-course and work related contingencies, such as maternity, old age, unemployment, sickness and accidents. Labour market regulations are legal frameworks aimed at ensuring minimum standards for employment and work and safeguarding workers' rights. Social assistance includes tax financed policy instruments designed to address poverty and vulnerability (Barrientos and Hulme, 2008). Garcia and Gruat (2003, cited in Abebrese, 2011, p. 4) report the ILO as viewing social protection as "having security in the face of vulnerabilities and contingencies...having access to health care and working in safety."

These broad definitions allow for the fact that different categories of people require different forms of social protection. Examples are the chronic poor, including groups such as the rural, landless and orphans; those who are economically at risk, such as people living with HIV and AIDS, internally displaced persons and refugees; and the socially vulnerable, including ethnic minorities, people living with disabilities, and child-headed households. Each of these groups requires different forms of social protection (Lund, 2008). Social transfers, for example, to the disabled or child grants, social services, home-based care, education and healthcares are safety nets (Rawlings and Rubio, 2003). The more typical notion of social insurance, including contributory pensions are also encompassed within the notion of social protection, although clearly only reserved for those able to pay.

Social protection programmes in poor countries are usually established in response to constraints on accessing welfare, such as limited scope for social insurance, high levels of self-employment of unstable irregular wage employment and wide spread underemployment. Gentilini (2005) indicates that other constraints include the limited resources for formal social protection measures; low tax generated revenue, and competing demands on national budgets. Additionally, Pellisery (2005) identifies the limitation in reaching rural informal sector populations who are spatially scattered, occupationally diverse and administratively difficult to reach. These restrict the range of social protection services offered in most poor countries.

2.2 A Global View of Conditional Cash Transfers

According to Ellis et al. (2009) there are a number of social transfer programmes in operation in every corner of the world today. For example Norway, Denmark and South Africa have non-contributory social pension schemes that provide social cash transfers to elderly citizens in addition to cash transfers. Brazil has an input subsidy programme that provides subsidized fertilizer and seed to vulnerable but viable farmers; and Zimbabwe has a Basic Education Assistance Module that provides school fee waivers. Ghana also provides antiretroviral (ARV) drugs to people living with HIV/AIDS. Particular attention has been paid to the role of social cash transfers in promoting pro-poor development (MOH, 2005). Arguably the area of social protection that is most immediately relevant to pro-poor development is a social transfer programme. Social transfers are on-budget and predictable non-contributory social assistance programmes. They take various forms: cash, vouchers, food, agricultural inputs, medicines, and school fees or health care waivers.

Rawlings and Rubio (2003), Michael et al. (2006), Devereux and Sabates-Wheeler (2007), and Barrientos and Hulme (2008) assert that social transfer programmes are regular payments by governments and non-governmental organizations (NGOs) to individuals or households in exchange for active compliance with human capital conditionalities such as sending children to school, regular visits to health centres and registration of births and deaths. Further, they all agree that these social transfers could be conditional or unconditional transfers.

Rawlings and Rubio (2003) assert that conditional social transfers constitute a significant part of a generation of development programmes that seek to foster the accumulation of human capital among the young as a means of breaking inter-generational poverty. They observe this as a marked departure from the traditional supply side mechanisms of subsidies, or investments in schools, nutrition and health centres or other social services to a reliance on market principles of demand side interventions. These programmes, Rawlings and Rubio (2003) indicate, are often linked to infrastructural investments initiatives, which increase the supply of health and educational services. The authors also observe that these programmes have been established in numerous countries in recent years particularly in Latin America and in the Caribbean. Established examples include the Mexican Progrema de Educacion Saludy Alimentacion (PROGRESA) now Opportunidades, the first large scale conditional social transfer in Latin America. Brazil also has the Programa de Bolsa Escola and Programa Erradicacao do Trabalho Infantil (PETI). Columbia had the Familias en Accion Programme (FA) whilst Honduras had the programa de asignacion Familiar (PRAF). Other established examples include the Programme of Advancement through Health and Education (PATH) of Jamaica, the Red de Proteccion Social (RPS) of Nicaragua amongst others (Rawlings & Rubio, 2003).

Samson et al. (2006) maintain that the transfers provide monies to poor families under an agreement between the programme agency and the beneficiaries. In addition, Lindert (2005) observes that they also provide immediate social assistance. Lindert (2005) argues that the compliance with conditionalities can foster long-term human capital investments. Scholars, including Rawlings and Rubio (2003) and Morley and Coady (2003, cited in Michael et al., 2006), who have acknowledged the novelty of this transfer mechanism, and concede that further critical evaluations are required have commended the mechanism nonetheless. They claim that initial evidence on its social impacts shows clearly that programmes that employ the transfer mechanism have been favourable on investments in human capital.

South Africa

The social pension and the child support grant are the two social cash transfer programmes widely studied in Southern Africa. In South Africa, the social pension is an old-age pension scheme which begun in the early 1990s. Its maximum transfer in 2002 was 24% of average income. The transfer is reduced if the income of recipients is above the means tested threshold. Women over 60 and men above 65 are eligible with a mean test applied to self-reported income. Uptake among African communities is almost universal. The social pension is widely shared within recipient households improving nutrition and health status, facilitating household investment, improving school enrolment and reducing child labour. It cost 1.4% of GDP in 2002. The child support grant is paid to caregivers of 13 or less year old children in poor households. They received 72 Rand per child per month. This increased the incidence of women searching for a job by 6% and women finding a job by 3% costing 0.7% of the GDP. The end of programme assessment on the social pension indicated 63% improvement in the beneficiary households even though this also cost 1.38% of the GDP (Devereux et al., 2007).

Finally, analysis of households' survey data indicated that, the social grants reduce South Africa's poverty gap by 47 percent (Michael et al., 2006). The data for the Lesotho universal pension scheme for the aged above seventy (70) also shows that the cash received are spent on children's education, health and other necessities (Devereux et al., 2005).

Mexico

Progresa (Opportunidades) was introduced in 1997 in Mexico to support poor households with children in rural areas. The intervention had a conditionality of children attending school and mothers and infants attending regular primary health care. The programme paid the elderly 15 $P and a selected household received 24 $P for each child in school. Average per capita consumption for Mexico was 450 $P per month in 1999. Findings showed that transfers went to the bottom 20% and 80% to the bottom 40%. The programme provided mean benefit equivalent to 20% of household income, reducing the poverty gap by 36%. Seventy per cent (70%) of households showed improved nutrition. School attendance rose by 8% for girls and 4.5% for the boys and beneficiary households showed reduction in stunting for children between 1 and 3 years. Additionally, illness at birth declined by 25% and adults reported 18% fewer days in bed due to illness. Also, women reported greater control over household resources (Harvey et al, 2005).

2.3 Social Protection Policies in Ghana

According to the Ministry of Manpower, Youth and Employment (2007), Social protection policies and programmes in Ghana were initiated by different stakeholders pursuing their separate agenda and interests in different sectors. Examples of such programmes include interventions during the1983 food crisis, emergency food aid, food-for-work and school feeding

programmes with support from Ghana's development partners. Food aid has also been monetized to support agricultural income-generating activities, such as palm-oil processing, cereals marketing, and non-traditional export development (MMYE, 2007).

The increasing commitment of Ghana to social protection and a more explicit policy framework focusing on vulnerable and excluded groups as indicated in the GPRS I and II, and the growing national and international pressure for a more concrete actualization of the constitutional principles of social justice and equity (Government of Ghana, 1992), contributed to the passing of various legislation into law. These pieces of legislation included the Children's Act, 1998 (Act 560), the Criminal Code Amendment Act, 1998 (Act 554), the Intestate Succession Law, 1985 (PNDC Law 111), the Social Security Law, 1991 (PNDC Law 247), the Child Rights Regulations, 2003 (L.I 1705), the National Health Insurance Act, 2003 (Act 650), the National HIV/AIDS Policy (2003), the Persons with Disability Act 2007 (Act 715), the Labour Act 2003 (Act 615), the Human Trafficking Act, 2005 (Act 694), the Aging Policy (2003), the Juvenile Justice Act, 2003 (Act 653), the Adolescent and Reproductive Health Policy, the Gender and Children's Policy (2003), Early Childhood Development Policy (2004) and the Domestic Violence Act, 2007 (Act 732). These legal documents define a regulatory framework for addressing the interests of the vulnerable and excluded populations of the society.

Ghana adopted a National Social Protection Strategy (NSPS) in 2007. This is "to help lift the socially excluded and vulnerable from situations of extreme poverty and to build their capacity to claim their rights and entitlements in order to manage their livelihoods" (GoG, 2007). The NSPS intends also to enhance social protection coordination. Its flagship social grant programme is the Livelihood Empowerment against Poverty (LEAP) targeting the bottom 20% of the "extreme poor" population.

2.4 The LEAP in Ghana

Livelihood Empowerment Against Poverty (LEAP), a flagship programme of the National Social Protection Strategy, has been designed and targeted at the bottom 20% of the extreme poor in Ghana. The LEAP is aimed at providing support to the extreme poor to help them 'leap' out of poverty. The Department of Social Welfare (DSW) with the mandate to support and rehabilitate vulnerable and excluded groups is the lead-implementing agency. The Ministry of Gender, Children and Social Protection (MGCSP) – formerly, the Ministry of Employment and Social Welfare – and DSW also have the responsibility to assist and coordinate other Government of Ghana (GoG) programmes in other sectors (Ministries, Departments and Agencies) to effectively target the poorest in implementing their pro-poor programmes, and facilitating the establishment of linkages between the various interventions targeted at the poorest of the poor.

LEAP was developed with the assistance from the Brazilian government through the Brazil-Africa Cooperation Programme on Social Protection through its Ministry of Social Development and Fight Against Hunger (MDS) to African countries in the development of social policies and programmes (GOG, 2007; MMYE, 2007).

LEAP, like most social cash transfers programmes in Less Development Countries, is modelled after Brazil's Bolsa Familia programme and also based on the Growth and Poverty Reduction Strategy II (GPRS II) of Ghana. LEAP is a conditional and unconditional five (5) years pilot social cash transfer programme which originally targeted subsistence farmers and fisher folk, extremely poor elderly above 65 years with no productive capacity and assistance, care givers grant scheme for Orphans and Vulnerable Children (OVC) particularly Children Affected By AIDS (CABAs) and children with severe disabilities, caregivers grants for

incapacitated /extremely poor persons living with HIV and AIDS (PLWHA) and social grants for pregnant women/ lactating mothers with HIV/AIDS. At the moment, not all the targeted beneficiaries mentioned above access the grant, they will be brought on board as the programme scales up. However, the OVC, the elderly above 65 years without support and severe disabled person with no productive capacity are currently benefiting from the grant (DSW, 2009; MESW, 2009).

LEAP uses a mixed method of identifying its target group. These are proxy means testing, self-targeting, geographical targeting and community-based selection. The process including an initial verification of the list of beneficiaries by the community, the ranking of potential beneficiaries with indicators previously selected and later, submission of the ranking list of the beneficiaries to the Community LEAP Implementation Committee for verification. The LEAP beneficiary household is paid GHC 24.00 and this amount ranges up to GHC 45.00 depending on the number of beneficiaries in the household. The payments are made every two months through the Ghana Post Company. Through LEAP; the Government intends to enhance the beneficiaries' access to other pro-poor programmes, which target the most vulnerable. The LEAP programme assists targeted groups to become socially empowered by increasing their access to education, healthcare, and other social services through cash transfers with conditionalities.

2.5 Conditionality and Compliance with LEAP

The LEAP social grants programme views conditionalities as developmental measures rather than means to punish households for non-compliance. The conditionalities are intended to

encourage poor households to prioritize the human capital development of the beneficiaries. This is essential for tackling the inter-generational cycle of poverty.

Effective conditionalities are dependent on successful allied services such as education, health, nutrition and other human capital dimensions, including reduction of the worst forms of child labour. It is important to understand the nature of barriers to achieving these priorities through research. For example, are education backlogs supply-side or demand-side challenges? Given that LEAP considers conditionalities as a necessity for certain types of grants to be provided, it may be necessary to commence assessment on the programme to ascertain elements that inhibit or promote compliance with these responsibilities of the households.

2.6 LEAP Conditionalities

The LEAP programme beneficiary households are required to comply with certain conditions while they remain on the programme. These conditions are:

1. To enrol and retain all school-aged going children in the household in public basic schools. This will afford the children the opportunity to also benefit from the ongoing capitation grant and school feeding programmes.
2. All members of the household must be registered with the NHIS and be able to produce a receipt in the absence of a card.
3. New born babies (0-18 months) must be registered with the Birth and Deaths Registry, attend required post natal clinics and complete the Expanded Programme on immunization.
4. To ensure that no child in the household is trafficked or engaged in any activities constituting the Worst Forms of Child Labour (WFCL) (MMYE, 2007).

2.7 Issues of Compliance with Conditionalities in LEAP Programme

LEAP beneficiaries are given a 'grace' period of the first six months within which they must provide evidence of efforts to comply with LEAP conditionalities (MMYE, 2007, DSW, 2009). After 6 months, if there is no evidence of compliance, beneficiaries will receive a first warning in the form of verbal messages through the Community LEAP Implementation Committee (CLIC). Within the next three months, regular follow-up and encouragement/counselling of dodging beneficiaries will be carried out by the CLIC members. After a year if they fail to comply with no tangible reason, they may be considered for removal from the scheme upon the recommendation of the CLIC, approved by the District LEAP Implementation Committee (DLIC). They may be reinstated following compliance.

According to MESW (2009) and Samson (2009), the decentralized implementation structures and more flexible enforcement of conditionalities are more conducive to the development approach. This is observed from experiences in Brazil, Honduras and Mexico. MESW (2009) is of the view that attaching health conditionality to the LEAP grant is to increase access to health and also enhance health-seeking behaviour in extremely poor households.

The DSWs have noticed, in their implementation that some poor households have inaccurate information on the benefits of school and health, high discount rate or credit constraints. These make them resort to child labour and prostitution. The outcome from these activities is regarded as more important than higher lifetime earnings (Cassidy, 2010). For example, the Philippines' Conditional Cash Transfer programme has recorded close to full compliance from beneficiaries with 96% of beneficiaries sending their children below age five for monthly checkups at the government health centres. Compliance among households with school going aged children increased to 96.8% (Juliano-Soliman, 2011).

2.8 Compliance with Health Conditionalities in LEAP Programme

Many Health centres do not normally keep individual records on children who have been immunized, although they monitor the overall number of children. The most reliable way to check whether a child has been immunized is through the immunization card that is kept by the mother/caregiver. The immunization cards or growth monitoring cards of these children can be checked by the pay point manager at the time that beneficiaries receive their bimonthly transfer and also by the community facilitator and DSW staff.

Caregivers of new born babies are to be given a six month grace period to prove that children are attending post natal clinics and to complete the EPI. Caregivers are also to be given a grace period to prove that they have made efforts to register their babies with the Birth and Deaths registry.

According to the NSPS (2007), beneficiary households in Ghana are also to enjoy a grace period of 6 months to justify that they have made efforts to register on the National Health Insurance Scheme (NHIS). A receipt of payment for the scheme could be used as proof and presented to the DSW district office. Having an NHIS card is a requirement that households have very little control of in terms of when they can be expected to receive it from NHIS. Though the NHIS Act 650 says a card will be issued within six months registration, currently it can take up to a year to be issued with NHIS card (MOH, 2007).

2.11 Conceptual Framework

The conceptual framework is based on the notion that there is a possible link between the livelihood and background characteristics of households and beneficiaries of LEAP households' compliance with NHIS registration. That is the notion that compliance is influenced by

household characteristics and size of grant. The study examines how compliance is influenced by demographic factors such as age, sex, level of awareness of the conditionalities, occupation, rural/urban location, access to health facility and availability of the NHIS in the District as well as size of cash grant. As stated earlier the size of grant is determined by the number of eligible persons in a household. All these variables could facilitate or inhibit compliance with conditionalities by the household. The conceptual framework consists of three (3) levels of participation of LEAP beneficiary households in actions aimed at fulfilling the NHIS registration conditionality.

Processes of Compliance

Stage 1: Enrolment

First and foremost, you must be enrolled as follows: a beneficiary or beneficiaries who fall within the OVC categories of 1 to 4 OVCs in a household

Stage 2: Awareness and Acceptance

Beneficiaries / caregivers must be aware of and accept the conditionality.

Stage 3: Compliance

The third level of participation requires compliance with the NHIS registration.

In this conceptual framework the pattern of compliance is captured in terms of four (4) different periods of registration. The periods include the following:

Households who registered within six (6) months

Households who registered between 6 months to 12 months

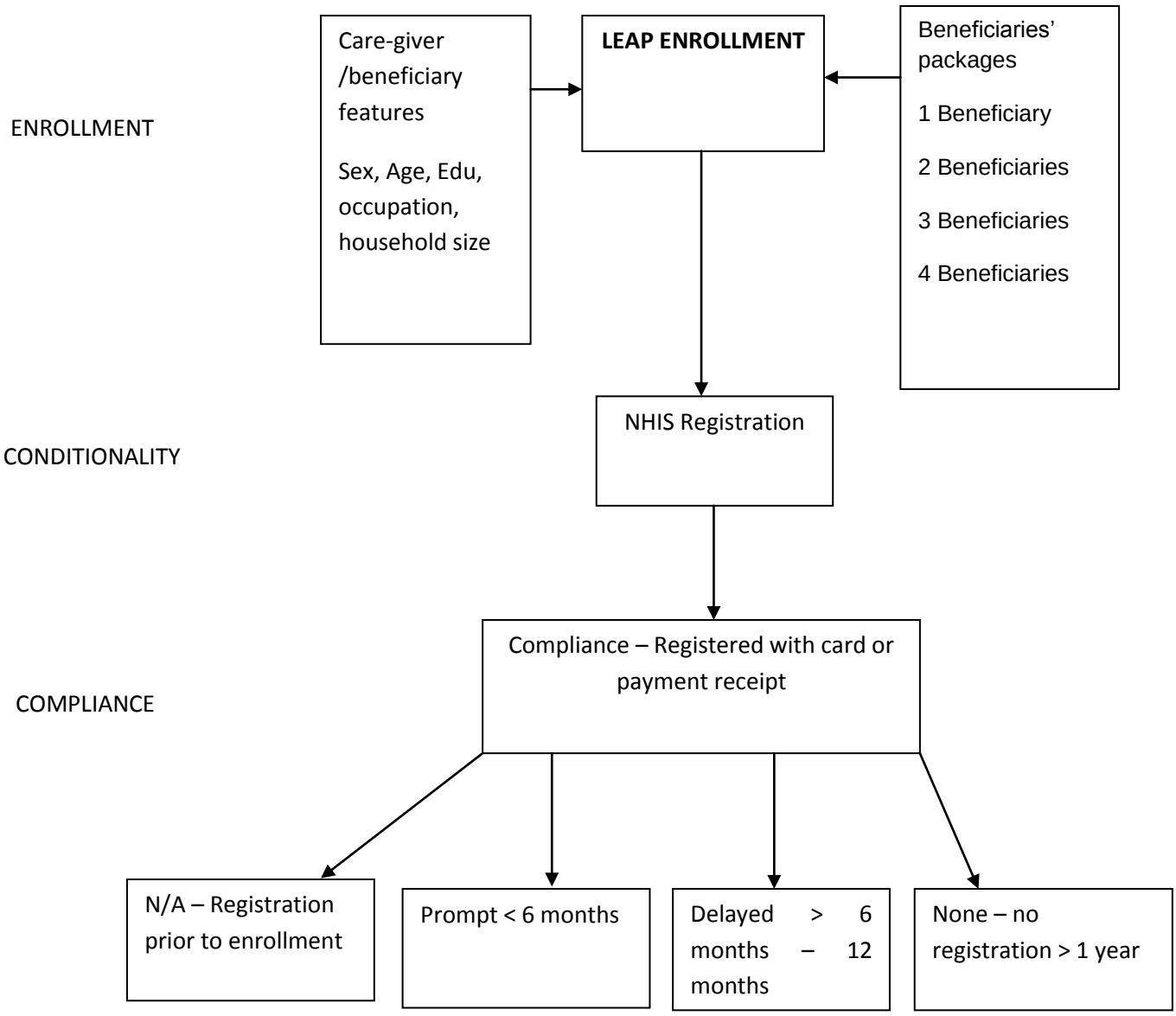
Households that registered before enrolment

Households that had not registered after 1 year

The assumption behind this study is that the pattern of compliance is to some extent influenced by background characteristics of the household.

The NHIS registration card or receipt of registration with the NHIS serves as proof of compliance with one of LEAP conditionalities. The diagram below illustrates the conceptual framework.

Figure 2.1: **Conceptual Framework:**



CHAPTER THREE

RESEARCH METHODOLOGY AND STUDY AREA

3.0 Introduction

This section outlines the research methodology I used to address the objectives of the study. It presents a profile of the study area, the Yilo Krobo District, focusing on the physical and demographic characteristics of the District as well as the social services available within the District. I also administered questionnaires to the respondents mainly at the household level. The Ghana Living Standard Survey defines a household as consisting of a person or group of persons who live together in the same house or compound, share the same house keeping arrangements and are catered for as one unit (GLSS5, 2007).

3.1 Study Design

The study adopted a quantitative cross sectional design, using semi structured questionnaires to elicit responses from LEAP beneficiary households who have benefited since the onset of the programme in 2008. Data collected from respondents in the selected communities were analysed to examine the level of the beneficiary household's compliance with the NHIS Registration conditionalities, the influence of these conditionalities on households' access to health facilities and their well-being and how the beneficiaries understood the LEAP programme and how this affected their registration.

3.2 Sampling Procedure

The Yilo Krobo District was selected due to my familiarization with the area. A multi-stage sampling procedure was used to select respondents for the study, including stratified sampling to allow for the selection of four beneficiary communities in the District. These are New Somanya, Ahinkwa, EtwisoYoyim and Aketebour. A list of LEAP beneficiaries in the Yilo Krobo District was obtained from the District Social Welfare office and the District National Health Insurance Scheme. This was used to compile the sampling frame. The next stage of sampling involved the systematic random selection of 62 household heads from the sampling frame to represent households for the interview to be conducted. The households were selected at four (4) household's interval until 62 were obtained. Fifteen (15) respondents each were selected from two of the four identified communities and sixteen (16) each from the other two communities. The unit of analysis is the household but with a focus on the caregiver.

3.3 Data Sources and Collection

The study used both primary and secondary data. Primary data was obtained from the caregivers in the Yilo Krobo District. This was obtained through the use of a semi-structured questionnaire instrument with support from the Community LEAP Implementation Committee (CLIC). The questionnaire was used to collect data on age of respondent, sex of household head, level of education, occupation, rural/urban location and access to health facility.

The data from secondary sources was collated and reviewed from published materials, bulletins, journals, working papers, reports and data from the District Social Welfare office on the LEAP beneficiaries in the District.

3.4 Method of Analysis

Data from the field analyzed quantitatively using the Statistical Package for the Social Sciences (SPSS) 16.0 version. Simple bivariate as well as multivariate methods such as Pearson Correlation were used to determine households' compliance with conditionalities.

Table 3.1: Method of Analysis

OBJECTIVE	SOURCE OF DATA	DATA COLLECTION METHOD	ANALYTICAL PROCEDURE
To ascertain LEAP beneficiary households' timing of registration with the National Health Insurance Scheme by socio-economic characteristics.	Personal interview with 62 household heads	Primary interview	Timing of registration in four categories. Descriptive statistics
To find out the influence of the NHIS registration conditionality on households' access to health facilities and their well being.	Personal interview with 62 household heads	Primary interview	Analysis of the household use of health facilities in relation to compliance
To examine the interpretation given to LEAP conditionalities by the beneficiaries and how this affects their registration.	Personal interview with 60 household heads	Primary interview	Classification of meanings given to the conditionality by households

LEAP enrolment was analyzed in relation to age of the household head, sex of household head, level of education, occupation, rural/urban location and access to health facility and other socio-economic factors were the intervening. LEAP household characteristics were expected to have some influence on the compliance with the NHIS by the beneficiary households. Compliance with NHIS registration was linked with background characteristics (age, sex of household head, level of education, occupation, rural/urban location and access to health facility and other socio-economic factors).

3.5 Profile of the study area

This section provides a background information on the Yilo Krobo District; the study district. It offers a brief description of the physical characteristics of the District, the demographic characteristics and the socio- economic profile of the District.

3.6. Physical Characteristics

This section describes the location, relief, climate, vegetation and settlement of people, socio demographic characteristics, socio economic profile of the District.

3.6.1 Location

The Yilo Krobo District with Somanya as its capital is one of the twenty-one districts in the Eastern Region. It shares boundaries with Manya Krobo District in the North and East; the Dangme West and Akwapim North Districts in the South; New Juabeng, East Akim and Fanteakwa Districts in the West and has an estimated land area of 805 sq. Km. (YKD MTDP, 2009).

3.6.2 Socio Demographic Characteristics

According to the 2010 Ghana Population and Housing Census, the total population of the District is 87,847 with a sex ratio of 96:100 indicating the presence of more females than males. The population in the age group 0-14 years accounts for 39.07% of the total population in the District whilst those above 60 years accounts for 8.45% of the total population. The District has a population density of 107 persons per sq. km and an average household size of 4.9 persons with males heading majority of the households in the District. The District is predominantly rural with more than 67% of its population living in rural areas. There are about 237 settlements in the District with only about 25 having populations of up to 500 people. The only urban settlement in the District is Somanya.

3.6.3 Socio Economic Profile of District

The major economic activity in the District is agriculture. However, residents are engaged in other small scale manufacturing activities such as pottery, services, trading and bead making. Close to 58% of the economically active population are engaged in agriculture whilst services, trading and small scale industrial activities, respectively, employ 18.1%, 12.9% and 7.2%.

3.7. Health Profile/Situation

Health conditions of people are crucial for improved income levels and poverty reduction, due to the fact that ill health is both a consequence and cause of poverty. It is therefore important to improve the health status of the people through direct health care and preventive services.

3.7.1 Health Facilities in the District

Both private providers and Government own the health facilities in the District. There are three (3) private clinics, seven (7) Reproductive/Child Health/Family Planning (RCH) Clinics, one (1) Health Centre, three (3) Private Maternity Homes, and seventy-two (72) trained Traditional Birth Attendants (TBAs). There are also eight (8) Community Health Planning and Services (CHPS) Centres at Obenyemi, Wurapong, Labolabo, Aboabo, Oterkpolu, Ahinkwa, Ponponya and Opersika. A polyclinic has been established in Somanya and it is fully equipped. Despite the above facilities, health service delivery is still not adequate due to the absence of a district hospital. The available health facilities in the district are stated in table 3.1 below.

3.7.2 Major Diseases

Malaria has been the most prevalent disease in the District since 1994. Records available at the District Health Management Team (DHMT) office indicate that malaria is the number one health problem among households. This means that the situation in the District has not improved since 1994. This situation is not significantly different from that of the entire Eastern region. Education and Sale of bed nets is on-going in the District to help reduce the incidence of malaria. There is however, prevalence of other communicable diseases like diarrhoea, cholera, tuberculosis, sexually transmitted diseases (STDs) and others like skin diseases, hypertension, diabetes, mental illness and anaemia in pregnancy, and malnutrition in child.

3.7.3 Treatment of Diseases

The District health report which has been emphasised in the District Medium Term Development Plan for 2010-2013 shows the mode of treatment of diseases in the District. Self-medication and treatment by quack doctors are the main ones in the District. This can in fact

pose a major health risk to the people in the district. The situation can perhaps be due to the fact that health facilities in the District are not adequate. Method of treating diseases by individuals/households is shown in table 3.2.

Table 3.2: Method of treating diseases by individuals/households and their implications

Method	Implication
Self-medication	-Many people seek hospital treatment only when their conditions deteriorate with complications and only when self-medication fails. -To intervene more health facilities must be cited close to communities
Herbal treatment/Quack Doctors	- The association of traditional practitioners to network with those in Orthodox practice - Should prepare their concoctions in a hygienic way - Should have their preparations tested for potency - Task force to ban all unlicensed practitioners
Use of Private/Government Hospitals	- Correct diagnosis given - Correct drugs supplied - Attended to by qualified health personnel - Need to improve relationships between clients and hospital staff - District Assembly to sponsor more qualified nurses to work in the district.

Source: YKD, *District Medium Term Development Plan, 2010-2013.*

3.8 District Mutual Health Insurance Scheme (DMHIS)

The District Mutual Health Insurance Scheme's report for Yilo Krobo has shown an increase in membership since the inception of the Scheme in 2005. The number of registered beneficiaries under the scheme stood at 78,917 as at December, 2009, as against 7,000 recorded

in August, 2005. This represents 83.7% rise. The DMHIS enrolment also rose from 8.0% to about 80% over the same period. The introduction of the scheme has improved access to health care across the district. The breakdown of membership in terms of Categories of Payment is presented in table 3.3.

Table 3.3: Membership of DMHIS in terms of Categories of Payment

NHIS enrolment category	**Members**
Above 70 years	7,513
Below 18 years	37,299
Informal sector paying direct cash	25,917
Private Workers	1,845
Indigent	2,105
SSNIT Pensioners	367
SSNIT Contributors	3,871
Total Registered Members	**78,917**

Source: Yilo Krobo Dist. Mutual Health Insurance Office, Somanya, 2009

The District National Health Insurance Scheme report indicated the several challenges faced during implementation, including delay in the release of subsidy and reinsurance, in spite of the successes chalked under the scheme. Logistics in the form of vehicles, motor bikes and additional computers and accessories must be made available to enhance the operation of the scheme. Additional staff with the requisite qualifications and experience is also required to augment the existing small number. A comprehensive human resource policy must be formulated to better the conditions of service of workers under the scheme.

3.9 Education

According to the Yilo Krobo District Medium Term Development Plan (YKD MTDP 2006-2009), there were about 92 kindergarten/nursery schools, 96 primary schools, 42 Junior Secondary School and one Teacher Training Institution. Out of this, only about 48% are in good condition (YKD MTDP, 2006-2009).

Rates of participation in education decline as one climbs higher in the educational ladder. Secondary school participation is very low due possibly to the higher cost of secondary education. There are a total of 1,171 teachers in the District with a teacher to pupil (student) ratio of 1:36, 1:27 and 1:17 for Kindergarten, primary and Junior Secondary School now Junior High School. There has also been an increase in enrolment of pupils into schools due possibly to the capitation grant, School Feeding Programme and the LEAP programme. Out of the total population in the District, only about 45.7% of the adult population is literate.

The majority of the people within the research area are mainly poor and have low levels of education; this makes a significant percentage of the population illiterates. The people within the research area are mainly peasant farmers and petty traders.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.0 Introduction

This chapter presents the results and the findings of the study into beneficiary compliance with National Health Insurance Registration Conditionality in LEAP Beneficiary Households in the Yilo Krobo district of Ghana. They are discussed in sections that reflect the objectives of the study. The sections are:

- Demographic Background of LEAP Beneficiaries
- Timing of NHIS Compliance among LEAP Beneficiaries
- Influence of NHIS Registration on Access to Health Facilities
- Influence of NHIS Registration on Well-Being
- Beneficiaries Interpretation of LEAP Conditionalities and its effects on Registration

4.1Demographic Background of LEAP Beneficiaries

The Livelihood Empowerment Against Poverty (LEAP) is a community-based programme that covers almost 68, 000 households in Ghana. It has been implemented in 83 districts selected from all ten regions of the country. In the Eastern Region where this study was conducted, the LEAP has been rolled out in nine District Assemblies and over 135 communities, with the Yilo Krobo District being one of the first districts to enjoy LEAP in the country after it was piloted. Currently, fifteen (15) communities benefit from LEAP in the District. Table 4.1 gives a distribution of LEAP communities in the Yilo Krobo District, showing the number of beneficiary households and their year of enrolment.

Table 4.1: List of LEAP Beneficiary Communities in Yilo Krobo District, 2008 and 2009

Name of Community	Year (2008)	Number of Beneficiary Households	Year (2009)	Number of Beneficiary Households	Total Number of Beneficiaries
Ahinkwa	2008	44	2009	-	44
Akatebour	2008	10	2009	5	15
Akorley	2008	-	2009	23	23
Akutunya	2008	-	2009	44	44
Bosotwi	2008	-	2009	24	24
EtwisoYoyim	2008	12	2009	26	38
New Somanya	2008	35	2009	-	35
Nsutapong	2008	-	2009	35	35
Ogome	2008	-	2009	15	15
Okornya	2008	-	2009	25	25
Opersika	2008	-	2009	39	39
Plau	2008	-	2009	18	18
Ponponse	2008	-	2009	17	17
Yilo Begoro	2008	-	2009	31	31
Yilo Zongo	2008	-	2009	27	27
Total	2008	**100**	2009	**329**	**429**

Source: LEAP data, Department of Social Welfare, [2009].

The LEAP cash transfer programme at its initial stages (2008-2011) paid a basic grant of eight Ghana Cedis (GH¢ 8) per month to individual beneficiaries irrespective of location or condition. The amount paid to beneficiary household increased by two to three Ghana Cedis for each household member who met the eligibility criteria. The maximum amount paid to a household was Fifteen Ghana Cedis (GH¢15), and that is to households with four (4) or more beneficiaries. A review of the transfer led to an upward adjustment to bring the size of the grant vis a vis the minimum wage, in line with others in Latin America. The programme currently disburses a basic grant of GH¢24 for 1 eligible household member, GH¢30 for 2 eligible household members, GH¢36 for 3 eligible members and GH¢45 for 4 or more eligible household members. Table 4.2 show eligibility and the amount paid to beneficiaries.

Table 4.2: Number of Eligible Members and Transfer Amount for 2008-2011 and 2012/13

Household composition	Transfer amount per month from March, 2008 – Dec., 2011	Transfer amount per month from Jan 2012 – 2013
Extremely poor households with 1 eligible member	GH¢ 8	GH¢24
Extremely poor households with 2 eligible members	GH¢ 10	GH¢ 30
Extremely poor households with 3 eligible members	GH¢ 12	GH¢ 36
Extremely poor households with 4 or more eligible members	GH¢ 15	GH¢ 45

Source: MESW/DSW, 2012

4.1.1 Demographic Background of Respondents

This section indicates the demographic characteristics of the 62 respondents who were interviewed for this study, using simple descriptive statistics.

Table 4.3: Sample Distribution by Communities

Community	LEAP Households	Households Benefiting per Community
Akatebour	15	15
EtwisoYoyim	15	38
Ahinkwa	16	44
New Somanya	16	35
Total Sample	**62**	**132**

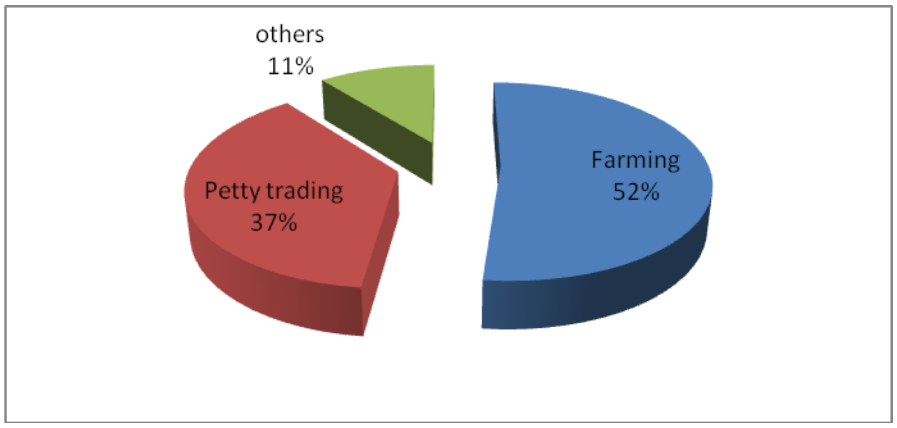
Source: Fieldwork, 2012

A total of sixty-two (62) questionnaires were administered to LEAP households in four (4) communities in the Yilo Krobo District. The research administered fifteen (15) questionnaires in two and sixteen (16) questionnaires in another two of the four LEAP communities directly to caregivers in LEAP beneficiary households.

The average household size in all four communities is 4.0; this is slightly lower compared to the district average household size of 4.9 but equal to the national average of 4 (GSS, 2007). Out of the total respondents, 85.5% were females and 14.5% were male, which reflects the preference for the selection of female caregivers in the LEAP programme. This conforms to existing literature that suggests that female-headed households are more likely to be vulnerable compared to male-headed households. In relation to this, Oduro et al. (2011) in *Measuring the Gender Asset Gap in Ghana*, concluded that there is prevalence of gender disparity in assets ownership and control and further suggested the vulnerability of women and/or females as a result. Similarly, the data collected on the religious affiliation of respondents did not show a deviation from the national situation where Christians dominate the population. Over eighty percent (80.6%) of respondents were Christians compared to 8.1% who identified themselves as Muslims.

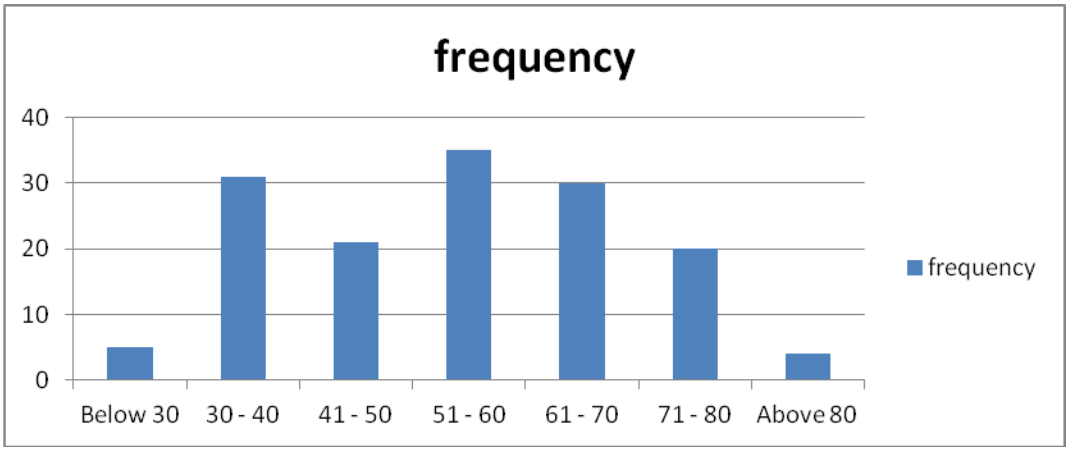
Close to half (47%) of respondents were engaged in farming as their main source of livelihood, conforming to the District and national distribution where majority of rural dwellers are farmers. The second most predominant form of livelihood that respondents were engaged in was petty trading, with 33.9% of respondents in this sector. Only 9.7% of the respondents were involved in other forms of livelihood apart from farming and petty trading. Figure 4.1 shows the distribution of respondents by occupation.

Figure 4.1: Occupational Distribution of Household Heads, in Percent



The average age of respondents was 54.5 years. This age profile shows that many of respondents were close to the public service retirement age of 60 years. The ages of care-givers were such that a few (4%) of them were below the age of 30 and 2.7% above 80 years with majority between the ages of 40 and 60.

Figure 4.2: Age Distribution of Respondents



Source: Fieldwork, 2012

4.1.2 Educational Level of Household Heads

The data on the educational status of the household heads are presented in Table 4.4. Comparing this with the national population, the Ghana Living Standards Survey 5 reported

educational levels for the whole population of Ghana as follows: those with no schooling, 30.8 percent; those with less than MSLC/BECE, 17.1 percent; those with MSLC/BECE/VOC, 38.6 percent; and those with secondary or higher, 13.6 percent (Ghana Statistical Service, 2008). Thus it appears that the respondents had generally lower levels of education compared with the entire population of the country, assuming that the educational levels of the entire population have not changed much during the period.

Table 4.4: Educational Levels of Household Heads

Educational level	No. Frequency	% Percent
Primary	13	21.0
Middle school/JSS	11	17.7
Secondary/SSS	3	4.8
None	31	50.0
Missing data	4	6.5
	62	**100.0**

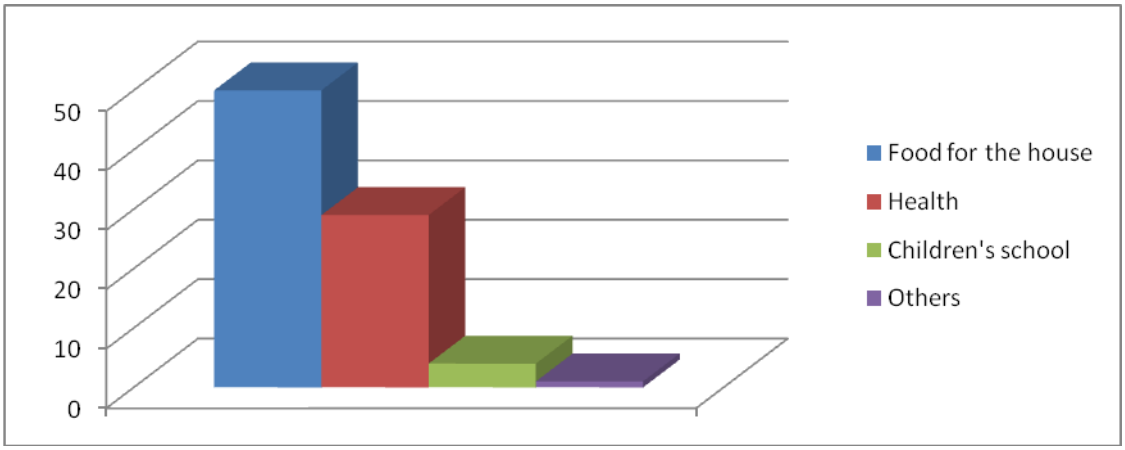
Source: Fieldwork, 2012

4.1.3 Use of LEAP Cash Grants

This section analyzes the use of LEAP transfers and respondents' perceptions on the LEAP programme. The study found that, majority of LEAP beneficiary households (59.5%) use the cash transfer to cater for food. While 34.5% use the cash transfer to take care of their health needs, only 4.8% of the respondents use the cash transfer to cater for the school needs of their children. This situation could be attributed to the implementation of the nationwide Free

Compulsory Universal Basic Education (FCUBE) programme in all four (4) communities the study took place. Most respondents (98.8%) mentioned the fact that the money handed to them was not adequate for the various purposes to which they put the cash transfer. This can be attributed to the fact that the LEAP programme has one of the lowest amounts paid to beneficiaries as compared to Conditional Cash Transfer programmes in the literature. About 58.1% of the respondents had been on the LEAP programme for four years at the time of the survey, while 35.5% had been on the programme for two years with the rest being on the programme for barely a year. In figure 4.3 below, the graph shows a distribution of the use of the LEAP cash transfer.

Figure 4.3: Use of Leap Cash Handouts



Source: Fieldwork, 2012

Data from the study suggest that about one-quarter (24.2%) of the respondents have monthly incomes of between GH¢20 and GH¢39. About 6.5% of respondents had no monthly income aside the monthly LEAP cash handout making them depend on the cash handout for all their financial needs. Table 4.5 shows the distribution of average income of respondents.

Table 4.5: Average Monthly Income of the Respondents

Average Income (¢)		Frequency	Percent	Valid Percent
	GHC40 +	7	11.3	21.2
	GHC20 - 39	15	24.2	45.5
	GHC10 and less	7	11.3	21.2
	no income	4	6.5	12.1
Missing	data	29	46.8	
Total		**62**	**100.0**	

Source: Field work, 2012.

The fact that LEAP is considered to be an income supplement and not income replacement appears to be lost on the beneficiaries.

4.2 LEAP BENEFICIARIES TIMING OF NHIS REGISTRATION

4.2.1 Period of Compliance with NHIS Registration

The conditionality of the LEAP programme which is the focus of this study is that all members of LEAP beneficiary households must be registered with the National Health Insurance Scheme (NHIS) and be able to produce a receipt in the absence of a card. The study found that 79% of respondents were registered under the NHIS while 21% were not registered, at the time of the study violating the six months grace period within which to register after enrolment. Further investigation revealed that of the respondents who had registered, 56.5% of them were registered under NHIS before enrolling onto the LEAP programme. This gives a clear indication that the LEAP NHIS conditionality has had very little influence on households' decision to enrol onto the NHIS among the respondents.

The table below gives details of NHIS registration among respondents before the LEAP intervention. NHIS before LEAP

Table 4.6: NHIS Registration before LEAP

Are you registered on NHIS	NHIS before LEAP	
	Yes	No
Yes	35	14
No	0	13
Total	35	27

Source: Fieldwork, 2012.

Table 4.7 below indicates that most of respondents who were not registered on the NHIS programme before the introduction of the LEAP intervention had not done so because of lack of the financial means to register. From the data, 72.73% of those who had not registered with the NHIS (21%) had not registered because they did not have money to do so. Other reasons respondents gave included proximity to registration points. The table below shows details of respondents' reasons for non-registration with NHIS before LEAP.

Table 4.7: **Reasons for Non-Registration with NHIS**

Sex	**No Money**	**Expensive**	**Distance**
Male	5	0	0
Female	19	1	2
Total	24	1	2

Source: Fieldwork, 2012.

Beneficiaries of the LEAP intervention are to ensure that they are registered on the NHIS programme within six (6) month of enjoying the LEAP intervention. This is to ensure that beneficiaries have access to good health and at an affordable rate and to encourage them to access the formal health care rather than unsafe traditional health facilities which could result in loss of life and other complications.

The analysis of the data indicates that, 57.14% of beneficiaries who were not registered with NHIS before LEAP complied with the NHIS conditionality of the LEAP intervention. That is to say that they enrolled with the NHIS within six (6) months of enrolment into the LEAP intervention.

Table 4.8: LEAP Beneficiaries Compliance with NHIS Conditionality

Time of registration	
Before Enrolment	35
Within 6 months	8
Within 1year	4
After 1year	2
Not Registered	13
Total	62

Source: Field work, 2012.

4.2.2 NHIS Conditionality Compliance and Socio-Economic Background

This section looks at the relationship between NHIS conditionality compliance and other variables such as education, sex of house head, age, occupation, and rural/urban location of household and household size. Here, the study examined the relationships between the NHIS compliance and educational level of household head, age of head of household and household size influence on households' compliance to NHIS.

A Pearson correlation was run to determine the relationship between the dependent variable, NHIS compliance among low-income households and the three independent variables mentioned above. It was found that there exist no significant correlation between the NHIS compliance and two of the variables (age of household head and education of household head). That is to say that, from the data collected in all four (4) research communities, age and educational level of household head do not influence the decision to enrol household members onto the NHIS. The study found that there exist a positive relationship between size of household and NHIS enrolment (NHIS compliance), that is to say the larger the size of the household the greater the likelihood of the household complying with the NHIS conditionality. Table 4.6 gives the correlation between all three variables and the NHIS compliance.

Table 4.9: Correlation between NHIS Compliance and Selected independent Variables

Variable		age of respondent	Educational level of respondent	size of household	are you registered on NHIS
age of respondent	Pearson Correlation	1	.601**	-.248	-.325**
	Sig. (2-tailed)		.000	.061	.010
	N	60	58	58	60
sex of respondent	Pearson Correlation	.160	.378**	.206	.212
	Sig. (2-tailed)	.215	.003	.121	.098
	N	60	58	58	60
religion of respondent	Pearson Correlation	-.100	-.163	-.135	-.176
	Sig. (2-tailed)	.468	.254	.344	.199
	N	55	51	51	55
Occupation of household head	Pearson Correlation	.226	.350**	-.085	-.070
	Sig. (2-tailed)	.094	.010	.549	.608
	N	56	54	52	56
Educational level of respondent	Pearson Correlation	.601**	1	-.180	-.326*
	Sig. (2-tailed)	.000		.194	.013
	N	58	58	54	58
size of household	Pearson Correlation	-.248	-.180	1	.417**
	Sig. (2-tailed)	.061	.194		.001
	N	58	54	58	58
are you registered on NHIS	Pearson Correlation	-.325**	-.326*	.417**	1
	Sig. (2-tailed)	.010	.013	.001	
	N	60	58	58	60

To test the extent to which independent variables explain the NHIS compliance of the household, a simple regression was ran with NHIS compliance as the dependent variable and age of household head, size of household and education of head of household as independent variables was used. This also confirmed a significant relationship between household size and NHIS compliance. It was found that the size of household explains about 41.7% of changes in

the NHIS compliance. This relationship was significant at 99% with an F-statistic of 11.77. The table 4.7 shows the output of the regression.

Table 4.10: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.417[a]	.174	.159	.386

a. Predictors: (Constant), size of household

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1.753	1	1.753	11.777	.001[a]
	Residual	8.334	56	.149		
	Total	10.086	57			

a. Predictors: (Constant), size of household

b. Dependent Variable: are you registered on NHIS

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.974	.089		10.964	.000
	size of household	.072	.021	.417	3.432	.001

a. Dependent Variable: are you registered on NHIS

4.3 NHIS INFLUENCE AND ACCESS TO HEALTH IN LEAP BENEFICIARY HOUSEHOLDS

4.3.1 Influence of NHIS Registration on Access to Health Facility

The study found that a majority (72.6%) of respondents (LEAP beneficiaries) since enrolling on LEAP were more likely to access formal health care if the need arose. Also, the data showed that it took respondents not more that forty-five minutes to reach a government health care facility. There were no private facilities in the communities.

Table 4.11 LEAP Beneficiaries' Access to Healthcare, 2012

Access to Health	**Frequency**	**Percent**
Has Access to Health care	45	72.6
Has no access to health care	10	16.1
Total	55	88.7
Missing data	7	11.3
Total	62	100.0

The study established that majority (86.4%) of respondents preferred to visit primary and secondary health facilities; this situation could be attributed to easy access to such facilities compared to other forms of health facilities in the communities of study. Further investigation into the high preference for formal forms of health facilities revealed that, respondents might have such preference due to the absence of user charges at such facilities. About seventy-three (72.6%) of respondents indicated that they did not pay any charges when they visited the hospital because of the NHIS membership. The situation conforms with the increasing access of low-income households' to formal health care made possible by social interventions such as the NHIS (NDPC, 2010). Table 4.11 shows access to health facilities by low income households.

4.3.2 Perceived Influence of NHIS Registration on Well-Being

In response to whether the LEAP intervention has improved living conditions of the respondents, majority (98.4%) of the beneficiaries mentioned that the LEAP programme has helped to improve their living conditions. In identifying exactly what LEAP has improved in the living conditions of the beneficiaries, 30.6% of the respondents indicated that the programme ensures that they have some amount of money for their individual private use, 40.3% also mentioned that the cash has helped them to engage in some form of petty trading to improve their average incomes. Another 22.6% of the respondents indicated that the advent of the LEAP programme and its associated free NHIS subscription ensures that they visit the particular facilities when they are in need of such services. Table 4.12 below gives the distribution of ways in which LEAP has improved the living conditions of the beneficiaries.

Table 4.12: Reported Ways in which LEAP has improved lives of Beneficiaries

Improvements		Frequency	Percent
	we have money	19	30.6
	have NHIS card	14	22.6
	petty trading	25	40.3
	paying fees	3	4.8
	Total	61	98.4
	Missing data	1	1.6
Total		62	100.0

In ranking the level of improvement of their living conditions, 40.3% of respondents rate the improvement as good, while 35.5% had a rating of moderate and 24.2% of the respondents felt the improvement was satisfactory. It appears that the LEAP programme as intended and expected assists targeted groups to become socially empowered by increasing their access to healthcare and other social services.

4.4 BENEFICIARIES' INTERPRETATION OF LEAP CONDITIONALITY AND ITS EFFECTS ON REGISTRATION

About 77.4% of the respondents were aware of the NHIS conditionality in the LEAP programme. In addition, the majority (95.3%) of respondents were of the view that the NHIS conditionality in the LEAP programme was necessary and useful. Further investigation with a section of the beneficiaries revealed that, the conditionality was to help them attend hospital and get good health. As inferred from one of the respondents, "for me, since I had the NHIS card, I sent my children twice to the hospital" (Aketebour Community).

CHAPTER FIVE

SUMMARY OF MAJOR FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Major Findings

This research was aimed at studying the compliance with national health insurance registration conditionality in LEAP beneficiary households in Yilo Krobo. Four LEAP beneficiary communities were selected for the study. Secondary data sources included scholarly materials, administrative records of the Ministry of Employment and Social Welfare, Department of Social Welfare, the Yilo Krobo District Assembly (DNHIS and DSW offices) while primary data were collected from the field.

Percentage distribution revealed that, the average household size in the research communities was 4.0 like the national average, but just below the district average household size of 4.9 (GSS, 2007). Female respondents, purposively selected to be enrolled on LEAP were in the majority (85.5%) in the study population as expected. Also, the results showed that about half of the respondents had no formal education and those who had been to school had basic school education.

Furthermore, the study found that, majority of LEAP beneficiary household (59.5%) used the cash transfer to cater for food while one-third of them used the cash transfer to fund health related expenses.

The study indicated also that 79% of respondent were registered with the NHIS while 21% were not registered. Using the Pearson Correlation analysis, it was found that there exist a positive relationship between size of household and NHIS registration conditionality (NHIS

compliance) and no significant correlation between NHIS compliance and age of household head as well as education of household head. A simple regression was used to further investigate and test the extent to which age of household head, size of household and education of household head (independent variables) influence the NHIS registration compliance (dependent variable). This also confirmed a significant relationship between household size and NHIS compliance. This further revealed that, size of household explains about 41.7% of changes in the NHIS compliance and this relationship was significant at 99% with an F-statistic of 11.77 (Table 4.10). In addition, majority (95.3%) of respondents were of the view that the NHIS conditionality in the LEAP programme was necessary.

Finally, 98.4% of the beneficiaries stated that the LEAP programme has improved their living conditions. This finding falls directly in line with what is documented in the literature, where it is concluded that conditional cash transfers increase livelihood of poor households (see Devereux and Sabates-Wheeler, 2007 and Samson et al., 2007). There is a concern, however, that OVC needs may not be getting adequate attention from caregivers as this did not feature strongly in the list of improvements.

5.2 Conclusion

Positive synergies can be achieved between social cash transfer and health care services to the poor (the exemption policy), with the former equipping poor households to benefit from the latter, but complementary interventions are vital to alleviate the hardship and also break the intergenerational poverty.

The findings from the study indicate that cash transfers conditioned on health or access to medical services helps to improve well-being among low income households. Notwithstanding

the many challenges associated with the LEAP intervention in the country, it still provides an opportunity to reduce the burden of poverty on households, most especially improving access to health care among low-income households. It is clear, however, that caregivers see the cash as primarily an investment fund first and consumption support second. While this may help them to increase income earning opportunities it may also have negative implications for meeting OVC needs which should be investigated.

5.3 Recommendations

In spite of the positive benefits of the LEAP more studies are required to determine whether it is serving the purpose it was intended to – namely: helping to supply the immediate needs of beneficiaries, or whether it is simply providing investment capital to caregivers. In addition, the following steps could be part of regular monitoring exercises:

- Periodic education on the purpose of LEAP and the developmental use of conditionalities
- Interviews with OVC about their living conditions (food, health, school supplies) after LEAP
- Studies on health seeking behaviour to assess contribution of NHIS registration to health care and well-being

There is a need to follow up on this group to find out what their constraints are, in order to find solutions. The study recommends on the basis of this that the designed monitoring and evaluation plan in the LEAP programme's operational manual be rolled out. The Department of Social Welfare also needs to be adequately resourced to implement the plan outlined for the conditionalities.

REFERENCES

Abebrese, J. (2011). Social Protection in Ghana: An Overview of Existing Programmes and their Prospects and Challenges. Accra: Friedrich Ebert Stiftung. Retrieved from http://www.fesghana.org/uploads/PDF/FES_SocialProtectionGhana_2011_FINAL.pdf

Asenso-Okyere W. K., Anum A. and Appiah, E. N. (1997),"The Willingness to Pay for Health Insurance in a Development Economy: A Pilot Study of the Informal Sector of Ghana Using Contingent Valuation", *Health Policy, 42: 223-237.*

Asenso-Okyere W. K., Anum A., and Adukonu A. (1998), "Cost Recovery in Ghana: Are There Any Changes in Health Care Seeking Behaviour*?" Health Policy and Planning, 13(2): 181-188.*

Asian Development Bank (2003). "Our Framework Policies and Strategies". Asian Development Bank. Mandaluyong City, Philippines.

Barrientos A., and Hulme, D., (eds.) (2008). Social Protection for the poor and poorest: Concept policies and politics. London: Palgrave.

Cassidy, T. (2010), Zap cash transfer Project Report, The effect of mobile phones on Migration, Niger.:http://www.econ.yale.edu/conference/neudc11/papers/paper_340.pdf

Chen, R. and Wang, F (2006)" How relevant is targeting to the success of an antipoverty program?" Cited in the World Bank Res. Obs (2009) 24 (2): 205-231. doi: 10.1093/wbro/lkp009 First published online: September 2, 2009

Coady, D. (2002) 'Social Safety Nets, Human capital and the poor: Evidence from Recent Programme Evaluations'. Paper prepared for ADB/IDB Workshop on social protection

for the Poor in Asia and Latin America: Concepts and Experiences. Manila, Philippines, October.2002.

Conway, T., de Haan, A. and Norton, A. (Eds.) (2000). Social Protection: New Directions of Donor Agencies. London: Department for International Development.

Corazon, J-S. (2011). Conditional cash transfer and sustainable social enterprises: A key to rural women empowerment? New York: United Nation.

Department of Social Welfare (DWS), (2009) Livelihood Empowerment Against Poverty Annual Report, Department of Social Welfare, Accra, Ghana

Devereux, S. and R. Sabates-Wheeler (2004), Transformative Social Protection, IDS Working Paper No.232, Brighton: Institute of Development Studies.

Devereux, S., J. Marshall. J. MacAskill and L.Pelham (2005).”Making Cash Count: Lessons from Cash Transfer Schemes”. Save the Children UK, Help Age International and Institute of Development Studies.

Devereux, S. and Sabates-Wheeler, R. (editors) (2007) ‘Debating Social Protection’, *IDS Bulletin* 38(3). Brighton: Institute of Development Studies.

DFID (2005), ‘Can low-income countries in Africa afford social transfers?’ Social protection briefing note series, number 2, November 2005.

Ellis et al (2008, 2009),’We Are All Poor Here’’: Economic Difference, Social Divisiveness, and Targeting Cash Transfers in Sub-Sahara Africa’ Conference paper, learning from experience, cited 2009, Kampala, Uganda.

Garcia, A. B., & Gruat, J. V. (2003). Social Protection and Social Justice - A Life Cycle Continuum Investment.

http://www.ilo.org/public/english/protection/download/lifecycl/lifecycle.pdf

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

Gentilini, Ugo (2005). 'Mainstreaming Safety Nets in the Social Protection Policy Agenda: A New Vision or the Same Old Perspective?' United Nations World Food Programme. Mimeographed document.

Government of Ghana (2007), 'Livelihood Empowerment Against Poverty' (LEAP) Social Grants Pilot Implementation Design', Final Draft Report, Ministry of Manpower, Youth and Employment, Accra, November.

Ghana Statistical Service, annual report 2007.

Government of Ghana (1997) 'Ghana Vision 2020: The First Medium Term Development Plan (1997-2000)', Accra.

Ghana Living Standard Survey (2008). Ghana Statistical Service, Ghana Living Standard Survey, Report of the Fifth Round (GLSS 5).

Gilson and Mills, 1995, Health financing to promote access in low income settings-how much do we know? Cited-The lancet, 2004, DFID.

Government of Ghana. (1992) Republic of Ghana Constitution, 1992 Constitution. GoG

Government of Ghana (2003), National Health Insurance Act, 2003 (Act 650), Accra.

Government of Ghana (2004), National Health Insurance Regulations, 2004 (L.I. 1809), Accra.

Government of Ghana (2006).The National Social Protection Strategy (NSPS): Investing in People. DRAFT. Ministry of Manpower, Youth and Employment, Accra.

Government of Ghana (2007). "The National Social Protection Strategy: Investing in People", Executive Summary, Ministry of Manpower, Youth and Employment.

Ministry of Manpower, Youth and Employment (2008). "The Livelihood Empowerment against Poverty (LEAP) Manual of Operation", Government of Ghana

GSS (2003), "Ghana Demographic Health Survey, 2003", Statistical Service, Accra.

GSS (2006), "Ghana Multiple Indicator Cluster Survey, 2006", Statistical Service, Accra.

GSS (2007), "Patterns and Trends of Poverty in Ghana: 1991-2006", Statistical Service, Accra.

GSS (2008). Ghana Living Standard Survey, Ghana Living Standard Survey, Report of the Fifth Round (GLSS 5).

GSS 2012, 2010 Population and Housing Census: Summary report of the final results. May 2012.:http://www.statsghana.gov.gh/docfiles/2010phc/Census2010_Summary_report_of_final_results.pdf.

Harvey, P., R.Slater and J. Farrington (2005). "Cash Transfers – Mere 'Gadaffi Syndrome', Or Serious Potential for Rehabilitation and Development?".

Help Age International. (2006) A transformative agenda for the 21st century: Examining the case for basic social protection Help Age International briefing on workshop, 2006.Livingstone, Zambia. Available at: http://www.helpage.org/researchandpolicy/socialprotection/pensions.htm

Huntington D. (2009). The impact of conditional cash transfers on health outcomes and the use of health services in low- and middle-income countries: RHL commentary (last revised: 1 May 2010). The WHO Reproductive Health Library; Geneva: World Health Organization.

ILO (2001). Social Security. A New Consensus. Geneva: International Labour Office.

Kingsley K.(2012)"District Mutual Health Insurance Scheme, Annual Progress Report(APR) Yilo Krobo District Assembly, Somanya, Ghana.

Lindert, K. (2005b). "Brazil: Bolsa Familia Programme. Scaling up Cash Transfers for the Poor". LCSHS, World Bank.

Lund, F. (2008) Changing Social Policy. The Child Support Grant in South Africa. Cape Town: HSRC Press.

Michael, *et al*. (2006), "Designing and Implementing Social Transfer Programmes" Economic Policy Research Institute Press: South Africa.

MESW (2009), Ministry of Employment and Social Welfare, National plan of action (NPA) for the elimination of the worst forms of child labour in Ghana, 2009-2015.

Ministry of Health. (2005) *"Facts & Figures",* Ghana Health Services, Ghana, Accra.

Morley, S. and Coady, D. (2003). "From Social Assistance to Social Development: Targeted Education Subsidies in Developing Countries". The Center for Global Development and the International Food Policy

National Development Planning Commission (2009), Implementation of the GPRS, 2006-2009, 2008 Annual Progress Report (APRI), Accra, Ghana.

Nyonator, Frank and Joseph Kutzin. (1999). Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning* 14(4): 329-341.

Oduro, Abena, Baah-Boateng, William and Boakye-Yiadom Lawrence. (2011) "Measuring the Gender Asset Gap in Ghana" Economic Department, University of Ghana.

Pellissery, S. (2005). "The Effects of Process Deficits of Anti-Poverty Programmes on the Chronic Poor", School of Environment and Development, University of Manchester.

Rawlings, L.B and Rubio, G.M (2003). "Evaluating the Impact of Conditional Cash Transfer Programmes: Lessons from Latin America". Policy Research working paper 3119, Latin America and the Caribbean Region, Human Development Sector Unit, The World Bank.

Samson, M., K. Mac Quene and I. van Neiekerk (2006). "South Africa's Social Grants" International Inequality Facility Policy Brief Number 1 (February).

Samson *et al*. (2009). "Social Cash Transfers and Pro-Poor Growth", Finance and Economics Directorate, Department of Social Development, EPRI, Cape Town.

Sowa, N. K. (2002). An Assessment of Poverty Reducing Policies and Programmes in Ghana. A paper presented at the MIMAP Workshop on Assessing Poverty Policies, Rabat, Morocco; January 25-31, 2002. Retrieved from cepa.org: http://cepa.org.gh/researchpapers/Assessing%20Poverty%20Programs%20and%20Policies%20in%20Ghana54.pdf

Sultan, Sonja, & Tamar Schrofer (2008). Building Support to Have Targeted Social Protection Interventions for the Poorest – the Case of Ghana. Paper for the Conference on Social Protection for the Poorest in Africa: Learning from Experience, Entebbe, Uganda, 8-10 September 2008.

UNICEF, 2009 Ghana Child Labour Survey, Accra, UNICEF.

World Bank. (2001). *Adjustment Lending Retrospective*, Report 22723: Washington, DC.pg 73.

YKD, 2010 Medium Term Development Plan, Yilo Krobo District Assembly, 2010-2013, Somanya, Ghana.

APPENDIX: QUESTIONNAIRE FOR HOUSEHOLDS

INSTITUTE OF STATISTICAL SOCIAL AND ECONOMIC RESEARCH

UNIVERSITY OF GHANA

COMPLIANCE WITH NATIONAL HEALTH INSURANCE SCHEME REGISTRATION CONDITIONALITY IN LEAP BENEFICIARY HOUSEHOLDS IN YILO KROBO

Questionnaire No…….

This study is being conducted to examine compliance with NHIS registration conditionality of the beneficiary LEAP households in three selected communities in the Yilo Krobo District. This is in partial fulfilment of the requirement for the award of a Master of Arts Degree in Development Studies. I hereby, solicit your support and consent in this study. I promise that all answers for this study would remain confidential and would be used for academic purposes only.

SECTION A

1. Name of Community……2.Interviewer……..3.Date……

SECTION B

SOCIO DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Age of respondents……
2. Sex of Respondents 1. Male 2. Female
3. Religion?1. Christian2.Islam 3.Traditional 4. Other(s) specify……
4. Occupation of household head? 1.Farming. 2. Teacher 3.Petty trading 4.Teacher 5.Others specify ….....
5. Marital Status of Respondent 1. Married 2.Single 3. Divorced 4. Separated 5.Widowed
6. Educational level of Household head? 1. Primary 2.Middle school/JHS 4. Secondary/SSS 5.Technical/Vocational/Secretarial 6.Tertiary 7.Other(s) Specify……

7. Size of household……
8. Household's main Source of Income……
9. What is the average amount of income that you receive in a month?

SECTION C

INFORMATION ON LEAP

10. How long have you been on to the LEAP Programme? 1)1yr 2) 2yrs 3) 3yrs 4)4yrs
11. Has the LEAP improved living condition of your household? 1. Yes 2.No.
12. If yes, in what way? 1. We have money 2.have NHIS card 3.Petty trading 4.other(s) specify……
13. How would you rate the improvement from LEAP? 1. Satisfactory 2.Moderate 3.Good 4.Unsatisfactory.

SECTION D

INFORMATION ON NHIS AND CONDITIONALITY

14. Are you registered with the NHIS? 1.Yes 2.No (skip to 20)
15. If yes, how long did it take you to register with the NHIS after enrol unto LEAP? 1.Within 1 Week 2.1-3 weeks 3.1-6months 4.7month-1year 5.1year more 6.Other(s) specify……
16. How long did it take you at the NHIS registration point?
    1. 30min 2.1hr 3.5hrs 4.10hrs 5.others
17. When your NHIS card expires how long does it take you for renewal?
18. Which health professional usually attends to household members when sick? 1.Doctor 2.Pharmacy/Drug stores 3.Traditional healers 4. Other(s) specify ……
19. Who takes the decision to enrol on NHIS within your household? 1. Husband 3.Wife 4. Both couple 5. Other(s) specify……
20. Were you enrolled in the NHIS before LEAP? 1.Yes 2.No
21. If yes, why did you register with NHIS? 1. To access health any time 2.not to pay at every visit 3.to get drug free of charge. 4 Other(s) specifies.

22. If no, why didn't you register with NHIS? 1. No money 2.It is expensive 3.Long distance to facility 4. Other(s) specify.
23. Have you ever accessed health care since enrolled in the LEAP programme? a) Yes b) No
24. If yes, what kinds of health care have you since accessed? 1. Hospital visit 2. Hospitalization 3. Laboratory services 4. Delivery 5.Surgery 6. Other(s) specify.
25. What type of facility is it? 1. Primary 2. Secondary 3. Tertiary 4.traditional 5.Pharmacy
26. Who operates it? 1. Government 2.private business 3. Private practitioner 4.other organizations
27. Were you made to pay any money? 1. Yes 2.No
28. If yes, has any reason be given, if yes (State)
29. How far is the closest health facility? …….
30. Are you aware of LEAP conditionality?
31. Do you think the condition attached to the LEAP grant is necessary? 1. Yes 2. No
32. If yes, give reason……..
33. If no, give reason……
34. Were you forced to enrol with NHIS? 1. Yes 2. No If, Yes, who?.....
35. Did you face any difficulties when enrolling for the NHIS? 1. Yes 2. No.
36. What kinds of difficulties? (Mention)…….
37. Have you since renewed your membership? 1. Yes 2.No. If no, (Give reasons).

WAY FORWARD

38. Do you think the LEAP NHIS Conditionality is necessary? 1. Yes 2. No (Give reason)

…….

39. What suggestions would you like to give on how best to make the programme sustainable?.....
.....

THANK YOU FOR YOUR TIME