Improving health insurance coverage in Ghana: A case study
Kotoh, A.M.

Citation for published version (APA):
Kotoh, A. M. (2013). Improving health insurance coverage in Ghana: A case study

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
Introduction

The National Health Insurance Scheme (NHIS) was introduced to address inequity in financial access to healthcare, one of the most enduring problems in Ghana since independence. Although the NHIS has made gains in improving access to healthcare, it has been beset with low enrolment and the inability to retain members. Concerns have also been raised at various forums about community and institutional barriers that undermine the achievement of the NHIS policy goals. Thomas, a District Health Insurance Scheme (DHIS) manager expressed his frustration about the limited progress despite efforts to expand NHIS coverage:

It is so disappointing that after all the education we have been carrying out doing everything possible to get people insured, many people have refused to register. We go to schools, hospitals, churches and communities, yet people are not registering. Some register but do not renew their membership. It’s really difficult for us. For example, Ofram (not real name), the community you are conducting your study in is a difficult one. I don’t know how you are going to help improve enrolment there.

Thomas’ concerns were typical of responses given when low enrolment was discussed with DHIS officials. Efforts being made to expand the NHIS coverage and retain members were not yielding the desired results. His comment also indicates how the DHISs were tackling the problems of low enrolment and high non-renewal rates without sufficiently engaging other stakeholders – community members and health providers. In many cases, the NHIS target populations were not consulted to voice what prevents them from responding positively to the policy. Health providers were also left out and had not been consulted to speak about the NHIS implementation challenges that confront them. Decisions about how to manage problems of low
enrolment and retention rates are made by those who may not be in tune with the enormity of NHIS implementation challenges. Many studies have shown the value of engaging stakeholders in intervention programmes (Green et al. 2001, Hawkes et al. 2004), but how such collaborative groups operate has not been well discussed in the literature. This study fills this gap by closely monitoring the multi-stakeholder problem-solving programme (MSPSP)

The MSPSP was based on a multi-level perspective (MLP) that encourages stakeholder engagement for addressing a social phenomenon (see chapter one). As Farmer (2005) and Scheper-Hughes (1992) argue, without considering what happens at local levels, decision makers miss the majority of people whose lives are affected by their decisions. The rationale of the PSG concept was the assumption that engaging actors involved in public policy to address the challenges is more likely to achieve an impact than a single-level approach. This chapter describes the pathways of this study’s intervention and examines the activities and strategies the PSGs used to identify and address barriers to enrolment in the NHIS and retention of members.

Problem-solving process

PSGs are normally formed around defined problems and in this study that was the low enrolment and retention of members in the NHIS. The pre-intervention household survey established the size of the problem that needed to be solved. The survey showed that of the 13,857 individuals covered, only a third (30%) were currently insured, 15.7 per cent had been previously insured and 54.3 per cent had never enrolled (Table A.3, Appendix 2). To carry out their task, the PSGs adapted problem-solving tools from the literature and used approaches that were tailored to the local context. Though PSG facilitators were introduced to three problem-solving tools (brainstorming, ‘but why’ and flow charts) during their training, they found two were the most beneficial for their task – brainstorming and ‘but why’. According to facilitators, these tools were easy to explain and use. The PSGs were given a ‘free hand’ to operate and not restricted to any tool or approach. Facilitators were only required to follow the principles of the MLP and effective facilitation outlined in the ‘SHINE Ghana training manual for facilitators developed by us (the research team) to guide the PSG facilitators when performing their task (see Kotoh et al. 2009).

Figure 5.1 shows the cyclical route that the PSGs went through to identify barriers to enrolment and develop and implement interventions. It started with problem identification and prioritisation and ended with the implementation of action plans. Some steps were repeated within the cycle, depending on the feedback, after an intervention activity was carried out. Throughout the process, facilitators engaged members in interactive activities to critically analyse their experiences, interests,
behaviours and all issues raised to help understand the identified problems, and develop and implement solutions.

**Figure 5.1** Steps followed in the problem-solving process

![Diagram showing steps 1 to 5]

- **Step 1:** Identify & prioritise problems
- **Step 2:** Analyse problems
- **Step 3:** Develop solutions & implementation strategies
- **Step 4:** Draw action plan
- **Step 5:** Implement action plan

**Step 1: Problem identification and prioritisation**

The venue where the PSGs met was typically a health centre, community centre or classroom, depending on the availability of a convenient place for such an exercise. The meetings were usually held on ‘taboo days’ (no work days). Generally, the first session started with facilitators briefing members about what brainstorming and ‘but why’ entail. The facilitator then would lead the group in a discussion to develop rules to guide the process by typically making them aware that: “Though the session involves ‘free talk’ it must be structured with rules to guide the process and encourage everyone to talk in a systematic way.”

After a lengthy discussion about the techniques, the rules that were agreed upon included: nobody should interrupt when someone was talking without the facilitator’s permission and every member had to make at least one contribution during the session. I must say that these rules motivated even members who appear to be shy to

---

1 ‘Taboo days’ are days set aside by communities and people are not expected to work on their farms or go fishing. In farming communities, one can carry farm produce, but not engage in clearing the land or sowing crops. These days vary from community to community. In fishing communities, fishermen use the day to mend their nets. Generally, communities hold most of their social events such as naming ceremonies, meetings or community development activities on taboo days.
talk. The first activity of the problem-solving process was the identification and prioritisation of problems. Facilitators led the group in brainstorming using questions and answers. The main questions were: “Why are some people not registering with the NHIS?” “Why do some people not renew their registration?” and “What experiences do people have with the NHIS?” Health providers and DHIS staffs were asked specific questions about challenges in implementing the NHIS. All identified problems were listed on a flip chart in no particular order and without censoring. The duration of a typical brainstorming session was about two hours.

An extract of the first brainstorming session is presented below.

Facilitator [DHIS representative]: Today, we begin identifying barriers to enrolment. As we have already discussed, reasons why people do not enrol or renew their NHIS card can be found in the community, health facility and my outfit [DHIS]. We will start with community members, then health providers and DHIS staff. We will mention barriers we know while the secretary writes them down and later select those to be addressed. Everybody should endeavour to talk. We must be honest with what we say. If you are not sure of anything, don’t say it. Now, can anybody tell us about problems he or she, family members or friends experienced or witnessed others go through?

Community representative: I have personally gone through a lot. I’ll start with registration. I registered six of us and had five cards after four months. That of my last child came after six months. Meanwhile, I was paying his hospital bill. Just last week I had to pay for a drug covered by the NHIS when I sent a prescription the doctor gave me to an accredited pharmacy.

DHIS staff: My problem is the behaviour of nurses. Some of them don’t respect insured patients and collect unauthorised fees especially in the evenings and weekends. Our concern in this town is not getting all drugs from the health centre. We have to travel to other towns to get most of our drugs.

Community representative: I’ll also add poverty. There are people who have no income and cannot pay. Though I appreciate all these problems, the underlying factor for the majority of us not enrolling is lack of commitment to health insurance. The reality is that we have not yet accepted health insurance and made it part of our budget. It is not part of our culture to insure ourselves against ill health. We wait till we are sick before we think of insurance.

Health providers and DHIS staff also spoke about the NHIS implementation challenges that undermine their work. When ideas had been exhausted, similar problems were put together and arranged according to the level at which they were experienced or occurred and prioritised based on consensus. From my observation, this was an efficient way of eliciting problems from PSG members.

The first problem identification and prioritisation sessions were usually characterised by heated arguments when health providers and DHIS staff defended and rejected negative behaviours and practices attributed to them by others. For example, allegations of malfeasance against DHIS staff and health providers resulted in many arguments. However, the situation changed when facilitators reminded group members about the goal of the intervention and re-echoed the need for objective discussions. In subsequent meetings, I realised that the members were more relaxed and discussions were characterised with occasional jokes and laughter. The lesson
was that in such groups, time should be allowed for members to adjust to the group and grasp the task at hand and the essence of the exercise.

After problem identification and prioritisation sessions, PSGs held meetings with community leaders to solicit their reaction to the identified problems. These meetings were used to discuss challenges rather than apportion blame to any group. Generally, the community leaders’ reactions provided new insights into identified problems while new ones emerged. For example, the use of chemist and pharmacy shops as alternatives to seeking healthcare at health facilities usually came up at community leaders’ meetings. A community leader in one of such meetings explained the situation as follows:

I did not renew my card because I find the pharmacies [also referring to chemist shops] a better option than the hospital. It is faster and you do not experience any negative behaviour of nurses as is often the case when you go to the hospital. At the hospital you could spend several hours waiting and you are not treated with respect. Wommu ye (They [health providers] don’t respect us).

In addition, PSGs also held discussions with individuals in the communities by performing house-to-house visits to further explore problems not identified at their meetings. For instance, the issue of ‘not often sick’ and politics as reasons for not enrolling in the NHIS were mentioned only in individual conversations.

Since the PSGs could not solve all identified problems, they selected those they could address and usually sought the support of the District Directors of Health Services (DDHSs) and DHIS managers at stakeholders meetings in dealing with others. This was because solving some of the problems required changing structures and operational systems at the national level, which was beyond the capacity of the PSGs. For example, the problem of heavy workloads and the complex nature of NHIS forms could not be solved by PSGs since they required policy action. However, PSG activities and recommendations raised awareness and highlighted the need for change and could put pressure on policy makers to act.

Step 2: Problem analysis
Another important component of carrying out an intervention programme is to understand the problem to be addressed. Before PSGs started looking for solutions, they analysed the problems to make sure every member understood the issues they were trying to address. For every problem, the group looked for a root cause(s). PSGs generally used the ‘But why’ technique (see Serrat 2009) to get to the root cause(s). During this process community members, health providers and DHIS staff brought up experiences regarding the NHIS at their respective levels. Details of problem analysis sessions are presented below.

‘But why?’ Asking ‘but why?’ is a technique used to explore the root causes of a problem to ensure that all issues that contribute to the problem are well understood.
Here, facilitators usually stated the problem and asked about why it occurred. He or she continued to ask follow-up questions using ‘But why?’ after every answer till the group could offer no further explanations. The last response was then taken as the root cause. However, there could be more than one root cause to a problem or one root cause could result in more than one problem. Below are examples of how the ‘But why’ technique was used to find the root cause(s) of problems and discussion that ensued between facilitators and PSG members (see Boxes 5.1-5.3). It must be noted that the process is not as straightforward as presented here. This is a complex activity that has been simplified for easy comprehension by readers. In practice, each ‘But why’ question elicited many answers which were discussed and agreement reached on which was the most feasible cause(s) of the problem.

**Box 5.1 Analysis of “no money to pay reason for low enrolment”**

| Question (Q): Why are people not enrolling? | Answer (A): Because they don’t have money to pay for everybody in the household. |
| Q: But why don’t they have money to pay? | A: Because premium and registration fees for all household members are too much for the head of household to pay. |
| Q: But why is premium for the household too much when it covers the whole year? | A: Because they have competing needs, yet they have to pay registration fee for children and premium for other dependents above 18 years. |
| Q: But why do you have to pay for adult dependents? | A: Because they are not working. |

In the above case, other root causes identified were the lack of a health-related risk, aversive culture among community members, lack of confidence in the NHIS, poverty and dissatisfaction with quality of healthcare services.

**Box 5.2 Analysis of the delay in issuing NHIS ID cards**

| Question (Q): Why is there delay in issuing NHIS ID cards? | Answer (A): Because it takes so much time to process registration forms. |
| Q: But why is so much time needed to process the forms? | A: Because of the difficulty of matching names with pictures. |
| Q: But why is it difficult to match names with pictures? | A: Because people use different sets of names to register and take pictures since they were not done at the same time. |
| Q: But why do people use different names? | A: Because people have several names and they tend to use different ones at different places depending on the situation. |
Other root causes of delay in issuing NHIS ID cards included: people did not know the implications of being inconsistent with the names they used for official documents and inadequate and non-functional computers and cameras. In some cases, collectors spent monies collected from registrants and delayed the submission of their forms. There were other problems peculiar to communities outside DHISs’ office locations. These included DHISs staff’s delay in taking photographs after people had been registered as a result of frequent break down of their motor bikes or inadequate cameras to go round the numerous communities in the district.

Box 5.3  Analysis of shortage of drugs at health facilities

<table>
<thead>
<tr>
<th>Question (Q)</th>
<th>Answer (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why do you experience shortage of drugs in your facility?</td>
<td>Because we don’t always have money to buy drugs.</td>
</tr>
<tr>
<td>But why don’t you have money to buy drugs?</td>
<td>Because of delays in claims payment.</td>
</tr>
<tr>
<td>But why does claim payment delay?</td>
<td>Because there are problems with claim processing.</td>
</tr>
<tr>
<td>But why are there delays in claim processing?</td>
<td>Because the NHIS claim forms are complex and the bureaucracy involved in vetting them.</td>
</tr>
</tbody>
</table>

An additional root cause of drug shortages at health facilities was the low patronage of health facilities resulting in a low level of internally generated funds (IGF) to help maintain drug stock levels when the National Health Insurance Authority (NHIA) delayed paying health facilities. Normally, the DHISs vet bills prepared by accredited health facilities and submit them to the NHIA who pays the health facilities directly.

The ‘But why’ technique illustrated above shows the complex linkages that exist between problems and their root causes at various levels. It indicates how community, health provider, DHIS and national level factors converge to adversely affect enrolment in the NHIS and retaining members.

PSG problem analysis sessions were supported with a variety of activities. One activity was meeting with opinion and community leaders, health providers and DHIS staff. In coastal towns, PSGs met the chief fisherman, boat owners, *pataase* leaders and members with health providers and DHIS staff in attendance. The meetings were chaired by community PSG facilitators. Similar meetings were held with chief farmers, and cocoa purchasing clerks in farming communities. These meetings usually discussed the root causes of low interest in health insurance identified by the PSGs among others. In the case of health facility level barriers, meetings were held with the entire staff to discuss their concerns about increased
workloads and the cumbersome bureaucratic processes that NHIS brought into the healthcare delivery system. On the part of DHISs, the issue of people using multiple names only came up during meetings with the entire staff. As usual, these meetings were interactive and gave everybody the opportunity to express his or her concerns. Reactions from this group thus gave PSGs more insight into the problems.

Another popular activity that the PSGs used in problem analysis was house-to-house visits by members that were generally conducted by community representatives. The approach allowed for one-to-one interactions between community members and PSG representatives and provided an opportunity for individuals who were not confident talking in public to voice their concerns.

The main concerns usually expressed were: long waiting times at health facilities and DHIS offices, delays in issuing NHIS cards, health providers not respecting insured patients, shortages of drugs at health facilities, the difficulty of getting prescribed drugs in accredited pharmacy and chemist shops and having to pay for drugs covered by the NHIS. These activities provided in-depth information and better insight into the barriers the PSGs had identified, since they had the opportunity to probe further for the root causes. After a problem analysis session, a PSG representative told me: “Now I appreciate problems faced by health providers in providing better healthcare to insured patients. This has changed some of the negative perceptions I had about them.”

This highlights the importance of the PSG problem-analysis sessions that brought out issues, which had not been captured at PSG sessions. For example, the issues of registration fee payments and premiums for many children and dependents that made the total amount of money to be paid by poor heads of households unaffordable were observed at first hand.

Lessons learnt: The broad-based involvement of the community through house-to-house visits and meetings with opinion leaders brought up many experiences related to key problems that had not been captured at PSG problem-analysis sessions. This showed the complexity of barriers to enrolment with the NHIS and retention of members and suggested that all the stakeholders did not know all the problems in the community. Therefore, depending on one category of stakeholders alone for information can lead to what Chambers (1983) described as ‘people bias.’ Chambers criticised the behaviour of development professionals who spoke of participation by targets of their development projects, but who had only spoken to rural leaders and people who represented the elite, dominant and wealthy groups. People bias can occur if stakeholder collaborations formed to address barriers to achieving a public policy promotion limit their problem identification and analysis activities to their own group members. To diminish this bias, it is necessary to step out and listen to
ordinary people in the community and workers in the institutions involved in an intervention’s implementation.

In this study, people who were directly affected by the intervention and those purported to be the causes of the problem were jointly engaged to analyse the problem. This reduced aggressive reactions and created conducive atmosphere during the PSG problem-analysis sessions. Thus, the consideration given to all stakeholders’ perspectives during the problem analysis reduced the initial aggression exhibited by some and led to an appreciation of others’ complaints about them. The result was an agreement on the root cause(s) of the problems and made the issues less sensitive in the end. This suggests that there is great benefit in bringing stakeholders together to discuss even the most controversial issues. It is important to handle the sensitivities of all stakeholders tactically during the discussions to ensure that tempers are controlled (especially at the beginning), since they begin to appreciate each other’s perspectives as the meeting progresses.

The problem-analysis sessions also highlighted the following conflicting interests of actors involved in the NHIS implementation:

- Some health providers sell drugs to insured patients and collect unauthorised fees.
- DHIS staff collects money and issue NHIS cards to patients without waiting for the mandatory three-month waiting period.
- NHIS collectors charge more than the approved premium and registration fees.
- The DHISs are reluctant to grant exemptions, especially to the core poor.

These revelations show that the behaviour of individuals at the frontline of the NHIS implementation is not homogenous and often conflicts with the policy goals. While policy makers’ may be enthused with equity issues, those at the frontline of NHIS implementation may be more concerned with economic gains.

**Step 3: Finding solutions to problems and implementation strategies**

After the probable root cause(s) of problems were identified, measures to address them were developed. To ensure that the interventions had maximum impact, the questions of when, where and how to carry out solutions were found to be critical and explored. At this stage, facilitators explained the objective of the session to members and engaged them in finding appropriate solutions and implementation strategies. Brainstorming was usually used to critically reflect on the NHIS policy and the implementation challenges to generate possible solutions. To encourage members to talk, the PSGs adopted the slogan ‘no idea is bad’ used during facilitators’ training workshop, which I observed encouraged everyone to contribute to discussions. All ideas were listed because some sounded ridiculous at the beginning, but turned out to be good after analysis.
Tailoring the interventions: The PSGs also developed strategies for implementing solutions to the identified barriers. This involved selecting specific targets, implementation sites, persons to implement solutions, and where and how to reach all target groups. Thus, the PSGs tailored their solutions to particular target group(s) and identified the venue and who should be involved considering local conditions and available resources. Although the PSGs utilised well-known DHISs approaches, such as education at community durbar bars and health facilities, new implementation strategies were developed to ensure all target populations were reached. These included education at churches, mosques, markets, the beach, basic schools and households. The PSGs also held joint meetings with community leaders, health providers and DHIS staff to solicit their support in carrying out intervention activities.

PSG members were divided into small groups of about four. Each group was assigned one or two problems to consider and report on. Next, a member of each group presented their work and explained their proposed solution(s) and implementation strategy(s) during the following meeting. PSGs then agreed on the presented alternatives (if any) and which one to implement. For example, when the solution was to provide education to fishermen on the need to insure oneself against ill health, the site was the beach and the team was made up of health providers and DHIS staff with community members in charge.

From my observation, the most significant impact of these interactions was establishing and/or strengthening the relationship between community members, health providers and DHIS staff. A PSG member after one of such sessions expressed his joy as follows:

We are motivated to contribute to discussions because facilitators appreciate the role everybody is playing in solving the problems identified. They encouraged us to talk about our experiences and reservations about the NHIS freely and suggest solutions to address the challenges. This made us appreciate others experiences and why they do certain things.

This comment shows that by involving others in finding solutions to problems, everyone developed the commitment to help solve them. The body language of PSG members suggested this was a major first step in reducing identified barriers. For example, the facial expressions of community members during problem-analysis sessions suggested that they appreciated the challenges confronting health providers and DHIS staff in implementing the NHIS policy. Similarly, health providers and DHIS staff acknowledged the community members’ concerns. They normally nodded their heads when community members were talking about experiences indicating some level of appreciation of their concerns.

PSGs, community leaders, health providers, and DHIS staff work together: At this stage, the PSGs again strategically used stakeholders’ and community leaders’
meetings to solicit support in carrying out intervention activities. As usual, they gave an overview of the groups’ activities and the need to develop appropriate solutions and ensure that the intervention reached all their members so that enrolment and retention rates could be improved and ultimately, more people would have access to healthcare. My observations and comments by community members during these meetings indicated that they appreciated the health providers’ presence at these meetings. A pataase leader’s comment at one such meeting suggested that for the community members, the health providers and DHIS staff’s presence conveyed a stronger message of their commitment to the NHIS than hearing it from only DHIS staff and the collector. He said:

It is good health providers and DHIS staffs are also here to talk to us. Some of them make us feel they don’t like insurance. Nurses’ attitudes don’t show they support it. If you go to the hospital, they make you wait for too long. I hope when you go back you will tell the rest what we are saying.

This kind of reaction gave the PSGs more insight into how to involve community leaders, health providers and DHIS staff in implementing intervention activities in the communities. It helped them to change their strategies. For example, in coastal communities, the PSGs changed their implementation strategies when they realised that community durbars were not an effective means to reach the majority of the population, particularly the men. Men, mostly fishermen, spend all day at the beach either mending their nets or engaged in playing games. With this insight, the PSGs in coastal communities focused more on small group activities such as pataase meetings and house-to-house visits instead of community-wide activities to ensure everybody was reached. However, documentary films shown in the evenings in the community were also well patronised by community members including men.

**Peer-to-peer conversations:** One approach the PSGs used was to engage insured community members to educate their peers about the benefits of health insurance using their experience. During one of such meeting, a boat owner shared the NHIS’ benefits to his household with his colleagues. His colleagues asked the boat owner about the details of the benefits and quality of healthcare services. Others, who were complaining about the viability of the NHIS at the beginning of the discussion, appeared to be convinced that insurance was better than cash and carry in the end. These peer interactions and the information shared about NHIS’ benefits and experiences at health facilities reduced the negative perception about health providers’ attitudes towards insured patients.

The benefit of the stakeholders’ involvement in the development of solutions to barriers was that speaking about the NHIS’ financial protection against ill health had a greater effect on people. It appeared that what PSG community representatives, community leaders and health providers say at such meetings had more weight than
what DHIS staff and collectors had been telling the community. For example, the NHIS’s protection against catastrophic healthcare payments that was addressed by community members sharing their own experiences and citing cases of people they knew made their peers appreciate the NHIS better. This proved to motivate more people to enrol in the NHIS than the DHIS staff and collectors telling them what to do.

Step 4: Drawing an action plan

To facilitate the implementation of intervention activities, the PSGs drew action plans to guide the process. Table 5.1 presents an example of an action plan drawn and implemented by a PSG. Action plans served as road maps for the implementation of intervention activities. For the purpose of this intervention, PSGs adopted the following guidelines to help develop the outline of their action plans at our PSG facilitators training workshop:

- State the problem being addressed
- Set targets to be achieved at the end of each activity
- State the specific activity to be carried out
- Decide on the most appropriate person(s) to be responsible for each activity
- Do not assign all the tasks to one person
- Have a time frame within which each activity should be carried out
- Provide feedback at the end of every activity
- Provide evidence to show that the event has taken place for the purposes of monitoring

<table>
<thead>
<tr>
<th>Table 5.1</th>
<th>Action plan for August-October, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Community durbar</td>
</tr>
<tr>
<td>Target(s)</td>
<td>Community leaders &amp; members</td>
</tr>
<tr>
<td>Persons responsible</td>
<td>Kofi, Jacob, Lucy &amp; Mercy</td>
</tr>
<tr>
<td>Time frame</td>
<td>August</td>
</tr>
<tr>
<td>Resources needed</td>
<td>Canopy, P.A system, chairs, refreshment</td>
</tr>
<tr>
<td>Budget</td>
<td>GH¢ 99</td>
</tr>
<tr>
<td>Feedback</td>
<td>Not well patronised</td>
</tr>
<tr>
<td>Evidence for monitoring</td>
<td>Pictures &amp; report of events on file</td>
</tr>
</tbody>
</table>
The PSGs agreed that intervention activities with the potential of reaching most community members would be given priority in their action plan. Brainstorming was generally used to break down solutions into specific activities to develop an action plan for every quarter of the year. Items in the action plans included specific activities, targets for intervention activities, time lines set for each activity and a budget. For example, the third intervention activity in Table 5.1 above was mass registration. For this activity, the entire community was targeted. Four members of each PSG were appointed to be directly responsible for organising the event and time frame. Items needed for the occasion were stated and a budget provided. Impressions about the event were written as feedback and photographs were taken as evidence that the activities had taken place for the purpose of monitoring the intervention. Feedback also provided information that served as a guide for the next line of action or for modifications of an intervention activity, if necessary. Evidence for monitoring helped ensure that the PSGs adhered to what they stated in their action plans and the guidelines of the intervention programme.

*Step 5: Implementing intervention activities*

The consensus at the PSG meetings was that since barriers to enrolment were multi-dimensional they would be better addressed when all stakeholders worked together to implement the activities outlined in their action plans. Thus, the PSGs provided structures for community members, while the DHIS staff and health providers met regularly to exchange ideas on how to reach all target groups. The PSGs’ involvement in the delivery of intervention activities ensured smooth implementation and made it possible for all target populations to be reached. Since barriers to enrolment and member retention were multifaceted and linked to the culture of the communities and the context within which health providers and DHIS staff operated, intervention activities were delivered at the three levels of NHIS implementation – communities, health facilities and DHIS offices – to ensure maximum impact.

**Intervention activities at the community level**

At the community level, intervention activities projected the NHIS’ benefits and tried to persuade communities to embrace the NHIS as a better alternative to paying cash at health facilities. The NHIS’s operational challenges confronting health providers and DHISs staff were also explained. The main barriers were:

1. Low community member interest in health insurance
2. Misapplication of the operational principles of informal mutual support groups such as *nnoboa* and *pataase* to the NHIS. In the case of *nnoboa*, people join the groups when they need support and withdraw thereafter
3. Delays at health facilities experienced by insured patients when accessing healthcare with their NHIS card
4. Delays at DHIS offices when collecting NHIS cards
5. Payments for unauthorised fees and for drugs covered by the NHIS
6. Undersupply of prescribed drugs at health facilities
7. Community members’ over-reliance on chemist and pharmacy shops for treatment
8. Political perception of the NHIS

Implementation strategies employed were meetings in community durbar, homes, beaches, markets, lorry stations, churches, mosques, schools, PTA meetings and health facilities. These forums were used to educate community members on the need to be insured against ill health and about the NHIS’ protection against catastrophic healthcare costs. The meetings also created platforms where detailed information was provided on NHIS’ operational guidelines and challenges that the health providers and DHIS staff faced in implementing the NHIS. The intention was to enable community members to appreciate the reality of the challenges in delivering healthcare under the NHIS regime. As enhanced knowledge does not necessarily translate into action, promotional activities were also carried out to whip up interest in the NHIS, build trust and confidence in the NHIS and improve the credibility of health providers and DHIS staff in communities.

Community durbars: Community durbars in Ghana are held at designated places for large gatherings such as community centres and village squares. They are convened either by traditional leaders, opinion leaders, or community groups. Outsiders are invited or an institution may be invited to discuss important issues of public concern. The durbars are usually characterised by drumming, dancing, speech making and question and answer sessions.

The first intervention activity the PSGs organised was a community durbar. Many PSGs organised durbars every three months. The usual format was the observation of traditional protocol such as exchange of greetings between community leaders and invited guests. Next, PSG community facilitators provided information on the rationale for the intervention and outlined various activities to be carried out. Drumming and dancing followed, after which the PSG representatives from the community, health providers and DHISs’ staff and other invited guests took turns addressing the gathering. The question and answer sessions fostered open discussion of the identified barriers and community members’ concerns about the NHIS. Chiefs and elders, assemblymen and Unit Committee members, heads of health facilities, the District Director of Health Services (DDHSs) and DHIS managers or their representatives addressed most of the durbars I attended.

---

2 Parent Teacher Association is an association of parents of children of a particular school. They meet to discuss issues that concern the welfare of their children.
All speakers at these durbars typically delivered explicit messages to sensitize the gathering about health insurance. They projected the NHIS as a resilience-building factor that provides financial protection and has the potential of helping achieve the ultimate goal of equity in access to healthcare. This was intended to create a commitment from the people to insure themselves against illness and consistently renew their membership. The speakers often used the experiences of people in the community to illustrate how health insurance had helped them avoid catastrophic healthcare payments and enabled them to manage the adversities of ill health. For example, a diabetic patient explained how her health became better after enrolling with the NHIS.

This hospital card [NHIS card] is good. It has really given me relief from thinking about my sickness. I no more have complications. I’m able to go for reviews and get my medicines every month so my worries about the disease have gone. You have seen how diabetics nearly destroyed my life. So for me, I always renew my card.

Health providers re-echoed the NHIS’ benefits. They informed community members about how the insurance reduces patients’ complications and vulnerability to ill health. They narrated specific instances where lives were saved due to health insurance and deaths occurred because patients did not have money to seek early healthcare. While acknowledging the barriers that community members had mentioned, health provider PSG representatives, heads of health facilities and officials from the District Health Directorate explained the cumbersome bureaucratic processes that the NHIS brought to the healthcare delivery system. They informed the public about the increase in their administrative and clinical workload due to the time spent filling out the NHIS forms. They explained that this prolonged the insured patients’ consultations and the time they spent at health facilities. They also told them why health facilities were unable to provide patients with essential drugs at all times. This reduced the insured patients’ complaints about spending more time at health faculties than the uninsured and the shortage of drugs at health facilities. Health providers used the durbars to assure community members of their intention to improve the services, but explained that they were constrained by NHIS implementation challenges.

DHIS representatives and DHIS managers in the PSGs also told community members about the NHIS benefit package. They acknowledged the community members’ concerns about the delays in issuing NHIS cards and described the bureaucracy involved in processing NHIS claim forms. They also explained the implications of using multiple names and emphasised the need for patients to be consistent with the names they use in official documents such as the NHIS, hospital and voter ID cards, school and church records. One of them explained: “The use of different names to register and take pictures makes us spend so much time in processing the forms. This contributes to the delay in issuing the cards.”
My observation and conversation with community PSG representatives during these durbars indicated that community members were encouraged by the health providers’ and DHIS staff’s acknowledgement that their colleagues’ bad behaviour towards insured patients. They were also happy about the attempts being made to remedy the situation and improve quality of service. The DHIS staff’s efforts influenced community members to respond positively and play an active part in the intervention. Also, using examples of beneficiaries to demonstrate the benefits of the NHIS had a positive effect. Several people usually enrolled after the durbars. Further, the explanation that patients needed to be consistent with the names they used in official documents reduced the complaints against DHIS staff.

*Film shows and drama:* Documentary films and drama are known to capture the attention of viewers and make a story more real and vivid. This technique was used by some PSGs to follow-up the community durbars and other intervention activities to make the NHIS implementation challenges real to the communities. The films documented actual NHIS registration and users accessing healthcare. The film shows were interjected with discussions to reinforce very important messages. The films and drama demonstrated the reality of barriers and illustrated the challenges health providers and DHIS staff faced. The intention was to attract community members’ sympathies with the aim of changing their attitudes towards health insurance. For example, some PSGs showed documentary films to explicate problems created when various names were used for photographs and registration and how this delayed the processing of registration forms. The films were shown in the evenings on ‘taboo days’ when everybody was at home, so they were generally well patronised.

The power of films in creating vivid and more lasting impression on the minds of people was apparent. I observed that the films were more appealing to those community members who were reluctant to attend community durbars. I often heard people discuss the films and debate issues that were raised long after they had been viewed. Community members often referred to the films in conversations and discussions during PSG meetings. As the community members saw people they knew in the films giving testimonies about the NHIS’ benefits and using their card to access healthcare, the advantages of being insured was made real. Also, questions asked and comments made after the films indicated that the more people were exposed to the NHIS’ benefits, the greater the likelihood that they would appreciate it as better than ‘cash and carry’.
Some PSGs also used community groups, such as mother-to-mother support groups, to stage short dramas to demonstrate the difficulties the DHISs face when processing NHIS registration forms. They used the drama to portray how cumbersome it is for a mother to go to the DHIS office several times before she can get her NHIS card just because she used one name to register and another name for her photograph. In one community, in a drama, children showed how mothers wrote the names of all members of the household before registering them and then showed the names to the registrar and the photographer. School children were also used by some PSGs to stage a short play emphasising how non-enrolment can lead to delays in healthcare by staying at home and the death of children, especially those under five years.

Opinion and community leaders’ engagement to promote NHIS: As Viswanathan et al. (2004: 28) observe: “Integration of residents’ knowledge of what will work in their community makes it more likely that findings will address the problems.” This study also found that it is not enough to integrate stakeholders’ knowledge into intervention activities, but it is also necessary to engage them in knowledge dissemination. PSGs worked together with opinion and community leaders to implement intervention activities. Short meetings, not more than two hours, were regularly held with traditional, religious and opinion leaders to solicit their support in implementing intervention activities in communities. PSG community facilitators led discussions at these meetings. The leaders were informed about the dangers of over reliance on pharmacy and chemist shops as alternatives to seeking healthcare at facilities. They were also encouraged to talk about the benefits of health insurance with community members to help improve NHIS coverage. Next, religious leaders included health insurance-related themes in their sermons and initiated discussions with their congregations.

In fishing communities, PSG members engaged chief fishermen, boat owners and pataase leaders to educate fishermen and mobilise them to enrol in the NHIS. PSGs in farming communities also met chief farmers and cocoa purchasing clerks and solicited their support to educate community members. From my observations and discussions with community members, the meetings helped clarify misconceptions about health insurance and raised their interest in the NHIS. For example, cocoa farmers who lived on their farms during the cocoa season and came to the communi-

---

3 Mother-to-mother support groups (MtMSGs) are groups of lactating mothers who organise themselves into clubs and engage in various activities. They share the common purpose of providing a safe environment where women can learn from one another, exchange experiences and concerns, and support one another in a variety of ways. MtMSGs affiliated with the GHS’ Baby-Friendly Hospital Initiative are committed to improving infant and young child feeding practices and maintaining formal links between health institutions and communities (Linkages and Partners 2003).
ty only occasionally and others who spent the greater part of the day on their farms and were difficult to capture during durbars, house-to-house visits or film shows were reached through their leaders. Though the leaders continued to complain about payment for drugs and services covered by the NHIS, the meetings usually ended with some of their community members actually registering. After one such meeting during the bumper harvest, a boat owner pre-financed the registration of twenty of his employees. When I asked him why he did that, he explained his action as follows:

Irrespective of the problems associated with health insurance, it is still better than cash payment. My workers usually borrow money from me to pay their hospital bill during the dry season. So convincing them to register will take that burden off me.

Thus, by engaging chief farmers, cocoa purchasing clerks, chief fishermen, boat owners and pataase leaders in the intervention process, ‘the difficult to reach’ target populations were captured. One NHIS collector told me after our meeting with the cocoa farmers that some farmers came to register afterwards. I followed up to find out how the purchasing clerks had managed to convince the farmers to enrol. The purchasing clerks who were insured said they had shown the farmers their NHIS cards and told them about the benefits they had been enjoying. They explained how being insured reduced their vulnerability since they would not have to borrow money, give out their farms for a number of years or sell their farms or land to pay hospital bills during the dry season as was usually the case. The uninsured purchasing clerks also encouraged their peers to enrol. A pataase member told me after one of their meetings that “[k]nowing that our leaders are insured influenced those of us who are still apprehensive about the viability of the NHIS to change our mind.”

These comments suggest that engaging opinion and community leaders, purchasing clerks, informal sector employers and business owners could help promote the NHIS. They could be consulted at harvest time to encourage their members, employees and people who do business with them to enrol. This is an important factor that needs to be considered when developing implementation strategies and the timing of intervention activities to ensure all sub-groups are reached at the appropriate time.

Schools: Basic [elementary] schools were another site for PSG intervention activities because that is where the children and teachers could be reached. As a PSG facilitator explained: “Basic schools provide good settings for reaching children, their families and teachers. Children need healthcare most, yet they do not have adequate knowledge of health insurance.”

PSGs discovered that even though children are exempted from paying premiums and are only required to pay registration fees, most of them and their parents were not aware of this status. So, PSGs carried out educational activities at basic schools
to explain the NHIS operational guidelines to them. They reasoned that sensitising children about the need to be insured against ill health before they become adults would help reduce apathy towards health insurance, one of the enduring problems confronting the NHIS. Teachers could also educate their pupils and parents on the benefits of health insurance and help promote the NHIS. Teachers thus engaged parents in discussions during PTA meetings and other school activities and encouraged them to enrol every member of the household especially children. PSG community representatives explained that many older children earn some income during harvest season and could pay their registration fees if their parents could not pay for them. A PSG community representative stressed the importance of this as follows:

When children and teachers value health insurance, they will in turn influence parents to enrol. Children will engage their parents in discussions about the need to enrol all household members and maintain their membership. This will gradually improve their attitudes towards health insurance.

In summary, sensitising children about the need to insure against ill health had a positive impact not only on them but their parents as well. It improved knowledge about the NHIS and resulted in many households enrolling all members.

**Health facility-based education:** PSG community representatives, health providers and DHIS staff carried out both educational and advocacy activities in health facilities to reach patients. Nurses, volunteers, collectors and DHIS staff were specifically tasked to perform this role. They usually mounted platforms in the out-patient department (OPD) and pre- and post-natal clinics to educate patients on health insurance and encourage them to enrol and remain in the scheme. Pregnant women and mothers were told about the need to renew their card and register their babies before they were three months old, since free care under a mothers’ card expires after this period. They explained the processes that insured patients have to go through in accessing healthcare and why they sometimes have to give prescriptions to patients to look for drugs elsewhere. The discussions were normally interactive and people asked questions and expressed their concerns about the NHIS.

It is worth mentioning the illustration by a medical assistant who showed her NHIS ID card to uninsured patients as a way of building their confidence as mentioned in chapter three. When I asked her why she did that, she told me: “Some patients need to be convinced by us [health providers] that health insurance is good for them. I believe if they know that we are also insured, they will be motivated to enrol.”

**Other PSG intervention activities in the community:** Other intervention activities at the community level were visits to households, beaches, markets and lorry stations
on ‘taboo days’ when most people stayed at home. In fishing communities, for example, visits to households and markets were targeted mostly at women. Men were met at their places of work, such as the beaches and lorry stations. Both men and women were reached at home on ‘taboo days’ in farming communities.

Also, through the initiative of PSG community representatives, registration points were mounted in communities every ‘taboo day’ during the harvest period to encourage people to enrol. For example, a PSG set up a SHINE office in a community, which served as a registration point. The SHINE offices were used for meetings, registration and delivery of NHIS cards. A collector, assisted by other PSG community representatives, ran the office. This created interest in the NHIS as it brought the service to the doorstep of the community.

Regarding the difficulty of obtaining prescribed drugs in communities where there were health facilities, but no accredited pharmacy or chemist shops, PSG community representatives argued that although they knew that it was not the DHISs’ responsibility to convince pharmacy and chemist shop owners to apply for accreditation, they had the moral responsibility to intervene. Therefore, the PSGs persuaded pharmacy and chemist shop owners inside and outside the district to apply for NHIA accreditation and open branches where hospitals and health centres are located.

In the case of payment for drugs covered by the NHIS inside and outside health facilities and paying unauthorised fees to health providers and DHIS staff, PSG members encouraged insured patients to report such cases. I must mention that some reports were made, but only in a few cases were these followed up because insured patients were not bold enough to lead PSG members to confront the staff involved. I did witness two cases when insured patients paid for hospital ID cards and drugs covered by the NHIS and PSG members confronted the officials involved. The officials were made to refund the money to their patients.

I must also mention that in all the intervention activities, time was set aside to engage individuals who could not raise their concerns during group discussions and activities in one-to-one conversations. I observed that these strategies made it possible for PSGs to reach almost every community member. They improved the level of understanding of health insurance and appreciation for some NHIS operational challenges.

**Intervention activities at the health provider level**

PSG intervention activities were used to address challenges that the NHIS brought to the healthcare delivery system and the effect on health providers and ultimately on clients. The three main NHIS implementation challenges faced by health providers and addressed by PSGs were:
• Time spent filling out what they described as “the complex NHIS forms.”
• Heavy workloads as a result of increased utilisation of healthcare services by insured patients
• Irregular payment schedule of NHIS claims, which contributed to the health facilities’ inability to provide essential drugs to insured patients at all times.

Two main strategies, stakeholders meetings and documentary films, were used to tackle the problems.

Stakeholders’ meetings
PSG members made a decision that the NHIS implementation challenges would be better addressed if all stakeholders worked together to implement intervention activities. Rather than apportioning blame to specific stakeholders, intervention activities were intended to be a negotiation on how to improve enrolment and retention of members in the NHIS. As a result, regular meetings were held where PSG facilitators emphasised that although some NHIS operational problems were systemic, their negative impact on enrolment could be minimised. These meetings were usually attended by community leaders, heads of health facilities and their staff, DDHSs and DHIS managers or their representatives. Discussions focused mainly on health facility-level barriers, their relative contribution to low enrolment and high dropout rates, and how to improve the situation.

In a typical meeting, officials from the District Health Directorate working on NHIS claim forms explained the need to carefully complete the forms and avoid making mistakes to prevent rejection. DHIS managers took turns to inform health providers on the operational guidelines of the NHIS. They acknowledged that the NHIS has increased the managers’ workload and persuaded them not to vent their frustration on insured patients by being rude, but rather to communicate the challenges they face in a friendly manner to the patients.

Regarding delays at health facilities, the position of facilitators on how to address the problem was mentioned as follows:

Since filling the NHIS forms is part of healthcare delivery procedure and can only be changed at the national level, we could only educate people about what to expect when they seek healthcare with the NHIS card. This will show that the problem is real and not perceived as inefficiency on the part of health providers. Hopefully, this will help change the negative perception they have about us.

In the case of heavy workloads, the discussions focused on how to improve the quality of services in the midst of the increasing number of patients at health facilities and manage the stress. Health providers were urged to exercise patience with insured patients since this was an issue that PSGs could not solve. The PSGs suggested that the negative impact could be reduced through regular interaction with stakeholders to explain the health providers’ difficult working conditions. Citing cases of few staff attending to many patients at busy facilities, District Health
Directorate staff were invited to advise health providers on how to effectively combine their administrative and clinical workload to reduce the time insured patients spent at health facilities. These activities usually ended with a call to health providers by community leaders and DHIS staff to use open communication to make their clients understand the enormity of the challenges they faced.

In addition, PSGs held separate meetings with health providers and DHIS staff to discuss measures that they could take to minimise the negative effect of delays in claim payments on facilities. After lengthy discussions on how delays in claim payments contribute to the shortage of drugs and undermine the quality of healthcare services, DHIS managers and staff expressed their sympathy and described the situation as unfortunate. They explained that the problem was largely due to delays in claim submission, mistakes in the forms and the bureaucratic procedures. They assured the PSGs that the DHIS staff who vet the NHIS claim forms would contact health staff immediately to resolve problems to speed up the process. A medical assistant told me that these meetings established linkages that improved the relationships between health providers and DHIS staff working on the NHIS forms. She asserted: “DHIS staff now call me to discuss problems with NHIS claim forms and we are able to thrash out issues concerning the forms faster than was the case previously.”

For accusations of disrespect, collection of unauthorised fees and priority being given to cash-paying patients levelled against health providers, PSG facilitators and health providers’ representatives made a special appeal to their colleagues to convince community members that health providers support the scheme, but are constrained by operational problems when interacting with insured patients during consultations. In one such meeting, a facilitator who is also a health provider emphasised the need to change health providers’ behaviour and respect insured patients:

We need to convince people that we support health insurance and explain to them the difficulties we have in the facility in a friendly way. Much as we want them to appreciate our problems, we need to respect them. We can only show that we are committed to ensuring the policy succeeds, but our desire to provide quality service is undermined by inadequate staff and delay in claim payment, if we stop collecting unauthorised fees from insured patients and giving preference to patients who pay cash. These negate efforts at improving enrolment with the NHIS and retaining members.

This statement resulted in arguments in the meeting, but many health providers accepted that the issues raised were significant factors that they ought to address to help PSGs improve the enrolment and retention of NHIS members, while others thought it was an exaggeration of the situation. At one meeting, a District Director of Health Services (DDHSs) who was the chair, intervened and re-echoed his colleagues’ concerns, but reminded them that they needed to adhere to their motto.
for service delivery – the interest of the client comes first and every patient requires respect. He emphasised:

As to whether these allegations are true or not, we cannot just dismiss them. Even though it might not be widespread, it is our responsibility to weed out the ‘bad nuts’ among us. If we are able to do this, our commitment to the scheme will not be in doubt. We should realise that under the NHIS we are dealing with a new type of customer who is empowered to demand quality service because he has paid before coming to us. If we charge them any unauthorised fees or make them pay for drugs covered by the NHIS then they are paying double. This undermines the credibility of the NHIS and they have the right to complain. We therefore need to develop new work habits and uphold our professional ethics. Insured patients must not be made to bear the consequences of problems we have with the NHIS. Otherwise how can we convince them to understand our problems?

DHIS managers spoke about the need for health providers to see their work as a business enterprise and handle their clients with decorum. They emphasised the critical role of health providers in promoting the NHIS and pointed out that its success or failure depended very much on them. He said:

How health providers present the NHIS to patients influences how people perceive it. Discussions so far show that almost everybody is not happy about the quality of service at your facility. I’ve also had numerous complaints about the practices that go on in your facility which discourage people from enrolling or renewing their membership with the scheme. I appreciate your problems especially the delay in reimbursing claims but it is no reason to make patients pay the price. If you do that, your problems will not be appreciated. So if you improve your services many people will enrol.

The frank discussions among key stakeholders at these meetings, contributed immensely to bridging the knowledge gap between what the policy states and the reality on the ground. The PSGs had better insight into the NHIS operational challenges confronting health providers. A PSG health provider representative asserted:

Such meetings would have saved us from many of the accusations community members levelled against us and the high hopes they have about the NHIS. DHIS projected the NHIS as covering everything, so insured patients believe they do not have to pay anything and should be given all drugs at the facility.

In addition, speakers at all intervention activities called on health providers to improve their relationship with insured patients, respect them and embrace the non-cash transactions under the NHIS to show that they support the scheme, since this would help build confidence in the NHIS. The PSGs seriously suggested that all health workers should show a personal commitment to promote health insurance and desist from collecting unauthorised fees from insured patients and making them pay for drugs covered by the NHIS. This was a call to health workers to demonstrate a true commitment to the implementation of the NHIS and improvement of their public image. In this regard, health providers in particular advised their colleagues to give up the practices and behaviours of the user-fees regime (health providers sometimes selling their own drugs to patients and collecting unauthorised fees) and
commit to the NHIS. I observed that despite all the nice things that DDHSs and 
DHIS managers said, these were tough issues in the health system and not easy to 
address. Community members’ facial expressions during these discussions suggest-
ed that they felt helpless. A PSG community facilitator lamented after one of these 
meetings as follows:

Stopping corruption among health providers is a difficult task. None of the ‘bosses’ [DDHSs and 
DHIS managers] seem to have the zeal needed to fight these negative behaviours and corrupt 
practices head on. They seem not to be ready to punish severely those involved in cheating to 
deter others from doing the same things. So we [PSG members] can only appeal to the con-
science of the perpetuators.

These comments show how handicapped the PSGs were in addressing some of 
the challenges. Despite the PSG members’ scepticism about the health providers’ 
williness to change their negative behaviour, the intervention activities sensitised 
them about the contribution they could make to expand NHIS coverage.

Films
Some PSGs used documentary films of scenes of overcrowded health facilities with 
the few health providers having difficulty attending to so many patients. After 
acknowledging the negative behaviour of some of his colleagues, a health provider 
pointed out the issues that account for some of those problems. He explained:

Our heavy workload and long working hours make some of us resort to collection of unauthor-
ised fees to compensate for their long working hours. Also, the frequent shortage of drugs and 
other supplies to take care of ever-increasing numbers of patients undermines our desire to 
provide quality healthcare.

The situation was made real in the films. Strategies they could adopt to manage 
the situation to reduce delays were discussed thereafter. The discussions also 
highlighted how some health providers maintain quality of service delivery even in 
the midst of the challenges to encourage others to do the same, since this is one of 
the core complaints that discourage people from enrolling.

I noticed that by the end of the intervention, health providers talked to patients 
about health insurance and the need to enrol and regularly renew their memberships 
and discussed the challenges of providing good healthcare with the patients more 
than they had done at the beginning of the programme. This suggests that some 
 improvement in the situation could happen even if it was slow.

Intervention activities at the district health insurance scheme level

The main NHIS implementation challenges that were found to undermine DHISs’ 
work and by consequence discourage people from enrolling or renewing their 
memberships were:
• Delays in processing NHIS registration forms attributed to the use of multiple names when registering and having photographs taken
• Delay in issuing NHIS cards due to inadequate staff, office space and computers to process NHIS registration forms
• Difficulties of granting exemption to indigents

Specific intervention activities PSGs used to address these challenges were meetings, set community registration points and provide collectors with cameras.

Stakeholders’ meetings
Stakeholders’ meetings that were organised by the PSGs created a platform and opportunity to reduce the negative effect of the NHIS implementation challenges confronting DHISs. At these meetings, DHIS staff were advised to be quite meticulous when registering people, so that they could detect the use of two sets of names – one to register and one for the photograph. They were urged to develop effective strategies to instruct people who register with one name and have their photograph taken with another to prevent mismatch of names and photographs on their NHIS cards. For example, interrogating people to be sure they used the same names to register and have their photograph taken and correct the inconsistency immediately.

Regarding delays in issuing NHIS cards, DHIS staff cited inadequate computers and cameras as making the registration procedure very complicated and prolonging the waiting period beyond the three-month period. They attributed this situation to insufficient funds from the government to meet their immediate needs such as repairing computers and providing adequate cabinets to properly file their documents including registration forms and NHIS cards. The issue of insufficient funds was linked to low enrolment and high non-renewal rates. The following summary was a typical advice given to the DHISs’ staff at stakeholders’ meetings:

Since much cannot be done about the government funding, we can only appeal to the NHIA through DHIS managers to increase the number of permanent staff, provide more computers and cameras. While we wait for more computers, which might not be provided now, we have to strategise to increase our revenue so we can repair our equipment promptly and ultimately reduce the delay in issuing ID cards. Fortunately, the PSG will help us improve coverage and increase revenue so we can repair our computers immediately when they break down and buy more cameras to reduce delays in issuing NHIS cards and improve service.

To counter corrupt practices, PSG community representatives, DHIS staff and managers explained how these undermine attempts to improve enrolment from their perspective. They explained how charging more than the approved premium and registration fees, prevents poor parents from registering all their household members. They emphasised that this menace should be addressed in a holistic manner. First, DHIS managers appealed to DHIS staff to desist from the shameful act and devise ways of providing efficient service to their clients. Collectors were asked to stop collecting more than the approved fees and pay the money collected to DHISs
promptly to overcome the temptation of spending it on their personal needs. Second, PSG community representatives were told to tell people to report any DHIS staff or collector who demanded money from them to avoid waiting for the three-month mandatory period. Third, community representatives suggested that DHIS managers monitor their own staff and collectors by occasionally visiting communities to check on the premium and registration fees being collected. A community facilitator argued:

The practice of collecting more than the approved fees and registering people through ‘the back door,’ will not help build confidence in the NHIS. It will rather encourage people not to enrol and renew their membership regularly. They will think they can be issued NHIS card instantly when they pay money to DHIS staff.

At the end of the discussions, the health providers and DHIS staff agreed that barriers to enrolment and renewals of membership exist and need to be resolved. Evans & Davies (1999: 379) describe what occurs in a policy transfer when those implementing a programme are not likely to do: “Exactly what was intended or specified by those who formulated it.” In this respect, the PSGs adopted a ‘no blame’ stance and advised DHIS staff to give up all negative practices and show true commitment to expanding NHIS coverage through a gradual process of desisting from current practices and adopting practices that build confidence in the scheme. A PSG facilitator re-echoed this concern and described the situation as: “Difficult issues for the group to solve since they are endemic, but we will keep on talking.”

These comments show how handicapped PSGs were in addressing the corruption that adversely affected enrolment in the NHIS and retention of members. However, concerns by PSG members sparked debates and made service providers more conscious of their behaviours that were undermining attempts to expand NHIS coverage than they had been at the beginning of the intervention.

The difficulty of identifying the core poor for exemption was also addressed by PSGs during stakeholders’ meetings. After extensive debate, PSG community representatives and facilitators asked DHIS PROs and collectors to play lead roles in the implementation of the exemption policy. They urged them to educate community members on the exemption policy and collaborate with community members to identify and recommend the core poor for exemption. During one of such meetings, a facilitator cited the case of a volunteer who persuaded the collector and DHIS staff to grant exemption to a woman described as core poor. He discussed how community members, DHIS staffs and collectors could help address the difficult issue of granting exemption to the core poor. He argued:

Though it took a lot of effort to grant her exemption, it indicates the core poor can be easily identified. If DHIS staff and collectors work with opinion and community leaders they can make the process less controversial. PSGs can come up with names and justify their nominations since their status is not questionable rather than sticking to the homelessness condition, which does not reflect the situation.
In this regard, DHISs were asked to liaise with community leaders and PSG representatives especially collectors and volunteers to identify and recommend the core poor for exemption.

**Other PSG activities to address NHIS implementation challenges at DHISs**

PSGs urged DHISs to appoint collectors in communities where there were none and set up registration centres to aid the registration campaign and help explain new policy directives to community members. Some PSGs purchased cameras for collectors to enable them to register people after their promotional activities, since more people registered when their photographs were taken at the same time. This helped speed up the registration process because when both activities took place simultaneously, difficulties associated with people using multiple names to register and having their photograph taken were reduced. Certainly, the cameras and the presence of collectors in the communities improved the registration process and subsequently reduced the delay in issuing NHIS ID cards, which increased confidence in the scheme. This underscores the need to provide every collector with a camera.

In conclusion, all intervention activities provided structures for community members, DHIS staff and health providers to exchange ideas about pertinent issues that negatively impact on NHIS coverage. Sociologists refer to this as creating opportunity structure – a form of enablement for collective action (see Boudreau 1996). In this case, the MSPSP created linkages and provided opportunities for community members, health providers and DHIS staff to be part of the process of improving enrolment and retention in the NHIS. Moreover, though the systemic challenges were beyond the scope of PSGs, their intervention activities created awareness about the depth of the problem and generated discussions among stakeholders. The intervention activities set the tone for more critical reflection by community members about insuring themselves against ill health. It also caused DHIS staff and health providers to reflect on their work and how their behaviours and practices impact NHIS coverage.

**Reflections on problem-solving sessions**

This discussion examines two main issues: (1) how PSGs were able to reach most of their targets and (2) the behaviour of some PSG members during the problem-solving sessions.

As a whole, PSG members felt the multi-level and participatory approaches helped create synergy\(^4\) that enabled them to reach their target populations. But, it is

\(^4\) Synergy refers to cooperative interaction among group members. It successfully combines effort, skills and resources of group members to achieve objectives (Lasker & Weiss 2003, Pathman 2008).
important to mention that enthusiasm for participation was not given and synergy did not just happen; facilitators played a key role. As Pathman et al. (2008: 10) note, synergy develops because “[l]eaders spotted opportunities and resources to support synergy, brokered relationships … value and learnt how to create synergy.” In this study, bringing stakeholders together to participate in the intervention was not as simple as presented above; it was a daunting task. However, the facilitators training provided specific strategies that helped them create synergy, which elicited their commitment to participate in the intervention. Strategies that worked well were: (1) presenting the intervention as something that would reduce the NHIS’ implementation challenges at three levels (communities, health facilities and DHISs), (2) the recognition that PSG members’ and stakeholders’ were capable of contributing towards the success of the NHIS and (3) allowing PSG members’ and stakeholders’ to lead intervention activities. The three strategies created trust and a sense of responsibility among the PSG members. The history of participation has shown that plurality of methods and adjusting to local conditions yields better results. As Chambers (1994: 1449) notes: “Scientific method is not competent to predict or prescribe for the complex open systems which matter most.” This implies that what happens in the field depends on the decisions and actions of individuals and these are relevant for success of interventions. In this study, the facilitators’ openness and sharing of ideas during the intervention brought out a range of locally tailored techniques that helped reach all target populations.

The question of whether my presence in the PSGs limited discussions at meetings and problem-solving sessions was discussed in chapter two. Here, I wish to emphasise that with the exception of a few cases where participants denied accusations of negative behaviours and practices, the PSG members quite willingly shared their experiences and opinions. However, social desirability made some of them withheld information about their own negative behaviours. As discourse analysts point out, speakers construct alternative and sometimes contradictory versions of reality to achieve a goal (Potter & Wetherell 1987, 1994, 1995). In this study, my observation confirms earlier studies that individuals blame others and the social structure for their own failures (cf. Turner & Stets 2006). They portrayed an overly positive picture of themselves and attributed negative behaviours to others. Despite this shortcoming, my dual role helped maintain the group’s focus on providing the information needed to get to the root causes of barriers and helped develop locally tailored solutions and implementation strategies.

Conclusion

This chapter shows the potential of problem-solving tools and participatory approaches in opening spaces for community members, health providers and DHIS staff to work together to increase confidence in the NHIS. Interestingly, stakehold-
ers’ meetings were accepted as safe places that provided a collegial setting not only for providing information for addressing problems, but also for establishing and strengthening relationships among them.

Furthermore, the chapter showed that the effective engagement of community leaders, informal sector employers such as boat owners and cocoa-purchasing clerks created a synergy that made it possible for the intervention to reach all target populations, particularly community members who were difficult to reach. Community members and leaders’ testimonies about the NHIS’ benefits and health providers’ explicit support for the insurance scheme helped create the impression that the NHIS could ensure that everyone has access to healthcare and this increased the community members’ interest in the scheme.

The findings thus contribute to the literature on the benefits of engaging stakeholders from the onset of interventions and using them to mobilise support for uptake of public policies. The results show that adopting multi-level and participatory approaches helped overcome the central issue of a lack of collaboration among community members, health providers and DHIS staff in promoting the NHIS. The approaches gave ‘voices’ to those at the front-line of NHIS implementation and those affected by the policy; these views are rarely heard. Therefore, the DHISs could consider the multi-level perspective as a useful framework to guide them in planning and implementing interventions to address barriers at various levels to achieve maximum impact. It was assumed that these effects would multiply and be continued in a network of stakeholders. Whether PSG activities yielded positive outcomes is the focus of the next chapter.

The next chapter assesses the outcome of the intervention in terms of the increment in enrolment in the NHIS and retention of members by comparing pre- and post-intervention survey results. It also presents qualitative information from community members, health providers and DHIS staffs within and outside PSGs to explain the outcome of the PSG intervention activities.