Baseline Report for "Ghana LEAP and Integrated Social Services Impact Evaluation (2021-Phase 1)"

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LIST OF ACRONYMS

CHN	Community health nurse
CHPS	Community-based health planning and services
DSWCDO	District social welfare and child development officer
DSWO	District social welfare officer
FGD	Focus group discussion
GBV	Gender-based violence
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
HH	Household
IDI	In-depth interview
IGF	Internally Generated Funds
ISS	Integrated social service
ISSER	Institute of Statistical, Social, & Economic Research, University of Ghana
KII	Key informant interview
LEAP	Livelihood Empowerment Against Poverty
LMS	LEAP Management Secretariat
MDA	Municipal and district assemblies
MMDA	Metropolitan, municipal, and district assemblies
MoGCSP	Ministry of Gender, Children, and Social Protection
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NHRC	Navrongo Health Research Center
OHLGS	Office of the Head of the Local Government Service
PMT	Proxy means test
SWIMS	Social Welfare Information Management System
UNC	University of North Carolina at Chapel Hill
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Overview and design: This report provides information on the baseline data for the LEAP-ISS impact evaluation (IE). The study uses a mixed-methods approach. The qualitative component was conducted in six districts across three regions, and included key informant interviews with district leadership, focus groups with frontline service providers, in-depth interviews with beneficiaries, and observations of social welfare and health services. In total we interviewed 19 key informants (KIs), 33 front line workers (social workers, district health promotion officers, youth program officers, disaster manager) in six focus groups (FGDs), and 49 beneficiaries. The quantitative components comprised a multi-topic household survey administered to 2,520 households in 15 districts, half from LEAP only districts (comparison) and half from LEAP-ISS districts (LEAP+ISS).

Characteristics of LEAP households: In Ghana, the extremely poor in rural areas are younger households compared to LEAP beneficiaries, with more children aged 0-4 and 5-9, and more prime-age adults, while LEAP households have few children age 0-4, more older adults age 50+, more females, and average household size is smaller. Relative to the extreme poor in rural Ghana, LEAP household heads are about ten years older, more likely to be female (46 versus 20 percent), and less likely to have ever attended school (53 versus 70 percent). This highlights the unique profile of LEAP households compared to the generally poor in Ghana.

LEAP transfer value and payments: We calculated that the inflation factor between January 2010 and September 2021 was 3.63, that is, prices increased 3.63 times during that time period. Adjusting the current nominal transfer value for inflation, we calculate that the real value of the transfer is slightly greater than the real value in 2010, before the transfer size was tripled. As a result, the median transfer represents just five percent of the consumption of beneficiaries, an extremely low value compared to international standards. This low value has implications for the impact that LEAP can have on beneficiaries. The qualitative interviews also consistently identified the low value of the transfer as limiting the potential impact of the programme.

For the current survey, we obtained the dates of the transfer payments made since January 2019 from the LEAP management. Before the onset of COVID in March 2020 there was some consistency in providing regular payments during 2019 and early 2020. In the 10 months prior to the start of the 2021 survey fieldwork (August 2021), beneficiary households had only two pay dates, in January 2021, and then five months later, in June 2021. However, LEAP provided double payment amounts in each of those pay days. The increased irregularity and delays of payments

experienced in the last year is reflected in the beneficiaries' expectations about the timing of the next payment—40 percent of recipients do not know when the next payment will happen.

Linkages: The core objective of the ISS initiative is to increase the linkages of LEAP with other social services. The quantitative survey indicated very low presence of the Ghana Health Services and the NHIS at payment points; Social Welfare was reported to be present by only 1 out of 5 respondents. However, even when the social services were present at the pay points, they had a low level of interaction with the beneficiaries. The qualitative interviews were consistent with this finding, with a near universal absence of engagement with social welfare services among participants across all three regions. Most participants did not know what social welfare services entailed or where they could be found if needed; this was most prominent in Northern Region where communities were more isolated and far from services. Awareness and familiarity with social welfare was noticeably higher in Greater Accra where there was greater proximity.

Interviews with front line workers provide insight on LEAP-ISS operations. A key challenge is limited engagement with LEAP beneficiaries because they feel reluctant using referrals to SWCD because they are not comfortable being labelled as poor. From an institutional perspective, SWCD faces numerous challenges that affect their role as the lead institution in the LEAP+ISS implementation. These include insufficient resources, centralized bureaucracy, access to community focal persons, transportation, office space. Throughout the interviews, focus group discussions, and observations, there was clear evidence that the SWCD does not have sufficient funding and resources to play the central role in facilitating implementation of the LEAP+ISS program, which limits integration across agencies.

General impression of government services: In the quantitative survey respondents were asked about the *public service environment in local government*. Sixty-two percent of respondents believe that an intermediary is necessary to obtain services, and that they are hassled when seeking services, while 78 percent believe that those with connections get work done quickly. On the *behavior and attitude of public service employees*, the issue of hassle was again a key concern, and the fact that not all customers are treated the same. Overall women rated government employees more favorably than men.

NHIS: LEAP has made excellent progress in facilitating access of beneficiaries to NHIS, and the household survey shows that individuals living in LEAP households are more likely to have ever been enrolled (85 versus 73 percent) or to have a current valid card (71 versus 53 percent) relative to the extremely rural poor in Ghana. The qualitative interviews indicated that the renewal process of expired cards continues to be a barrier for LEP households, especially those living in isolated areas, or where there is no NHIS office. The LEAP programme has helped members by bussing them to NHIS offices outside the area, or gathering expired cards and taking them themselves for renewal, both of these responses are highly appreciated and valued. The qualitative interviews revealed mixed opinions about the usefulness of NHIS. While some feel it increases their access to care, others feel it is less useful since it does not cover everything. Health care is perceived to be lower quality and take longer to receive for NHIS cardholders. To get quality healthcare, participants noted that they had to pay cash or go to a private facility.

The effect of COVID-19: Respondents in the quantitative survey report greater handwashing and use of masks and sanitizers in response to the pandemic, with less change in movements for shopping or gathering for religious activities or with family. Just 38 percent said they were worried about catching Covid-19, and just 24 percent said the pandemic caused them to receive less help from relatives or friends and neighbors. However, there is a noticeable difference between male and female respondents, with female respondents more likely to report receiving less help than male respondents (25 versus 19 percent).

Differences by sex: Differences by sex were assessed in numerous domains. Though female headed households (FHHs) were not poorer in monetary terms than their male headed counterparts (MHHs), female heads themselves reported more health and well-being issues relative to male heads. For example, female heads had worse physical health outcomes, lower social support, slightly higher perceived stress, lower social capital, and lower subjective well-being.

Conclusions: The quantitative component of the evaluation was successful ins electing a comparison group that is similar to the LEAP+ISS group. The study design is thus well set up to follow households and measure the impact of the ISS component of LEAP-ISS. The qualitative component in turn has provided rich information on the likely challenge to the smooth

implementation of ISS, which will be helpful for program managers. The table below provides a snapshot of key indicators from the baseline quantitative survey for ease of reference.

Table 1: Summary of Baseline Indicators in Program Objective Areas (% unless stated otherwise)

Household composition		**Living standards**	
Average household size	5.3	2+ meals per day	68
Average age of members (years)	34.3	Never/rarely worry about food	31.6
Share female	56.6	Life will be better in the future	86
Age of head (years)	59.6	Consumption per capita (annual)	2,778.90
Female head	46.2	Have electricity	61.7
Head married	54.4	Protected water	80.6
Head never attended school	52.7	**Schooling**	
LEAP Operations		Enrollment 5-12: boys	75
Selection process very/somewhat clear	58/27.3	Enrollment 5-12: girls	75.5
Selection process very/somewhat fair	55.6/30	Enrollment 13-17: boys	74
Payments on time in last year	9.5	Enrollment 13-17: girls	72.5
Waiting time more than one hour at pay point	39.1	**Health and NHIS**	
Don't know when will receive next payment	41.5	Currently has NHIS card	71
Received lower amount than expected in past	12.4	Ever had NHIS card	84.5
Perceptions of public services (agree)		Did not seek care when sick	38.5
Services can be received without hassle	37.2	**Child health**	
Do not need connections to get work done	22.6	Fully vaccinated (ages 12-59 m)	84.5
Satisfied with service		Ate iron rich foods (age 6-23m)	55.5
Roads	30.5	4+ food groups (age 6-23m)	11.5
Electricity	50.5	Birth Registered	75
WATSAN	38.5	Slept under mosquito net	74.5
Gov't employee behavior	67	Assisted delivery	75.5
Social Welfare	77.5	**IPV experience (women aged 18-49)**	
CHPS compound	79	Emotional - lifetime	46
Main respondent well-being		Physical - lifetime	24.5
Life will be better in 1 year - women	79	Sexual - lifetime	16
Life will be better in 1 year – men	83	All three - lifetime	52.5
Quality of life scale – women (higher is better)	15.6	**Livelihoods**	
Quality of life scale - men	16.6	Own any livestock	56
		Non-farm enterprise	33
		Purchased fertilizer	41
Sample size:	**2515**		

1. INTRODUCTION AND BACKGROUND

This report has been prepared by the Research Consortium hired to implement the baseline research activities (Phase 1) for the Ghana LEAP-ISS evaluation. The Consortium lead is ISSER, with partners NHRC and UNC. It should be noted that this report should be read in concert with the earlier submitted inception report which describes the sample selection procedures and other technical aspects of the evaluation.

The Livelihoods Empowerment Against Poverty (LEAP) Programme, the object of this impact evaluation, is Ghana's flagship poverty alleviation program. Implemented by the LEAP Management Secretariat (LMS), the program provides cash payments to extremely poor households. Households are selected via proxy means test (PMT), combined to date with categorical vulnerability criteria. In order to promote continual performance improvement, the LEAP M&E calls for the implementation of period impact evaluations (roughly every 5 years) to aid in period program adjustments.

In line with national policy, LEAP aims to create linkages with other social protection programmes, as well as social and economic services. An initiative to test and strengthen these key service linkages at the district level is being created by the Ministry of Gender, Children and Social Protection (MoGSCP), the Office for the Head of Local Government Service, the National Health Insurance Authority, and the Ghana Health Service, in partnership with UNICEF. This initiative—the Integrated Social Services (ISS) initiative—involves strengthening complementary services between social protection programmes, social welfare, community development, and the Ghana Health Service and National Health Insurance. Strengthening is accomplished, in part, by simulating different forms of collaboration amongst these actors. It involved the transfer of capacity and resources to 60 MMDAs in Ghana in 2020, working in tandem with the national level MDAs and through regional councils and district assemblies. The specific activities of the ISS pilot phase are:

Social Welfare and Case Management

- Strengthening social welfare case management at MMDA level via implementation of the case management Standard Operating Procedures for children in need of care and protection1, training and capacity building

- OHLGS and MoGCSP updates and roll-out of in-service training curriculum for Social Welfare and Community Development Officers, including implementation of the Intersectoral SOPs for child protection and family welfare2.
- Providing tools to manage information, monitoring and reporting using online case management and information managements system (Social Welfare Information Management System – SWIMS) for social and child protection services.

Between LEAP and NHIS:

- Improvement of outreach capacity of NHIA, including through collaboration with LEAP, DSWOs and community-based health planning and services (CHPS) compounds
- Systematic tracking of NHIS-card validity and usage for LEAP households
- Assessment of whether there are barriers on the demand and supply side to accessing the NHIS for particular groups, e.g., people living with disabilities Exploring possibilities for technological innovations to increase both outreach and efficiency, such as offline capacity for enrollment, and linking LEAP and NHIS Management Information Systems. Extension of the insurance validity period for the exempt categories

Between Social Welfare and GHS/CHPS

- Using LEAP payment days as opportunity for health sensitization and promotion, through cooperation between LEAP and District Health Promotion Officers.
- Community health outreach/home visits by CHPS/CHNs, in line with existing CHPS priorities (e.g., maternal, adolescent and child health, health and nutrition education, etc). Concretely to include sharing of LEAP participant lists with CHPS compounds, tracking of LEAP households in CHPS registers, including prioritization of LEAP household home visits as mandate of Community Health Nurses.
- GHS training and participation in referrals system and Intersectoral SOPs, including in relation to GBV and child protection risks.
- Basic training for DSWCDOs to be able to identify critical health needs and forms of violence

2. OVERVIEW OF EVALUATION APPROACH

Overview:

The technical approach is an embedded, mixed-methods design to address questions about impact *(what*) as well as process and pathways (*how and why*). In an embedded mixed-method design, quantitative and qualitative data sources are used to address distinct aspects of a complex programme, such as quantitatively measuring outcomes and qualitatively assessing pathways of influence and operational processes. Such an approach is particularly well suited to the complex nature of the LEAP programme and the interest in understanding the role and influence of linkages and complementary services.

Quantitative

Our primary objectives with this component are to establish the causal effects of ISS on LEAP households in the domains specified in the terms of reference, and to ensure that LEAP and ISS are gender sensitive and inclusive. Secondary objectives include an analysis of targeting effectiveness and assessment of the implementation performance of ISS and LEAP as reported by recipients. The core design will entail comparing a sample of LEAP+ISS households in the 60 pilot districts (the intervention area – T) with LEAP-only households in comparable districts outside the pilot areas (C). This report provides information on the sampled households at the baseline. Subsequent follow-ups (not part of this contract) will allow a comparison of changes in the relevant indicators across the two study arms.

Qualitative

The qualitative component entails an explanatory case study methodology. Explanatory case studies aim to provide explanations about programme impact, including both positive and negative and planned and unplanned. Case study is an appropriate methodology to evaluate LEAP+ ISS because: 1) this is a **complex intervention** with many different actors and components that cannot be fully assessed without speaking to beneficiaries, communities, front-line workers, and district-level authorities; 2) we are interested in **process-oriented questions** of how and why linkages work or don't work to enhance impact; and 3) there is a need to consider **context** in the interpretation of outcomes. By embedding a longitudinal case-study approach into the larger quantitative component, we are able to respond to all 3 evaluation aims of assessing: 1) LEAP Programme outcomes, 2) processes and outcomes of LEAP and complementary services on gender dynamics and inclusiveness; 3) household coping and resilience.

We focus on LEAP+ISS beneficiary participants in the qualitative sample as the goal is to improve understanding of how and why the programme functions and achieves impact. In addition to data triangulation, this embedded approach also offers efficiency in the sampling and identification of participants, in particular beneficiary households that have already been identified for the quantitative survey. We selected two regions from the quantitative sample and identified three districts in each region as a case in order to obtain comprehensive understanding of the impact of ISS among LEAP beneficiaries from the perspective of district leaders, health and social welfare agents, communities and individual beneficiaries. Within each of the three districts in the qualitative sample we used a combination of individual and group interviews as well as observations of key services and points of contact between ISS and LEAP beneficiaries. Each case included the following five data collection activities:

- Key informant interviews with district leadership (n=2-3 per district)
- Focus groups with frontline health and social welfare workers (n=1-2 groups per district)
- In-depth interviews with beneficiaries (n=5-8 per district)
- Focus groups with beneficiaries (n=1-2 per district)
- Observations of social welfare and health services (varied per district)

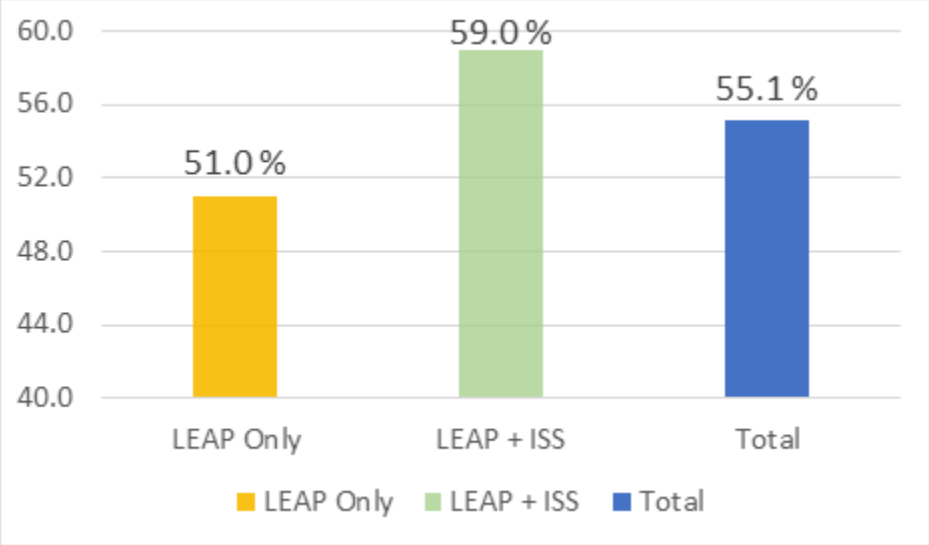
For all three case studies, the fieldwork team also engaged in direct observations of services (CHPS compounds, social welfare offices) and moments of programme interaction (payment days, NHIS enrollment/renewal efforts) to obtain additional data on context and services.

3. QUANTITATIVE FIELD WORK SAMPLE AND ISSUES RELATED TO RE-ASSESSMENT OF LEAP BENEFICIARIES

The survey was successful in undertaking household interviews in 250 communities as planned. It is however worthy of note that 18 communities were entirely replaced because the teams were unable to get the minimum number of respondents needed for those communities to be interviewed due to various reasons. The reasons include inaccessibility of some communities, death of most of the respondents from the original sample for the community, refusal to participate because of nonpayment of transfers, relocation of households and inability of community members or LEAP focal persons to identify the household/respondent.[1]

At the end of the survey, the total number of households interviewed was about 55.1% of the main sample (Figure 1) with the rest being replacements. A breakdown of the households that were finally interviewed shows that, a little more than half and close to two-thirds of the sampled LEAP only and LEAP+ISS households were finally interviewed (Figure 1). The regional breakdown of the final number of interviews conducted from the original sample list is shown in Table 1. It is realized that across the regions, a significant proportion of replaced households were recorded in the Western (33.3%) and Greater Accra regions (38.9%) where less than 40% of the households interviewed were from the sampled list.

Figure 1: Percentage of main sample households interviewed



[1] A map of the LEAP+ISS and LEAP districts is provided in the annex.

The results from Figure 1 and Table 2 shows that a significant proportion (about 45.9%) of the final interviews conducted were replacement households. All replacements were drawn from the original list of households sourced from the LEAP MIS and were strictly based on the replacement criteria set out to the enumerators and field supervisors. All replacements were verified on real time basis by the ISSER PMT before final approval. The key reasons for replacement are displayed in Table 3.

Table 2: Percentage of main sample interviewed by region

Region	LEAP Only	LEAP ISS	Total
Ashanti	43.0	56.3	47.8
Bono	83.3	61.1	73.1
Bono East	50.0	52.4	51.3
Central	64.1	50.0	57.1
Eastern	53.3	57.9	55.4
Greater Accra	39.6	38.5	38.9
North East		81.0	81.0
Northern	64.6	74.5	69.7
Oti	41.7	71.4	57.7
Savannah	51.9	68.8	57.1
Upper East	55.0	60.0	58.2
Upper West		46.7	46.7
Volta	44.2	69.1	58.5
Western	38.1	28.6	33.3
Western North	49.1	61.1	52.1
Total	**51.0**	**59.0**	**55.1**

Table 3: Search and interview completion status of sampled respondents

Search and interview completion status	Main Sample	
	Freq	Percent
Beneficiary HH, interview completed	1,388	55.1
Beneficiary in town but not available for interview	103	4.1
Beneficiary travelled outside community	152	6.0
Beneficiary relocated to another community	128	5.1
Beneficiary in the HH dead	306	12.1
HH is unknown in the community	333	13.2
HH is not a beneficiary HH	21	0.8
Community is not accessible	28	1.1
Other	56	2.2
Total	**2,520**	**100**

Each of these reasons may have implications for the re-assessment exercise being discussed by LEAP Secretariat. Of the 45.9% replacement households, two of the reasons that may be a concern to policy makers is the relatively significant proportion of households that were replaced due to the death (12.1%) of the sampled beneficiary and the inability to locate the sampled household/beneficiary (13.2%) after exhausting all possible means of identification through the focal persons, as well as members of the community and their leaders. This is very critical as they (both cases) constitute more than a quarter of the main sample list and more than half (about 56.4%) of the total number of replaced households outside the primary sampled list. The final distribution of households across the two study arms by district is provided in Table 4.

Furthermore, it was observed that some caregivers were still receiving payments although the actual beneficiaries have long been dead. By observation it was obvious to note that some of the affected households genuinely need the transfers, but inaction by the implementers can also lead unscrupulous agents and other people to take advantage of the situation.

Table 4: Final distribution of interviewed households by study arm and districts

Region	LEAP Only	LEAP ISS	Total
Ashanti	20.8	11.4	16.0
Bono	3.3	2.8	3.1
Bono East	2.9	3.3	3.1
Central	6.4	6.1	6.2
Eastern	12.2	9.8	11.0
Greater Accra	3.9	6.1	5.0
North East	0.0	3.3	1.7
Northern	7.8	7.9	7.9
Oti	2.9	3.3	3.1
Savannah	8.8	3.7	6.2
Upper East	9.5	16.3	13.0
Upper West	0.0	7.0	3.6
Volta	9.8	12.5	11.2
Western	3.4	3.2	3.3
Western North	8.2	3.3	5.7
N	**1,231**	**1,284**	**2,515**

The other category of persons are those households who initially qualified as beneficiaries as a result of Orphaned and Vulnerable children (OVCs). It was observed that some of these children had grown and relocated or moved out of the household to live separately yet the caregivers are still receiving payments on their behalf.

We also observe that the climatic season for the survey period affected the smooth data collection. The survey was conducted around the rainy season (August and September 2021). This made some communities unmotorable and inaccessible due to the poor road and communication network.

3.1 Balance between the LEAP and LEAP+ISS groups

As described in the Inception Report, the evaluation strategy we use for examining the impact of the ISS is a longitudinal difference-in-differences design with the comparison group obtained by matching procedures using district-level characteristics.[2] This evaluation strategy works better the more similarities there are between the evaluation groups. Baseline data allow us to assess the similarities between the treatment group (LEAP+ISS) and the comparison group (LEAP-only) at the start of the evaluation. For almost all indicators presented in this report we examined whether the average values of the two groups were statistically equivalent or not. In order to do so, we estimated linear regression models with standard errors adjusted by the sampling design (clustering and stratification) and examined the statistical significance of the difference of the average values of the groups. We included the p-value of the difference of the averages for every indicator presented in the Findings section of this report. The working assumption is that there were no differences between the groups.

We examined 391 indicators and used a 5% level of statistical significance (95% of confidence level). We found that for 97.6 percent of the indicators there was no statistically significant difference between the average values of the two groups (p-value>0.05). This indicates a high level of balance between the LEAP+ISS and LEAP groups of this evaluation.

[2] Additional technical details can be found in Annex 2 and Annex 3.

4. HOUSEHOLD COMPOSITION AND LIVING CONDITIONS

The LEAP demographic eligibility criteria lead to a unique profile of households that are selected. Figure 2 shows the age and sex distribution of LEAP households on the left and the distribution for rural extremely poor households taken from GLSS7 on the right. In Ghana, the extremely poor in rural areas are younger households compared to LEAP beneficiaries, with more children aged 0-4 and 5-9, and more prime-age adults, while LEAP households have few children age 0-4 (despite the relatively new LEAP 1000 window, which only comprises eight percent of all beneficiaries), and more older adults age 50+, more females (the red bars), and many more women age 80+. This unique profile should be kept in mind when interpreting the pattern of program impacts. For example, since pre-school children are not a large proportion of LEAP households, we might not expect impacts on that group, but rather on older children age 10-19 and in particular, ages 15-19 where there are significantly more members (proportionately) in LEAP households compared to the rural extremely poor.

Figure 2: Population pyramids for LEAP and rural extremely poor

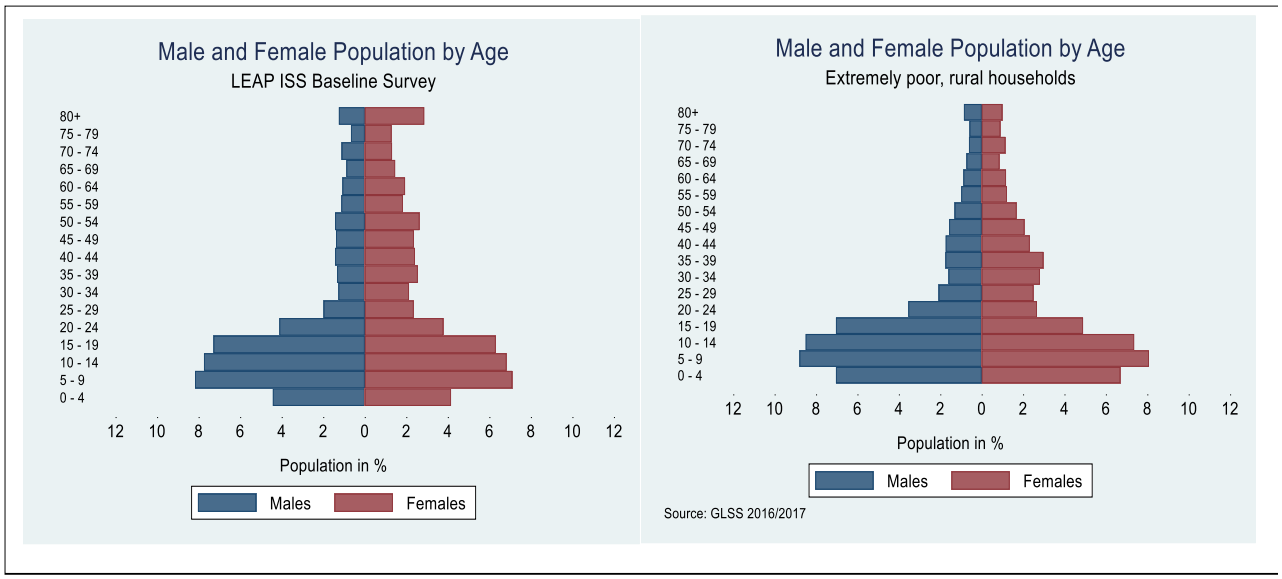


Figure 3 compares other dimensions of household composition between LEAP households and the rural extremely poor taken from GLSS7. LEAP households are slightly smaller in size, have more female members (56 versus 51 percent), and fewer proportion of members aged 0-12 (34 versus 47 percent).

Figure 4: Household head characteristics of LEAP vs rural extremely poor

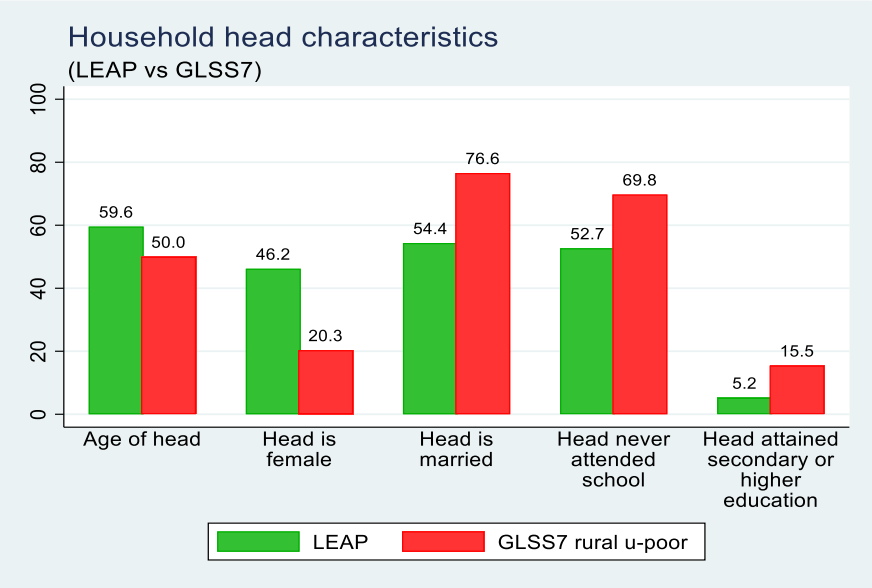


Figure 4 compares the characteristics of the household head between LEAP and the rural extremely poor. Consistent with the population pyramids shown in Figure 2, LEAP heads are about ten years older, more likely to be female (46 versus 20 percent), and less likely to have ever attended school (53 versus 70 percent) compared to rural extremely poor households in Ghana. These results further highlight the unique profile of LEAP households compared to the generally poor in Ghana.

5. LEAP OPERATIONAL PERFORMANCE

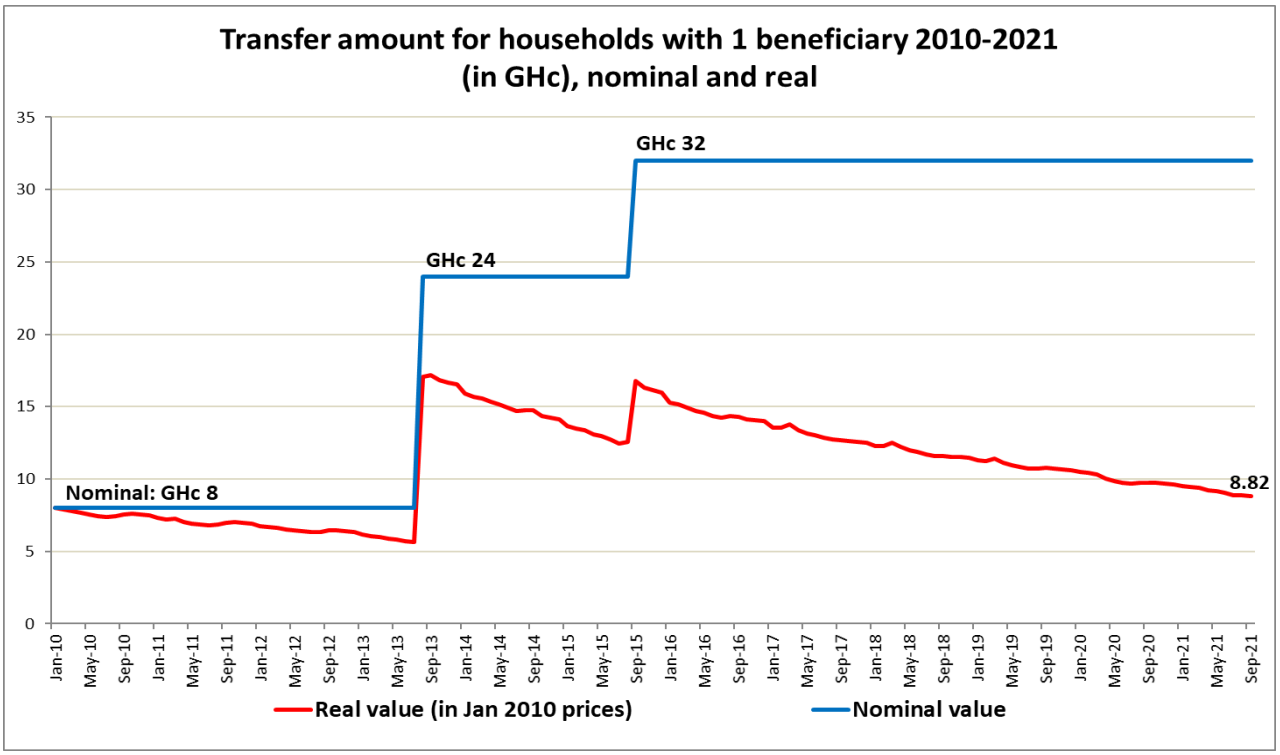
This section presents the findings on the operational performance of LEAP based on the operations module that was included in the baseline survey questionnaire and on LEAP programme reports obtained from UNICEF Ghana. There are two aspects of the LEAP programme that influence the impacts it could have on the target population: the value of the transfer amount and the implementation of the programme in the field. In this section we discuss both aspects from the point of view of the recipient households.

5.1 The nominal and real value of the LEAP transfer amount

The first aspect is the value of the transfer amount. The main objective of the LEAP intervention is to increase the purchasing power of beneficiary households by directly transferring money in cash. However, purchasing power depends on the prices of the goods and services the households buy and their evolution over time. We examine this issue for the case of households with one beneficiary. The nominal cash transfer amount for households with one beneficiary was 8 GHc per month in 2010[1]. The Government of Ghana increased it to GHc 24 in August 2013, and then to GHc 32 per month in October 2015[2], see Figure 5. However, during 2010 and 2021, Ghana experienced significant inflation of consumer prices which negatively affected the purchasing power of the transfer. To examine the evolution of the real value of the transfer (adjusting for inflation), we used the monthly time series of the consumer price index (CPI) published by the Ghana Statistical Service. We obtained the time trajectory of the real value of the transfer amount in constant prices of January 2010, by deflating the nominal amount by the accumulated inflation rate of each month relative to January 2010. The nominal and real values of the transfer amount are presented in Figure 5. The jumps in the trajectories correspond to the two increases made by the LEAP programme. We calculated that the inflation factor between January 2010 and September 2021 was 3.63, that is, prices increased 3.63 times during that time period. Using this factor, we obtained that the current nominal transfer amount of GHc 32 per month has a real value of GHc 8.82 in January 2010 constant prices, which is only 10% higher than the real value of the transfer observed in January 2010 (GHc 8.00).

As an alternative procedure, and as robustness check for our calculations, we used annual inflation rates since 2010 reported by the World Bank's World Development Indicators data set and calculated that the inflation factor between January 2010 and September 2021 was 3.69. This inflation factor implies that the current transfer amount of GHc 32 per month has a real value of GHc 8.66 in January 2010 constant prices, only 8.3% higher.

Figure 5: Nominal and real value of the transfer amount



5.2 The transfer amount as a share of household consumption

Another way to examine the value of the transfer is to compare it to the consumption of the households. This is what we called the household's "transfer share" and it is obtained by dividing the monthly transfer amount received by the household by its monthly consumption net of the transfer. The share is presented in percentage units[3]. As shown in Table 5, the transfer share is low, with an average of 6.4 percent in LEAP+ISS households and 4.2 percent in LEAP households. The median values are even lower, at 3.7 percent and 3.1 percent, respectively. This means that for half of the households in LEAP+ISS districts the transfer amount they receive is less than 3.7 percent of their household consumption.

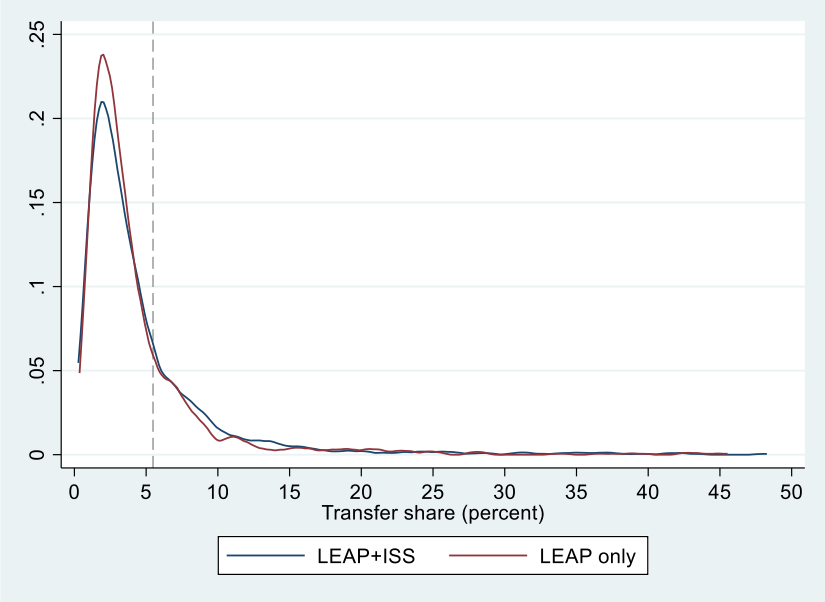
Table 5: Transfer amount as a share of consumption (in percent)

Indicator	LEAP+ISS	LEAP	p-value
Mean	6.4	4.2	0.020
Median	3.7	3.1	
N	**1,279**	**1,228**	

Table 6: Transfer shares in evaluation surveys

Survey	Average transfer share
LEAP baseline 2010	11.0
LEAP midline 2012	7.0
LEAP endline 2016	18.3
LEAP+ISS evaluation 2021	5.5

Figure 6: distribution of the transfer share



Note: The dashed vertical line indicates the overall transfer share average of 5.5%

Figure 6 presents the distribution of households by their transfer share. For both study groups, there is a large concentration of households on the left of the graph and with transfer shares lower than the overall average of 5.5 percent, which is indicated by the vertical dashed line. In fact, 73 percent of households have transfer shares lower than the overall average of 5.5 percent. As shown in Table 6, the current average level is well below the 18.3 percent observed in the 2016 LEAP evaluation endline survey (Ghana evaluation team, 2017) and near the 7 percent average transfer share observed in the 2012 LEAP evaluation survey (Handa & Park, 2011). This result is consistent with the finding on the current real value of the transfer amount presented in the previous section of this chapter. The current levels of the transfer share are low and well below the 20% percent recommended for expecting widespread impacts (Davis & Handa, 2015).

Table 7 shows that the transfer share is low even for households with one member, with a median of 11.4 percent for the T group and 7.6 percent for the C group. The share declines rapidly as the household size increases reaching 4.8 percent in the T group for households with

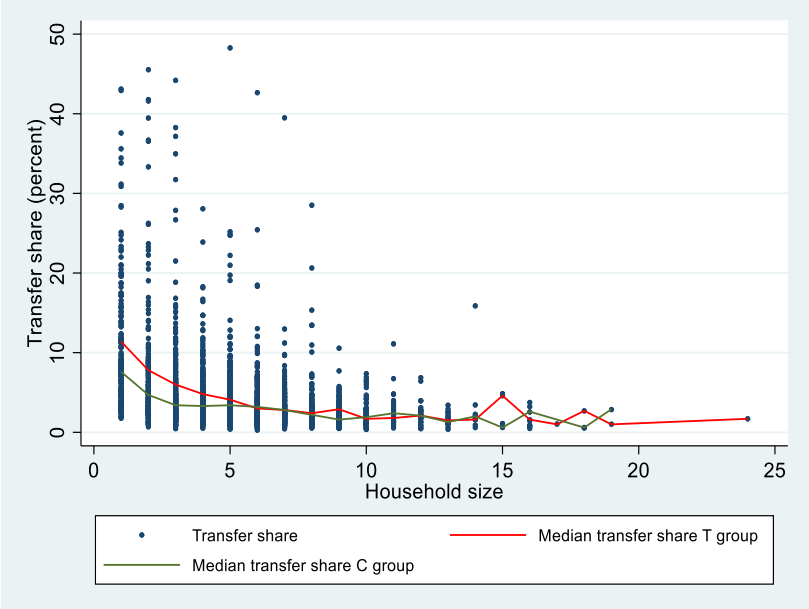
four members. Figure 7 presents the distribution of the households' transfer share by household size. The dots indicate households. It is clear that the large majority of households are concentrated at low levels of the transfer share for all household sizes. It is also clear that there are relatively few households with over 20 percent of transfer share.

For this analysis we have simulated the transfer value using the demographic profile of households. It would be good to confirm these values using the actual transfers received by households.

Table 7: Median transfer share by household size

Household size	LEAP+ISS	LEAP
1	11.4	7.6
2	7.8	4.7
3	6.0	3.4
4	4.8	3.3
5	4.1	3.4
6	3.0	3.2
7	2.8	2.8
8	2.4	2.2
9	2.9	1.6
10	1.7	1.9
11	1.8	2.4
12	2.1	2.1
13	1.5	1.3
14	1.6	2.0
15	4.6	0.6
16+	1.7	2.1
All households	3.7	3.1
N	**1,281**	**1,229**

Figure 7: Distribution of households' transfer share by household size



6. LEAP PROGRAMME OPERATIONS

The second aspect to examine is the operations of the programme in the field from the point of view of the beneficiary households. The information was obtained from an operations module included in the baseline household questionnaire. The respondent was the LEAP beneficiary in the household or the person most knowledgeable of the LEAP programme.

6.1. LEAP Targeting

At the start of the operations module all respondents were asked about their perception of the targeting and selection process used by LEAP. As shown in Table 8, the majority of respondents identified being old, very poor, widowed, and having a disability as criteria for being eligible for LEAP. Less than half of respondents identified having persons caring for many orphans or children as a criterion (43.9 percent in the LEAP+ISS group and 46.9 percent in LEAP), and even fewer identified not being able to work as an eligibility criterion (around 21 percent). As indicated in the program description section of this report, LEAP eligibility criteria include living in poverty, and having a household member in at least one of three categories: OVC, elderly (over 65), or a person with a disability unable to work. The survey findings indicate a somewhat accurate perception of the reasons used by the programme for selection.

Table 8: Perception of the LEAP eligibility criteria

Indicator	LEAP+ISS	LEAP	p-value
Old people	70.3	67.8	0.590
Very poor people	62.0	60.1	0.794
Widowed individuals	60.4	53.4	0.394
People with disability	60.4	52.9	0.417
Individuals caring for many orphans/children	43.9	46.9	0.672
Sick individuals	40.9	37.5	0.523
People not able to work	20.9	21.2	0.953
Pregnant women	18.3	23.1	0.550
Women with children<1	08.1	10.5	0.563
Other	00.1	00.3	0.423
DK	00.8	00.3	0.197
N	**1,284**	**1,231**	

A large majority of respondents have a positive view of the LEAP programme selection process' clarity and fairness. As shown in Table 9 and Table 10, about 85 percent of respondents consider the process is clear, and a similarly high level (about 84 percent) consider the process as fair. However, there is a group of about 15 percent of households that are either neutral or do not

consider the process clear or fair. This could indicate the need for reinforcing the communication from the programme to the households about the eligibility and selection process.

Table 9: Perception of the LEAP selection process as clear

Indicator	LEAP+ISS	LEAP	p-value
Yes, very clear	58.3	57.8	0.925
Yes, somewhat clear	25.5	29.0	0.513
Neutral	09.4	06.4	0.315
No, not so clear	05.7	05.1	0.601
No, not clear at all	01.0	01.7	0.430
N	**1,284**	**1,231**	

Table 10: Perception of LEAP selection process as fair

Indicator	LEAP+ISS	LEAP	p-value
Yes, very fair	57.7	53.4	0.465
Yes, somewhat fair	26.3	31.6	0.313
Neutral	09.9	06.6	0.239
No, not so fair	05.2	06.0	0.599
No, not fair at all	00.9	02.3	0.080
N	**1,284**	**1,231**	

6.2. Participation in LEAP

Households included in the survey were supposed to be programme beneficiaries according to the beneficiaries' lists. Nevertheless, households were asked about whether they had ever received LEAP payments. Close to 90 percent of LEAP+ISS households had ever received a LEAP transfer, which means that 10 percent had not (Table 11). This discrepancy could be due to the original beneficiary being away or dead for some time, to significant changes in household composition, or simply to memory problems of the respondent. About 88 percent of T households and 86.4 percent of C households reported being current LEAP beneficiaries.

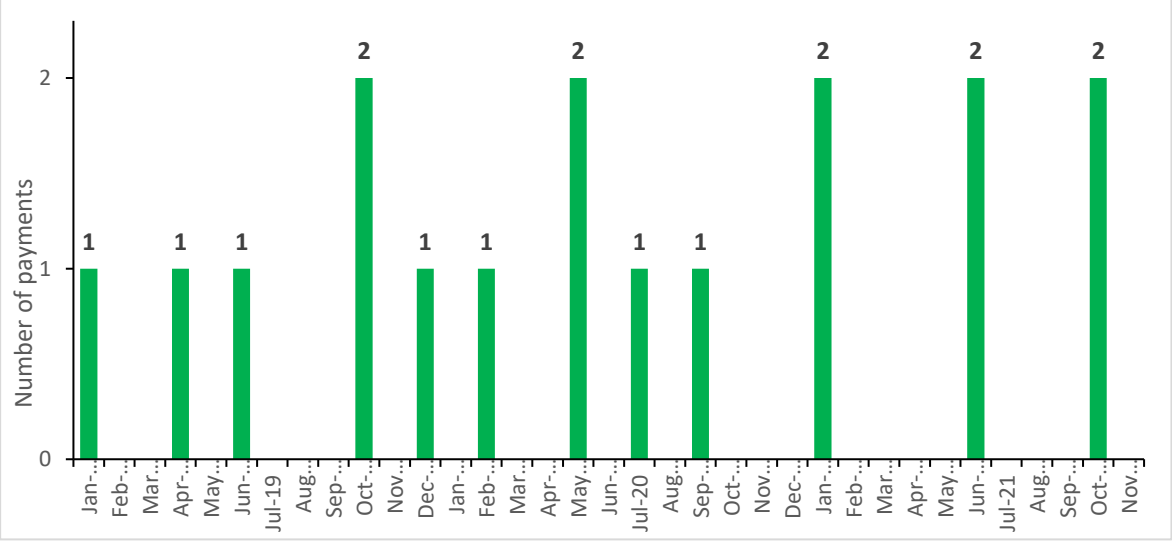
Table 11: Beneficiary status of the LEAP programme

Indicator	LEAP+ISS	LEAP	p-value
Ever received LEAP transfer	89.5	87.2	0.735
Current beneficiary of LEAP	88.4	86.4	0.768
N	**1,284**	**1,231**	

6.3. Timeline of payments

Regularity and predictability of payments are key aspects for the programme generating impacts as it allows households to adjust their decisions, consumption, time allocation, and productive activity patterns to a regular stream of supplemental income. Results from the 2012 survey showed that payments in earlier years of LEAP were irregular and unpredictable. The 2016 survey reported that payment frequency had improved notably with payments being made regularly every two months from 2013 to mid-2016 (the time of the survey). For the current survey, we obtained the dates of the transfer payments made since January 2019 from the LEAP management. Figure 8 shows that before the onset of COVID in March 2020 there was some consistency in providing regular payments during 2019 and early 2020. COVID seems to have created instability in the frequency and regularity of payments, particularly in the second half of 2020 and the first half of 2021. In the 10 months prior to the start of the 2021 survey fieldwork (August 2021), beneficiary households have had only two pay dates, in January 2021, and then five months later, in June 2021. However, LEAP provided double payment amounts in each of those pay days. This recent irregularity of payments seems to have created uncertainty on the expected continuity of payments among beneficiary households as we will see next in this section.

Figure 8: Timeline of payments



Source: LEAP Programme records.

6.4. Payment receipt and expectations

About 95 percent of respondents reported receiving the latest LEAP payment within the past 4 months with a large majority having received the latest payment within two months before the survey (Table 12). This is a high level of coverage of current beneficiaries. However, over 90 percent of respondents reported receiving the payments late or delayed at least once during the last year (Table 13).

Table 12: Number of months since last payment was received

Indicator	LEAP+ISS	LEAP	p-value
0-2 months	73.5	62.3	0.195
3-4 months	21.3	33.5	0.170
5-9 months	02.8	02.6	0.912
10 or more months	00.7	00.2	0.091
DK in 2021	01.7	01.4	0.699
N	**1,166**	**1,116**	

Table 13: Received payment late/delayed in the last year

Indicator	LEAP+ISS	LEAP	p-value
Once	16.1	16.7	0.889
Twice	40.0	33.5	0.141
Thrice	23.6	24.1	0.889
four times	10.6	16.4	0.381
No	09.7	09.3	0.926
N	**1,166**	**1,116**	

The increased irregularity and delays of payments experienced in the last year (see Figure 8 above) is reflected in the beneficiaries' expectations about the timing of the next payment (Table 14).

Table 14: Expectation of timing of next transfer payment (in months)

Indicator	LEAP+ISS	LEAP	p-value
In the next 2 months	57.0	52.9	0.613
In the next 6 months	03.6	02.8	0.695
In the next 12 months	00.0	00.3	0.264
After 12 months	00.0	00.1	0.386
Never	00.4	00.0	0.199
DK	39.0	43.9	0.507
N	**1,166**	**1,116**	

Recipients are split in two groups: A slight majority who expect to receive the next payment in the next two months, and another group of about 40 percent of recipients who does not know when the next payment will happen. In terms of how long recipients expect to continue receiving cash transfers, we found that almost all recipients expect to continue receiving LEAP payments for more than 5 years or even for the rest of their lives (Table 15).

Table 15: Expectation for duration of future payments

Indicator	LEAP+ISS	LEAP	p-value
0 - 6 months	01.3	01.0	0.735
6 months - 1 year	00.0	00.2	0.337
1 - 2 years	00.2	00.6	0.350
3 - 5 years	01.0	02.1	0.215
Longer/rest of my life	97.6	96.1	0.322
N	**1,166**	**1,116**	

6.5. Payment method and time costs

LEAP has implemented an electronic payment system that has improved accountability and provided safeguards and security to beneficiaries. However, payments are still made at the same payment locations where manual payments were administered. This leads to recipients to continue to travel to pay points to collect payments. As shown in Table 16, about two out of three recipients reported using the e-payment for the last payments and the other one out of three reported receiving cash directly. However, all recipients reported travel and waiting times for collecting payments.

Table 16: Payment method used last payment

Indicator	LEAP+ISS	LEAP	p-value
Cash payment in the community	33.2	30.6	0.830
E-payment	66.8	69.4	0.830
N	**1,166**	**1,116**	

About 62 percent of recipients reported traveling for less than 30 minutes back and forth to the payment point. However, close to 15 percent of recipients in the LEAP+ISS group and 11 percent in the LEAP group reported long travel times of over one hour (Table 17). Once recipients reach the payment points, they have to wait long times to receive payments. As shown in Table 18, about 40 percent of recipients in both T and C groups have waiting times of over one hour. Waiting times of over three hours were reported by 15 percent of LEAP+ISS recipients and by almost 20 percent of LEAP recipients.

Table 17: Travel time of collecting most recent payment (round trip)

Indicator	LEAP+ISS	LEAP	p-value
30 min or less	62.9	62.6	0.970
31-60 min	22.4	26.2	0.616
61-120 min	10.0	08.7	0.595
Over 2 hours	04.7	02.5	0.133
N	**1,166**	**1,116**	

Table 18: Waiting time at the payment point, most recent payment

Indicator	LEAP+ISS	LEAP	p-value
30 min or less	39.4	39.7	0.958
31-60 min	20.5	22.2	0.777
61-120 min	16.3	11.0	0.090
121-180 min	09.2	07.4	0.459
181-239 min	04.7	05.2	0.811
Over 4 hours	09.9	14.5	0.384
N	**1,166**	**1,116**	

6.7. Payment collection practices

Beneficiaries are usually notified when the next payment will be made. In the survey interview, we asked who informed them that the next payment was ready to be collected at the payment point, and whether the information was given in public (in front of other community member) or in private. The majority of beneficiaries, 79.5 percent in each group, were informed about the last payment in public, while 20.5 percent were informed in private (Table 19). The communication in public was done mostly by the CFP member or by another beneficiary. The information in private was given mainly by the CLIC/CFP member.

Table 19: Source of information that payment was ready for collection, main source

Indicator	LEAP+ISS	LEAP	p-value
In Public:			
CFP member	37.2	36.7	0.958
Another beneficiary	22.2	28.1	0.510
Community leader	15.7	09.0	0.212
Other	04.5	05.8	0.550
In Private:			
CLIC/CFP member	17.2	18.5	0.815
Other	03.3	02.0	0.389
N	**1,166**	**1,116**	

We asked respondents if at any point before or after the payment they were asked to give money or gifts or if they voluntarily gave money or gifts to anyone in order to receive the payment. The large majority of recipients, over 95 percent, answered "No" to the question (Table 20). Only a small number of recipients, 2.1 percent in the LEAP+ISS group and 2.9 percent in the LEAP group, reported they were asked and they did so.

Table 20: Reported transfer leakages before or after payment

Indicator	LEAP+ISS	LEAP	p-value
No	96.5	95.2	0.549
Asked and did so	02.1	02.9	0.584
Asked and refused	00.1	00.0	0.375
Offered and person accepted	01.2	01.6	0.685
Offered but person refused	00.1	00.1	0.838
DK/Refused	00.0	00.2	0.100
N	**1,166**	**1,116**	

We also asked respondents if they had ever received an amount lower than expected. About three out of four beneficiaries reported never receiving an amount lower than expected (Table 21). However, 10 percent of LEAP+ISS respondents and 14 percent of LEAP respondents answered "Yes". Another similar percentage of respondents did not know if that ever happened.

Table 21: Ever received an amount lower than expected

Indicator	LEAP+ISS	LEAP	p-value
No	77.9	72.6	0.417
Yes	10.7	14.0	0.379
Don't know/refused	11.4	13.4	0.711
N	**1,166**	**1,116**	

Table 22: Safety and satisfaction with payment method

Indicator	LEAP+ISS	LEAP	p-value
Yes, I feel safe at pay point and in transit	95.9	97.2	0.443
No, I feel unsafe during transit	03.7	02.0	0.287
Happy with current payment method	94.8	91.9	0.434
N	**1,166**	**1,116**	

There is a high level of safety and satisfaction with the payment method. As shown in Table 22, the vast majority of respondents reported feeling safe at the payment point and during the travel

to and from the payment point. There is also a large majority of respondents who reported being happy with the current payment method.

6.8. Linkages: Presence of other services at the payment point

The core objective of the ISS initiative is to increase the linkages of LEAP with other social services in order to provide a comprehensive array of support services to vulnerable households. We asked respondents about the presence of social services at the payments point. As shown in Table 23, there is very low presence of the Ghana Health Services and the NHIS at payment points in the LEAP+ISS areas and almost no presence in LEAP areas. Social Welfare was reported to be present by only 1 out of 5 respondents. However, even when the social services were present at the pay points, they had a low level of interaction with the beneficiaries. Table 24 shows that a very small number of respondents were approached by or talked to representatives of the social services present.

Table 23: Services present at the payment point, last payment

Indicator	LEAP+ISS	LEAP	p-value
Ghana Health Services	4.9	2.3	0.259
NHIS	10.6	2.6	0.029
Social Welfare	21.7	22.7	0.902
LEAP Management Secretariat	59.1	57.4	0.904
N	**1,166**	**1,116**	

Table 24: Approached by or spoke to services present at the payment point, last payment

Indicator	LEAP+ISS	LEAP	p-value
Ghana Health Services	2.4	1.9	0.819
NHIS	7.5	2.0	0.032
Social Welfare	15.8	19.9	0.527
LEAP Management Secretariat	50.8	49.5	0.926
N	**1,166**	**1,116**	

6.9 Use of the transfers

The operations module asked about the main uses to which households put their transfer payments. Up to three main uses were collected from respondents. As shown in Table 25, the large majority of households use the transfer for food (about 80 percent in both groups). The second main use is health care as reported by slightly more than half of respondents. The third main use is to cover formal government education expenses (fees, textbooks, uniforms) which

was reported by 22 percent of households. These results are consistent with those found by the 2016 evaluation survey.

Table 25: Main uses of the transfers

Category of use	LEAP+ISS	LEAP	p-value
Food and nutrition	83.4	78.1	0.465
Health care	51.5	51.8	0.942
Formal govt education	22.0	22.4	0.892
Agriculture/farming	19.9	13.7	0.062
Other education	6.4	8.2	0.455
Investment/small business	5.8	7.2	0.649
Savings/susu	5.6	3.2	0.289
Clothing/shoes	5.1	5.1	0.99
Shelter/rent/accommodations	1.6	1.1	0.429
Formal social occasions (weddings, funerals, others)	1.1	0.6	0.219
Other	1.7	1.3	0.685
N	**1,284**	**1,231**	

[1] We use 2010 as the starting point of reference because the baseline survey of the first LEAP evaluation was done in early 2010.

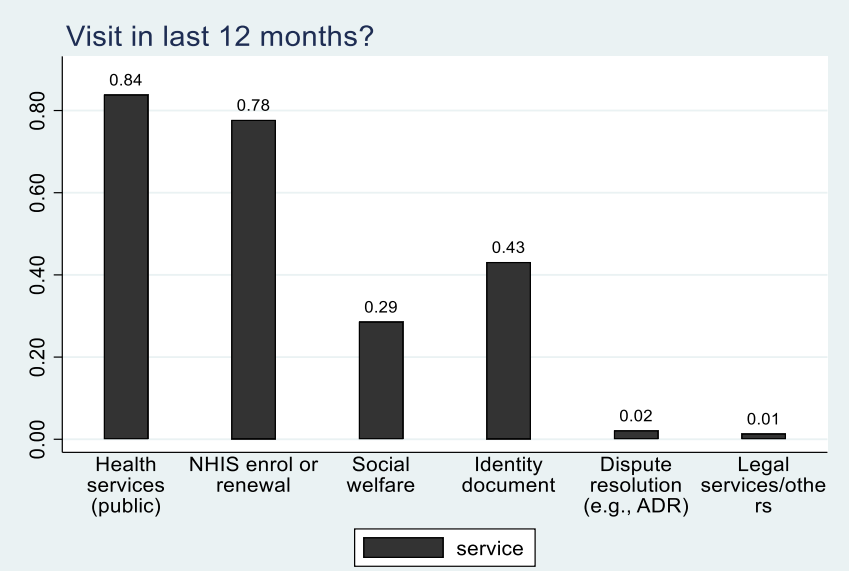
[2] Households with two, three, or four or more eligible beneficiaries receive GHc 38, GHc 44, and GHc 53 per month, respectively. We use the case of one beneficiary as most LEAP households reported having only one eligible household member.

[3] At the time of writing this preliminary report we do not have the actual amounts received by the sampled households. We calculated each household transfer amount by counting how many household members would be eligible according to the LEAP eligibility criteria and then applying the transfer amount schedule used by the program (GHc 32 for 1 eligible person, GHc 38 for 2 eligibles, GHc 44 for 3 eligibles, and GHc 53 for 4 or more eligible in the household).

7. USE OF GOVERNMENT SERVICES

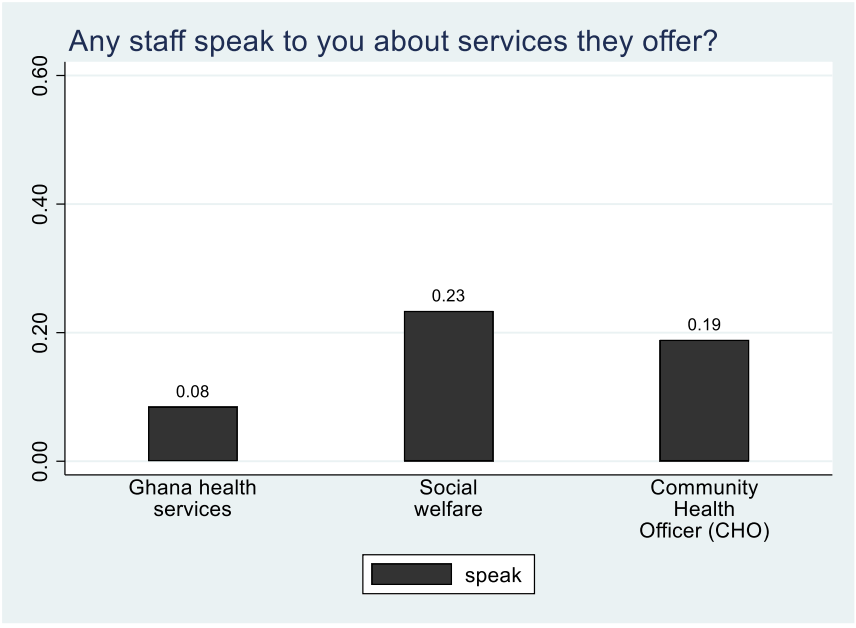
Main respondents of the survey were asked a series of questions about their use of public services, and their satisfaction with service provision and the quality of service performed by staff. We begin by checking *whether they had visited any services in the last 12 months*—Figure 9 shows that health services and NHIS were the most frequently visited with 84 and 78 percent of respondents respectively saying they had at least one visit in the last 12 months. Only 29 percent reported visiting social welfare, and very few had gone for legal services.

Figure 9: Visit service in last 12 months



Respondents were then asked *whether staff from Ghana Health Services, Social Welfare or a Community Health Officer had spoken to them*. Figure 10 shows that this is a rare occurrence, only 8 percent had been approached by GHS, and 23 percent by Social Welfare.

Figure 10: Any staff speak to you about services offered?



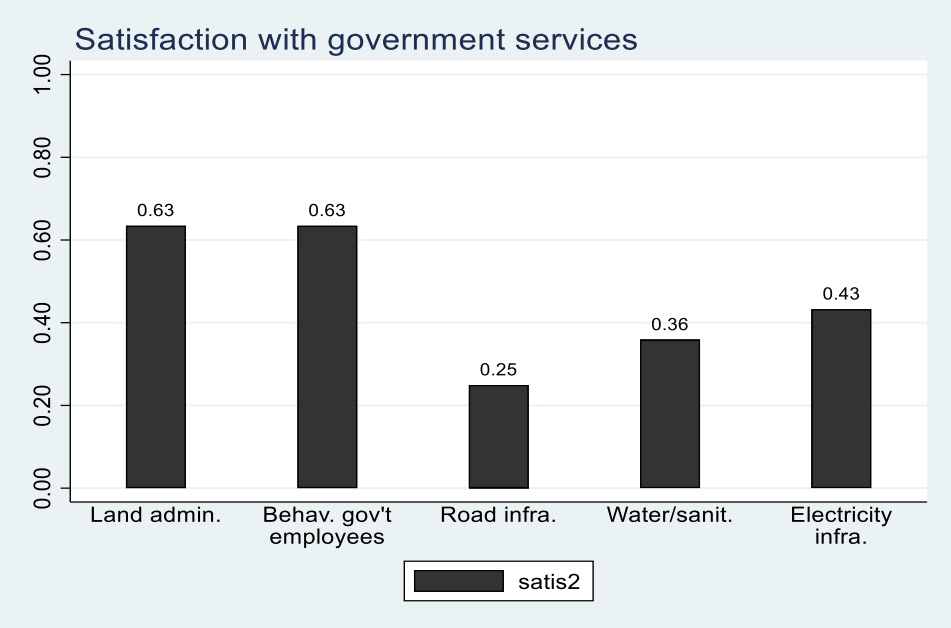
Next respondents were asked to assess the extent to which they were *satisfied with a series of public services*, with responses on a four-point scale ranging from fully satisfied to fully dissatisfied. Responses were coded into fully satisfied or satisfied to some extent, versus dissatisfied to some extent or fully dissatisfied. A few respondents indicated

they didn't know, and these responses were coded as 'not satisfied' since there was an absence of a positive response. Results for 11 different public services are shown in Figure 11.

Respondents are the least satisfied with public utilities—roads, electricity and water and sanitation, with just 25 percent satisfied with roads and 36 percent with WATSAN. On the other hand, satisfaction is quite high with health services in general, and social welfare. In the case of social welfare, respondents' primary contact will be through the LEAP program, as Figure 9 shows that just 29 percent actually visited the social welfare office. Respondents were further read a set of statements about the *public service environment in local government*, and asked to agree or disagree with each statement, with responses on a four-point scale. Positive responses (strongly agree or agree) were coded together versus negative responses (disagree or strongly disagree). Figure 12 shows the responses for each of the statements broken down by LEAP+ISS and LEAP samples. The responses across the two samples are almost identical, indicating no systematic difference in how respondents rate the functioning of local government service.

About half of respondents agree that services are provided according to specific standards and within the stipulated time. Furthermore, just 28 percent agree that bribing is not necessary to get work done. However, just 38 percent agree that services can be received without any hassle, and a similar percent agree that no intermediary is necessary. To put it another way, 62 percent believe that an intermediary is necessary, and that they are hassled when seeking services. And 78 percent believe that those with connections get work done quickly.

Figure 11: Satisfaction with services



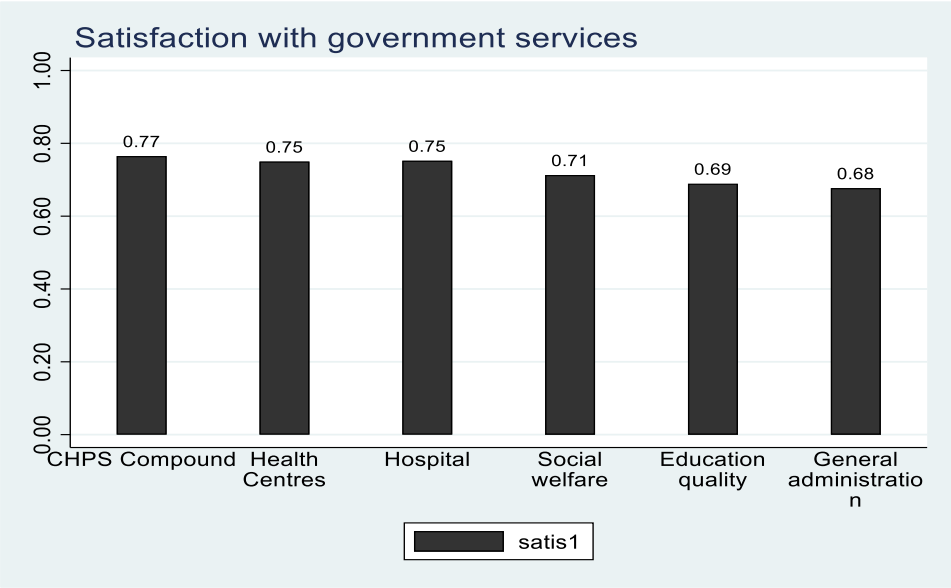


Figure 12: Agree with statements about service providers in general

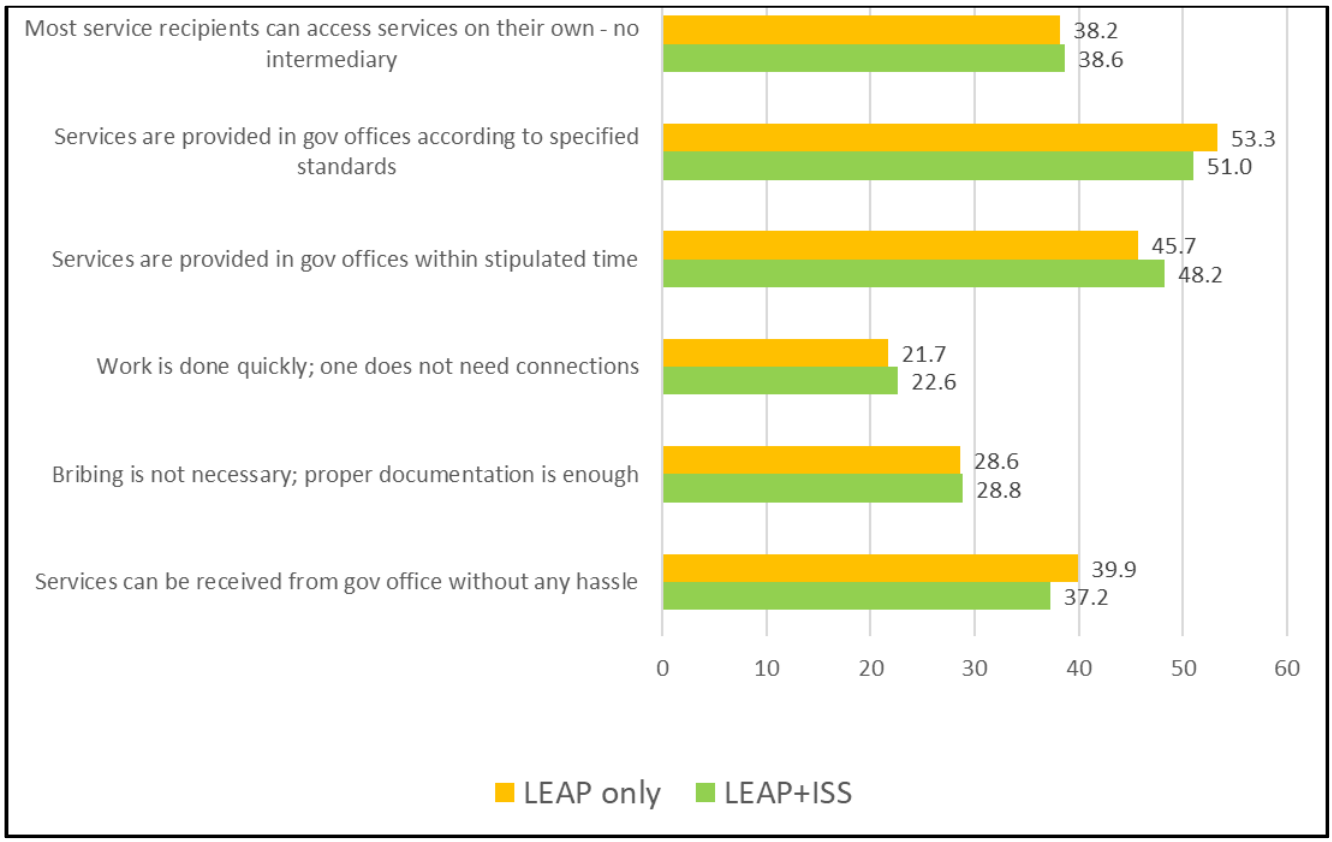


Figure 13 reports results from a set of questions about the *behavior and attitude of public service employees*, again on a four-point scale with the two positive responses (agree, strongly agree) coded together versus the two negative responses. The issue of hassle once again arises here, where this statement received the least positive responses. The other issue of concern is that not all customers are treated the same (just 44 percent agreeing that this was true), which is similar to the concern from the previous figure that those who had connections received faster service. The most positive quality of employees is politeness (60 percent) followed by properly listening to the concerns of the customer (58 percent).

Figure 13: Government employees

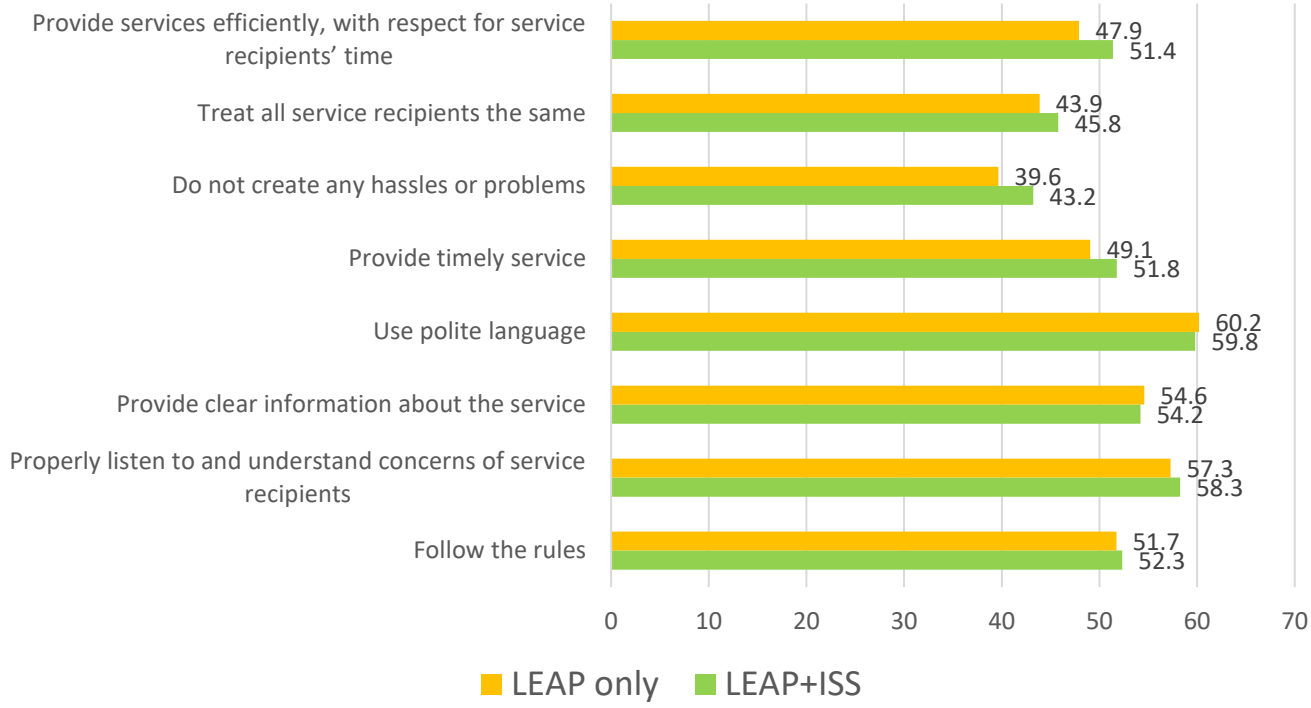


Table 26 provides the statistical tests for differences in all these indicators across the LEAP+ISS and LEAP samples; none of the responses are statistically different.

Table 26: Use and perceptions of government services

Indicator	LEAP+ISS N=1,284	LEAP N=1,231	p-value
	(1)	(2)	(3)
main respondent voted in 2020 Presidential elections	0.96	0.95	0.784
main respondent knows the name of their MP	0.66	0.70	0.521
Public Service: Health services (public, not private)	0.86	0.81	0.009
Public Service: NHIS enrolment or renewal	0.77	0.79	0.732
Public Service: Social welfare	0.29	0.28	0.938
Public Service: Identity document	0.40	0.48	0.560
Public Service: Dispute resolution (e.g., ADR)	0.02	0.02	0.750
Public Service: Legal services/others	0.01	0.01	0.974
In the last twelve months, did any staff from the Ghana health services speak to	0.09	0.08	0.925

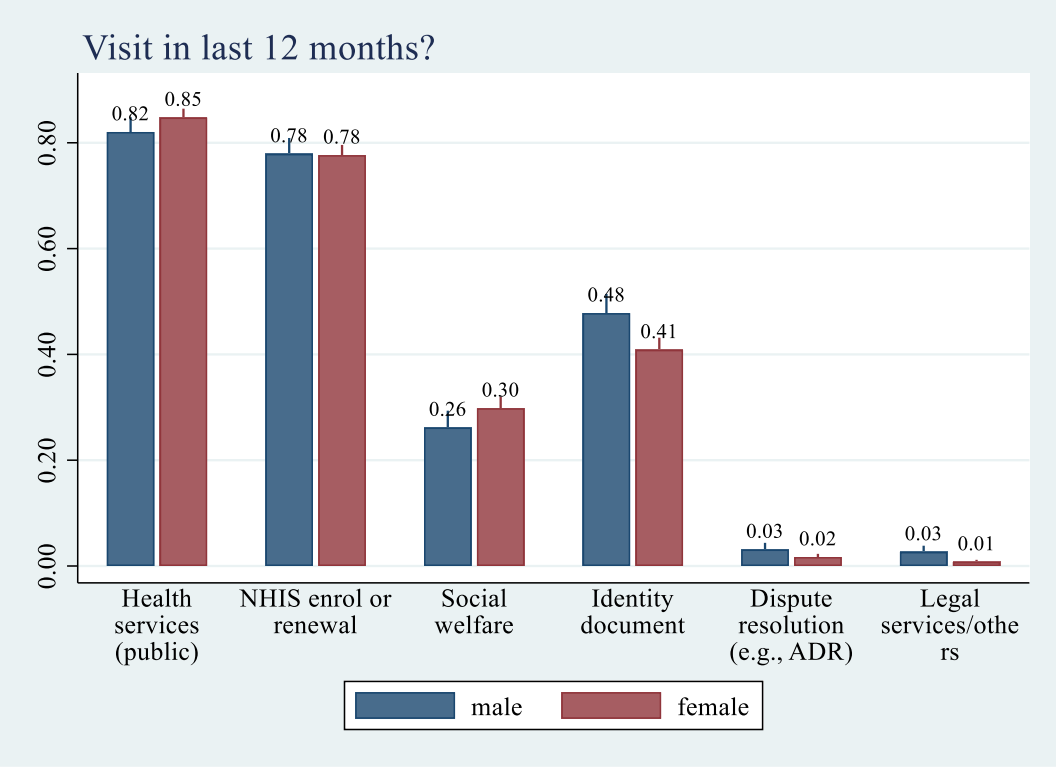
In the last twelve months, did any staff from social welfare speak to you about	0.21	0.27	0.462
In the last twelve months, did any Community Health Officer (CHO) speak to you a	0.18	0.20	0.862
Satisfied with Health services provided by government health posts/CHPS Compound	0.81	0.77	0.349
Satisfied with Health services provided by government health centre	0.82	0.78	0.343
Satisfied with Health services provided by government hospitals	0.82	0.79	0.561
Satisfied with Social welfare services	0.78	0.77	0.803
Satisfied with Educational quality in government schools and colleges	0.73	0.71	0.581
Satisfied with General administration services	0.71	0.74	0.618
Satisfied with Land administration services	0.62	0.65	0.623
Satisfied with Behaviour of government employees toward service recipients	0.65	0.69	0.473
Satisfied with Road infrastructure	0.29	0.32	0.815
Satisfied with Water and sanitation infrastructure	0.43	0.34	0.173
Satisfied with Electricity infrastructure	0.53	0.48	0.730
services can be received from gov office without any hassle	0.34	0.40	0.197
bribing is not necessary; proper documentation is enough	0.27	0.24	0.443
work is done quickly; one does not need connections	0.22	0.21	0.730
services are provided in gov offices within stipulated time	0.44	0.46	0.622
services are provided in gov offices according to specified standards	0.45	0.54	0.095
most service recipients can access services on their own - no intermediary	0.37	0.37	0.998

Indicator	LEAP+ISS N=1,284	LEAP N=1,231	p-value
gov employees follow the rules	0.47	0.48	0.777
gov employees properly listen to and understand concerns of service recipients	0.54	0.53	0.838
gov employees provide clear information about the service	0.48	0.53	0.474
gov employees use polite language	0.55	0.54	0.890
gov employees provide timely service	0.47	0.43	0.398
gov employees do not create any hassles or problems	0.40	0.37	0.553
gov employees treat all service recipients the same	0.43	0.45	0.709
gov employees provide services efficiently, with respect for service recipients	0.48	0.49	0.972
government experience scale; higher is better	19.26	19.26	0.998

7.1 Use of Government Services from a Gender Perspective

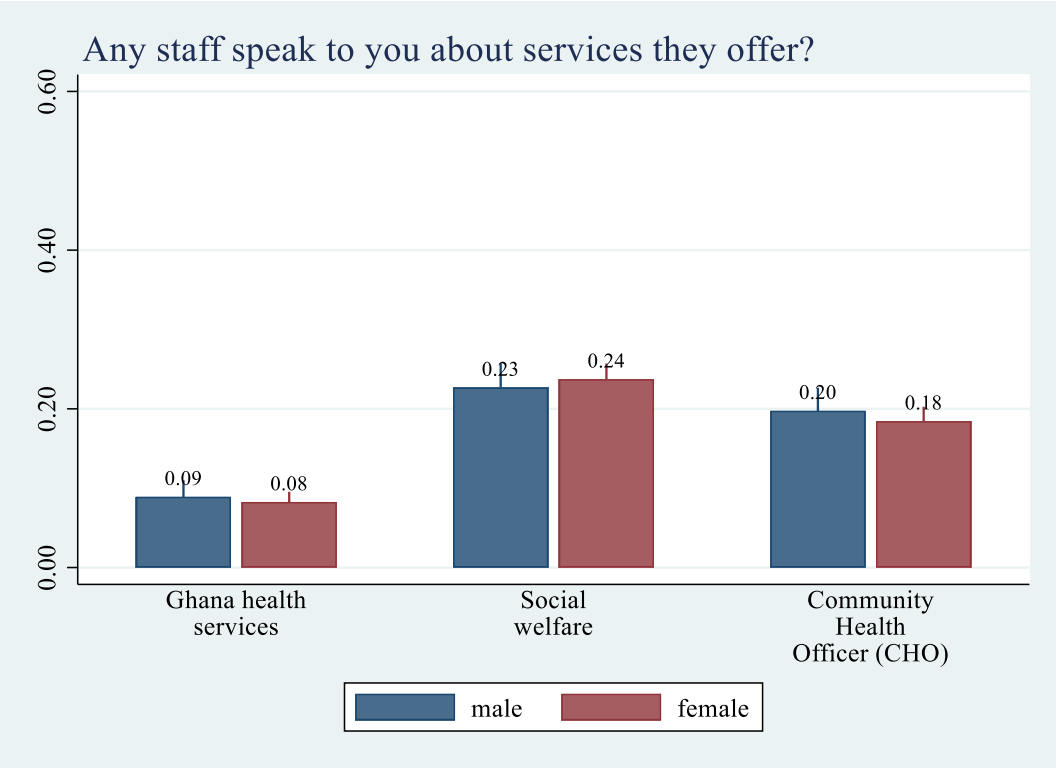
We disaggregate the experiences of the main respondent with the use of government services by gender. We begin by checking gender differences in *whether they had visited any services in the last 12 months*—Figure 14 shows that only 41 percent of female household heads reported visits for identity documents in the last 12 months, relative to 48 percent of male heads. Visits by health services and social welfare were, respectively, 85 and 30 percent for female household heads who reported at least one visit in the last 12 months, an additional 3-4 percentage points relative to male heads of household.

Figure 14: Visit service in last 12 months, by gender



Male and female respondents were then asked *whether staff from Ghana Health Services, Social Welfare or a Community Health Officer had spoken to them*. Figure 15 shows that both genders were approached by staff at equally low rates - only 1 to 2 percentage point differences in being approached by GHS, Social Welfare, and by a CHO.

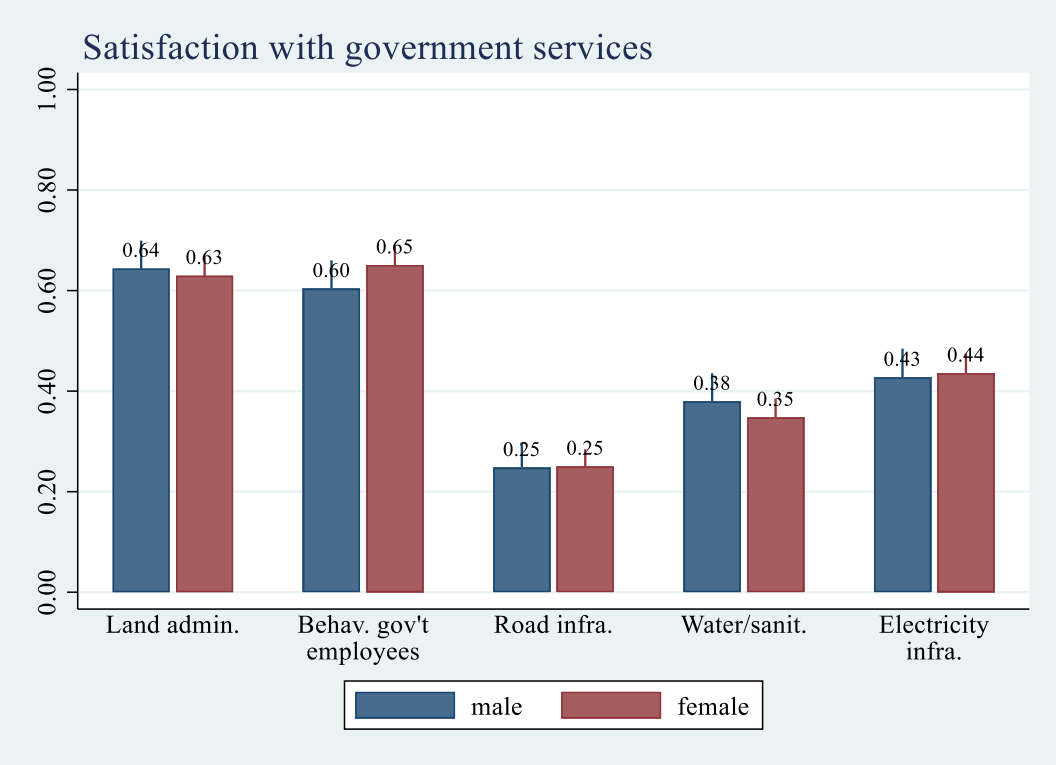
Figure 15: Any staff speak to you about services they offer? by gender



Gender breakdown in responses for satisfaction with 11 different public services is shown in Figure 16. When asked to assess the extent to which they were *satisfied with a series of public services*, 65 percent of female main respondents were satisfied with the behavior of government employees, an additional 5 percentage points over male respondents. *Female satisfaction is generally higher with health services.*

On the other hand, the share of female respondents satisfied with education quality and with water and sanitation is lower than male respondents, with 68 percent of females satisfied with education quality and 35 percent with WATSAN, relative to 70 and 38 percent of male respondents.

Figure 16: Satisfaction with government services



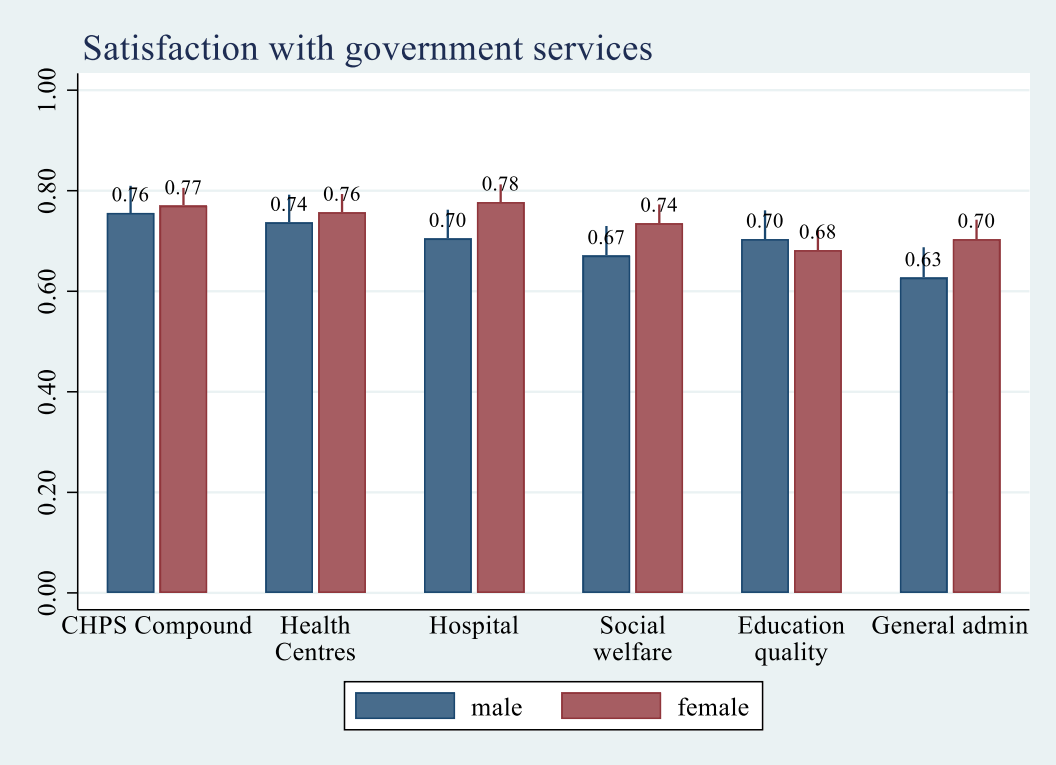


Figure 17 shows the responses for each of the statements about local government service providers, broken down by female and male respondents. Compared to male respondents, female respondents, on average, show 4 percentage points lower agreement with the statement that government provides services without connections and bribery. On the other hand, male respondents are 4-6 percentage points less likely to believe that services can be received without any hassle or without an intermediary. Male and female respondents provide similar agreement with the statements that services are provided according to specific standards and within the stipulated time.

Figure 17: Agree with statements about service providers in general, by gender

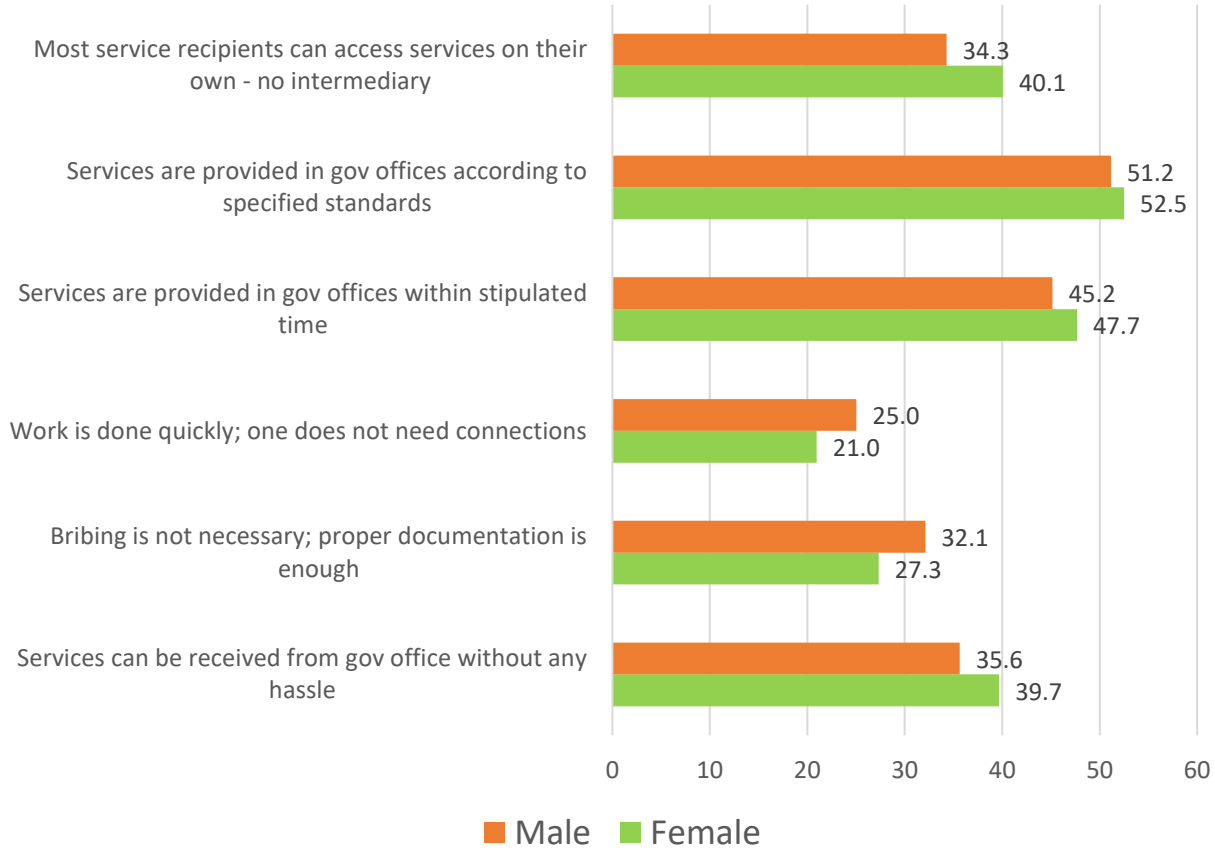
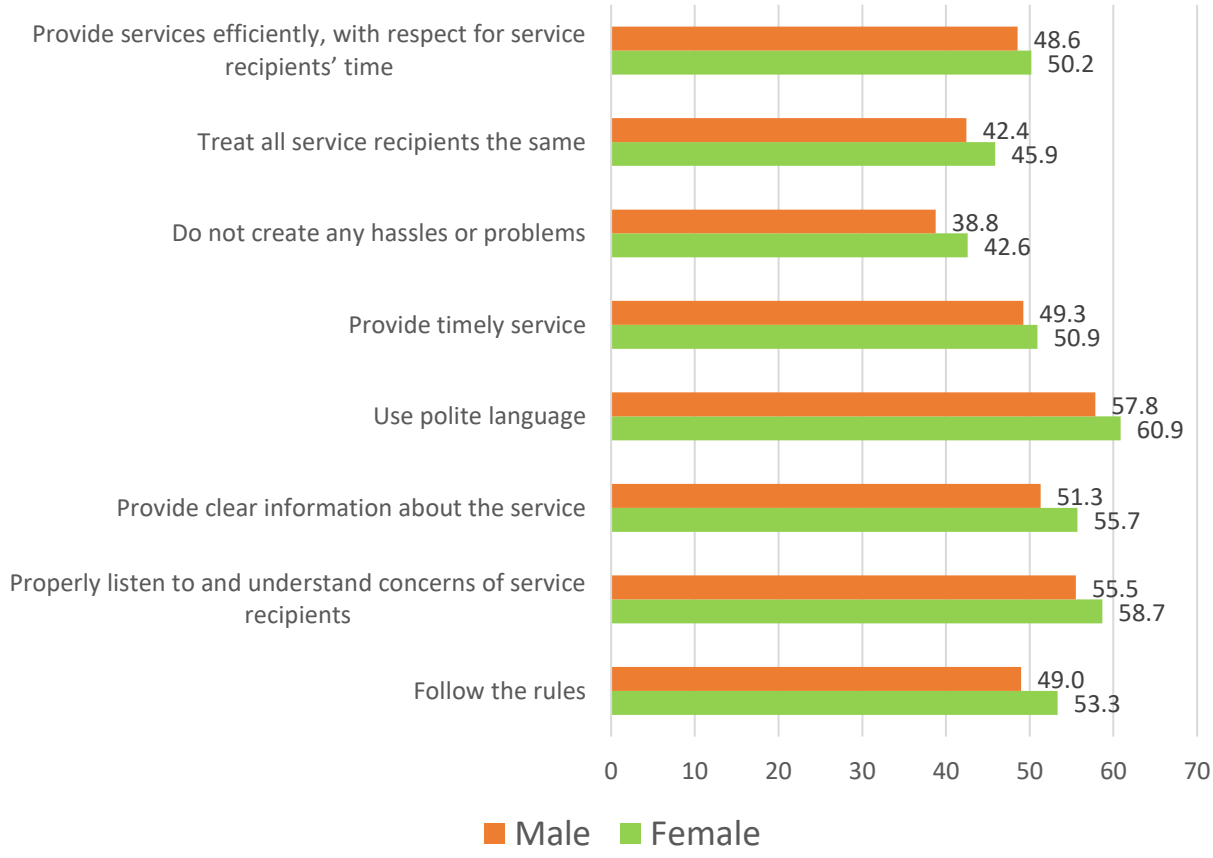


Figure 18 reports the gender breakdown for results from a set of questions about the behavior and attitude of public service employees. *Across every indicator, it appears that female main respondents are rating government employees more favorably.* The results echo Figure 15 where females report higher satisfaction with the behavior of government employees. The ratings by female main respondents show an additional 2-4 percentage point increase over males, with females being most satisfied with the use of polite language and proper listening.

Figure 18: Government employees, by gender

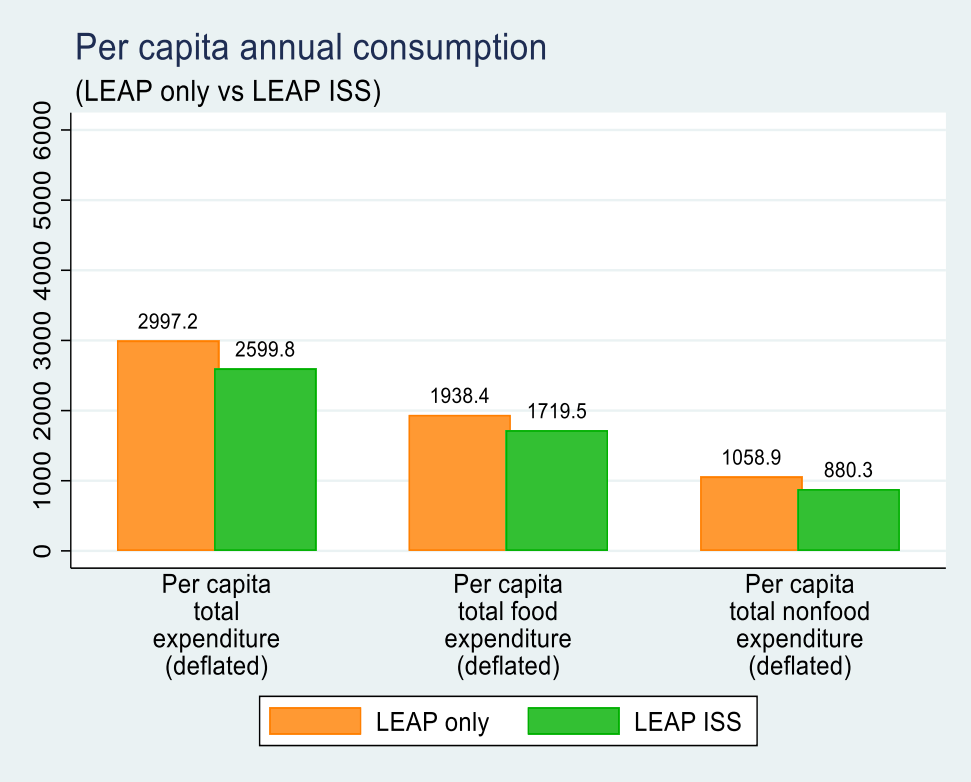


8. CONSUMPTION, FOOD SECURITY AND WELL-BEING

8.1 Consumption

Consumption expenditures are measured through a detailed module covering 150 individual items of food and non-food with varying recall periods depending on the item. For example, food expenditures are captured on a one week recall, while lumpy durable goods are on a one year recall, and other items on a three month recall.

Figure 19: Consumption and components (trimmed)



We report total consumption expenditure, which excludes non-consumption spending such as on agricultural inputs, investment spending and savings. We exclude imputed rent since households in our sample live in their own houses typically on ancestral land and there is no rental market with which to estimate imputed rent. Figure 19, which removes the highest and lowest five percent of the consumption distribution (appropriate when the data include extreme outliers, as is the case with consumption), shows that LEAP only households are slightly better off than LEAP+ISS. Overall consumption per capita is GH2,449 which is somewhat high because the baseline data was collected just after the harvest season and stocks of food were high.

Table 27 shows both per capita and per adult equivalent consumption expenditures, this time for the full sample without trimming the top and bottom five percent. The LEAP group continues to have slightly higher consumption relative the LEAP+ISS group. The table also reports

the poverty headcounts using the national poverty line (inflated to August 2021) and the international $1.90PPP poverty line. Poverty headcount among LEAP is 51 percent (individual level), which is significantly higher than the all-Ghana poverty rate of 23 percent as reported in GLSS7. Extreme or food poverty is also much higher in LEAP, 18 percent versus 8 percent in all of Ghana. Note that due to economic growth over the last five years, the poverty rates in Ghana have likely declined somewhat, so that the difference between LEAP and the all-Ghana rates are likely to be even larger.

Table 27: Consumption expenditures (untrimmed)

Indicator	LEAP+ISS	LEAP	p-value
Poverty headcount (individual level)	0.56	0.44	0.005
Extreme poverty headcount (")	0.22	0.14	0.025
Poverty headcount: < $1.90 (")	0.36	0.27	0.040
Total expenditure per capita	2,230.28	2,631.18	0.040
Total expenditure per adult equivalent	3,061.76	3,473.50	0.039
Food consumption - per capita	1,453.66	1679.98	0.035
Non-food consumption per capita	866.61	951.20	0.277
N	**1,284**	**1,230**	

Table 28: Consumption expenditures (untrimmed), by sex of main respondent

Indicator	Female	Male	p-value
Poverty headcount (individual level)	0.51	0.51	0.904
Extreme poverty headcount (")	0.19	0.18	0.976
Poverty headcount: < $1.90 (")	0.33	0.31	0.428
Total expenditure per capita	2,417.37	2,509.65	0.441
Total expenditure per adult equivalent	3,209.39	3,276.48	0.675
Food consumption - per capita	1,487.22	1,661.47	0.026
Non-food consumption per capita	930.12	848.18	0.263
N	**1,778**	**735**	

In Table 28 we breakdown consumption and poverty by the sex of the main respondent. There are no significant differences in the various poverty rates by sex of the respondent, though male headed households do have higher average consumption levels, particularly food consumption.

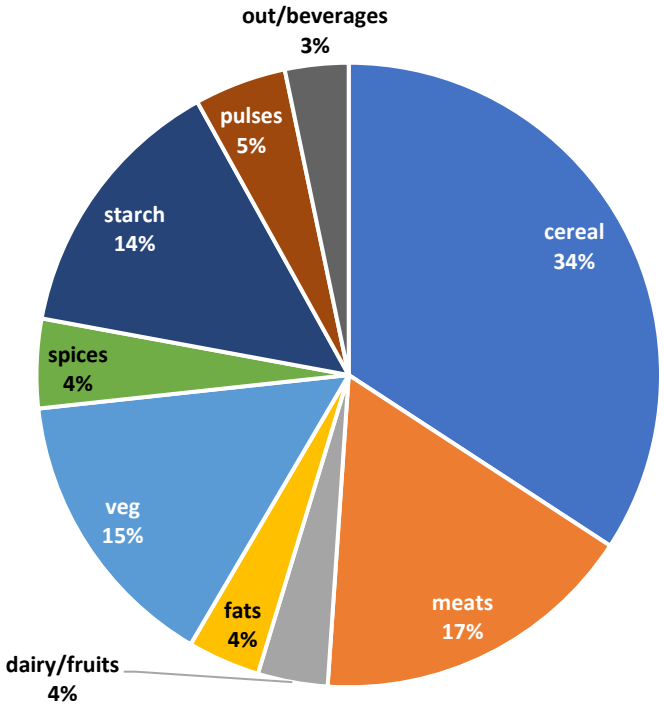
The distribution of consumption among LEAP households is shown in Table 29. The majority of consumption goes to food (58 percent), followed by health (17 percent), education (5 percent), housing services and transportation. This profile of consumption is typical among poor households throughout Africa.

Table 29: Consumption shares

Indicator	LEAP	LEAP+ISS	p-value
Food consumption - share	57.22	59.39	0.281
Alcohol & Tobacco - share	0.28	0.51	0.078
Furnishing & Housing Services - share	4.63	3.95	0.012
Housing - share	2.72	2.18	0.194
Clothes & Footwear - share	3.57	2.95	0.149
Health - share	17.18	17.11	0.963
Education - share	5.09	5.04	0.935
Transportation - share	3.08	2.61	0.320
Communication - share	1.52	1.49	0.911
Recreation & Culture - share	1.91	2.25	0.590
Miscellaneous Goods & Services - share	2.81	2.53	0.318
Total nonfood expenditure - share	42.78	40.61	0.281
N	**1,230**	**1,284**	

Within the food budget, almost half is devoted to cereal and starch, which form the staple part of the diet (maize, cassava, yam). Other important items in the food bundle are meats (17 percent) and vegetables (15 percent). Again, this pattern of food consumption is typical of rural poor households throughout Africa.

Figure 20: Consumption of food budget



8.2 Food Security

Food security indicators are shown in Figure 20 and these are quite high since the survey was conducted just after the harvest season. As a point of comparison, the LEAP 1000 data collected in 2017 showed that just 13 percent of households never worried about food in the last

seven days, compared to 35 percent in the current survey. Similarly, just 38 percent of LEAP 1000 households in 2017 ate 2+ meals per day compared to 71 percent in the current survey. This seasonality will be important to bear in mind when a follow-up survey is conducted on this sample of households.

8.3 Subjective well-being

A suite of questions on subjective well-being were asked of the main respondent, typically the main LEAP beneficiary. Questions include an eight-item quality of life (QoL) scale and optimism about the future—whether the respondent believed their life would be better in 1, 3 or 5 years. Generally, respondents were very optimistic about the future, with 86 percent saying they believed their lives would be better at some point in the future. Men were more likely to be optimistic about the future than women (Table 30), 89 percent of men believed their life would be better at any point in the future, compared to 84 percent for women.

Figure 21: Food security indicators

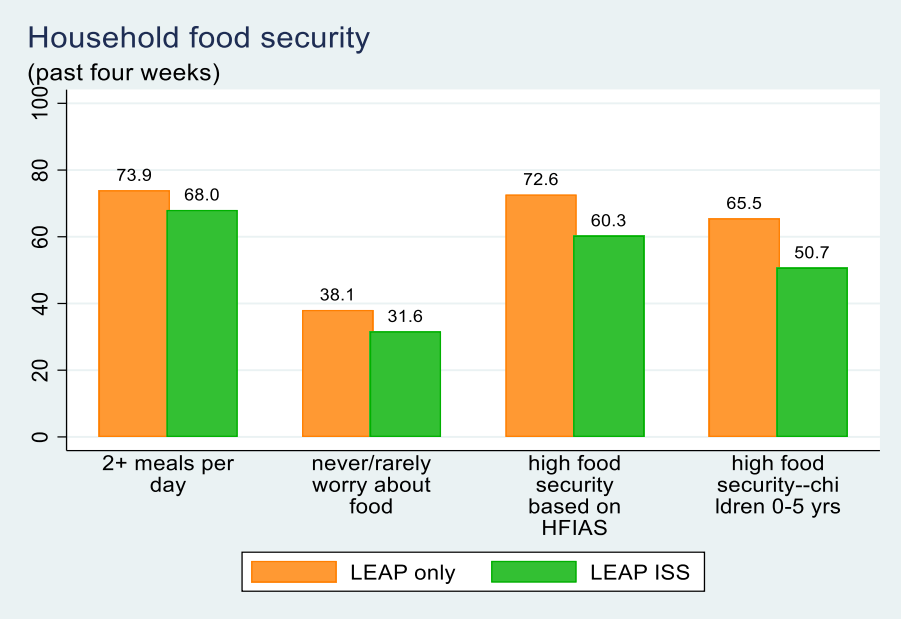


Table 30: Subjective well-being of main respondent

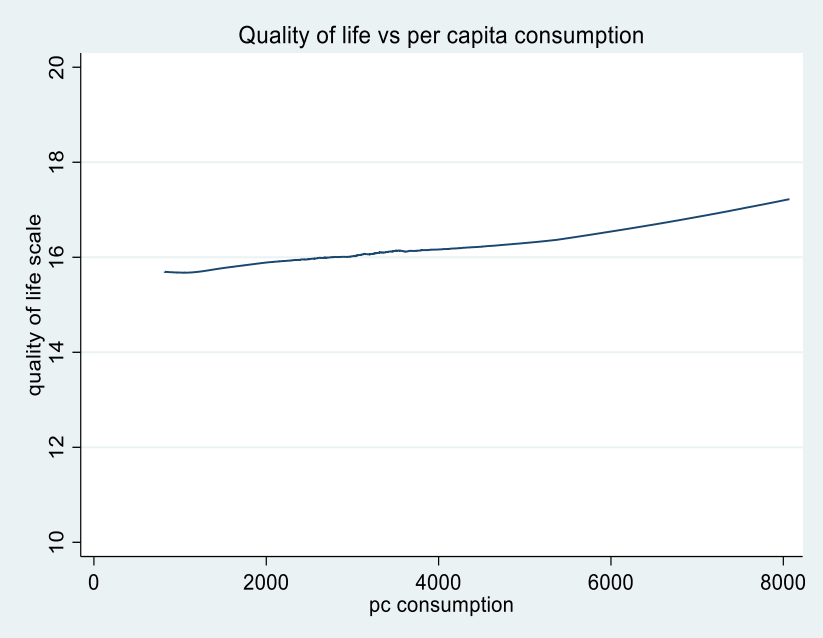
Indicator	LEAP+ISS	LEAP	p-value
lifebetter_1yr	0.80	0.81	0.765
lifebetter_3yr	0.81	0.82	0.658
lifebetter_5yr	0.77	0.80	0.554
Life better, any period in future	0.86	0.86	0.875
quality of life scale: higher is better	16.14	15.70	0.100
N	**1,284**	**1,231**	

Table 31: Subjective well-being of main respondent, by gender

Indicator	Male	Female	p-value
	(1)	(2)	(3)
Life will be better in 1yr	0.83	0.79	0.247
Life will be better in 3yrs	0.86	0.79	0.008
Life will be better in 5yrs	0.83	0.76	0.001
=1 if life better in any period	0.89	0.84	0.063
quality of life scale: higher is better	16.61	15.64	0.000
N	**735**	**1,779**	

We plot the relationship between per capita consumption and the QoL scale (which ranges from 7 to 28, higher being better) in Figure 22. This shows a slight positive relationship between the two, indicating that while higher consumption does lead to a higher QoL score, the relationship is not exactly one-to-one, and thus other non-monetary factors also enter into the subjective assessment of QoL.

Figure 22: Quality of life and consumption



We end this section by comparing a few housing indicators between LEAP and the extremely poor rural population from GLSS7 (Figure 22). Again, it is important to remember that GLSS7 is from 2016-17, and thus living conditions have likely improved, which might explain why LEAP households display better levels of improved sanitation and mud walls and thatched roof. However, they are significantly less likely to have access to electricity (38 versus 64 percent) and the rates of protected water are the same. Water and sanitation and electricity are highly supply driven, and determined by government initiatives to provide services in these rural districts, rather than the household's own capacities.

9. ECONOMIC ACTIVITIES

The survey questionnaire captured economic and productive activity through several different sections including time-use, spending on agricultural inputs, and dedicated modules on non-farm enterprise (NFE) and livestock. Although the instrument does not ask directly about land, the typical household is living on a family plot and will have at least a kitchen garden and usually a larger plot either next to the homestead or further away with staple and other crops.

Figure 23 shows the percent of households reporting each of three livelihood activities of NFE, livestock rearing and agriculture. Agriculture is not directly asked but is inferred from spending on agricultural inputs and work on the farm, NFE and livestock are directly asked, and households who did not report any agricultural work or spending, nor NFE or livestock or classified as 'not reported', though they would of course still need to have some source of consumption--11 percent of the sample are classified in this category. The most common livelihood activity is agriculture with 79 percent engaged, followed by livestock rearing (56 percent) and then NFE (32 percent).

Figure 23: comparison of housing indicators

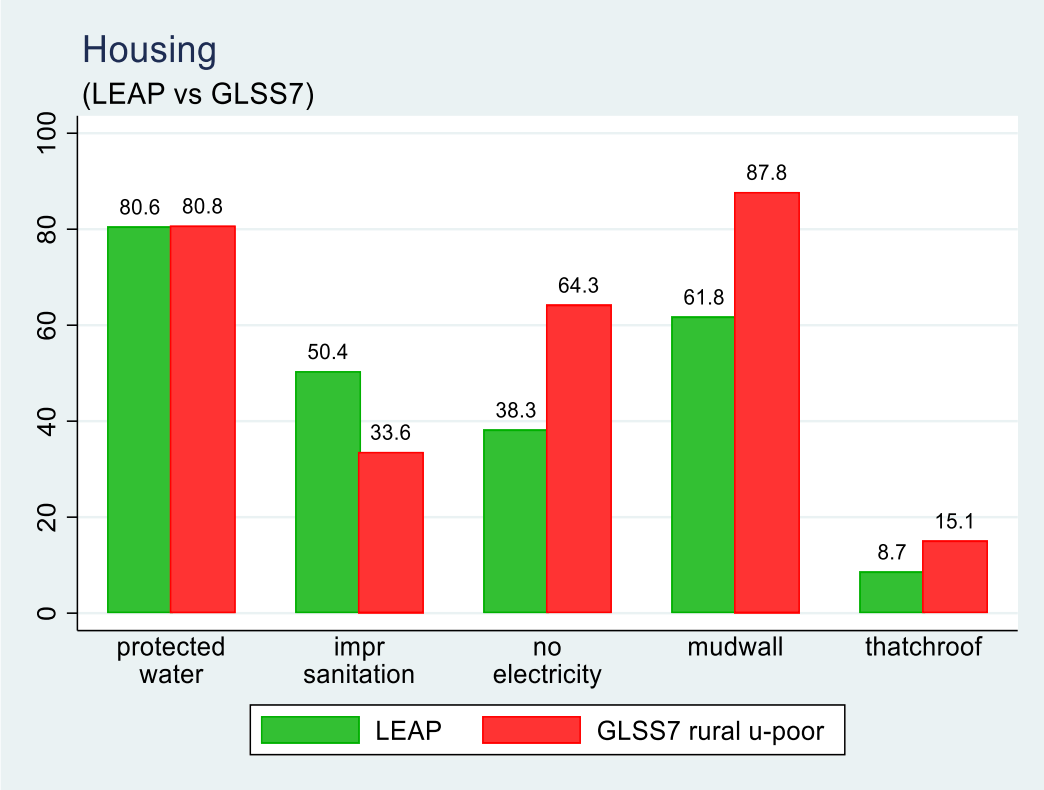


Figure 24: Livelihood category reported

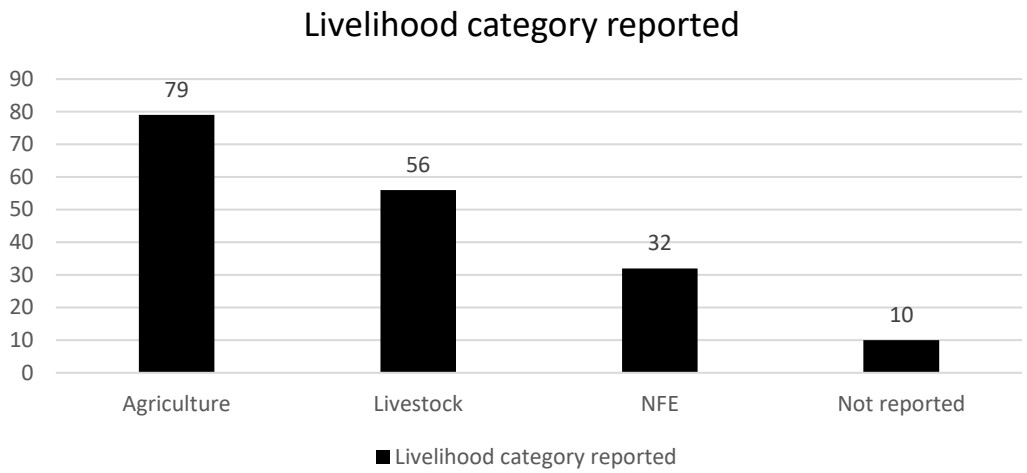
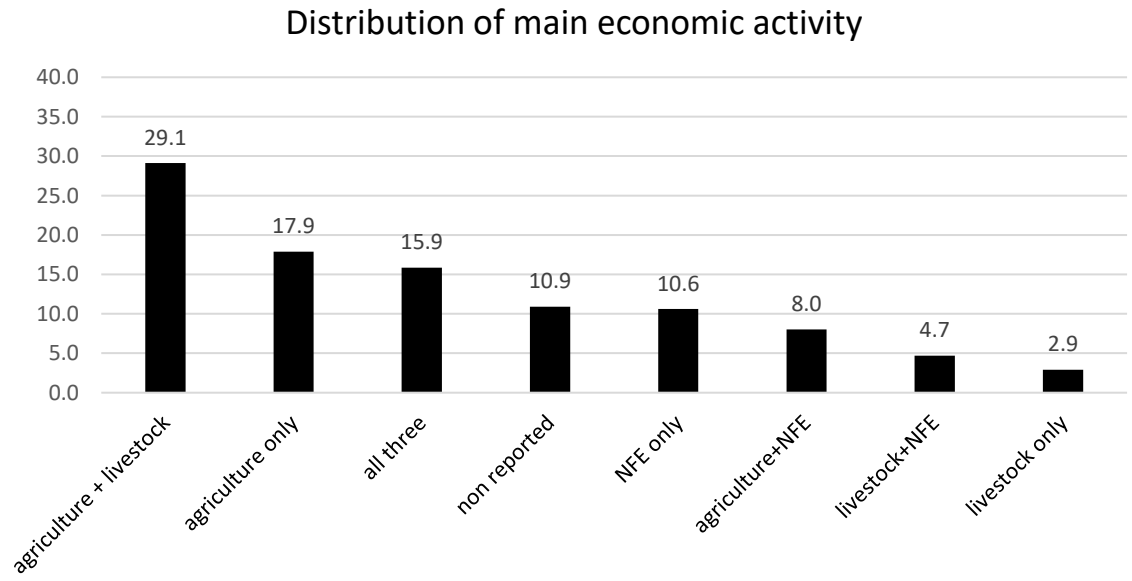


Figure 25 shows the distribution of livelihood profiles to illustrate what activities each individual household is engaged since households will tend to engage in multiple activities. The most common livelihood profiles are agriculture and livestock, followed by agriculture only (18 percent) and then all three (16 percent). Thus, 63 percent of households have multiple livelihood strategies with agriculture plus one other being the dominant approach.

Figure 25: Distribution of main economic activity



9.1 Time use

Table 32 depicts time-use characteristics of LEAP ISS and LEAP only households. Overall, LEAP ISS and LEAP only households have comparable levels of participation in economic activities. For example, while LEAP only households reported spending more days preparing land and planting (3.43 days for LEAP only and 3.01 days for LEAP ISS), this difference is not statistically indistinguishable from zero.

Table 32: Time use

Indicator	LEAP ISS	LEAP only	p-value
Hours spent on domestic chores, last 24 hours			
Collecting water	0.09	0.09	0.903
Collecting firewood or other fuel	0.12	0.12	0.839
Taking care of children, cooking or cleaning	0.90	0.95	0.656
Days spent in the current rainy season on agricultural activities, last 30 days			
Land preparation or planting	3.01	3.43	0.395
Weeding, fertilizing or other non-harvest work	3.43	4.05	0.273
Hours spent on other work activities, last 7 days			
Run or help in non-agricultural business	1.46	1.72	0.599
Livestock-related activities	0.23	0.24	0.822
Collecting nuts, fruits, honey, other food	0.18	0.31	0.539
Casual labour	0.37	0.34	0.831
Wage, salary, payment in kind labour	0.27	0.28	0.866
N	**6,181**	**5,447**	

Table 33 shows time-use indicators by sex and as expected there is a sexual division of labor in the household, with females spending more time in domestic activities, males spending a bit more time in agricultural activities, including casual labor and livestock. One interesting observation is that females spend slightly more time in non-farm enterprises relative to males, and both spend equal amounts of time in wage work (which tends to be very rare in this context).

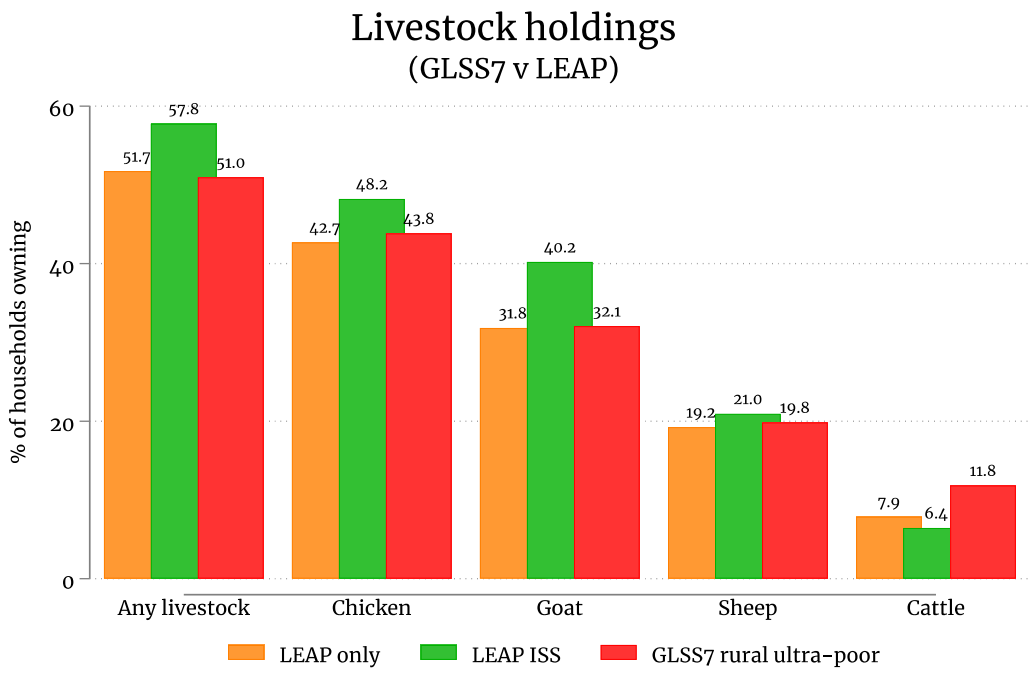
Table 33: Time use, by gender

Indicator	Male	Female	p-value
	(1)	(2)	(3)
Hours spent on domestic chores, last 24 hours			
Collecting water	0.03	0.14	0.000
Collecting firewood or other fuel	0.04	0.19	0.000
Taking care of children, cooking, or cleaning	0.21	1.54	0.000
N	5,359	6,249	
Days spent in the current rainy season on agricultural activities, last 30 days			
Land preparation or planting	3.96	2.51	0.000
Weeding, fertilizing or other non-harvest work	4.92	2.59	0.000
N	5,364	6,338	
Hours spent on other work activities, last 7 days			
Run or help in non-agricultural business	1.07	2.00	0.000
Livestock-related activities	0.39	0.09	0.000
Collecting nuts, fruits, honey, other food	0.16	0.29	0.079
Casual labour	0.43	0.29	0.185
Wage, salary, payment in kind labour	0.27	0.28	0.951
N	**5,323**	**6,303**	

9.2 Productive livelihood

As reported above just over half of the sample are engaged in livestock rearing. As shown in Figure 26, Livestock ownership in our sample is comparable to that of the rest of ultra-poor households in rural Ghana. The GLSS7 data shows that about 51 percent of ultra-poor households in rural Ghana reported owning at least one livestock. In both GLSS7 rural ultra-poor sample and our sample, most households reported owning chicken (43 percent of LEAP only, 48 percent of LEAP ISS, and 44 percent of GLSS7 rural ultra-poor), followed by goats (32 percent of LEAP only, 40 percent of LEAP ISS, and 32 percent of GLSS7 rural ultra-poor), and sheep (19 percent of LEAP only, 21 percent of LEAP ISS, and 20 percent of GLSS7 rural ultra-poor). Very few households reported owning cattle (8 percent of LEAP only, 6 percent of LEAP ISS, and 12 percent of GLSS7 rural ultra-poor).

Figure 26: Livestock holdings



Overall, livestock ownership is equivalent between LEAP ISS and LEAP only households. Only one out of nine indicators in Table 34 are statistically significant. LEAP ISS households own about half a goat more than LEAP only households. *Larger differences are observed between male- and female-headed households, where male-headed households have significantly more livestock holdings overall (72 versus 48 percent)*, and also hold more of each type of the most predominant types of livestock (goat, chickens, sheep and guinea fowl).

Table 34: Households' livestock ownership, last 12 months

Indicator	LEAP ISS	LEAP only	p-value
Own any livestock, farm animals, or poultry	0.58	0.52	0.204
Number of draught animals owned	0.02	0.01	0.521
Number of cattle owned	0.21	0.32	0.393
Number of sheep owned	1.10	1.04	0.852
Number of goats owned	2.36	1.58	0.028
Number of pigs owned	0.06	0.02	0.133
Number of chickens owned	5.72	5.33	0.720
Number of guinea fowl owned	1.91	1.70	0.731
Number of ducks owned	0.04	0.06	0.530
N	**1,281**	**1,226**	

Table 35: Households' livestock ownership, last 12 months, by gender

Indicator	Male	Female	p-value
	(1)	(2)	(3)
Own any livestock, farm animals, or poultry	0.72	0.48	0.000
Number of draught animals owned	0.03	0.01	0.152
Number of cattle owned	0.53	0.12	0.001
Number of sheep owned	1.73	0.75	0.000
Number of goats owned	3.07	1.53	0.000
Number of pigs owned	0.08	0.03	0.058
Number of rabbits owned	0.00	0.00	
Number of chickens owned	8.43	4.17	0.000
Number of guinea fowl owned	3.18	1.18	0.000
Number of ducks owned	0.09	0.03	0.131
N	**730**	**1,776**	

9.3 Debt and access to credit

Table 36 reports mean values of households' debt and access to credit by LEAP+ISS status. About 40 percent of households holds an outstanding debt and 71 percent have access to credit (if they need it). The total outstanding debt currently held by LEAP households is GH280, which represent about two percent of total expenditure of the household. Overall, the figures are much higher among LEAP only households relative to LEAP ISS households. However, across all seven indicators reported in Table 36, only one (likelihood of have any outstanding debt) is statistically significant.

Table 36: Households' debt and access to credit, last 12 months

Indicator	LEAP ISS	LEAP only	p-value
Number of loans	0.45	0.50	0.332
Any outstanding debt	0.38	0.46	0.077
Total amount borrowed	237.38	451.24	0.042
Total amount outstanding	209.16	356.02	0.092
Purchased food/goods on credit	0.19	0.16	0.612
Could purchase on credit	0.55	0.56	0.921
Can access credit	0.69	0.74	0.266
N	**1,284**	**1,231**	

Turning to sex differences in credit and debt, we see that male-headed (MHH) and female-headed (FHH) households are equally likely to take on debt, *but the amounts outstanding are larger*

among MHHs. FHHs are more likely to have purchased food on credit, and seem more able to access credit when they need it.

Table 37: Households' debts and access to credit, last 12 months, by gender

Indicator	Male	Female	p-value
	(1)	(2)	(3)
Number of loans	0.48	0.47	0.703
Any outstanding debt	0.43	0.41	0.503
Total amount borrowed	398.39	291.78	0.057
Total amount outstanding	334.95	239.32	0.018
Purchased food/goods on credit	0.10	0.21	0.000
Could purchase on credit	0.48	0.59	0.004
Can access credit	0.67	0.73	0.026
N	**735**	**1,779**	

Households rely on informal networks to obtain credit. The most important source of credit for these households is relatives, friends, and neighbours (20 percent), followed by susu scheme (14 percent). About 23 percent of LEAP ISS and 22 percent of LEAP only households reported obtaining loans from relatives, friends, or neighbors. Whereas for formal sources of loans, less than 2 percent of households reported obtaining loans from banks (1 percent of LEAP ISS and 2 percent of LEAP only). Overall, sources of loans are statically equivalent between LEAP ISS and LEAP only households.

Table 38: Source of the loan, last 12 months

Indicator	LEAP ISS	LEAP only	p-value
Bank, state or private	0.01	0.02	0.198
Coop., gov't agency, NGO	0.01	0.01	0.544
Money Lender	0.01	0.02	0.269
Susu scheme	0.15	0.12	0.588
Trader, farmer	0.03	0.10	0.058
Relatives, friends, or neighbours	0.23	0.22	0.860
Other	0.02	0.02	0.870
N	**1,284**	**1,231**	

9.4 Expenditure on agricultural inputs

Table 39 shows mean values of expenditures on agricultural inputs in the current agricultural season by LEAP+ISS status. Overall, expenditures are balanced between LEAP ISS and LEAP only households. Out of the 14 indicators reported in Table 39, only one (total expenditure on

equipment and tools) is statistically significant, p-value is 0.09. Average spending is highest for fertilizer though just 41 percent of households engage in this spending, while the most common spending item is pesticide, with 56 percent of the sample engaged in any spending on this item.

Table 39: Expenditures on agricultural inputs, current agricultural season

Indicator	LEAP ISS	LEAP only	p-value
Seeds			
Any expenditure	0.42	0.44	0.839
Total expenditure	59.33	68.28	0.605
Equipment or tools			
Any expenditure	0.42	0.49	0.157
Total expenditure	35.70	53.21	0.090
Hired labor for production			
Any expenditure	0.30	0.36	0.493
Total expenditure	66.37	101.23	0.267
Fertilizer or manure			
Any expenditure	0.40	0.42	0.842
Total expenditure	163.66	223.15	0.258
Bags, container, strings, or packaging			
Any expenditure	0.06	0.04	0.319
Total expenditure	1.35	0.71	0.246
Pesticides			
Any expenditure	0.12	0.16	0.334
Total expenditure	10.39	13.31	0.455
Weedicides and herbicides			
Any expenditure	0.52	0.59	0.316
Total expenditure	71.33	113.84	0.119
N	**1,279**	**1,212**	

9.5 Non-farm enterprises

Table 40 reports mean values of non-farm enterprises (NFE) activities separately for LEAP ISS and LEAP only households. Overall, NFE activities are balanced between LEAP ISS and LEAP only households. Out of the 14 indicators reported in Table 40, only one indicator (number of NFE that operated for 12 months) is statistically significantly different between LEAP ISS and LEAP only households. *NFEs tend to be operated by women, and average revenue among female-run NFEs is three times higher than for those operated by males, and profit twice as high.*

Table 40: Households' engagement in non-farm enterprises (NFE)

Indicator	LEAP ISS	LEAP only	p-value
Operate any NFE	0.30	0.35	0.261
Number of non-farm enterprises	0.35	0.40	0.366
Male-run NFE	0.07	0.09	0.279
Female-run NFE	0.28	0.31	0.451
Number of NFE that operated for 1-4 months in the last year	0.04	0.04	0.770
Number of NFE that operated for 5-8 months in the last year	0.07	0.04	0.153
Number of NFE that operated for 9-11 months in the last year	0.03	0.04	0.388
Number of NFE that operated for 12 months in the last year	0.21	0.28	0.091
Total NFE revenue in the average month	217.88	249.93	0.519
Total male-run NFE revenue in the average month	51.72	64.02	0.524
Total female-run NFE revenue in the average month	162.37	166.12	0.926
Total NFE profit in the average month	79.11	86.63	0.707
Total male-run NFE profit in the average month	22.96	24.77	0.828
Total female-run NFE profit in the average month	51.65	53.69	0.890
N	**1,276**	**1,230**	

10. EDUCATION

Figure 27 below shows lowest smoothed values of school enrolment by age separately for the LEAP only (orange line) and LEAP ISS (green line) households. School enrolment has an inverted U-shaped relationship with age and peaks around age of 11 and begins to decline after that. Overall enrolment is higher among LEAP only households than among LEAP ISS households. However, this difference in enrolment rates between LEAP only and LEAP ISS households is not statistically significant.

Figure 27: School enrolment by treatment status

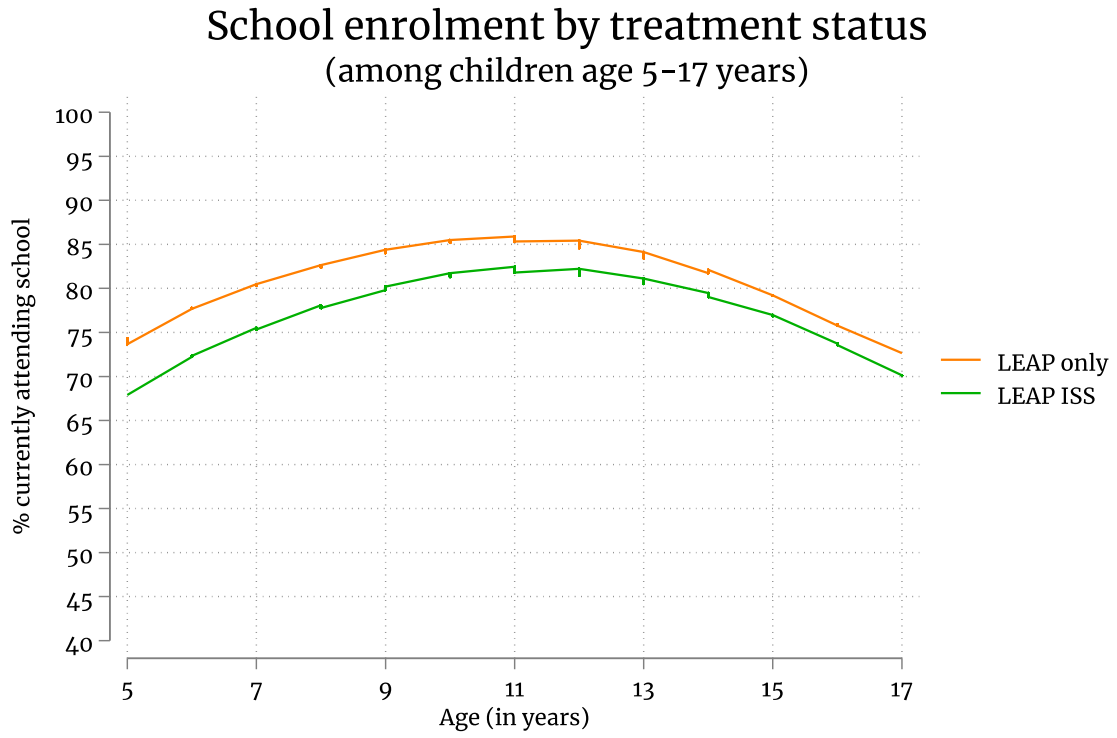


Figure 28 depicts school enrolment by age separately for boys (blue line) and girls (maroon line). While girls tend to have higher enrollment than boys around ages 7-9, their drop-out rates start earlier, around age 10, compared to boys whose dropout rates starts at age 11 or 12. However, the drop-out rate for boys overtake that of girls by age 15, so that after age 15 girls are more likely to be enrolled in school than boys.

Figure 28: School enrollment by sex

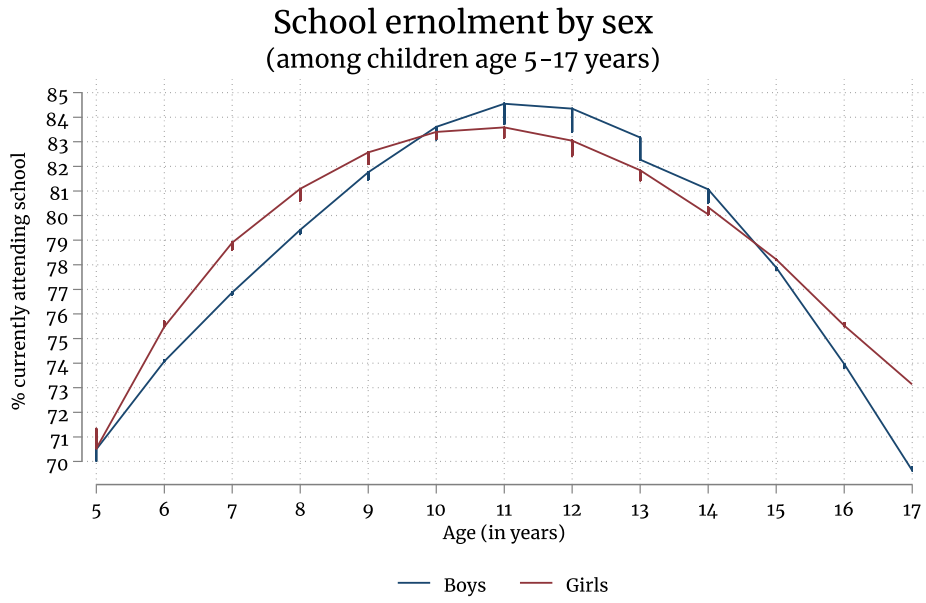


Table 41 breaks down school enrolment and education attainment of LEAP ISS and LEAP only households by age and sex—none of the enrollment rates are statistically different between the two groups. Table 41 shows that a large proportion of adults in LEAP households have never attended school, 43 and 62 percent of women and men.

Table 41: Enrollment and educational attainment

Indicator	LEAP ISS	LEAP only	p-value
School-enrolment-girls 5-17 years	0.75	0.74	0.892
N	1,416	1,286	
School-enrolment-girls 5-12 years	0.75	0.76	0.938
N	900	819	
School-enrolment-girls 13-17 years	0.75	0.70	0.557
N	516	467	
School-enrolment-boys 5-17 years	0.74	0.75	0.907
N	1,272	1,112	
School-enrolment-boys 5-12 years	0.73	0.77	0.711
N	798	668	
School-enrolment-boys 13-17 years	0.76	0.72	0.590
N	474	444	

Female 18 years and older			
Never attended school	0.45	0.41	0.515
Attended primary school	0.10	0.13	0.221
Attended secondary school and above	0.39	0.40	0.793
N	1,562	1,326	
Males 18 years and older			
Never attended school	0.61	0.63	0.690
Attended primary school	0.09	0.06	0.233
Attended secondary school and above	0.25	0.27	0.792
N	**2,181**	**1,947**	

11. HEALTH AND WELL-BEING OF HOUSEHOLD MEMBERS AND MAIN RESPONDENT

The health and well-being of the household and its members is captured through four main sections of the household questionnaire. The *health module* captures information on recent morbidity, curative and preventive care and NHIS coverage for all members. A *young child module* is aimed at members age 0-5 years and covers specific childhood morbidities, particulars about the birth, and foods eaten in the last day. A *fertility module* captures information on child birth and anti-natal care for women age 15-49 and finally, a *main respondent module* asks a series of questions about the main respondent's health and well-being, including subjective well-being (reported in Section 10), and use of government services (reported in Section 7).

11.1 Health and Access to Insurance

This section presents findings related to health and access to health insurance from the health section (Table 42), focusing on members aged five and older since we have a special young child focused health module. A comparable 21-25 percent of the sample experienced illness or injury

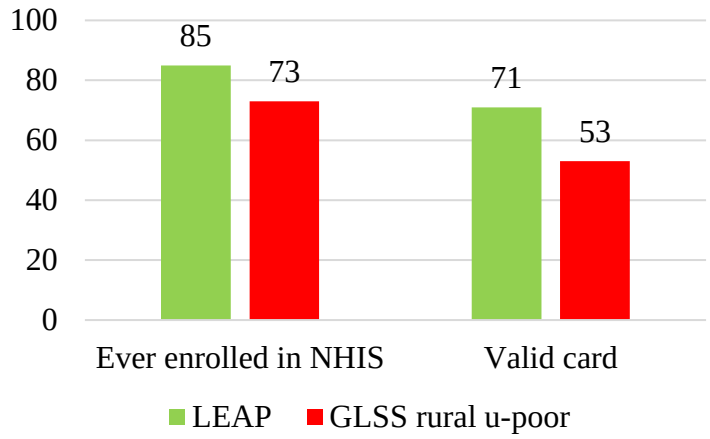
Table 42: Health indicators of household members, five years and older

Indicator	LEAP+ISS	LEAP	p-value
Illness or injury in last 2 weeks	0.25	0.21	0.261
Sought care in last 2 weeks	0.59	0.64	0.290
Sought care: doctor/nurse/medical assistant	0.53	0.50	0.643
Sought care: pharmacist/drug vendor	0.05	0.13	0.094
Sought care: traditional/spiritualist healer	0.01	0.02	0.474
Did not seek care for illness	0.41	0.36	0.290
Spending on medical consultations last 2 weeks	14.91	13.89	0.720
Spending on medical supplies last 2 weeks	7.08	5.52	0.139
Total medical spending last 2weeks	21.99	19.41	0.453
NHIS: Ever been enrolled	0.84	0.85	0.924
NHIS: Holds valid card	0.71	0.71	0.910
Disabled	0.05	0.04	0.102
N	**7,026**	**6,214**	

in the last 2 weeks of the survey. Around 60 percent of the sample sought care for their illness, mainly from doctors, nurses or medical assistants (52 percent), and the amount spent on consultations in the last two weeks was GH 14. A significantly higher share of the LEAP only

households sought care from a pharmacist or drug vendor, relative to LEAP+ISS households. Disability rates are similar, representing 4-5 percent of the sample.

Figure 29: NHIS coverage

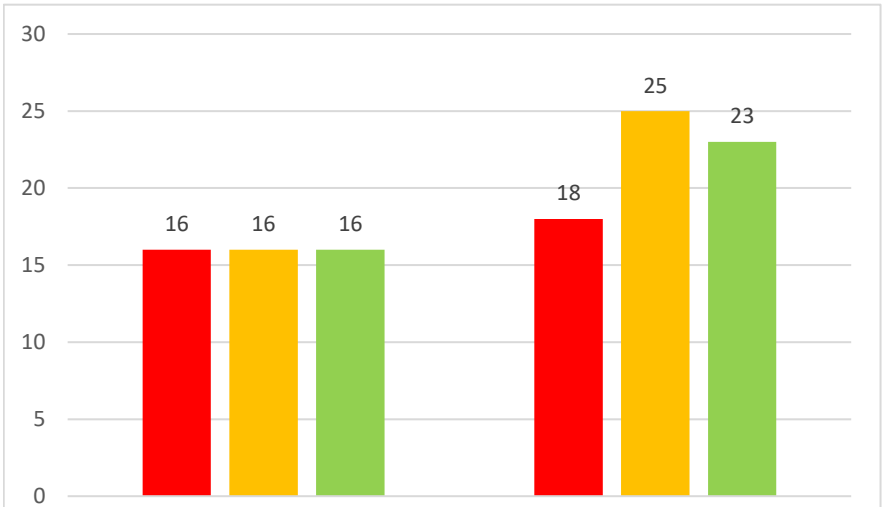


LEAP+ISS and LEAP only beneficiaries are all eligible for enrollment in the National Health Insurance Scheme (NHIS). However, the survey finds less than full enrollment, in line with previous findings. Only 84-85 percent of the sample have ever been enrolled, and only 71 percent hold a valid NHIS card. This is an increase from the GLSS7 rural ultra-poor sample where only 73 were ever enrolled and just 53 percent held a valid card (Figure 29), indicating that LEAP is doing a better job of getting beneficiaries into the program.

11.2 Young child health and nutrition

This section presents baseline findings on child health and nutrition. The survey asks eligible women about health indicators and care for illness for each child under age 5. We asked about the three most common childhood morbidities and report the incidence in the last two weeks in Figure 30.

Figure 30: Childhood morbidity in last 2 weeks



The baseline data indicates that 73 percent of eligible women have taken their child to a health facility in the last 12 months (for any reason)—Table 43. Care-seeking behaviors are similar and considerably high across all households. The exception is whether women have sought care

for a child's coughing in the last two weeks before the survey (91 percent in LEAP+ISS and 97

Table 43: Child health and care for illness

Indicator	LEAP+ISS	LEAP	p-value
child taken to a health facility in last 12 months	0.73	0.73	0.974
N	595	541	
sought care for diarrhea last 2 wks	0.97	0.99	0.468
N	95	85	
sought care for cough last 2 wks	0.91	0.97	0.022
N	152	88	
sought care for fever last 2 wks	0.96	0.95	0.707
N	135	99	
sought care for any illness last 2 wks	0.38	0.29	0.106
N	595	541	
child slept under mosquito net last night	0.70	0.79	0.139
N	**595**	**541**	

percent on LEAP only households). The share of children sleeping under a mosquito net is between 70-79 percent and is statistically balanced across the two samples.

Table 44 presents baseline findings on vaccination coverage for children ages 12-23 months. The survey asks whether children have completed the routine immunization schedule for BCG, Polio, Penta, measles and yellow fever. The baseline results show slightly less balance for vaccines that coincide with a second or third dosage. This is true for the third dose of Polio (Polio 3) and the second and third doses of Penta (Penta 2 and Penta 3) where the rate of completing those vaccinations is slightly higher in LEAP only households. Nevertheless, the rate of fully vaccinated children is comparable across the sample, with 84-85 percent of children fully vaccinated before they reach age of five (5) years.

We measure infant and young child feeding (IYCF) through a dozen different food items that the child ate in the last day. The WHO recommends complementing breastfeeding with solid or semi-solid foods after six months. The survey asks about complementary food intake and dietary diversity among children ages 6-23 months. Dietary intake is measured by 7 food groups: 1) grains, 2) vegetables and greens, fruits, 3) meat, eggs, and fish, 4) beans, 5) milk and cheeses, 6) sugars, oils and fat. The rate of children consuming more than 4 food groups (excl. sugars) is very low at 9-14 percent of the sample indicating that diet diversity is a potential issue in this population. Reported consumption of iron-rich foods is higher at about 52-59 percent of the sample. Over 70 percent of children have received Vitamin A supplements, and a much smaller share have received micronutrient powders (10-14 percent).

Table 44: Vaccination coverage

Indicator	LEAP+ISS	LEAP	p-value
BCG	0.97	0.97	0.844
Polio 0	0.89	0.87	0.785
Polio 1	0.96	0.97	0.609
Polio 2	0.93	0.96	0.114
Polio 3	**0.90**	**0.95**	**0.024**
Penta 1	0.94	0.97	0.226
Penta 2	**0.92**	**0.96**	**0.030**
Penta 3	**0.87**	**0.93**	**0.021**
Measles	0.85	0.89	0.167
Yellow fever	0.85	0.88	0.273
N	595	541	
Fully vaccinated, age>=12 months and age<59 months	0.85	0.84	0.851
N	**491**	**457**	

Table 45: Child feeding

Indicator	LEAP+ISS	LEAP	p-value
6-23 months: 4+ food groups, excl. sugars	0.09	0.14	0.297
6-23 months: consumption of iron rich food	0.52	0.59	0.514
Received Vitamin A	0.77	0.74	0.756
Received Micronutrient powder	0.14	0.10	0.406
N	**174**	**159**	

The survey asks about the process of obtaining of a birth certificate and solicits reasons for not registering where a birth certificate was not obtained. Over 70 percent of births are registered at the time of the survey, and around 40 percent of the time, a birth certificate was presented during the interview. During the survey, 38 percent of LEAP only households did not present proof a birth certificate relative to 29 percent of LEAP+ISS households. The bottom panel of Table 46 shows the main reasons for not registering birth. The primary constraint for not registering is reported to be high cost. Having to travel too far, a cost on time, is also reported and is statistically significantly higher for LEAP+ISS households.

Table 46: Birth registration

Indicator	LEAP+ISS	LEAP	p-value
Birth registered (with or without certificate)	0.71	0.79	0.251
Among children whose birth was registered:			
birth certificate seen	0.39	0.40	0.877
birth certificate not seen	0.29	0.38	0.357
birth registered with authorities only - no certificate	0.04	0.01	0.173
N	595	541	
birth registered within one year of birth	0.99	0.97	0.341
N	415	377	
Children whose birth was not registered	180	164	
Reasons for not registering birth:			
cost too much	0.10	0.10	0.982
must travel too far	0.03	0.01	0.069
did not know it should be registered	0.03	0.05	0.582
did not want to pay fine	0.01	0.01	0.512
did not find it important	0.01	0.01	0.814
do not know where to register	0.04	0.02	0.297
N	**595**	**541**	

The survey asks about antenatal care (ANC), delivery care and birthweight (Table 47). Overall, a large percentage of women received ANC and delivery assistance from a skilled provider (doctor, midwife, nurse or community health worker). Further, for 5 to 10 percent of births, the baby's size at birth is recorded as small. Newborn births reported as 'very small' indicate a high risk of mortality and constitute only 3 percent of the sample.

Table 47: Delivery care

Indicator	LEAP+ISS	LEAP	p-value
ANC from skilled provider: delivery with assistance from doctor, midwife, nurse, CHW	0.80	0.70	0.245
Delivery assistance from skilled provider: delivery in health facility: hospital, health facility, village health post	0.80	0.71	0.312
N	595	541	
size at birth small	0.05	0.10	0.091
size at birth very small	0.03	0.03	0.593
N	**593**	**539**	

11.3 Main Respondent well-being

This section presents baseline results for self-reported health, measures of cognitive and emotional well-being of the main respondent in the survey, typically the LEAP beneficiary. The survey asks the main respondent whether they have any savings. The results indicate that about a third of the sample has financial savings, which indicates future-oriented behavior. The amount saved last month ranges from around GH 130-200. Most respondents report feeling that life will be better in the future (1 year, 3 years, 5 years). Across all households, the responses are slightly lower for the longest horizon (5 years) but remain well above two-thirds of the sample. Conversely, around 50 percent of the sample report feeling anxiety and stress (Table 48). The result is based on scoring over 30 on the Cohen stress scale, which ranges from 10-50 (higher is worse).

Table 48: Health and well-being of main respondent

Indicator	LEAP+ISS	LEAP	p-value
main respondent physical health rating	0.57	0.68	0.001
main respondent health compared to 1 year ago	0.69	0.70	0.781
daily living scale; higher is worse	9.34	9.10	0.350
disability scale; higher is worse	4.65	4.46	0.085
main respondent is currently saving	0.34	0.31	0.533
N	1,284	1,231	
main respondent amount saved last month	127.75	204.70	0.167
N	372	300	
Life will be better in 1yr	0.80	0.81	0.765
Life will be better in 3yr	0.81	0.82	0.658
Life will be better in 5yr	0.77	0.80	0.554
=1 if life better in any period	0.86	0.86	0.875
N	1,284	1,231	
main respondent social support	29.95	30.23	0.812
Indicator	**LEAP+ISS**	**LEAP**	**p-value**
instrumental support; higher is better	15.54	15.66	0.826
emotional support; higher is better	14.41	14.57	0.805
N	1,284	1,231	
Cohen stress scale >=30; higher is worse	0.56	0.51	0.410
agency: higher is better	22.16	22.06	0.817
empowerment; =1 if in top quartile	0.21	0.16	0.480
cognitive social capital: higher is better	11.38	11.47	0.827
quality of life scale: higher is better	16.14	15.70	0.100
grit: lower is better	9.49	9.50	0.978
N	1,284	1,231	

Using a modified Medical Outcomes Study Social Support Survey (MOSS), the survey solicits responses to a set of questions related to finding companionship and other types of

support in times of need. Only 30 percent of the sample reports having good social support, half of that is emotional (shared understanding) and the other half is instrumental (help with doctor visits, meals, and chores).

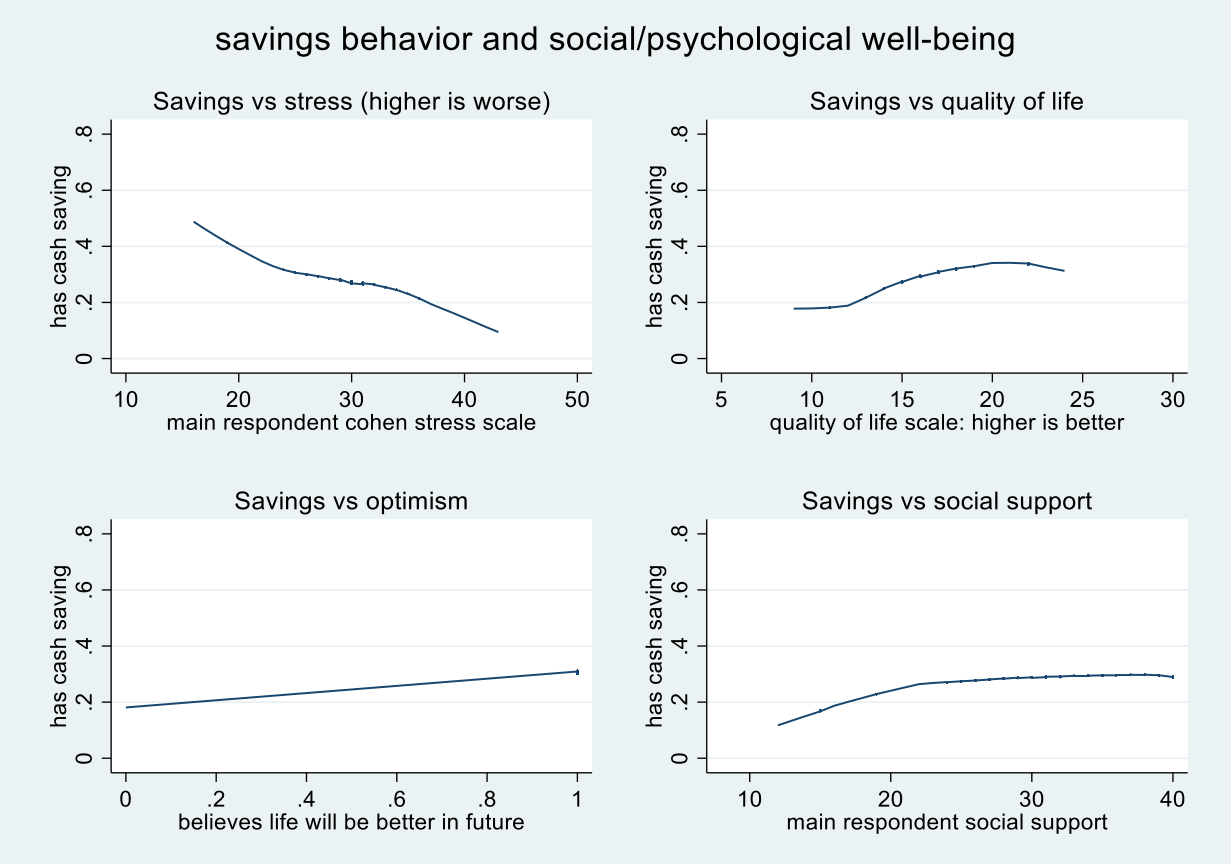
Cognitive social capital is measured using 3 responses to questions about the cohesiveness of the community. The maximum (best) score is 15, and the average responses are 11. Agency is self-reported on a scale of 1-5 across 7 questions, resulting in a maximum (best) score of 35. The sample score is 22 on average.

We report the health and well-being indicators by sex of respondent in Table 49. *There is a clear pattern where men report better health, higher optimism, greater social support, lower stress and higher quality of life*. Here is it important to understand that men and women may report on different scales, so direct comparisons may not necessarily be meaningful. However, changes in these indicators would be comparable.

Table 49: Health and well-being of main respondent, by gender

Indicator	Male	Female	p-value
	(1)	(2)	(3)
main respondent physical health rating	0.65	0.60	0.128
main respondent health compared to 1 year ago	0.69	0.69	0.823
daily living scale; higher is worse	8.85	9.43	0.018
disability scale; higher is worse	4.57	4.57	0.966
main respondent is currently saving	0.31	0.34	0.123
main respondent amount saved last month	243.42	119.64	0.036
N	211	461	
Life will be better in 1yr	0.83	0.79	0.247
Life will be better in 3yr	0.86	0.79	0.008
Life will be better in 5yr	0.83	0.76	0.001
=1 if life better in any period	0.89	0.84	0.063
main respondent social support	31.07	29.58	0.010
instrumental support; higher is better	16.03	15.38	0.024
emotional support; higher is better	15.05	14.20	0.005
Cohen stress scale >=30; higher is worse stress	0.51	0.55	0.225
agency: higher is better	23.13	21.63	0.000
Empowerment: =1 if in top quartile	0.19	0.19	0.667
cognitive social capital: higher is better	11.61	11.32	0.071
quality of life scale: higher is better	16.61	15.64	0.000
grit: lower is better	9.18	9.65	0.003
N	**735**	**1,779**	

Figure 31: Relationships between saving and psychological/social states



A relatively new line of research suggests that an individual's psychological well-being can affect decision-making in a way that perpetuates the cycle of poverty (Molotsky 2020). Individuals who feel less optimistic about the future, are anxious or experiencing chronic stress may not focus on the future, and end up displaying myopic behavior, thinking only of the present and not investing or engaging in other activities that yield higher returns in the future. Figure 31 illustrates this idea using data on the main respondent. The four graphs show the relationship between holding cash savings, a future oriented behavior, with stress (top left), self-assessed quality of life (top right), optimism (bottom left) and experiencing social support (bottom right). All four of these indicators display a positive relationship with savings, in that when the individual scores better on the indicator, the probability of saving also increases (note that the stress scale is reverse coded, so higher values mean more stress—a bad outcome—hence the slope of the line is negative). These results from LEAP households suggest that there may be some merit to the idea that psychological states can affect decisions that can have consequences in the future.

11.4 Domestic Violence

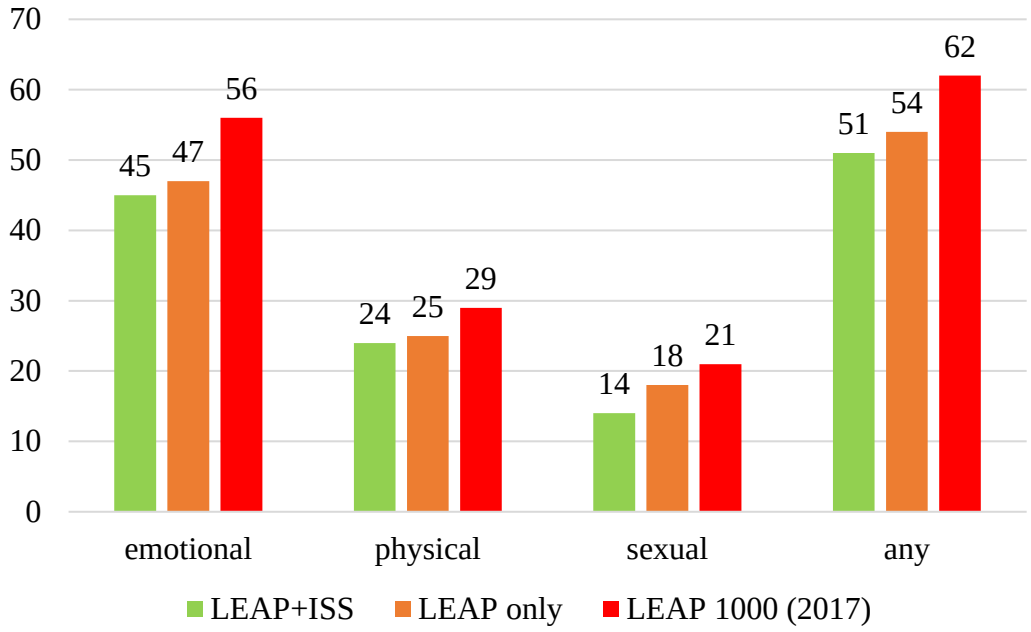
The survey asks women to report on condition of privacy any experience of emotional, physical and sexual violence from an intimate partner (IPV) over their lifetime and in the last 12 months—here we report the lifetime statistics as they are similar to the last 12-month reports. Figure 32 shows that reports of intimate partner violence are lower among LEAP+ISS relative to LEAP only and LEAP 1000 beneficiaries.[3] Across all samples, emotional IPV is reported more than twice the reports of physical and sexual IPV. Overall, 51 percent of women in LEAP+ISS households experience any IPV during their lifetime, a reduction from 54 percent in LEAP only households, and 62 percent in LEAP 1000. In both LEAP+ISS and LEAP only households, women describe their partners as having comparable levels of alcohol consumption. The difference in partner drinking (ever, often, or sometimes/often), is not statistically indistinguishable from zero. The key difference in the current LEAP sample and LEAP 1000 and is that the main respondent in LEAP 1000 is significantly younger (about half the age) that main respondents in the current LEAP sample, which might explain the higher experience of IPV.

Table 50: Intimate partner violence

Indicator	LEAP+ISS	LEAP	p-value
Experienced controlling behaviors-12 months	0.63	0.63	0.992
Experienced emotional IPV-lifetime	0.45	0.47	0.654
Experienced emotional IPV-12mo	0.41	0.40	0.877
Experienced physical IPV-lifetime	0.25	0.24	0.808
Experienced physical IPV-12mo	0.24	0.19	0.285
Experienced sexual IPV-lifetime	0.14	0.18	0.502
Experienced sexual IPV-12mo	0.14	0.15	0.823
Experienced emotional/physical/sexual IPV-lifetime	0.51	0.54	0.510
Experienced emotional/physical/sexual IPV-12 months	0.47	0.47	0.928
Current/last partner ever drinks	0.25	0.17	0.149
Partner often drunk	0.07	0.04	0.113
Partner sometimes/often drunk	0.20	0.15	0.257
N	**672**	**574**	

[3] To read the reports on the 2012 LEAP and 2017 LEAP1000 reports see here: https://transfer.cpc.unc.edu/countries/ghana/#reports . Data on intimate partner violence was collected in the LEAP 1000 study, which makes it a useful comparison for the current study.

Figure 32: Intimate partner violence in LEAP-ISS and LEAP1000

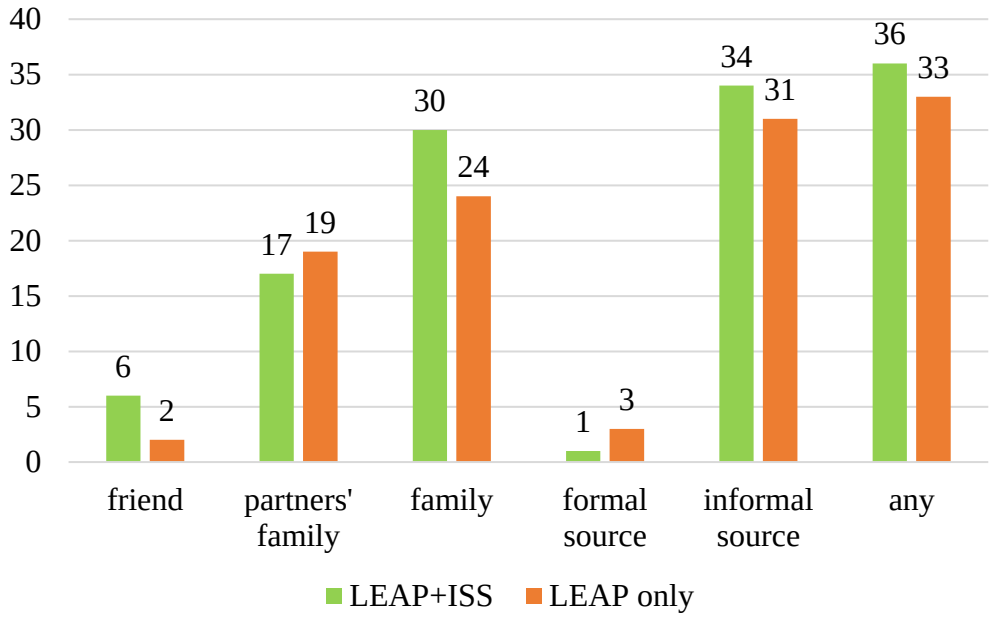


Women experiencing any IPV report seeking help mostly from their own family and their partners' family (Table 51; Figure 33). Seeking help from a friend or neighbor is less common. Reports of formal sources of support are almost negligible relative to informal sources that women in both groups seek for help. Overall, around 36 percent of the LEAP+ISS sample has sought support for IPV, relative to only 31 percent of the LEAP only sample.

Table 51: Sought help with IPV

Indicator	LEAP+ISS	LEAP	p-value
Sought help/told someone about IPV	0.36	0.33	0.761
Told/sought help for IPV from friend	0.06	0.02	0.017
Told/sought help for IPV from family	0.30	0.24	0.527
Told/sought help for IPV from partner's family	0.17	0.19	0.789
Told/sought help for IPV from neighbor	0.00	0.01	0.363
Told/sought help for IPV from formal source	0.01	0.03	0.285
Told/sought help for IPV from informal source	0.34	0.31	0.707
N	**190**	**179**	

Figure 33: Sought help with IPV



12. SHOCKS AND COPING MECHANISMS

12.1 Shocks and coping mechanisms

This section presents balance test on negative shocks faced and coping mechanisms used by households in the last 12 months. Overall, the distributions of negative shocks and coping mechanisms are statistically equivalent between LEAP only and LEAP ISS households. *Figure 34* shows percentage of households affected negatively by shocks. Inflation (unusually high prices for food and transportation) is the most prevalent shock in our sample. About 26 percent and 34 percent of LEAP only and LEAP ISS households, respectively, reported being negatively affected by inflation in the last 12 months. Drought or irregular rain is the second most prevalent negative shock among households and appears to affect LEAP only households more than LEAP ISS households. 28 percent of LEAP only households were affected by drought, whereas only 18 percent of LEAP ISS households were affected by drought. Table 52 shows that the differences in prevalence of drought between LEAP only and LEAP ISS households is statistically different from zero (p-value is 0.055).

Figure 34: Percentage of households affected negatively by shocks

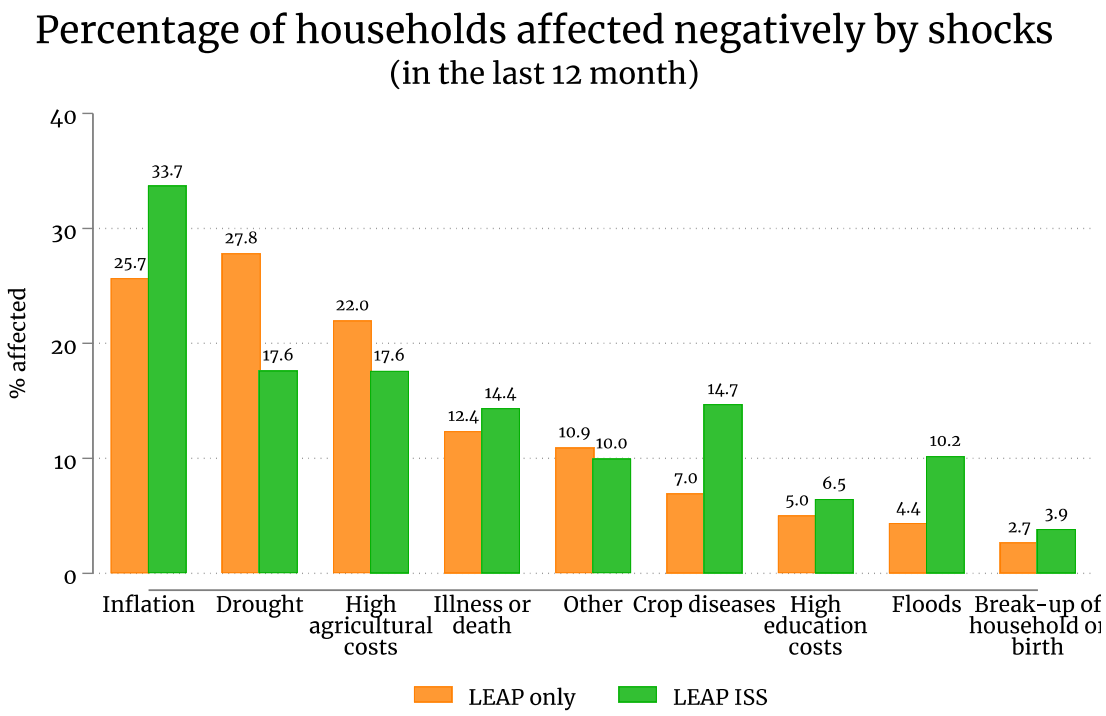


Table 52: Whether affected negatively by shocks, in the last 12 months

Indicator	LEAP+ISS	LEAP	p-value
Drought/irregular rains	0.18	0.28	0.055
Floods/Landslides	0.10	0.04	0.106
Unusually high level of crop/livestock pests or disease	0.15	0.07	0.008
Unusually high prices for food and transport	0.34	0.26	0.119
High education costs	0.06	0.05	0.565
Unusually high costs of agricultural inputs or low prices of agricultural output	0.18	0.22	0.224
Serious illness, Covid-19 infection, or death of household income earner	0.14	0.12	0.359
Birth in the household or break-up of the household	0.04	0.03	0.251
Other (theft, conflict, or destruction of house, crops, or harvest)	0.10	0.11	0.715
N	**1,284**	**1,231**	

Figure 35 depicts households' most important coping strategies for the negative shocks faced in the last 12 months. About 28 percent of all households (27 percent and 28 percent of LEAP only and LEAP ISS, respectively) did not do anything to address shocks. 19 percent of household relied on friends and relatives, and 15 percent tapped into their savings. Overall, the most important coping strategies are balanced between LEAP ISS and LEAP only households (Table 53).

Figure 35: Whether affected negatively by shocks, in the last 12 months

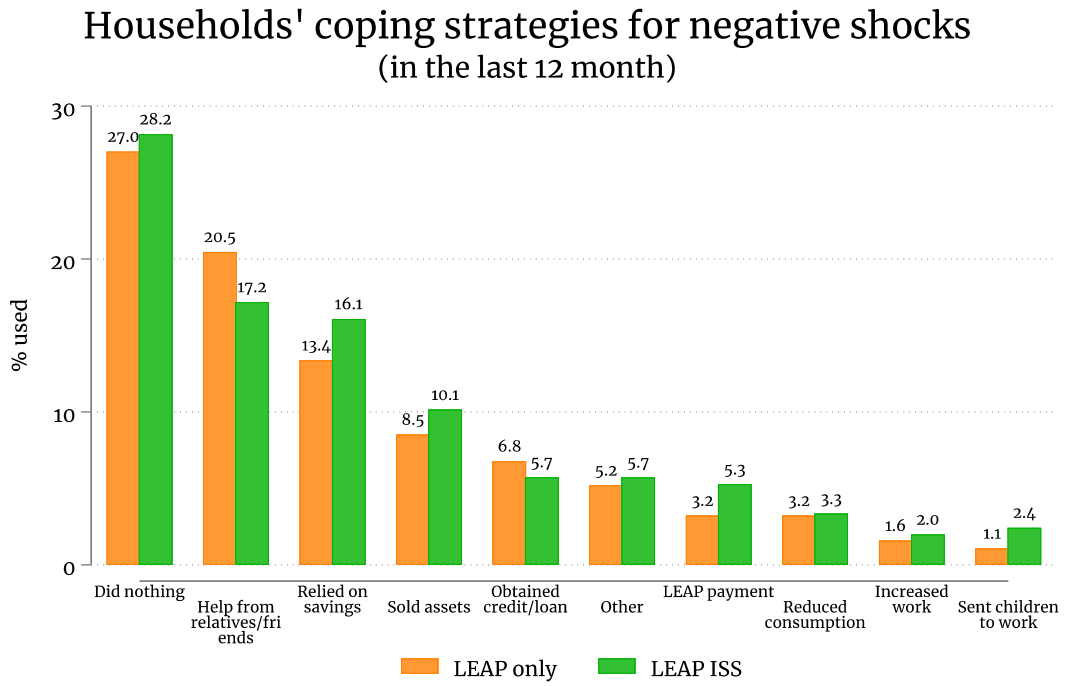


Table 53: Main coping strategy for negative shocks

Indicator	LEAP+ISS	LEAP	p-value
Relied on own savings	0.16	0.13	0.450
Received unconditional help from relatives/friends	0.17	0.20	0.594
Obtained credit/took loan	0.06	0.07	0.564
LEAP payment	0.05	0.03	0.164
Did not do anything	0.28	0.27	0.847
Increase employment, fishing, or farming	0.02	0.02	0.607
Sold assets	0.10	0.09	0.631
Child labor	0.02	0.01	0.090
Reduce expenditure on health or education, or change eating patterns	0.03	0.03	0.928
Other (help from government, NGO/religious institution, migrated, prayers)	0.06	0.05	0.818
N	**1,284**	**1,231**	

12.2. Covid-19 effects

The survey instrument included a short set of questions on whether households had changed their behavior in response to the Covid-19 pandemic, and whether the pandemic had affected the financial support they previously received from relatives or friends. As reported in Table 54, only

8-11 percent reported canceling or changing their travel plans, a quarter of LEAP+ISS households reduced movements in the market, relative to a significantly lower share of LEAP only households (14 percent). Meanwhile, hand washing, and masking were relatively high across the sample, and about 37 percent of the sample were worried that they or a close family member would contract the infection. Because of the pandemic, 22-25 percent of the main respondents report a large decline in in-kind and financial support received from friends, neighbors, and other relatives.

Table 54: COVID behaviors and effects on support received

Indicator	LEAP+ISS	LEAP	p-value
	(1)	(2)	(3)
Wash hands more often than used to?	0.88	0.80	0.124
Avoid handshake or physical greeting?	0.58	0.39	0.000
Avoid large gatherings such as parties, family gatherings or religious activities?	0.37	0.31	0.135
Cancel or change travel plans?	0.11	0.08	0.338
Reduce movements to the market or shops?	0.25	0.14	0.013
Use of Nose mask/Sanitizer	0.90	0.84	0.349
Worried that you or your immediate family member might contract C19	0.40	0.34	0.372
Has the coronavirus reduced the support/help you receive from friends, neighbors?	0.25	0.23	0.788
Has the coronavirus reduced the financial support/help you receive from friends, neighbors?	0.22	0.22	0.980
N	**1,284**	**1,231**	

We explore differences in COVID responses and effects by MHHs and FHHs in Table 55. *Women respondents seem to have changed their behavior more than men, and also report larger negative impacts of the pandemic, specifically being more likely to have experienced reduced support from friends, neighbors and relatives*.

Table 55: COVID behaviors and effects on support received, by gender

Indicator	Male	Female	p-value
	(1)	(2)	(3)
Wash hands more often than used to?	0.80	0.87	0.004
Avoid handshake or physical greeting?	0.47	0.51	0.177
Avoid large gatherings such as parties, family gatherings or religious activities?	0.31	0.37	0.040
Cancel or change travel plans?	0.12	0.09	0.195
Reduce movements to the market or shops?	0.21	0.20	0.667
Use of Nose mask/Sanitizer	0.85	0.89	0.279
worried about the possibility that you or someone in your immediate family might contract C19	0.35	0.39	0.156
Has the coronavirus reduced the support/help you receive from friends, neighbors?	0.20	0.26	0.038
Has the coronavirus reduced the financial support/help you receive from friends, neighbors?	0.18	0.24	0.038
N	**735**	**1,779**	

13. QUALITATIVE DESIGN

For the qualitative component of the evaluation, we used an explanatory case study methodology as explained in Section 2. Explanatory case studies aim to provide explanations about programme impact, including positive and negative and planned and unplanned impact (USAID, 2013). Our case study approach addressed a gap in past evaluations of LEAP, which relied almost exclusively on formal data collection with only beneficiaries. Given the current focus on evaluating LEAP + ISS, engaging with both beneficiaries and implementers at distinct levels was essential in obtaining insights into the integrated intervention approach.

We used an embedded design, as we have done in the past LEAP evaluations and evaluations of cash transfer programmes in other settings, whereby we recruited participants for the qualitative sample from the quantitative sample to take full advantage of the multiple sources of information generated through the evaluation activities (MoGCSP, 2018; Plano Clark, 2008). In addition to data triangulation, this embedded approach offered efficiency in the sampling and identification of participants, in particular beneficiary households that had already been identified for the quantitative survey. To preserve the "objectivity" of the survey assessment, we conducted fieldwork for the case studies shortly after the completion of survey fieldwork.

The qualitative component was conducted across three regions and within each region, two districts (Table 56). This selection was based on a combination of geographic considerations together with review of ISS data, which aided us in focusing on districts where ISS processes had begun and could provide richer insights into the process than districts that are not yet involved (referred to as ISS Phase 1).

Table 56: Selected districts for LEAP qualitative impact assessment

Location	Region	District Name	District Type	ISS Phase
Northern	Northern	Kumbungu	District	1
		Tolon	District	1
Middle	Ashanti	Asokore	Municipal	1
		Afigya Kwabre	District	1
Southern	Greater Accra	Adenta	Municipal	1
		La Nkwantanang Madina	Municipal	1

Within each district, we used a combination of individual and group interviews and observations. Each district-level case included the following four data collection activities:

- Key informant interviews with district leadership
- Focus groups with frontline service providers
- In-depth interviews with beneficiaries
- Observations of social welfare and health services (varied per district)

13.1 Qualitative Training

Qualitative team training was facilitated by Dr. Raymond Aborigo (NHRC) and Dr. Akalpa J Akaligaung (independent consultant) from August 25th to 28th 2021. Other remote participants in the training included Dr. Clare Barrington (UNC) and Mrs. Christiana Gbedemah and Mr. Robert Osei-Tutu (UNICEF). The field team participants included six graduate-level research assistants (RAs) who had at least 1 year experience in conducting qualitative research and were fluent in at least one of the languages of the study regions.

The RAs were given an overview on the LEAP program and prior evaluation findings by Mr. Robert Osei-Tutu. Drs. Aborigo and Akaligaung then reviewed the evaluation aims and guidelines for conducting focus group discussions and in-depth interviews and honed the skills on interviewing/probing, community entry and seeking informed consent. Most of the training period was spent on reviewing data collection tools. The facilitators reviewed questions with the RAs and supervised translation into the various local languages – Twi, Dagbani and Ga. This often led to rewording of the questions to ease the translation process. The 4-day training ended with the facilitators taking the RAs through labelling of audio recordings, fieldnote preparation, and how to produce verbatim transcripts.

13.2 Qualitative sampling

For the qualitative component, each district was defined as a "case" and included: 3-4 key informant interviews; 1 focus group; and 8 in-depth interviews (Table 57). The proposed numbers of interviews and focus group per case were guided by the concept of thematic saturation, which is the point at which new ideas cease to emerge and relevant categories and concepts have been identified and explored (Guest et al 2020). We aimed to saturate our understanding of LEAP impact at the case level and identify initial processes related to ISS implementation.

Table 57: Summary of data collection activities per region and district

Region	District	Type of interview	Number
Northern	Tolon	KII*	4
		IDI**	8
		FGD***	1
	Kumbungu	KII	3
		IDI	8
		FGD	1
Ashanti	Asokore Mampong	KII	3
		IDI	8
		FGD	1
	Afigya Kwabre South	KII	3
		IDI	8
		FGD	1
Greater Accra	Adenta	KII	3
		IDI	8
		FGD	1
	La Nkwantanang	KII	3
		IDI	8
		FGD	1

KI: Key informant interview; **IDI: In-depth interview; ***FGD: Focus group discussion

13.3 Qualitative data collection

Two teams were formed to facilitate simultaneous data collection in across districts in each region. Each district team consisted of a lead investigator (Aborigo or Akaligaung) and 3 RAs with at least one RA who was fluent in each of the local languages. Data collection started in the Northern region on 30th August and ended the Greater Accra region on 18th September 2021. We developed semi-structured guides for each data collection activity including open-ended questions and probes to use as a starting point for conversations. Interviews were encouraged to probe further based upon participants' responses. We audio recorded all interviews and focus groups. In all three regions, the fieldwork team also observed services (CHPS compounds, social welfare offices) to obtain additional data on context and services. These observations were documented in a fieldnote template to facilitate standardization and easy retrieval of information.

13.4 Key informant interviews

Key informants included regional and district-level LEAP programme and health and social welfare leaders and managers. We elicited an overview of the landscape of health, social

protection, and child protection services at the district level as well as any specific district-level policies, programmes, and approaches that may be important to consider in the interpretation of impact and could provide lessons learned for other districts. We probed specifically on how integrated case management is functioning in the district as well as about training activities for the social welfare workforce.

13.5 Focus group discussions

Participants included district-level representatives from SWCD, NHIS, GHS, LEAP and other governmental institutions as well as NGO and private sector representatives. We probed on how linkages and referrals between LEAP and other services, opinions on how programme linkages could be strengthened, and experiences with training and capacity building. We also probed specifically on services related to maternal and child health, violence, and disability in the context of each district and region.

13.6 In-depth interviews with individual beneficiaries

In the in-depth interviews we elicited descriptions of overall impact of LEAP and experiences with the LEAP, NHIS and linkages. We also probed beyond discrete outcomes to identify if there are any examples of processes of transformation at the individual or household level that could be attributed to the programme.

13.7 Observations

During fieldwork we observed "typical days" at service delivery points, such as health facilities and NHIS offices, to determine the quality and quantity of services and supplies. We also observed the conditions and context of different partners in the ISS program.

13.8 Analysis

All audio files were transcribed verbatim and translated to English (as needed) and checked for quality. We used rapid analysis procedures included matrices and memos for the current report grounded in comprehensive reading of fieldnotes and interview transcripts as they became available and systematic thematic analysis around the key domains of the evaluation. We compared themes across districts to identify shared domains of impact and unique processes and pathways that may be contextually bound to a particular district.

14. SUMMARY OF IN-DEPTH INTERVIEWS WITH LEAP BENEFICIARIES (n=47)

14.1 Key Takeaways

LEAP impact:

- The amount of the transfer is not enough to achieve significant impact beyond survival and improved food security.
- There are very few examples of larger effects of more sustainable impact on households.
- LEAP money is most frequently used for food and children's needs (shoes, school fees etc.).
- Several participants experienced delayed payments, inconsistent amounts, and bribery.
- Participants speak of feeling happy when they get it and having less stress, but it only lasts until the money is gone.

NHIS and health services:

- Despite nearly universal enrollment in NHIS among LEAP beneficiaries, NHIS renewal continues to be varied with most households having at least some members with expired cards. Renewal varied across and within districts and regions due to proximity to renewal site and support for renewal.
- Participants consistently refer to paying for NHIS enrollment and renewal though the amounts vary.
- There are mixed opinions about the usefulness of NHIS. While some feel it increases their access to care, others feel it is less useful since it does not cover everything.
- Health care is perceived to be lower quality and take longer to receive for NHIS cardholders. To get quality healthcare, participants noted that they had to pay cash or go to a private facility.
- Malaria is the most mentioned ailment for children. High blood pressure is the most common ailment affecting adults, which requires regular visits to health facility.

Linkages to social welfare services:

- LEAP participants have had none to very minimal contact with social welfare services. Shame and lack of access are the two main barriers to engagement.
- Most salient social welfare issues include: intimate partner violence; teenage pregnancy; custody and child support.

14.2 Description of the sample

We conducted forty-seven in-depth interviews with LEAP beneficiaries. Mean age of IDI participants was 57 years. Most (71%) participants were women. Mean number of households members was 8.7 and mean number of biological children was 4.4. Just over half (54%) had ever attended school, though this was noticeably less in the Northern Region sample. Forty-four percent of participants were in monogamous unions, 21% in polygamous and 35% were widowed. Time in LEAP ranged from one year to 10 years.

14.3 LEAP Impact

Across the 3 regions, participants had been in LEAP from less than 1 year to over 10 years. Many participants could not remember exactly how long they had been in LEAP and, with assistance from the interviewer, anchored their responses around the president or political party in power when they entered the program. There were a few examples of inherited benefits when the original beneficiary had passed away or moved and another family took over the payments. In one household, both the husband and wife were LEAP beneficiaries and in some polygamous households, two co-wives were formally recognized as co-recipients and three co-wives were all separate beneficiaries. One participant indicated his community questioned why he was a recipient given his economic situation and a few mentioned jealous in the community towards those in LEAP.

Overall, impact of LEAP was described in immediate terms as enabling participants to buy more and better food; a few attributed weight gains to their improved nutrition with LEAP. The other most common use of the money was to support children, especially with shoes and other expenses related to school. Some participants, both male and female, commented on the money reducing stress and conflict in the household, using words like happiness and peace to describe their feelings when they receive the cash. One of the main reasons for these positive feelings was not having to ask others, including husbands, for money. However, it was also noted that this peace and happiness lasts only as long as the money does, and some indicated using the money

to pay off debt accrued between payments. One example was a participant who received delayed payments in a lump sum and used that money to improve his roof.

Across regions, a few participants indicated using the money to invest in a small business or livestock and agriculture. A few appeared to be "high flyers" and had been able to fundamentally improve their overall economic situation, though it is important to note that this was rare. One woman expressed that she was no longer poor since being in LEAP as she had been able to invest the money into a profitable business and participated in a community VSL. Another had invested in a fruit business and had been able to buy food and clothes as well as improve the floor of her house. Another woman had started a small shop that generated income and reduced her household's food insecurity. In contrast to these participants, many others commented that they did not participate in any community savings groups out of fear that they would not be able to make payments on time, reflecting their ongoing sense of vulnerability and social isolation.

LEAP impact was consistently identified as being limited by the size of the transfer. This was more pronounced in the Greater Accra area where nearly all participants commented on the insufficient amount.

14.4 NHIS and health services

The enrollment and renewal situation continues to reflect varied access to support and expectations of process and cost. Across the 3 regions, the majority of participants and their household members had enrolled in NHIS. Whether and how much people paid for renewal varied reflecting that there does not appear to be a consistent policy regarding how many household members can be enrolled and renewed for free. Cost also varied with some participants using the transfer money to pay for renewal while others paid nothing. Many participants indicated having paid for at least some of their household members to enroll and renew. Some participants had received support from social welfare or LEAP officers with renewal. The main impact of insurance was improving access to care. As one participant explained,

> *I use it to go to the hospital and the money I spent when I didn't have the card has reduced since I started using the NHIS card.*

Participants indicated feeling less worry and fear about seeking health services since being enrolled. Having access to the cash transfer also provided more resources for expenses not covered by NHIS (ex, transport). Participants whose cards had expired feared getting sick since they were not covered. However, there were also several comments about how NHIS used to

provide better coverage and many participants felt that the current coverage was less comprehensive than in the past,

> *Now everything has change(d). When I went for the operation, I didn't pay anything because of the insurance but is quite a long time and with the insurance now adays if you visit the hospital, you will spend some money.*

Additionally, many participants expressed frustration that not all medications and services were covered, and some felt this diminished the usefulness of insurance.

> *In the beginning we were told if you have the insurance and you go to the hospital you would be taken care of, given drugs, and everything. When I look at it that is not how it is, it is not like that. When you go it is only the folder it covers…**you would have to buy the drugs yourself**. I see that there is no benefit with it, there is no benefit with it, I hope you understand me.*

There was also a recurring theme across regions that individuals who are paying cash for health services get faster and better-quality care. One participant said that to get care you must pay something. Others described having to wait for hours to get care, while those who were paying cash appeared to be attended to more quickly. These experiences and perceptions of quality and timeliness of care were a major influence on whether participants had renewed.

Across regions, the perception of less coverage and lower quality care decreased motivation to renew as they did not feel that it was worthwhile. Other barriers to renewal were more context-specific. For example, in the Northern region, renewal had to be done in Tolon, which was a 1–2-hour trip for participants, in addition to the 1-2 hour wait for renewal. One effective strategy was to send one family member with all the cards to renew at one time, therefore minimizing the time and transport costs. Some participants in the Northern region had given their cards to an Assemblyman or other political representative and had never received the renewal while others in Ashanti had been able to renew with the help of an Assemblyman. Distance to renewal was less of a challenge in the Greater Accra region, especially in the LaNkwantanang district where community visitors came to communities to renew. In the Asokore district of Ashanti region, some participants were only a 10-minute walk to the renewal site, which greatly facilitate the process. A few participants had renewed "over the phone", though this was rare and did not yet seem to be a mainstream renewal strategy.

14.5 Linkages to social welfare services

The most prominent finding was the nearly universal absence of engagement with social welfare services among participants across all three regions. Reflecting this, a participant in Northern Region, where awareness of social welfare was the lowest said,

> *No unless you tell me. Apart from this discussion I have never heard that there is help for such cases.*

The majority of participants did not know what such services entailed or where they could be found if needed; this was again most prominent in Northern Region where communities were more isolated and far from services. Awareness and familiarity with social welfare was noticeably higher in Greater Accra where there was greater proximity.

Beyond knowledge and familiarity with services, there were mixed reactions to whether participants would seek out support from social welfare services if needed, with some expressing openness while others had reservations or a total lack of interest. A woman who had experienced intimate partner violence had reported the situation to her husband's family but said she would not report to social welfare,

> *I have reported it to the mother, but she is supporting the son. Now I won't say anything to the family. I won't pass behind my God to send him to social welfare…. If he has brought his children into this world and he doesn't want to take care of them, on the judgment day God will ask him, God will ask him. I am also praying to God to give me strength, he should put money in my hands, get a job to take care of my children for their future.*

One participant in Greater Accra had reported a case of custody concerns for one of her grandchildren to Social Welfare and she was advised to wait until the child was older. Three other participants had experience with custody concerns but did not engage with Social Welfare. The other main social welfare concern was divorce, which 4 participants described having to face but again without any involvement with social welfare. Participants turned to family and religious leaders to discuss issues and concerns with marriages. Three participants had received orientation from social welfare regarding these issues. Finally, teenage pregnancy was mentioned as a pressing social concern with mixed feelings about the role of social welfare.

Five women reported intimate partner violence perpetrated by their husbands with the greatest concentration of cases was in Northern region (n=3) with one each in Ashanti and Greater Accra. None of the women reported the violence to authorities or healthcare providers.

They believed that such issues were better to handle within the family and community setting and worried about bringing shame onto their families. Family members provided support by protecting women, caring for them and speaking to the perpetrators. One woman reflected the orientation towards turning to family as well as her lack of familiarity with social welfare officers in the following exchange,

> *P: …I myself, I am a victim of violence from my husband, as for my husband if you say something that does not go down well with him he will beat you.*
>
> *I: With whom did you talk about this situation?*
>
> *P: His father and uncles talked about the situation.*
>
> *I: Did you receive any advice or support from a social welfare officer? Tell me about the advice and support that you received.*
>
> *P: No, we do not know any social welfare officer to talk to.*

One woman threatened to report her husband, who was also using drugs and alcohol, which helped to get him to stop and they eventually divorced.

Responses were mixed regarding comfort seeking out support from Social Welfare. The main barrier to engaging was stigma and shame and the feeling that problems should be resolved in the family and community and not with outsiders. In contrast, some participants felt that it would be beneficial to receive support and orientation from social Welfare and believed more engagement could be beneficial.

15. Summary of Key Informant Interviews and Focus Group Discussions

15.1 Key Takeaways

- Impact is focused on food security and acute stress relief but not sustainable change or economic empowerment
- Impact of LEAP is perceived to be limited by the size of the transfer.
- There is good will towards integration and linkages across sectors involved in ISS.
- NGOs are also contributing to linkages across sectors
- Despite the good will, social Welfare lacks sufficient resources to facilitate linkages.
- Bureaucracy within and across sectors is another barrier to more effective coordination.

15.2 Description of the sample

We interviewed 19 key informants (KIs) in individual interviews and 33 front line workers in six focus groups (FGDs). Mean age of KIs was 34 years and just over half (53%) were male. FGD participants had a mean age of 41 and 67% were male. Education range among KIs was a bachelors through a PhD and among FGD participants diploma though masters. Participants represented SWCD, GHS, NHIA, Municipal/District Assembly, Police, GES, Disaster, NGOs and private sector. KI roles in these institutions included SW Unit Head, District Director of Health and NHIA District Manager. FGD participants were social workers, district health promotion officers, youth program officers, disaster manager, an Iman representative and a pastor. KIs had been in their current role for 8 years on average and FGD participants for 7 years.

15.3 Introduction and context

The Social Welfare and Community Development (SWCD) department operates within the district and municipal assemblies. Currently, the department covers persons with disabilities, child protection programs, and other social protection programs. It is the main agency that operates the LEAP program and is therefore integral to the implementation of the Integrated Social Services (ISS). With regards to the LEAP+ISS program, SWCD collaborates with the National Health Insurance Scheme (NHIS) on enrollment and renewal, Ghana Health Service (GHS) to educate beneficiaries to attend antenatal and other health programs, law enforcement anytime crime is perpetrated against beneficiaries, among others. SWCD also mobilizes LEAP beneficiaries for payments, sensitizes community members on social protection, facilitates

support for persons with disabilities (attend school or learn a trade), supports the vulnerable in income generation activities, and provides grants and orientation on how to use the money.

Understanding the current state of social welfare services requires consideration of the context and characteristics of each region and variation across regions. For example, in the northern region, LEAP beneficiaries are mostly natives to the region and live in patriarchal communities where women and girls have limited access to education and livelihood beyond farming. Key informants were also mostly natives who were also affected by the social welfare issues affecting their communities. They felt strongly about the importance of involving traditional leaders such as chiefs and religious leaders (pastors and Imams) in the implementation of LEAP+ISS. In contrast, in the Ashanti region, LEAP+ISS partners viewed their clients as outsiders as many were migrants to the area. In the Greater Accra region, LEAP beneficiaries were a mix of native and migrants who were characterized as highly mobile and lacking precise addresses and phones. We present cross-region themes while also commenting on context-specific considerations from each region where appropriate.

Most key informant interview and focus group participants were familiar with LEAP and described it as a cash grant that supports poor and vulnerable households to buy food, ensure that children of school going age are in school, and enable household members to access health care through free registration and renewal of NHI cards. In all regions, study participants mentioned training workshops organized by UNICEF for LEAP+ISS partners to interact and establish relationships that would strengthen linkages. Since then, some districts have formed committees and held quarterly meetings to plan and strengthen linkages in the delivery of social services to LEAP beneficiaries, and other vulnerable populations.

Below, we present findings on perceptions of LEAP impact and challenges with LEAP implementation. We then review perspectives on enrollment and renewal in NHIS. Finally, we summarize opinions and perspectives on linkages between LEAP, SWCD, Ghana Health Service (GHS), Ghana Education Service (GES) and other sectors.

15.4 LEAP: Impact and Challenges

Most key informants from across sectors were knowledgeable about the objectives and structure of LEAP. Participants from the SWCD could speak more to the history of LEAP in their districts and knew the amounts of cash received by beneficiaries while participants from NHIS and GHS were less familiar with such details, which may reflect limited participation at pay points to sensitize LEAP beneficiaries about the package of health services available to them.

In the Northern region, participants perceived the main impact of LEAP as **reduced hunger and improved quality of meals** during payment. Participants relayed that beneficiary households were happy on payment days as *"today they will not sleep (with) hunger, they will get better food to eat"*. Key informants also perceived that LEAP had contributed to **improved financial literacy.** A participant in the Northern region described a LEAP beneficiary holding a 50 Ghana cedis note for the first time in her life in the except below,

> *She was almost in her seventies, sixty, sixty, plus to seventy and had not seen a 50 Ghana note before; in fact, it was really sad. So, it actually attests to how, I mean, how poor or let's say privileged some people are. She was happy to see that note, in fact that one actually really touched me hm.*

In Greater Accra and Ashanti regions, perceptions of impact were less positive with more discussion of the transfer being too small.

Participants shared several operational challenges that inhibited LEAP impact. One such challenge was **enrolment and payment procedures**. Participants, especially in the Ashanti and Greater Accra regions, reported interference from politicians who send party foot soldiers to work with SWCD to enroll LEAP beneficiaries. The participants described the foot soldiers as "*round pegs in square holes"* who lacked the necessary training as social workers and motivation to engage in appropriate enrolment procedures. Participants also reported that the LEAP secretariat sends multiple lists to SWCD that creates confusion during enrolment and payments.

There were also reports of **delays in payments due to the banking crisis**. For instance, some LEAP beneficiaries have cards from third party financial service providers that are no longer licensed to pay. Also, some LEAP beneficiaries are not listed in the GHIPSS platform and therefore do not get paid. The quote below summarizes these payment challenges.

- *For instance, the defunct banks, they are still holding their cards from that time up till now, the cards were not changed. And it's not something that I will call the banks or someone else to come and change the cards and they will get their money. Its beyond me. Recently that they've given me the green light and they are working on it, are you getting it. Now, they enrolled some people some years back, they enrolled them, but they were not put on the GHIPSS platform. And they are also there, they are there holding the cards that they are LEAP beneficiaries, yet they don't receive the money; it's something that is beyond me……As at now, I have*

> *sat down and looked that even the pay points and realized they were not well created. So, I am working out for them to be cleared, to be done and then when I get the pay points, I will get the substantive community focal persons.....it will interest you that even the LEAP secretariat has come out now that we should put the people, re-enrollment that we are doing, it took me to write to the minister…. And the minister sent a certain man called [name withheld] and when he came, he realized the issue was very bad. Then they instructed them and they also sent a certain man called [name withheld] from the LEAP office. And he also came, and he also realized that the issue was very bad…So, after that before they sent a list; another list that we should work on. Now they've sent another list that we should hold on with those ones, these ones supersede them. So, we should work with these ones, so re-enrollment which we started on the second of this month…. And they are threatening me that this will be the last one, after that I will collate all the LEAP beneficiaries who are not getting their money and I will write to the minister again. Because that is the only way the beneficiaries can have some relief.*

Key informants also identified **unreliable E-zwich**, including damaged e-zwich cards, **and network issues at payment points** as some challenges that affect timely payments.

Another structural challenge across regions was the **bad roads, which create too long travel times and high-cost of transport,** especially from hard-to-reach communities, to payment points was reported as a major challenge for some beneficiaries who cannot afford the fares. This partly contributed to delays in accessing their transfers as contained in the excerpt below.

> *…one of the things is that the beneficiaries normally travel to come for the cash, like they have to gather them at one place. So, some may not have transportation fare to come, that is one of my observations I saw when we met them. because some people will come late and they will use the Twi word 'I didn't have money for transport oh', you understand that one.*

Beyond these challenges, many key informants were of the view that **the transfer size was too small** to support LEAP household expenses between payment cycles, as reflected below,

> *…the money that is being given to them is to me, not something to empower them but rather just a means of getting something to support themselves for a short period"…they*

are always in that category of vulnerable, because anytime they get the money they just spend the money and they are back to their vulnerability... .

Some participants thought that the goal of *"the money that is given is to sustain them not actually to [help them] come out of the poverty."* Another participant expanded on the limits of the transfer size,

P: I think the money is not enough looking at their economic situations, the money is not enough.

I: Why do you think it's not enough?

P: Last year for instance, a gallon of oil was sold for GHC45, early this year, GHC70 so if you have children to take care of, how many months will you use the oil? Rice, yam; yam season is now coming so one tuber of yam costs GHC10, GHC12. I bought some yesterday and the least was GHC10 so if you give somebody something like GHC50 per head or household, I mean now even kenkey is sold at GHC2 and the least is GHC1.5ps in Madina here. Kenkey is not sold at 1 cedi, it's either GHC1.5ps or GHC2 so when you have two children to feed a day, you cannot tell me you will eat once a day, you will skip breakfast, skip supper and eat only lunch, no. If you are taking care of somebody, do it so that the person will know he or she has been taken care of, but doing it halfway...Lets make the system in such a way that the least vulnerable person can have two square meals a day and also to access healthcare and to go to school, that is it.

15.5 State of NHIS

The NHIS obtains a list of all LEAP beneficiaries from the headquarters in Accra and registers, renews, and replaces cards for them. They also sensitize beneficiaries to know when to seek renewal, what to do if they lose their cards, and about the types of services they are entitled to. Some districts have outreach programs where they move their machines to the community to register beneficiaries or renew their cards. At the district offices, some of the scheme managers set up systems to prioritize the registration and renewal of cards of beneficiaries. Enrollment and renewal of LEAP beneficiaries is technically free, but replacement of lost cards costs 8 Ghana cedis, though there was variation across regions with this fee. For example, in Greater Accra, both renewal and replacement were done for free. In Northern region, participants described having to pay the replacement fee for beneficiaries who were prepared to abandon their cards at the office due to not having the funds for replacement.

Technically, enrolling participants into NHI has been simplified for new registrants, who can dial *929# to register. Unfortunately, participants explained that many LEAP beneficiaries, especially in Northern region, are illiterate and in parts of the Ashanti region (specifically Afiyga Kwabre South) have mobile phone connectivity challenges and therefore are unable to use the service. NHIS officers therefore must travel to the communities to register them. Potential beneficiaries who miss the community registration must travel to the nearest NHIS office, which in some regions can be far away from communities, to register. Participants also mentioned that there is a movement away from having a separate NHIS card, and using the National Identification Card instead, which was considered a positive development that would eliminate challenges around replacing lost or expired cards.

> *For now, I don't think LEAP beneficiaries are going to pay the replacement fees anymore, because now they have the Ghana card, if you have the Ghana card, you just get your number and merge the two, for you to use the Ghana card if you go out and we see a beneficiary who has lost the card or something of the sort. And that's what we're going to do. Because for now you can use the Ghana card for healthcare too but you have to merge before you do that; if you do a fingerprint, we can find your membership number from our system. As soon as you get a membership number, we'll link it to your Ghana card so that you can use the Ghana card for healthcare. So, I believe with the issue of replacement of lost cards, I think it's been solved now in a sense.*

In all regions, NHIS operates in decent office spaces and appears to be sufficiently staffed. However, due to demarcations of new districts some NHIS offices serve more than one districts, as is the case in Tolon and Afigya Kwabre South. Across regions, study participants reported that the LEAP+ISS collaboration works well overall in terms of registration and renewal of NHI cards of LEAP beneficiaries. NHIS and SWCD staff collaborate to use the pay points as one of the avenues to enroll LEAP households and renew their expired NHI cards. This was described by a SWCD office in a focus group in Afigya Kwabre South,

> *Like I said there is understanding between us (SWCD and NHIS). They are being very supportive anytime we have sent our clients to them to help with either fresh registration or renewal, they do it without complaining because they know they are also dealing with vulnerable people. My only challenge is what I said earlier. I didn't know we will get to that one the only challenge that has to do with vulnerable groups that are not necessarily LEAP beneficiaries ahaa that has to do with the approval system but with LEAP I did not have*

any challenge with him now. Because when we were even going on the mass registration, like he said, team work was very effective. We planned together and moved together. Besides that one if there is anything, they tell me, officer can you help me with this community? We want to go to this community can you get us all the people there? So the working relationship is very-very cordial very effective, corporative and understanding yes.

In some districts in the Ashanti and Greater Accra regions, NHIS has agents stationed in health facilities to register and renew LEAP beneficiaries. In these cases, there are opportunities to build on and strengthen the LEAP+ISS collaboration to allow NHIS to improve access and better deliver its services to the poor and vulnerable in these regions.

In most of the health facilities, we use to have the National Health Insurance agents at the facility level so when you come, they will renew your National Health Insurance for you. We also have an office within the district where if you have not been doing yours, you can go there and renew so we've been working together.

The downside to the above strategy described in the quote is that registration and renewal of cards is being done at the point of care at a time when LEAP beneficiaries are sick and need NHIS cards to access health care. Nurses also use the list of LEAP households (that the SWCD shared with them) to check if they have NHIS cards and whether the cards need renewal. Beneficiaries without NHIS cards or those that need renewal are referred to the NHIS for their needs to be addressed.

In the Northern and some districts in Ashanti region, NHIS does not have an office and must resort to bussing beneficiaries to other districts for registration and renewal. This was described as working well overall, especially in Northern region, where CFPs were able to mobilize beneficiaries to be bussed to NHIS offices, as described below by a participant in Northern region,

When the leap management secretariat gives me the information, I channel it to the focal person in the community and he/she gives the information out to the community through the mosque and "gong gong" beaters. Everywhere, LEAP has a focal person who mobilizes them and gives them information so when I tell the focal person he/she does it either through "gong gong" beating, house to house visits or even at the mosque and churches they will announce it so that the beneficiaries will be aware of the day the registration will kick start. If they are supposed to come to the district level for the

registration, we bus them to the place and they will do the registration for them and they and their focal persons will go back.

However, this strategy increases LEAP+ISS operational cost related to mobilizing beneficiaries, transporting, feeding, and accommodating them. The cost elements associated with the two strategies have implication for effective LEAP+ISS linkages and referrals. In some districts, CFSs gather expired cards and send them to the NHIS via SWCD for renewal. When possible, LEAP beneficiary households that cannot be bussed because they are in hard-to-reach communities are given transport allowance to enable them get to registration point but this is not always possible. A NHIS representative from Adenta described the challenge of transport and renewal in the quote below,

Most of them is means of transportation, sometimes when they come here, they complain they have spent most of their money in queue buying things for their kids, so sometimes going back home is a challenge for them, sometimes they even ask us if we can help them to get transportation back home.

Despite these efforts, across regions the NHIS faces operational challenges that prevent them from fully benefiting from these collaborations. In each district, participants described limited resources and logistical constraints for registration and renewal, including lack of available machines and cards. For example, in Afigya Kwabre South, the BMS machines were stolen, creating delays as the office serves two districts.

Another operational challenge is unreliable telecommunications network that prevent smooth operations during NHIS enrollment and renewals. Unreliable network problems are often due to maintenance being carried out by the telecommunication companies or the payment location has poor network coverage during the payment period. In some districts, NHIS and SWCD are unable to work together because of network challenges that compel separation of LEAP payment points and NHIS registration and renewal points. This can create a major barrier to enrolment and renewal as the pay points tend to motivate large turnouts of beneficiaries, as described by a NHIS representative in the Greater Accra region.

Usually, when they give us a list and we submit for approvals and we go on the ground to register the people the turnout is always low, we always register lesser than what they are giving to us…..We believe the turnout is low because the social welfare couldn't do massive mobilization, mobilization of the people to the point that they have given us to go

and register, we realized that the people turnout more when there is time for them to come for their money, that is time for payment, for they are there to receive their money, so we take that as an advantage to also register the people, but we don't get the people if social welfare tells them that we are going to do NHIS registration, they are mostly not interested in getting our card but they are interested in getting their money.

The quote below illustrates how the NHIS works with SWCD staff and CFPs to address the network challenges.

No, it was the May, May, when the time is due [name withheld] he will call me that oh PRO (public relations officer) the time is due, we are about to make payments. He will just let me know the schedule, that is moving from pay point to the other point. So, based on that I will organize my officers and we will send the machine round and register them. And at times looking at what the network may not be favorable to them, so those who bring their cards we will just collect it and then come to the office and then do it and give it back to the focal person and he will distribute it. And those who are supposed to do it first, when the network comes back to normal we liaise with social welfare through the focal person and then go and meet them and do the cards.

NHIS participants also complained about inconsistency in the names in their databases and those that the beneficiaries identify by in their communities. According to participants, some beneficiaries use different names to register with the NHIS and for LEAP. Reconciling this while in the field has been a major challenge for NHIS.

The renewal process was described as long and cumbersome. To initiate renewal in one district in the Greater Accra region, for example, the SWCD has to prompt NHIS that LEAP beneficiaries are due for renewal by sharing a list with NHIS who then sends the list to NHIS national office for approval. NHIS alerts SWCD that the list is approved. SWCD then organizes the beneficiaries at one place for NHIS to go carry out the renewal exercise.

No, social welfare always gives us the prompt that they have people who are due for renewals, so they give us the list and we submit the list to our head office for approval before we go, so when are going, we go with the social welfare.

Renewing the NHIS cards of LEAP beneficiaries that have expired for more than three months does not guarantee the holder immediate use of the card to access health care. Also, per the operations of the NHIS, when a card expires for more than three months, the holder must wait

for one month before it can be renewed. This applies to all card holders that are five years old and above including poor and vulnerable people. Although LEAP beneficiaries are entitled to free NHI enrollment and renewal, if they allow their cards to stay expired for more than three months, the one month wait period still applies to them, which means that they cannot use their cards to access health care during the one month wait period.

> *Per the system when the card expires, now health insurance does not do anything to help that person, unless the person, as I said, is less than five years or if the person is a pregnant woman. These are the two categories who don't observe any history or waiting period, apart from that if you are more than five years and the card expires more than three months you have to wait for the waiting period. Even if you are a LEAP beneficiary, you have to wait for that one.*

According to the participant, a policy adjustment is required to address the problem. For example, they believed that the policy that allows children under five years and pregnant women to use their NHIs card, regardless of expiration, to access health care should be extended to all LEAP beneficiaries. This way, no LEAP beneficiary will be made to pay for health care because their NHIS cards are expired or caught up in the one month wait period. The respondent offered this suggestion in the quote below,

> *……. it's by our superiors, by our superiors waiving that aspect that if the person is a vulnerable and a LEAP and the card has expired more than three months. By waiving that away as it has been done to the children under five years and pregnant women.*

Also, the NHIS has a code that their clients can use to check expiry dates of their cards. However, for replacement of cards, this is what they had to say;

> *The only problem we don't do for them is replacement, when you have come and the card is expired and we renew for you and it is missing and you are coming back for replacement, you have to pay a replacement fee of 8ghs. So, we do for them as and when they come, there is no particular period that they are supposed to come. Every day, we are liberty to do for you. That is what we do, the moment you come then we do it for you unless there is a special program like what they have asked us to do where we go to the communities and then do it. When you bring a card and its active, we will tell you that your card is active so you may go.*

There is also a weak link between NHIS and GHS in some districts. NHIS does not support LEAP beneficiaries beyond registration and renewal of cards. When LEAP beneficiaries present their NHIS cards at health facilities, NHIS expects them to be treated like any NHIS subscriber.

> *As I said we hardly work with the health facility in a sense that when it is about the Leap beneficiary when they visit the health facility, they don't go as Leap beneficiary, they go as NHIS subscribers so all the information that we may get from the health facilities is our client visited them not a Leap beneficiary visited them and we usually have a monitoring of the health facilities, usually is not tailored to the Leap programme.*

Another example of both challenges and responses in the context of LEAP+ISS was described in the case of how services respond to vulnerable cases such as child sexual abuse,

> *So, when we meet my organization assist by giving them NHIS card then assuming that a vulnerable child is raped, the first point of call is the health service so when the go to the hospital and it happens the person don't have NHIS card or don't have money [i]to pay her bills how do we go about these, the person is already vulnerable and has been exposed to this danger and now you say the person should pay how will she pay, so it seems the system has not been friendly to her. So, we met the last time and discussed that in such cases the police involved first so if they bring the victim to hospital whether she has NHIS card or not they attend to her before informing the social welfare and social welfare also inform NHIS then we also start the process to issue the person NHIS card if he doesn't have one, that one should not stop the care taken. We have held ISS meetings so that if there is a problem above me, the other bodies can come in and help so that the victim will not be left out because he doesn't have money.*

All of these factors - long bureaucracy, travel cost that discourages beneficiaries from taking up renewal services, network challenges, one-month wait period to re-activate expired NHI cards and lack of support at health facilities due to weak linkages between NHIS and GHS – create barriers to continuous NHIS enrollment among LEAP beneficiaries. However, as reflected in the quote above, shared commitment and communication are also helping to overcome barriers and identify innovative solutions. For example, because the cards are renewed annually, some of the scheme managers organize mass renewals for the beneficiaries in the months they did mass registrations so that everybody gets to renew their cards.

15.6 Linkages between LEAP and other programs

In addition to the formal linkages between LEAP and NHIS, other governmental and non-governmental programs provide opportunities for linkages and additional benefits within LEAP+ISS. The partners displayed openness to collaboration and reported that the linkages were working very well through distinct approaches used across different regions. In some districts, partners created Whatsapp platforms for their interactions. Others had each other's numbers and communicated at will. Some of the participants reported that prior to LEAP+ISS, SWCD was seen as a burden on the assembly because they only "leak resources" and did not generate any revenue, as explained by the quote below,

> *In the past "dierrr" you will call your colleague and even go there and they will tell you that they don't have time because social workers we don't give money, there is nothing to offer. They were not taking us serious like that even the assembly, they said you people always throw out, you are not bringing anything in. but now because of the training and the ISS program, there are linkages.*

Reflecting on how integration has benefitted the SWCD, one participant said,

> *In the past, the challenge was where a LEAP beneficiary will walk directly to our office without passing through the social welfare but now with the integration this challenge has been solved.*

15.6.1 Linkages

LEAP+ISS also appears to benefit from linkages to NGOs working in the three regions. For example, in the Northern region, with support from Resiliency in Northern Ghana (RING), a USAID poverty reduction program designed to improve the nutrition and livelihood status of vulnerable households, the district assembly has been able to organize financial literacy and numeracy training for LEAP beneficiaries.

Other programs supporting the population in the Northern region are school feeding, free education, and Planting for Food and Jobs program. Other support services mentioned by key informants included community savings groups called *adakabila* and Village Savings and Loans Association (VISLA), which are women's' savings group formed by the district assembly to build capacity to save and start businesses. Group members are given boxes to save their money along with pads, pens and other supplies. The SWCD department monitors the activities of the groups and coaches them on how to draw constitutions and choose leaders to guide the group and its activities. Through these structures, groups have been able to use their savings to access low

interest borrowing, which they can use for their livelihood activities. Common livelihood activities in Northern region included shea butter extraction and groundnut processing. Catholic Relief Services (CRS) also provides various forms of support including transport and tricycle ambulances for remote communities. Communities form committees for maintenance of the tricycles including fuel and repairs which is funded by contributions and levies from community members. A token of about 5ghc is paid by families of patients to fuel the tricycles. Pregnant women and children under 5 are given priority in terms of use.

In the Ashanti region, the SWCD collaborates with NGOs to help settle poor migrant families that arrive in the municipality, including helping with apartment rentals. SWCD also collaborates with the Planned Parenthood Association of Ghana to provide LEAP beneficiaries with social services including sanitary pads, health checks (in collaboration with GHS), referrals for NHI registration, and sensitization on gender-based violence (in collaboration with DOVVSU). As one participant described,

> *We organized them for NHIS registration, we did sensitization on gender-based violence and we have NGOs assisting in giving them umm let's say sanitary pads, assisting in organizing health checks for them.*

Other support services provided in some districts include politicians taking up the bills of people who seek care at the health facility and cannot pay the bills. The World Food Program (WFP) also gives out food to help address malnutrition. SWCD supports people with disability to set up businesses such as apprenticeship to learn a trade that involves selling fridges and sewing machines. The Department provides this support by writing to the municipal assembly to draw money from the common fund.

15.6.2 Ghana Education Service (GES)

SWCD collaborates with GES to address teenage pregnancy issues in schools and to support girls return to school after delivery. This quote highlights the importance of collaboration across sectors to support the most vulnerable populations,

> *We have a situation where the GES referred a girl who was impregnated by a colleague in SSS. And this girl, because she is pregnant, she cannot go to school, so when they brought the case, we were able to trace the families of the, I can say the respondents…..the office, social welfare brought in the boy that impregnated the colleague aha, they were all in SS1 or so. And the school (inaudible), they were all in SS1, so*

because this girl is pregnant, she was not taken good care of. And the parents too decided that if she is pregnant, she should be with, the boy's parents should take care of her. So, I can say they also neglected the girl. So we went, the social welfare and then invited the family of the boy. And by this social welfare assisted in getting the family come into the picture for them to take this girl, maintaining her. And what we have thought, and when I say we; GES, social welfare we have thought of, you know, in future when she gives birth, the family will take care of the child and the girl will go back to school and continue aha.

SWCD also works with GES to enroll children of LEAP beneficiaries in school and retain them. They also work with education to reinstate children who have dropped out from school.

For education, we go to the communities and to the schools to educate these school children to return to school especially those dropping out and going to "kayaye" we meet with these kids and their parents to tell them about the negative aspects of "kayaye" because education is good; when you educate your child you will not have any future problems. We have a lot of engagement with education; we want the children to be enrolled and also staying in school.

The social welfare department also works with the GES to sensitize community members on key issues that affect the vulnerable and very poor in their districts.

We do community engagement, community sensitization and other trainings that we do. Recently we embarked on community sensitization together with GES. We went to schools, we went to market centers, we went to communities, so, we have been doing community engagement education. And then, we also have PWE cases that we handle and let's say general social protection cases so over there we have the child and family welfare talking about acids, reconciliation, maintenance, child abuse, child labor issues, all these are issues that we handle.

15.6.3 Ghana Health Service (GHS)

Participants reported effective collaboration between the social welfare and the Ghana Health Service (GHS). Community health workers look out for LEAP beneficiaries to provide them services while the social welfare staff review ANC cards to ensure that beneficiaries are taking up health services. Participants said they work together to address challenges and refer cases to each other. In one district, a LEAP officer is based at the main hospital to support LEAP

beneficiaries access health services to facilitate these processes. In another district, upon overcoming an initial challenge of GHS not having access to the list of LEAP beneficiaries, they were able to facilitate attention to LEAP beneficiaries through health screenings and home visits in the communities,

> *Yes, for now, that issue has been resolved, they have been provided with the LEAP household list. They go round house to house, what do you call that, home visits, when they have issues, they discuss with us, they share with us and then we also help them out where they have difficulties, challenges reaching the communities or some of the household members. We facilitate that process as to how to get to the focal person to lead them to that particular household. So, there is that partnership, there's that understanding the teamwork; we are collaborating effectively with health.*

Another example of effective integration and collaboration was in the case of supporting malnourished children. Through the activities of the LEAP+ISS program, the GHS refers LEAP beneficiaries to social services including health services, and nutrition programs to address malnutrition challenges among children in LEAP households.

> *Because we wanted to know their (LEAP beneficiaries) number that we can call ourselves and that is why we have a nutrition officer here who will be doing those things. Because some of them are malnourished and we have to also write a report on them on how best we can. Some of them too even if we got to know them, we can also enroll them into our program, WFP program so that we can also take care of the child who is malnourished. So, they gave us the list and we started calling, some of them it's not going through but all the same we are working in collaboration with all of them, hand in hand without any issue. And now we are always being briefed, recently we had a stakeholders' meeting with us and they briefed us on what is supposed to be done, so it is.*

Aside from these examples of effective coordination, SWCD participants raised concerns about the quality of the services provided to their LEAP clients. They said they had received complaints from the beneficiaries that they are not treated fairly when they visit the health facilities.

> *But on other ISS issues, we have a few challenges. For example, when they go to the facilities, health centers, and it's not only peculiar to our districts, it's nationwide in terms of referrals; when you refer cases from the office, there is usually no urgency at the facility. There is usually a bit of reluctance. on the part of the facility. I remember there was a*

case that we had a missing child; the HOD (head of department), herself was around, the officer was around, and they issued a referral letter to one of our facilities, and then the head over there was a bit reluctant to cooperate effectively with us in assessing that poor child for onward transfer to the RHC, that is residential home for children orphanage. It's a requirement that before you send any child to the facility, you go through the medicals, for them to do an assessment to ensure that they are okay. So that was it that we wanted to undertake, and that the new officer there didn't want to cooperate. Sometimes, you know, they would have to do some payment; they would need to pay for cards up there. But we are not supposed to do all those things. So sometimes it becomes a border, to their facility. So that is where, because that is where they also get their IGF (Internally generated funds).

The Community-based health planning and services (CHPS) compounds that are accessible to most beneficiaries and are considered their "hospitals" provide very limited services. They do not manage many conditions and where beneficiaries are able to access health facilities, they must spend out of pocket on medications. The participants reported that some medications can only be prescribed at the hospital level but some of the districts did not have hospitals and where these hospitals exist, they are poorly stocked and therefore do not serve the needs of the beneficiaries. This has contributed to reluctance in accepting referrals, as described below,

Yeah, I think I must also come in here. In fact, he's right. He's right that NHIS doesn't cover anything that one goes to do, but we have this policy. Sometimes, most cases that goes to health centers might not have the ability to give certain drugs to people for them to bill us. They have levels. So, you can go to health center for a particular case. But if you go there, and the case is not his level, he has to refer you to another, you know level you have level. So, what I'm trying to say here is that in fact our system or our scheme doesn't cover everything, for that one I must admit that sometimes to the, the facility should help us by referring cases, because you can buy a certain drug at the health center. But when you go to when you go to a hospital, or maybe a clinic, that drug will be given to you for free of charge. So sometimes we have challenge on some of these things. So, I think we must all try and know and sometimes, they say the patient needed an attention.

They noted that the phenomenon was not limited to the beneficiaries but extends to all clients of the scheme and therefore called for the authorities to intervene.

15.6.4 Police

SWCD also works with the national police and Domestic Violence and Victim's Support Unit (DOVVSU) to prosecute incidence of violence, physical and sexual, towards LEAP beneficiaries. Participants explained that in some communities, cases of rape and violence are usually shielded by the community to prevent the family from the stigma and shame. Cases are therefore settled at home or in the community setting, because if they are reported to the law enforcement agencies, it would eventually create conflict within the home or the community. However, SWCD sensitizes communities to change those perceptions and begin prosecuting perpetrators of such violence, as described by one SWCD officer in Northern region:

> *Like (laughs) this, my brother said. Our people don't like reporting cases like defilement, rape. They always shield these cases. When an adult defiles a child they will settle it among the household. If you report a case to the police, it becomes a conflict for ages. One day you may find someone to marry you and they will say this house; don't go there they report people to the authorities. We are still doing sensitization and things are changing. Recently we had a defilement case which was reported by a teacher. He came (in) and we said it is a criminal case and they took it up.*

This quote highlights the prevailing impact of local culture and norms around reporting along with signs of change and increased engagement with police and SWCD in cases of violence and rape.

The SWCD and police also work together to cancel fees associated with the completion of the police medical forms. In some of the districts, medical officers insist on charging beneficiaries before signing the police form to cater for fuel and other incidentals in case they are called to the court as witnesses.

> *And the hospital issue, the abuse, rape cases that the doctors have to endorse before, it has been an issue. Initially, they were endorsing for them, but along the line, when you take them to the doctor, they say we have to pay. The last time I did that, he just drew a paper, a communique that the medical doctors have put on a paper that they are not going to do it for free so he drew the paper and gave it to me to read so that I know it myself that it is not him who is denying us that service. He explained that, when they do that and they are called to the court to come and testify because they assessed everything, they wouldn't like to attend to a case that they didn't take a penny and one day you will be there and they will call you and you will use fuel up and down. It would not be once, sometimes twice or three times, so they would not like to be using their fuels to follow up such cases*

and so those people have to pay. Even if they do not pay the total amount, at least they have to collect a little and so I remember the last time he made me pay GHC200 instead of GHC300 and something. At least he reduced it, so now, they are not signing it for free so it's an issue. And even the medical officer in charge emphasized on it in one of our meetings that it is not for free, for rape cases and all that.

15.7 Barriers to Implementing LEAP+ISS

One of the main challenges to implementing LEAP+ISS is limited engagement with LEAP beneficiaries. Participants explained that some LEAP beneficiaries feel reluctant using referrals to SWCD because they are not comfortable being labelled as poor. As one KI explained, "*But that referral some people, they are not feeling very comfortable with it at all*." Some beneficiaries also resist referral to health facilities because of the time and cost,

First of all, the referral is one of them. Once we do the home visit and then we refer them is one. Apart from that, we can also expand the health facilities, bring them closer to them because some places the facilities may be a bit far so even if you refer the person, the person may feel a bit reluctant from going to access the health care. But if the facility is a bit closer, the person can easily walk. I think we have to spread our tentacles, by way of increasing the health facilities around us. We have CHPS zones, that's where our CHOs go to the communities see to the LEAP beneficiaries. But at that level they can't take care of them fully so they need to be referred to maybe a health center or polyclinic and if those facilities are not a bit closer to beneficiaries, it also becomes a challenge. If the person does not have money to even board a vehicle to the place, then it also becomes a challenge, so maybe we can link the transport services to some of these people so that maybe in referral if the ambulance is not around, some of them do not even need ambulance unless is very critical, but if you link them to the transport that I have beneficiary A over here, the person doesn't have money so can we arrange maybe with GPRTU, those kind of things will make their lives a bit comfortable.

Across regions, SWCD teams are run by experienced and passionate personnel who showed a lot of commitment to their work. However, SWCD faces numerous challenges that affect their role as the lead institution in the LEAP+ISS implementation. **These include insufficient resources, centralized bureaucracy, access to community focal persons, transportation, office space.** Throughout the interviews, focus group discussions, and observations, there was clear evidence that the SWCD does not have sufficient funding and resources to play the central role in facilitating

implementation of the LEAP+ISS program, which limits integration across agencies. This lack of funding comes out in the descriptions of transportation and space barriers below.

Another challenge is centralized bureaucracy which limits efficiency in the work and in the release of funds in a timely manner, especially for quarterly meetings to facilitate sharing of information among LEAP+ISS partners. Participants emphasized the need for more horizontal coordination across agencies, rather than trickle down, vertical control. While ISS networks have created WhatsApp groups, participants commented that it is not enough for detailed discussion of cases and for sharing of documents, as described by one focus group participants,

> *At times whenever there is information, they said sharing information and it is a serious thing. There are situations where you need serious information, we can't get it at our corner but you can get it at Fauzia's end. So, I think sharing information is the basic need. I can remember there were situations when some people came and I needed to register them but the names were not on our system. It means they were having those names in Accra and I was still having the old list. Then Fauzia came with a complete list of beneficiaries and when I checked the names were there. So, I think information sharing is paramount, if we can do those things, I don't think we will have problems with each other.*

> *If we can have program meetings like this where we can come together and deliberate on progress of our work, I think it will really help. As boss said; he was having the old data and the new data was sitting somewhere. It is not everything that you can put on the platform but when we have one interaction, we can see how best we can streamline some certain challenges. So periodic meetings will also help.*

Social services committee exists in the districts, and they are supposed to meet quarterly but due to financial challenges, the committee is unable to meet as expected. For example, the committee relies on UNICEF to release funds for the quarterly meetings but at the time of the fieldwork (in 3rd quarter), the district had received funds for only the 1st quarter so only one committee meeting had been organized in the year. According to participants, the delay in accessing UNICEF funds for the quarterly meetings is caused by the local government that is responsible for submitting requests on behalf of the 60 districts that are participating in the LEAP+ISS program. Participants suggested that each district should prepare and submit their own requests to UNICEF to reduce the bureaucracy that delays the process at the local government.

With regard to CFPs, there was some variation across regions in the **availability and role of CFPs as well as the voluntary nature of the role**. In some settings, leadership have organized CFPs to assist with mobilizing beneficiaries and helping to link the beneficiaries to social services. For example, in the rural setting in the Northern region, CFPs were easy to locate and were highly connected to LEAP beneficiaries and well positioned to assist in connecting them to service providers. CFPs were essential to getting anything done in these communities as they are identifiable and trusted. In contrast, in the peri-urban and urban settings of Ashanti and Greater Accra regions, CFPs were difficult to reach and less connected to communities, raising the question of how they were helping LEAP beneficiaries' access NHI and key social services such as health, birth registration, education and social welfare in the Ashanti and Greater Accra regions. In the Ashanti region, CFPs were identifiable but they relied mostly on phone calls to reach beneficiaries. It was hard to locate beneficiaries that changed their phone lines because some CFPs in in Ashanti did not know where to find them. CFPs in the Northern regions knew the situation and location of beneficiaries and could locate them when phone lines were not reachable. The lack of CFPs has a direct impact on the potential for linkages, as described below by a GHS representative in Adenta,

> *And then focal persons, we were told that they have focal persons in the communities that can assist the nurses maybe when you are having challenges. But those people we can't find them. In fact, I have been on the social worker, the social welfare officer for a very long time and he has given me a few, about three or four and so we can't access them. We need, especially, we need the focal persons in the communities because they know the beneficiaries to assist us to get to them, but we are not getting them.*

The reason service providers are not finding CFPs may be because of what some participants described lack of resources to motivate CFPs to play their roles. Across regions, participants feel that CFPs need to be given some form of renumeration to incentivize them to effectively play their role.

> *Maybe their T&T and other things, that's the only way because they will say they want T&T for A, B, C, those kinds of things so that they can visit them more often but apart from that, it is their duty that they do it but to motivate them to do.*

Another challenge across regions was **lack of transport for SWCD** to carry out their work with LEAP+ISS. The SWCDs reported that they have no control over vehicle, drivers and resources for other expenses in the field.

> *Well for the human resource aspect, we have the staff, we have the numbers, we have the capacity but then, when it comes to logistics especially with the vehicle an official vehicle is a challenge so we have issues with our response time when we need to come in and work on our social delivery let's say we need to pick a child to a health center and all of that to the orphanage and bringing the person back for assessment and all of that, is a challenge and I think basically I think is the official vehicle aspect that is a challenge.*

They typically rely on the assemblies to assign them transport (vehicle, driver and fuel) for fieldwork to investigate cases or rescue victims and even after accessing the vehicle, the SWCD has to go through other layers of bureaucracy to get fuel money and a driver before they can use the vehicle. The SWCD is not given priority when it comes to access to transport because they do not generate revenue. In the quote below, the head of SWCD in one of the districts expressed a frustration shared by SWCD across regions,

> *For social welfare we need a car, we need the money. As (I) am speaking now there is nothing like impress in my office, so if someone says, you get an emergency from a LEAP beneficiary, PWD or any aged, destitute case, now before the assemblies oh, financial administrative law, procurement law (laughs), procurement law, this law, this law. Vulnerable is there like, now before you will be going through the laws. So, the laws are not also helping the vulnerable enough, some of the laws are not helping them enough.*

Beyond transport and resources, this quote also highlights the challenge of the legal framework creating additional challenges to implementation and agility on the part of SWCD. Another participant extended the discussion of resources to also include commentary on the need to innovate the SWCD approach, in addition to needing more resources,

> *We need money and we need capacity building. Social work deals with human beings and human beings are being sociable, for that matter the vulnerable need changes. Now we are in the era of technology. They are human beings like you and I, they also know good things, they want to go to good schools. How are we meeting them, if we are not meeting them fully, half way? So, before we meet them to that effect we need to be having conferences and then seminars, workshops to bring us at par with other service providers and the beneficiaries to make sure we give them what is due. With that I think we will be making a headway.*

In some districts, the SWCD had motorbikes provided by UNICEF to enable staff go to the field, but participants emphasized the need for a readily available pick-up to respond rapidly to the needs of clients.

> *We have our regions having the pickups and other things and since time immemorial we've been using motors, it is motor, motor throughout…. We should be mobile, the district we should at least see a situation whereby maybe these pickups are here and it is meant for districts, social welfare and community development offices. Because I know it can be done because we see other establishments having it and that makes them strong. They have been able to move anytime that they want to move to the people, but we are handicapped. If I come and I have it, I know I'm to move but if I don't have the means maybe I will just play aloof lackadaisically which is very bad. We force, honestly, we force but we feel our burden can be less if our plight is addressed.*

Another participant commented in frank terms,

> *Let me add to this, if they think motorbike is the best, when they come for monitoring from Accra, they should use motorbikes. I want it to be put on record, if they think motorbike is the best for these activities, when they come, they should use the motorbike given to us to use in the community, it's not the best. They should also give the officers here comfort to work and work well. That is the problem we have in this place.*

SWCD across regions also face enormous challenges with **office space to effectively do their work.** Some districts, especially in the Northern region, had decent office space with the head of the department occupying separate space from that of the unit heads. However, a cross-region challenge was lack of private, well-ventilated space to work with clients, an especially salient concern in the era of the Covid-19 pandemic. This was especially noticeable in the Northern region and Greater Accra. In the Ashanti region, some of the buildings occupied by the SWCD were still under construction but offered a promising future when completed.

The office space for one of the SWCDs in the Greater Accra region had the poorest office situation. From the outside, the SWCD building structure looked modern. However, the research team observed congestion in the office that made it hard to move around in the room because of overcrowding of people and furniture. The department head shared space with multiple officers in the same room and some were seen providing services to clients in the same room,

undermining client privacy. The office also lacked space for equipment and case file storage. The head of the department reflected on the challenge of office space below.

> *We need more than the structure they put up; you came there I was in one office with my officers. Small, not even big, small with the same officers and that is what we use for everything, you were there and you have office yourself. Compare that with my office, does it even qualify to be called an office, we don't even have an office. So, we need structures and then we can get a case workers office. Where when there is a case, like we will be handling cases every day in that office and it will ease the pressure on the vulnerable because some of them have issues. When they come some of the issues are confidential. You see you were sitting under the tree; I would have kept you in an office, but you were sitting under a tree because there is no office. Sometimes that is where I meet some of the clients under the tree, that is where I meet them because of confidentiality. And they don't trust some of the officers and some of them even know some of the officers when they come in. And as an officer and the head of department who has worked for 21 years in this frustrated situation, you can imagine. I don't even have office to myself, you can imagine, you can imagine.*

To address the office space and covid-19 challenges, SWCD in some districts have resorted to running shifts and were hopeful that the government and UNICEF will provide the needed resources to improve the current situation.

> *Look at the people coming to us, we have Covid, you know, down there we are compelled to run shifts and at times we run that shifts and then you need the personnel too. Because today for instance we have cases that we need to handle and if you look at the place it doesn't make, you know, giving out effectively, you see. We wish that the government will see our plight (laughs), we are talking of UNICEF and I'm mentioning government, so maybe UNICEF will see our plight and give us that support so that we will get the logistics apart from furniture and other things.*

Beyond the office, the impact of COVID-19 was also felt at the community level in the Greater Accra region. It disrupted payments in the region because LEAP beneficiaries did not receive the transfer for 3 cycles. The SWCD used the period to put in place precautionary measures to prevent spread of the virus among the poor and vulnerable. The quote below shows the support services that were delivered to help beneficiaries cope with the shock.

Yes, the COVID really hit hard on them because I think during the COVID, we were not able to pay them for some months……... They said we should hold on because of the COVID so that we will put measures in place before we can go into the community so I think it delayed for 3 cycles but when we went, we paid all. During that time, we were able to liaise with some people and we had donations from some NGOs, we had one Charismatic Evangelistic Ministry that supported our persons with disabilities with food items, mattresses, wheelchairs, assisting devices, a lot of items, all the PWDs in the municipality were able to get something. Also, Tanlo also liaise with one NGO and they got the LEAP beneficiaries fruitful stuffs, bean carton each, cereals, fish, tomatoes, 5litres of oil, rice and everything and they were really happy. They took the items to the communities to the LEAP beneficiaries but just that they were not able to give all of them, it's just some selected ones, they selected from some of the communities.

As part of the efforts to facilitate and strengthen linkages and referrals among LEAP+ISS program partners, the SWCD has shared beneficiary lists with NHIS and GHS to enable these institutions to play their part in the implementation of the program. However, for a variety of reasons, these institutions across regions are facing a number of challenges using the lists to locate LEAP beneficiaries and deliver services. Participants' views as to whether linkages and referrals are happening among LEAP+ISS partners were mixed. In some regions, partners are working hard to find ways to work together to build a better society for the poor and vulnerable including LEAP beneficiaries. In these districts, LEAP+ISS partners have formed committees that include government, non-governmental, traditional and community leaders. Members of these committees have expressed strong desire to meet quarterly but are constrained by funding to finance these meetings.

Other participants felt that LEAP+ISS is only working at the leadership level with mandatory quarterly meetings. Leaders are forced to attend these meetings where LEAP+ISS issues may be discussed. Beyond leadership, participants feel that LEAP+ISS is not effective because collaborative work is lacking among their subordinates. The quote below throws light on how some of these leaders feel about the implementation of LEAP+ISS in these districts.

At the level of the assembly, on the health committee, we have the social welfare and all the relevant bodies represented. And on several other committees we get to meet so we are able to share our challenges at the level of leadership. *So, for example, erm when this idea of the NHIS trying to register them on the NHIS came about,*

because we have reps we were able to link up and tell them what we were doing on the health side. And they also support us because they are on the social service side, so at the level of leadership that works. ***However, I think on the ground itself it's not very effective.*** *And that is because most of the time I think what we are doing in health, for example we will come through Ghana health service. So, they will tell us there is a program and there is a part of it that we have to do and we also pass it down to the officers who are supposed to be doing it. Those officers usually do not get a linkage with them, from the officer in charge from the other unit, basically because there is no broader body that brings us all together.* ***It's only the leadership that are together because of the fact that we have certain meetings that we need to attend to, and these issues may come up. So, that really is where the challenge is, if you go into a sub district and you are having a challenge it means the person has to report to me to report to social welfare in charge. Before he also gets to his person on the ground before, there is no, she doesn't know who to talk to if she has a challenge on the ground or who to link up with, no, that, that part is lacking.*** *For instance, with health insurance, I think if we go and then this person's card has expired, you should be able to talk directly to health insurance or link them. But now we have to call the social welfare who will have to come or they will be there.* ***I think that is because its mandatory quarterly meetings (laughs) aha so we are forced to meet aha****.*

Summing up findings related to barriers to linkages for LEAP+ISS, one participant summarized in the following manner,

I think it's (LEAP+ISS) a very good thing that needs to be looked at holistically to help the vulnerable. As I said, the programme is for poor people, so first of all, the amount of money that they receive monthly can be looked at because, I don't think it's good enough for them. Then, the monitoring aspect, motivating the staff…renewing their National Health Insurance regularly so that if they are sick, they can be catered for and then we having regular meetings can as help improve upon it. I think it's a good thing that the Government of Ghana is embarking on, and resources that are being channeled to the programme must be well structured so that it gets to the right people for them to also benefit so that they don't feel rejected."

16. RECOMMENDATIONS AND CONCLUSIONS

16.1 Recommendations

Below are suggestions for improving impact of LEAP and strengthening linkages for LEAP+ISS derived from the qualitative and quantitative surveys as well as the stakeholder workshop held to discuss these results.

1) **Increase the cash transfer received by the LEAP beneficiaries.**

The analysis of the real value of the transfer shows that is represents just five percent of household consumption and has returned to its value in 2010. There was a uniform sentiment in the qualitative interviews that the LEAP cash is used for survival and is not achieving economic empowerment of beneficiaries because it is too small, especially in households with large membership. Related to this was the recommendation to improve linkages to NGO programs that could help to supplement nutrition, for example, freeing up the cash to be used for investment. One participant also suggested building more capacity and equipping beneficiaries with skills,

> *If these people are identified and they are strong enough that they can get some work to do, opportunity will be created. Maybe they will put them, LEAP will put them into maybe sewing or any apprenticeship work so that at the end of the day the person will get handy work to do. That one will also help because that one the person will not be depending on anyone again because for the apprenticeship for two years you have finished the apprenticeship. So, maybe the LEAP will get them sewing machines and other things and establish them the only thing the person will not be in need again. Though the money you will get from the sewing will sustain the person and they can also come out of poverty. It's a suggestion if that one will be good.*

At the validation workshop, stakeholders discussed this recommendation and made the following comments:

- LMS representatives recognize the impact of the low transfer amount in the findings and informed that LMS/MoGCSP is in talk with MoF to establish an incremental approach to determining transfer size.
- MoF voiced support for a soft budgeting approach, suggesting future design of a funding mechanism allowing LMS to petition for further funding as it is determined necessary.

- MoF also raised concerns that the current budget is quite tight, leaving little room for on-demand grant increases.

2) Improve effectiveness of service providers at LEAP pay points

In discussing increasing provider representation at pay points, stakeholders at the validation workshop made the following recommendations.

- Since DSWOs assume similar responsibilities to LMS officers at pay points and are branded similarly, there was concern that recipients are unable to distinguish DSWOs. Participating DSWOs discussed diverting payment responsibilities fully to LMS and CFPs to allow them space and recognition to interact meaningfully with recipients.
- NHIS representatives supported internal prioritization of field deployment among regional officers, resolving to call for more community-based enrolment campaigning.
- Across agencies, recipients report low interaction and poor experiences with ISS officers at pay points. MoGCSP, GHS, NHIA, OHLGS and LMS, favourably discussed ramping up sensitivity training for field agents in order to remedy high respondent dissatisfaction with the temperament and collegiality of service providers.
- Build capacity of staff on ISS guidelines
- Sensitization drives in communities by DSWCD
- Improve monitoring and coaching
- Social welfare should be provided with the necessary resources to enable them live up to their mandate

3) Decentralize and reduce bureaucracy.

To strengthen linkages and referral, and reduce red tape among SWCD, NHIS and GHS at the district level, there is a need to decentralize the system so that LEAP beneficiaries can access services from NHIS and GHS without always passing through SWCD. Participants also suggested the use of an application to facilitate referral between the agencies. They wanted something like the Social Welfare Information Management System (SWIMS) that the partners can easily log-in to see if cases have been referred to them, the reasons for the referral, and the progress of the support given to the case.

> *"For all these years, social welfare has been the first step to the beneficiary……., so I will suggest if there will be a way that, there will be a forum that NHIS, Ghana Health and the social welfare that all of us will be part, a general forum for us let them know that these three institution are there for you, so if there is any issue that you are having, this is what you can do with NHIS, this is what you can do with Ghana Health Service and this is what social welfare can do for you, then people are empowered that any of these three institution they can walk up to them to*

access any need they may require so coming back to the question I think social welfare has to bring the two of us on board when they are registering them or when they are trying to communicate with them, that we should be involved so that it wouldn't be a one way channel that all the time they have to pass through social welfare before they get to NHIS."

In group discussion at the validation workshop, the representative from GHS brought to light the issue of data transmission as a barrier to information flow. Several shortcomings and solutions were discussed to this point:

- Current LMS database does not disaggregate LEAP recipient data by CHPS zone which results in difficulties directing beneficiaries to appropriate resources.
- LMS has no established directory of CFPs. Representatives from LMS suggested establishing a communication platform between CFPs and LMS as part of standardizing the role of CFPs.
- Because there are not NHIA offices in every MMDA, some recipients register at external offices, which leads to inaccurate reporting. In discussion, representatives from both agencies expressed interest in creating a coding system to identify recipients who lived in districts with no NHIA office.
- OHLGS rep proposed the idea of regional "command and control centres" which would serve as cross-agency points of accountability and monitoring—liaising between central agency and local officers to streamline processes and resources. This plan also would seek to foster improved communication between agencies at the local level to manage overlapping issues.
- Key informant interviews conducted by the research team suggested "abolishing the approval process," a proposal which was met critically by the MoGCSP and MoF, as it would remove the flow of information between different levels of government, and diminish the ability to monitor service access and affect accountability across levels.
- MoGCSP and MoF jointly recommended more regionalized approval processes, including dispersing some central approval capacity from Accra between regional offices to reduce approval delays.
- OHLGS proposed more regional monitoring of ISS programming to decrease bureaucratic clutter at the central office.

4) Expand and sustain information sharing among LEAP+ISS stakeholders

Related to regular meetings, another recommendation was to promote and sustain continuous sharing of information among LEAP+ISS institutions to help institutions learn from each other in terms of how problems affecting LEAP beneficiaries are being addressed. The respondent also called for regular meetings so the LEAP+ISS participating institutions can get to know one another and find ways to improve relations.

> *"it's all about continuous sharing of information, because when you share information among those stakeholders any institution or stakeholder who is facing that challenge will know that oh this happened to this institution and this is how they were able to go through to solve it." (Asokore, NHIS)*

In addition, Group 3 at the validation workshop recommended Harmonization of data between LEAP, GHS, NHIS and GES as part of efforts to promote and improve collaboration among ISS implementing partners.

5) Expand ISS agencies

Participants suggested expanding the LEAP+ISS partner network to include the National Commission on Civic Education, the Judicial Service, Births and Deaths, and Commission on Human Rights and Administrative Justice. These agencies were identified as providing critical services that could benefit LEAP+ISS beneficiaries. In the urban centres, one respondent wanted to involve housing and food support for the LEAP+ ISS beneficiaries.

> *P: Okay to me I think that one will be a long-term plan. Most of them do not have a place of abode, like accommodation, decent place. So maybe the works and housing may come to provide some affordable houses for them and their food. As I said, some people cannot even afford a day's meal, so if maybe Agric can also be on board so that we can give them* something apart from the money that they receive, maybe some food and other things. LN-KII

6) Address LEAP Secretariat delays with disbursing funds.

Currently, death certificates are required to replace a caregiver that has passed on in a beneficiary household but there is low use of births and death services in some communities where affected households do not have death certificates because culturally, they do not take their dead to the mortuary which will enable them to obtain a death certificate. This delays the replacement and payment process. To ease the burden on the affected families, SWCD is willing to accept a written note as proof from the Imam that buried the dead but sometimes it is hard to get such notes, especially if the Imam involved cannot write because he has no formal education. If there is a way to speed up the process involved in replacing a deceased caregiver, it will help continuous flow of LEAP funds into affected families who are negatively impacted whenever there is a delay in payment.

7) **Invite LEAP beneficiaries to give testimonies**

When stakeholder institutions come together to share successes and challenges, invite LEAP beneficiaries to share their experiences. There is also a need for more education/sensitization to encourage traditional authorities to better participate in the LEAP+ISS activities. Some traditional authorities need additional sensitization to fully understand and appreciate the LEAP+ISS program.

8) **Use more integrated and efficient implementation strategies**

For example, one recommendation was to use **CHPS compound as one-stop shop** where multiple services are offered including receiving cash payments, healthcare, and NHI enrollment and renewal. This will strengthen linkages, save operational cost, and reduce travel cost for beneficiaries. It will also bring officers from partner institutions to deliver services at these locations. Some participants acknowledge that this idea has its limitations because it will present challenges for NHI registration if there are network challenges at these locations. Also, in places like Afigya Kwabre South, out of 27 CHPS zones, only one has a physical structure and therefore such approach may need to be district specific.

9) **Standardize access to designated community focal persons to facilitate collaboration and referral at the community level.**

Participants also recommended providing support to enable nurses to visit communities to identify LEAP households and improve indicators that UNICEF wants GHS to contribute to LEAP+ISS efforts.

> *"From the health insurance, yes. I think all the parties that are enjoying the integrated social services should have focal persons. So that if at the health directorate you know that this is the focal person for that activity. At the other side this is the focal person, so it makes it easy. So, when you call the focal person, that focal person can do the internal work for you and give you a response aha. But because there are no designated focal persons, then I will get a call from social welfare over an issue that if they had called the focal person it could have been done directly. So, I think that really is what should be done going forward."*

Resources should be in the form of fuel and lunch package for community health nurses. Group 3 at the validation workshop agrees that CHPS should be well resourced to be able to provide efficient service delivery.

10) **Increase motivation of CFPS**

Participants suggested that households of CFPs be included as beneficiaries of the scheme as a way of motivating them to play their role. Others suggested that they are put on the National Youth Employment program and some said they should be given T-shirts to facilitate identification and mobile phones to facilitate communication between them and the partners. Others suggested an increase in the amount paid them during payment cycles as the current 15 Ghana cedis paid them is not motivating enough.

11) **Training on Investments:**

Some participants noted that beneficiaries need training and coaching on investments and how to sustain them. They said they need sensitization on feasible income generating activities based on their income levels. They suggested that the program should facilitate access to loans from microfinance companies to enable them go into meaningful businesses and farming. They also noted that the beneficiaries would do well with vocational training to enable them transition out of poverty using their skills. Some participants want the program to provide men in LEAP households with farm implements, fertilizer, and seedlings to enhance their participation in agriculture.

12) **Revitalize educational campaigns and introduce policies to address operational difficulties in the NHIS**

Stakeholders at the validation workshop made the following recommendations to NHIA operational difficulties on enrolment, and using NHI card to access health care.

- Many recipients have expressed that using NHIS as compared to cash payments at health facilities results in longer wait times and possible additional cash fees. Reps from NHIA expressed that these concerns have been known for some time; according to them, this can be due to lack of availability of essential medications at pharmacy facilities.
- GHS reps remarked on the poor information distribution of NHIS services, suggesting revitalized educational campaigns run by local NHIA officers/more IEC to reduce enrolment hesitancy due to lack of programme knowledge.
- Developing jingles in local languages and other accessible formats for easy understanding and knowledge of packages for beneficiaries

- There should be more education in the communities among beneficiaries to remove stigma, fear and cultural beliefs.
- Review of policies documentations on the medicine list and service packages for LEAP beneficiaries.
- NHIA representatives voiced support for commissioning a review of medication prices to fill in gaps of market price vs. NHIS coverage price.
  In group discussion, several stakeholders raised the point of extending the validity period of NHIS enrolment to lessen the burden of renewal on recipient households.
- There is the need for the review of the drug list to take care of other health/medical conditions
- Government can strengthen policy to improve infrastructure and connectivity to address network challenges Satellite stations to be provided. Provision of more CHPS compound and policy upgrade of underserved areas/communities to address delays in accessing NHIS services.

13) Take action to bolster the budgets of ISS agencies aimed at addressing barriers to increasing the capacity of social services

Several government stakeholders at the validation workshop identified key areas in which increased resources would increase the capacity of ISS service delivery. the Ministry of Finance offered several insights as to how to bolster the budgets of ISS agencies within the current budgetary framework:

- MoF proposed diverting funds from Disability Common Fund to DSW/CD.
- MoF, OHLGS & MoGCSP included a clause in 2022 Budget Guideline for MMDAs to allocate greater funds to DSW/CD. Additionally, the Minister urged Assemblies to reallocate some funding for GES and GHS (both nationally funded) to direct additional support to DSW/CD (wholly Assembly funded).
- MoF further encouraged present agencies to examine their own budgets to free up funds to streamline internal ISS-related capacity building.

14) Expand training opportunities for partners

Some participants were of the view that meetings at the national level that focus on integration of social services should be attended by all the partners at the district levels. They were also of the view that the public relations officers of the various departments and agencies should participate in the ISS meetings because they are the implementers in the field and can speak to the practical challenges or issues that require better integration.

15) **Use electronic platforms to foster integration**

Participants also suggested the use electronic platforms to facilitate referral between the agencies. They wanted something similar to the Social Welfare Information Management System (SWIMS) that the partners can easily log-in to see if cases have been referred to them, the reasons for the referral, and the progress of the support given to the case. The social welfare staff suggested that for now, the partners at the district level should be given access to SWIMS to facilitate data sharing.

16. **Mid-term qualitative study to understand ISS implementation, and quantitative follow-up in August 2023**

The study team recommended a mid-term qualitative study to learn about ISS implementation and potential impacts on LEAP households. This would mimic the baseline approach and involve in-depth interviews with beneficiaries to see if there was greater use of other services, as well as focus groups with front lien workers to obtain their experiences with implementation. Results from this study would provide actionable evidence for improvements in ISS. Provided the ISS was being successfully implemented, and there was initial indication of improved service use by LEAP households, a quantitative follow-up could be implemented two years after baseline to measure impacts.

16.2 Conclusions

The quantitative and qualitative components of the LEAP-ISS baseline were successfully completed in August 2021, with an in-person workshop to discuss results held in March 2022 with all major stakeholders. The quantitative survey as successful in creating a well-balanced LEAP+ISS (LEAP+ISS) and comparison (LEAP only) group to measure impacts over time. The qualitative component provided rich information about potential implementation challenges for ISS, and barriers to service access for beneficiaries, especially access to NHIS (renewal of cards) and quality of health services.

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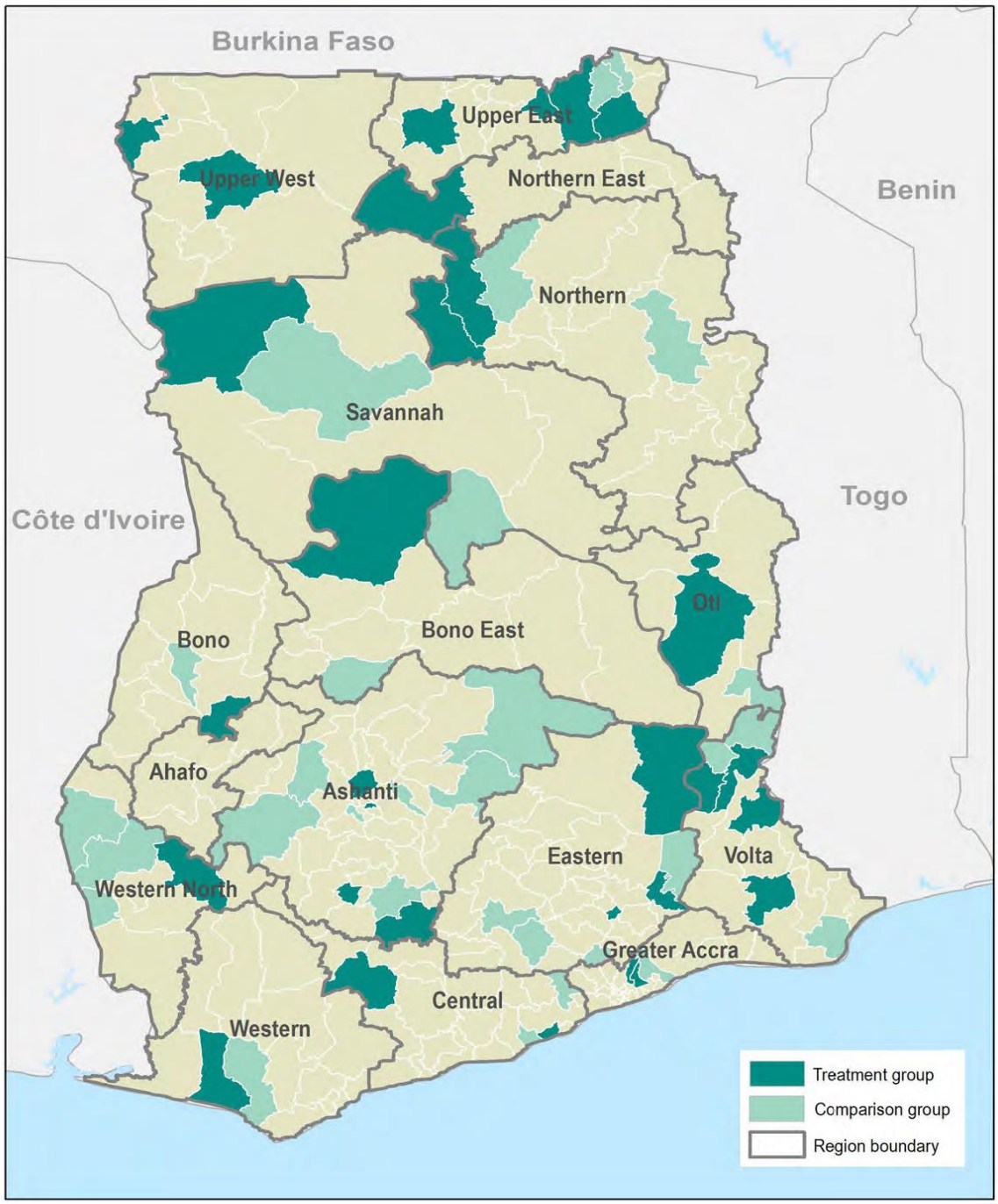
ANNEX 1: Map of LEAP+ISS and LEAP districts.



Annex 2: Sampling design and weights calculation

This note describes the procedure for the selection of the sample of analysis and the calculation of sampling weights for the evaluation of the LEAP+ISS in Ghana. The impact evaluation is based on a difference-in-differences quasi-experimental design which will compare changes over time in the treatment group (LEAP+ISS) to changes in a sample of the comparison group (LEAP only).

Selection procedure

There are three stages of selection of the sample: first, selection of districts; second, selection of communities in the selected districts; and the third is selection of households in the selected communities.

1st stage: Selection of districts

Treatment group (LEAP + ISS): The treatment group was originally defined as the 100 districts where LEAP+ISS was being implemented by 2021. However, we dropped 15 districts from the list because of two reasons: the ISS included all six (6) metropolitan districts of Ghana and it would have been not possible to find comparison districts for them, so we didn't include these six districts in the evaluation; and we further dropped nine (9) districts because they had very few LEAP beneficiary households and they were sparsely located. For the first stage of selection, we used the list of remaining 85 LEAP+ISS districts. We obtained 30 districts from that list using a systematic random selection procedure. The systematic selection used region, type of district (municipal and ordinary) and ISS implementation phase as ordering variables.

Comparison Group (LEAP only): The comparison group was defined as the 98 districts that were not in any of the three ISS phases[4] and where LEAP is active[5]. With the purpose of making the comparison sample more comparable to the treatment sample we conducted a matching procedure to selected 30 comparison districts. We used district-level data to implement a nearest neighbor propensity score matching without replacement technique. The matching was done using population projection estimates for 2020, annual population growth rate between 2010 and 2020, District League Table score, LEAP household counts, share of the 2020 population in LEAP, number of officers with social welfare background and with community welfare

[4] The ISS had three phases of implementation: Phase I started in 2020 in 60 districts, Phase II started in 2021 in 40 districts, and Phase III started in 2022 in 60 districts. The ISS was not implemented in 100 districts.
[5] Two of the 100 non-ISS districts didn't have available data.

background, share of government votes in the 2020 presidential elections, and geographical zone.

2nd stage: Selection of communities

In each selected district, 4 communities were selected using a systematic random sampling procedure applied to the list of communities with at least 10 LEAP households. The ordering variable was the number of LEAP households in the community. A total of 125 communities were selected in the 30 treatment districts[6]. A similar procedure was implemented in the 30 comparison districts to select 125 communities.

3rd stage: Selection of households

In each selected community about 10 LEAP households were randomly selected.

Weighting

The sampling weights were calculated according to the sampling design, as follows

$w = Hf_1f_2/R$

Where,

f_1 = Number of households in the community / number of households selected

f_2 = Number of communities in the district / number of communities selected

R = District response rate

H = a factor that makes the sum of weights to replicate the total number of households in the treatment and in the control groups.

[6] Five communities were selected in 5 treatment districts, and the same was done in 5 comparison districts.

Annex 3: Targeting performance of LEAP

We conducted an assessment of targeting performance in LEAP following the methodology proposed in Cody, Grosh and Hoddinott (2004)[7]. They develop an index that compares the share of program beneficiaries in a certain income relative to the share if there was no targeting (or random targeting). For example, say a program would like to reach the poorest 20 percent of the population. If there was no (or random) targeting, we would expect that 20 percent of beneficiaries would be in the poorest quintile. If, due to program targeting, we find that actually 40 percent of beneficiaries are in the lowest quintile, the index is (40/20) two. In words, the program is twice as effective as random or no targeting.

We apply this index to the LEAP data using three thresholds: 1) The lower poverty line; 2) the upper poverty line; 3) the poorest 40 percent. The last threshold is used in order to provide a comparison with the results from the Cody, Grosh, Hoddinot paper, who construct the index for 190 programs across the world. Results are shown in Figure 36 below. Using the two national poverty lines we see that LEAP is over twice as effective as random or no targeting, which is excellent. The index values reported in the above-mentioned article are 1.8 for 190 programs across the world, and 1.22 when considering just 122 cash transfer programs only. Their threshold is the poorest 40 percent; when using that (admittedly high) threshold in LEAP we get an index value of 1.85, 40 percent higher than the average value across 122 cash transfer programs shown in the figure.

[7] For the full source see here: https://doi.org/10.1093/wbro/lkh016

Figure 36: Improvement over no targeting