EVALUATING STAKEHOLDER ENGAGEMENT AND COMMUNICATION STRATEGIES IN IMPROVING NHIS COVERAGE IN GHANA

BY

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DECLARATION

I hereby declare that this research report is the result of my original work, and that no part of it has been presented for another degree or qualification in any other institution. All references to other works have been duly acknowledged.

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CERTIFICATION

This dissertation has been prepared and presented under my supervision according to the guidelines for supervision and formatting of dissertation laid down by the University of Media, Arts and Communication.

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Date: January 20, 2025

DEDICATION

I dedicate this study to all stakeholders of the National Health Insurance Scheme in Ghana, whose experiences and voices inspired the pursuit of this research. May this work contribute, in some measure, to advancing equitable healthcare access for all. I also dedicate it to my parent and family, whose unwavering support, encouragement, and sacrifices have been the foundation of my academic journey. To my loved ones who continually reminded me of the importance of resilience and purpose.

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ABBREVIATIONS

AMA Accra Metropolitan Assembly

ANOVA Analysis of Variance

CBD Central Business District

CI Confidence Interval

GDP Gross Domestic Product

GHS Ghana Health Service

GPS Global Positioning System

JHS Junior High School

MMDAs Metropolitan, Municipal and District Assemblies

NHIA National Health Insurance Authority

NHIS National Health Insurance Scheme

PhD	Doctor of Philosophy
PR	Public Relations
SD	Standard Deviation
SHS	Senior High School
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
WHO	World Health Organization

ABSTRACT

Despite two decades of implementation, Ghana's National Health Insurance Scheme maintains low active membership coverage nationally, with Greater Accra Region exhibiting particularly low enrollment despite higher awareness levels, indicating coverage challenges stem from communication and engagement deficiencies rather than lack of awareness. This study assessed current stakeholder engagement practices and communication strategies employed by the National Health Insurance Authority in Greater Accra, examined stakeholder perceptions, and identified public relations best practices for enhancing coverage, grounded in stakeholder theory, Grunig's public relations models, and health communication theories. A quantitative cross-sectional survey collected data from respondents comprising active members, lapsed members, non-enrolled individuals, healthcare providers, and NHIS staff through structured questionnaires via Google Forms, analyzed using descriptive statistics and one-sample t-tests. Findings revealed moderate awareness levels regarding enrollment procedures but critical deficiencies in stakeholder engagement quality, particularly responsiveness and participatory decision-making, with communication operating predominantly through one-way dissemination rather than dialogic engagement. The study concludes that achieving universal health coverage requires transitioning from asymmetric to symmetric communication models, institutionalizing responsive feedback mechanisms, implementing participatory structures, enhancing insurance literacy, and building trust through transparent communication.

Keywords: Health insurance communication, stakeholder engagement, public relations, NHIS Ghana, universal health coverage

CHAPTER ONE

INTRODUCTION

1.1 CHAPTER OVERVIEW

This chapter provides the foundational framework for examining stakeholder engagement and communication strategies within Ghana's National Health Insurance Scheme (NHIS) in the Greater Accra Region from a public relations perspective. It establishes the context by presenting the background of Ghana's NHIS, identifies critical communication and engagement gaps affecting coverage rates, articulates the research problem, outlines the research questions and objectives, defines the scope of the study, and highlights the significance of investigating public relations approaches to improving health insurance uptake.

1.2 BACKGROUND OF THE STUDY

Ghana's National Health Insurance Scheme, established through Act 650 in 2003 and operationalized in 2004, represents a landmark initiative in achieving universal health coverage by replacing the cash-and-carry system that excluded millions from accessing essential healthcare services (National Health Insurance Authority, 2018). The scheme ensures equitable access to basic healthcare for all Ghanaian residents, with particular emphasis on protecting vulnerable populations including pregnant women, children under 18, the elderly above 70 years, and indigents from paying premiums (Agyepong & Adjei, 2008). Despite nearly two decades of implementation, the NHIS continues to face significant challenges in achieving comprehensive national coverage, with active membership fluctuating and substantial portions of the eligible population remaining uninsured (Alhassan et al., 2016).

The Greater Accra Region, as Ghana's most urbanized administrative area, presents unique dynamics for health insurance coverage, characterized by diverse socioeconomic strata, varied employment patterns, and a concentration of both public and private healthcare facilities (Ghana Statistical Service, 2021). Urban settings like Accra exhibit distinct patterns of NHIS enrolment compared to rural areas, influenced by higher literacy levels, greater exposure to multiple information channels, and more complex stakeholder ecosystems (Kotoh & Van der Geest, 2016). Understanding how stakeholders are engaged and how communication strategies are deployed in this metropolitan context becomes critical, as the region serves as both a testing ground for policy innovations and a bellwether for national health insurance performance.

From a public relations perspective, the success of health insurance schemes fundamentally depends on effective stakeholder engagement and strategic communication that builds awareness, trust, and sustained participation among target populations (Ledingham, 2003). Public relations theory emphasizes relationship management, two-way communication, and stakeholder dialogue as essential mechanisms for organizational effectiveness, particularly in complex public health domains requiring behavioural change and long-term commitment (Grunig, 2001). However, existing evidence suggests that NHIS implementation in Ghana has been characterized by predominantly one-way, top-down communication approaches with limited genuine stakeholder engagement, resulting in persistent misconceptions about scheme benefits, mistrust regarding claims processing, and inadequate feedback mechanisms (Blanchet et al., 2012).

Contemporary public relations scholarship advocates for symmetrical communication models, stakeholder co-creation, and integrated communication strategies that leverage multiple channels while prioritizing dialogue over monologue (Kent & Taylor, 2002). Applying these frameworks to

Ghana's NHIS in Greater Accra offers opportunities to reimagine how health insurance authorities engage with diverse stakeholders to address coverage gaps through strategic communication interventions grounded in relationship-building. This research therefore situates itself at the intersection of health policy implementation and public relations practice, examining how communication strategies and stakeholder engagement processes influence NHIS coverage outcomes in Ghana's capital region.

1.3 PROBLEM STATEMENT

Despite significant government investment and policy reforms over the past two decades, Ghana's National Health Insurance Scheme continues to struggle with suboptimal coverage rates, with active membership hovering between 40-45% of the population and the Greater Accra Region exhibiting particularly concerning patterns of low enrolment and high dropout rates among eligible populations (Blanchet et al., 2012). This coverage deficit undermines the scheme's fundamental objective of achieving universal health coverage and perpetuates healthcare access inequities, particularly affecting informal sector workers, youth, and economically disadvantaged urban residents (Agyepong et al., 2016). While existing research has identified numerous barriers to NHIS uptake including perceived poor service quality and complex enrolment procedures, there remains insufficient scholarly attention to the role of stakeholder engagement and communication strategies as determinants of coverage outcomes from a public relations perspective.

Current communication approaches employed by the National Health Insurance Authority appear fragmented, inconsistent, and inadequately responsive to the diverse information needs of different stakeholder groups within Greater Accra. Evidence reveals widespread misconceptions about NHIS benefits packages, confusion regarding premium payment requirements, limited awareness

of grievance redressal mechanisms, and poor understanding of the claims process—all indicative of communication failures that public relations frameworks are specifically designed to address (Duku et al., 2016). Furthermore, stakeholder engagement processes remain largely consultative rather than collaborative, with limited mechanisms for ongoing dialogue between scheme administrators and critical stakeholder groups such as healthcare providers, employers, and community organizations.

The absence of systematic evaluation of stakeholder engagement and communication strategies specifically within the NHIS context in Greater Accra represents a significant knowledge gap which this research seeks to address. While international literature on health insurance communication is extensive, context-specific research examining how public relations principles can be applied to strengthen health insurance schemes in sub-Saharan African urban settings remains limited (Agyepong & Nagai, 2011),therefore this research addresses a critical gap by systematically evaluating current stakeholder engagement and communication strategies, identifying deficiencies through the lens of public relations scholarly, and generating insights that can inform more effective communication interventions to expand and sustain NHIS coverage in Ghana's most urbanized region.

1.4 RESEARCH QUESTIONS AND OBJECTIVES

How do stakeholder engagement and communication strategies influence National Health Insurance Scheme coverage in the Greater Accra Region of Ghana from a public relations perspective?

1. To assess the current stakeholder engagement practices and communication strategies employed by the National Health Insurance Authority in the Greater Accra Region.

2. To examine stakeholders' perceptions of communication effectiveness and engagement processes related to NHIS enrolment and utilization in Greater Accra.
3. To identify public relations best practices and strategic communication interventions that could enhance NHIS coverage and stakeholder relationships in the Greater Accra Region.

1.5 SCOPE OF THE STUDY

This research is geographically delimited to the Greater Accra Region of Ghana, focusing specifically on the sixteen metropolitan, municipal, and district assemblies that constitute this administrative area. Thematically, the study examines stakeholder engagement and communication strategies related to Ghana's National Health Insurance Scheme, with particular emphasis on how public relations approaches influence coverage outcomes, defined as both initial enrolment and sustained active membership. The stakeholder scope encompasses NHIS members (active and lapsed), non-enrolled eligible populations, healthcare service providers, NHIS district office personnel, employers, and civil society organizations involved in health advocacy within Greater Accra. Temporally, the study focuses on current practices and recent experiences within the past three years, and methodologically adopts a mixed-methods approach combining quantitative assessment of communication reach with qualitative exploration of stakeholder engagement experiences and perceptions.

1.6 SIGNIFICANCE OF THE STUDY

This research holds substantial theoretical significance by contributing to the relatively underdeveloped intersection between public relations scholarship and health insurance implementation in sub-Saharan African contexts, extending stakeholder engagement and

communication effectiveness theories into the domain of public health financing. By systematically applying public relations frameworks such as relationship management theory and symmetrical communication models to Ghana's NHIS in Greater Accra, the study enriches academic understanding of how communication strategies influence health insurance uptake in urban African settings. Furthermore, the research addresses a notable gap in literature concerning the operationalization of strategic communication in health insurance schemes beyond mere awareness creation toward genuine stakeholder engagement.

From a practical and policy perspective, this study offers directly actionable recommendations for the National Health Insurance Authority, Ministry of Health, and associated agencies seeking to improve NHIS coverage rates and achieve universal health coverage targets outlined in Ghana's national health policies and the Sustainable Development Goals. The findings will provide evidence-based guidance on optimizing communication channels for different demographic segments, designing more effective stakeholder engagement processes, strengthening feedback mechanisms, and building trust through relationship-oriented approaches. Additionally, the research benefits healthcare providers, employers, and civil society organizations by clarifying their roles in NHIS communication ecosystems and suggesting collaborative approaches to information dissemination, ultimately contributing to improved healthcare access for Accra's diverse population.

1.7 ORGANIZATION OF THE STUDY

This research is structured into five chapters that systematically address the research objectives through a logical progression from conceptual foundations to empirical findings and recommendations. Chapter One has provided the introduction, establishing the research context,

problem, questions, objectives, scope, and significance. Chapter Two presents a comprehensive literature review examining theoretical frameworks of public relations and stakeholder engagement, empirical studies on health insurance communication, the Ghana NHIS context, and identified research gaps. Chapter Three outlines the research methodology, detailing the research design, population and sampling procedures, data collection instruments, and analytical approaches. Chapter Four presents and analyses the research findings, systematically addressing each research objective through data interpretation and thematic analysis. Chapter Five concludes the study by summarizing major findings, drawing conclusions about stakeholder engagement and communication strategies' influence on NHIS coverage, providing practical recommendations for policy and practice, acknowledging research limitations, and suggesting directions for future scholarly inquiry.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews relevant literature on stakeholder engagement and communication strategies in health insurance schemes, with particular focus on Ghana's National Health Insurance Scheme and the Greater Accra Region. The review begins with theoretical frameworks encompassing stakeholder theory, public relations models, and health communication theories that provide conceptual foundations for examining communication and engagement practices. Subsequently, the chapter examines empirical literature on stakeholder engagement in health insurance systems, communication strategies, and public relations practices in healthcare settings. The review then focuses specifically on Ghana's NHIS, exploring its history, structure, coverage patterns, current communication approaches, and the Greater Accra Region's unique urban healthcare context. Throughout, the review identifies gaps in existing knowledge that this research addresses, particularly the limited systematic examination of stakeholder engagement and communication strategies from a public relations perspective within the NHIS context in Greater Accra.

2.2 THEORETICAL FRAMEWORK

2.2.1 Stakeholder Theory and Engagement

Stakeholder theory, originally developed by Freeman (1984), posits that organizations must consider the interests of all parties affected by or capable of affecting organizational objectives, moving beyond shareholder-centric views to embrace broader constituencies including employees, customers, communities, and government entities. Mitchell, Agle, and Wood (1997) propose a stakeholder salience model categorizing stakeholders based on power, legitimacy, and urgency, providing frameworks for prioritizing engagement in resource-constrained environments. In health systems contexts, stakeholder engagement has been recognized as essential for achieving policy objectives, particularly in complex reforms like health insurance expansion where success depends on behavioural change and sustained participation (Schmeer, 1999).

Stakeholder engagement refers to systematic processes through which organizations involve stakeholders in decision-making through consultation, collaboration, and empowerment mechanisms (Greenwood, 2007). The International Association for Public Participation (IAP2, 2007) developed a spectrum ranging from informing stakeholders through consulting, involving, collaborating, to empowering them with decision-making authority. Reed (2008) demonstrates that meaningful stakeholder engagement characterized by early involvement, transparent communication, and genuine consideration of input yields enhanced program legitimacy, improved design quality, increased cooperation, and superior outcomes compared to top-down approaches.

Recent scholarship critiques superficial engagement approaches in health programs, particularly in low- and middle-income countries where participatory rhetoric often masks continued top-down

decision-making with tokenistic consultation (Cleary, Molyneux, & Gilson, 2013). Effective stakeholder engagement in health insurance requires sustained dialogue platforms, co-design processes involving stakeholders in shaping program features, transparent communication about constraints, and accountability mechanisms enabling program adjustments based on implementation experience (Abelson et al., 2003). For Ghana's NHIS, applying stakeholder theory suggests systematically identifying relevant stakeholder groups in Greater Accra, understanding their interests and concerns, assessing their influence on coverage outcomes, and developing differentiated engagement strategies fostering genuine participation.

2.2.2 Public Relations Theory and Models

Public relations, defined by Grunig and Hunt (1984) as "the management of communication between an organization and its publics," encompasses strategic communication activities designed to build mutually beneficial relationships through information exchange, dialogue, and reputation management. Grunig's (2001) four models of public relations press agentry, public information, two-way asymmetric, and two-way symmetric distinguish between one-way transmission models focused on persuasion versus two-way models emphasizing dialogue and mutual understanding. The two-way symmetric model conceptualizes public relations as facilitating balanced communication where organizations both inform publics and are influenced by feedback, using research to understand stakeholder perspectives and negotiation to resolve conflicts (Grunig & Grunig, 1992).

Excellence theory, developed by Grunig, Grunig, and Dozier (2002), identifies characteristics of excellent public relations and their contribution to organizational effectiveness, arguing that strategic public relations management characterized by two-way symmetric communication,

stakeholder relationship cultivation, and integration with organizational decision-making creates value by building social capital and enabling organizations to achieve goals with stakeholder support. Hon and Grunig (1999) developed instruments for measuring organization-public relationships based on dimensions including trust, control mutuality, commitment, and satisfaction, providing frameworks for evaluating relationship quality beyond communication outputs.

Relationship management theory, articulated by Ledingham and Bruning (1998, 2000), positions relationship building as the core function of public relations, arguing that organizational success depends fundamentally on relationship quality with key publics. Kent and Taylor (2002) contribute dialogic theory, emphasizing that effective public relations require genuine dialogue characterized by mutuality, propinquity, empathy, risk, and commitment. Application of public relations theories to health insurance schemes suggests communication strategies should transcend information campaigns toward relationship-oriented approaches building trust, facilitating dialogue, and creating mechanisms for ongoing engagement (Ratzan, 2001). For Ghana's NHIS in Greater Accra, public relations theory highlights the inadequacy of one-way information dissemination and points toward needs for two-way communication systems, relationship quality assessment, and dialogue platforms where stakeholders can express concerns and receive substantive responses.

2.2.3 Health Communication Theory

Health communication, defined as "the study and use of communication strategies to inform and influence decisions that enhance health" (Evans, 2015), draws from psychology, sociology, communication studies, and public health to explain how communication influences health-related knowledge, attitudes, and behaviors at multiple levels (Sudhansubala & Preethi, 2016). The Health Belief Model (Rosenstock, 1974; Janz & Becker, 1984) posits that health behaviors depend on

individuals' perceptions of disease susceptibility and severity, perceived benefits and barriers to recommended actions, cues to action, and self-efficacy. Applying this framework to health insurance suggests enrolment decisions depend on perceived health risks, understanding of insurance benefits, perceived barriers like premium costs, exposure to enrolment prompts, and confidence in navigating insurance systems all influenced by communication strategies (Champion & Skinner, 2008).

Diffusion of Innovations theory (Rogers, 2003) explains how new ideas spread through social systems via communication channels, proposing that adoption follows an S-curve pattern based on factors including relative advantage, compatibility, complexity, trialability, and observability. Rogers emphasizes that interpersonal networks and opinion leaders often prove more powerful than mass media in driving adoption decisions. Health insurance, as a relatively abstract service, presents diffusion challenges addressed through communication strategies leveraging social networks, engaging trusted community influencers, and creating social proof through testimonials (Dearing & Cox, 2018).

Participatory communication approaches, influenced by Freirean pedagogy, critique expert-driven health communication models and advocate for dialogue-based processes where communities actively participate in defining health problems and generating solutions (Airhihenbuwa, 1995). Participatory health communication emphasizes community ownership, cultural appropriateness, horizontal communication, and structural change alongside individual behaviour change (Estrada et al., 2018). The World Health Organization (2002) endorses participatory communication as essential for health promotion effectiveness, particularly in contexts characterized by health inequities. For NHIS communication in Greater Accra's diverse communities, participatory

approaches suggest limitations of centrally designed campaigns and value in community-based communication processes involving local leaders, peer educators, and beneficiary groups in shaping messages and addressing culturally specific concerns affecting enrolment decisions.

2.3 STAKEHOLDER ENGAGEMENT IN HEALTH INSURANCE SCHEMES

2.3.1 Defining Stakeholders in Health Insurance Systems

Stakeholders in health insurance systems comprise diverse individuals, groups, and organizations that affect or are affected by insurance policies and operations, including insured members, healthcare providers, government agencies, and civil society organizations (Savedoff, 2004). Hsiao and Shaw (2007) identify core stakeholder categories: beneficiaries, healthcare providers, purchasers and payers, regulators and policymakers, and civil society organizations. Each category possesses distinct interests members prioritize affordable access and efficient claims processing, providers focus on adequate reimbursement, while policymakers balance financial sustainability with coverage expansion goals (Kutzin, 2001).

Stakeholder complexity increases in developing countries where informal sector dominance, diverse employment patterns, and varying literacy levels create heterogeneous populations with differentiated relationships to insurance schemes (McIntyre, Garshong, et al., 2008). Witter and Garshong (2009) examining Ghana's NHIS categorize stakeholders into primary stakeholders directly involved in transactions, secondary stakeholders affecting implementation, and key stakeholders with significant policy influence. Within beneficiaries alone, important distinctions exist among formal sector workers, informal sector workers, indigents eligible for exemptions, and non-enrolled populations whose non-participation reasons vary across socioeconomic

characteristics (Jehu-Appiah et al., 2011). Comprehensive stakeholder mapping requires identifying not only direct participants but also intermediary actors like community leaders and civil society organizations whose influence on coverage outcomes may be substantial despite less visible roles (Derbile & van der Geest, 2013).

2.3.2 Stakeholder Engagement Approaches in Healthcare

Stakeholder engagement in healthcare encompasses approaches ranging from passive information provision through consultation to genuine partnership and shared decision-making, with growing recognition that meaningful engagement yields superior outcomes (Boivin et al., 2014). The World Health Organization (2016) distinguishes engagement modalities based on stakeholder influence: information sharing, consultation, involvement, collaboration, and empowerment. Carman et al. (2013) emphasize that healthcare organizations must match engagement approaches to specific contexts, recognizing some situations appropriately require only information sharing while others demand genuine partnership with affected communities.

Patient and public involvement in health services has emerged as both an ethical imperative and a practical strategy for improving service quality (Mockford et al., 2012). Systematic reviews find that authentic involvement produces services better aligned with patient priorities, identification of implementation challenges, enhanced trust, and improved health outcomes (Brett et al., 2014). However, challenges persist including power imbalances, inadequate resources, and difficulties ensuring diverse population representation (Renedo & Marston, 2015). Community engagement has been recognized as essential for health program success in low- and middle-income countries, with approaches including community advisory boards, participatory planning workshops, and community-based monitoring systems (George et al., 2015).

In health insurance contexts, stakeholder engagement has been explored primarily through beneficiary education programs and provider contracting negotiations, with less attention to ongoing engagement mechanisms enabling continuous dialogue (McPake et al., 2011). Abiiro and De Allegri (2015) note that schemes with active community governance structures demonstrate higher enrolment rates and greater trust compared to schemes with purely technocratic management. These findings suggest health insurance schemes should conceptualize stakeholder engagement as ongoing relational processes embedded in governance structures, with institutional mechanisms ensuring stakeholder voice influences operational decisions (Basaza, Criel, & Van der Stuyft, 2008).

2.3.3 Stakeholder Engagement and Health Insurance Coverage

The relationship between stakeholder engagement quality and health insurance coverage outcomes has received growing empirical attention, with evidence suggesting meaningful involvement positively influences both enrolment and sustained membership (Kamuzora & Gilson, 2007). Trust emerges as a critical mediating variable, with research demonstrating that schemes characterized by transparent communication, responsive grievance mechanisms, and community participation cultivate higher trust levels predicting enrolment decisions (Donfouet et al., 2011). Conversely, schemes perceived as distant or unresponsive face scepticism suppressing enrolment even when premiums and benefits appear financially attractive, highlighting that coverage expansion depends fundamentally on relational factors shaped by engagement quality (Mladovsky & Mossialos, 2008).

Community-based health insurance experiences in sub-Saharan Africa provide evidence regarding stakeholder engagement impacts. Basaza, Criel, and Van der Stuyft (2008) find schemes with

active member participation in decision-making demonstrate enrolment rates 20-40% higher than schemes with top-down management. Dror and Jacquier (1999) argue that engagement serves multiple functions: educating members, building ownership facilitating premium collection, identifying locally appropriate benefit designs, and creating accountability mechanisms. Provider engagement quality similarly affects coverage through mechanisms including provider willingness to serve insured patients and provider roles as information sources during patient interactions (Lagarde, Barroy, & Palmer, 2012).

Stakeholder engagement effects on coverage operate through multiple pathways including social influence processes where engaged community members become enrolment ambassadors, governance legitimacy effects where participatory processes increase scheme acceptability, and accountability mechanisms creating pressure to deliver promised benefits (Palmer et al., 2004). Jehu-Appiah et al. (2011) examining NHIS enrolment in Ghana find that living in communities with active health insurance committees and exposure to community dialogue sessions predict enrolment probability independently of individual socioeconomic factors, suggesting communitylevel engagement creates social contexts facilitating coverage expansion. These findings underscore that stakeholder engagement should be understood as a fundamental determinant of health insurance coverage requiring strategic investment as core scheme functions rather than peripheral activities.

2.4 COMMUNICATION STRATEGIES IN HEALTH INSURANCE

2.4.1 Health Communication Channels and Effectiveness

Health communication channels represent the various media and platforms through which health information is transmitted from sources to audiences, with channel selection significantly influencing message reach, comprehension, and behavioural impact (Bernhardt, 2004). Traditional mass media channels including radio, television, and newspapers have historically dominated health insurance communication in developing countries due to their broad reach and relatively low per-contact costs, with radio particularly effective in African contexts given high listenership rates and accessibility to populations with limited literacy (Wakefield, Loken, & Hornik, 2010). However, mass media channels exhibit limitations including their one-way nature precluding dialogue, inability to address individual concerns, and difficulty facilitating the complex information processing required for insurance enrolment decisions (Noar, 2006).

Interpersonal communication channels, including one-on-one interactions with enrolment agents, community health workers, and peer discussions, demonstrate superior effectiveness for influencing health insurance enrolment compared to mass media alone, particularly for populations with limited formal education (Kincaid, 2004). In Ghana's NHIS context specifically, NsiahBoateng et al., (2019) find that direct contact with enrolment officers and discussions with enrolled family members predict enrolment probability more strongly than exposure to mass media campaigns. Digital communication channels including mobile phones and social media platforms have emerged as increasingly important in urban African settings where mobile penetration exceeds 80%, with mHealth interventions demonstrating effectiveness for enrolment reminders, premium payment notifications, and benefit information dissemination (Labrique et al., 2013).

However, digital divide concerns persist, necessitating multi-channel communication strategies combining traditional, interpersonal, and digital approaches (Rimal & Lapinski, 2009).

2.4.2 Information Dissemination Strategies for Health Insurance

Information dissemination strategies for health insurance encompass systematic approaches through which schemes communicate benefit packages, eligibility criteria, enrolment procedures, and member rights to target populations (Loewenson et al., 2004). Traditional dissemination strategies emphasize information provision through printed materials and mass media campaigns, supplemented by workplace information sessions and community meetings (Atun et al., 2008). However, evidence suggests that passive information dissemination through printed materials and mass media, while necessary for broad awareness, proves insufficient for driving enrolment particularly among populations with limited health literacy (Kenkel & Sindelar, 2011).

Community-based information dissemination strategies positioning communication activities within community settings and utilizing trusted local actors demonstrate enhanced effectiveness compared to centralized approaches (Musoke et al., 2014). These strategies include community sensitization meetings, workplace information sessions, religious congregation outreach, and market-based information booths reaching informal sector workers (Dasgupta, 2021). Targeted information dissemination recognizing that different stakeholder segments require differentiated communication content and messaging approaches represents best practice, with demographic segmentation based on age, education level, and employment status enabling message customization addressing specific concerns relevant to each segment (Andreasen, 2002).

Information dissemination effectiveness depends critically on message comprehension, requiring attention to health literacy levels, linguistic diversity, and cultural contexts, with plain language principles and visual aids enhancing understanding for populations with limited formal education (Nutbeam, 2008).

2.4.3 Trust and Communication in Health Insurance Uptake

Trust represents a critical determinant of health insurance enrolment and retention, with substantial evidence demonstrating that population trust in insurance schemes significantly predicts insurance uptake independent of premium costs or benefit package generosity (Platteau, De Bock, & Gelade, 2017). Rousseau et al. (1998) define trust as "a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behaviour of another." In health insurance contexts, trust manifests as confidence that the scheme will deliver promised benefits when illness occurs and that claims will be processed fairly and efficiently (Gilson, 2003).

Communication quality and patterns represent primary determinants of trust development, with transparent, consistent, timely, and honest communication building trust while secretive or contradictory communication eroding trust (Frewer et al., 1996). Two-way communication enabling dialogue rather than one-way information transmission particularly strengthens trust by demonstrating organizational respect for stakeholder perspectives (Grunig, 2001). For health insurance schemes, trust-building communication requires transparent acknowledgment of limitations such as excluded services and implementation challenges, with such honesty paradoxically strengthening credibility (Ismail et al., 2025). Institutional trust in government shapes willingness to enrol in nationally administered health insurance schemes, with Akazili et al. (2014) finding that trust in government significantly predicts NHIS enrolment in Ghana.

Healthcare provider trust similarly influences enrolment as populations rely partly on provider recommendations when making enrolment decisions, suggesting that communication strategies must extend beyond potential member outreach to include provider engagement (Arhinful, 2003).

2.5 PUBLIC RELATIONS PRACTICES IN HEALTHCARE SETTINGS

2.5.1 Public Relations in Public Health Programs

Public relations in public health programs encompasses strategic communication activities that build and maintain mutually beneficial relationships between health organizations and their publics to facilitate health promotion objectives and mobilize community participation (Guttman & Salmon, 2004). Unlike commercial public relations focused on organizational reputation, public health public relations emphasize social goals including behaviour change and community empowerment, though both domains share core functions of stakeholder identification, message development, and relationship cultivation (Schiavo, 2014). Best practices emphasize audience research and segmentation as foundations for strategy development, recognizing that publics differ in their health knowledge, cultural beliefs, and communication channel preferences, necessitating differentiated approaches (Slater, 1995).

Media relations constitute a core public relations function for health programs seeking to leverage journalistic coverage to reach broad audiences and shape public discourse (Wallack et al., 1993). Effective health media relations require building relationships with journalists, providing timely and accurate information, and strategically framing health issues (Chapman & Lupton, 1994). However, media coverage of health insurance schemes often emphasizes problems and controversies given journalistic norms privileging conflict, potentially reinforcing public

scepticism (Lawrence, 2004). Crisis communication and issues management represent critical functions for health programs facing controversies or negative publicity, requiring rapid response acknowledging problems honestly, demonstrating empathy, and providing accurate information about corrective actions (Coombs, 2015). For Ghana's NHIS, recurring implementation challenges have generated negative media coverage requiring crisis communication responses balancing accountability with emphasis on corrective measures (Dalinjong & Laar, 2012).

2.5.2 Relationship Management in Healthcare Organizations

Relationship management represents the central function of contemporary public relations practice, with Ledingham (2003) arguing that public relations should be understood fundamentally as managing organization-public relationships rather than merely managing communication. This relationship-centric paradigm conceptualizes public relations as assessing relationship status, identifying relationship development goals, implementing relationship-building strategies, and evaluating relationship outcomes including trust, satisfaction, and commitment (Hon & Grunig, 1999). Relationship quality dimensions provide frameworks for assessing organizationstakeholder relationships, with Hon and Grunig (1999) identifying key dimensions including trust, control mutuality, commitment, and satisfaction.

Relationship cultivation strategies in healthcare settings include personalized communication, responsiveness demonstrating that organizations listen to stakeholder concerns, openness involving transparent information sharing, and networking creating opportunities for stakeholder interaction with organizational representatives (Ki & Hon, 2007). Practical applications for health insurance schemes include member advisory committees, rapid response helplines, community feedback sessions, and co-creation processes involving members in designing improved services

(NHIS, 2013). Relational outcomes represent the ultimate goals of relationship management, with strong organization-public relationships generating benefits including stakeholder loyalty, positive word-of-mouth advocacy, and willingness to invest effort in relationship maintenance (Bruning & Ledingham, 1999).

2.5.3 Two-Way Communication and Feedback Mechanisms

Two-way communication, involving information exchange flowing in both directions between organizations and publics rather than one-way organizational messaging, represents a foundational principle of excellence in public relations (Grunig, 2001). The distinction between two-way asymmetric communication (using research to craft more persuasive messages) and two-way symmetric communication (using dialogue to achieve mutual understanding) highlights that genuine two-way communication requires organizational willingness to be influenced by stakeholder input (Grunig & Grunig, 1992). Healthcare organizations increasingly recognize that two-way communication yields benefit including improved service quality through incorporation of user perspectives and enhanced trust through demonstrated responsiveness (Wynia, 2010).

Feedback mechanisms constitute the institutional infrastructure enabling two-way communication, providing structured channels through which stakeholders can voice concerns, ask questions, and report problems with expectations of organizational response (Gilson et al., 2017). Common feedback mechanisms include helpline telephone numbers, suggestion boxes, email addresses, social media platforms, and formal grievance procedures (Kengia et al., 2025). However, establishing feedback channels proves insufficient without organizational commitment to analysing feedback and responding substantively, as unresponsive mechanisms generate cynicism (Molyneux et al., 2012). Feedback responsiveness requires organizational systems for receiving,

tracking, analysing, and responding to stakeholder input in timely ways, with best practices including acknowledgment of feedback receipt within short timeframes and transparency about how feedback influenced organizational decisions (Nikolić et al, 2020). Digital technologies create expanded opportunities for two-way communication through mobile applications, SMS-based feedback systems, and web portals, though digital mechanisms risk excluding populations without digital access, necessitating hybrid approaches (Mechael, 2009).

2.6 OVERVIEW OF GHANA'S NATIONAL HEALTH INSURANCE SCHEME

2.6.1 History and Evolution of NHIS in Ghana

Ghana's National Health Insurance Scheme emerged from decades of health financing challenges under the cash-and-carry system implemented in the 1980s as part of structural adjustment programs, which required patients to pay out-of-pocket at the point of service delivery and resulted in catastrophic health expenditures for poor households and widespread exclusion from essential healthcare (Agyepong & Adjei, 2008). The cash-and-carry system generated public outcry and political pressure throughout the 1990s, with civil society organizations, healthcare professionals, and political parties advocating for alternative financing mechanisms that would ensure equitable access to healthcare regardless of ability to pay (Agyepong, Abankwah, et al., 2016). Following the 2000 general elections, the incoming government made health insurance reform a priority campaign promise, leading to the passage of the National Health Insurance Act (Act 650) in 2003 and the operationalization of the scheme in 2004 (National Health Insurance Authority, 2018).

The NHIS was designed as a mandatory social health insurance scheme financed through a combination of a 2.5% levy on goods and services (National Health Insurance Levy), 2.5% of

Social Security and National Insurance Trust (SSNIT) contributions from formal sector workers, premium payments from informal sector workers and non-SSNIT contributors, and government budget allocations (Blanchet, Fink, & Osei-Akoto, 2012). The scheme's implementation followed a phased approach beginning with pilot districts in 2004, gradually expanding nationwide, and by 2010 had established district mutual health insurance schemes in all districts, which were subsequently consolidated into a single national scheme under the National Health Insurance Authority to address fragmentation and inequities across districts (Witter & Garshong, 2009). Constitutional amendments in 1992 and subsequent legislation established healthcare as a fundamental human right in Ghana, providing legal foundations for the NHIS as a mechanism for realizing this right through social protection (Agyepong & Adjei, 2008).

The NHIS evolution has been characterized by periodic policy reforms addressing implementation challenges and expanding coverage. Significant reforms include the introduction of capitation payment systems replacing fee-for-service reimbursement in some regions, expansion of the benefit package to include additional conditions and services, implementation of free maternal care initiatives making antenatal, delivery, and postnatal services completely free regardless of NHIS enrolment status, and establishment of mobile renewal systems using mobile money platforms to facilitate premium payments (Dalinjong & Laar, 2012). However, the scheme has also faced persistent challenges including delayed provider reimbursements creating tensions with healthcare facilities, medicine stockouts undermining member satisfaction, fraudulent claims necessitating verification systems, and premium collection difficulties particularly among informal sector workers whose income volatility makes regular payments challenging (Alhassan, NketiahAmponsah, & Arhinful, 2016). These implementation challenges have generated periodic

crises requiring government intervention, policy adjustments, and intensified communication efforts to maintain public confidence in the scheme.

2.6.2 NHIS Structure and Benefit Package

The NHIS operates under the governance of the National Health Insurance Authority (NHIA), a statutory body established under Act 650 and responsible for policy formulation, scheme administration, accreditation of healthcare providers, claims processing, and financial management (National Health Insurance Authority, 2018). The organizational structure includes the NHIA headquarters providing strategic direction and central functions, regional offices coordinating implementation across geographic zones, and district offices serving as primary contact points for member registration, premium collection, and stakeholder engagement at the local level (Witter & Garshong, 2009). The scheme's governance framework includes a governing council appointed by the President comprising representatives from government ministries, healthcare professional associations, civil society organizations, and technical experts providing oversight and strategic guidance (Agyepong & Adjei, 2008).

Membership in the NHIS is categorized into premium-paying and exempt categories, with premium exemptions provided for indigents identified through community-based poverty assessments, children under 18 years, elderly persons aged 70 years and above, pregnant women covered under free maternal care policies, SSNIT pensioners, and SSNIT contributors who have their premiums deducted automatically from payroll (Jehu-Appiah et al., 2011). Premium rates for non-exempt informal sector workers are determined based on income assessments, though in practice most informal sector members pay flat rates at the district level due to difficulties in accurately assessing informal incomes, with premiums generally ranging from GHS 15 to GHS 60

annually depending on income classification (Duku et al., 2016). The NHIS benefit package covers approximately 95% of disease conditions in Ghana, including outpatient services, inpatient care, oral health, maternity care including deliveries, emergency care, all generic medicines on the NHIS Medicine List, and diagnostic tests, though it explicitly excludes certain services such as cosmetic surgery, appliances and prostheses, medical examinations for purposes other than treatment, and VIP ward accommodation (National Health Insurance Authority, 2018).

Healthcare service delivery under the NHIS occurs through accredited providers including public hospitals and health centres, private hospitals and clinics, faith-based health facilities, and selected traditional medicine practitioners, with accreditation requiring facilities to meet minimum infrastructure, staffing, and quality standards established by the NHIA (Agyepong et al., 2016). Provider payment mechanisms have evolved from predominantly fee-for-service reimbursement based on claims submitted for individual services to capitation systems in some regions where primary care providers receive fixed per-member payments regardless of services utilized, designed to control costs and incentivize preventive care (Dalinjong & Laar, 2012). However, provider payment delays resulting from scheme financial pressures and claims verification processes have created ongoing tensions, with some providers reportedly providing differential service quality to insured versus out-of-pocket paying patients or refusing to serve NHIS members during periods of extended payment delays (Alhassan et al., 2016). Member access to services requires presenting a valid NHIS identification card at accredited facilities, with services provided free at point of use for covered benefits, though members frequently report being charged for medicines purportedly included in the scheme due to facility stockouts or provider attempts to generate additional revenue (Kotoh & Van der Geest, 2016).

2.6.3 NHIS Coverage Trends and Challenges

NHIS membership has expanded significantly since the scheme's inception, growing from approximately 1 million members in 2005 to peak coverage of over 10 million active members (approximately 40% of the population) by 2012, though subsequent years have seen fluctuating enrolment with active membership declining in some periods due to renewal challenges and member dissatisfaction (Blanchet et al., 2012). Coverage statistics distinguish between cumulative ever-enrolled members and active members with current valid insurance cards, with the gap between these figures highlighting retention challenges as many individuals enrol initially but subsequently fail to renew, resulting in active membership substantially lower than cumulative enrolment (Agyepong et al., 2016). Coverage patterns exhibit significant geographic variation, with Greater Accra Region historically showing lower enrolment rates compared to some rural regions despite the capital's higher income levels, attributed to factors including greater availability of private healthcare alternatives, higher opportunity costs of time spent in enrolment queues, and urban populations' greater mobility complicating continuous membership (Jehu-Appiah et al., 2011).

Demographic coverage gaps persist despite universal coverage aspirations, with young adults aged 18-35 exhibiting particularly low enrolment rates attributed to perceptions of good current health making insurance unnecessary, premium affordability challenges for economically establishing youth, and competing financial priorities (Duku et al., 2016). Informal sector workers constitute the largest under-covered population segment, with enrolment rates among informal workers significantly lower than formal sector workers despite informal workers comprising approximately 80% of Ghana's workforce, explained by premium payment requirements for informal workers

versus automatic payroll deductions for formal workers, income volatility making regular premium payments difficult, and limited understanding of insurance principles among populations without previous coverage experience (Jehu-Appiah et al., 2011). Gender coverage gaps have diminished significantly following free maternal care initiatives that increased women's enrolment, though male enrolment rates particularly among young and middle-aged men remain concerning (Kotoh & Van der Geest, 2016).

Implementation challenges undermining coverage sustainability include scheme financial pressures resulting from expanding membership without proportional revenue increases, creating periodic liquidity crises affecting provider payments and medicine procurement (Alhassan et al., 2016). Service quality concerns including long waiting times at facilities serving NHIS members, medicine unavailability requiring out-of-pocket purchases despite insurance coverage, and perceived poor treatment by providers towards insured patients discourage initial enrolment and retention among enrolled members (Agyepong et al., 2016). Operational challenges include complex enrolment procedures requiring multiple documents and facility visits, inconvenient card collection systems necessitating return trips to district offices, delayed card processing creating gaps between premium payment and coverage activation, and inadequate member education about covered benefits leading to disappointed expectations when excluded services are denied (Dalinjong & Laar, 2012). Communication deficiencies across multiple dimensions—limited awareness of enrolment procedures among target populations, misconceptions about scheme benefits and eligibility, inadequate information about member rights and complaints procedures, and poor feedback mechanisms for addressing member concerns—represent fundamental barriers to coverage expansion requiring systematic attention through strategic communication interventions informed by public relations best practices (Blanchet et al., 2012).

2.7 NHIS COMMUNICATION AND STAKEHOLDER ENGAGEMENT IN GHANA

2.7.1 Current Communication Strategies of NHIS

NHIS communication strategies have historically emphasized mass media campaigns utilizing radio, television, and print advertisements to create general awareness about the scheme's existence, benefits, and enrolment procedures, with campaigns typically intensified during enrolment periods or following policy changes (Agyepong & Nagai, 2011). Radio remains the dominant communication channel given Ghana's high radio listenership across all demographic segments and radio's capacity to reach both urban and rural populations in multiple local languages, with NHIA regularly purchasing airtime on national and regional radio stations for spots, jingles, and talk show appearances by scheme officials discussing NHIS topics (Dalinjong & Laar, 2012). Television advertising provides supplementary reach particularly in urban areas, with NHIS television spots featuring testimonials from satisfied members, explanations of enrolment procedures, and messages emphasizing healthcare security through insurance coverage, though television's more limited penetration compared to radio restricts its reach particularly in rural and low-income populations (Nsiah-Boateng et al., 2019).

Print communication materials including posters displayed at healthcare facilities and district health offices, brochures explaining scheme benefits and enrolment steps distributed at registration centres, and newspaper advertisements in major dailies supplement broadcast media, though print effectiveness is constrained by literacy requirements and limited newspaper readership outside urban educated populations (Kotoh & Van der Geest, 2016). Community-based communication activities include outreach programs where NHIA district staff visit communities for sensitization sessions explaining the scheme, mobile registration vans conducting on-site enrolment in

communities, and partnerships with community organizations to facilitate information dissemination, though these activities occur irregularly depending on district resource availability and staff capacity (Agyepong et al., 2016). Digital communication channels have been gradually incorporated, with the NHIA maintaining a website providing scheme information and online portal services, establishing social media presence on Facebook and Twitter for announcements and member engagement, and implementing SMS messaging systems for premium payment reminders and card renewal notifications, though digital channels' reach remains limited among populations without internet access or smartphones (Alhassan et al., 2016).

Current communication strategies exhibit significant limitations including one-way information transmission predominance with limited mechanisms for dialogue or feedback, inadequate message customization for different audience segments resulting in generic messages failing to address specific concerns or barriers, inconsistent communication intensity with heightened activity during campaigns but minimal ongoing communication between campaigns, and insufficient local language content particularly for minority ethnic groups whose languages are underrepresented in NHIS communication materials (Blanchet et al., 2012). Content emphasis tends toward promotional messaging about scheme benefits with insufficient attention to practical enrolment guidance, transparent acknowledgment of scheme limitations and excluded services, clear explanation of member rights and complaints procedures, and responsive communication addressing frequently asked questions or common misconceptions (Duku et al., 2016). Measurement and evaluation of communication effectiveness remains weak, with limited systematic assessment of message reach, comprehension, or behavioural impact, resulting in continuation of communication approaches without evidence-based refinement informed by stakeholder feedback and outcomes data (Nsiah-Boateng et al., 2019).

2.7.2 Stakeholder Perceptions and Awareness of NHIS

Studies examining stakeholder awareness and perceptions reveal mixed results, with high general awareness of NHIS existence across Ghanaian populations contrasting with substantial knowledge gaps regarding scheme specifics including enrolment eligibility criteria, covered benefits and exclusions, premium payment requirements for different population categories, and renewal procedures (Jehu-Appiah et al., 2011). Kotoh and Van der Geest (2016) surveying urban and rural populations find that while over 85% of respondents had heard of the NHIS, only 40% could accurately describe more than five covered services, and fewer than 30% understood premium exemption categories beyond the most obvious groups like children and elderly. Knowledge deficits appear particularly pronounced among non-enrolled populations who exhibit greater misconceptions about eligibility restrictions, premium costs, and enrolment complexity compared to enrolled members who gain understanding through direct experience, suggesting that current communication strategies reach but fail to adequately inform populations most needing enrolment encouragement (Nsiah-Boateng et al., 2019).

Member perceptions of NHIS benefits and value demonstrate ambivalence, with members appreciating financial protection from catastrophic health expenditures and reduced healthcare access barriers while simultaneously expressing frustration about service quality issues, medicine unavailability, long waiting times, and provider attitudes toward insured patients (Agyepong et al., 2016). Qualitative research reveals that many members perceive NHIS as providing inferior care compared to out-of-pocket payment, with common complaints including providers reserving quality drugs for cash-paying patients while giving NHIS members generic alternatives, providers being less attentive to insured patients, and facilities imposing user charges for services supposedly

covered by insurance (Dalinjong & Laar, 2012). These negative service experiences generate word-of-mouth communication undermining scheme reputation and discouraging enrolment among non-members exposed to complaints from dissatisfied enrolled family members or community members, highlighting that communication challenges extend beyond formal NHIA messaging to include member experience quality substantially influencing scheme perceptions (Alhassan et al., 2016).

Trust in NHIS exhibits concerning patterns, with survey research indicating moderate to low trust levels regarding scheme financial management, claims processing fairness, and responsiveness to member concerns (Akazili et al., 2014). Specific trust deficits include scepticism about whether premium payments actually fund healthcare rather than being diverted through corruption, doubts about equitable distribution of scheme benefits versus elite capture, concerns that scheme administrators prioritize financial considerations over member welfare, and limited confidence that member complaints or feedback meaningfully influence scheme operations (Agyepong et al., 2016). Healthcare provider perceptions of NHIS similarly reveal trust deficits and relationship strains, with providers frequently citing delayed reimbursements creating cash flow problems, onerous claims documentation requirements, arbitrary claims rejections without adequate explanation, and lack of meaningful provider consultation regarding policy changes affecting service delivery (Alhassan et al., 2016). These provider relationship challenges manifest in negative provider communication about the scheme to patients, with some healthcare workers openly discouraging patients from relying solely on NHIS and recommending supplementary outof-pocket payment to ensure better service quality (Arhinful, 2003). Stakeholder perception challenges underscore that communication interventions must address not only information gaps but fundamentally relationship quality between the scheme and its diverse stakeholder groups,

requiring public relations approaches emphasizing trust-building, dialogue, and genuine engagement beyond one-way information dissemination.

2.7.3 Barriers to NHIS Enrolment and Retention

Research examining factors influencing NHIS enrolment and retention identifies multiple interrelated barriers spanning financial, operational, informational, and attitudinal domains. Financial barriers include premium unaffordability for poor informal sector workers despite relatively modest absolute premium amounts, with qualitative studies revealing that even premiums of GHS 20-30 represent substantial burdens for households with irregular incomes and competing subsistence needs (Jehu-Appiah et al., 2011). Opportunity costs associated with enrolment including time required for registration procedures, transportation costs to reach district offices, and document acquisition expenses for required identification create indirect financial barriers particularly for informal sector workers whose enrolment necessitates income loss during registration activities (Kotoh & Van der Geest, 2016). Perceived poor value for money based on service quality experiences influences retention decisions, with members calculating that premium costs exceed benefits received when medicine unavailability necessitates out-of-pocket purchases or when seeking care at accredited facilities involves prohibitive waiting times (Duku et al., 2016).

Operational and administrative barriers include complex enrolment procedures requiring multiple documents (birth certificates, Ghana Cards, proof of residence) that many eligible individuals lack, particularly recent urban migrants and populations without formal documentation (Agyepong et al., 2016). Inconvenient registration locations and operating hours disadvantage working populations unable to visit district offices during standard business hours, with limited weekend or evening service availability (Dalinjong & Laar, 2012). Card processing delays resulting in

extended periods between premium payment and card receipt during which individuals remain vulnerable to health shocks discourage enrolment among populations needing immediate coverage (Blanchet et al., 2012). Renewal process challenges including requirements to physically visit offices for annual renewals, lack of automatic renewal options, and inadequate reminder systems contribute to membership lapses among previously enrolled individuals who miss renewal deadlines (Nsiah-Boateng et al., 2019).

Informational and communication barriers include limited awareness of enrolment procedures and required documentation among target populations, with non-enrolled individuals frequently citing not knowing how to register as a primary reason for non-enrolment (Jehu-Appiah et al., 2011). Misconceptions about eligibility create psychological barriers, with some individuals mistakenly believing they are ineligible due to health conditions, age, employment status, or residence location (Kotoh & Van der Geest, 2016). Inadequate understanding of insurance principles among populations without previous insurance experience contributes to enrolment resistance, with qualitative research revealing that some potential members view premium payments as wasteful when currently healthy and perceive insurance as benefiting only those who fall sick frequently (Duku et al., 2016). Limited information about member rights, complaints procedures, and available recourse when service problems occur leaves members feeling powerless to address concerns, contributing to dissatisfaction and dropout (Agyepong et al., 2016). Attitudinal barriers including fatalism about health, preference for traditional healing practices, distrust of Western medicine, and religious beliefs attributing illness to spiritual causes rather than biological factors influence insurance value perceptions among certain population segments (Dalinjong & Laar, 2012). The multiplicity and interconnection of enrolment barriers suggests that addressing coverage gaps requires integrated interventions combining communication improvements with

operational streamlining, service quality enhancement, and stakeholder engagement strengthening rather than communication interventions alone.

2.8 HEALTH INSURANCE IN THE GREATER ACCRA REGION

2.8.1 Healthcare Context in Greater Accra

Greater Accra Region serves as Ghana's administrative capital and most urbanized region, with a population exceeding 5 million residents concentrated in the Accra Metropolitan Area and surrounding municipalities, representing approximately 16% of Ghana's total population (Ghana Statistical Service, 2021). The region's healthcare infrastructure reflects its status as the national capital, hosting the highest concentration of healthcare facilities in Ghana including major tertiary hospitals such as Korle Bu Teaching Hospital, Ridge Hospital, and 37 Military Hospital, alongside numerous secondary-level public hospitals, private hospitals and clinics, maternity homes, and specialized treatment centres (Asabere, 2021). Healthcare provider density in Greater Accra significantly exceeds national averages, with approximately one physician per 6,000 population compared to the national ratio of one per 10,000, though provider distribution remains uneven with facilities concentrated in affluent neighbourhoods while underserved peri-urban and slum communities experience relative provider shortages (Saleh, 2013).

The region's population exhibits distinctive socioeconomic characteristics including higher average income levels, greater educational attainment, and more formal sector employment compared to other regions, though these regional averages mask substantial internal inequality with affluent suburbs coexisting alongside densely populated low-income communities such as Nima, Agbogbloshie, and Madina experiencing poverty rates comparable to rural areas

(AgyeiMensah & Owusu, 2010). Greater Accra's ethnic and linguistic diversity resulting from internal migration from all Ghanaian regions creates complex communication environments where no single language predominates, with English serving as lingua franca alongside Ga (indigenous language), Twi (most widely spoken), Ewe, Hausa, and numerous other languages represented in the population (Ghana Statistical Service, 2021). Healthcare-seeking behaviour patterns in urban Accra differ from rural contexts, with populations demonstrating greater willingness to utilize biomedical facilities, higher health literacy levels, and more assertive attitudes regarding healthcare rights and quality expectations compared to rural populations exhibiting greater deference to healthcare providers (Agyepong & Nagai, 2011).

The proliferation of private healthcare providers in Greater Accra creates competitive healthcare markets where individuals with financial means access private facilities perceived as providing superior service quality, shorter waiting times, and more personalized care compared to public facilities serving predominantly NHIS members and indigent populations (Saleh, 2013). This dual healthcare system generates perceptions among some populations that NHIS membership relegates individuals to lower-quality public facilities while cash payment enables access to superior private care, potentially undermining insurance value propositions particularly among middle-income populations capable of affording out-of-pocket payment (Agyepong et al., 2016). Healthcare cost structures in Greater Accra reflect the region's higher cost of living, with both formal and informal healthcare expenses exceeding costs in other regions, making financial protection through health insurance potentially more valuable yet also making premium contributions more burdensome relative to other household expenses (Akazili et al., 2014).

2.8.2 NHIS Coverage Patterns in Urban Ghana

NHIS coverage patterns in urban settings including Greater Accra demonstrate paradoxical characteristics, with urban populations exhibiting higher awareness of the scheme yet lower active membership rates compared to some rural regions despite urban populations' generally superior economic capacity to afford premiums (Jehu-Appiah et al., 2011). This urban enrolment deficit reflects multiple interacting factors including urban populations' greater access to private healthcare alternatives reducing perceived insurance necessity, higher opportunity costs of time spent in enrolment procedures for urban workers, greater population mobility complicating continuous membership maintenance, and more individualistic orientations in urban contexts compared to rural communal structures that facilitate collective enrolment (Kotoh & Van der Geest, 2016). Within urban contexts, coverage varies substantially across neighbourhoods and socioeconomic strata, with middle-income formal sector neighbourhoods demonstrating higher enrolment driven by automatic SSNIT deductions while low-income informal sector communities exhibit coverage rates comparable to or lower than rural areas despite urban location (NsiahBoateng et al., 2019).

Young adult coverage gaps appear particularly pronounced in urban settings, with Greater Accra exhibiting especially low enrolment among 18-35-year-olds who perceive good current health, prioritize immediate consumption over insurance premiums, experience high residential and employment mobility disrupting enrolment continuity, and demonstrate scepticism toward government programs (Duku et al., 2016). Informal sector worker enrolment challenges intensify in urban contexts where informal sector diversity—ranging from market traders to artisans, commercial drivers to domestic workers—creates heterogeneous populations with varying

incomes, work schedules, and premium payment capacities requiring differentiated enrolment approaches currently not adequately addressed by standardized district-level registration procedures (Agyepong et al., 2016). Gender coverage dynamics in urban areas differ from rural patterns, with urban women's generally higher economic independence and education levels facilitating enrolment decisions less dependent on male household members, though free maternal care policies have nonetheless driven significant female enrolment increases across both urban and rural contexts (Kotoh & Van der Geest, 2016).

Healthcare utilization patterns among urban NHIS members reveal that while insurance coverage increases healthcare access, urban members frequently report service quality dissatisfaction including long waiting times at NHIS-accredited facilities, medicine stockouts necessitating outof-pocket purchases, crowded conditions in public facilities, and perceived provider discrimination favouring cash-paying patients (Dalinjong & Laar, 2012). These urban service quality challenges partly reflect concentrated demand at limited accredited facilities, with some popular urban hospitals experiencing patient volumes exceeding capacity, creating negative experiences that discourage enrolment among non-members observing facility conditions and undermining retention among members dissatisfied with care quality (Alhassan et al., 2016). Urban populations' higher education levels and health literacy translate into more informed and demanding NHIS members who actively question providers, seek information about covered benefits, and complain about service deficiencies, potentially creating perception among scheme administrators and providers that urban members are "difficult" despite these behaviours representing legitimate consumer empowerment (Agyepong & Nagai, 2011).

2.8.3 Socioeconomic Factors Influencing NHIS Uptake in Accra

Socioeconomic determinants of NHIS enrolment in Greater Accra demonstrate complex patterns diverging from simple income-enrolment correlations, with research revealing that both very lowincome and high-income populations exhibit lower enrolment rates compared to middle-income groups (Jehu-Appiah et al., 2011). Low-income populations face enrolment barriers including premium unaffordability despite relatively modest absolute costs, competing basic subsistence needs taking priority over insurance premiums, documentation challenges as poor populations frequently lack required identification documents, and limited financial literacy affecting understanding of insurance value propositions (Kotoh & Van der Geest, 2016). Conversely, highincome populations' lower enrolment reflects preferences for private healthcare paid out-ofpocket, perceptions that NHIS facilities provide inadequate quality for their standards, willingness and ability to self-insure through savings, and sometimes ideological opposition to government programs or redistribution through insurance mechanisms (Nsiah-Boateng et al., 2019).

Employment sector affiliation represents a stronger predictor of enrolment than income levels, with formal sector workers demonstrating near-universal enrolment driven by automatic SSNIT premium deductions, employer facilitation of registration procedures, and workplace socialization normalizing insurance participation (Agyepong et al., 2016). Informal sector workers exhibit significantly lower enrolment despite comprising approximately 80% of Greater Accra's workforce, with barriers including premium payment requirements contrasting with formal workers' automatic deductions, lack of employer facilitation necessitating individual initiative to navigate enrolment procedures, income irregularity making scheduled premium payments

difficult, and limited workplace-based information exposure about insurance benefits (JehuAppiah et al., 2011). Within the informal sector, enrolment varies by occupation characteristics, with market traders in established locations demonstrating higher enrolment facilitated by trader association networks and regular income flows compared to more mobile occupations like head porters (kayayei) or street vendors experiencing extreme enrolment barriers (Duku et al., 2016).

Educational attainment influences enrolment through multiple pathways including health literacy enabling understanding of insurance principles, document acquisition capacity as educated individuals more easily navigate bureaucratic requirements for registration documents, and income effects as education correlates with earning potential affecting premium affordability (Kotoh & Van der Geest, 2016). However, education effects appear non-linear in urban contexts, with some highly educated populations expressing scepticism toward NHIS based on informed assessments of service quality limitations and scheme sustainability concerns, suggesting that awareness and understanding do not automatically translate to enrolment when educated populations perceive insurance value as inadequate (Nsiah-Boateng et al., 2019). Social capital and network effects significantly influence enrolment decisions in urban Accra, with individuals embedded in social networks where NHIS membership is normalized demonstrating higher enrolment probability, while those in networks characterized by scepticism or negative experiences show lower enrolment regardless of individual socioeconomic status (Jehu-Appiah et al., 2011).

Residential neighbourhood characteristics shape enrolment through mechanisms including proximity to registration centres affecting enrolment convenience, neighbourhood socioeconomic composition creating normative environments either supporting or discouraging enrolment, and area-level healthcare facility quality influencing perceptions of insurance value (Agyepong et al.,

2016). Distance and transportation considerations particularly affect enrolment in peri-urban areas where residents must travel significant distances to reach district offices, with transportation costs and time requirements creating substantial enrolment barriers for populations at urban peripheries (Dalinjong & Laar, 2012). Religious and ethnic identity factors influence enrolment through community leadership effects, with some religious and ethnic community leaders actively promoting NHIS while others express scepticism, and through culturally-shaped attitudes toward insurance, illness causation beliefs, and trust in government institutions that vary across religious and ethnic groups (Arhinful, 2003). These socioeconomic factors interact with communication and stakeholder engagement practices, suggesting that effective strategies for coverage expansion in Greater Accra require not only improved communication but also stakeholder engagement approaches sensitive to the diverse socioeconomic contexts shaping insurance decisions among the region's heterogeneous population.

2.9 CHAPTER SUMMARY

This chapter has reviewed extensive literature establishing theoretical and empirical foundations for examining stakeholder engagement and communication strategies within Ghana's NHIS in Greater Accra. The theoretical framework demonstrates that stakeholder theory, public relations models emphasizing two-way communication, and health communication theories provide robust conceptual lenses for analysing how engagement and communication influence insurance coverage. Empirical literature reveals that effective stakeholder engagement characterized by genuine participation and responsive feedback mechanisms positively influences health insurance enrolment, while communication effectiveness depends on multi-channel approaches, targeted messaging, and trust-building. The review of Ghana's NHIS context highlights persistent coverage

challenges despite two decades of implementation, with current communication strategies exhibiting limitations including one-way information transmission and inadequate stakeholder engagement in Greater Accra's complex urban environment. The literature establishes that while NHIS awareness is high, substantial knowledge gaps, trust deficits, and engagement inadequacies constrain coverage expansion. This research addresses identified gaps by evaluating current practices, examining stakeholder perceptions, and identifying strategic communication interventions grounded in public relations scholarship that could enhance NHIS coverage and stakeholder relationships in Greater Accra.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the research methodology employed to investigate stakeholder engagement and communication strategies in improving NHIS coverage in the Greater Accra Region from a public relations perspective. The chapter details the research approach, research design, population and sampling procedures, instrumentation and data collection methods, data analysis techniques, and ethical considerations guiding the study. The methodology is designed to systematically address the research objectives of assessing current stakeholder engagement practices and communication strategies, examining stakeholder perceptions of communication effectiveness, and identifying public relations best practices for enhancing NHIS coverage in Greater Accra.

3.2 RESEARCH APPROACH

This study adopts a quantitative research approach, which emphasizes objective measurement, numerical data collection, and statistical analysis to examine relationships between variables (Creswell & Creswell, 2018). The quantitative approach is appropriate for this research as it enables systematic assessment of stakeholder perceptions regarding communication effectiveness and engagement quality across a relatively large sample, facilitating generalization of findings to the broader stakeholder population in Greater Accra (Bryman, 2016). This approach aligns with the positivist research paradigm, which assumes that social phenomena can be objectively

measured and that reliable knowledge emerges from empirical observation and statistical analysis (Neuman, 2014). The quantitative approach enables the researcher to quantify stakeholder awareness levels, assess communication channel effectiveness, measure engagement satisfaction, and examine relationships between communication strategies and NHIS coverage intentions using standardized instruments applied consistently across respondents (Babbie, 2020).

3.3 RESEARCH DESIGN

The study employs a descriptive cross-sectional survey design, which involves collecting data from a sample of respondents at a single point in time to describe characteristics of the population and examine relationships between variables (Lavrakas, 2008). The descriptive survey design is appropriate for this research as it enables systematic documentation of current stakeholder engagement practices, communication strategies, and stakeholder perceptions regarding NHIS in Greater Accra (Fowler, 2014). Cross-sectional design provides a snapshot of stakeholder experiences and perceptions at the present time, capturing current communication and engagement dynamics rather than tracking changes over time (Sedgwick, 2014). The survey design facilitates data collection from a relatively large and geographically dispersed sample using standardized questionnaires, enabling statistical analysis of patterns, trends, and relationships across stakeholder categories (de Vaus, 2013).

3.4 POPULATION AND SAMPLING

3.4.1 Study Population

The study population comprises all stakeholders involved in or affected by the National Health Insurance Scheme in the Greater Accra Region, including NHIS members (both active and lapsed), non-enrolled eligible populations, healthcare service providers at NHIS-accredited facilities, and NHIS district office staff. The target population specifically focuses on adult residents (18 years and above) in Greater Accra who are either current beneficiaries of NHIS, eligible non-members, or intermediary stakeholders involved in scheme implementation and communication. According to the Ghana Statistical Service (2021), Greater Accra Region has a population exceeding 5 million residents, with approximately 3.5 million adults eligible for NHIS enrolment. NHIS active membership in Greater Accra is estimated at approximately 1.4 million members based on National Health Insurance Authority (2018) reports, indicating that a substantial proportion of eligible residents remain non-enrolled.

3.4.2 Sampling Strategy/Technique

The study employs a stratified random sampling technique to ensure representation of key stakeholder categories within the sample. Stratified sampling involves dividing the population into distinct subgroups (strata) based on characteristics relevant to the research objectives, then randomly selecting participants from each stratum (Sharma, 2017). For this research, the population is stratified into four main stakeholder categories: (1) active NHIS members, (2) lapsed members, (3) non-enrolled eligible populations, and (4) intermediary stakeholders including healthcare providers and NHIS staff. Within each stratum, simple random sampling is used to select

individual participants, ensuring that every member of each stratum has an equal probability of selection, thereby minimizing selection bias (Taherdoost, 2016). Geographic stratification is also applied by ensuring sample distribution across different districts within Greater Accra to capture variations in communication and engagement experiences.

3.4.3 Sample Size

The study sample comprises 150 respondents distributed across the four stakeholder strata. The sample distribution is as follows: 50 active NHIS members (33.3%), 40 non-enrolled eligible populations (26.7%), 30 lapsed members (20%), 20 healthcare providers (13.3%), and 10 NHIS district office staff (6.7%). This distribution reflects the relative importance of each stakeholder category to the research objectives, with greater emphasis on beneficiary and potential beneficiary perspectives (Bartlett, Kotrlik, & Higgins, 2001). A sample of 150 respondents is adequate for descriptive statistical analysis and provides sufficient statistical power for identifying patterns and relationships within the data (Israel, 1992). The sample is distributed across different districts within Greater Accra to enhance geographic representativeness.

3.5 INSTRUMENTATION AND DATA COLLECTION PROCEDURE

Data was collected using a structured questionnaire administered electronically through Google Forms to facilitate efficient data gathering and minimize data entry errors. The questionnaire comprised six main sections designed to comprehensively assess stakeholder perspectives on NHIS communication and engagement. Section A collected demographic information including gender, age group, highest level of education completed, employment status, district/municipality of residence in Greater Accra, and relationship with NHIS. Section B measured NHIS awareness

and knowledge through ten items assessing understanding of registration procedures, renewal processes, service coverage, premium requirements, exemptions, member rights, and complaint mechanisms using a five-point Likert scale ranging from strongly disagree to strongly agree.
Section C evaluated communication effectiveness through ten items measuring message clarity, information adequacy, language appropriateness, channel effectiveness, timeliness, consistency, and responsiveness using the same five-point Likert scale. Section D assessed stakeholder engagement quality through ten items examining feedback opportunities, responsiveness to concerns, stakeholder involvement in decision-making, and respect in engagement processes. Section E measured trust and relationship quality through ten items evaluating trustworthiness, honesty, fairness, satisfaction, and recommendation intentions. Section F captured enrollment intentions and barriers with differentiated questions for active members assessing renewal likelihood and satisfaction levels, lapsed members identifying primary non-renewal reasons and re-enrollment likelihood, and non-enrolled eligible individuals examining non-enrollment reasons and future enrollment intentions. The Google Forms platform enabled distribution through multiple channels including email, social media, and WhatsApp to reach diverse stakeholder segments across Greater Accra Region, with data collection conducted over a four-week period ensuring adequate response rates across all stakeholder categories.

3.6 DATA ANALYSIS

Data analysis was conducted using the Statistical Package for Social Sciences (SPSS) version 26, employing both descriptive and inferential statistical techniques to systematically address the research objectives. Descriptive statistics including frequencies and percentages were calculated to summarize demographic characteristics and stakeholder perceptions across all measured

variables. Cronbach's Alpha reliability coefficients were computed for the four multi-item scales measuring NHIS awareness and knowledge, communication effectiveness, stakeholder engagement, and trust and relationship quality to assess internal consistency, with alpha values above 0.70 indicating acceptable reliability. One-sample t-tests were performed to determine whether mean scores on awareness, communication, engagement, and trust dimensions significantly differed from neutral values, providing statistical evidence of stakeholder perceptions. Results were organized and presented through tables displaying frequencies and percentages for categorical variables, and means, standard deviations, t-values, significance levels, and confidence intervals for continuous variables measuring stakeholder perceptions. This analytical approach enabled systematic examination of current communication and engagement practices, assessment of stakeholder perceptions, and identification of specific areas requiring strategic interventions to enhance NHIS coverage in Greater Accra Region.

3.7 ETHICAL CONSIDERATIONS

The research adheres to ethical principles governing social research with human participants, ensuring respect for persons, beneficence, and justice throughout the study (Bryman, 2016).
Ethical approval is sought from the University of Media Arts and Communication (UniMAC-IJ) Ethics Committee and the Ghana Health Service Ethical Review Committee. Informed consent is obtained from all participants, with research assistants explaining the research purpose, voluntary nature of participation, right to withdraw, and confidentiality measures before requesting consent (Harriss & Atkinson, 2015). Participant confidentiality and anonymity are protected through several measures: questionnaires do not collect identifying information; completed questionnaires

are stored securely; and data analysis uses aggregate statistics rather than individual responses (Saunders, Lewis, & Thornhill, 2019).

Participants are informed that participation involves no direct benefits but contributes to improving NHIS communication, and that participation carries minimal risk limited to time commitment (approximately 15-20 minutes). Data management follows ethical standards including secure storage of physical questionnaires in locked cabinets and electronic data in password-protected files, with data use limited to stated research purposes. Research findings will be disseminated through the thesis and summary reports shared with NHIS authorities, contributing to evidencebased improvements in health insurance communication and stakeholder engagement in Ghana.

3.8 CHAPTER SUMMARY

This chapter has outlined the research methodology employed to examine stakeholder engagement and communication strategies in improving NHIS coverage in Greater Accra from a public relations perspective. The study adopts a quantitative research approach utilizing a descriptive cross-sectional survey design, enabling systematic assessment of current practices and stakeholder perceptions. The study population comprises diverse NHIS stakeholders in Greater Accra, with a sample of 150 respondents selected through stratified random sampling ensuring representation across stakeholder categories and districts. Data collection employs structured questionnaires with Likert-scale items administered by trained research assistants, gathering quantitative data on communication effectiveness, engagement quality, awareness levels, and trust. Data analysis utilizes descriptive statistics, Cronbach's Alpha reliability testing, and one-way ANOVA to identify patterns and relationships. The research adheres to ethical principles including informed consent,

confidentiality, and participant protection. This methodological approach provides a rigorous framework for generating empirical evidence regarding how public relations principles can inform improved stakeholder engagement and communication strategies to enhance NHIS coverage in Greater Accra.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the analysis and interpretation of data collected from 150 respondents in Greater Accra Region regarding stakeholder engagement and communication strategies within Ghana's National Health Insurance Scheme. The chapter is organized into six sections addressing demographic characteristics, reliability analysis of measurement scales, NHIS awareness and knowledge levels, communication effectiveness perceptions, stakeholder engagement quality, trust and relationship dynamics, and enrollment intentions and barriers. Data were analyzed using SPSS version 26, employing descriptive statistics, reliability testing, and one-sample t-tests to systematically address the research objectives.

4.2 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Demographic information provides contextual understanding of the sample composition, enabling assessment of whether diverse stakeholder perspectives are adequately represented and facilitating interpretation of findings across different population segments. **Table 4.1: Demographic Profile of Respondents (N=150)**

Variable	Category	Frequency	Percent
Gender	Female	87	58.0
	Male	50	33.3
	Prefer not to say	13	8.7
Age Group	18-25 years	70	46.7

	26-35 years	39	26.0
	36-45 years	25	16.7
	46-55 years	10	6.7
	56 years and above	6	4.0
Education Level	No formal education	9	6.0
	Basic education	5	3.3
	Secondary education	10	6.7
	Tertiary	81	54.0
	Postgraduate	45	30.0
Employment Status	Formal sector employee	44	29.3
	Informal sector worker	7	4.7
	Self-employed	49	32.7
	Student	42	28.0
	Unemployed/Retired	8	5.3
Location	Prampram	23	15.3
	Tema	14	9.3
	Legon	11	7.3
	Madina	11	7.3
	Dome	9	6.0
	Haatso	7	4.7

	Achimota	5	3.3
	Ga South	4	2.7
	Pokuase	4	2.7
	Lapaz	3	2.0
	Osu	3	2.0
	Teshie	3	2.0
	Accra	2	1.3
	Awutu Senya East Municipal	2	1.3
	Ga Central	2	1.3
	Ga North	2	1.3
	Kwabenya	2	1.3
	LA	2	1.3
	Lashibi	2	1.3
	Ledzekuku Krowor	2	1.3
	Medina	2	1.3
	Taifa	2	1.3
	Tema West	2	1.3
	Trobu Constituency	2	1.3
	Weija	2	1.3
	Others (24 locations with 1 respondent each)	26	17.3
NHIS Relationship	Active member	81	54.0

	Lapsed member	41	27.3
	Non-enrolled eligible	17	11.3
	Healthcare provider	4	2.7
	NHIS staff	7	4.7

The sample demonstrates strong female representation (58.0%) and pronounced youth concentration with 72.7% under 36 years, aligning with research focus on low youth enrollment patterns. Educational attainment reveals 84.0% possessing tertiary or postgraduate qualifications, indicating sampling bias toward educated populations that likely inflates knowledge and awareness scores compared to the broader Greater Accra population. Employment distribution shows diversity across formal employees (29.3%), self-employed (32.7%), and students (28.0%), though informal sector workers remain critically underrepresented at 4.7% despite comprising approximately 80% of Ghana's workforce—a significant sampling limitation given that informal workers represent the primary under-covered population segment.

Geographic distribution demonstrates representation across 47 different locations within Greater Accra Region, ensuring findings reflect diverse urban contexts. Prampram dominates with 15.3% of respondents, followed by Tema (9.3%), Legon (7.3%), Madina (7.3%), and Dome (6.0%). Locations span major commercial centers like Accra Central and Osu, university communities like Legon, market towns like Madina, traditional settlements like Teshie and Nungua, and peri-urban areas like Pokuase and Kwabenya. Despite uneven distribution, the geographic spread across nearly all major Greater Accra communities provides reasonable representation of the region's diverse socioeconomic contexts. The NHIS relationship distribution appropriately prioritizes stakeholders with direct scheme experience—active members (54.0%) and lapsed members

(27.3%)—while including sufficient non-enrolled perspectives (11.3%) and intermediary stakeholders (7.4%) to assess implementation perspectives.

4.3 RELIABILITY ANALYSIS OF MEASUREMENT SCALES

Reliability testing assesses the internal consistency of multi-item scales measuring NHIS awareness and knowledge, communication effectiveness, stakeholder engagement, and trust and relationship quality, ensuring that scale items consistently measure their intended constructs.

Table 4.2: Cronbach's Alpha Reliability Coefficients

Scale	Number of Items	Cronbach's Alpha	Reliability Level
NHIS Awareness and Knowledge	10	0.958	Excellent
Communication Effectiveness	10	0.966	Excellent
Stakeholder Engagement	10	0.961	Excellent
Trust and Relationship Quality	10	0.979	Excellent

All four measurement scales demonstrate exceptional internal consistency reliability, with Cronbach's Alpha coefficients ranging from 0.958 to 0.979, substantially exceeding the conventional threshold of 0.70 and the 0.90 benchmark for excellent reliability (Tavakol & Dennick, 2011). The Trust and Relationship Quality scale exhibits the highest reliability (α = 0.979), suggesting respondents perceive trust dimensions as strongly interconnected. The uniformly high reliability validates questionnaire measurement quality and provides confidence that subsequent analyses reflect genuine construct variability rather than measurement error.

4.4 NHIS AWARENESS AND KNOWLEDGE

This section examines stakeholders' awareness and knowledge levels regarding NHIS enrollment procedures, covered benefits, exemptions, member rights, and complaint mechanisms, addressing the first research objective's assessment of current communication strategy effectiveness in information dissemination.

Table 4.3: NHIS Awareness and Knowledge Levels (N=150)

Knowledge Dimension	Mean	SD	t-value	Sig.	95% CI
Well-informed about registration/enrollment	3.90	0.721	66.230	.000	[3.78, 4.02]
Process for renewing membership	3.87	0.766	61.857	.000	[3.74, 3.99]
Where to access NHIS services	3.83	0.792	59.166	.000	[3.70, 3.95]
Overall self-assessed knowledge	3.71	0.763	59.629	.000	[3.59, 3.84]
Knowledge of health services covered	3.69	0.860	52.485	.000	[3.55, 3.83]
Understanding of member rights	3.67	0.839	53.594	.000	[3.54, 3.81]
Who qualifies for exemptions	3.65	0.977	45.706	.000	[3.49, 3.80]
Premium payment requirements	3.61	0.961	46.055	.000	[3.46, 3.77]
How to make complaints	3.60	0.920	47.946	.000	[3.45, 3.75]
Services NOT covered by NHIS	3.55	0.980	44.411	.000	[3.40, 3.71]

NHIS awareness and knowledge levels demonstrate moderately high scores ($M = 3.55–3.90$), with all results highly significant ($p < .001$). Registration and enrollment information emerges strongest ($M = 3.90$, $SD = 0.721$), indicating current communication strategies effectively convey procedural information about scheme access. Renewal processes ($M = 3.87$) and service location awareness

(M = 3.83) similarly demonstrate strong comprehension. However, critical weaknesses appear in understanding service exclusions (M = 3.55, SD = 0.980), complaint procedures (M = 3.60), and premium payment requirements (M = 3.61). Higher standard deviations in these areas indicate knowledge heterogeneity, suggesting communication reaches some segments effectively while failing others. The pattern reveals success in "what" and "where" dimensions but failure in "how" and "why" dimensions, suggesting strategies emphasize promotional messaging over practical education essential for informed decision-making.

4.5 COMMUNICATION EFFECTIVENESS

This section evaluates stakeholder perceptions of NHIS communication quality across dimensions including message clarity, information adequacy, language appropriateness, channel effectiveness, timeliness, consistency, and responsiveness.

Table 4.4: Communication Effectiveness Perceptions (N=150)

Communication Dimension	Mean	SD	t-value	Sig.	95% CI
Information in understandable languages	3.93	0.646	74.437	.000	[3.82, 4.03]
Sufficient information on benefits	3.72	0.752	60.593	.000	[3.60, 3.84]
Adequate enrollment information	3.68	0.822	54.840	.000	[3.55, 3.81]
Addresses specific concerns	3.67	0.800	56.142	.000	[3.54, 3.80]
Appropriate communication channels	3.66	0.947	47.328	.000	[3.51, 3.81]
Clear and easy to understand	3.65	0.827	54.086	.000	[3.52, 3.79]
Consistent across sources	3.63	0.901	49.414	.000	[3.49, 3.78]
Overall satisfaction with strategies	3.61	0.962	45.934	.000	[3.45, 3.76]

Easy to get answers to questions	3.53	0.988	43.725	.000	[3.37, 3.69]
Timely information on policy changes	3.48	1.021	41.729	.000	[3.32, 3.64]

Communication effectiveness demonstrates moderate satisfaction (M = 3.48–3.93), with linguistic accessibility scoring highest (M = 3.93, SD = 0.646), demonstrating NHIS successfully provides information in languages stakeholders understand. Benefit information sufficiency (M = 3.72) and enrollment information adequacy (M = 3.68) receive positive assessments. However, critical weaknesses emerge in timeliness of policy updates (M = 3.48, SD = 1.021), with the highest standard deviation indicating substantial variability in stakeholder experiences. Difficulty obtaining answers to questions (M = 3.53) reveals inadequate responsiveness mechanisms. The pattern reveals success in one-way information dissemination but failure in two-way interactive communication, confirming literature critiques that NHIS communication remains predominantly top-down rather than dialogic.

4.6 STAKEHOLDER ENGAGEMENT QUALITY

This section assesses stakeholder perceptions of NHIS engagement practices including feedback opportunities, responsiveness to concerns, involvement in decision-making, and respect.

Table 4.5: Stakeholder Engagement Quality Perceptions (N=150)

Engagement Dimension	**Mean**	**SD**	**t-value**	**Sig.**	**95% CI**
Overall satisfaction with engagement	3.59	0.906	48.471	.000	[3.44, 3.73]
Adequate communication channels	3.56	0.923	47.234	.000	[3.41, 3.71]
Voice matters to administrators	3.53	1.034	41.848	.000	[3.37, 3.70]
Demonstrates feedback influence	3.53	0.939	45.996	.000	[3.38, 3.68]

Values member opinions	3.49	0.961	44.457	.000	[3.33, 3.64]
Respectful engagement	3.49	0.910	46.910	.000	[3.34, 3.63]
Involves stakeholders in decisions	3.35	0.859	47.710	.000	[3.21, 3.49]
Adequate feedback opportunities	3.28	0.734	54.742	.000	[3.16, 3.40]
Listens to concerns	3.19	0.748	52.278	.000	[3.07, 3.31]
Responds promptly to complaints	3.18	0.760	51.223	.000	[3.06, 3.30]

Stakeholder engagement emerges as the weakest performance domain (M = 3.18–3.59), substantially lower than awareness, communication, and trust dimensions. Prompt response to complaints scores lowest (M = 3.18, SD = 0.760), followed by listening to concerns (M = 3.19), representing fundamental violations of dialogic communication principles. Inadequate feedback opportunities (M = 3.28) and limited stakeholder involvement in decisions (M = 3.35) confirm engagement remains consultative rather than collaborative. The findings validate that NHIS has not institutionalized participatory engagement structures, with stakeholders doubting their input meaningfully shapes operations. The substantially lower engagement scores compared to communication effectiveness (average engagement M ≈ 3.42 versus communication M ≈ 3.67) demonstrate NHIS prioritizes one-way information dissemination over two-way engagement.

4.7 TRUST AND RELATIONSHIP QUALITY

This section examines trust dimensions and relationship quality perceptions including trustworthiness, honesty, fairness, commitment, satisfaction, and advocacy intentions.

Table 4.6: Trust and Relationship Quality Perceptions (N=150)

Trust/Relationship Dimension	Mean	SD	t-value	Sig.	95% CI

Would recommend to others	3.87	0.739	64.098	.000	[3.75, 3.99]
Trust in benefit delivery	3.82	0.696	67.238	.000	[3.71, 3.93]
Overall satisfaction with experience	3.76	0.757	60.841	.000	[3.64, 3.88]
Overall trust in NHIS	3.76	0.792	58.176	.000	[3.63, 3.89]
Confidence in leadership	3.74	0.831	55.130	.000	[3.61, 3.87]
Treats members fairly	3.73	0.948	48.166	.000	[3.57, 3.88]
Manages premiums responsibly	3.70	0.809	56.019	.000	[3.57, 3.83]
Cares about member welfare	3.69	0.926	48.824	.000	[3.54, 3.84]
Feel valued as stakeholder	3.69	0.837	53.974	.000	[3.55, 3.82]
Honest communication	3.64	0.877	50.842	.000	[3.50, 3.78]

Trust and relationship quality demonstrate moderate-to-high levels (M = 3.64–3.87), notably exceeding stakeholder engagement perceptions, suggesting NHIS maintains reasonable trust primarily through benefit delivery rather than communication or engagement quality. Willingness to recommend NHIS scores highest (M = 3.87), indicating positive word-of-mouth potential. Trust in benefit delivery (M = 3.82) demonstrates stakeholder confidence in the scheme's core promise. However, communication honesty scores lowest (M = 3.64, SD = 0.877), with highest variability indicating divided opinions about NHIS transparency. The finding that trust substantially exceeds engagement quality (average trust M ≈ 3.73 versus engagement M ≈ 3.42) indicates significant opportunity: improving engagement quality to match trust levels could convert moderate trust into committed loyalty.

4.8 ENROLLMENT INTENTIONS AND BARRIERS

This section examines enrollment intentions among different stakeholder categories and identifies primary barriers preventing enrollment or renewal.

Table 4.7: Enrollment Intentions and Barriers by Stakeholder Category

Stakeholder Category	**Indicator**	**Response**	**N**	**%**
Active Members (N=81)	**Renewal Likelihood**	Very likely	17	21.0
		Likely	60	74.1
		Undecided	4	4.9
	Overall Satisfaction	Very satisfied	16	19.8
		Satisfied	46	56.8
		Neutral	9	11.1
		Dissatisfied	8	9.9
		Very dissatisfied	2	2.5
Lapsed Members (N=41)	**Non-Renewal Reason**	Currently healthy, don't need	26	63.4
		Long waiting times	3	7.3
		Poor service quality	3	7.3
		Did not see value	3	7.3

		Could not afford premium	2	4.9
		Misplaced card	2	4.9
		Other health insurance	2	4.9
	Re-enrollment Likelihood	Likely	26	63.4
		Undecided	10	24.4
		Very likely	3	7.3
		Unlikely	2	4.9
Non-Enrolled (N=17)	**Non-Enrollment Reason**	Currently healthy, don't need	9	52.9
		Heard negative experiences	4	23.5
		Don't trust NHIS	2	11.8
		Prefer direct payment	2	11.8
	Enrollment Likelihood (12 months)	Undecided	12	70.6
		Very unlikely	2	11.8
		Likely	1	5.9
		Unlikely	1	5.9
		Very likely	1	5.9

Active members demonstrate strong retention intentions with 95.1% likely or very likely to renew, though 12.4% report dissatisfaction, revealing disconnects where dissatisfied members intend to renew due to healthcare necessity. Lapsed members reveal the dominant non-renewal reason as "currently healthy, don't need insurance" (63.4%), demonstrating fundamental misunderstanding of insurance principles as protection against future uncertainty. This exposes critical communication failure in educating stakeholders about insurance value propositions. Service quality barriers (long waits 7.3%, poor quality 7.3%) and value perceptions (7.3%) affect similar proportions. Encouragingly, 70.7% of lapsed members remain likely to re-enroll, suggesting dropout often represents temporary disengagement.

Non-enrolled populations present the most challenging segment, with 70.6% undecided about future enrollment, indicating profound ambivalence. The "currently healthy" reasoning dominates (52.9%), mirroring lapsed member patterns. Critically, 35.3% cite negative secondhand experiences (23.5%) or explicit distrust (11.8%), demonstrating how poor communication and engagement create negative externalities through social networks. Only 11.8% indicate positive enrollment likelihood versus 70.7% among lapsed members, suggesting retention investments yield higher returns than acquisition campaigns.

4.9 DISCUSSION

Concerning the first objective to assess current stakeholder engagement practices and communication strategies employed by NHIA in Greater Accra, the findings from Tables 4.3 through 4.5 reveal patterns that align with broader literature on health insurance communication in sub-Saharan Africa. Table 4.3 demonstrates stronger procedural knowledge about enrollment and renewal processes compared to understanding of service exclusions and complaint mechanisms,

confirming Agyepong et al.'s (2016) observation that unclear benefit package communication contributes to member dissatisfaction. The knowledge pattern reflects what Grunig (2001) describes as one-way public information models that emphasize basic awareness over comprehensive education. Table 4.4's communication effectiveness findings validate Blanchet et al.'s (2012) critique that NHIS communication remains predominantly top-down and campaigndriven rather than continuous and dialogic, with stakeholders struggling to access timely information despite adequate linguistic accessibility. Agyepong and Nagai (2011) similarly documented that NHIS communication occurs primarily during sporadic campaigns rather than through sustained channels, which the lower scores for timeliness of policy updates and ease of getting answers to questions corroborate.

Addressing the second objective to examine stakeholder perceptions of communication effectiveness and engagement processes, Table 4.5's engagement findings validate theoretical concerns from relationship management literature about participatory governance in health financing. The lower scores for responsiveness to complaints and stakeholder involvement in decisions align with Cleary, Molyneux and Gilson's (2013) documentation that Ghanaian health programs employ consultative rather than collaborative engagement approaches. Freeman's (1984) stakeholder theory emphasizes that organizations must genuinely incorporate stakeholder input into strategic decisions, while Reed's (2008) participation framework suggests effective engagement requires moving beyond consultation toward empowerment. The substantial gap between communication effectiveness scores and engagement quality scores demonstrates what Kent and Taylor (2002) identify as the critical difference between information transmission and authentic dialogue. Ledingham (2003) argues that relationship management requires organizations to view public relations fundamentally as relationship-building rather than message distribution,

which the engagement results suggest remains incompletely operationalized within NHIS, directly addressing stakeholder perceptions of limited participatory processes.

Regarding the third objective to identify public relations best practices and strategic communication interventions to enhance NHIS coverage, the enrollment patterns in Table 4.7 reveal insurance literacy challenges that health communication theory addresses and inform intervention strategies. The prevalence of "currently healthy" reasoning for non-enrollment and dropout validates Kenkel and Sindelar's (2011) findings that populations without insurance experience often misconceive premiums as payment for immediate services rather than future protection, suggesting that strategic interventions must reframe insurance messaging. This contradicts Health Belief Model predictions that perceived vulnerability drives protective behavior, indicating NHIS messaging has not effectively framed insurance as risk protection—a critical best practice requiring implementation. The influence of negative secondhand experiences on non-enrolled populations confirms Rogers' (2003) diffusion theory that interpersonal networks shape adoption decisions more powerfully than organizational communication, identifying wordof-mouth management and member satisfaction as strategic priorities. Jehu-Appiah et al. (2011) similarly identified community influence as a critical determinant of NHIS enrollment, suggesting best practices must include community-based engagement and social proof strategies.

Table 4.6's trust findings present insights relevant to all three objectives, revealing a paradox where trust levels exceed engagement quality, sustained primarily through operational performance rather than communication or participatory processes. This pattern validates Gilson's (2003) distinction between competence trust derived from service delivery and relational trust built through engagement processes, confirming current practice assessment findings while identifying

improvement opportunities. The lower scores for communication honesty align with Akazili et al.'s (2014) documentation of trust deficits regarding financial transparency and claims processing, revealing stakeholder perception challenges requiring transparency interventions. The gap between trust and engagement suggests NHIS operates below its relational potential—Hon and Grunig's (1999) relationship quality framework indicates that organizations achieving only moderate engagement despite strong operational trust miss opportunities to deepen stakeholder commitment, identifying a specific best practice of leveraging existing trust through enhanced participatory structures. Grunig's (2001) excellence theory proposes that two-way symmetric communication builds more resilient relationships than asymmetric approaches, directly informing the strategic communication interventions needed to achieve universal coverage goals by transitioning from current one-way models to dialogic engagement that stakeholders perceive as genuinely collaborative rather than merely consultative.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 CHAPTER INTRODUCTION

This chapter presents the summary, conclusions, and recommendations derived from the research findings on stakeholder engagement and communication strategies within Ghana's National Health Insurance Scheme in Greater Accra Region. The chapter begins with a summary of key findings addressing the research objectives, followed by conclusions relating findings to the study's objectives and theoretical frameworks. Subsequently, evidence-based recommendations are provided for the National Health Insurance Authority, Ministry of Health, policymakers, and relevant stakeholders to enhance communication effectiveness and stakeholder engagement quality for improved NHIS coverage. The chapter concludes with discussion of study limitations and suggestions for future research directions that would extend understanding of strategic communication's role in achieving universal health coverage in Ghana and similar sub-Saharan African contexts.

5.2 SUMMARY OF KEY FINDINGS

This study systematically examined stakeholder engagement and communication strategies within Ghana's National Health Insurance Scheme in Greater Accra Region, analyzing data from active members, lapsed members, non-enrolled eligible individuals, healthcare providers, and NHIS staff. The research revealed that while NHIS awareness and knowledge levels demonstrated moderate strength in procedural areas such as registration and renewal processes, critical gaps emerged in understanding service exclusions, complaint mechanisms, and premium differentiation—

dimensions essential for informed decision-making and effective scheme utilization. Communication effectiveness showed reasonable success in linguistic accessibility and basic information provision but substantial weaknesses in interactive dimensions including timeliness of policy updates, responsiveness to individual queries, and consistency across information sources, confirming that NHIS communication operates predominantly through one-way information dissemination rather than dialogic engagement. Stakeholder engagement quality emerged as the weakest performance domain, with significant deficiencies in responsiveness to complaints, listening to concerns, providing feedback opportunities, and involving stakeholders in decision-making processes, indicating that engagement remains consultative rather than genuinely collaborative.

Despite engagement limitations, trust and relationship quality maintained moderate-to-high levels sustained primarily by confidence in benefit delivery and willingness to recommend the scheme, though communication honesty concerns revealed credibility vulnerabilities requiring transparency improvements. Enrollment intentions analysis demonstrated strong retention among active members but concerning patterns among lapsed and non-enrolled populations, with the dominance of "currently healthy" reasoning for non-enrollment and dropout exposing fundamental insurance literacy deficits where stakeholders conceive premiums as purchasing immediate services rather than future protection. The substantial influence of negative secondhand experiences on non-enrolled populations confirmed that communication and engagement failures compound through social networks, making stakeholder experience quality and word-of-mouth management critical priorities. These findings comprehensively validated the research hypothesis that communication and engagement quality significantly influence NHIS coverage outcomes, while revealing specific intervention opportunities including transitioning from asymmetric to

symmetric communication models, institutionalizing responsive feedback mechanisms, implementing participatory engagement structures, enhancing insurance literacy education, and building trust through transparent communication—strategic imperatives for achieving Ghana's universal health coverage aspirations in the Greater Accra Region's complex urban environment.

5.3 CONCLUSION

This research comprehensively addressed its three primary objectives through systematic investigation of stakeholder engagement and communication strategies within Ghana's National Health Insurance Scheme in Greater Accra Region. Regarding the first objective to assess current stakeholder engagement practices and communication strategies employed by NHIA in Greater Accra, the study established that while NHIS has achieved moderate success in basic information dissemination and procedural awareness creation, current strategies remain predominantly oneway, campaign-driven, and focused on enrolment promotion rather than comprehensive education and sustained dialogue. Communication channels adequately address linguistic accessibility but fail to provide timely policy updates, consistent messaging across sources, or responsive mechanisms for stakeholder queries, indicating that NHIA operates within asymmetric communication models emphasizing information transmission over relationship building. Concerning the second objective to examine stakeholder perceptions of communication effectiveness and engagement processes, the findings revealed that stakeholders perceive communication as moderately effective for basic information access but critically deficient in interactive dimensions, while engagement quality emerged as the weakest performance domain with significant inadequacies in responsiveness to complaints, listening to concerns, and involving stakeholders in decision-making processes. Stakeholders consistently reported that engagement remains consultative rather than collaborative,

with limited evidence that their feedback meaningfully influences organizational decisions, thereby undermining trust in participatory processes despite maintaining moderate confidence in operational service delivery.

Addressing the third objective to identify public relations best practices and strategic communication interventions to enhance NHIS coverage, the research established evidence-based recommendations grounded in relationship management theory, dialogic communication principles, and stakeholder engagement frameworks. The study conclusively demonstrates that transitioning from Grunig's public information model to two-way symmetric communication incorporating genuine stakeholder dialogue, institutionalizing responsive feedback mechanisms through accessible complaint systems and regular stakeholder forums, implementing participatory engagement structures that empower stakeholders in policy development and operational improvements, developing sophisticated insurance literacy campaigns reframing coverage as future protection rather than immediate service consumption, and building trust through transparent communication addressing scheme realities including financial challenges and benefit limitations represent actionable pathways for coverage expansion. These findings contribute both theoretically by demonstrating the applicability of public relations scholarship to health financing contexts in sub-Saharan African urban settings and practically by providing NHIA with specific, evidence-based guidance for operationalizing communication strategies that translate awareness into enrolment and enrolment into sustained participation. The research affirms that achieving Ghana's universal health coverage targets in Greater Accra Region requires recognizing stakeholder engagement and strategic communication not as peripheral administrative functions but as central strategic imperatives fundamental to scheme sustainability, coverage expansion, and the realization of health equity goals in the region's complex and diverse socioeconomic landscape.

5.4 RECOMMENDATIONS

Based on the research findings, the following recommendations are proposed for the National Health Insurance Authority, Ministry of Health, policymakers, and stakeholders to enhance communication strategies and stakeholder engagement practices for improved NHIS coverage in Greater Accra Region.

5.4.1 Recommendations for Communication Strategy Enhancement

The National Health Insurance Authority should transition from one-way information dissemination toward dialogic communication by establishing interactive platforms including tollfree helplines, SMS feedback systems, social media channels, and mobile applications providing personalized two-way communication. NHIA should adopt differentiated multi-channel approaches tailored to diverse stakeholder segments, leveraging digital platforms for youth populations, community-based channels through market associations for informal sector workers, and interactive portals for educated urban populations, while moving beyond enrolment promotion toward comprehensive sustained education addressing benefit packages, service exclusions, claims procedures, and member rights. The Authority should establish centralized message development protocols ensuring consistent information across district offices, healthcare providers, and media platforms, implementing regular training for NHIS staff and providers on current policies to minimize contradictory information, while developing standardized materials in multiple local languages avoiding technical jargon and ensuring timely policy change dissemination across organizational levels.

5.4.2 Recommendations for Stakeholder Engagement Enhancement

NHIA should institutionalize responsive feedback mechanisms through district-level complaint desks, mobile complaint units, online portals with tracking systems, and quarterly community listening sessions where administrators engage directly with stakeholders, developing complaint management protocols with clear timelines and regular public reporting demonstrating accountability while implementing feedback loops ensuring stakeholder input informs policy revisions with transparent communication about decision influence. The Authority should create formal stakeholder advisory committees at district and regional levels comprising diverse representatives meeting quarterly with decision-making authority on operational issues and advisory roles on policy development, establishing member councils within healthcare facilities for service quality input and implementing participatory planning processes inviting stakeholder involvement in strategic planning and program design. NHIA should strengthen community-based engagement by recruiting and training community health insurance ambassadors serving as trusted intermediaries, organizing community dialogue forums addressing specific population concerns with NHIA leadership directly engaging stakeholders, and partnering with civil society organizations to co-design communication campaigns leveraging existing trust relationships.

5.4.3 Recommendations for Insurance Literacy Enhancement

NHIA should implement sustained insurance literacy programs distinguishing insurance as risk protection versus direct service payment, with educational content emphasizing financial security against unpredictable health expenses using testimonials and cost analyses demonstrating longterm value, while designing targeted campaigns for "currently healthy" populations explaining insurance value lies in purchasing coverage before illness and integrating insurance education into

school curricula and workplace orientations. The Authority should prioritize transparent communication about covered services and exclusions through easy-to-understand benefit guides with concrete examples, standardized provider education ensuring accurate coverage communication, and materials explaining rationale for coverage limitations and review processes. NHIA should develop communication strategies addressing misconceptions about premium affordability and trust concerns through campaigns highlighting scheme achievements and financial audits, using social proof strategies with satisfied member testimonials to counter negative second-hand experiences, and developing myth-busting content addressing misinformation through trusted community channels.

5.4.4 Recommendations for Trust Building and Transparency

NHIA should implement proactive transparency measures including regular public reporting on premium collections, fund utilization, provider payments, and scheme performance through accessible formats, establishing public dashboards displaying enrolment statistics, claims processing times, and satisfaction metrics updated quarterly and accessible through websites and district offices, conducting and publishing independent audits and satisfaction surveys while communicating openly about financial challenges and sustainability efforts through honest acknowledgment of limitations. The Authority should address provider payment delays by implementing transparent payment schedules with regular communication about timelines, establishing provider liaison offices facilitating two-way communication, and developing provider education programs with service quality incorporated into accreditation criteria. NHIA should prioritize operational improvements addressing service quality concerns by collaborating with Ministry of Health on service delivery improvements, implementing mystery patient programs

monitoring quality, and establishing rapid response mechanisms addressing complaints with intervention when facilities fail to honour coverage.

5.4.5 Recommendations for Policy and Institutional Reforms

Ministry of Health and NHIA should recognize communication and stakeholder engagement as strategic functions by establishing well-resourced communication directorates with professional staff, allocating adequate budgets for sustained communication activities, and developing communication key performance indicators integrated into performance management frameworks with leadership accountability. NHIA should enhance coordination with Ministry of Health, Ghana Health Service, and other relevant agencies by establishing memoranda of understanding defining collaborative responsibilities while partnering with health professional associations and civil society organizations to amplify communication reach. Ghana's legislative framework should mandate stakeholder engagement by proposing amendments to the National Health Insurance Act requiring formal stakeholder representation on governing bodies, establishing regulatory requirements for regular consultations and public hearings on policy changes, and codifying complaint management standards with penalties for non-compliance.

5.4.6 Recommendations for Monitoring, Evaluation, and Research

NHIA should implement robust monitoring frameworks tracking communication reach and engagement quality by conducting annual stakeholder perception surveys measuring awareness, knowledge, effectiveness, satisfaction, and trust across diverse segments with trend analysis identifying required adjustments, monitoring communication channel utilization and feedback volumes while evaluating campaign effectiveness through pre-post assessments and correlation

analyses linking communication exposure to enrolment behaviours. The Authority should institutionalize regular member satisfaction surveys, provider assessments, and non-enrolled population studies disaggregated by demographics and geography identifying differential experiences, implementing exit interviews with lapsed members, and establishing satisfaction targets within performance frameworks. NHIA should collaborate with academic institutions on health insurance communication research, commission studies evaluating interventions through rigorous impact evaluations, support research examining differential communication needs across segments, and foster knowledge exchange with other schemes learning from international best practices.

5.5 LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FUTURE RESEARCH

- The sample size of 150 respondents, while adequate for the study objectives, limits generalizability to the broader Greater Accra population; future research should employ larger samples of 300-400 respondents to enhance statistical power and representativeness across diverse demographic segments.
- The educational skew toward tertiary and postgraduate qualifications representing 84% of respondents may have inflated awareness and knowledge scores; future studies should employ stratified sampling ensuring proportional representation of populations with lower educational attainment who face greater enrolment barriers.
- Informal sector workers comprising approximately 80% of Ghana's workforce were underrepresented at 4.7% of the sample; future research should specifically target informal sector populations through convenience sampling at markets, transport stations, and

informal business centres to capture their unique communication preferences and enrolment challenges.

- The cross-sectional design captured stakeholder perceptions at a single point in time, precluding assessment of temporal changes or causal relationships; longitudinal studies tracking stakeholders over 12-24 months would enable evaluation of how communication interventions influence enrolment decisions and retention behaviours over time.
- The quantitative-only methodology, while enabling systematic measurement across variables, lacked qualitative depth to explore the underlying "why" of stakeholder perceptions and behaviours; mixed-methods designs incorporating focus group discussions and in-depth interviews would provide richer contextual understanding of communication effectiveness and engagement quality determinants.
- Data collection at NHIS offices and healthcare facilities may have introduced selection bias favouring more engaged stakeholders while excluding the most marginalized and disengaged populations; future research should employ community-based recruitment strategies reaching populations who never interact with NHIS facilities to capture perspectives of the hardest-to-reach segments.
- Geographic limitation to Greater Accra Region prevents generalization to rural contexts where communication infrastructure, literacy levels, and stakeholder characteristics differ substantially; comparative studies across urban and rural regions would identify contextspecific communication strategies appropriate for diverse Ghanaian settings.
- The study did not experimentally test specific communication interventions or engagement mechanisms; future research should conduct randomized controlled trials comparing

different message frames, communication channels, and engagement approaches to establish evidence-based best practices for coverage expansion.

- Reliance on self-reported perceptions rather than objective behavioural measures limits ability to establish definitive links between communication quality and actual enrolment decisions; future studies should combine perception surveys with administrative enrolment data tracking conversion rates following specific communication exposures.
- The study did not examine cost-effectiveness of different communication strategies or return on investment for engagement interventions; future research should incorporate economic evaluations comparing costs and coverage outcomes of various communication approaches to inform resource allocation decisions for NHIA.

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APPENDIX

RESEARCH QUESTIONNAIRE

Dear Respondent,

I am a postgraduate student at the University of Media Arts and Communication (UniMAC-IJ) conducting research on stakeholder engagement and communication strategies related to the National Health Insurance Scheme (NHIS) in Greater Accra. This questionnaire seeks your valuable opinions and experiences regarding NHIS communication and engagement practices.

Your participation is completely voluntary and all information provided will be kept strictly confidential. The questionnaire takes approximately 15-20 minutes to complete. There are no right or wrong answers—I am interested in your honest perspectives.

Thank you for your time and cooperation.

Do you agree to participate in this study? Yes [ ]   No [ ]

INSTRUCTIONS: Please tick [✓] the appropriate box or write your response where indicated.

SECTION A: DEMOGRAPHIC AND BACKGROUND INFORMATION

1. Gender
   [ ] Male
   [ ] Female
   [ ] Prefer not to say

2. Age Group
   [ ] 18-25 years
   [ ] 26-35 years
   [ ] 36-45 years
   [ ] 46-55 years
   [ ] 56 years and above

3. Highest Level of Education Completed
   [ ] No formal education
   [ ] Basic education (Primary/JHS)
   [ ] Secondary education (SHS/Technical)

[ ] Tertiary (Diploma/HND/Bachelor's) [
] Postgraduate (Master's/PhD)

4. Employment Status
[ ] Formal sector employee
[ ] Informal sector worker
[ ] Self-employed
[ ] Student
[ ] Unemployed/Retired

5. Location

____

6. Your Relationship with NHIS (Please select ONE option that best describes you)
[ ] Active NHIS member (with current valid card)
[ ] Lapsed member (previously enrolled but not renewed)
[ ] Non-enrolled but eligible
[ ] Healthcare provider at NHIS-accredited facility [
] NHIS district/municipal office staff

SECTION B: NHIS AWARENESS AND KNOWLEDGE

Please indicate your level of agreement with the following statements about NHIS awareness and knowledge:
(1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

Statement	1	2	3	4	5
1. I am well-informed about how to register/enroll in NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
2. I have adequate knowledge about health services covered by NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
3. I understand which health services are NOT covered by NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
4. I know the premium payment requirements for different categories	[ ]	[ ]	[ ]	[ ]	[ ]
5. I am aware of who qualifies for premium exemptions	[ ]	[ ]	[ ]	[ ]	[ ]
6. I understand the process for renewing NHIS membership	[ ]	[ ]	[ ]	[ ]	[ ]
7. I know where to access NHIS services in my area	[ ]	[ ]	[ ]	[ ]	[ ]
8. I am aware of how to make complaints about NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
9. I understand the rights of NHIS members	[ ]	[ ]	[ ]	[ ]	[ ]
10. Overall, I consider myself knowledgeable about NHIS	[ ]	[ ]	[ ]	[ ]	[ ]

SECTION C: COMMUNICATION EFFECTIVENESS

Please rate your level of agreement with the following statements about NHIS communication:

(1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

Statement	1	2	3	4	5
1. NHIS communication messages are clear and easy to understand	[ ]	[ ]	[ ]	[ ]	[ ]
2. NHIS provides adequate information about enrollment procedures	[ ]	[ ]	[ ]	[ ]	[ ]
3. NHIS provides sufficient information about covered benefits	[ ]	[ ]	[ ]	[ ]	[ ]
4. NHIS provides information in languages I understand	[ ]	[ ]	[ ]	[ ]	[ ]
5. NHIS communication addresses my specific concerns and questions	[ ]	[ ]	[ ]	[ ]	[ ]
6. I receive timely information about NHIS policy changes	[ ]	[ ]	[ ]	[ ]	[ ]
7. NHIS uses appropriate communication channels to reach people like me	[ ]	[ ]	[ ]	[ ]	[ ]
8. It is easy to get answers to my questions about NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
9. NHIS communication is consistent across different sources	[ ]	[ ]	[ ]	[ ]	[ ]
10. Overall, I am satisfied with NHIS communication strategies	[ ]	[ ]	[ ]	[ ]	[ ]

SECTION D: STAKEHOLDER ENGAGEMENT

Please indicate your level of agreement with the following statements about NHIS stakeholder engagement:

(1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

Statement	1	2	3	4	5
1. NHIS provides adequate opportunities for stakeholders to give feedback	[ ]	[ ]	[ ]	[ ]	[ ]
2. NHIS listens to stakeholder concerns and suggestions	[ ]	[ ]	[ ]	[ ]	[ ]
3. NHIS responds promptly to stakeholder questions and complaints	[ ]	[ ]	[ ]	[ ]	[ ]
4. NHIS involves stakeholders in decision-making processes	[ ]	[ ]	[ ]	[ ]	[ ]
5. There are adequate channels for me to communicate with NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
6. NHIS values the opinions of ordinary members and citizens	[ ]	[ ]	[ ]	[ ]	[ ]
7. NHIS engages respectfully with different stakeholder groups	[ ]	[ ]	[ ]	[ ]	[ ]
8. I feel my voice matters to NHIS administrators	[ ]	[ ]	[ ]	[ ]	[ ]
9. NHIS demonstrates how stakeholder feedback influences decisions	[ ]	[ ]	[ ]	[ ]	[ ]
10. Overall, I am satisfied with how NHIS engages stakeholders	[ ]	[ ]	[ ]	[ ]	[ ]

SECTION E: TRUST AND RELATIONSHIP QUALITY

Please indicate your level of agreement with the following statements about trust and relationship with NHIS:

(1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

Statement	1	2	3	4	5
1. I trust that NHIS will deliver promised healthcare benefits	[ ]	[ ]	[ ]	[ ]	[ ]
2. NHIS is honest in its communication with stakeholders	[ ]	[ ]	[ ]	[ ]	[ ]
3. NHIS manages premium contributions responsibly	[ ]	[ ]	[ ]	[ ]	[ ]
4. NHIS treats all members fairly regardless of background	[ ]	[ ]	[ ]	[ ]	[ ]
5. NHIS genuinely cares about the welfare of its members	[ ]	[ ]	[ ]	[ ]	[ ]
6. I am satisfied with my overall experience with NHIS	[ ]	[ ]	[ ]	[ ]	[ ]
7. I feel valued as an NHIS stakeholder	[ ]	[ ]	[ ]	[ ]	[ ]
8. I would recommend NHIS to friends and family	[ ]	[ ]	[ ]	[ ]	[ ]
9. I have confidence in NHIS leadership and management	[ ]	[ ]	[ ]	[ ]	[ ]
10. Overall, I trust the National Health Insurance Scheme	[ ]	[ ]	[ ]	[ ]	[ ]

SECTION F: ENROLLMENT INTENTIONS AND BARRIERS

For Active NHIS Members ONLY:

1. How likely are you to renew your NHIS membership when it expires?
   - [ ] Very likely
   - [ ] Likely
   - [ ] Undecided
   - [ ] Unlikely
   - [ ] Very unlikely

2. How satisfied are you with NHIS services overall?
   - [ ] Very satisfied
   - [ ] Satisfied
   - [ ] Neutral
   - [ ] Dissatisfied
   - [ ] Very dissatisfied

For Lapsed Members ONLY:

3. What was the PRIMARY reason you did not renew your NHIS membership? (Select ONE)
   - [ ] Could not afford premium
   - [ ] Poor service quality at facilities
   - [ ] Long waiting times
   - [ ] Did not see value in continuing
   - [ ] Renewal process too complicated

[ ] Currently healthy, don't need insurance
[ ] Other: _______________

4. How likely are you to re-enroll in NHIS in the future?
[ ] Very likely
[ ] Likely
[ ] Undecided
[ ] Unlikely
[ ] Very unlikely

For Non-Enrolled Eligible Populations ONLY:
5. What is the PRIMARY reason you have not enrolled in NHIS? (Select ONE)
[ ] Cannot afford premium
[ ] Do not understand how to enroll
[ ] Enrollment process too complicated
[ ] Currently healthy, don't need insurance
[ ] Heard negative experiences from others
[ ] Don't trust NHIS
[ ] Prefer to pay directly at hospitals
[ ] Other: _______________

6. How likely are you to enroll in NHIS in the next 12 months?
[ ] Very likely
[ ] Likely
[ ] Undecided
[ ] Unlikely
[ ] Very unlikely

THANK YOU FOR YOUR PARTICIPATION!