International Journal of Research
Available at https://edupediapublications.org/journals
p-ISSN: 2348-6848
e-ISSN: 2348-795X
Volume 04 Issue 01
January 2017

Examining The Disparities in Access to Social Intervention Programmes among Foster and Non Foster Children in Rural Ghana; A case study of Tain District

Augustine Djan

Wenchi Methodist Senior High School, P O Box 88, Wenchi-B/A, Ghana.

Email: djanisco2005@yahoo.co.uk

Abstract

Harm done to children in their formative years can be extremely devastating and difficult to reverse. The government of Ghana has therefore implemented forty four (44) pro-poor social intervention programmes to bridge the gap between the advantaged and the disadvantaged persons including rural children in the country. The objective of this qualitative case study was to examine the disparities in access to three of these interventions (The National Health Insurance Scheme –NHIS, The Free School Feeding Program-SFP and The Capitation Grant to Schools-CG) among foster and non foster children in three rural communities (Yabraso, Fabewoso and Hiamankyene) in the Tain District of Brong Ahafo Region. Access was conceptualized in the study to mean availability and utilization (benefits). Using data from both primary and secondary sources, results of the study indicate that foster children in the communities consistently have lower access to all the three interventions. The disparities arose not so much from the availability of the interventions to the children (SFP—5.6%, CG—0%, NHIS—48.94%) but from their utilization (SFP-94.4%, CG—100%, NHIS—51.06%). The paper identified eleven major barriers that account for the disparities and also offered thirteen tangible strategies in addressing the disparities. The paper concludes with a recommendation to government to formalize foster care system in Ghana as the best way to reduce the level of disparities in access to interventions between foster and non foster children in rural Ghana.

Keywords: Disparities in access; Social intervention programmes; Tain District; Foster children; Ghana

1. Introduction

Deprivation of access to basic necessities in life which others take for granted is real and a very excruciating experience for the disadvantaged (e. g foster children) (World Development report, 2000/2001; O' Donnell et. al. 2008). Harm done to children in their formative years can also be extremely devastating and difficult to reverse (Magnuson & Waldfogel, 2005; Nancy, 1996;

National Institute of Child Health & Human Development Early Child Care Research Network, 2005; Vandell et. al., 2010; Pears et. al. 2011; UNICEF, 2008; IOM & NRC, 2014). The fate of every country in a few years from today will be in the hands of today's children; making children every nation's greatest resource and hope (Hamilton, 1991). In these regard, Ghana, like many other countries has since independence in 1957 made frantic efforts to promote the rights and the welfare of her children, especially orphans and the vulnerable (United Nations, 1989; GOG, 1992). Therefore the country, with support from multi-national donor agencies such as USAID, UNICEF, and the World Bank has implemented many pro-poor social intervention programs (Abubakari & Yahaya, 2013; Powell-Jackson, & Ansah, 2015; Essuman & Bosomtwi-Sam, 2013; Dixon et. al. 2014).

An official government source, according to Kale-Dery (2014) puts the number of interventions currently in operation in Ghana at forty four. All these interventions directly and/or indirectly affect children. The most popular of these interventions include the National Health Insurance Scheme –NHIS (Dalinjong & Laar 2012, Jehu-Appiah et.al 2010; Dixon et al. 2014)), the Livelihood Empowerment Against Poverty Program --LEAP (Ghana News Agency, 2015), The Free School Feeding Program (Nsowah, 2008; Osei-Fosu, 2011), The Capitation Grant to schools (Asante 2011), Free Textbooks and Uniforms Distribution to students (Ghana News Agency, 2015).

A large body of empirical studies have been done to examine children's access to these interventions (Osei-Fosu, 2011; Asante ,2011; Osei et al., 2009; Essuman & Bosomtwi-Sam, 2013; Adamu-Issah et al, 2007; Ghana News Agency,2015; Kale-Dery,2014; Dalinjong & Laar, 2012). Even though a few of the studies such as Osei et al., (2009) interestingly disputes the significant impact of some of the interventions (e.g., capitation grant) on school enrollment component of education, many of the studies have been unanimous in conclusion regarding how beneficial these programs have been (WFP, 2006; Ahadzie,2008; Essuman & Bosomtwi-Sam, 2013, Dalinjong & Laar, 2012; Jehu-Appiah et.al. 2010). For instance, Kale-Dery, (2014), observes that the School Feeding Programme alone provides one hot and nutritious meal a day to 1.6 million Ghanaian children thereby increasing school enrollment, attendance and retention by 80%. The Ghana News Agency (2015) also reported from a UN conference in New York of a free distribution of 1,601,700

school uniforms and 87,074,160 exercise books to Ghanaian school children in 2012/14. Nana Oye Lithur, the government Minister responsible for the Ministry of Gender, Children and Social Protection is reported by Kale-Dery (2014) to have stated that "the NHIS had registered and was providing free healthcare for over one million vulnerable beneficiaries, while over 88,908 persons had been employed under the labour intensive public works with 52,177 of them being women".

Another Director (for Social protection), at the same ministry, Mr. Mawutor Ablo, is also reported by the Ghana News Agency (2015) to have remarked that, "...the Livelihood Empowerment Against Poverty (LEAP) which started with only 1,645 households in 2008, currently covers over 90,000 households and is projected over 200,000 by Dec. 2015"

While this study applauds this impressive and unprecedented performance, it raises a very fundamental question of equitable access to the interventions by rural children in foster care compared to their non foster cohorts. Access to the interventions by other minority children groups such as the disabled have been studied and they have been found to suffer reduced access compared to other children without disabilities (UNICEF, 2000). Unfortunately, for foster children in the rural areas in the country, such as the Tain District, their access to the interventions has not been adequately explored. The few studies which have been done focused only on the northern parts of the country (Dalinjong & Laar, 2012; CREATE 2011; CREATE, 2010; Abubakari and Yahaya, 2013).

This study therefore seeks to examine fostering situation in the Tain District and how it impacts equitable access to three of the most popular and important social interventions---National Health Insurance Scheme (NHIS), School Feeding Programme (SFP) and Capitation Grant(CG) to schools. The paper uses three traditional communities (Yabraso, Hiamankyene and Fabewoso) in the Tain District of the Brong Ahafo Region of Ghana as a case study. It specifically takes a critical look at the types of foster systems in the communities and factors which account for them. It also examines the factors that influence disparities in access to available social interventions and provides recommendations on how the inequality could be addressed.

Due to its proximity to the north, relative peace, favourable climatic weather conditions (double

maxima rainfall pattern of about 1200mm in average), land availability and fertility, Tain District and the three villages surveyed have attracted a lot of migrant farmers from the poverty-stricken three Northern regions of Ghana over the past few years. Close to 80% of them are illiterate and poor with very large unplanned family sizes. A sizable number of them are in polygamous marriages. Rival wives compete among themselves regarding the number of children they can have. The more children a wife has, the more favour she receives from the husband. Farms and foodstuffs are all shared according to the number of children. These have given rise to a large number of children populations in the study area. According to the Ghana Statistical Services (2010) the average household size in the area is 5.4. This far exceeds the national average of 4.5 by 0.9 points over the same census period.

Premature deaths due to the economic and social stress, suicide, unintentional accidents, HIV/AIDS and other diseases have therefore risen very sharply in these rural communities. So has the number of parents who abandon their families and children. These have increased the number of children needing foster care in the study area very significantly. Unfortunately, no detailed studies have been done on them to enable policy-makers tailor-size any social intervention programme to address the specific needs of this vulnerable rural foster population. They have been forced to rely on the uniform social intervention programmes available on the assumption that they are benefiting from them like all other children. This might turn out to be false base on an observation by Coriell & Cohen (1995). According to them, intervention seen by the provider as very beneficial may not be regarded to the same extent by the recipient. Worse of it all, foster population has empirically been reported to experience worse, multiple, acute and chronic conditions of physical, mental and developmental health outcomes and demands coordinated care more than the general population (Hansen et.al., 2004; Leslie, Hurlburt & LandsverkJ,et. al.,2003; Steele & Buchi, 2008).

Illustratively, foster children in the Tain District are currently experiencing "triple agony"; First, as children in Ghana (Lockheed and Verspoor, 1991; UNICEF, 2000; UNICEF, 2008). Secondly, as children from a rural area (Sowa, 2002; World Development Report, 2000/2001) and lastly, as foster children (Gassman-Pines & Yoshikawa, 2006; Garland et al., 2001; Deutsch

& Fortin, 2015; Steele & Buchi, 2008; CREATE, 2010; Abubakari and Yahaya, 2013).

Therefore, on the grounds of fairness and equal justice, this study is highly justified.

The ultimate goal of this study was therefore to draw attention of policy makers to the injustices and unequal treatment being meted out to foster children in rural Ghana so that they can be addressed.

It will also provide an objective assessment for the various donor funded social intervention programs in the communities by empirically shedding some light on who is enjoying what proportion, why and how? This can ultimately lead to improvement in the design, execution, monitoring and evaluation of future programmes. This is in line with the assertion by Littell & Shlonsky (2010) that accurate, reliable, and exhaustive information are very essential in making well-informed decisions on social intervention programmes.

Social intervention programmes that impact health (Health Insurance) and education (Capitation Grant and School feeding program) have been strategically targeted by this study because these variables, are known from empirical studies to form the cornerstone for economic development and prosperity of individuals, their societies and nations (Barro, 1991; Marlaine E., et. al., 1991; NDPC, 2015).

The study will also add to existing knowledge on foster care phenomenon in rural Ghana and also serve as a framework for future research

Equitable access can be defined as equal opportunity to benefit from the same interventions by all subgroups. For the sake of clarity, this study conceptualizes access to mean availability and utilization (benefits) of the interventions. The success of every social intervention depends on the interaction of these two major factors; availability and utilization. Availability does not only address the question of physical presence but also involves its quality and effectiveness in terms of usefulness, appropriateness, timeliness and even the professional and cultural competence of the persons delivering the interventions.

Utilization involves the decision of beneficiaries to patronize the program based on many factors including perceived and real benefits,

complementary cost, opportunity cost, cultural and religious pressures.

1.2. Brief overview of the selected social intervention programmes

1.2 (a). The National Health Insurance Scheme (NHIS)

The National Health Insurance Scheme (NHIS) which is based on a district wide mutual health insurance scheme system is one of the most popular government's pro-poor social intervention programs in Ghana since Independence in 1957 (Dixon et. al.2014; GOG,2003). It was born out of parliament in 2003 through the passage of the National Health Insurance Act (Act 650) as part of the New Patriotic Party (NPP)'s 2000 election campaign promises (Jehu-Appiah et.al. 2010). It however became fully operational in 2005 (Dalinjong & Laar, 2012). It was introduced to replace the "cash and carry" health financing system in Ghana. The "cash and carry" system was a full cost recovery by which people had to pay for the full cost of health care treatment (medication, care and facilities) directly from their pockets at the point of service delivery, just before and/or after receiving treatment. User fees payment, coupled with poverty have been great barriers globally in accessing health care (World Development report 2000/2001, LaVeist, 2005; Lagarde & Palmer, 2006; James, 2006).

The main reason for the introduction of this District wide NHIS was therefore to promote equitable and universal access to basic quality health care for all residents in Ghana irrespective of the person's economic, social, ethnic and/or religious background (Jehu-Appiah et.al., 2010, Dalinjong & Laar 2012).). Even though the realization of this objective has empirically been challenged by a few researchers including Sarpong at al., (2010) and Jehu-Appiah et.al. (2010). from an observation by Jehu-Appiah et.al (2010) they documented a "compelling evidence of inequality in enrollment in the NHIS". In fact, they demonstrated that "….the NHIS is not reaching the poor in general"

Currently, to subscribe to the Insurance Scheme for an annual coverage against most common sicknesses, a regular adult between 18 to 69 years pays an annual premium of GHC 14 and a registration (membership ID card) fee of GHC 4.00. Children below the age of 18 years pay only the GHC4.00 registration fees. Persons above the age of 70, pregnant women and

indigents do not pay anything at all. The rest of the funding for the scheme according to Dalinjong & Laar (2012), Jehu-Appiah et.al. (2010) is generated from a 2.5% levy on certain goods and services, 2.5% monthly payroll deductions of formal workers contribution to the National Insurance Trust (SSNIT), government annual budgetary allocations and donor support. Medical bills for insured clients who attend accredited service providers, are footed by the NHIS far later after treatment is provided.

In the Communities where this study took place, even though the mandatory nature into the scheme is yet to be enforced like other parts of the country (Dalinjong & Laar, 2012), the aggressive, innovative and attractive marketing strategies which have been adopted by the District Insurance Scheme have enabled approximately 65% of the residents to enroll into the Scheme. In Ghana, in general, in spite of the usual isolated cases of long waiting times, lack of proper examination, referral to buy very common drugs in the open market, delay in payment to service providers by the government--leading to intermittent curtailment of services to insured clients, health insurance has been extremely beneficial to both clients and service providers. For insured clients, it has actually led to an increase in health care utilization. For service providers, Health Insurance has enabled them to mobilize huge revenues leading to significant expansion in their infrastructure (NHIC, 2011; Dalinjong & Laar, 2012). Table 1 below shows outpatients and inpatient utilization of healthcare services by insured clients between 2005 to 2011 in Ghana.

Table 1: Utilization of healthcare services by NHIS insured clients in Ghana

Year	Healthcare Services utilization (millions)	
	Inpatients	Outpatients
2005	28,906	0.6
2010	724,440	16.9
2011	14,515,96	25.5

Source: NHIC (2011) Annual report

1.2 (b). The Capitation Grant (CG)

Improvement in education in the form of universal basic education for all Ghanaians has been one of the major developmental agenda of the Government of Ghana over the past decades (NDPC,2015). This is not only due to its imposition on the government by the 1992 Republican Constitution but due to its potential to reduce poverty, improve quality of life and enhance the productive capacity of the country

(Lockheed and Verspoor,1991).This effort however had been thwarted by the payment of fees and other charges. This warranted the introduction of the Capitation Grant to public basic schools in Ghana.

With support from USAID and other multinational donor agencies, the grant was first piloted in 40 districts and was rolled out nationwide in 2005 (Asante 2011;USAID, 2007; NDPC,2015). This form part of the government's effort in achieving 2 of the Millennium Development Goals (MDGs) in education; To ensure universal primary education (MDG 2) and to eliminate gender disparity in primary and secondary education (MDG 3) (World Development report 2000/2001). Better put, the main aim of this grant is to ensure equitable access to education by all children in Ghana (USAID, 2007; NDPC, 2015). The realization of this objective has however been empirically challenged by others like Osei et al., (2009).

By this policy, the government pays an amount of GHC 4.50 per every kindergarten, primary and junior high child per year. According to the NDPC (2015), the CG is to be used specifically on teaching and learning materials, sports and culture, in-service training for teachers and transportation during official duties.

The schools are not therefore to charge any form of fees which could serve as a barrier to the children from extremely poor households. After 10 years of implementation, however, schools still charge fees in the name of culture, sports, examination, utilities, PTA, etc., (NDPC, 2015; Asante, 2011).

Despite reported cases of delays and insufficient nature of the amount, some studies including Asante (2011), and National Development Planning Commission (2014) have hailed this policy as having been associated with increase in school enrolment, attendance, academic achievement and/or the nutritional level of the children at least at the basic level.

1.2 (c).The School Feeding Programme (SFP)

The School Feeding Programme (SFP) is one of the school-based pro-poor social interventions by the government of Ghana. An inventiveness of the Comprehensive Africa Agricultural Development Programme (CAAP) with support from the New Partnership for Africa's Development (NEPAD), the SFP was introduced in 2005 as part of the efforts in achieving three of

the of the Millennium Development Goals (MDGs); To eliminate extreme poverty and hunger (MDG 1), to ensure universal primary education (MDG 2) and to eliminate gender disparity in primary and secondary education (MDG 3) (World Development report, 2000/2001).

The SFP according to Abebrese (2014), Bundy et al.(2009), Adelman et al. (2007) and Abad (2005) is principally aimed at achieving three main objectives:

1. Increase school enrolment, attendance and reduce school dropouts.
2. Reduce hunger and malnutrition
3. Increase local food production

All the children in the beneficiary schools are provided with one hot nutritious meal a day free of charge Essuman & Bosomtwi-Sam, 2013

Schools in Yabraso and Hiamankyene are beneficiaries of the feeding programme. Reports from both the parents and the teachers of the schools studied, indicated that the school feeding programme has led to a very significant increase in their schools populations. They also contended that dropouts and absenteeism rates have gone down considerably especially for girls due to this intervention. Besides, it has also created jobs and ready markets for some of the residents in the communities who are predominantly farmers with very low incomes.

These reports are consistent with empirical studies in other parts of the country (Nsowah,2008; Osei-Fosu,2011). The problem of low quality meals served to the children and the long delay in reimbursing the contractors who serve the meals are the major problems reported by the stakeholders (Osei-Fosu, 2011)

1.3. The study area

The study took place in the Tain District, specifically, in Yabraso, Hiamankyene and Fabewoso. These are small rural communities located at the southern corner of the District.

The District is one of the 22 Administrative Districts in the Brong Ahafo Region, located in the middle zone of Ghana. It was carved out of the Wenchi District in 2006. It has a population of 108,386 with 49.7% males and 50.3% females (Ghana Statistical Services, 2010). This accounts for approximately 6% of the total population in the Brong Ahafo region. The residents are 78.7% Akans by ethnicity.

Yabraso, Hiamankyene and Fabewoso are located at a distance of 9km, 12km and 17km respectively from Nsawkaw, the capital town of the Tain District. They have populations of 2,600 (Yabraso), 1800 (Hiamankyene) and 1,550 (Fabewoso) approximately. The average household size in the area is 5.4 which far exceeds the national average of 4.5 by 0.9 points over the same accounting period (Ghana Statistical Services, 2010).

The inhabitants are predominantly crop farmers. They produce mainly yam, maize and pepper. A small percentage is into tree (cashew) production while similar proportion is into livestock rearing. Other small scale activities in the villages include pito (local alcoholic beverage) brewing, charcoal production and retail trading. Relying on nature, about 80% of the farmers here produce mainly to feed their families. Close to 75% of the remaining farmers who produce beyond subsistence level in the communities are migrant farmers who have relocated to these communities from the Northern regions of the country. The three Northern Regions (The Upper West, Upper East and the Northern Region) are the least developed and the poorest zones in the country (Abebrese,2014); Kuuire et al., 2013; Konadu-Agyeman, 2000; IMF, 2012).The natives are however very hard working individuals who migrate with great determination to farm and send some of the proceeds back home to the rest of the family left there. They have been attracted to these villages due to their proximity to the north, relative peace, favourable climatic weather conditions (double maxima rainfall pattern of about 1200mm in average), land availability and fertility. In general, the settler farmers constitute just about 9% of the entire population in the communities but paradoxically produce close to 65% of the total food production in the area.

No wonder, the prevalence rate of income poverty is very high in these communities, When asked to comment on the poverty levels in one of the villages during a focus group discussion, one parent remarked that;

"*my son, the kind and the number of thatched and mud houses you see here, coupled with the clothes you see us wearing should tell you everything you want to know about our poverty levels—it is simply endemic, if you maliciously want me to tell you*".

Road networks that link these three communities are in terrible shape especially from Fabewoso to Yabraso. The people rely on foot, bicycles, motor bicycles, and tricycles as the main means of transportation in the area. Major economic problems in the communities include lack of

electricity, health care facilities, access to credit facilities, portable drinking water and adequate schools. Other social problems are unplanned families and high illiteracy rates. Another worrying situation that is thwarting their effort at ever escaping from poverty, according to the residents, is bush fires which destroy their farms and sometimes their houses.

1.4. Foster care situation in the area

Fosterage is a global phenomenon practiced in the U.S (U.S Department of Health and Human Services 2008, Williams, 1999), Britain (Greeff,1999), Netherlands (Portengen et. al. 1999) and Belgium (Merchand,1999). However, it is more prevalent in the West-African sub region ((Isiugo-Abanihe,1985:56; Pilon 2003; Page,1989;Goody,1982). For instance while it accounts for less than 8% in the US (U.S Department of Health and Human Services ,2008; Barth et al., 2005), the rate is close to 40% in Sierra Leone and Cameroon (Bannell, P, 2005), and over 25% in Senegal and Cote D'Ivoire (Pilon ,2003). In Ghana, though there is no consensus on the prevalence rate, empirical studies indicate that it is somewhere between 10% (CREATE, 2010) and 12% (CREATE 2011)

Fosterage is broadly defined as a system of temporary and reversible living arrangement between two families, where non-biological parents assume guardianship for a child (Goody,1982;Serra,2009;Fiawoo 1978 ; IOM &NRC 2014). In the communities studied, foster care is still at the informal traditional level. It lacks government intervention and/or regulations like other parts of the African continent (Goody 1982) and Ghana. It is one of the few socio-cultural practices which is popularly practiced by many ethnic groupings in Ghana; including the Dagombas in the Northern Region (CREATE 2010, CREATE 2011). Not all the types however, are practiced by all ethnic groupings. The reasons for the practice also vary slightly from region to region.

1.4 (a).The extent of fosterage in the communities surveyed

Close to 80 % of the factors which influence fosterage in other communities do not exist or are not popular in the three communities studied. Therefore, fosterage as a matter of fact is not a very popular socio-cultural practice in the communities studied. It accounts for only about 8% of all children in the communities, according to the survey results. This is far lower than the national prevalent rate of 10% (CREATE, 2010)

and 20% among the Gonja ethnic group in the Northern region (Goody,1973). Abubakari & Yahaya (2013) also observed that among the Dagombas in the northern Region, the rate is 43.2% among women above 16 years and 18% for men.

Notwithstanding, it is worth examining, because the Constitution of Ghana guarantees equal treatment and protection for all Ghanaians. Jehu-Appiah et. al. (2010), also observes that equity is a very important element in access to social interventions like health no matter the number of people it disadvantages.

During a focus group discussion in the communities, parents gave the following reasons regarding why why fosterage is not so popular in these communities:

1. Children in the communities are not interested in learning trade and or furthering their education beyond the Junior High school level. These two push factors could have led the children to relocate to live with other foster families in other communities as observes by Pilon (2003) and Klomegah (2000).
2. The communities do not have any cultural practice that makes it mandatory or attractive for living families to send out and/or receive children into fosterage like groups in Dagbon (Oppong,1973, CREATE, 2011) and the Dagombas (Oppong 1977, Abubakari 2008; CREATE (2010)).

1.4 (b).Categories of foster parents

The study also examined the categories of persons who foster in children in the three communities. The results have been presented in the frequency distribution table (2) below.

Table 2.

Category of foster parent	**Frequency**	**%**
Grandmothers	10	11.1
Grandfathers	7	7.8
Uncles	6	6.7
Successors	58	64.4
Aunts	5	5.6
Non-relatives	4	4.4
Totals	**90**	**100**

Source: Field work, 2015

As indicated in the table, majority of the foster children (64.4%) in the communities live with

successors of the biological parents. Grandmothers come next (6%), followed by Grandfathers (4%). Total strangers (non-relatives) hold the least number of foster children in the communities.

1.4 (c) Types of foster care systems practiced in the communities

There are five types of child fostering in Ghanaian societies; Alliance, Apprentice, Domestic, Educational and Crisis child fostering. In the communities surveyed, only two of these types of child fostering are popular; Crisis and Domestic fostering. The reasons have clearly been illustrated in section 1.4(a) above.

1.3 (c) i. Crisis fosterage

This is a situation where crisis such as death, sickness and/or poverty hits a household and renders it incapable to care for its children (Serra,2009). As a result, the children are passed on to another member of the extended family (kinship) to raise. In the communities surveyed, death accounts for over 98% of these calamities which necessitate crisis fostering. When this occurs, it is the person who inherits the deceased who wins the custody bid to foster the children. No wonder, table 6 awards the highest percentage (64.4%) of foster cases to heirs of deceased relatives.

Thus crisis fosterage is the most common case of fostering in the communities studied just like all other parts of Ghana. The system of inheritance is very intriguing. Nonetheless, it directly influences who actually fosters a child and why and how. Major characteristics of the system of inheritance and its implications in child fostering are highlighted below:

1. Inheritance is through one's mother's blood line
2. Inheritance is sex specific. That is, a female is inherited by a female and vice versa.
3. It is the child of the diseased elder or younger mother who inherits him/her. That is, one cannot be inherited by one's direct sibling
4. In the absence of any suitable candidate as in above, a deceased is inherited by his /her nephew / niece.

The implication of this in child fostering is that the system does not consider the issue of ability and the availability of resources of the foster parents. Unlike the formal system of fosterage, which is voluntary and involves a thorough safety and capability background assessment of the potential foster parent, here, it is a complete imposition. This contravenes the observation by Bledsoe & Isiugo-Abanihe (1989). It thus come

as a total shock (Deininger et al., 2003) and is not preceded by any formal training and or negotiation between the sending and the receiving parties. This is also inconsistent with the conclusions of many other studies (Ntozi, 1995, Johnson-Hanks,2006). So in the first place, both the child and foster parent appear psychologically unprepared for the fostering task.

1.4(c) ii. Domestic fostering

As the name suggests, in this fostering module, parent give-out their children to other person(s) primarily to provide domestic labor services to the person with very little in return (Fiawoo, 1978; Goody, 1975). This study therefore prefers to label this child fostering as " charity" fostering.

The receiving household could be a relative, an acquaintance, or a total stranger. As seen in table 3, 18.9% of the receiving relatives who enjoy this charitable foster placement are grandparents. Uncles come next with 6.7% and then aunts and others who are usually childless. Acquaintances who are usually considered are teachers in the community, or traders who visit the communities from nearby cities and show kindness. To be considered, an acquaintance must proof his/her kindness by buying at most a loaf of bread or a piece of soap worth GHC 5.00 ($1) for the sending household at most twice.

The sending parent does not negotiate for anything in return apart from sleeping space and food for the foster child. So a casual look at the motive will term it as purely charitable. However, a deeper examination of the profiles of parents who indulge in this cultural practice reveals a "hidden motive". They are parents with more children than they can care for. More than 75% of them have between 5 to 12 children living in a maximum of 2-bedroom apartment in a family house with shared facilities. The household survives on less than GHC 10.00 ($2) a day. From this illustration, it is clear that lack of sleeping space, access to food, clothing and health are the hidden realities which compel most parents to give-out their children under this foster module (Isiugo-Abanihe,1985)

Though reversible, this is a long term placement, because getting out of the conditions which necessitate the placement in the first place is quite impossible in the short term.

When children are "advertised" girls receive offers more than boys because girls are known to be better domestic workers than boys.

The older the child, the more likely he/she is to find foster placement. A child who is in school is also less likely to be considered compared with one who is not in school when sex and age are controlled for. One sending parent in giving out her child to a potential foster parent remarks that

> "Take her away, I've given her to you for good as a gift.
> I have no use of her. Keep her until she ages and gets married.
> Don't worry, as for children I have 8 more.
> Even how to feed them is a headache".

1.5. Reasons for fosterage in the communities

1. Families foster in and out children in order to counterbalance economic insufficiency and social insecurity. Fosterage thus enables orphans and vulnerable children to obtain the much needed care and training. In an area where protective social interventions programs for orphans and vulnerable children by the government are non-existent, families have no choice but to devise their own means in caring for the large number of children whose parents die each year due to the HIV/AIDS pandemic, crimes, unintentional accidents and other diseases. Children from large unplanned families with insufficient access to basic necessities in life such as food, clothing, shelter and training also obtain them when they are fostered out to more privileged families.

   Besides, in the communities studied, if a member of a particular family engages in a culturally abominable act such as stealing, gossip, infidelity, or even develops any (mental/physical) disorder, his/her entire family is shamed and stigmatized. It is therefore the duty of the entire family to use fosterage to provide training and proper socialization to children who are unable to obtain this training from their biological parents.

2. Families also foster out their children to other demographically disadvantaged members of the family who are barren, disabled, inexperienced or aged to aid them in their day-to-day domestic and/or commercial activities. This fair re-distribution of labour services in the family also solves the ubiquitous witchcraft puzzle. Witchcraft---a supernatural act of causing harm to others

is traditionally believed to principally stem out of envy, jealousy, and hatred (. Individuals who are thus barren, disabled (physically/mentally), indigent or very old (90+) are traditionally suspected of possessing witchcraft which can be used to harm the more fortunate family members in terms of wealth and/or children unless they are somehow compensated.

3. Fosterage also is used to preserve family unity. It is used to demonstrate family ties to foster children and helps the children to in turn identify their relatives. No wonder, as beneficiaries of the extended family system, foster children become its best advocates when they grow up. Growing up for instance in an uncle's house as a foster child, logically makes the uncle's children part of the child's extended family.
4. Fosterage also increases the wealth of families. In the communities surveyed, both the sending and receiving families benefit economically from the labour of foster children as farm labourers or farmers themselves.
5. Some families also take in foster children as a form of social insurance in the event of old age or serious sickness. In Ghana, some parents care for their children not as a natural and legal duty as enshrined in the 1992 constitution but so that the children will in turn care for them when they grow older.
6. Fosterage is also used as a stress-coping mechanism. Upon passing away of one's parent(s), one is fostered in by another family member to mitigate the agony which might lead to further depression and/or behavioral problems.

2. Theoretical framework.

This qualitative study was guided by two statistical models; direct and indirect effect models. These models were originally designed to explain how supports impact health. They have been modified slightly for the purposes of this study.

The direct model as illustrated in figure 1 (A) argues that Social Interventions can be taken directly to foster children instead of transmitting them through foster parents as intermediaries (Baron & Kenny, 1986). That is, social support can have direct impact on the welfare of foster

children. While its proponents argue that it is cost effective and guarantees the delivery of the right care to foster children at the right time, its critics assert that it is plagued with one major weakness of completely ignoring the presence and the role of foster parents as mediators. However, in real world situation, this assumption does not hold. Parents, whether foster or otherwise have so much influence on the day to day transactions of children that it is quite impossible to completely sideline them in any social intervention. Besides, it will mean bringing on board professional social workers who will act as parent substitute in providing the much needed care to foster children at an additional cost to the intervention. In a poverty-stricken nation with per capita income of less than $ 300 (Sowa, 2002), this will further aggravate both our social and economic woes.

The indirect effect model as seen in figure 1 (B) recommends that interventions should be channeled through foster parents. That is, social support for foster children can fully be mediated by foster parents. Detractors of the indirect model argue that it gives foster parents too much power and commission. It also means that the success of any social intervention programme does not depend entirely on its effectiveness and/or attractiveness but on the skills and the goodwill of foster parents as intermediaries. That is, it is the parents who finally decide whether or not the foster child should be taken to a hospital and/or school irrespective of how available, free and/or attractive they are.

This study as seen in the recommendations, favour a mixed model approach in delivering social interventions. Here, social support has an indirect effect and can also have a significant direct effect (Wills et al. 1995). See fig 1 (C). Simply put, this study is of the opinion that to achieve value for money, foster parents should be involved as mediators in accessing support for foster children but they should not be the only persons with this responsibility as is currently the case in the Ghana. Trained child care professionals should assist foster parents in their duty. At least, teachers are present in every village in the country. They can be given some little training as part of their overall teacher training and motivated to assist foster parents in caring for foster children.

(A)

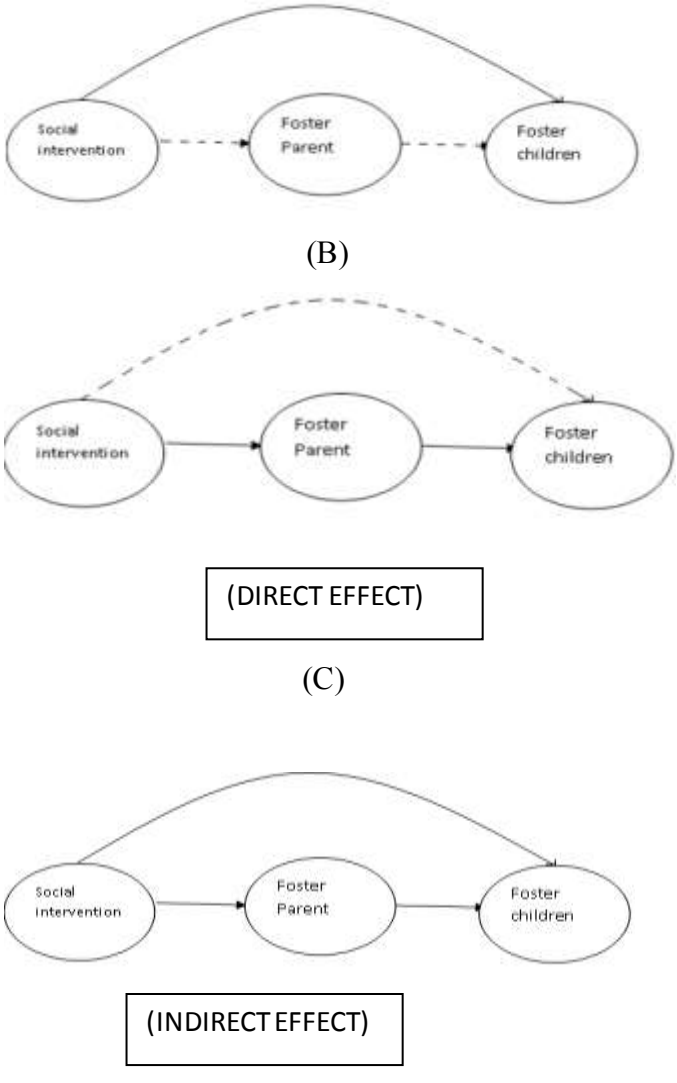


Fig 1. Relationship between Social Interventions, foster parents and foster children.(A) Direct effect (B) Indirect effect

(C) Mixed model

3. METHODOLOGY

3.1. Subject recruitment

The snowball approach used by Abubakari and Yahaya (2013) to examine fosterage and educational inequality in rural Dagbon was employed as the main recruiting technique. Through the Assembly member for the area, one foster and one non foster households were indentified in each of the communities. They led the researcher to locate other participants. Foster household referred to any household with at least one foster child.

From an initial pool of approximately 270 parents, children, teachers and medical staffs, 178 representing 65.93% agreed to participate in the study

Through randomization, 139 (78.09%) out of this number were finally selected to constitute the final sample size as shown in table 3 below. The table was adapted from Sarpong (2011) but was however modified slightly to suit this study. Nominees who refused to avail themselves for the study cited "fatigue" as the main reason. They claimed that they had earlier taken part in a large number of similar surveys, but had not benefited from anyone of them, their plight remained the same. They did not see the reason why they should not go their farms but waste their precious time on another "useless" survey.

Detailed breakdown of the sample per group and child category have been presented in table 4. The ages of the children involve ranged from 3 to

18 years (mean age= 9.6; SD=0.48), But only children above 10 years were interviewed. Gender balance was considered in all sample categories.

Table 3. Research Questionnaires Response Rate

Sample Units	Sample Size	Questionnaires				
		Dispensed	Received	Response rate	Selected	%
Parent	100	100	51	51%	40	42.12%
Children	150	150	109	72.67%	90	82.57%
Teachers	10	10	8	80%	5	62.5%
Health workers	5	5	5	100%	2	40%
Health Insurance workers	5	5	5	100%	2	40%
Total		270	178	65.93%	139	78.09%

Source: Adapted from Sarpong (2011)

Table 4. Detailed breakdown of final sample population.

	Parents	Children	Teachers	Healthcare workers	Health Insurance workers
Yabraso					
Foster	10	20	5	2	2
Non foster	10	20			
Hiamankyene					
Foster	5	15			
Non foster	5	15			
Fabewoso					
Foster	5	10			
Non foster	5	10			
TOTAL	40	90	5	2	2

Source: Field work, 2015

3.2. Measures

In the study, access to three social interventions (National Health Insurance Scheme, Capitation Grant and School feeding Programme) by the sample was measured. For each of them, access was divided into two parts; availability and utilization (benefits). The table below summarizes how each was measured. As seen on table 5 below, Utilization of NHIS was measured with the rate of attendance to a health care

facility using the NHIS membership card in the 6 months preceding the study. Utilization for both the Capitation Grant and the School feeding programmes were measured using school enrollment, attendance, dropout and academic achievement.

Table 5: Measurement of interventions

Social Intervention programme	Access	
	Availability	Utilization (benefits)
National Health Insurance Scheme	Enrollment into the Scheme. **Indicator**: Possessing of valid membership I.D card	Health care facility attendance (for the last 6 months)
Capitation grant	1. Enrollment into a beneficiary school. 2. Per school records, responses from parents, children and teachers	Effect on schooling (for the last 6 months): Enrollment, attendance, dropout, and academic achievement
School feeding Programme	1. Enrollment into a beneficiary school. 2. Per school records, responses from parents, children and teachers 3. Personal observation	Effect on schooling (for the last 6 months): Enrollment, attendance, dropout and academic achievement.

3.3. Scores

3.3 (a) NHIS availability (enrollment into the scheme)

In each community, the number of foster children (in the sample population) possessing valid NHIS membership I.D card were simply counted. This was converted into a percentage score in relation to the sample population. Non foster children were also treated in the same way.

Rate of enrollment into NHIS= number of members possessing valid membership I.D Card x 100%

Total number of members in sample population

As indicated on the table above, utilization of NHIS was measured by the rate of attendances to health care facility in the last 6 months preceding the study. It was computed as :

Rate of NHIS utilization / healthcare facility attendance = Number of attendance x 100%

Total number of sick times

Sick times: The number of times the person reported sick (complaint or experience of any form of ill health (headache, malaria, diahorrea, unintentional injury, loss of appetite, etc.) that needed medical attention.

Hospital attendance: A visit to any healthcare facility (clinic, hospital, CHPS Compound, etc) for medical treatment.

3.3(b) School feeding Programme (SFP) and Capitation Grant (CG)

Availability score rate

The number of each sub group in each community studied benefiting from the SFP and the CG were counted. Each was converted into a percentage score in relation to the sample population. The mean rate for each sub group was then computed.

Rate of availability = Number of members benefiting x 100%

Total number of members in sample population

Utilization of SFP and CG

To measure the rate of utilization of SFP and the CG, their effects on school enrollment, attendances, dropout and academic achievement for the last 6 months (2 preceding terms) were calculated. The mean rate for each sub group was computed.

School enrollment : Number of children of sub group in school x 100%

Sample size

School attendance: Aggregate number of school days present in school by group x 100%

Total school learning days on school calendar for 2 terms (120 days) x Number on roll

Dropout rate : Number of students who dropout in the course of 2 terms x 100%
Sample size

Academic performance: Total raw scores for 2 terms x 100%
Total scores

3.4. Research design

The study used survey research design to examine fosterage and equitable access to social intervention programs in rural Ghana. Survey, according to Trochim (2006), cited in Sarpong (2011) can take the form of "a paper-and-pencil feedback form or one-on-one in-depth interview". This study used both forms to obtain the needed information from respondents (children, parents, teachers, hospital and Health Insurance staff). As key informants, the respondents were also verbally interviewed in addition to the questionnaires which were personally administered. Besides, at least, two focus group discussions in each community were also held to gather relevant primary data. A very good rapport was established with the respondents to make them feel comfortable though care was taken not to compromise their objectivity and independence in answering the questions.

The study collected data from both primary and secondary sources. The primary data used were collected from parents, children, teachers, key hospital and health insurance staffs. Secondary sources included school records (admission registers, attendance registers, and terminal reports), hospital records, publications, reports, and brief papers by governmental institutions, works of other researchers
(online articles, journals and books).

3.5. Results and analysis

Data gathered from the study through the use of questionnaire, observations, key informant interviews and focus group discussions and other secondary sources were analyzed descriptively. Tables, frequency distributions and charts have been used to summarize the data. They have also been used in the analysis and discussions.

3.5(a) School Feeding Program & Capitation Grant availability

Table 6 indicates rates of availability of SFP and CG to the children. SFP is 100% available to all

categories of children enrolled in primary schools. Across board, children in the Junior High School (JHS) are not officially entitled to the school feeding programme. Table 7 shows utilization of SFP and CG. The data indicates consistent lower rates of enrollment, attendance, retention and academic achievement for foster children in all the three communities than their non foster cohorts. In Yabraso for instance, a foster child has 10% (90%-80%) chance lower than a non-foster child in attending school. While in Hiamankyene the chance of a foster child dropping out of school is 16.9% points higher than a non foster child. Fabewoso recorded the highest disparity rate in dropout rates 36.7% points.

These translate into disparity in the overall access to SFP and CG as seen in figures 2 and 3. Regarding SFP, foster children in Hiamankyene enjoyed the least disparity 9.7% while those in Fabewoso experienced the worst disparity (11.58%). The trend remains the same for foster children in Fabewoso in terms of access to CG with 10.98% points lower than their non foster cohorts. This is due to the absence of school in Fabewoso. This presents a lot of problems to the foster children there as illustrate in 3.6 below. Fabewoso is also the remotest village reflecting the highest demand and utilization of foster labour

.

Table6. Availability of School Feeding Program & Capitation Grant by child category and community

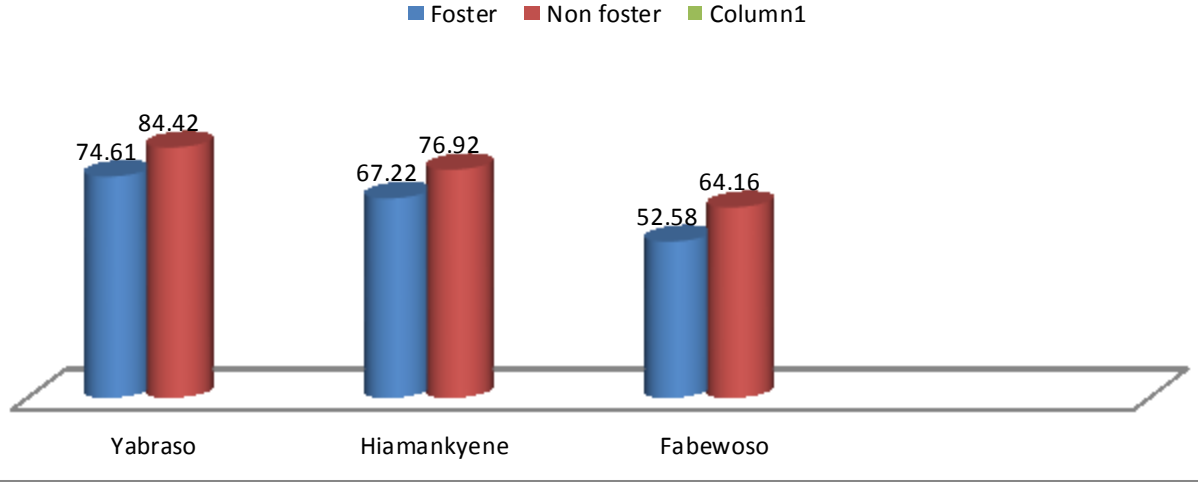
	Yabraso				Hiamankyene				Fabewoso			
	Total	Number In Primary school	% of total number	Disparity	Total	Number	%	Disparity	Total	Number	%	Disparity
School Feeding Progemme												
Foster children	16	13	81%	2	10	8	80%	3	5	4	80%	3
Non foster children	18	15	83		13	10	77%		6	5	83%	
Capitation Grant												
Foster children	16	16	100%	0	10	10	100%	0	5	5	100%	0
Non foster children	18	18	100%		13	13	100%		6	6	100%	

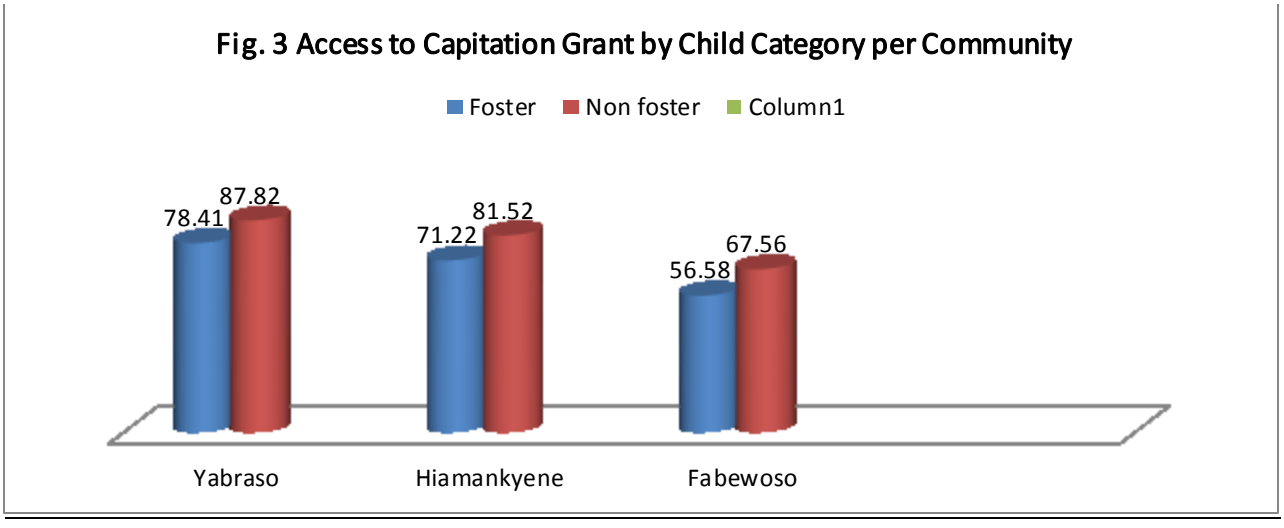
Utilization of SFP And CG

Table 7. Utilization of School Feeding Programme (SFP) & Capitation Grant by child category per community

	Yabraso				Hiamankyene				Fabewoso			
	Total	Number	%	Disparity	Total	Number	%	Disparity	Total	Number	%	Disparity
Enrollment												
Foster children	20	16	80%	10	15	10	66%	10	10	5	50%	10
Non foster children	20	18	90%		15	13	86%		10	6	60%	
Attendance												
Foster children	1920	1344	70%	6	1200	768	64%	7.9	600	324	54%	6
Non foster children	2160	1814	84%		1560	1122	71.9%		720	432	60%	
Dropout												
Foster children	16	3	18.75 %	7.64	10	4	40%	16.9	5	3	60%	36.7
Non foster children	18	2	11.11 %		13	3	23.1%		6	2	33.3 %	
Academic performance												
Foster children	100	60.8	60.8%	16	100	66.1	66.1%	6.7	100	48.9	48.9 %	2.2
Non foster children	100	76.2	76.2%		100	72.8	72.8%		100	51.1	51.1 %	

Fig 2. Access to School feeding Programme by Child Category per community





3.5(b) School attendance and age

The study also examined rates of school attendance and the ages of the children. The results have been presented in figure 4 below.

There was positive correlation between the rate of school attendance and the age of non foster children. As the children age, their attendance also increased. At age 14-17 years, school attendance is highest for non foster children. This reflects the time where the services and labour of the children are needed most by parents for domestic and/commercial purposes. Here it appears, the children use school attendance to escape services at home, a choice which foster children do not have. Thus, for the foster children, as they age, school attendance decreases to free more hours for services at home. This is synonymous to what LaVeist (2005) describes as "weathering".

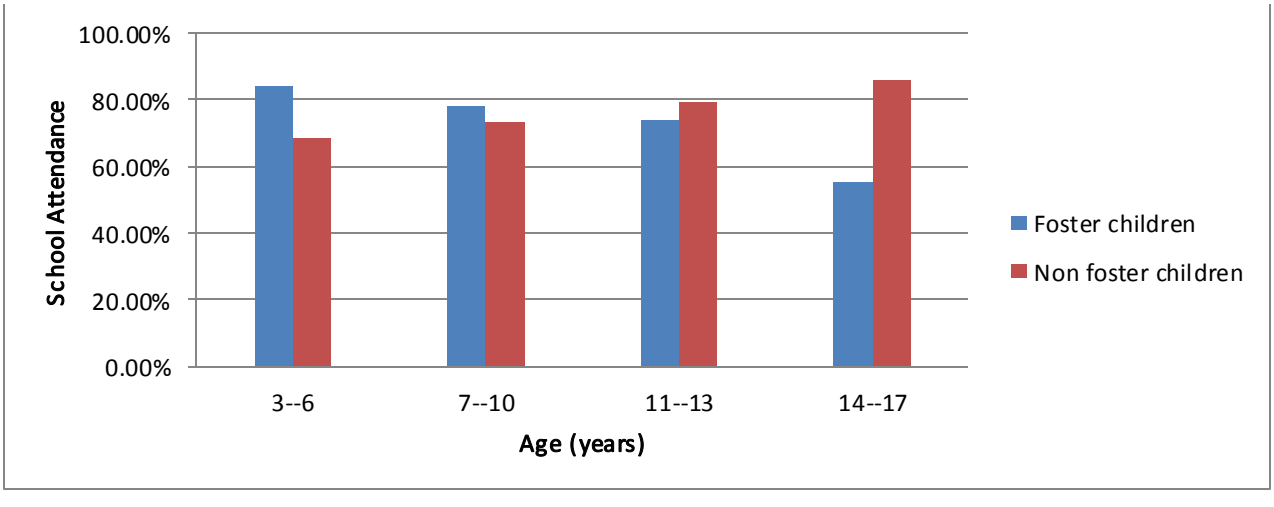


Fig 4. School attendance by age of foster children

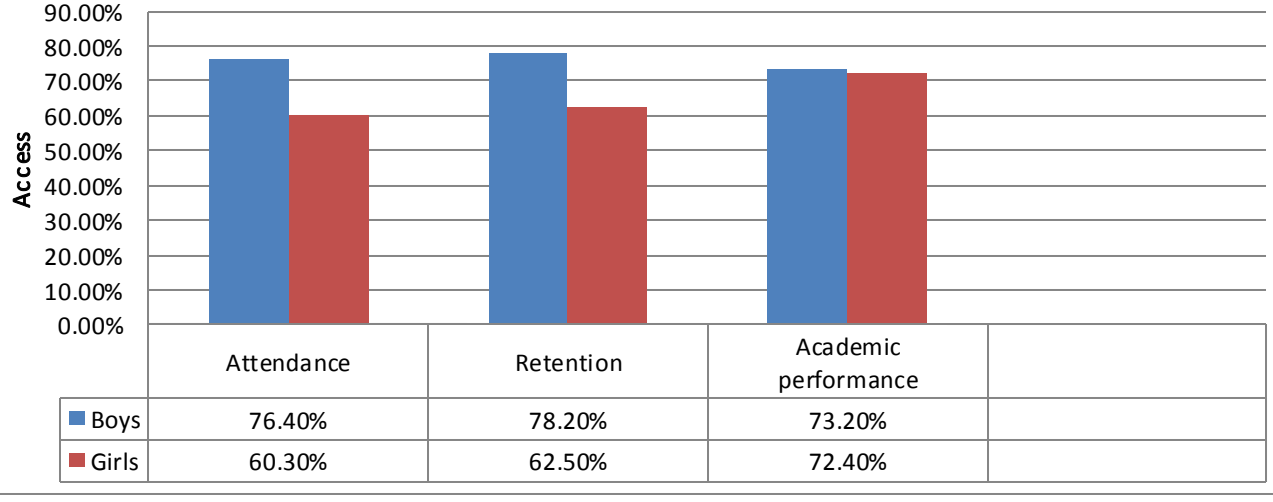
3.5 (c) Fosterage and gender disparities in access to education

Among foster children, gender disparities in access to the utilization of the interventions (access to education) was also explored in the study. The results have been presented in fig 5 below and table 8.

First, girls are preferred to boys as foster children. Also, the figure demonstrates disproportionate burden of foster effects for foster girls than boys regarding school attendance, retention and academic performance. On all the three variables mentioned, boys have higher measures than girls. This, as revealed in table 8, reflects a greater demand for the services for girls at home as baby sitters (100%), dishwashers (100%), cooks (100%) and cleaners (100%). They are thus left with lesser time to concentrate on school activities such as home work, reading, etc. They also get to school late and exhausted. Besides, cutting or stopping school is more frequent among girls than boys.

This finding concurs with Pilon (2003)'s assertion that though boys and girls access' to education is negatively impacted by foster experiences, girls bear far greater burden than boys. Abubakari (2008) also adds that gender differences in access to education is not so pronounced at young age until the foster girls reach adolescence where the opportunity cost for schooling becomes significantly higher.

Fig. 5 Access to Education by gender



3.5(d). Results for the National Health Insurance Scheme (NHIS)

Availability, Utilization And Overall Access to the NHIS

As seen in figure 6 below, there is unequal access to National Health Insurance Scheme among foster and non foster children. For both availability and utilization, foster children in all the three villages consistently have lower rates (table 9). A non foster child in Yabraso for instance has7.39% points higher in accessing NHIS than a foster. This gap even represents the least disparity rate. At Fabewoso the disparity rate is the highest (16.19%). This presents a clue to policy makers interested in bridging the gap between the advantaged and the disadvantaged children to pay attention to the gap between becoming a member of the NHIS and taking advantage of the membership. That is, the distance between enrollment and healthcare utilization. Table 9 presents overwhelming evidence to suggest that many insured clients in the rural areas do not still seek health care due to the barriers discussed in 3. 6

This however contradicts findings of other studies which argue that under certain circumstances, no disparities exist between foster and non foster children in health outcomes (Shell-Duncan 1994) and nutritional status (Castle 1995)

	Percentage(%) of Children											
	Yabraso				Hiamankyene				Fabewoso			
	Total		%	Disparity	Total		%	Disparity	Total		%	Disparity
Enrollment into NHIS												
Foster children	20	16	80%	5%	15	11	73.3%	6.7%	10	5	50%	20%
Non foster children	20	17	85%		15	12	80%		10	7	70%	
Hospital Attendance												
Foster children	288	178	61.81%	9.69%	264	114	43.18%	10.99%	120	48	40%	12.38%
Non foster children	204	145	71.57%		144	78	54.17%		84	44	52.38%	

Table 9 Enrollment and utilization (Hospital attendance) of NHIS by child category and community

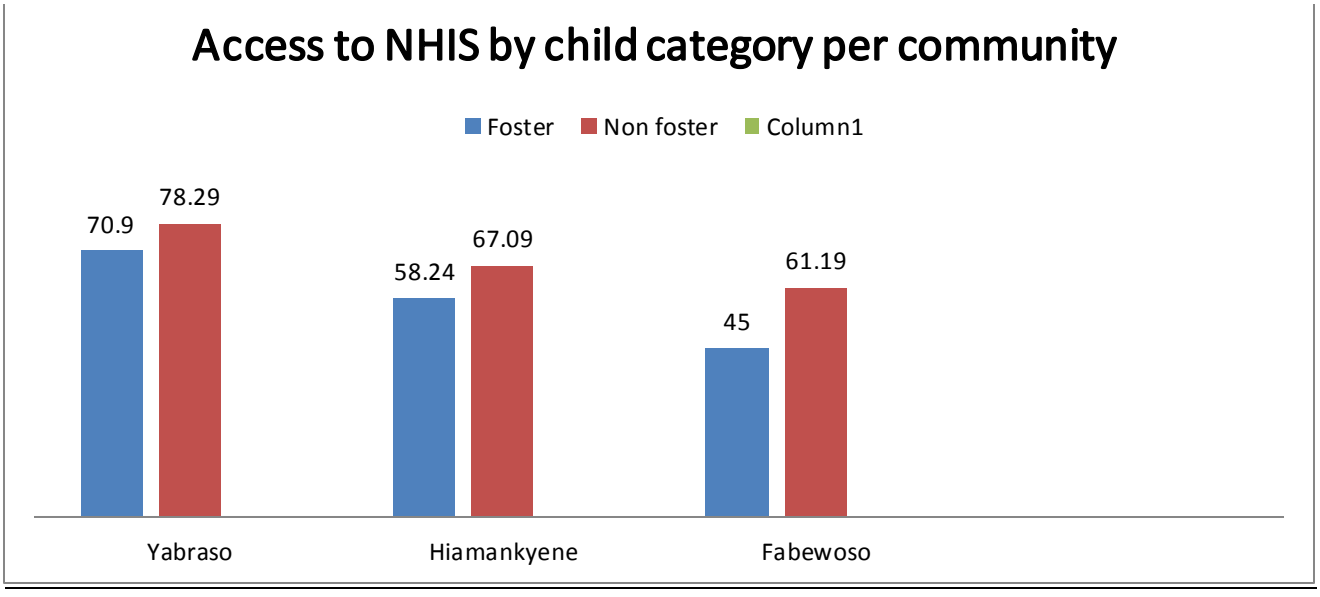


Fig 6.

3.6. Factors that account for the disparities in utilization of SFP and CG

The study also sampled opinions and gathered relevant data regarding factors that influence disparities in the utilization of the interventions (SFP and CG---access to education). The results have been presented below:

3.6 (a) Factors that account for disparities in access to education among foster and non foster children

i. Lack of schools

One of the communities, Fabewoso, does not have a school, the only school close to the village is located at Yabraso, a distance of 11km. The children cover this distance twice (in and out) each school day. Though this affect both foster and non foster children, it disproportionately disadvantages foster children more. Parents and children who responded to a question regarding this distance to school indicated that non foster parents committed as they are, provide their children with means of transportation such as bicycles, tricycles and motor bikes to enable them save some energy and time for learning. Foster children on the contrary have to cover the distance by foot each day. They thus feel more fatigue and dirty by the time they get to school. Worse of it all, some get raped, others get bitten by dangerous tropical snakes, while a few most unfortunate ones are killed by ritual murderers as they trek on the lonely bushy muddy farm path from Fabewoso to Yabraso receive education. Occasionally, foster children above 10 years who are girls receive compulsory lift from boys in the

villages with access to bicycles or motor bikes. Even here, the girls have to compensate the boys for this "unsolicited extraordinary generosity" with unprotected sex which normally takes place in the bush somewhere along the way. About 40% of the girls in these villages lose their virginities and/or become pregnant through this act.

Besides, foster children in Fabewoso have to remain in the house until they reach about 8 – 10 years, when they are old enough to walk 18 km each day to and from Yabraso to attend school. This explains why for both foster and non foster children, the village has the lowest rate of enrollment, retention, absenteeism and academic achievement as seen in table 7.

These dangers and their net effect on the children's access to education, according to 60% of parents interviewed, actually make proximity to school the most critical factor that influences disparity rate in educational access in the village. This gives credence to other studies done in other countries which rate proximity to school the number one barrier to school for children in Egypt (Robinson et al., 1984), Nepal (CERID/WEI,1984), Brazil (Psacharopoulos and Arriagada, 1987) andS Cote d'Ivoire (Glewwe,1988).

ii. Complementary Cost of Education

Despite the impressive subsidization of educational cost as a result of the introduction of the Capitation Grant programme, education in Ghana is still not absolutely free (Word Bank, 2010, Asante 2011;) and so is the situation in the communities surveyed. All the parents (100%) who responded indicated that they pay examinations fees, development levy, cultural fees, school repair charges, and/or security charges. Other charges are Parents'-- Teacher Association (PTA) levy and examination fees. They again revealed that they buy footwear, uniforms, desks and exercise books for their kids. Though there was no consensus on the exact amount of money spent yearly per child as complimentary cost to education, it is estimated to be between GHC 60.00 and GHC 150.00. Compared to an average annual foster household income of approximately GHC 450.00, the complimentary cost is prohibitive enough for foster children not to be enrolled and/or be kept in school at a rate comparable to that of non foster children. CREATE (2011) also observed similar trend in the Savelegu-Nanton District. In an annual nationwide survey on the impact of the Capitation Grant in eliminating school fees and charges at the basic level, the National Development Planning Commission (2014) also observes that; " the payment of special levies and

fees leads to children absenting from school if they are unable to pay. Majority of the head-teachers interviewed (72 percent) admitted most parents find it difficult to pay these levies". The Situation Analysis report (1989-90) on children and women by the Government of Ghana and UNICEF (1990) similarly found poverty as the main reason for school dropout and non-attendance.

This finding is in line with other empirical studies, suggesting that family's asset wealth has positive correlation with children's access to school (USAID, 2007, Elliott and Beverly 2010, Loke and Sacco 2011 Essuman,A., & Bosomtwi-Sam,.C., 2013). Though another finding by David et.al.,(2015) disputes this direct relationship between household asset wealth and academic performance by children.

iii. Demand For Household Labour

Parents who responded to the survey questions and children interviewed, revealed that in the communities, labour of foster children is very essential to the household income. Close to 18% of the households surveyed actually survive on the meager income earned by the foster children through farming and/or other commercial activities. Besides, it is clear from the table below that all the difficult activities are carried out by foster children. Boys for example, pound fufu (100%),Go to farm (100%), run errands (100%), hew wood (100%) and undertake commercial activities (75%).

The table also indicates that foster girls serve as baby sitters for babies in the family and also do most of the domestic chores such as cooking (100%), sweeping (100%) and dishwashing (100%). There are isolated cases where foster girls are used as short term collateral for monies collected from male adults. The opportunity cost of the child attending school is therefore too great for the household to endure. Even where the child is lucky enough to attend school, he/she is not regular and his/her academic achievement is also weakened. Foster children also revealed that they are in fact the first to wake up (4.00am) and the last to go to bed (10.00pm) everyday. This significantly drains them both physically and mentally, ultimately reducing their alertness, concentration and interest in class. Feeling fatigued and sleepy in class are thus not uncommon among foster children surveyed according to the teachers who were interviewed.

Table 10.

Activity	Children (N=90) engaged in							
	Foster (n=45)				Non foster(n=45)			
	Girls (n=23)		Boys (n=22)		Girls (n=23)		Boys (n=22)	
	Number	%	Number	%	Number	%		%
Taking care of children	**23**	100%	10	45%	18	78%	10	45%
Pounding of fufu	14	61%	**22**	100%	8	35%	13	59%
Fetching of water	**23**	100%	13	59%	19	83%	10	45%
Sweeping of compound	**23**	100%	6	27%	18	78%	6	27%
Running errands	**23**	100%	**22**	100%	19	83%	15	68%
Selling provisions	18	78%	18	82%	8	35%	12	55%
Cooking	**23**	100%	15	68%	15	65%	11	50%
Going to farm	14	61%	**22**	100%	9	39%	19	86%
Washing dishes (domestic / commercial)	**23**	100%	18	82%	9	39%	4	18%
Other commercial activity	16	70%	17	77%	9	39%	11	50%
Hewing of wood	15	65%	22	100%	6	26%	12	55%

Source:Filed,work,2015

iv. Health Status

Results from the study indicate that per their circumstance, foster children in the communities receive less protection, supervision, nutrition, rest, health check-ups, etc. compared with non foster children. They also engage more in risky health behaviours which LaViest (2005) defines as "actions individuals engage in that increase the likelihood of developing a disease or sustaining an injury or disability at sometime in the future". These behaviours in the communities surveyed include, walking without sandals, eating contaminated food, sleeping without mosquito nets, smoking marijuana, alcohol abuse, stealing and fight. In addition, foster children experience more physical and emotional abuse. The overall manifestation of these conditions has been excessively

poor levels of physical, mental and developmental health outcomes for foster children compared with non foster children. This is consistent with findings from other empirical studies (Deutsch S. A., and Fortin K.,2015, Steel J.,and Buchi K.,2008, Justin R.,2003;Hansen R, et. al 2004). Illustratively, foster children in the communities have more stunted growth, underweight bodies and behavioral problems. The poor health statuses of the foster children in the communities have had a very severer negative impact on their school enrollment, attendance, retention and academic performance as declared by their teachers

v. Lack of Enforcement and Regulations.

Generally, enforcement regarding school attendance comes from three sources; the government, community, and/or parents. In the communities in question like other parts of the country the government has not been able to make education compulsory for any child. Besides, results from the survey indicate that the communities endorse some acceptable level of neglect for these foster children as compared to non foster children. If a foster child is spotted wandering in the community during school hours, it does not constitute any news. However, if a non-foster school-going aged child is found in the house repeatedly instead of being in the school, the parents are castigated and gossiped about. The gossip alone, a social control mechanism forces the parents to send their biological children to school, stay until completion and also do well academically. The apathy towards the promotion of the welfare of foster children is a recipe for neglect which leads to disparity in educational attainment between them and non foster children in the communities. Four elderly participants illustrated during focus group discussions that they have three very popular clichés in the communities which clearly demonstrate their indifference towards the welfare of the foster child in the communities;

1. “Se woni wu a na w’abusua asa” — the death of one’s mother indicates that one’s entire

   family is wiped out.

2. "Agyanka dabre ne bamaso" — The ideal sleeping place for the orphan is the corridor.
3. "Agyanka kusa wo bankye" — Hey Orphan, focus on the roasting of your cassava

In the western societies, where government strictly monitors and regulates the foster care system, one must agree to enroll children placed in one's care in school before one's application will be considered. After placement also, social workers follow up. Any minor breach in this protocol gives the parent a lot of troubles. Unfortunately, in Ghana and in the communities surveyed, lack of government regulations means that the fate of many 100s of foster children depend completely on luck (Ibrahim, 2001). Foster parents are at the liberty to decide whether or not to allow foster children to access education and/or other social interventions available.

vi. Anticipated helplessness towards school progression and returns

In Ghana, government's subsidy and other social interventions that make education more attractive and less expensive tend to diminish as one climbs higher up towards college (Essuman, A.,& Bosomtwi-Sam,.C.,2013). Given the fact that foster parents in the communities are predominantly peasant farmers while their abilities, productivity and disposable income correlate negatively with age, 85% of the respondents revealed that the situation gives a sense of hopelessness towards the academic progression of the foster children. Thus, the parents do not see the sense in putting foster children in school where clearly they would not have the opportunity to finish or progress to the next stage such as Senior High School, or College. CREATE (2011) equally found this as one of the major barriers in educational access in the Saveleugu-Nanton district. In a society where poverty makes employability enhancement the major reason for going to school, and tertiary graduates with good classes find it extremely difficult to secure jobs, finding jobs for students who stop halfway remains a chimera. This "zero returns" on education according to these foster parents, does not justify the huge expense on it.

In the case of non foster children, they do not face the threat of having to abrogate their studies half way due to lack of money so far as their parents are alive. This serves as a big boost which motivates non foster children to enroll, remain, outperform foster children when all other factors are controlled for.

3.6(b). Factors which account for disparities in utilization of NHIS (access to health care)

i. Distance to health care facility

According to 84% of the respondents, one of the most critical determinants for the utilization of health care facilities in the communities is the distance to the location of the facility. None of the communities have any health care facility. In fact, the closest one, a hospital, is at Nsawkaw—the district capital. Persons, including young children who are sick must make the journey by foot, bicycle, tricycle or a shared car (locally called "trotro"). Distances, cost and the time taking to commute from the communities to the nearest hospital have been summarized in table 11 below.

Foster children in the communities disproportionately bear the burden of this long distances to the care centre as their parents are three times less willing to bear this cost compared with children in non foster children. As a result, though both categories of children have health insurance coverage, great disparities exist between the way they are utilized to access health care. Non foster children attend hospital 62% of sick time as against 48% in the case of foster children (figure7). Sickness in the study was defined as complaint of headache, fever, stomachache, diarrhea, loss of appetite or accidental injury for the past 6 months.

Table 11. Distance, mode of transport, time and cost of travelling to a healthcare facility by community

Community	Distance (km) to healthcare centre (Nsawkaw)	Transport mode	Time needed (hours)	Cost (GHC)
Yabraso	9	Foot	2.40	----
		Bicycle	1.30	20.00 (charter)
		Motor cycle	0.18	35.00 (charter)
		Car	0.15	4.00 (shared)
Hiamankyene	19	Foot	5.10	---
		Bicycle	2.50	30.00 (charter)
		Motor cycle	0.30	55.00 (charter)
		Car	0.28	10.00 (shared)
Fabewoso	20	Foot	5.50	---
		Bicycle	3.00	35.00 (charter)
		Motor cycle	0.34	60.00 (charter)
		Car	0.32	150.0 charter)

ii. Exclusion list / Co-payment)

Health insurance coverage is readily available to both groups of children surveyed; it however has 3 major limitations which put foster children at greater disadvantage compared with non foster children (Dalinjong & Laar 2012). First, the insurance does not cover all drugs. Insured clients have to buy them from the open market at very exorbitant prices. Since foster children have less access to money and live with more difficult parents, they are unable to attend hospital as often as their other counterparts. If they do, they do not equally benefit from it.

In addition, the insurance does not cover all diagnoses. Some dental, physiotherapy and

burns cases form part of the exclusion list. In the communities surveyed it was however revealed that the prevalence rate of these conditions was far higher among foster children than their non foster counterparts. The reason is that foster children lack supervision and monitoring. They thus engage in riskier activities such as climbing of trees, running around without shoes, and street fighting. They break their bones, lose their teeth and experience fracture more frequently than their other counterparts. They thus do not benefit equally from the insurance like non foster children.

Foster children also suffer more physical abuse and are made to engage in tasks which exceed their physical and mental strengths. Coupled with the fact that they lack vital bone-strengthening nutrients such as calcium, it is just logical that they require more dental and physiotherapy services more than children in their biological homes which unfortunately is not covered by health insurance.

One other limitation associated with the NHIS is co-payment. There are situations where the insurance covers clients diagnosis alright, but does not pay the full cost. Here, the insured client is obliged to settle the difference between the actual cost and the insurance payment. This does not favour foster children and induce disparity in the utilization of the insurance.

iii. Effectiveness of services/quality of care

In the communities, the study revealed that 60% of the times when foster children attend hospitals, they go alone (those above 10 years), accompanied by minors or adult acquaintances with no knowledge about the history of the child's condition. This significantly affects the doctor-patient communication and interactions leading to a reduction in the quality and the effectiveness of care they receive. Foster children also fail to attend hospital with their hospital attendance cards which aid in the retrieval of their medical historical records. This further complicates the already bad situation regarding the quality of care they receive.

Moreover, for lack of supervision and motivation, foster children fail to adhere to treatment regimen more than children non foster children. They fail to take their medications as prescribed by doctors, eat

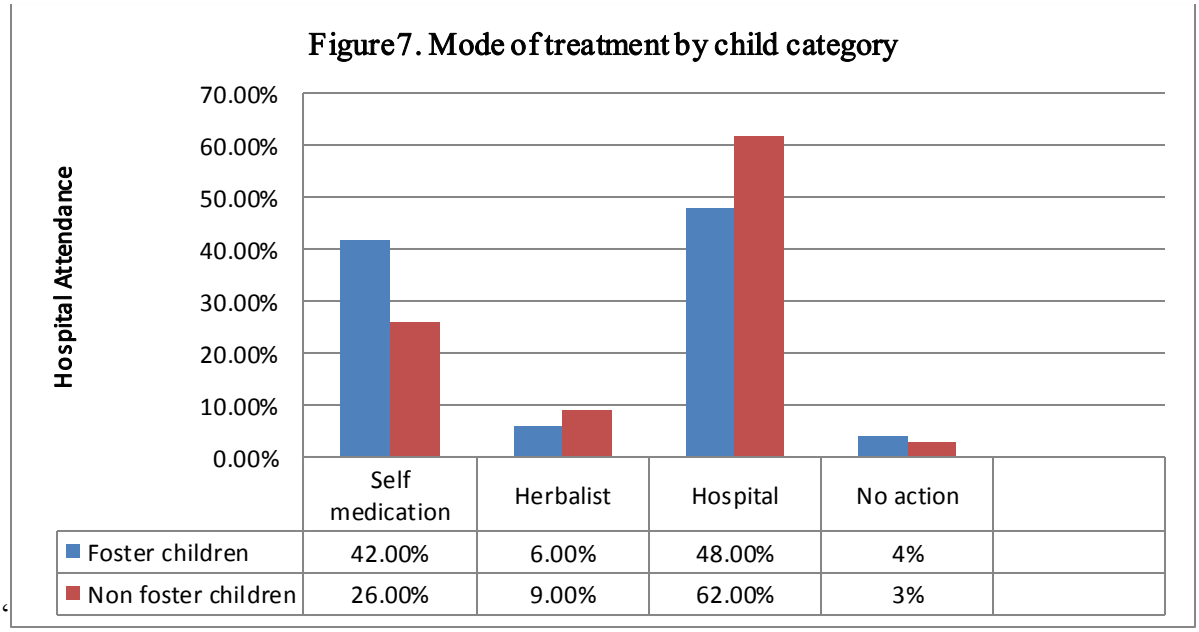
food and engage in activities that further compound their conditions against doctor's advice. They also refuse to attend hospital reviews more than their other counterparts. All these translate into a higher risk profile for foster children as noted by Zlotnik et.al.(2015).

Disparity in the health care utilization between foster children and their non foster cohorts is thus inevitable.

iv. Delay / refusal in seeking professional health care

Although timely and professional health care seeking behaviour is generally poor especially among rural dwellers in Ghana, according to this study, it is worse among foster children in the communities studied. Foster parents are more reluctant in sending their foster children to hospitals than biological children. They diagnose the conditions themselves and initiate treatment with medications bought from unlicensed mobile and quack chemical sellers or leftover drugs from previous treatments. They send foster children to hospital only 48% of the time as against 62% for non foster children. They also refuse to take any action even when the child reports sick 4% and 3% of the time for foster and non foster children respectively.

Figure7. Mode of treatment by child category



By the time, foster children are sent to hospital for professional care, the condition would have deteriorated very greatly. It is quite ironical that foster children per their circumstance have greater need for health care but have lower rate of hospital attendance.

During a focus discussion, some parents cited in addition to the traditional barriers to health care such as poverty and the distance to healthcare centre, they sometimes simply get overwhelmed by the health care demands of the large number of foster children they are "forced to care for".

One foster parent with 5 biological children and 4 foster children from a deceased sibling illustrated that; "*Hardly do I personally get time to groom myself with so many children and a husband to care for*"

v. Risk behaviours

The study revealed a higher prevalent rate of health compromising behaviours among foster children compared to non foster children. These include unprotected sex, illegal abortions, alcohol abuse and smoking of marijuana and cigarette. By rank and sex, some of the most common risk behaviours foster children engage in have been tabulated in table 12 below:

Table 12. Risk behaviours of foster children by rank and gender

RANK	BOYS	GIRLS
1st	Smoking of Indian Hemp	Unprotected sex
2nd	Alcohol abuse	Illegal Abortion
3rd	Unprotected sex	Absconding from home
4th	Gang association	Peer influence
5th	Stealing	Stealing

4.1 Promoting equitable access to social intervention programs by children in foster care

From the study, it is obvious that under listed strategies can help reduce the disparities in access to the SFP, CG and the NHI between foster and non foster children

4.1(a). School Feeding Programme (SFP) and Capitation Grant (CG) (Improving access to education)

To promote equitable access to education, Lockheed and Verspoor (1991) advises that

policies must be geared towards increasing supply, demand and the learning process. However, in the communities studied, improving supply and demand alone should be necessary and sufficient to improve equity in access to basic education. Supply involves availability and quality of the school system in terms of facilities, materials, and teachers. Demand refers to the desire of parents to enroll their children in school due to economic, cultural and social factors.

Increasing Supply

i. Building new schools

Locating schools close to the homes of children can greatly improve school enrolment, attendance, dropout rates and academic achievements for the disadvantaged, in this case, foster children.

It is obvious that building new schools is very expensive for a developing and poverty-stricken country like Ghana. Yet very innovative techniques that are less expensive could be employed. The use of local raw materials such as grass and mud bricks could significantly reduce the cost of constructing new schools. In other parts of the world such as Niger, Senegal, Burkina Faso and Mali, local raw materials have been used to significantly reduce the cost of constructing new schools (Lockheed and Verspoor, 1991).

Besides, instead of giving out the construction of the school building on outright contract, building materials could be supplied to the communities while they provide free and voluntary labour. This would also mean that ownership, construction and maintenance responsibilities will no longer be the concern of only the central government but the community's as well. In Yabraso, through the partnership between the community and an International Non Government Organization(NGO) (I.E.S), the residents have built for themselves a state-of-the-art classroom block for their Junior High School at a very cheap cost.

The use of local artisans, contractors, and more transparent contract bidding process have the potential to also greatly reduce the cost of constructing new schools. If all these measures prove improbable, a modest beginning of starting the new schools under tress will be a better alternative than no school at all.

ii. Teacher recruitment and retention

Establishing new schools certainly requires not only new buildings but teachers as well. With the current embargo on employment in Ghana as part of the conditionality by the World Bank and the International Monetary Fund (IMF) for loans contracted, recruiting new teachers remains one of the biggest obstacles in establishing new schools. The way out could be an extension in the practice period for teacher trainees from colleges and Universities. With just a single supervisor, a whole set of school teachers could be recruited from these teacher trainees for a period of about 1 year at no additional cost to the government.

In addition, with little in-service training, senior high school graduates could be recruited and deployed to these rural communities. With similar training and supervision, even primary school graduates were recruited according to Lockheed and Verspoor (1991) in Tanzania to teach in isolated rural areas with success. With flexible time tables and little incentives, teachers resident in nearby communities could also be recruited to staff these new schools. Retired teachers could also be re-called to help in these new schools at a very low budget. Convicted individuals with the right pedagogical skills can also be made to teach in these deprived rural schools as part of their community service sentencing instead of keeping them in prisons camps.

iii. Multiple shifts

This is a system where classes are organized into separate sessions, such as morning and afternoons. This will enable foster children who are unable to attend school or do so late each day due to farm attendance or some form of mandatory engagement in the mornings to attend school in the afternoon and vice-versa. This system will also reduce the overhead cost regarding the building of new schools and/or accommodation for new teachers.

Despite the concerns from critics of this system as being associated with reduction in contact hours, many countries across the globe; Zambia, Jamaica, Malaysia have relied on it to increase school access and make huge savings (Lockheed, & Verspoor, 1991).

iv. Complementary basic education

Given the conditions at Fabewoso village, complementary basic education would be

helpful. This is a non formal school system that can provide at least literacy and numeracy skills to children who miss out the normal school starting age of 6 years by at most 2 to 6 years. It relies on voluntary teachers who reside in the same community with children and can use the local dialect as the medium of instruction. The calendar and the time table are normally designed to be flexible to allow children the chance to maintain usual routine schedule of helping their parents in the farm, in the house and also in the market. After about 6 years of this education, the children are integrated into the main stream educational system. DANIDA supported a similar complementary education in the three northern regions of Ghana called School For Life (SFL). For a period of about 13 years, over 100,000 students were assisted to obtain basic education under this system in 3 phases (Asante, 2011). According to Onyango (1988) and Myers (1988), similar nontraditional educational systems have been used in Kenya and India to significantly improve access to basic education among working children.

Increasing Demand

v. Reducing complementary cost

Complementary cost of education include the cost of school uniforms, exercise books, pencils, erasers, PTA dues, extra classes, ICT dues, and unapproved charges by teachers, etc. Reducing or removing these charges could significantly enhance access to school for foster children. The best way is to increase the Capitation Grant paid per child per year. The capitation amount currently stands at less than GHC20.00 per child per year. The total complementary cost is also about GHC60.00. This should be backed by strict regulations and monitoring else, heads of the schools would still invent and charge further unapproved charges. Head teachers who fail to comply with this "no fee policy" must severely be punished. Another way of improving equitable access to education is to improve special scholarship to foster children. China, Bangladesh, Indonesia, Kenya, Tanzania and Pakistan used this cost incentive to improve disparity in access to education between rural and urban girls and boys (Lockheed, & Verspoor, 1991. Wearing of school uniforms and shoes should also not

be made compulsory as part of the requirements to attend school. This will make school environment attractive for foster children who normally appear in tattered school uniforms.

vi. Regulations and Enforcement

Putting in some sort of regulations will compel caregivers of foster children to allow them to utilize health care in a manner that commensurate their health care needs.

Given the fact that Capitation Grant (CG), School Feeding Programme, and other social policies pay for at least 96% of both implicit and explicit cost of basic education, it has thus become heavily subsidized or virtually free. It should therefore be made unacceptable for any parent to refuse to send her/his foster child to school. The various local development and the traditional authorities could be involved in this enforcement. Public campaigns can also be lunched to sensitize foster parents on the importance of education. This can take the form of a bi-weekly radio broadcast in the local dialect and large bill boards.

Parents should also be involved in the educational process. This can be done through Parents-Teachers Associations (PTSs), School Management Committees (SMCs), Open, Speech and Prize-Giving days. At the same time, schools should be made attractive and profitable as a form of social insurance and investment against old age and sudden sickness.

vii. Attitudinal Change

In a typical traditional Ghanaian society, orphans, foster children and other vulnerable children face some kind of implicit discrimination and stigmatization. Orphans for instance, are seen as pitiable, unfortunate, weak, and vulnerable individuals without any potential and resiliency. Caretakers including even teachers feel uneasy and reluctant to train and discipline orphans as if they were some kind of breakable fragile materials. During this study I observed a class where the teacher repeatedly refused to ask an orphan challenging questions “due to his condition”. Overwhelmed by this discriminatory and victim-blaming attitude, orphans adopt self-fulfilling lifestyle which leads to isolation and depression and for that matter, reduction in interest in school process. Textbooks which enforce this negative attitude by

portraying orphans as beggars on the street, losers in fights, takers of leftovers, and victims of abuse should be rewritten Folktales and stories which demonstrate only the weaknesses of orphans should be forbidden in class. Teachers, playmates, and caregivers should be sensitized to change this perception. Orphans, foster children and other vulnerable children who are able to advance in life should be deployed back to work in their communities as role models.

4.1(b) Improving equitable access to NHIS

Per the results of this study, disparity in access to NHIS among foster and non foster children is not due to its availability /enrollment but utilization. As seen in table 4, utilization of the NHIS, involves seeking medical care at a health facility. This predisposes that improving equitable access to NHIS means improving access to health care. This study recommends the following strategies towards achieving equitable access to NHIS.

i. Building new clinics

Building clinics close to people homes eliminates the burden of travelling long distances to seek health care which puts foster children at greater disadvantage compared to non foster children.

Just like building new schools, the use of local raw materials, artisans, contractors, voluntary community labour, and transparent contract bidding process can significantly reduce the cost of constructing these new clinics in the communities which lack them.

ii. Staff recruitment and retention

New staff required to manage new clinics can be attracted into these rural communities with incentive packages such as extra allowance, motor bikes and promotions. Retired health staff can also be engaged and deployed into these rural areas at a budget half of what it will take to retain a regular new entrant in the deprived communities. Residents can also contribute to train one of their own children who will be willing to serve in his/her own rural community.

She/he will also serve as a role model for other children in the rural communities.

iii. Eliminating complementary cost to health care

If health care is made completely free in the form of payment for drugs, food (while on admission), foster parents will be more willing to seek health care for foster children. This can be achieved if health insurance expands its current drug/disease inclusion list to include drugs used to treat common sicknesses such as worm infestation, diarrhea, malaria, unintentional injuries, snake bites and dog bites. The Central government could also offer foster parents some direct cash payment or tax relief incentive to help ameliorate their economic burden in paying for the additional cost of health care for foster children.

iv. Regulations and enforcement

Putting in place regulations making medical neglect punishable by law can greatly improve access to health care for foster children. Teachers, health workers and other professionalswho work closely with the children and live among the residents can be made mandatory reporters of this offence. The regulations should not only compel foster parents to seek health care for the children but do so under appropriate conditions that will enable them to receive quality care comparable to that enjoyed by all other children. Specifically, foster children should attend hospital only in the company of adults. They should not also delay unduly in the house, refuse to go with their attendance cards, and/or refuse to take their medications as prescribed by the physicians. Refusal to send the children for reviews and/or provide them with basic nutrition should all form part of the medical neglect offence.

v. Sensitization and training

Inasmuch as we would expect foster parents to determine the need for healthcare for foster children under their guidance, and also take steps in seeking the right care for them, the government should also provide them with some form of skills and resources to be able to effectively do this job. This can take the form of quality training, monthly stipend and support from professionally trained social workers. Close to 75% of the foster parents in the communities surveyed are illiterates, inexperienced, ill informed,

and poor. Lack of access to vital historical health information alone on foster children by foster parents can seriously complicate the problems that confront them (Simms, Dubowitz, and Szilagyi 2000). Margie K. & Behrman (2004) also observes that, "Foster parenting is one of the most demanding jobs a person can assume. Foster parents are expected to provide a home for the children in their care; ….. to ensure that children's needs are met; …... The difficulties of foster parenting are compounded by the high level of care foster children often require, the low reimbursement rates…. and the inadequate support foster parents receive...".

It is thus not uncommon for foster parents to downplay the level of severity of a foster children's medical condition and accordingly refuse to seek treatment for them due to naivety.

Furthermore, foster parents could be sensitized on their rights and responsibilities. They should also be educated on the need to adopt preventive measures such as encouraging the children to sleep in mosquito nets, eat balanced diets (at least inexpensive locally prepared ones), take adequate rest, and engage the children in tasks that are not injurious to their physical, emotional and intellectual well-being.

Besides, measures should also be instituted to reward good foster parents who show commitment, love and adequate compliance.

5. Conclusion

The study sought to examine the disparities in access to the NHIS, SFP and CG among foster and non foster children.

Results from the study clearly indicate that foster children have lower access to NHIS, CG and the SFP in the communities surveyed. The study found it very unfortunate that even though Ghana has made great progress with the introduction of 44 pro-poor social interventions to bridge the gap between the advantaged and the disadvantaged such great disparities still exist in access after over 10 years. This raises a very serious concern regarding the effectiveness of the status quo in addressing the needs of the most vulnerable in our society.

It was also revealed that it is the utilization of the interventions, health care treatment for the NHIS and access to education for

SFP and CG that have fueled the disparities. Therefore if access to healthcare and education is improved, inequality could be addressed and foster children would equally enjoy services which other children take for granted as enshrined in the 1992 Constitution of the Republic of Ghana.

Besides, the study found out that foster children have greater need for health care, yet it is their sub population that paradoxically experiences lesser access to NHIS and for that matter, health care treatment. The study considers this situation as not only unfair, unconstitutional and "un-Ghanaian", but also illogical and unwise .

Considering the trend, the study sees very little hope of these disparities reducing to 0% in the future. It is even feared that if pragmatic policies are not put in place, the disparities may escalate to an epidemic level in 15 years time. This makes the nation's future very bleak and uncertain.

The government must therefore do everything possible to address these disparities as a matter of urgency. For inasmuch as the establishment of the 44 social intervention programmes is highly commendable, the existence of disparities in access to these interventions is equally condemnable. Ghana is a small country with a lot of resources, there is no justification therefore for a section of its children's population (12%) to suffer such limited access to the most important human needs; healthcare and education. It is hoped that if the strategies suggested in this study are adopted, the disparities can be addressed.

It must however be noted that

6. Recommendations

To improve equitable access to the NHIS, SFG and CG for foster children, policies must gear towards improving utilization. This means, removing all barriers that impede foster children's access to education and healthcare as clearly illustrated above under discussion.

In the long term, formal foster care must be considered in the country. At least we can start with kinship care on a small or pilot scale and later roll it out to cover the whole nation just like how the national health insurance started in the country in 2003. Under this, professional child welfare workers will be trained and deployed to

assist foster parents in providing the necessary care to about 1.6 million rural foster children, victims of such bitter disparities and deprivation. Monitoring will also be in place to ensure compliance under the formal foster care. As it stands now, foster care in Ghana is informal and unregulated. The universal guiding principle of the best interest and safety of the child in all child welfare programmes is thus left to chance and luck. Depending on the religious, moral, social and educational background of the foster parent involve, the relation between the sending family and the receiving one and many other factors, child fostering in rural Ghana now may be detrimental or beneficial to the child.

It must however be noted that the study examined only 3 out of 44 social intervention programmes currently in operation in Ghana. Besides, only three rural communities (Yabraso, Hiamankyene and Fabewoso) out of over 150 in the Tain District and about 31,300 in the nation were studied.

Furthermore, the researcher identified certain factors as being associated with the disparities in access to the social interventions. The study employed a correlational survey research design technique, it could therefore not firmly establish any causal relationship between these factors and the disparities.

Therefore on the advice of Sulemana (2010) regarding the weakness in survey research methodology, generalizing the results of this study by anyone must be done with great caution.

In his own words, Sulemana (2010) observes that "the fact that two variables are related does not mean that one caused the other".

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