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SOCIAL PROTECTION INITIATIVES AND ACCESS TO QUALITY HEALTHCARE AMONG OLDER PERSONS IN GHANA – EVIDENCE FROM MAMPONG MUNICIPALITY

BY

OTTIE-BOAKYE DORIS

(10051336)

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ACCEPTANCE

Accepted by the College of Humanities, University of Ghana, Legon, in fulfilment of the requirement for the award of PhD in Population Studies degree.

Thesis Supervisors

Dr. Ayaga Agula Bawah — September 3, 2020

Date

Dr. Naa Dodua Dodoo — September 2, 2020

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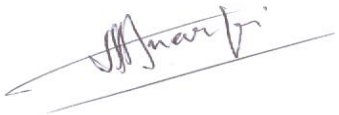

Professor John Kwasi Anarfi — September 3, 2020

Date

DECLARATION

I, Doris Ottie-Boakye, do hereby declare that, except for references to other people's work, which have been duly acknowledged, this is the result of my research and it has neither in part nor in whole been presented for another degree.

September 3, 2020

DORIS OTTIE-BOAKYE DATE

DEDICATION

This work is dedicated to my sweet Mother, Madam Winifred Baah (alias Eno Ama Dentaah) and Mr Samuel Boakye Agyeman, for all their support and prayers throughout my PhD Programme, and to my lovely Father, Mr Theophilus Boakye Ottie of blessed memory.

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ABSTRACT

Background: Population ageing is a major social issue and has become a public health concern which affects both developed and developing countries. Social protection interventions/initiatives (SPIs) that cover older persons have been implemented in many developing countries to improve household food consumption and reduce out-of-pocket payments in accessing healthcare. To reduce the poverty level, promote financial access to healthcare, and improve their health conditions among older populations, SPIs like the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme (NHIS) have been enacted to create an efficient and safety net. Yet, the extent to which older persons' participation in SPIs influence access to quality healthcare is virtually unknown in most developing countries including Ghana.

Objective: This thesis investigated the linkage between social protection initiatives and access to quality healthcare among older persons (60 years and above) in the Mampong Municipality in the Ashanti Region of Ghana. This thesis was premised on two (2) main concepts and theories: Andersen Healthcare Services Utilization Behaviour and the Donabedian's Structure, Process and Outcome models. These were integrated with access to care, and quality of care concepts and theories.

Methodology: This study employed a triangulation mixed-method research design comprising of both quantitative and qualitative data collection and analysis in addition to the use of community scorecards. For quantitative research, a structured questionnaire embedded in an electronic device was utilized to collect data from 400 non-institutionalized older persons in the study area. Methods of analyses employed for the quantitative research were descriptive statistics, a multivariable reduction (factor analysis) method, and multiple logistic regression modelling with the help of STATA version 14.0 software. For the qualitative research, a total of eight (8) focus group discussions segmented by sex (male and female) and location (rural

and urban) among purposively sampled older persons, and thirteen (13) in-depth interviews with key informants (program planners and implementers, and service providers) were carried out. Interview guides were used for data collection and analysed with Atlas-ti version 7.5.7 software using thematic analysis.

Results: About 96.0% of study participants were aware of the existence of at least one form of SPIs in their communities. Overall, 64.5% of the participants were beneficiaries of SPIs. The significant predictors of participating in SPIs were: age, household food security, and place of accessing healthcare service. The generated sub-scales on perceived access to quality of care were adequate service delivery, provider attitude, patient/client dignity, easy accessibility to the facility, and patient autonomy. Further, 63.7% had good perception level about the quality of care accessed as against 36.3% with poor perception. The main promoter of quality healthcare was a good attitude of health staff while drugs perceived to be of low quality was the main barrier. Participating in SPIs did not significantly predict the perceived level of access to quality healthcare (quality of care). Rather, the predictors of access to quality healthcare in the context of SPIs participation were age, household food security, household size, and primary caregiver. Other established factors that influenced this linkage emanated from both the community and institutional levels.

Conclusion: Addressing access to quality of care among older persons in the context of SPIs participation requires a multidimensional approach, in addition to strengthening the associated promoters to accessing quality health services. This could contribute to model healthcare for older persons in Ghana, especially in the study setting.

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LIST OF ABBREVIATIONS

AU	African Union
BMI	Body Mass Index
CBR	Crude Birth Rate
CT	Cash Transfer
CCT	Conditional Cash Transfer
CDR	Crude Death Rate
CHAG	Christian Health Association of Ghana
CHPS	Community-Based and Health Planning Services
CHW	Community Health Worker
CME	Continuing Medical Education
CNCDs	Chronic Non-Communicable Diseases
CSC	Community Score Card
COSE	Coalition of Services of the Elderly
DHRC	Dodowa Health Research Centre
DHSs	Demographic and Health Surveys
DSW	Department of Social Welfare
EAs	Enumeration Areas
ECH	Ethics Committee for Humanities
EFA	Exploratory Factor Analysis
ERC	Ethics Review Committee
FA	Factor Analysis
FAO	Food and Agriculture Organisation
FGDs	Focus Group Discussions
FSPIs	Formal Social Protection Initiatives
GFR	General Fertility Rate
GHS	Ghana Health Service
GNHQS	Ghana National Health Quality Strategy
GNSPP	Ghana National Social Protection Policy
GSS	Ghana Statistical Service
GPRS	Ghana Poverty Reduction Strategy
HAI	HelpAge International
HIV	Human Immunodeficiency Virus
HSMTDP	Health Sector Medium Term Development Plan
IBRD	The International Bank for Reconstruction and Development
IDIs	In-depth Interviews
IEO	Independent Evaluation Office
ILO	International Labour Organisation
IMF	International Monetary Fund
IPCIG	international Policy Centre for Inclusive Growth
ISPIs	Informal Social Protection Initiatives
ISSA	International Social Security Association
ISSER	Institute of Statistical, Social and Economic Research
KMO	Kaiser-Meyer-Oklin
LACs	Latin American Countries
LEAP	Livelihood Empowerment Against Poverty
LI	Legislative Instrument
LIPW	Labour Intensive Public Works
LMIC	Low and Middle Income Countries
MDAs	Ministries, Departments and Agencies

MDGs	Millennium Development Goals
MESW	Ministry of Employment and Social Welfare
MGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MMHD	Mampong Municipal Health Directorate
MoGCSP	Ministry of Gender, Children and Social Protection
MIPAA	Madrid International Plan of Action on Ageing
MMAAP	Mampong Municipal Assembly Annual Progress
NFSPI	Non-formal Social Protection Initiatives
NHI	National Health Insurance
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
NCDs	Non-Communicable Diseases
NGEC	National Gender and Equality Commission
NGOs	Non-Governmental Organisations
NSPS	National Social Protection Strategy
OOP	Out-of-Pocket Payment
OPD	Out Patient Care Service
OSSREA	Organisation for Social Science Research in Eastern and Southern Africa
PHC	Population and Housing Census
POA	Plan of Action
PMT	Proxy Means Test
PPP	Preferred Primary Provider
PSIA	Poverty and Social Impact Assessment
PWD	Persons With Disabilities
QoC	Quality of Care
QUOTE	Quality Of Care 'Through the patients' Eyes
SAGE	Study on Global AGEing and Adult Health
SD	Standard Deviation
SDGs	Sustainable Development Goals
SFSPIs	Semi-Formal Social Protection Initiatives
SHI	Social Health Insurance
SPIs	Social Protection Initiatives
SSA	Sub-Saharan Africa
SSNIT	Social Security and National Insurance Trust
TFR	Total Fertility Rate
UN	United Nations
USA	United States of America
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPD	United Nations Population Division
UNRISD	United Nations Research Institute for Social Development
USA	United States of America
WHO	World Health Organisation
WHODAS	World Health Organisation Disability Assessment Schedule
YEA	Youth Employment Agency

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Globally, population ageing is a major social issue (Mane, 2016; Apt, 2002) and a public health concern (Kowal et al., 2010), affecting both developed and developing countries. Population ageing has implications for health systems, policy, and programmes (Mather et al., 2015; Parmar et al., 2014). The number of older persons residing in developing countries constitutes two-thirds of older persons worldwide, and it is expected to rise relative to that in developed countries (Bennett & Zaidi, 2016). By 2050, persons aged 60 years and above will outnumber those under 15 years (Bennett & Zaidi, 2016). It is expected that every country will experience a substantial rise in the population size of older persons who are 60 years or older between 2015 and 2050 (Bennett & Zaidi, 2016).

The shift in the demographic characteristics of many populations mainly in low-and-middle-income countries (LMIC) has extensive implications for health systems. This is particularly in the provision of suitable, age-appropriate healthcare services, and a decent standard of living for older persons (Parmar et al., 2014). The social change associated with modernization in developing countries has profoundly affected the traditional way of caring for older persons (Mane, 2016; Apt, 2002). This situation may result in social isolation that will become obvious especially among rural older persons in developing countries (Mane, 2016; Apt, 2002).

Given the vulnerability of the aged population in health needs, targeted social protection interventions/initiatives (SPIs) that cover this age group have been implemented in many developing countries. Social Protection has been defined as “all public and private initiatives

that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized, with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups" (Devereux & Sabates-Wheeler, 2004 as cited in Browne, 2015; Page 2). Social protection initiatives have been accepted as an integral part of development (Ramesh, 2014). SPIs became of the essence after the World War II where formal sector workers and their families benefited from pension schemes, and this covered a small proportion of the population (Jones, Ahadzie and Doh, 2009). The options left for the majority of the poor were subsistence agriculture and the informal sector (Jones, Ahadzie and Doh, 2009). Hence, SPIs became crucial in Europe to ensure poverty reduction and human development (Jones, Ahadzie and Doh, 2009), and this swept across different parts of the world including Latin American Countries (LACs). Though LACs were inspired on SPIs policies from Europe, the latter's socio-economic conditions in terms of urbanization, industrialization and the consolidation of formal labour markets were not the same as that of the former (Cecchini, 2014). The adoption of SPIs in many LMICs over two to three decades has made progress since the 20th century (ILO, 2017) despite the large gaps in parts of Asia and Africa (ILO, 2017).

Social protection initiatives cover social insurance, cash or in-kind transfers (means-tested or categorical, and could be conditional or unconditional), labour-intensive public works programmes for the unemployed, price subsidies or fee waivers for essential services (such as healthcare, education and utilities) and compulsory savings and microfinance (Ramesh, 2014). SPIs are divided into different categories in the different context and are based on the target population (Ramesh, 2014). Other scholars have classified SPIs into three typologies (formal, semi-formal and informal mechanisms) based on the guiding principles, source of funding and

accountability-related issues (Amdissa, 2011 as cited in OSSREA, 2013). The actors in the provision of SPIs often are state (government) and non-state (Okello, 2015).

SPIs usually are different in terms of how they work, associated cost, and whom they assist (Ramesh, 2014). Nevertheless, as a result of political and institutional rigidity, and misunderstandings among policy-makers, social protection programmes are usually misdirected and poorly designed (Ramesh, 2014). Some authors argue that though SPIs are meant to benefit the poor, they often play a limited role in the protection of the poor, and in some cases are excluded (Ramesh, 2014). The development of social protection systems is enshrined in human rights usually based on national legislative frameworks and the extension of legal coverage (ILO, 2017). Although, it is disputed that this does not guarantee effective coverage of the population neither does it improve the quality and level of benefits (ILO, 2017).

Emphasizing on vulnerability reduction as part of its poverty reduction strategies, Ghana has rolled out several SP programmes (Jones, Ahadzie and Doh, 2009). Those with the specific focus on older persons include Social assistance programmes (such as the Livelihood Empowerment Against Poverty (LEAP) for aged/older persons ≥ 65 years since 2008), Social insurance schemes (such as the NHIS under the Act of Parliament in 2003; revised in 2012) where there exist Premium Exemption Policy for older persons ≥70 years, Social welfare services for formal employees ≥60 years (such as the SSNIT, National Pensions (Amendment) Act, 2014 Act 883), and Social equity measures (such as legislations that protect older persons against discrimination or abuse). For instance, social health insurance schemes and cash grants are used in some LMICs including Ghana to promote equity in accessing healthcare (Kotoh & van der Geest, 2016), and improve basic household consumption and nutrition (LEAP Programme Ghana, 2016).

SPIs seek to reduce out-of-pocket (OOP) payments in accessing healthcare; promote financial access to care, and create an efficient and safety net for this population (Parmar et al., 2014; Gatenio, 2012). This will reduce the poverty level among the older population and improve their health conditions. Social protection is influential in achieving a wider range of development goals such as health, investment in human capital and poverty reduction (Browne 2015). It is a human right issue (Brown, 2015). Social protection is perceived to be a 'state-citizen' contract, where both nations and inhabitants have rights and responsibilities towards each other (Harvey et al., 2007 as cited in Browne, 2015).

Poverty adversely affects older persons and evidently, the risk of poverty among older persons is significant relative to younger adult persons (Ministry of Gender, Children and Social Protection (MoGCSP), 2015). Older populations do often fall into the poorest population groups in most developing countries due to inequalities some may have experienced in earlier life (Apt, 2002). Non-contributory pension schemes have been implemented in some countries to address poverty in old age (Kimosop, 2013). This is essential in meeting the needs of older persons to achieve the Sustainable Development Goals (SDGs). These goals include SDGs 1, 2 and 3 that seek to reduce all forms of poverty, ensure healthy lives and promote well-being, and achieve gender equality respectively (United Nations (UN), 2015).

In Africa, there is an increase in the population of older persons. This has predisposed the elderly to diseases and ill-health challenges as a result of urbanization and the disintegration of family structures. This is also accompanied with a high cost of meeting quality and appropriate healthcare services (Parmar et al., 2014). Yet, social health protection programmes for this sub-group in most African countries are non-existent (Parmar et al., 2014). Older populations are believed to be at risk of age-related ill-health and disability (Aboderin, 2011). This has been

attributed to the continuous exposure to conditions of deprivation and the growing proportion of existing modifiable chronic non-communicable diseases (CNCDs) among the older population. This older population is still faced with the problem of access to proper healthcare (Parmar et al., 2014).

Ghana with an estimated ageing index of 50.0% by 2050 compared to 12.3% in 2000 (GSS, 2013b), has existing laws and policies that try to protect the elderly under many of the international conventions. But, given the huge proportion of Ghana's population in its youthful stage just like many developing countries, this may fuel the ageing population shortly. Hence, there is need to enhance quality health and social services that will be available for older persons.

In Ghana, the influence of social protection on poverty reduction has been well documented (Gbedemah, Jones & Pereznieto, 2010). The different forms of social protection instruments operational in Ghana include social assistance (example; the Livelihood Empowerment Against Poverty (LEAP), a cash grant, and social insurance (National Health Insurance Scheme (NHIS) (Gbedemah, Jones & Pereznieto, 2010). Another operational social protection instrument is social equity that includes the Domestic Violence Act 2007 (Gbedemah, Jones & Pereznieto, 2010) and the Persons with Disability Act 715 (Persons with Disability Act, 2006).

Ghana's healthcare financing has changed from free healthcare services solely financed through tax revenue in 1957, to cash and carry system in user fee until 2003 when the NHIS was established (Abebrese, 2011). The scheme sought to ensure that all residents of Ghana have equitable and universal access to a quality package of essential healthcare. The Exemption Policy under the NHIS makes it mandatory for persons such as indigents (poor), pregnant

women, and LEAP beneficiaries not to pay for premium nor processing fees. Also, Social Security and National Insurance Trust (SSNIT) pensioners and the elderly (70 years and above) do not pay the premium. However, they are expected to pay processing fees. Informal sector actors often pay for the premium and the processing fees. As part of Provider Payment Mechanism, the new reform under the NHIS, the Capitation Model was piloted and successfully implemented in 2012. It is an additional payment mechanism with the main objective of introducing efficiency in the management of claims paid to health service providers (NHIS, 2012). Under the model, subscribers select their preferred primary provider (PPP) and this was pilot-tested in the Ashanti Region of Ghana (National Health Insurance Authority (NHIA), 2012). It is, thus, pertinent to explore how these social protection instruments affect the quality of healthcare service accessed by a progressively ageing population.

This study, therefore, investigates the extent to which social protection initiatives influence access to quality healthcare among older persons in the study area. Thus, this study conceptualizes social protection initiatives focusing on LEAP; a Government of Ghana's cash transfer programme, and the NHIS. Towards the end, the various forms of SPIs, quality of healthcare promoters, barriers and predictors, experiences (awareness, participation and perceptions), and external factors (community and institutional perspectives) influencing SPIs and quality healthcare linkage at the municipality level using various innovative methods were explored.

1.2 Statement of the Problem

Globally, population ageing has become a crucial phenomenon, even though various countries are at different stages in the demographic transition (United Nations Development Programme (UNDP), 2015). It is estimated that by the year 2050, a total of 1.5 billion older persons (over

60 years old) will be added to the global population (United Nations (UN), 2009a). It is predicted that by 2050, 80% of all older persons will be found in LMICs (Aboderin, 2012; Beard et al., 2011). Population ageing became of the essence at the global level at the first UN World Assembly on Ageing in Austria in 1982. This led to the concerted efforts in 2002 at the second UN World Assembly on Ageing in Madrid that resulted in the adoption of the Madrid Plan of Action on Ageing. The issue of ageing became essential to address the needs of older persons at the global level.

Population ageing puts pressure on health expenditures and the required contribution rate in social health insurance systems (The International Bank for Reconstruction and Development (IBRD) & The World Bank, 2010). Older people have higher unmet needs for healthcare. This usually results in forfeiting treatments for illness compared with younger population groups. Additionally, older persons pay a high cost to seek care (McIntyre, 2004; Saeed et al., 2012). Current estimates show that, globally, there is a shortfall of 13.6 million care workers. This has an effect on long-term care services for older persons aged over 65 years (UNPD, 2015). With older persons making up an increasing proportion of national populations due to longevity and decreasing fertility (UNDP, 2015), this has implications for human development. Hence, understanding the difference in the context of care needs, available care provision, and the provision of social protection (UNDP, 2015) is crucial for policy reforms.

The Universal Declaration on Human Rights states evidently that everyone has a right to a standard of living which is sufficient and appropriate for health and well-being of him/herself and family. This also includes food, medical care and the right to security, social services resulting from unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control (UN, 2015). Hence, the right to quality

health service delivery is not only crucial for human existence but also a key obligation on the part of governments. Older adult populations are usually socially excluded from health facilities which may hinder their access to healthcare services (van Rooy, Mufune and Amadihila, 2015). They have less access to basic health services which Aboderin (2011) refers to as "the element of age-related exclusion" relative to the younger age group. Access to healthcare is hampered by numerous aspects of barriers which include geographic access, availability, affordability and acceptability (Jacobs et al., 2011). Also, the loss to physical functioning hinders the elderly from benefiting from the healthcare system (de Carvalho et al., 2013).

Historically, older populations have depended on their adult children for the provision of support and care where necessary. The demographic transition has affected the structure of families (United Nations Population Fund (UNFPA) and HelpAge International, 2012). Given the current changing patterns in family formation and marriage, this may result in a decline in the availability and the willingness of adult children to render care for their older parents soon. (Mather, et al., 2015). The growing complexity of the living arrangements of such children will result in weaker family ties and the lessening in support of ageing parents (Mather et al., 2015). The increasing number of an ageing population calls for concerns with the rise in future needs especially the cost of age-related social programs (Mather et al., 2015). The vital contributions of social protection programmes in the lives of individuals and households cannot be overemphasized. Their contribution to the survival and livelihoods of beneficiaries are enormous (Ralston et al., 2016; Twine et al., 2007; Case & Deaton, 1996). Hence, there is a need to understand older persons' participation in SPIs and its influence on quality healthcare.

Many of the studies involving older persons especially in Ghana have focused on household characteristics (Biritwum et al., 2013), body weight (Blackshon & Hall, 2012), non-communicable diseases (Snodgrass et al., 2015; Wu and others, 2015; Ayernor, 2012; Thapa, Martinez & Clausen, 2014), family support (Aboderin, 2004), caregiving (Drah, 2014), wellbeing characteristics (Duda et al., 2011), subjective health status, lifestyle characteristics (Martinez et al., 2011), living arrangements (Mba, Addico & Adanu, 2007), Poverty (Mba, 2004), health service utilization (Peltzer et al., 2014), and nutrition (Tayie et al., 2006). Also, studies on the participation of older persons in social protection programmes in Ghana focused on NHIS (Alidu, Dankyi and Tsiboe-Darko, 2016; Duku, van Dullemen and Fenenga, 2015; Nantomah and Adoma, 2015) and cash transfer (Fisher et al., 2017; Alidu, Dankyi and Tsiboe-Darko, 2016). However, there is limited available data on health outcomes such as access to quality healthcare among older persons in the context of SPIs.

The insurgence of non-communicable diseases (NCDs) among older persons will widen the gap between care needs and access to healthcare services (George-Carey et al., 2012; Holmes and Vinaph, 2011; Alam et al., 2010). The elderly population is usually associated with diseases and illnesses which can be attributed to previous lifestyles including improper dieting (Minicuci et al., 2014). The response to the health needs of older persons through the allocation of resources for the health systems is crucial (Minicuci et al., 2014).

Many of the focus of evaluating social protection policies and programmes have been on economic risks and vulnerability (Gbedemah, Jones & Pereznieto, 2010), range of household and child-level outcomes (Handa et al., 2013), children's schooling (Baird et al., 2013; Handa et al., 2013; Barrientos & Niño-Zarazua, 2011), health utilization and morbidity among under 18 years (Handa et al., 2013), social networks (Handa et al., 2013), maternal and child health

(Barrientos & Niño-Zarazúa, 2011; Lagarde, Haines & Palmer, 2009), nutrition (Bhutta et al., 2013; Manley et al., 2012), and household food security (Hoddinott et al., 2013). However, the effects of these policies and programmes on quality health service delivery among the elderly have received limited attention. The effect of SPIs on the quality healthcare services for this aged population has remained invisible to health surveys. Despite the tremendous growth in the elderly population size, between the time Ghana became a republic (1960) and in 2010 when the last Population and Housing Census (PHC) was conducted, the knowledge and perceptions about the quality of health services delivery for older persons in the context of SPIs remain inadequate.

Again, there is limited evidence on the extent to which the elderly in Ghana has benefited from social protection programmes. Ghana's NHIS as a form of SPIs covers about 95% of all disease conditions as part of the benefits package to subscribers. Despite the continuous high-level Government pledges to successful reforms, the scheme has had challenges such as poor quality of healthcare services, failure to meet the health needs of clients, and the absence of equipment for medical procedures (Ashford et al., 2006). For cash grants, the National Social Protection Policy states clearly the inadequate coverage of LEAP that provides social assistance to older persons (MoGCSP, 2015). Hence, understanding the extent to which older persons participate in SPIs and the influence on their quality of care is crucial.

The adequacy of access to quality healthcare services within the health systems of Ghana has been a major setback. Beneficiaries of social protection are not protected adequately due to the quality of healthcare services delivered (International Labour Organisation (ILO), 2014). The need to view the quality health service delivery from the perspective of users has received tremendous attention (Moore et al., 2015, Roelen & Chettri, 2014). But, many studies have

focused on the general population or skewed towards other sub-populations such as children (Roelen & Chettri, 2014) with little or no relationship with social intervention programmes. Several social intervention policies have been introduced to improve the lives and overall well-being of the Ghanaian elderly. This is notwithstanding the changing social, economic and cultural conditions. Yet, there has been no exploration at different levels (individual, household, community and institutional) the connectivity between SPIs and access to quality healthcare on the general living arrangements, care and social support for the Ghanaian elderly.

Therefore, understanding what influences these disparities in access to quality healthcare among the elderly is thus crucial, especially in the context of social protection initiatives.

1.3 Research Questions

To fill the identified gaps in the literature, this study seeks to answer the following research questions;

1. What are the forms of social protection initiatives among older persons (60 years and above)?
2. What are the predictors of participating in social protection initiatives among older persons?
3. What are the promoters and barriers to access to quality healthcare among older persons?
4. To what extent have social protection initiatives influenced access to quality healthcare among older persons?
5. What are the experiences (awareness, participation, and perceptions) of social protection initiatives and access to quality healthcare linkage among older persons from the communities' perspectives?

6. What are the institutional-related factors (legal, economic, social, political, technological and environmental/geographic) that influence the linkage between social protection initiatives and access to quality healthcare among older persons?

1.4 Rationale of the Study

Firstly, older persons are likely to suffer from both personal income and social inequalities (Hren, Prevolnik & Srakar, 2015). Unlike most other studies on older persons in Ghana, this study explores older persons' participation in social protection programmes and how their participation influences the quality of health service delivery they receive. This study makes a valuable contribution to the evaluation of SPIs on the quality of health service delivery for older people in LMICs. This research work therefore will serve as a platform to further understand what promotes age-friendly services for the elderly, aligns health systems to older population; and how overall healthcare for the aged is understood.

Secondly, older people are often faced with social exclusion and are at a disadvantage in enrolling unto social health programmes with the focus on lessening financial barriers (Parmar et al., 2014). The lack of data on how social protection has influenced the quality of health service delivery for the elderly will make the elderly population invisible in social protection programs and health service delivery. This study, therefore, utilizes purposively collected primary data that addresses the limitations of secondary data sources such as the Study on Global AGEing and Adult Health (SAGE), and the Demographic and Health Surveys (DHSs). These secondary data sources may not fully help address the linkage between SPIs and quality healthcare among older persons. The use of a primary data for this research work allows for the exploration of, and the identification of the predictors of SPI participation, the objective measurement of quality healthcare from the elderly's perspective, barriers and promoters of quality healthcare and how these (SPIs and quality healthcare) are linked. This may contribute

to policy formulation as stipulated under the SDGs indicators 1.3 and 3.8. These indicators focus on countries achieving significant social protection systems and universal health coverages respectively (UN, 2015).

Thirdly, the absence of information on the experiences (awareness, participation and perceptions) of healthcare delivery in the context of social interventions, makes it extremely difficult for policymakers, programme implementers and service providers to understand the extent to which such poverty-alleviated programmes have improved access, availability, utilization and quality health service delivery for the elderly. This research work addresses the knowledge gap of examining the different levels (individual, household, community and institutional) of factors that influence the linkage between SPIs and access to quality healthcare among older persons. This will promote the evaluation of culturally acceptable healthcare services, gain adequate information concerning ways to care for older persons and to reduce ageism (abuse and discrimination).

Lastly, the study will assist service providers, programme implementers and planners to understand the needs, expectations, and preferences to properly ensure paramount results in healthcare delivery for older age groups. This will broaden our horizon on how the older adult population can improve their health outcomes. This could be achieved by determining how health services are provided to them as well as the guidelines/policies that focus on quality healthcare. Also, this will enhance our perspectives on the need to understand and mitigate the quality of health service delivery for the elderly. Additionally, this study will help improve the social and economic capacity of older persons and their contributions.

1.5 Objectives of the Study

1.5.1 General objective

The main objective of this study is to investigate the linkage between social protection initiatives and access to quality healthcare among older persons (60 years and above) in the Mampong Municipality in the Ashanti Region of Ghana.

1.5.2 Specific Objectives

1. To explore the forms of social protection initiatives for older persons;
2. To identify the predictors of participating in social protection initiatives for older persons;
3. To examine the promoters and barriers to quality healthcare for older persons;
4. To investigate the extent to which social protection initiatives affect access to quality healthcare for older persons;
5. To understand communities' perspectives on social protection initiatives and access to quality healthcare linkage among older persons; and
6. To explore institutional-related factors (political, economic, technological, legal, environmental and socio-cultural) that influence social protection initiatives and access to quality healthcare linkage among older persons.

1.6 Study Organisation

This study has been structured under nine chapters. Chapter One focuses on the introduction of the study. This is made up of the background of the study, the statement of the problem, the research questions, and the rationale of the study, objectives and the study organisation. Chapter two reviews the appropriate literature relevant to ageing, social protection of interest and access to quality healthcare. The chapter also focuses on the theoretical and conceptual framework guiding this study. Chapter three gives a description of the study area and the methodology. Chapter four examines the various SPIs in the study area. It further explores the awareness and perceptions of social protection initiatives (LEAP and NHIS) among the study participants. Chapter five provides an overview of the characteristics of the study population

in the study area. The chapter also focuses on the predictors of participating in SPIs among the study participants. Access to quality healthcare promoters, barriers and predictive factors are discussed in chapter six. The influence of social protection initiatives on access to quality of care among the study participants is discussed in chapter seven. Communities' perspectives and institutional-related factors on the linkage between SPIs and access to quality healthcare among the study participants are examined in chapter eight. Finally, chapter nine provides a summary of the findings, recommendations and conclusion for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter reviews the main concepts of the research work, namely; ageing, social protection and quality of care. The term "social protection" is used interchangeably in this study with "social protection initiatives" or "social protection programmes". The chapter further explains the concept and definition of ageing and the ageing process. Additionally, it explains the dynamics and linkages in ageing, social protection and quality of care drawing examples from both developed and developing countries. Factors associated with these links are also explored. The chapter, therefore, provides understanding to older persons' participation in social protection and their access to quality healthcare. Contextual factors such as but not limited to demographic, social, cultural, legal, technological, economic, and environmental factors and how they influence this linkage are also explored.

2.2 The concept and definition of Ageing

The ageing process has no universally acceptable definition (Viña, Borrás and Miquel, 2007). The need to conceptualize and define ageing and the ageing process has resulted in the postulation of varying theories from different perspectives like sociology, biology, and psychology including nursing. Theories and models such as the biological, psychological and social scientific have tried to explain the process of ageing (Pierce and Timonen, 2010). The definition of ageing highlights different dimensions of the effects and consequences and has an impact on policy (Pierce and Timonen, 2010). Early research works in the 1970s included areas in Africa (Glascock, 1980), and proposed chronological age, change in capabilities (functional), and the change in social role (social) in defining old people to be more appropriate in the African context (WHO, 2020; Glascock, 1980).

In this chapter, Chronological Age theory in addition to emerged ageing definitions is explained. These emerged theories are linked to those that explain the determinants (positive or negative) of well-being in old age (Holmes, 2006). Theories that explain the determinants of well-being in old age are those related to the structural-functional perspective. This perspective views society as a complex system, and how the different parts work to promote stability and cohesion (Holmes, 2006). Older persons constitute one of society' vital parts. Three different social theories are explained in line with the ageing process. These are Disengagement, Activity and Continuity theories.

The use of Chronological Age Theory is usually connected to ageing and has become crucial in the regulation of many welfare entitlements. Chronological age is the number of years a person has been alive (Basaraba, 2020). Chronological time plays an important role in developed countries due to the retirement age at 60 or 65 years (Pierce and Timonen, 2010). Presently, chronological age is also becoming relevant to developing countries including the African continent, given that due to low life expectancy and retiring age of 60 years, those ≥ 60 years are defined as older persons (GSS, 2013b). A huge majority of social protection programmes such as social transfers and insurance for older persons are based on chronological age. However, other eligibility criteria like income (means-testing), prior contributions (social insurance payments) and need (for example, care needs) are considered (Pierce and Timonen, 2010).

In most African countries, persons ≥ 60 are considered to be old to benefit from social protection programmes. For instance, in Kenya, persons ≥ 65 years are eligible to be recipients of the Older Persons Cash Transfer programme (Kisurulia, Katiambo and Tanui, 2015). In other countries like Ghana, persons ≥ 65 years without any form of support benefit from the

government's cash grant programme, the Livelihood Empowerment Against Poverty (LEAP) (LEAP Programme, Ghana-2020). Beneficiaries of contributory pension schemes (SSNIT) in Ghana are usually are formal employees ≥ 60 years (National Pensions (Amendment) Act, 2014 Act 883). While Chronological time has become central to the study of ageing (Pierce and Timonen, 2010), other authors have underscored the weakness of using chronological age as it does not address the disparities between older persons of the same age (Baar, 2009). For instance, in a pension scheme, older persons are confronted with the rules of institutions and organisations for participation or entitlement (Baar, 2009). Again, Chronological age differs markedly from functional age which is crucial in defining ageing in rural subsistence agricultural context in Africa (National Research Council, 2006). For instance, in some sub-Saharan African settings, persons are considered old due to the status roles they play, though they may be younger than 60 years (National Research Council, 2006). Also, in most African countries, the use of official records to establish age add to the difficulty in defining ageing (WHO, 2020). Another challenge is the influence of comparability of data across settings, region and countries given the traditional African definition of old people (WHO, 2020). Lastly, though the definition of old age in the African context has followed that of the developed world through the setting of retiring age by governments. This definition is also problematic given that many of the African regions especially in SSA reside in rural communities and are often engaged in the informal sector where access to retirement benefits are non-existent (WHO, 2020).

The Disengagement theory was propounded by Cumming and Henry (1961) to explain the social-psychological aspects of human ageing (Bond, Briggs and Coleman, 1993). As a structuralist-functional theory, it explains that as older people age, they willingly give up their roles for society to continue to function (Bond, Briggs and Coleman, 1993). Further, it explains

that society prepares in advance the structure of its members to keep it functioning to avoid disruption in case of the inevitable (Bond, Briggs and Coleman, 1993). This inevitable which results in the disengagement could be caused by incapacitating disease or death (Bond, Briggs and Coleman, 1993). The theory is criticized for not being self-evident where old people in powerful positions do not give up freely on their power and prestige with ageing (Turner, 1989). Turner (1989) added that democratic and socialist systems are mostly managed by men who have passed the default retirement age.

Ageing is characterized by loneliness and physically inactive (Bernard, 2013), common in developing countries (Crewdson, 2016) including the African continent, and this corroborates with the Disengagement Theory of Ageing. The theory has been confirmed in the context of developing and less developed countries (Asiamah. 2017; Crewdson, 2016). In his study, Asiamah (2017) mentioned that in African countries such as Ghana, it will be culturally inappropriate for older couples to relax in night clubs. Settings with a well-entrenched culture of recreation and physical activity promote social engagement (WHO, 2014). For instance, Nyangweso, (1998) found that the feeling of not belonging to society resulted in the aged been inactive and withdrawn among old people in Kenya. The author suggested the need to support old people to remain active in society. However, there is evidence that the aged is not completely disengaged. For instance, evidence revealed that in African countries such as Kenya, South Africa, Zambia and Zimbabwe, it was found that older people cared for the sick, the dying and the vulnerable or orphaned children due to the HIV/AIDS pandemic (HelpAge International/International HIV/AIDS Alliance, 2003). Despite the flaws, the Disengagement model was the first major functional theory, and has also been influential in indicating the pathway to ‘successful’ ageing (Victor, 2005).

The Activity Theory was proposed by Cavan et al., (1949) and Havinghurst and Albrecht (1953). This was in reaction to the Disengagement theory. The theory takes a positive attitude towards growing old. The theory emphasises the continuous role of old people to actively integrate into society, and keep society functioning (Bond, Briggs and Coleman, 1993). The theory explains that successful ageing is achieved through the maintenance of activity patterns and values which are common during middle age (Havighurst, 1963). Denying the inception of old age and where the relationships or activities during middle age are lost, they are replaced with new ones to maintain life satisfaction (Bond, Briggs and Coleman, 1993). The theory is criticized for excluding other factors that may influence the relationship between life satisfaction and increased activity level such as lifestyle and socioeconomic status (Diggs, 2008). The Activity Theory has widely been utilised in research particularly to understand the well-being and survival of older adults specifically in developed countries (Asiamah, 2017; Heinz et al., 2017; Menec, 2003).

Activity theory is proposed to be applicable in settings where economic and social conditions enable the practice of social engagement of older persons (Asiamah, 2017). Developed countries received endorsement as the setting with higher social engagement and physical activity among older persons compared to developing and poor countries (WHO, 2014). Corroborating WHO's declaration, in a recent systematic review focusing mainly on longitudinal studies due to difficulty in establishing causality, Crewdson (2016) reported that almost all studies that validated this theory were carried out in developed countries such as Canada, UK, USA, Finland, and Sweden, and few from developing countries like Iran and Malaysia (Asiamah, 2017; Crewdson, 2016; Victor and Bowling, 2012; Stanley, Moyle and Ballantyne et al., 2010). None were from the African continent. However, though a cross-sectional study in Zambia, Mapoma and Masaiti, (2012) report of social isolation experiences

which exhibit in factors such as loss of appetite, stress, moody, hopeless, useless, unhappy and lonely among 690 older adults aged ≥ 60 years (Mapoma and Masaiti, 2012). A similar study in Uganda corroborates this finding (Nzabona, Ntozi and Rutaremwa, 2015). Asiamah (2017) attributed this variation to the existence of effective pension schemes that promote recreation and physical activity, the physical environment that influences social participation in activities like jogging and cycling, as well as the presence of cohort group due to higher life expectancy, allows social interactions. These are particularly common in developed countries compared to the developing world. Nevertheless, activities the aged in developing countries engage may not be necessarily similar to that of their counterparts in developing countries.

Another notable theory in social gerontology is Continuity developed by Atchley, (1989). This was to resolve the challenge of Activity and Disengagement (Phillipson and Baars, 2007). The theory assumes that in the ageing process, humans attempt to maintain the patterns of their early lifestyle such as participation in hobbies, roles and activities (Heinz et al., 2017). While Disengagement and Activity theory suggest that successful ageing is achieved in a single direction movement, continuity is premised that the individual tries to preserve the favoured lifestyle throughout. In explaining the consistent patterns of behaviour over time, the theory suggests the existence of external (such as relationships and living arrangements) and internal continuity (like temperament and preferences). The theory does not assert that an individual must disengage or become active as a strategy to cope with ageing (Victor, 2005). It does not assume the replacement of lost roles. The disadvantage of the theory is trying to test this empirically (Victor, 2005). It does not explain how social institutions impact individuals and the ageing process, as well as the neglect of chronic illness during the time individuals age (Bozinovki, 2000). Relating the theory from the aged perspective in Cameroon, Naah, Njong and Kimengsi, (2020) found that old people were increasingly attached to the place where they

live and had a clear preference to live there as long as possible. This is rather in line with what one wants to become more of as it has been for them rather than where one did not change throughout the ageing process (Minhat, Rahmah, and Khadijah, 2013).

The remarkable improvements in medical facilities coupled with public health, and advances in economic and industrial technology has led to increase in old age. This therefore calls for the need advocacy for research on this gradually growing population in Africa. Defining ageing and ageing process are viewed from varied perspective, which is chronological (the age starting from 60 or 65 years above) and functional (performance related to physical, cognitive, social and emotional tasks) (Tani, 2016). Irrespective of ageing definition, social protection initiatives is crucial in successful ageing. There is the need to ensure quality healthcare for persons in this developmental age given the physical, cognitive, social and emotional weaknesses associated with the ageing process (Tani, 2016).

2.3 Overview of Ageing and Ageing in Ghana

Globally, the fundamental drivers in population ageing are fertility decline and increasing longevity, and international migration contributed to a change in population age structure in some countries and regions (UN, 2017). It estimated that net migration will slow the growth of the proportion aged ≥ 60 years by least one percentage points in 27 countries (UN, 2017). According to the United Nations, persons aged 60 years and above are known as the elderly (GSS, 2013b). They are also referred to as the aged and could be synonymous to an individual or a population (GSS, 2013b). Persons are assumed to be ageing when they attain the ages classified as old ages. Hence, the process for which the proportion of older persons in a total population increases in a country is referred to as population ageing. Until recently, population ageing was typical of developed countries but is now being seen in developing countries including Ghana (GSS, 2013b). Given the high life expectancy and retiring age of 65 years

from active public economic activity, age 65 years and over are referred to as the elderly in developed countries. In developing countries including Ghana, age 60 years and above are defined as the elderly due to low life expectancy, and the age of 60 years being the age for retirement (GSS, 2013b). Older persons are usually classified by three functional age brackets; young-old (65-74 years), old-old (75-84 years), and the oldest-old (85 years and over).

The reduction in fertility and mortality rates, increasing life expectancy, improvements in health technology as well as advances in economic and industrial technology have contributed to population ageing (GSS, 2013b). Globally, the total fertility rate (TFR) which was about five children per woman in 1950 declined to about 2.5 in 2005. This is anticipated to further fall to two children per woman by 2050 (United Nations, 2011). Life expectancy is expected to increase to 75 years by 2050 as against 47 years in 1950 (Kwankye, 2013). Currently, 6.0% of older persons aged 60 years and above live in Africa, 10.0% in Latin America and the Caribbean, Asia has 11.0%, Oceania has 15.0%, 19.0% in Northern America, and 22.0% in Europe (Kwankye, 2013). It is projected that the number of people aged 60 years and above will reach about 2 billion by 2050. It is further projected that 80.0% of these people will live in LMICs (WHO, 2014). Whereas in Europe by 2050, 34.0% will be in the older person group, this will be 10.0% in sub-Saharan Africa, 24.0% each in Asia and Oceania, 25.0% in Latin America and the Caribbean, and 27.0% in Northern America (UNFPA & HAI, 2012).

Addressing challenges associated with population ageing with a global concerted effort, the First World Assembly on Ageing in Vienna in Austria in 1982 was held by the United Nations. Later in 2002, the Madrid Plan of Action was adopted (GSS, 2013b) in addition to the World Health Organization's *Active ageing: a policy framework* (WHO, 2002 as cited in WHO, 2015). These documents are situated in the international legal framework in the context of

human rights law (WHO, 2002 as cited in WHO, 2015), and highlight the strengths of the elderly to socio-cultural and economic contributions to development.

In Ghana, the number of older persons (60 years and above) has increased seven and a half folds between 1960 (213,477) and 2010 (1,643,381). Survival to older age has been attributed to the improvement in health and higher life expectancy due to advances in medication (Dhemba, 2013). Most of them are females (56.0%) and reside in rural (54.0%) communities. Compared to their female counterparts (33.3%), male older persons (75.0%) are more likely to be in marital unions. Older persons are affiliated to one religion or the other, and this is 95.0% for females and 91.0% for males. Older persons receive social protection from these religious institutions and organizations as well as build their social capital through networks and interactions (GSS, 2013b). The country has a National Ageing Policy that was revised in 2010 after its preparation and submission to Cabinet for approval in 2003 (Ministry of Employment and Social Welfare (MESW), 2010). This document provides a comprehensive, clear and well-specified policy on ageing (MESW, 2010). This policy document calls for the need to strengthen social protection schemes for older persons (MESW, 2010).

2.4 Ageing, Diseases, Disability and Risk Factors

The changing patterns of emerging health outcomes such as diseases (communicable and non-communicable disease (NCDs)) worldwide will be more experienced in LMICs (WHO, 2015; 2014; 2008). Growing older is associated with age-related ill-health and disability (Aboderin, 2011). Forty-six percent of older persons aged 60 years and above have one form of impairment or the other. Multi-morbidity is also associated with ageing (Anum and de-Graft Aikins, 2014; de-Graft Aikins et al. 2013; Ayernor, 2012). The causes of mortality among older persons are usually attributable to NCDs such as cancer and diabetes than communicable ones (WHO, 2014).

In a developed country like Germany, about 24.0% of older persons aged 70-85 years reported to have five or more diseases (Saß, Wurm, & Ziese, 2009). This has impact on the cost of seeking care and may affect healthcare utilization (Marengoni et al., 2011). Ageing is also linked to age-related neurodegenerative diseases like Alzheimer disease (Reeve, Simcox &Turnbill, 2014). In Ghana, health institutional report shows that among older persons, there is an increase in the disability burden of low vision and NCDs (Ghana Health Service (GHS), 2017).

Disability as a functional impairment goes beyond the loss of physical function only (van Tubergen et al., 2003). It is a multidimensional construct that covers disorders at the bodily, personal and social levels (Chatterji, Ustun, & Bickenbach, 1999). The World Health Organization Disability Assessment Schedule II (WHODAS 2) has been a useful instrument in measuring health status, and it has been reported to be different from other measurements for health status (van Tubergen et al., 2003). This is because, WHODAS 2 is based on an international classification system, cross culturally applicable, and is efficient in the determination of the level of functioning (van Tubergen et al., 2003). Huang et al., (2015) reported on higher scores in all domains for the Taiwan elderly persons in a long-term care facility relative to those in a community utilizing the WHODAS 2 that covered six (6) domains. These domains covered cognition, mobility, self-care, getting along with people, life activities and participation in society. The authors identified risk factors including being a male and severity of disease to be associated with institutionalization of patients with dementia.

Though, old age is characterized by multi-morbidities, most health systems are not tailored towards treating the complexities surrounding comorbidities (WHO, 2015). Again, there are

differentials by income countries and by sex; usually lower in high-income countries and among females than in low-income countries and males respectively ((WHO, 2008).

In a study conducted covering three geographical zones in Ghana utilizing a mixed-method, Agyeman (2014) identified that having to fend for one's self was one of the challenges among rural older persons in Ghana. This was attributed to the lack of pension schemes for older persons. However, the study reported that most rural older persons relied on social support systems such as remittances and supports from their children (Agyeman, 2014). In a qualitative study in a rural Ashanti region, Ofori-Dua (2014) found poverty and multiple deprivations to be associated with old age. This was attributed to the low levels of education among older persons (Ofori-Dua, 2014). Aside from the social transformation that affects the care and support for older persons resulting from modernization, the author identified the lack or inadequate economic preparation for old age as a factor.

2.5 The Concept of Social Protection and Social Protection Policies

The concept of institutionalizing social protection stems from the developed world with most countries having their systems of social protection evolving from the European welfare model (Cook & Kaber, 2009). The different stages of countries in both structural and demographic transitions called for the need for social protection programmes as a result of the variations in poverty patterns and vulnerability (Cook & Kaber, 2009). Social protection has presently not only become peculiar to the developed world but also developing countries. By 1920, the social protection system had begun in some European economies and by 1960, the most common social protection programme was social insurance. This was formal work employees and social assistance covering "materialistic" family and in-kind benefits (Cook & Kaber, 2009).

The underpinning of social protection systems on the European model was also adopted among countries in Africa (Cook & Kaber, 2009). The benefits have often covered unemployment insurance, disability benefits, and pensions (Cook & Kaber, 2009). However, the challenge has been the low coverage of the population benefiting from these social protection programmes (Devereux & Cipryk, 2009). The social protection system on the continent has also been sharpened by the responses to situations such as natural disasters, food insecurity and conflicts (Cook & Kaber, 2009). This has always been under the support of donors in reducing poverty, and emergency relief (Cook & Kaber, 2009). The conceptual framework of social protection has usually been guided by four (4) functions (protective, preventative, promotive and transformative) proposed by Devereux and Sabates-Wheeler (2004).

Globally, social protection has become the focal point of the 2030 Development Agenda (ILO, 2017). As stated in the World Social Protection report (2017-2019), social protection is not only an economic and social necessity but also reinforces the recognition of the human right to social security (ILO, 2017). Accordingly, having well-designed social protection systems to reduce poverty and inequality, also enhances social cohesion and political stability (ILO, 2017).

In developing countries, social protection was perceived to be expensive, ineffective and even disadvantageous to development (Holzmann, Sherburne-Benz & Tesliuc, 2003), but has gradually found its place on the developmental agenda. This is because, supporting individuals, households and communities to deal with various risks are paramount in achieving an accelerated reduction in poverty and increased economic and social development (Holzmann, Sherburne-Benz & Tesliuc, 2003).

In 2004, members of states of the African continent recognized the importance of social protection for its social policy enhancement in Ouagadougou (African Union (AU), 2008). Social protection as an institutionalized system had earlier been acknowledged as part of the Ouagadougou Declaration and Plan of Action (POA) for the African continent. Under the auspices of the AU, social protection had a turning point with a call for action referred to as the Livingstone Call for Action on social protection in Africa in 2006 (Taylor, 2008). This was to recognise the linkage between employment policies and poverty alleviation as an integral part of its comprehensive social development agenda (Taylor, 2008). To the African Union, social protection is defined as "a "package" of policies and programmes with the aim of reducing poverty and vulnerability of large segments of the population" (Taylor, 2008; page 9). In Ghana, social protection is defined as "a range of actions carried out by the state and other parties in response to vulnerability and poverty, which seek to guarantee relief for those sections of the population who for one reason are not able to provide for themselves" (MoGCSP, 2015; Page 2). Harvey et al., (2007) explain social protection to be the assistance and protection given to persons considered to be poor and vulnerable, and this includes older people, children, persons with disabilities and women. Social protection has been known to be "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups" (Devereux & Sabates-Wheeler (2004) as cited in Browne (2015; page 2). Social protection has also promoted different aspects of development such as health, poverty and education (Browne, 2015).

For this study, social protection focuses on LEAP, which is social assistance and the NHIS, social insurance. These two social protection programmes are covered within the scope of this

study since the two are integrated and prioritized programmes (MoGCSP, 2015). They are also health-related programmes older persons may utilize or benefit from. Older persons participating in any or both social protection programmes are assumed to be beneficiaries of SPIs while those who are not LEAP recipients and/or NHIS enrollees are classified as non-beneficiaries of SPIs in this study.

2.6 Typologies of Social Protection Programmes

Some scholars have classified social protection initiatives into different typologies covering formal, semi-formal and informal mechanisms (Pearson, Webb & Ashenafi, 2010). Formal social protection initiatives (FSPIs) are based on economic and social principles, financed from public revenues such as taxation and donor funding and are usually established, ran and managed through institutional arrangements, rules and regulations, and accountability processes (Amdissa, 2011 as cited in Organisation for Social Science Research in Eastern and Southern Africa (OSSREA, 2013)). Nevertheless, informal social protection initiatives (ISPIs) are guided by religious and cultural principles, values based on family and community, and are usually financed by individuals or communities (Amdissa, 2011 as cited in OSSREA, 2013). For semi-formal initiatives (S-FSPIs), although, they are not provided publicly, their operations are institutionalized, have accountability mechanisms, and are usually financed by the contributions from members (Amdissa, 2011 as cited in OSSREA, 2013).

These forms of programmes may be in short term such as offering support during crisis and are usually referred to as “safety nets” in other circles (Gentilini, Honorati & Yemtsov, 2014). Long term social protections are usually meant to completely lift people out of poverty (Babajanian, Hagen-Zanker & Holmes, 2014). There is a plethora of evidence on the extent of the impact the SPIs such as cash transfers and social insurance have had on reducing poverty, promoting access to education and children’s health improvements (Browne, 2015).

Nevertheless, these initiatives only do not completely promote the welfare of households (Browne, 2015). Adjasi and Osei (2007) reported that poverty increases with household size.

The various types of social protection include social assistance, social insurance, labour market interventions, traditional or informal social protection and other types of social protection (Browne, 2015). Social assistance is usually state-provided, and the funds are from national taxes (Barrierntos, 2010). It is either cash or in-kind resources that is directly and regularly given to poor and vulnerable individuals or households (Arnold, Conway, & Greenslade, 2011). It primarily covers cash transfers, social pensions, in-kind transfers and public works programmes (Browne, 2015). A social assistance programme such as the cash transfer (CT) has been documented as a policy instrument in supporting households in developing resilience in food access. This is as a result of the fact that the focus of cash transfer programs has been on poverty alleviation and the rise in food consumption (Bhalla et al., 2018).

Currently, social health insurance (SHI) schemes are used in some LMICs including Ghana to promote equity in accessing healthcare (Kotoh & van der Geest, 2016). For social insurance, individual participants make contributions to the scheme that will give financial support in the course of unemployment, ill-health or maternity (Barrientos, 2010). Examples of social insurance include contributory pensions, and health or funeral assistance (Norton, Conway & Foster, 2001), and this is usually limited to formal workers (Browne, 2015; Ibiwoye & Adeleke, 2008). Social insurance is usually funded through the contributions of participants. Generally, social protection programmes derive their sources of funding from government, households and through development assistance (Browne, 2015).

2.6.1 The influence of Social Protection on Health

According to Peabody et al., (1999), the existence of a policy is a major pathway to better health through increased utilization of health services. There are mixed impacts on the effects of SPIs on health (Bassett 2008). Old age and ageing are associated with chronic diseases, and social protection initiatives do not only benefit young people but also older persons (Barham and Rowberry, 2013). According to Zweifel et al., (2004), old age acts as a strong driver in the rise in healthcare consumption. There are existing policies and programmes particularly in developing countries to ensure older persons receive full benefits including health services (Behrman and Parker, 2013; Kasere, 1992). And there is strong evidence of the influence of social protection initiatives on health, particularly, among older persons.

2.6.1.1 Studies in developed countries

Universal health insurance coverage systems helped to reduce disparities in access to care in the United States (US). In a cross-national population-based survey, Lasser, David and Steffie, (2006) found that US residents compared to Canadians, were one-third less likely to have regular medical doctor, one-fourth more likely to have unmet healthcare needs, and twice or more times to forgo needed medicines. These problems were alarming for US residents especially the uninsured (David and Steffie, 2006). In a cross-sectional study of 6,237 older persons in the US, Artz et al., (2002) reported that type of insurance cover increased prescription expenditure among older persons. Though, prescription drug use is important in promoting the well-being of older persons (Artz et al., 2002). Although health insurance as SPIs is expected to provide financial access to healthcare, Baird (2016) had conflicting findings in nine developed countries including the US. Health insurance did not provide sufficient financial protection. Participants of low-income experienced OOP expenses in 6/9 countries, while about 10.0% of the elderly faced high medical expenses in 7/9 countries (Baird, 2016). OOP expenses have also been observed among older persons with chronic diseases in 15

European countries (Arsenijevic et al., 2016), and among women, the poor and the very old utilizing long term care (Scheil-Adlung and Bonan, 2013) in Europe.

SPIs such as cash transfers have been found to reduce the incidence of circulatory and respiratory illness among older persons. For instance, in the United Kingdom (UK), winter fuel payment, an unconditional cash transfer to a household with a member above the female state pension age reduced the incidence of high levels of serum fibrinogen by 6 percentage points (Crossley and Zilio, 2018). There exist mixed empirical findings on the effects of cash grants on child health in developed economies. Forget, (2011) found no variations in birth outcomes in a Canadian study of a guaranteed income experiment. On the contrary, Brownell, Chartier, and Nickel NC, *et al*. (2016) found prenatal social assistance (unconditional cash grant) to be associated with several positive outcomes such as the reduction in the risks of low birth weight, preterm birth and small for gestational age among mother–newborn pairs (2003–2010) in Manitoba, Canada.

2.6.1.2 Studies in developing countries

SPIs such as insurance are expected to promote access to healthcare. However, there is empirical evidence that this has not been completely achieved among older persons in developing countries. In a qualitative study in the Ashanti region of Ghana, despite NHIS, older persons in rural communities either avoided or delayed health service utilization due to the high cost of care (Bayuo, 2017). Similar studies have reported otherwise. Using data from World Health Organization (WHO) Study on Global Aging and Adult Health (SAGE) Wave 1 among 4,162 Chinese older people aged over 50 years with cardiovascular disease, insured patients utilized more services than the uninsured (Dou et al., 2015). Health insurance status was associated with outpatient care utilization but not the same as inpatient care. Age, gender, insurance and household wealth status were associated with outpatient care utilization while

age and insurance status had an association with inpatient care utilization. Dou et al., (2015) identified inequity to be more evident in outpatient care utilisation compared to inpatient care utilisation in the context of high health insurance coverage (86.0%) among study participants. Using data from the Indonesian Family Life Survey, Madyaningrum, Chuang and Chuang, (2018) reported that insured older persons were more likely to utilize out-patient services relative to the uninsured. The researchers suggested the need for expansion for insurance coverage especially for those in lower economic status.

Some studies have also shown the influence of SPIs such as cash grants on nutrition. In an Ekiti State in Nigeria, Social Security Scheme had a positive effect on beneficiaries' household dietary diversity (Adenuga et al., 2015). The researchers recommended the need to organize nutrition-oriented programmes for older persons (Adenuga et al., 2015).

The influence of cash grants as SPIs on health has also been established in the literature. For instance, in Ghana, multiple factors influencing health service utilization among poor older persons under the cash transfer programme (LEAP) in Ghana have been recognized. Older age, having basic education, not receiving family support, without past illness records, and with no diagnosed CNCD positively influenced the utilization of health services at facilities (Agyemang-Duah et al., 2020). The researchers further identified having no disability, consumption of low fruits and vegetables to be associated with a higher likelihood of healthcare utilization among recipients of the cash grant. Barham and Rowberry (2013) found a four percent decline in municipal level mortality for older persons aged 65 and older as a result of the introduction of the Mexican conditional cash transfer program, Progresa (now Oportunidades) between 1997 and 2000. The program witnessed a decline in not only infectious diseases-related deaths but also NCDs such as diabetes. There are some empirical

studies on the positive effect of cash benefit on health status. In South Africa, Case (2001) established that older persons who benefited from non-contributory state pensions had better health status relative to other household members controlling for factors such as age and sex.

The assessment of cash transfers as a form of SPIs suggested remarkable successes in other sub-populations in countries like Nigeria, Ecuador and Mexico. For instance, Kilburn et al., (2016) found that young people living in households that received cash transfers improved their mental health by 24 percent. This was more pronounced among young men particularly those aged 20-24 years and orphans (Kilburn et al., 2016). The authors attributed this to the differences in the complexity or depth of depressive symptoms by sex. Hence, cash grants become an effective tool in depression reduction in young men compared to young women (Kilburn et al., 2016). Some studies have also found women to be more depressed largely during adolescence (Piccinelli and Wilkinson, 2000; Nolen-Hoeksema and Girgus, 1994). Studies in Ecuador and Mexico have reported of mixed evidence on the effect of cash transfer programmes on maternal mental health (Paxson and Schady, 2007; Macours, Norbert and Renos, 2012; Ozer, Fernald and Weber et al., 2011).

Mixed evidence of the impact of cash grant on maternal and child health services have also been established. In a systematic review of data from 51 studies and 22 cash transfer and voucher programmes, Hunter et al., (2017) indicated that the strongest evidence of a positive effect of CCT was the uptake of antenatal care and the use of skilled attendant at birth. Vouchers had a positive effect on both services including postnatal care. The authors attributed these effects to the complexities in social and healthcare system barriers and facilitators (Hunter et al., 2017). Similarly, in rural areas of western China, CCT programme resulted in moderate improvements in maternal and child health (MCH) services and mothers' knowledge of MCH services (Zhou et al., 2020). On the other hand, the programme did not affect child health

outcomes. And this was attributed to the poor implementation of the CCT programme and the poor quality of health facilities in rural areas (Zhou et al., 2020). Other studies have found otherwise on the influence of cash transfer and child health. For instance, an intervention study in Mexico, households' participation in cash transfer programme was associated with improvements in child health, growth and development indicators such as lowering the prevalence of stunting, and higher haemoglobin concentration (Fernald, Gertler and Neufeld, 2008). Similar studies in Nepal corroborate these findings (Renzaho et al., 2019).

Other studies established no influence of insurance as an SPI on health-seeking behaviour. Contrary to previous studies, utilizing data from the Nouna Health and Demographic Surveillance System in Burkina Faso, Robyn et al., (2012) identified that the introduction of health insurance did not have any effect on treatment-seeking particularly on the use of facility-based professional care. Whereas the authors attributed this to poor perceived quality of care, Dong et al., (2009) ascribed this to reasons linked to health-worker attitudes and behaviours. Studies in Ghana have also cited reasons like convenience, benefits and price to influence voluntary enrolment and retention decisions in insurance (Jehu-Appiah et al., 2011).

Cash grant programmes have also been found to increase healthcare utilization among older persons (Lloyd-Sherlock & Agrawal, 2014). Also, there is evidence that these programmes improve the cognitive function of older persons. For example, Aguila and Casanova, (2019) found positive effects on cognitive outcomes among Mexican older persons. This effects were attributed to the mediation effects of increased healthcare use, decreased anaemia for both males and females, and improvement in food availability for men.

2.7 Ageing and Social Protection Programmes

Universally, the most widespread form of social protection for older persons is the pension scheme. At the global level, it is estimated that 68.0% of persons above the retirement age receive either a contributory or non-contributory pension (ILO, 2017). In developing countries, the coverage for the extension of the pension system has improved remarkably; yet, this is a mirage to some older persons especially in low-income countries. Most older persons residing in developing countries continue to depend on family support arrangements (ILO, 2017).

The dual (social and economic) functions of social protection have been recognized in different circles across the globe including the western part of Africa (International Social Security Association (ISSA), 2014). The African Union adopted the "African Union Social Policy Framework" in Namibia in 2008 (ISSA, 2014). There is a need for a variety of ways to ensure social protection, and this includes the LEAP and the NHIS in Ghana. Adult populations have been reported to be 10 percent better off than the older population (Deaton & Paxon, 1997). Tesliuc et al., (2013) found the incidence of poverty to be highest among the elderly group aside children. Cash transfer programmes as SPIs seek to lessen the burden of hardship among older populations (Barrientos & Lloyd-Sherlock, 2002). In the West African region, the proportion of older women and men above the statutory pensionable age benefiting from an old-age pension is 9.7% in Benin, 3.2% in Burkina Faso, 7.7% in Cote d'Ivoire, and 7.6% in Ghana. The rest are Mali (5.7%), Mauritania (9.3%), Niger (6.1%), Senegal (23.5%) and Togo (10.9%) (ISSA, 2014). Many of these countries have also adopted social protection policies and have promoted these through national visions, the MDGs, poverty reduction plans (ISSA, 2014), and the recent SDGs.

Though issues such as conditionality, targeting and graduation have been highlighted as emerging issues about cash grants as SPIs (Browne, 2015), the establishment of SPIs are usually guided by specific objective(s). This has implications for the form and function of these SPIs. This cuts across health, education, livelihood and poverty (Hanlon, Barrientos and Hulme, 2010).

Social protection has been formulated in different contexts such as an investment in human capital (Barrientos, 2010), vulnerability and risk reduction (Browne, 2015; Devereux & Sabates-Wheeler, 2007), and as a right and entitlement for humans (Jones & Shahrokh, 2013).

Existing research has shown both positive and negative impacts of social protection on poverty and vulnerability (Browne, 2015) as well as on education (Barrientos & Niño-Zarazúa, 2011). Social transfers like social pensions and cash transfers contributed to the decline in poverty and these are also benefited by the chronically poor (Barrientos & Niño-Zarazúa, 2011). In Latin America, Fiszbein and Schady (2009) reported that social transfers resulted in the reduction of inequality. On the other hand, Hagen-Zanker, McCord and Holmes (2011) found a negative effect of social transfers on poverty reduction. The impact of conditional cash transfers (CCTs) as a social protection programme on health outcomes is unclear (Browne, 2015). Where the impact of CCTs on health outcomes had some positive effects, it is less clear the extent of attribution (Lagarde, Haines & Palmer, 2009). According to the authors, the use of health services, nutritional status and self-reported episodes of illness were positively influenced by conditional cash transfer programmes (Lagarde, Haines & Palmer, 2009). In contrast, it had no effects on healthcare expenditure. Other studies have concluded on the positive effects of CCTs on health such as vaccination and medical check-up in qualitative review studies (Independent Evaluation Group (IEG), 2011; Fiszbein et al., 2009; Rawlings & Rubio, 2005).

Barrientos and Niño-Zarazúa, (2011) reported that in terms of meeting health needs, CCTs improved attending check-ups and immunisation for children in Latin America. Other studies have reported positive effects on other health outcomes such as improvement in maternal health (Barrientos & Niño-Zarazúa, 2011), preventive health services uptake and behaviours, and improvement in child growth (Lagarde, Haines & Palmer, 2009). Nevertheless, Manley, Gitter, and Slavchevska (2012) found a child's age and access to healthcare as important predictors of child growth than conditionalities of CCTs. Ruel and Alderman (2013) posited that social safety nets had no strong impacts on child nutrition. Studies on the effects of social protection on empowerment for the poor, vulnerable or the socially excluded have usually focused on women (Browne, 2015). But Molyneux (2008) reported a weak relationship between CCTs and women's empowerment. Barber and Gertler (2009) reported that CCT resulted in a better quality of prenatal care for low-income, rural Mexican women in a quantitative research study.

In a systematic review on the impact of health insurance involving about 159 studies in and across Africa and Asia, Spaan et al., (2012) found social health insurance and community-based health insurance (CBHI) to be strongly associated with service utilisation improvements and financial protection through the reduction in out-of-pocket payment. The authors, however, found a weak relationship with community empowerment.

There are limited evidence on social protection and social exclusion (Browne, 2015). Babajanian, Hagen-Zanker and Holmes (2014) posited that SPIs could eliminate some drivers of social exclusion. According to the World Bank (2011), formal workers are usually the beneficiaries of social insurance programme. This implies that working or employed in the agric sector or being an informal worker increases one's chances of exclusion.

The contribution of social protection to local economies cannot be overemphasized. Public works programme as social protection promotes labour demand (Slater, McCord & Mathers, 2014). According to the authors, it also promotes the flow of cash and community wealth creation.

Women, girls and children have usually been the beneficiaries of these social protection programmes. For instance, Holmes and Jones (2010) reported that women formed about 94% of beneficiaries of CCTs either as the recipient and or the manager. In sharp contrast, Garcia and Moore (2012) asserted that it is usually rare for female recipients to be specified specifically in unconditional programmes in sub-Saharan Africa (SSA).

Among older persons, the usual social protection is the old age pension and, a cash transfer (Holzman, Robalino & Takayama**,** 2009). This is often limited in coverage in most LMICs (Holzman, Robalino & Takayama**,** 2009) including Ghana (MoGCSP, 2015). This type of cash transfer is associated with formal employment with more men being beneficiaries than females. This is influenced by the extent of female participation in the formal sector ((Holzman, Robalino, & Takayama**,** 2009). In some SSA countries, old-age pensions have been found to have reduced child poverty (Roelen & Sabates-Wheeler, 2012). For instance, Devereux (2000) posited that Namibian pensioners spent as high as 78.0% of social pension money on other household members. In South Africa where the biggest social pension scheme in terms of numbers in SSA is found, it was established that older persons' participation in cash transfer program resulted in positive child outcomes such as an increase in high school enrolment (Edmonds, 2005; Duflo, 2003). In Malawi, a pilot study on universal pension scheme among older persons showed the reduction in witchcraft accusations (Ministry of Gender, Children, Disability and Social Welfare (MGCDSW) & HelpAge International (HAI), 2016). In Kenya,

it was established that the immediate benefits of CCTs were access to basic healthcare, social support network formation and household food security (National Gender and Equality Commission (NGEC), 2014).

Coverage gap has been found to exist among older persons, and this has been attributed to implementation or take-up problems (World Bank, 2007). Given the low coverage of contributed-based pension schemes in most SSA countries (Guven & Leite, 2016), both poverty-targeted cash transfer programs such as LEAP and universal programs like the NHIS have been seen as a stop-gap in fighting poverty for older persons. The performance of SPIs targeting older persons is inadequate relative to other targeting groups such as children (Coady, Grosh, & Hoddinott, 2004). To the policymaker, meeting the basic needs of the most vulnerable population is more appropriate than the issue of poverty-targeted programs vis-à-vis universal programs (Guven & Leite, 2016). Boateng and Awunyor-Vitor (2013) recounted in a cross-sectional survey in the Volta Region of Ghana that, the health status perception affects participation in social protection initiatives. Furthermore, the authors argued that the decision on uptake and renewal of health insurance policy was significantly influenced by perceived health status.

The issue of health and welfare is crucial in the life of older persons. In Kenya, older persons who participate in cash transfers can access medication or pay for transportation to health facilities (NGEC, 2014). Gender inequality has been reported to affect participation in cash transfers among the elderly. For instance, females constituted 76.0% of older persons participating in cash transfer compared to 24.0% of males (NGEC, 2014). Having a disability or being an elderly person were the main known attributes among participants as selection criteria for the cash transfer benefit (NGEC, 2014). In Yemen, a strong correlation was found

in households with an elderly as a member without a breadwinner and receiving benefits in a CT programme (International Policy Centre for Inclusive Growth (IPCIG), United Nations Development Programme (UNDP) and the United Nations Children's Fund (UNICEF), 2014). Recipients of CTs are less likely to be engaged in commercial agriculture; hence, the need for cash transfers (Slater et al., 2016). Midgley (2016) reported that urban dwellers especially workers in regular wage employment are often favoured in benefiting from social protection such as social assistance relative to the rural majority than those living in urban informal settlements in developing countries. According to the author, this heightens urban-rural inequalities.

The participation of older persons in social insurance programmes is crucial in accessing healthcare. However, in a developing country such as the Philippines, only 18.0% of older persons (60 years and above) are reported to be covered under social insurance (Mandigma, 2016). The authors attributed the low coverage to large informal sector, huge poverty incidence, and high unemployment and underemployment rates (Mandigma, 2016). Studies that examined the drivers of coverage of social insurance in different countries found possible variables such as years of education, and the number of children in the house (Mandigma, 2016).The low participation of the self-employed domestic workers and those in the informal sector in social insurance has also been found to be a setback on extending social security to the poor in Africa (Kaseke, 2000). Using a primary data to evaluate participating in NHIS among employees in the formal sector in Lagos, Nigeria, Ibiwoye & Adeleke, (2008) found NHIS to have the likelihood of promoting access to quality healthcare, especially, among educated couples. Other studies have also reported on the impact of an ageing population and rural-urban migration as drivers to participating in social insurance (Blechova, Janouskova & Sobotovicova, 2014). Mandigma, (2016) found the determinants of social insurance coverage

among older persons (60+) motivated by non-economic factors such as the feminist theory, education and poverty incidence. However, the informal sector had a negative relationship with participating in social insurance.

Utilizing the WHO SAGE data on older persons (≥50 years), Lloyd-Sherlock et al., (2012) asserted that most older persons with hypertension in countries like Mexico, Ghana and South Africa do not receive the appropriate healthcare irrespective of their health insurance status. According to the authors, barriers to receiving the required treatment among older persons have been associated with health education, health screening and the provision of adequate health service especially in rural areas (Lloyd-Sherlock et al., 2012). Huisman, Kunst and Mackenbach (2003) reported that, in the developed world, personal wealth is related to better health outcomes for all ages including older persons. Older persons who are civil servants enjoy occupation-specific health insurance scheme as part of being a member of a contributory pension scheme in most developing countries (Lloyd-Sherlock et al., 2012). Such older persons usually have higher education levels and have access to better health services (Lloyd-Sherlock et al., 2012).

Some studies have shown that older persons' health insurance status could affect the quality of health services received, and this varies depending on the type of health insurance (Lloyd-Sherlock et al., 2012). It has been documented that health insurance improves the level of access to different health services such as diabetes treatment of older persons in South Africa (Sosa-Rubí, Galárraga & López-Ridaura, 2009). However, it has been found otherwise in Ghana that accessing health services have been virtually impossible for most social groups (Witter & Garshong, 2009), which may include older persons. In the context of high access to health services, health insurance has been documented to have some effects (Lloyd-Sherlock

et al., 2012). Ninety percent of older persons that needed care and were able to seek for it had health insurance compared to 83.0% among those with no health insurance (Lloyd-Sherlock et al., 2012). In Ghana, though, some older persons had insurance, yet, they could not seek care. Barriers to accessing health services included cost among 26.0% of those with insurance as against 53.0% for non-insurers (Lloyd-Sherlock et al., 2012). The authors also found no variation by specific health condition (hypertension prevalence), and by insurance status. This was attributed to the low level of prioritization of risk factors associated with NCDs such as hypertension under the health insurance schemes (Lloyd-Sherlock et al., 2012). The authors further stated that even though, the elderly residing in rural communities were more likely to be abreast with their specific health condition as the urban older persons, they were more likely to receive inefficient treatment (Lloyd-Sherlock et al., 2012).

Other groups of persons usually considered under social protection include persons with disabilities (PWDs). Old age is associated with disability (Aboderin, 2011), and the United Nations Convention on the Rights of Persons with Disabilities calls on state parties the need to ensure that PWDs receive access to social protection programmes and services (ISSA, 2017). This will help in the promotion of active citizenship, social inclusion and community participation (ISSA, 2017). However, coverage of PWDs in social protection is low (Browne, 2015), and are often supported through unconditional cash transfers (Schneider, Waliuya, Munsanje & Swartz, 2011). The authors established the positive effects of CTs among PWDs with basic needs that led to health status improvement (Schneider, Waliuya, Munsanje & Swartz, 2011).

2.7.1 Social Protection Initiatives in Ghana

Ghana is a signatory to almost all important conventions, treaties and protocols of the UN and AU to both ageing and old age, and social protection. The country's constitution also pledges

the need for protection and promotion of basic human rights, freedoms and the need for welfare services, and this includes the rights of older persons (MoGCSP, 2015). At independence in 1957, the provision of free healthcare services to Ghanaians was funded from tax revenues. This was not sustainable, and it resulted in the provision of medical care based on direct payment (Sulzbach, Garshong & Owusu-Banahene, 2005).

The emergence and the institutionalization of social protection that swept through the various continents across the world did not exclude the African continent. In 1965, the Social Security and National Insurance Trust (SSNIT) was enacted in Ghana as a social security program (ISSA, 2013). Benefits under social security include old-age pension, disability pension and survivors grant (ISSA, 2013). In 2008, the existing law on social security was amended under the new pensions law, the National Pensions Act, 2008 (Act 766) (Databank, 2014), and a third-tier scheme was established (Abebrese, 2011).To further tackle extreme poverty as part of the Millennium Development Goal 1, measures such as the LEAP and the NHIS were implemented as part of poverty reduction strategies (Abebrese, 2011). Age was a crucial factor in both LEAP and NHIS. This was to ensure full participation of the older population in these programmes. The country adopted a National Policy on Ageing to ensure that older persons actively participate in society and development. But, the document does not adequately address the question of the social protection needs of older persons or develop appropriate social protection policies solely for older persons.

In 2016, the Ghana National Social Protection Policy (NSPP) was launched to make provision for a framework for the effective, efficient and coherent delivery of social protection (MoGCSP, 2015). This is because the country has existing informal social protection actors such as the traditional family, community and civil society. Besides, there are pro-poor

programmes that are carried out by the state. The framework also provides a good opportunity in the demonstration of the country's endorsement of the SDGs (MoGCSP, 2015). Currently, the existing flagship social protection programmes include the Livelihood Empowerment Against Poverty (LEAP), Labour Intensive Public Works (LIPW), National Health Insurance (NHI) Exemptions and The Ghana School Feeding Programmes. Others are The Education Capitation Grant and other Social Protection Interventions by Ministries, Departments and Agencies (MDAs) such as Food and Agriculture sector initiatives. The Free Senior High School is the recent social protection measure adopted and implemented in 2017 to promote access to quality education. These social protection programmes are managed, maintained and coordinated by various ministries. They are integrated to promote the full participation of beneficiaries including the poor and vulnerable, pregnant women, older persons, and school children. These programmes span across various sectors of the economy – health, education, agriculture and livelihood.

2.7.1.1 The National Health Insurance Scheme (NHIS)

Health insurance has been recognized as a healthcare financing tool in many countries. In Ghana, the NHIS was established in 2003 to ensure financial access to healthcare services (NHIA, 2009), and avoid out-of-pocket healthcare expenditure (NHIA, 2010). The funds for operating the NHIS are managed by NHIA, a statutory body with the oversight responsibility of registering, licensing and regulating health insurance schemes across the country. Additionally, the NHIA supervises the schemes' operations, granting of accreditations to healthcare providers and monitors quality service delivery (NHIA, 2009). To ensure quality healthcare services to NHIS subscribers, the NHIS Act, 2003 (Act 650) was passed, which allowed the NHIA to issue accreditation to service providers (NHIA, 2009). Accreditation and post-accreditation monitoring are also carried out in healthcare facilities as part of promoting quality healthcare services. As a social intervention program, the NHIS derives its source of

funding from the 2.5% National Health Insurance Levy (NHIL), premium income accrued from the informal sector in addition to other sources. Older persons aged 70 years and above aside other groups such as pregnant women, indigents, categories of differently-abled persons, and SSNIT pensioners are exempted from the payment of annual premiums (MoGCSP, 2015). The policy exempts categories of persons such as children under 18 years, SSNIT pensioners, persons 70 years and older, indigents, pregnant women and recipients of LEAP from paying a premium (Duku et al, 2015). However, all the listed categories pay a small processing fee except pregnant women, LEAP beneficiaries and indigents (Duku et al, 2015).

2.7.1.2 The Livelihood Empowerment Against Poverty (LEAP)

The LEAP, a national cash transfer programme came into full force in 2008 after the National Social Protection Strategy (NSPS) was developed in 2007. This became more necessary after the Poverty and Social Impact Assessment (PSIA) was carried out in 2004 as a component of the country's Ghana Poverty Reduction Strategies (GPRS) I and II (MoGCSP, 2015). The Government of Ghana's cash transfer programme, LEAP, is a social cash transfer programme which provides cash and health insurance to extremely poor households (Handa et al., 2013). It covers older persons aged ≥65 years without any form of support, severely disabled without productive capacity, orphaned and vulnerable children (OVC), and extremely poor or vulnerable households with pregnant women and mothers with infants (LEAP Programme, Ghana, 2020).

The LEAP programme guarantees that beneficiary households can improve their nutrition, access social services as well as the capacities of members (LEAP Programme, Ghana, 2016). Selection of beneficiaries for the cash transfer is done through households that are further selected stemming from the national, regional, district and community levels (LEAP Programme, Ghana, 2016). Beneficiary households are often selected utilizing a nationally

generated poverty map and rankings obtained from the Ghana Statistical Service (LEAP Programme, Ghana, 2016). Beneficiary households are then enrolled unto the programme after the administration of the Proxy-Means Test (PMT) questionnaire to a household member(s). Household(s) is/are then qualified based on the PMT formula and pre-defined thresholds or cut-off points (LEAP Programme, Ghana, 2016).

2.8 The Concept of Quality of Care

Quality of care has been defined and studied differently (Donabedian, 1980; Campbell et al., 1998; Weingart et al., 2000; Seddon et al., 2001). There is no general definition of quality of care (Campbell, Roland & Buetow, 2000). According to the Institute of Medicine, quality is defined as the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990; pp. 128-129). Campbell et al., (2000) define the quality of care for individual patients "as the ability to access effective care with the aim of maximising health benefit in relation to need" (Campbell et al., 2000, p. 1622). Ghana's National Healthcare Quality Strategy(GNHQS) document (2017-2021) defines healthcare quality as "the degree to which healthcare interventions are in accordance with standards and are safe, efficient, effective, timely, equitable, accessible, client-centred, apply appropriate technology and result in positive health outcomes, provided by an empowered workforce in an enabling environment" (GNHQS, 2016; p. 2).

Data are scare on quality of care and in settings where they are available they are based on routine data (Campbell et al., 2001). Quality of care has been examined using a single condition or perspective (Campbell et al., 2001) or in the context of providing specific health service (Bruce, 1990; Jain and Hardee, 2018). Other studies have also measured quality of care with the use of multi-dimensional scales in some developing countries (Sharma & Narang, 2011).

In rural India, Sharma and Narang (2011) used a 23-time scale comprising of five homogenous sub-scales based on Haddad et al., (1988) to measure patients' perception towards the quality of healthcare services. The most common tool for measuring quality has been the SERVQUAL developed by Parasuraman, Zeithaml and Berry (1985). The SERVQUAL has been utilised in settings like industrial, commercial, non-commercial, and services (Seock-Jin & ll-Soo, 2006; Babakus & Mangold, 1992). Critics of SERVQUAL have focused on its theoretical and operational aspects (Redman & Mathews, 1998; Cronin & Taylor, 1992; Carman, 1990; Babakus & Mangold, 1989), and the measurement in hospital context (Reidenbach & Sandifer Smallwood, 1990). It can also be said to have measured quality of care not from the perspectives of older persons.

According to Donabedian (1988), the measurement of quality of care must be translated to criteria and set standards of structure, process and outcome that can be quantified. Studies have also documented the variations that exist among the components of quality care (Wennberg & Gittelsohn, 1973). Some studies have focused on the variations in process of care. That is, what is done for patients when they come into contact with physicians. This has been reported to have a higher impact on their health status relative to the structural component of quality of care (eg: the facilities and equipment) (Donabedian, 1980). These variations also transcend geographic areas, the system of care as well as the cost involved (Skinner, Fisher & Wennberg, 2001). In a cross-sectional web-based survey among patient experiences with healthcare in the United States of America (USA), the authors found long waiting times to be linked to lower patient satisfaction. However, the strongest predictive factor of patient satisfaction was the time spent with the physician. The study concluded that the need to shorten the time patient spent waiting at the expense of the time they spent with the physician will improve the satisfaction scores of patients (Anderson, Camacho & Balkrishnan, 2007).

The delivery and receipt of care is the actual process of care and this is where clinical medicine is applied to an individual's health problem (Donabedian, 1980), and how users interact with carers (Campbell, Roland & Buetow, 2000). The end product of care is referred to as the outcomes of care (Campbell, Roland & Buetow, 2000), and can be measured based on health status (functional status or symptom relief) and user evaluation (satisfaction or enablement). Also, the structure of care has an influence on the process and the outcome either directly or indirectly, and the relationships among the three components may be non-linear (Campbell, Roland & Buetow, 2000). For example, a patient may not be satisfied (outcome) due to the limited number of health personnel available (structure) or how health personnel handled him/her (process).

Highlighting the neglected dimension in health service provision particularly on family planning services, Bruce (1990) offered a quality of care framework from the perspective of clients in line with Donabedian' structure, process and outcome model. The Bruce-Jain framework premised on six elements (Bruce, 1990; Jain and Hardee, 2018), and was intended to explain aspects of quality in family planning service delivery relevant to the use of both program and evaluation purposes (Jain and Hardee, 2018). Bruce (1990) re-counted how elements of the quality of care framework are often overlooked easily by clients such as providers' technical skills in service provision particularly family planning. Clients bore the effects of poor techniques such as pain and infection (Bruce, 1990). As part of the structure dimension (referred to as preparation), Bruce (1990) highlighted the need to explore the extent to which workers have absorbed information imparted in training in addition to some level of competence achieved. For the process dimension categorized as service delivery, Bruce (1990) suggested the use of indirect observations through interviews with both providers and clients after the provision of services. Other direct techniques such as tape recording, videotaping, and

observation by monitors were also proposed. The outcome dimension of the BJ's quality of care framework focused on vertical dimension comprising of three subjects; client's knowledge, behaviour, and satisfaction (Bruce, 1990).

Within a randomly selected 57 facilities in four municipalities in Macedonia, self-reported health status was found to be the main predictor variable of quality of clinical care among patients who used the facilities even after controlling for all other covariates (Peabody et al., 2006). Peabody, Luck, DeMaria and Menon (2014) asserted that the provision of higher (good) quality of care was associated with being a younger physician, a female physician as well as having received a recent Continuing Medical Education (CME) in chronic disease or health behaviours. The authors measured the structure aspect of quality of care utilising elements such as human, material and financial resources in addition to services and productivity data. This study used health facility-based nationally-representative data (Peabody et al., 2014). Other studies have also raised the issue of how a client who accesses care feel comfortable with providers with similar basic characteristics such as gender, marital status (Repetto, 1977; Bruce, 1990). Olusina, Ohaeri and Olatawura (2002) reported in their study conducted in Nigeria that, satisfaction measured from the patient's perspective is an important indicator of the equitable quality of care. Utilising the SERVQUAL questionnaire in a cross-sectional study in South Africa, Khamis and Njau (2014) established the overall dissatisfaction with quality of care among out-patient care (OPD) patients in a hospital. These levels of dissatisfactions were with five service dimensions; namely, assurance [-0.47], reliability [-0.49], tangible [-0.52], empathy [-0.55], and responsiveness [-0.72].

In Ghana, the ideal state of quality healthcare is outlined around three key aspects of quality planning (policy, resources, etc.), quality control (standards/guidelines, protocols, etc.) and

quality improvement (gap analysis, needs assessment, etc.). These cut across the various levels of the healthcare system, from the national to the patient, and the community (GNHQS, 2016). Quality in healthcare has been recognized as an important strategic focus area with the Ministry of Health being the lead institution with the Health Sector Medium Term Development Plan (HSMTDP) (2014-2017). The Ghana Health Service (GHS) had oversight responsibility in quality assurance in healthcare across the country until 2011 when quality assurance teams were set up in most facilities (GNHQS, 2016). Regular client satisfaction surveys are often used to identify gaps and the needed follow-up actions are undertaken (GNHQS, 2016).

The Patient's Charter was also developed with GHS as the lead institution with three editions of the quality manual as well as the most recent Quality and Patient Safety book (GNHQS, 2016) to protect the rights and responsibilities of patients (Yarney, Buabeng, Baidoo, Bawole, 2016). Yarney et al., (2016) found that healthcare staffs are aware of the existence of the Patients' Charter and some of its contents. On the contrary, patients did not know of the existence or the content of this document in peri-urban public health facilities in Central and Greater Accra Regions respectively. This current study measures quality of care based on 32 indicators adopted with modification (Appendix 2 – Section 9) from Sixma et al., (2000) quality of care from the perspective of elderly people's instrument; that is, the QUOTE-Elderly instrument. Sixma and colleagues developed this instrument based on the concept of Zastowny, Roghmann, and Hengst (1983) as cited in Sixma et al., (2000). Further information about the QUOTE-Elderly instrument could be found elsewhere (Sixma et al., 2000).

2.8 Ageing, Social Protection Initiatives and Access to Quality Healthcare

The use of healthcare systems rises with age in high-income countries while the reverse is true in LMIC (WHO, 2015). The right to good quality healthcare is for every patient and the responsibility of all staff within the health settings (Zineldin, 2006). In 2005, the World Health

Organisation and its member states passed the resolution to ensure citizens of member states benefit from universal health coverage (Carrin et al., 2008). Meeting the needs of older persons requires access to age-friendly and affordable services (UNFPA and HAI, 2012). The provision of quality healthcare complements universal health coverage in achieving health improvements (WHO, 2018).

Zhang et al, (2009) found no difference in the quality of care irrespective of SPI status such as insurance among adult patients diagnosed with diabetes. In an observational study in the US, Schneider, Zaslavsky and Epstein, (2002) found race to influence the link between SPI such as insurance and quality of care. Again, CCT as SPI has been reported to have improved the health of ageing adults in South Africa (Behrman and Parker, 2013). In a Latin American country, CCT has been found to have increased the vaccination rate among older persons (Salinas-Rodríguez and Manrique-Espinoza, 2013).

2.8.1 Studies in developed countries

An ethnographic study in rural southwestern New Mexico in USA among older persons aged over 64 years found the increasing cost of prescription drugs, issues of accessing healthcare and social isolation as the major healthcare challenges (Averill, 2002). The research suggested the need for health personnel education especially for professional nurses in the provision of special care for the elderly (Averill, 2002). An observational study in England among adult patients found high-quality care to be promoted by longer consolation times and good teamwork among health personnel (Campbell et al., 2001). Also, Shadmi et al., (2006) found that older persons (≥65 years) with high morbidity levels were more likely to have received low (poor) quality of primary care. The authors added that respondents with high morbidity levels reported of being dissatisfied with their care relative to their counterparts with low morbidity levels after controlling for age, sex, race and education level. Some strides have been

made in the measurement and definition of healthcare quality for older persons; yet, there have been limited efforts among providers, regulatory agencies and insurers to fulfil this agenda especially for insured older persons (Reuben, Shekelle & Wenger, 2003).

van de Pol et al., (2015) proposed the need for mutual understanding of good care for older persons among all stakeholders after exploring the views and needs of healthcare among older persons in elderly care homes and primary healthcare professionals in the Netherlands. This was in a qualitative mixed interview study design. Starfield and Shi (2004) asserted that a medical home (primary healthcare) is not warranted due to an insurance cover. This is because insurance has been seen to resolve the problem of financial access to healthcare and to remove inequity in services (Penchansky & Fox, 1970). However, its possession does not necessarily ensure the receipt or delivery of quality healthcare services (Starfield & Shi, 2004).

The role that health-service providers play in ensuring quality healthcare is not the same. The attitude of health service workers to a given patient group which also includes older persons is influenced by age, sex, education and area of practice specialty (Doherty, Mitchell & O'Neill, 2011). Although the education level is critical in the change in professional attitude (Holroyd et al., 2009), personal qualities and working conditions have also been established (Doherty, Mitchell & O'Neil, 2011). The availability of health personnel providing quality health service for older persons is critical. Generally, a negative attitude has been observed among health personnel especially nurses and nursing students towards older persons (Hanson, 2014). Hanson (2014) attributed this to the limited knowledge on the process of ageing and the inadequate time allocated for caring for the aged. Additionally, other studies attribute this negative attitude to the stress associated with caring for older persons (Higgins, van der Riet, Slater & Peek, 2007; Topaz & Doron, 2013).

McGlynn et al., (2003) constructed an aggregate score from 439 indicators to measure the quality of care for acute and chronic conditions in addition to preventive care among Americans in 12 metropolitan areas. Using telephone interviews and the RAND's Quality Assessment Tools System to understand the processes in quality healthcare, the authors found one in every two older persons receiving the required care. The model of health service delivery was found to have the highest variation with underuse being higher than the overuse of health services. This means overall, the required medical care processes are received by about half of Americans.

2.8.2 Studies in developing countries

In a facility-based study among in-patients to evaluate the extent of quality healthcare in two countries (Egypt & Jordan), a survey questionnaire form with 48 attributes measuring five dimensions of quality of care (quality of object, processes, infrastructure, interaction and atmosphere) was administered. Zineldin (2006) found the service quality dimension to be associated with patients' willingness to recommend health facility to others. In an ethnographic survey design utilizing data collection techniques such as interviews, focus group discussions, participant observation and documentary sources among older persons in Cameroon, Nangia (2016) reported that weak institutional support system and poverty were the factors influencing the well-being and care of older persons.

In a qualitative approach study among the elderly in the Asante-Akyem North District of the Ashanti Region, the researcher observed that despite NHIS, family support, accessibility and healthcare cost were found to have contributed to the less use of out-patient health services in hospitals (Bayuo, 2017). Duku et al., (2015) also identified NHIS coverage of 62.8% among older persons aged 70 years and over. The authors further established that, in the context of the Premium exemption policy, older persons aged 70 years and above were 1.7 times more likely

to enrol in NHIS than the lower age group. Other studies have reported about 57.0% coverage for older persons aged 70 years and over (ILO, 2014).

2.8.3 Gaps identified from ageing studies in developing countries

Studies on the influence of SPIs on health have increased several decades, and existing literature acknowledges the urgency of ageing and its associated challenges. The influence of SPIs has different magnitudes of effects on health among older persons including sub-populations. However, the available focus on SPIs especially cash transfers and health insurance in the context of quality healthcare is limited among older persons in developing countries. But, in a cross-sectional study in Ghana, Duku et al., 2018 stated that insured older persons (70 years or more) perceived the quality of healthcare accessed as poor relative to their non-insured counterparts.

The attempt to synthesize the evidence concerning social protection and quality of care among older persons is virtually impossible. Moreover, quality of care among older persons has predominantly featured evidence from developed countries with limited studies from developing countries especially Ghana. The tool for the measurement of quality of care by most studies is not based on older persons' perspective as being demonstrated by this current study. Again, the limited existing studies focused on older persons aged 70 years or older which is not in line with the statutory pensionable age of 60 years and above in Ghana, and in most developing countries.

Further, there is limited data on the linkage between quality of health service delivery and the extent of coverage of social protection programmes among older persons, and how the two interplays to promote the well-being of older persons. Whereas the current study utilises a

mixed-method (qualitative and quantitative), many of the published studies used either study design or a few being a systematic review.

2.9 Theoretical framework

2.9.1 Introduction

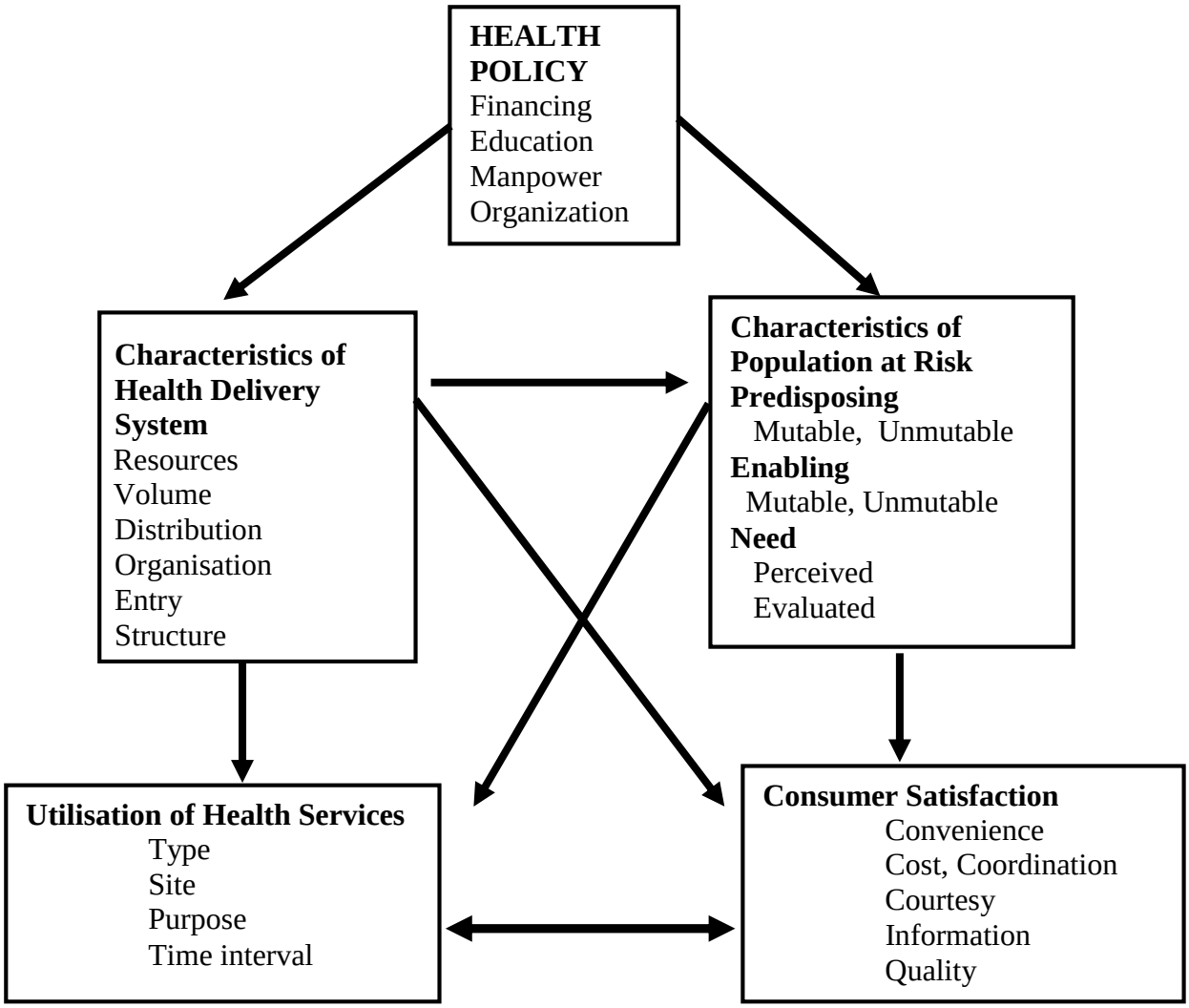
Access to healthcare has received attention in research areas such as health policy and health services. The provision of quality service to clients has become essential in healthcare and business research. Theories and models such as the Andersen's Healthcare Services Utilization Behaviour and the Donabedian's Structure, Process and Outcome have tried to explain "access" and "quality" healthcare respectively. These are described from varied dimensions such as from the characteristics of the population and the delivery system (Aday & Andersen, 1974) and the use of structure, process and outcome (Donabedian, 1980). These theories have acknowledged how "access" and "quality" healthcare are influenced by factors operating from different levels such as the individual (age, sex, education, insurance coverage, health status, sociocultural beliefs, etc), household (socioeconomic status/class, family size, etc), community (rural, urban, etc), and the delivery system (Aday & Andersen, 1974; Campbell, Roland & Buetow, 2000) perspectives. A social protection initiative such as having insurance coverage is identified to influence accessing healthcare (Aday and Andersen, 1974).

2.9.2 The Andersen Healthcare Services Utilization Behaviour Model

The Andersen Healthcare Service Utilization Behaviour model explains the factors associated with health service utilization (Phillips et al., 1998). This was developed to understand the determinants of utilizing acute healthcare services (Bradley et al., 2002). The model posits that access to care could be measured from two perspectives (Figure2.1). These include the characteristics of the healthcare delivery system and the characteristics of the population at risk in the context of health policy (Aday and Andersen, 1974). According to the authors, among the features of the healthcare delivery system are resources such as labour and health personnel.

The structures within which healthcare and education are made available, equipment and materials used in the provision of health service purported for healthcare are also features of the healthcare delivery system. These structures are often referred to as capital. Again, another feature is "organization" which symbolizes how both medical personnel and facilities are directed to provide healthcare. The use of a particular delivery organization as the measurement of "access" becomes a focus when the delivery system is the object to study. However, focusing on an individual as the unit of analysis calls for the use of the characteristics of the population at risk (Figure 2.1). Hence, the best method of data collection to utilize is a household survey. Aday and Andersen (1974) posit the existence of predisposing (age, sex, race and religion), enabling (income and insurance coverage) and need (level of illness) components that are the individual determinants of utilization where the individual is the object of study (Figure 2.1).

The theory adds that there are independent and dependent variables that need to be considered in the attempt to understand access to healthcare. The theory also acknowledges social indicators such as the "process" that includes the characteristics of the population at risk (age, sex, and race) and the characteristics of the health delivery system (number of physicians and bed). The other indicator is "outcome" that may explain the completion aspect of access to healthcare. This can be measured objectively or subjectively using satisfaction and utilization (Aday & Andersen, 1974). The theory highlights the pathways of both the user (individual consumer) and delivery system characteristics that will influence access to healthcare.



Source: Aday & Andersen, 1974.

Figure 2. 1: Framework for the study of access (Aday & Andersen, 1974)

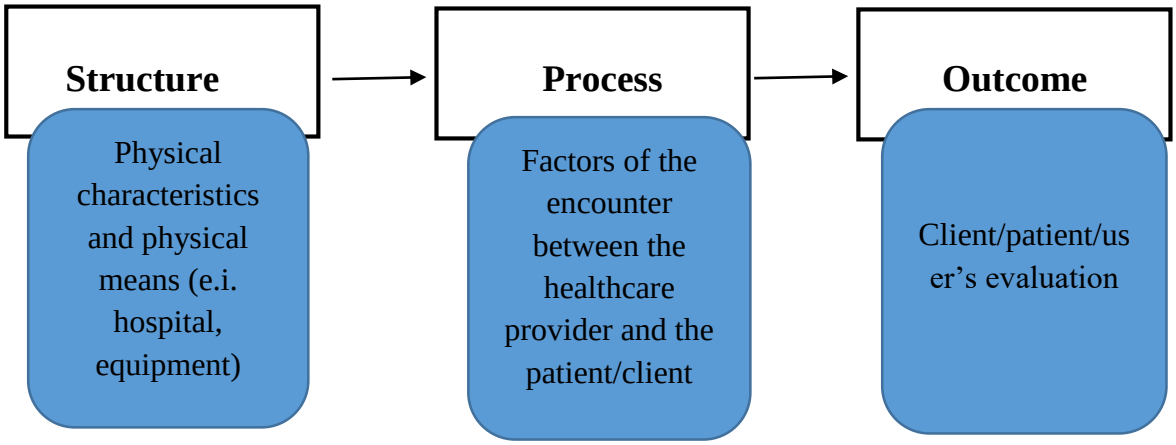
Nevertheless, it fails to explicitly demonstrate how other external factors such as the household, community, the environment as well as service provider-related factors (Phillips et al., 1998) influence access to healthcare.

In a systematic review search that resulted in 328 articles utilising this theory, Babitsch, Gohl and Lengerke (2012) reported significant differences in the variables used, variable categorization and inconsistencies in the findings. The authors attributed these variations to the use of secondary data sets in the majority of the studies limiting the available variables for the

study. Babitsch, Gohl and Lengerke (2012) suggested the need for primary studies to understand healthcare utilisation and the complexities associated with the processes. In applying the model in the context of race or ethnicity and long-term care, Bradley et al. (2002) found attitudes and knowledge, social norms and perceived control as the psychosocial determinants of health service use but these were not incorporated into the model. In this study, access to healthcare is measured from the perspective of the population at risk with the outcome variable focusing on the quality of health service received. Also, community and institutional-related factors that affect healthcare are incorporated.

2.9.3 The Donabedian's Structure, Process and Outcome model

The Donabedian model developed in 1966 has been seen as the framework relevant for the evaluation of healthcare (Sardasht et al., 2014, Simbar, Nahidi & Akbarzadeh, 2010) with its focus on bringing to the fore the satisfaction of outcomes as well as client's awareness (Ghaffari Sardasht et al., 2014). It defines quality in three different aspects that include structure, process and outcome (Figure 2.2) (Donabedian, 1980). The Structure aspect of the model denotes the organisational and physical factors through which the provision of care takes place (Donabedian, 1980; Campbell et al, 2000). The Process of quality of care focuses on how clinical medicine is applied to health problem (Donabedian, 1980), and it is usually seen as the interaction that takes place between users and the structure of healthcare (Campbell et al., 2000). The outcome in the model is usually the consequences of care, and this is directly or indirectly influenced by both structure and process (Campbell et al., 2000) in obtaining quality healthcare. According to Campbell et al., (2000), the extent of the significance of each of these three aspects of quality of care varies in different scenarios, and the linkages that exist among them are non-linear.



Source: Donabedian, 1980; Campbell et al., 2000.

Figure 2. 2: Framework for the study of quality of care

The pathways to have formal care are dependent on the populations' demographic characteristics (MacIntyre, McIver & Sooman, 1993; Sixma et al., 1998), health need (Feinstein, 1993), and lay support (Oakley, 1994). Other pathways include the frequency of attendance (Neal et al., 1998), health beliefs (van der Kar et al., 1992) and the attributes of the healthcare system that may determine consulting behaviour (Campbell et al., 2000).

Assessing the health structures and processes of care needed by individuals are crucial in understanding the quality of care (Campbell et al., 2000). Factors such as rurality (Cox, 1998), older persons' utilization of premises themselves (Bentham & Haynes, 1985), and access to a specialist clinic or other health personnel other than a doctor could be related to geographic barriers to care (Campbell et al., 2000). Other relevant issues include financial barriers but social commitment roles at the individual level are also relevant in accessing quality healthcare (Campbell et al., 2000).

The Donabedian Quality of Care Framework has been utilised in many studies. Camilleri and O'Callaghan (1998) used the SERVQUAL model and Donabedian's framework in comparing

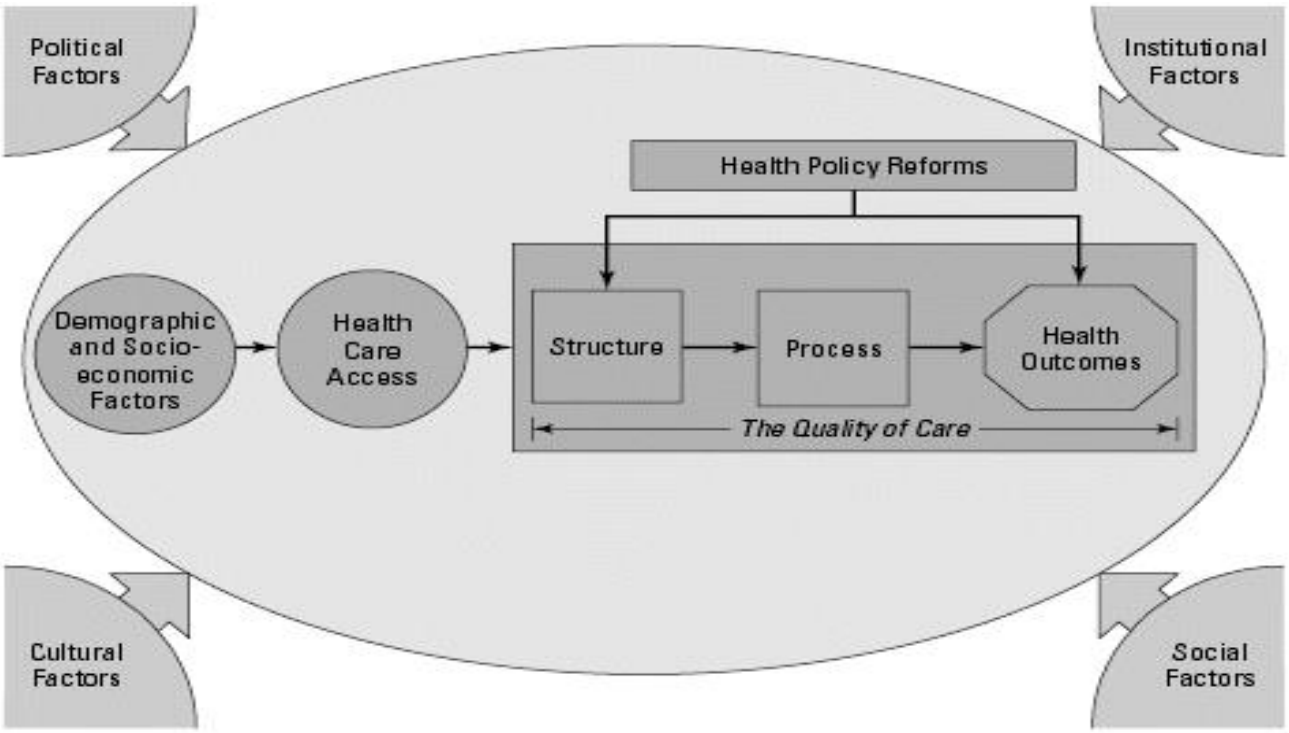
the quality of service between public and private hospital care utilising a Likert-type scale. The authors identified that professional and technical care quality in addition to the extent of personal attention as the most important service product among users. Several studies have been conducted based on the Donabedian Quality-of-Care Framework to understand the quality of maternal and child healthcare based on the structure and process aspects of the framework (Rani, Bonu & Harvey, 2008, Agha & Do, 2009; Naariyong et al., 2012). Other studies focused on the entire process from "structure" through "process" and the outcome (Simbar, Nahidi, and Akbarzadeh, 2010). Sardasht et al., (2014) on the other hand, focused on the "outcome" aspect of the model only. However, this study uses the Donabedian's framework to assess the structure, process and outcome aspects of quality of care among older persons in the context of SPIs.

2.9.4 Conceptual Model

Based on the Andersen's Healthcare Services Utilization Behaviour and the Donabedian's Structure, Process and Outcome Models, this study adopted a hybrid version by drawing on elements from these two theories.

It is expected that the Andersen Healthcare Services Utilization Behaviour Model will enable us to understand the effect of social protection initiatives on access to quality healthcare while controlling for other predictors. The social protection initiatives are conceptualized using LEAP and/or NHIS. It is measured as beneficiary (LEAP only, LEAP and NHIS, NHIS) and non-beneficiary (None of SPIs). The framework models the relationship between predisposing (social, economic, demographic, behavioural), enabling (social protection initiatives) and the need for care (health-related characteristics) factors, and quality of care (good and poor).

The Donabedian's Structure, Process and Outcome criteria are also used to explain, identify and understand the instruments for any plausible variation in care in the relationship between SPIs and access to quality of care among older persons in this study. It is a systems-based framework which has been used to define quality (Campbell, Roland & Buetow, 2000). According to the authors, an outcome is a consequence of care not a component of care while the structure is a channel through which care is delivered and received (Campbell, Roland & Buetow, 2000). This study adopts the "Structure-Process-Outcome" model to help assess the quality of healthcare service delivery older persons in the study area receive. This will assist in improving such service if it is perceived to be insufficient (poor), and to identify a proposed solution to upgrade it. From the perspectives of the Donabedian's healthcare quality model, improving the structure of healthcare will lead to improvements in the process of clinical care that will subsequently improve the outcome of carer or user of health system (Moore, Lavoie, Bourgeois & Lapaointe, 2015). Patients offered the recommended services can also be used to measure quality which is one of the classifications of measuring quality, that is, as a process or as an outcome (Car et al., 2008). Process measures are accurate when they correlate with health outcomes (Car et al., 2008). This study's conceptual framework was premised on the adapted version of Peabody et al's., (1999) framework (Figure 2.3) on quality of care.



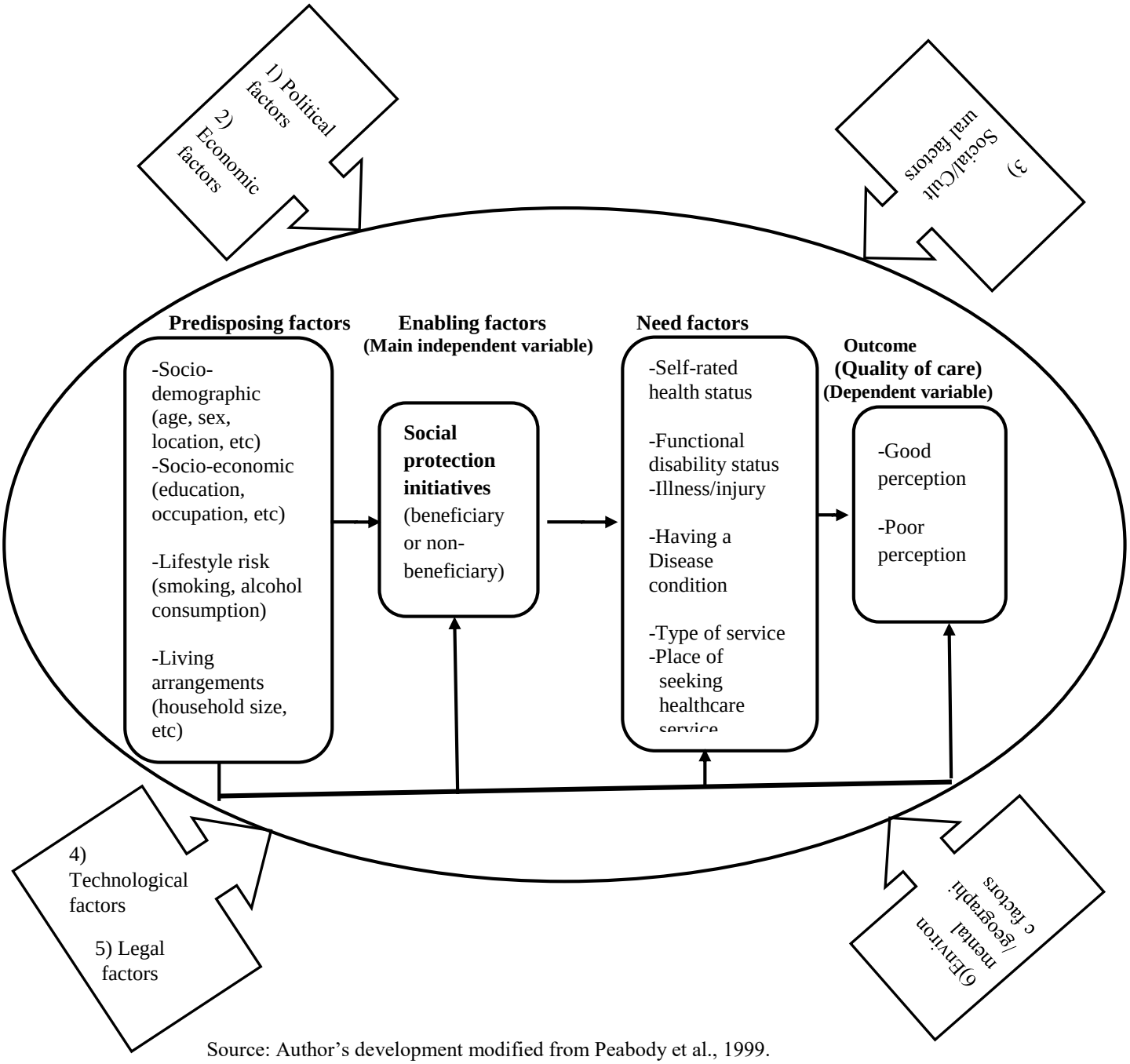
Source: Peabody and others 1999.

Figure 2. 3: Quality of Care Framework

According to the framework, activities are taken within the health system to improve health. These activities are undertaken and are determined by political, cultural, social, and institutional factors as presented in Figure 2.3. The make-up factors of individual seeking care such as demographic, socioeconomic, genetics, and personal resources impact on their health status. Although access to care is necessary to maintain or improve health, the application of the health system's capacities must be proficient (Peabody et al., 1999). Hence, quality is achieved when material inputs and the skill of the practitioner are optimized to produce health (IOM, 2001; Peabody et al., 1999).

Figure 2.4 depicts the conceptual framework that shows potential mechanisms through which SPIs directly or indirectly affect access to quality of healthcare for older persons. From the study of access (Andersen and Aday, 1974), several variables are associated with the utilisation of healthcare services, and the structure, process and outcome dimensions provide the

mechanism to evaluate the quality of care (Donabedian, 1966). In the current study, quality of care is conceptualized as an outcome variable based on the perceptions of study participants measured as good and poor perceptions. It is a function of predisposing (socio-demographic, socio-economic, lifestyle risk and living arrangements), enabling (SPIs), need (health-related), and community and institutional-related factors.



Source: Author's development modified from Peabody et al., 1999.

Figure 2. 4: Conceptual model showing the direct and indirect influence of SPIs on access to quality healthcare controlling for predisposing, need and external-related factors among older persons.

Factors that may influence the link between SPIs and access to quality healthcare in this thesis include 1) predisposing factors such as socio-demographic (age, sex, religious affiliation, marital status, and location), socio-economic (education level attained, occupation, received social support, household wealth index, and household food security), lifestyle risk (smoking status and alcohol consumption status), household living arrangements (household size and having a primary caregiver); 2) enabling factors such as social protection initiatives (beneficiary or non-beneficiary); 3) need factors such as self-rated health status, functional disability, having a disease condition, injury/illness, type of service and place of accessing healthcare service; 4) community (positive and negative experiences), and institutional-related (political, economic, technological, legal, socio-cultural, and environmental/geographic) factors.

The relationship between social protection initiatives such as LEAP and/or NHIS and access to quality healthcare is inconclusive. Being a beneficiary of SPI such as NHIS affects the perceptions of quality healthcare as one of the factors that inform one's decision in participation (Duku et al., 2018; De Allegri et al., 2006; Jehu-Appiah et al., 2012). Duku et al., (2018) established that insured persons perceived the quality of healthcare accessed as poor relative to the non-insured.

There are empirical studies that demographic factors such as age, sex, religious affiliation, and marital status influence SPIs participation such as social insurance among older persons. Participating in social insurance was found to be stronger for older adults aged 70 years and above compared to 60-69 years in rural Ghana (Wielen, Channon and Falkingham, 2018). This finding has been documented in other studies (Duku et al., 2015). Female older persons are covered under NHIS relative to their male counterparts (Saeed et al., 2015). This finding has

also been corroborated in other studies (Kotoh, Aryeetey and Van der Geest, 2018; Onadja et al., 2013; Dixon, Tenkorang and Luginaah, 2011). Belonging to the major religious group, that is, Christianity increased the odds of insurance enrolment as an SPI in Ghana and Senegal respectively (Parmar et al., 2014). The authors attributed this to the presence of discrimination against religious minorities, ethnic minorities, and women. On marital status, Wielen, Channon and Falkingham, (2018) showed that compared to those never married, separated or widowed, married older adults were more likely to be NHIS enrollees in rural Ghana.

Insurance as a form of SPI has been shown to be pro-rich bias. Parmar et al., (2014) established that older persons from richer households benefit from social insurance relative to their counterparts in poorest households in West African countries like Senegal and Ghana. With rural-urban differential, according to the Ghana SAGE study, urban dwellers compared to those in the rural areas are beneficiaries (WHO, 2014). In rural Ghana, Van der Wielen et al., (2008) observed that more educated older adults were more likely to be insurance enrolees. An inverse relationship was observed in Senegal (Parmar et al., 2014). Further, the researchers found that older persons residing in urban centres increase the odds of enrolment.

Household characteristics have been reported to have effects on SPIs. Whereas Kirigia et al, (2005) found larger household sizes to negatively influence insurance as an SPI in South Africa, Duku, (2018) reported otherwise in Ghana. The former attributed this finding to the reduction of the household per capita income given an increase in the number of household members relative to income (Kirigia et al, 2005).

Available evidence shows the adverse selection in participating in SPIs. Health-related factors are associated with benefiting from SPIs. For instance, Parmar et al., (2014) found that having

a chronic illness and being hospitalized in the last 12 months increased the odds of social insurance enrolment among older persons in Ghana. Similar relationships were observed among older persons in Senegal (Parmar et al., (2014). However, Fonta et al., (2017) found no association between social insurance and self-reported health among older persons in Ghana.

Previous studies have also documented the influence of individual and household characteristics on cash grants participation among older persons. Ralston et al., (2015) found non-recipients of cash grant among older persons in South Africa tend to be male, have poor socio-economic status and reside in smaller households. In Malawi, Jumi and Msilimba, (2018) reported that beneficiaries of social cash transfer (SCT) programmes tend to be women. But, sex was not significant in predicting affiliation to the cash grant programme among older Mexican people (Salinas-Rodríguez and Manrique-Espinoza, 2013). Beneficiaries of cash transfer programmes tend to have very little or no formal education (Jumi and Msilimba, 2018). Nevertheless, no association has been established between receiving cash transfer and disease condition such as hypertension or self-rated health status (Lloyd-Sherlock and Agrawal, 2014).

External factors such as institutional rigidities and socio-cultural practices have also played an important role in determining the decision to enrol in social insurance as a form of SPI in African countries such as Burkina Faso and Ghana (Fenny, A.P., Kusi, A., Arhinful, D.K. et al., 2016; Allegri, Sanon and Sauerborn, 2006). In other developing countries like Kenya, Malawi, Pakistan, Senegal and Sierra Leone including Ghana, politics strongly influenced decisions about SPIs such as cash grant programmes and insurance (Addei Mensah, 2016; NHIA, 2011; Farrington et al., 2006-2007). Political factors such as the degree of autonomy of civil servants and associations with political elites influence the effectiveness of SPIs such as social assistance (Besley and Ghatak 2007; Mookherjee 2004). Environmental/geographic

factors such as road accessibility have also been established to have an effect on SPIs like NHIS (Wielen, Channon and Falkingham, 2018).

The study, therefore, controls for these covariates that may influence access to quality healthcare such as predisposing, and need factors in the context of SPIs. Further, community and institutional-related factors that influence the linkage between SPIs and access to quality of care are explored. For instance, predisposing factors such as age have been found to influence access to quality healthcare. Age was inversely related to the quality of care. In a population-based follow-up study in Denmark, Palnum et al., (2008) reported that stroke patients over the age of 80 years received lower quality of care compared to those ≤ 65 years old. Peabody et al., (2006) identified health-related characteristics such as self-rated health status was associated with quality healthcare. In an urban health care facility, poor infrastructure, limited human resource and unavailability of drugs and/or medical equipment for health service are some of the technological factors that have been found to influence access to quality of care (Munga and Mwangu, 2013; Juma and Manongi, 2009). Figure 2.4 shows the direct and indirect relationships and the influencing mechanisms between SPIs (beneficiary or non-beneficiary) and access to quality healthcare (good or poor perception).

In conclusion, the findings from this study will offer how benefiting from social protection initiatives influence access to quality healthcare is determined by predisposing, need, and community and institutional-related (political, economic, socio-cultural, technological, legal and environmental/geographic) factors. The data collected for this study therefore sought to confirm or reject this position. This could contribute to formulating policies that can promote model healthcare for older persons in Ghana, especially in the study setting.

2.10 Hypotheses

This study's hypotheses are formulated around participating in SPIs based on their proposed effect on access to quality healthcare. It, therefore, hypothesized that:

1. Older persons 80-84 years are more likely to be beneficiaries of SPIs compared to those 60-64 years old.
2. Compared to those who seek healthcare at the hospital level, older persons who seek healthcare at the pharmacy/drug store/chemical shop are less likely to be beneficiaries of SPIs.
3. Older persons who are beneficiaries of SPIs have a good perception of the quality of care accessed than their non-beneficiary counterparts.
4. In the context of SPIs participation, older persons living with primary caregivers in the same household have a good perception about the quality of care accessed relative to their counterparts who reside in separate households with primary caregivers.

CHAPTER THREE

STUDY AREA AND RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides detailed information about the study area and the methodology used in this study. In this chapter, the study area, study design, sampling procedure, methods of data collection, study population and methods of analysis for this research work are described.

3.2 Study context

3.2.1 General profile of Ghana

According to the 2010 PHC, the country has a total population of 24,658,823, an increase of 30.4% relative to the 2000 census population which was 18,912,079 (GSS, 2012). Figure 3.1 displays the map of Ghana showing the Ashanti region. Ghana has a youthful population with 38.3% below 15 years. Older persons (60 years and above) constituted 6.4%. This has implications for the country's age structure, and it is shaped by the interaction between fertility and mortality rates. About 51.0% of the population resides in urban areas relative to 49.0% in rural areas (GSS, 2012). The average household size was 4.4. Ashanti region (location of the study area) is the most populous region with a population of 4,780,280 signifying 19.4% of the country's total population (GSS, 2012). The most predominant ethnic group is the Akans (47.5%) whereas the Mande forms the smallest group (1.1%). About 71.2% of the country's population are affiliated to the Christian faith. 17.6% affiliated to the Islamic religion, 5.2% to the traditional religion and 5.3% do not belong to any religion (GSS, 2012). Among those 11 years and older, seven in every 10 are literate, particularly in reading and writing of the English language (67.1%). About 24.0% of the population aged three (3) and older have no formal education. Those aged 5 years and older form 54.2% of the population who are economically

active (employed and unemployed). About forty-two percent are employed in the Agriculture sector with the next largest industrial sector is wholesale and retail trade (18/9%), and 10.8% for manufacturing (GSS, 2012). The majority (64.8%) of those who are economically active are self-employed. Sex differentials showed that females (69.4%) are more likely to be self-employed relative to males (60.0%).

Source: Ghana Statistical Service, 2014

Figure 3. 1: Map of Ghana showing Ashanti Region

The country's fertility rate has declined from 6.4 children per women (1988) to 4.2 children per women while childhood mortality between 1988 and 2014 showed a similar decline (GSS, GHS and ICF International, 2015). For instance, neonatal, infant, and under-5 mortality rates have declined from 41, 77 and 155 per 1,000 live births in 1988 to 29, 41 and 60 per 1,000 live births in 2014 respectively (GSS, GHS and ICF International, 2015). The number of older persons (60 years) constitutes 6.7% of the country's total population, and females form 55.9% while males are 44.1% (Kwankye, 2013).

In Ghana, NCDs contribute considerably to illness, disability and death (Ministry of Health. 2012). The main NCDs are cardiovascular diseases, cancers, diabetes, chronic respiratory diseases and sickle cell disease (GHS, 2017), and this has been attributed to risk factors such as tobacco, harmful use of alcohol, unhealthy diet and physical inactivity (GHS, 2017). Three (3) percent of the total population have some form of disability (GSS, 2012). Sex differential showed that disability is prevalent among females (52.5%) than males (47.5%) (GSS, 2012). The burden of NCDs like cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases is expected to rise due to ageing, rapid urbanization and unhealthy lifestyles (GHS, 2017). As at 2016, the country had 6,815 health facilities comprising of CHPS (4,185), clinics (1,003), district hospitals (137), health centres (855), hospitals (267), midwife/maternity (328), mines (3), polyclinics (34), and psychiatric hospital (3) (GHS, 2017).

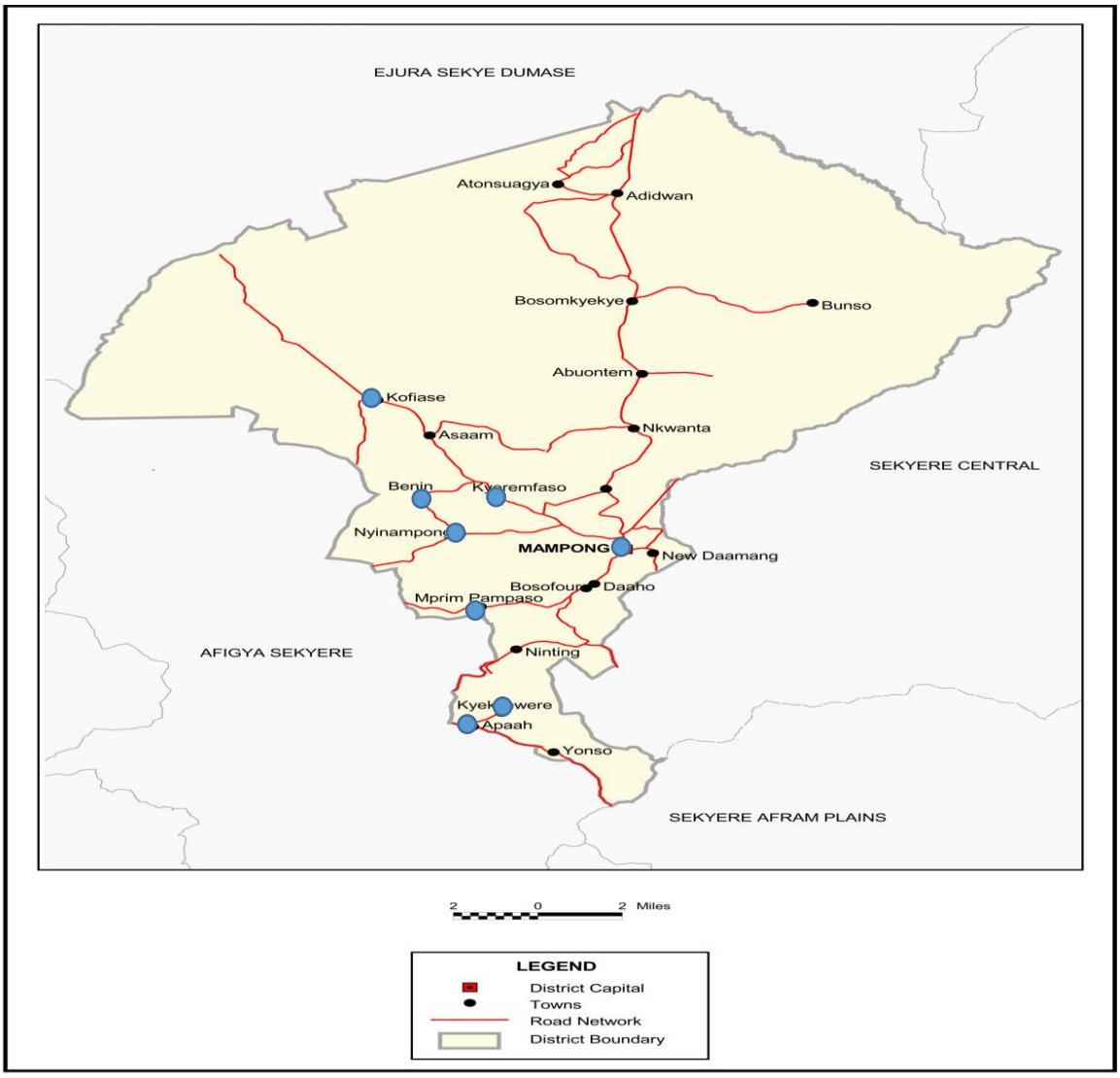
The country has employed several programmes with social protection prospects. In 2007, the National Social Protection Strategy was developed and was later revised in 2012 (MoGCSP, 2015). A holistic National Social Protection Policy became necessary, was developed and approved by Cabinet in 2014 after a Social Protection Rationalization Study in 2013 (MoGCSP, 2015). These programmes have made some significant strides. As of December

2015, many beneficiary households in 185 districts which include Mampong Municipality have benefited from the cash transfer programme, Livelihood Empowerment Against Poverty (LEAP). By 31st January 2017, 250,000 households were expected to be enrolled unto the programmed (MoGCSP, 2020). Also, 40.0% of the country's population was covered under the NHIS by 2014 (Wang, Otoo, and Dsane-Selby, 2017).

This provides the country's demonstration in endorsing the SDGs especially the Goal 1 that seeks to end all forms of poverty (MoGCSP, 2015), and this includes older persons. Hence, given the non-homogeneity of the elderly population, the need to understand how this sub-population participates in social protection programmes, and to what extent their access to quality healthcare is influenced is essential in promoting their overall well-being.

3.2.1.1 Demographic profile of Mampong municipality

This study was conducted in eight communities comprising of two urban centres (Mampong township and Kofiase) and six rural communities (Apaah, Benim, Kyekyewere, Kyeremfaso, Mprim and Nyinampong), all in the Mampong Municipality in the Ashanti Region of Ghana (Figure 3.2). These communities are the eight out of the 10 LEAP-selected communities and are among the 20 largest communities by population size in the municipality (GSS, 2014). They are Akan dominated; though, they have other ethnic groups from across Ghana and the sub-region (GSS, 2014). The municipality is one of the 30 administrative districts in the region formed from the former Sekyere West District by the Legislative Instrument (L.I.) 1908 (GSS, 2014). It has seven zonal councils and managed by the Mampong Municipal Assembly. The assembly plans and sees to the daily administrative maintenance in the provision of services in addition to policy formulation and implementation for its population (Mampong Municipal Assembly Annual Progress (MMAAP) Report, 2016).



Source: Ghana Statistical Service, 2014

Figure 3. 2: Map of Mampong Municipality in the Ashanti Region showing the selected Study site in blue polygons

According to the 2010 Ghana Population and Housing Census (PHC), the population in the municipal rose from 78,056 in 2000 to 88,051 by 2010 (GSS, 2014). However, the 2017 performance review report of the Municipal Health Directorate (MMHD, 2017) estimated the catchment population served to be 99, 924. There was a 12.8% increase in the population representing a 1.3% growth rate in a decade (that is; 2000-2010). The municipality has a female population constituting 51.6% while males form 48.4% of the total population. This translates

into a sex ratio of 0.94. Dependency ratio in the municipality is 84.1 and this is higher among males (86.9) than females (81.6). The demographic profile of the municipality shows its youthful population with a huge proportion of it below age 15 years (GSS, 2014). This has implications for the number and proportion of persons that progress into the old age group. The municipality is more rural (54.7%) than urban (45.3%).

Older persons (≥60 years) constitute about 7.1% of the entire population of the study area and this is slightly higher compared to the national figure of 6.7% (GSS, 2013b). Older females are 56.9% of the older population. About 42.0% of the older populations reside in urban centres compared to 58.0% in rural settings.

For the demographic indices, the municipality has one of the lowest crude birth rates in the region. The municipality has a death rate of 7.0 per 1,000 population, marginally higher than the national average of 6.8 deaths per 1,000 population (GSS, 2013c). Mortality rates are higher among males than females and this increases with age; especially in the older ages. This is not different from the national mortality pattern (GSS, 2013c). The crude death rate is higher among male older persons (29 deaths per 1,000 population) than female older persons (13 deaths per 1,000). Migrants constitute 29.1% of the municipal's population. The interplay among these three population dynamics has social, health, economic and cultural implications for the inhabitants including older persons.

3.2.1.2 Socio-economic context of Mampong municipality

About 54.6% of the municipality's population 11 years and older are literate and this is highest for both reading and writing English and Ghanaian language. Among the older population (≥60 years), the literacy rate is about 64.2%. Despite inadequate educational infrastructure for some deprived schools, the municipality has 72 Pre-schools, 85, 58 and 4 Primary, Junior and Senior

High School levels of facilities respectively. At the tertiary level, the municipality has four diploma awarding institutions. These are a Health Assistant Training School, a Midwifery Training School and two Teacher Training Schools. The municipality also has a degree-awarding institution (MMAAP report, 2016). For education, among the population 3 years and above, 1 in every 5 has never attended school and this is higher for females (21.3%) than males (14.6%).

The economy of the municipality is agriculture-based and most farming practices among households are not mechanized. About 61.0% of households are engaged in agriculture, and crop farming is the dominant form of agriculture. Whereas 78.6% of households in rural communities are engaged in agriculture, this is 42.4% among urban dwellers. About 63.0% of the population age 15 years and over are economically active. The main economic activity among residents of the municipality is skilled agricultural, forestry and fishery work (53.8%) followed by a craft and related trade work (10.2%). A majority are engaged in the private informal sector (87.6%), and this is higher for females (90.8%) than males (84.2%).

The municipality benefits from pro-poor social interventions such as the NHIS, LEAP, Youth Employment Agency (YEA), and the National School Feeding Programme (MMAAP report, 2016). Forty-six schools benefit from the National School Feeding Programme across the municipality. LEAP is carried out in 10 pro-poor communities. These include Nkwanta, Mprim, Kofiase, Apaah, Benim, Nyinampong, Kyekyewere, Mampong, Domi and Kyeremfaso. The LEAP covers beneficiaries such as elderly persons aged ≥65 years who are extremely poor, caregivers of orphans and vulnerable children, and persons with disabilities without productive capacity (MMAAP report, 2016). By the end of the fourth quarter in 2017,

the municipality had ten communities with a total of 825 households as LEAP recipients (DSW Report, Mampong Municipality, 2017).

3.2.1.3 Socio-cultural context of Mampong municipality

By traditional governance, the municipality has a paramount under the Mampong Traditional Council. It has 10 divisional or sub paramountcy that reports directly to the King of the Ashanti Kingdom, who are customarily referred to as Abrempong (MMAAP Report, 2016).

According to the 2010 PHC report, the municipality has 19,203 households and mean household size of about 4.5. About 61.0% of households are headed by males (GSS, 2014). Social intervention programmes such as the LEAP and the NHIS are sometimes targeted at the household level (GSS, 2014). This is because, households serve as the foundation in the study of social welfare (Tacoli, 2012).

Marriage is regarded as social status, a responsibility, trust and achievements (Animasahun and Fatile, 2011). One in every three persons aged 12 years and above are married and this is higher among females (40.1%) than males (38.5%). Among older persons, 1 in every 2 is married and this is higher among males (73.3%) than their female counterparts (33.1%). By religion, 68.8% of the population in the municipality is affiliated to the Christian religion while 15.8% belong to the Islamic religion.

3.2.1.4 Health-related context of Mampong municipality

With disability having a direct relation with poverty and a social development issue (GSS, 2014), 2.4% of the municipality's population has one or more forms of disability. The common disability in urban areas is sight impairment while physical disability is the commonest in rural communities. There is no difference by sex.

The top five OPD morbidity in the municipality in 2017 were Malaria, Upper Respiratory Tract Infections (URTIs), Rheumatism and other joint pains, diarrhoea diseases and hypertension (MMHD Report, 2017). The municipal observed a decline in the population prevalence of hypertension from 2.2% (2015), to 2.0% (2016) and 1.5% in 2017 (MMHD Report, 2017). Under-five mortality in the municipality is 29.8 per 1,000 live births. One in every 10 deaths is reported to be due to unnatural causes (GSS, 2014).

The municipality has 18 health facilities. This constitutes 12 public facilities (1 hospital, 5 health centres, and 6 CHPS compounds), 5 private and 1 Christian Health Association of Ghana (CHAG) facilities. By human staff strength, the municipality has 6 medical doctors, 6 medical assistants, 46 midwives, and 36 general nurses. The rest are 67 enrolled nurses, 41 community health nurses, one Public Health Nurse and 14 technical officers (MHD Report, 2017). The municipal's doctor to population ratio is 1:16,654 and that of the nurse is 1:538 (MHD Report, 2017). Significant health-related challenges for the municipality include the limited number of key health staff, poor referral system and poor staff attitudes (MHD Report, 2017). In dealing with poor staff attitudes, strategies outlined include query, transfer and the counselling of affected staff (MHD Report, 2017).

3.3 Methodology

3.3.1 Study Design

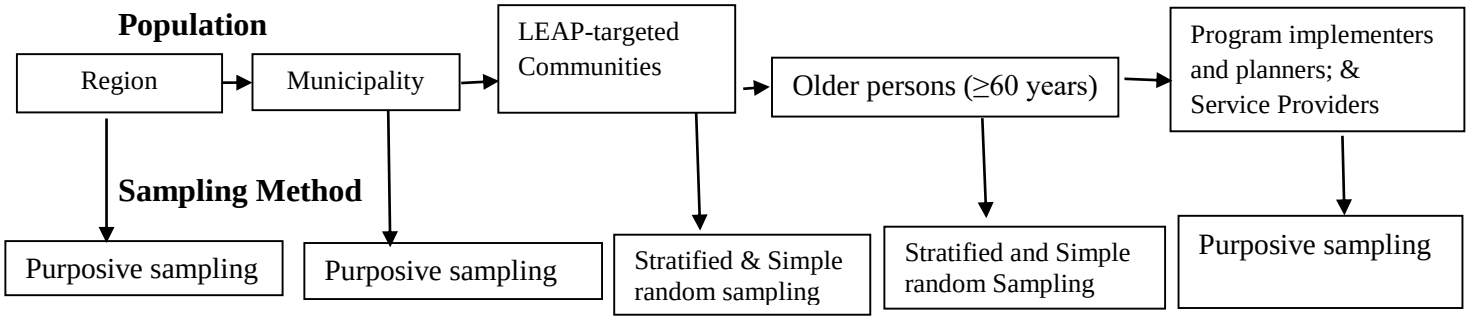
This study utilizes cross-sectional survey and employs a triangulation, mixed-method research design comprising of both quantitative and qualitative data collection, including the author embedding in the community to understand first hand, some of the issues. The study examines the linkage between social protection and quality of care from the individual, household, community and institutional levels. The study was carried out in two phases (qualitative and quantitative research methodology), and this involves the use of primary data collection.

3.3.2 Sampling Procedure and selection

The region for this study was purposively sampled due to its highest proportion (18.0%) of older persons (60 years and above) in Ghana (GSS, 2014). Again, the piloting of the recently abolished health reform, the Provider Payment Mechanism under the NHIS (Capitation Model) was first undertaken in the region. The municipality was also purposively selected. It was one of the four districts selected for the LEAP pilot project in 2008 in the region. Besides, its urban-rural dynamics were fairly similar in terms of the population size relative to the other three (3) districts which were either completely urban (Kumasi Metropolis) or more rural (Konongo and Obuasi Municipalities). The municipality also has close to 900 households under the LEAP programme as well as about 7,000 older persons (≥60 years).

The sampling process for the communities within the Mampong municipality was assisted by the Ministry of Gender, Children and Social Protection (MoGCSP)/Department of Social Welfare (DSW) at the municipal level. The MoGCSP/DSW had existing targeted and selected communities under the LEAP programme. These communities were obtained from the DSW office at the municipality. The eight communities had a total of 84 enumeration areas (EAs) which were made up of Apaah=4, Benim=4, Kofiase=9, Kyekyewere=2, Kyerefamso=3, Mampong township=59, Mprim=1 and Nyinampong=2. These enumeration areas were stratified by location (urban and rural). They were further randomly sampled with the assistance from the Ghana Statistical Service resulting in the selection of 12 EAs for the study with the following sub-units; Apaah – 2, Benim – 2, Kofiase – 2, Kyekyewere=1, Kyerefamso – 1, Mampong township- 2, Mprim - 1 and Nyinampong – 1. The LEAP programme was in full operation in all the selected areas at the time of this study. Two of the eight communities are urban centres, that is, Mampong township and Kofiase. The rest of the six communities are rural settings.

I designed a household register checklist (Appendix 1) to aid in the generation of a household register for the sampling selection. With assistance from research assistants, I carried out a household listing exercise (April 2017) using the household register checklist (Appendix 1) in the 12 EAs in the eight communities. Households with at least one older person (aged ≥ 60 years) were randomly selected from the generated household register. These households were stratified by location (urban and rural) and further by sex (male and female). A simple random sampling method was used to select households with at least one older person. Figure 3.3 shows the flow chart of the respective study population and its equivalent sampling methods.



Source: Author's Development, 2016

Figure 3. 3: A flow chart of the respective study populations and their equivalent sampling methods

To avoid biases, participation in the study was restricted to one older person per household based on the "willingness to participate" method in households with more than one older persons. Both individual and household questionnaires were administered in selected households with at least one eligible older person (Appendices 2 and 3).

3.3.3 Sample size calculation

I computed the sample size for the study based on 57.0% coverage for access to universal basic healthcare among older persons in Ghana (MoGCSP, 2015). The sample size was computed using the formula from OpenEpi Version 3.01 Open Source calculator--SSPropor (Dean, Sullivan & Soe, 2013-updated),

$$n = deff \times \frac{N\hat{p}\hat{q}}{\frac{d^2}{1.96^2}(N-1) + \hat{p}\hat{q}}$$

where

n = sample size

deff = design effect = 1

N=elderly population size in Mampong Municipality= 6,420 (GSS, 2014)

p = % frequency of access to universal basic healthcare for the elderly=57.0%±5

q = 1- p

d= desired absolute precision/absolute level of precision = 5.0%

Therefore,

n = [1*6,420(0.57)(1-0.57)]/[((0.05)^2/(1.96)^2 *(6,420-1)+0.57*(1-0.57)]

n = 356

This results in 356 participants. Due to non-responses, to maintain statistical power, 10.0% was factored into the sampling procedure. Hence, 400 participants were involved in the study.

3.3.4 Methods of data collection

Data collection was carried out at four different levels. These were the individual, household, community and institution. I conceptualized and designed the different data collection tools used for the study. The key areas and detailed data collection tools are presented in Appendices 2-7.

3.3.4.1 Qualitative data collection

3.3.4.1.1 Community-level data collection

I did the community-level data collection using focus group discussions (FGDs) to elicit information relating to community-level awareness and perception about older persons'

participation in SPIs with more emphasis on LEAP and NHIS. FGD as an in-depth interview undertaken in a group (Freitas et al., 1998) was used to further understand communities' perspectives on the experiences (opinion, participation, knowledge, perceptions and challenges) in the linkage between social protection initiatives and access to quality healthcare among older persons. FGD was used to complement the quantitative aspect (Freitas et al., 1998) of this study in gathering additional information. Information including the forms of social protection initiatives, barriers and promoters to quality healthcare, the characteristics of older persons participating in SPIs, and how SPIs influence access to quality healthcare was collected.

I was assisted by opinion leaders (current and former assembly members, and members of Community LEAP committee) who have worked extensively in the communities and have previously been involved in community mobilization and research support to do the data collection. However, I moderated the interviews after briefing the opinion leaders about the study purpose and objectives. I carried out a pilot study in December 2017 in a municipality with similar characteristics like the study area. I conducted the actual data collection for the FGDs in the same month after some interview guide modifications.

Eight FGDs stratified by sex (male and female) and by location (urban and rural) were carried out (Table 3.1). Two FGDs (by sex) were carried out in each of the two urban communities. A similar number was also conducted in the two biggest rural communities (Apaah and Benim). The segmentation by sex and location was to ensure proper representation of study participants to understand quality healthcare among beneficiaries in the context of SPIs. This was also to explore both the variations in participation and perceptions within and between FGD participants (Roelen & Chettri, 2014). Therefore, a total of 60 older persons were involved in

the discussions comprising 35 women and 25 men, and averagely, about seven participants per discussion.

Table 3.1: Number of completed focus groups by population segmentation

Focus Group Discussion Segmentation	**Urban**	**Rural**	**Total**
Male	2	2	4
Female	2	2	4
Total	**4**	**4**	**8**

Source: Author's FGD Qualitative data, December 2017

I collected the data using a semi-structured FGD guide (Appendix 4). Some of the information collected included participation in SPIs, promoters and barriers to quality of care, and the communities' experiences in the linkage between SPIs and access to quality healthcare among older persons. I moderated the sessions in Asante-Twi local dialect, the main dialect spoken in these communities. The selection of the settings for the group discussions were done on the advice of the opinion leaders and study participants' convenience considering their functional ability. These locations were church buildings, school buildings and enclosed corridors of participants' homes within the community to avoid or minimize noise, interruptions and interferences. The discussions were tape-recorded and averagely lasted 47 minutes each. Data in audio formats were translated and transcribed into English and supported with field notes that were taken during the discussions.

3.3.4.1.2 Institutional level data collection

I also conducted institutional level interviews using the in-depth interview (IDI) procedure. This was to gather the needed information, ideas and insights related to institutional-related factors that influence social protection initiatives and access to quality healthcare linkage among older persons. A total of 13 institutions were involved in the in-depth interviews. These were programme planners and implementers, and service providers. They included three municipal organisations – health directorate, MoGCSP/DSW and national health insurance, one representative each from the community LEAP committee by location (urban/rural), three private facilities, and five public facilities at different levels of seeking care (Table 3.2). The directors at the health directorate in charge of health services and the MoGCSP/DSW were interviewed respectively. Furthermore, I also interviewed a member each from the community LEAP committee by location (rural/urban). For each health facility, the administrator, head of administration and finance or the head/representative of the facility was interviewed.

Representatives of these institutions were given prior notice in addition to seeking permission to conduct interviews. I carried out a pilot study in January 2018 in a similar municipality as the study area. I conducted the actual IDIs in the same month. An interview guide, in a semi-structured format, was used for the data collection (Appendices 5-7). Information gathered were related to institutional factors that influence the linkage between SPIs and access to quality healthcare among older persons. I collected the data in both English and Asante Twi languages depending on how comfortable study participants were with the languages. The interviews were conducted at places convenience for study participants. These places of choice included the work premises and homes of study participants to ensure minimal distractions and confidentiality. Interviews were audio-taped and recorded, and on the average, interviews lasted for about 43.44 minutes per interview. With the support of the research assistants, I

transcribed and translated all the audio-files generated from interviews into English. Field notes taken during interviews were also added.

Table 3.2: Number of completed individual interviews by institutional segmentation

Institution	Number of interviews/participants
MoGCSP/DSW	1
LEAP Community Committee Member (rural/urban)	2
Health Services Directorate	1
Government Hospital	1
Health Centre (rural/urban)	2
Private Mission Clinic	1
Private Maternity	1
Private Clinic	1
CHPS Compound	2
NHIS office	1
Total	**13**

Source: Author's In-depth Interview Qualitative data, January 2018.

3.3.4.2 Quantitative data collection

3.3.4.2.1 Individual and Household-level data collection

The main technique I used to collect data at both the individual and household levels was the cross-sectional survey. Information collected at the individual level included the demographic, socioeconomic, behavioural and lifestyle risks, health and health behaviours, quality healthcare (expected and perceived), and disability. Others included work history and benefits, social insurance participation and healthcare utilization, and social networks and integration. Older persons were the main participants. At the household level, dwelling characteristics and

household possessions, food security, financial information and social protection participation were obtained from older persons and/or eligible household members. I collected the data using structured questionnaires (Appendices 2-3). For easy and quality data collection, processing and management, I converted the structured questionnaires into an electronic device using Census and Survey Processing System (CSPro) Data Entry and Analysis version 6.3.2 software (U.S. Census Bureau, ICF International and Serpro, S.A., 2016). Electronic devices embedded with the structured questionnaires were administered face-to-face to older persons (≥ 60 years) and eligible household members. Data collection for the survey was conducted from 25th September 2017 - 31st October 2017. In single households, older persons were the participants for the household level data collection. However, some older persons in more than one member households were assisted in providing accurate household-level information.

Data collection was carried out by four (4) interviewers for whom I recruited and trained for five days (11th September 2017 – 15th September 2017). To ensure quality, accurate and timely data, I organized two refresher training for the field team during data collection. Participatory techniques such as visualizing techniques, scaling and ranking methods utilizing scorecards usually referred to as Community Score Card (CSC) were integrated into the survey interviews. CSC methodology is a participatory process that helps users of services provided to give efficient and useful feedback about the performances of service providers (CARE Malawi, 2013). The use of the scorecard for Section 9 on the individual questionnaire (Appendix 2) was to make the interview more interactive aside helping participants in documenting their experiences (giving both their expectations and feedbacks) related to quality healthcare service provision. This was to solicit the perceptions on the quality of care older persons received, in addition to their expectation regarding seeking quality healthcare from health facilities. It was to help promote the extent to which health service provision for older persons could be

improved. Again, the scorecard was also used in conjunction with the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) to assess the disability status of participants (Appendix 2 – Section 7).

3.3.3 Subjects

3.3.3.1 Survey participants

The target population for this research comprised of older persons (60 years and above) who were residents of the Mampong Municipality residing in the eight selected LEAP-targeted communities. I carried out interviews in households with at least one older person randomly selected from the generated population register. The trained research assistants complimented my effort in conducting the interviews. The study population for this work comprised of all older persons aged 60 and above who did not reside in institutional homes but rather in households within LEAP-targeted communities at least within six months before data collection. A total of 416 older persons and their households were involved in the survey. However, the final data analysis covered 400 individuals and households with valid information on variables of interest for this research work.

3.3.3.2 Focus group participants

I did recruitment of participants for the focus group discussions with assistance from members of the community LEAP committee and assembly members under whose jurisdiction the study area falls. Study participants were desegregated by sex (male and female) and by location (rural and urban). Older persons were invited to partake in the study in their homes after they have been briefed about the study, and its benefits and risks. Written Informed consent was obtained from each participant either by thump-printing or appending their signature in the presence of a witness before the commencement of the discussions. The group had averagely seven participants per discussion and a total of 60 older persons for the eight discussions.

3.3.3.3 In-depth interview participants

I recruited participants for the in-depth interviews through their institutions. Prior to the interviews, I sent letters to the various institutions explaining the purpose, role and contribution to the study. The selected representatives (directors, heads, persons with key positions and members) of these institutions gave their written consent after obtaining detailed information about this research work. I conducted a total of 13 interviews covering representatives of community LEAP implementing committees, and the MoGCSP/DSW. The rest included the Municipal office for the National Health Insurance Scheme, Municipal Health Directorate, and persons in charge of selected health facilities (private & public) within the municipality.

3.3.4 Variables

3.3.4.1 Dependent variable

3.3.4.1.1 Quality of care

The main dependent variable for this study is the quality of care and was measured using the quality of care index generated from the perceived level of access to quality of care dimensions. According to Campbell, Roland and Buetow (2000), the concept, quality of care becomes very crucial when individual users are recipients. Access and effectiveness are the two dimensions of quality of care (Campbell, Roland and Buetow (2000). The basis for the definition of quality of care has been the Donabedian's model (Barker, 1995; Irvine & Danaldson, 1993) which is a systems-based framework covering the structure, process and outcome (Donabedian, 1966; 1988).

This study adapted the QUOTE-Elderly instrument to measure quality healthcare among older persons in the study area. The instrument has 32-items and further sub-divided into three scales covering the various components of care. Eight generic statements covered structure and process dimensions respectively with other 16 statements covering category-specific items

(Appendix 2). The QUOTE-Elderly instrument was used because it circumvents the difficulties associated with the level of quality of care based on patient satisfaction score that is usually more subjective (Sixma et al., 2000).

These statements were administered by a 4-point Likert scale with score categories from not-important - 1, fairly important - 2, important – 3, and extremely important -4. Adjustments were made for both culture and language. The feasibility, reliability and validity of the instrument were also tested [Appendices 16-23]. In using the QUOTE-Elderly instrument for this study, quality of care was measured from the perspective of how important each item was to study participants before (expected) and after (perceived) receiving healthcare. This gives the understanding of the extent to which each item was relevant in the provision of quality healthcare.

Again, using descriptive summary statistics and multivariable statistical method, expected and perceived quality of care were further generated respectively. For this, three approaches were used. For the first approach, the descriptive summary statistics on both expected and perceived measures of quality of care were generated respectively. This was based on 32 Likert-scale items. Secondly, the spearman rank correlation was employed to measure the strength of the relationships that exist among these 32 items per each measure.

Finally, Factor Analysis (FA) which is a multivariate statistical approach and a data reduction technique was used to generate expected and perceived quality of care by identifying the number of distinct dimensions for both analyses (Williams, Onsman and Brown, 2010). The Exploratory Factor Analysis (EFA) type of FA was utilized to transform the 32 sets of statements to assess the level of quality healthcare accessed for both measures of quality of

care. The size of the sample that makes up the study' dataset was checked for FA suitability. It is recommended that the ratio for each item per case should be 1 to 10; meaning each item should have 10 cases to be factor analysed (Nunally & Bernstein, 1978). For this study, given a sample size of 400 and 32 items measuring the quality of care, the ratio was 1 item to 12.5 cases. This indicated that the data were suitable for factor analyses. The Bartlett's test of sphericity (Bartlett, 1950) and Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was then applied to assess the factorability of data (Kaiser, 1970; Kaiser, Jiffy, & Mark, 1974). It is recommended that the KMO index should be a minimum of 0.6 for good factor analysis (Tabachnick and Fidell, 2007). The Varimax rotation and Kaiser Normalisation helped in the identification of the various statements that made up similar independent subsets of content.

For the perceived quality of care, study participants rated each of the 32 items of the QUOTE-Elderly instrument (Sixma et al., 2000) based on a five-point Likert scale categorised from *very dissatisfied* – 1, *dissatisfied* – 2, *average/normal* -3, *satisfied* - 4 and *very satisfied* – 5 utilising the patient satisfaction model. The patient satisfaction model helps in the measurement of healthcare quality evaluation (Atinga; 2011, Andoh-Adjei et al., 2018) as well as improving the quality of life of patients (Dagger & Sweeney, 2006). The patient's satisfaction model has also been used in other studies in measuring the perceived quality of care (Atinga; 2011, Andoh-Adjei et al., 2018).

3.3.4.3.1 Examination of expected quality of care

The Bartlett's test of sphericity was significant at 0.05 for FA to be done (Bartlett, 1950) while KMO was between 0 and 1 (Kaiser, 1970). Appendix 16 displays the KMO and Barlett's Test for expected quality of care. The Kaiser-Meyer-Oklin (KMO) value was 0.94, which exceeded the cut-off point of 0.6 for good factor analysis (Tabachnick and Fidell, 2007). The Bartlett's Test of Sphericity was also statistically significant ($X^2 = 9136.59$; $p < 0.001$) at 0.05.

Using the Cattell's scree test (Figure 3.3), the five factors above the breakpoint (that is, eigenvalues exceeding 1) on the scree plot of factors for the expectation scale were retained for further analysis. Five (5) factors with eigenvalues exceeding 1, which explained 17.0%, 14.2%, 13.9%, 13.2% and 7.3% of the variance were generated. These five factors explained a total of 65.6% of the variance (Appendices 17-19). These factors were communication and respect, adequate service delivery, provider attitude, cost and geographic accessibility.

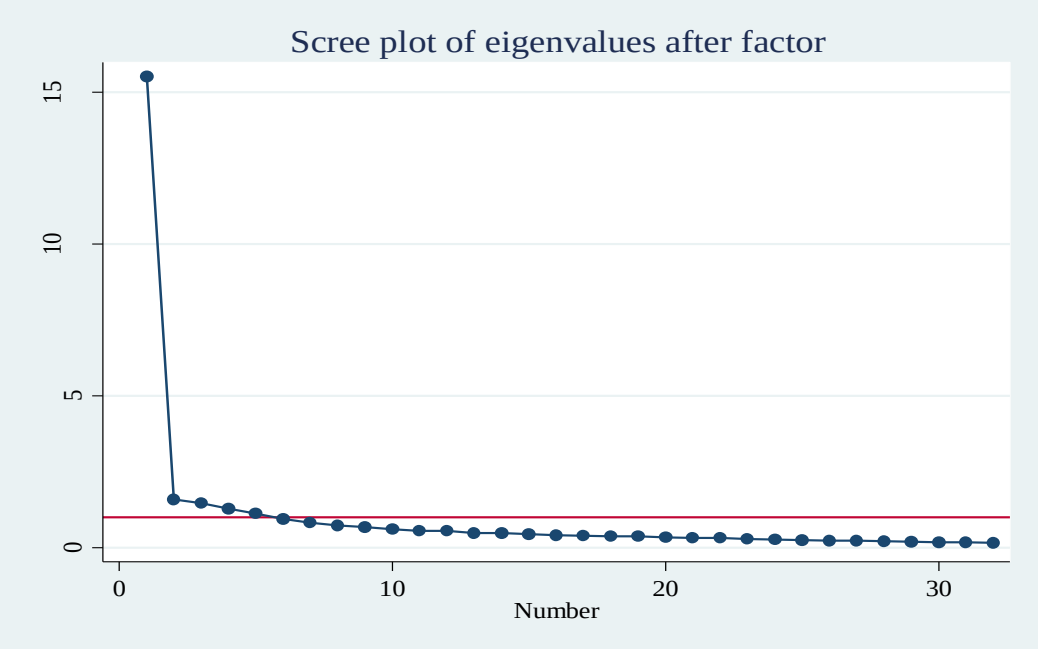


Figure 3. 4: Scree plot: The Expected quality of care based on the extent of importance

3.3.4.3.2 Examination of perceived quality of care

The examination of perceived quality of care was carried out among the study participants that utilised OPD or in-patient care services within the stipulated periods. These reference periods were based on participants' recent contact with the healthcare system to reduce the recall biases associated with self-reporting of experiences in health service utilisation.

The factor analysis was further used to explore the fewer underlining dimensions or factors of the 32 items of the QUOTE-Elderly scale to measure the perceived quality of care. The

Varimax rotation was then applied in the calculation of the extent of variables loaded onto a factor. Factor loading also shows the importance of a specific variable to a factor. The cut-off point was 0.5, and factors with variables below two were excluded. Variables with uniqueness more than 0.5 were dropped from the analysis. The factor analysis was re-run. This was used to measure the internal consistency of the variables in the QUOTE-Elderly questionnaire to determine its reliability between 0 and 1. This resulted in an overall coefficient of 0.932 for the scale. The Varimax rotation with Kaiser Normalisation carried out resulted in a KMO measure of 0.923 and the Bartlet test was significant ($p<0.001$) confirming the adequacy of the data sets docility to the statistical method, factor analysis. A total of six factors were extracted initially by visual inspection based on the Scree plot and the Eigenvalues that were more than one. A total of 27 items were further used for the re-ran and this resulted in the five factors with a KMO of 0.917 and a significant Barlett's Test of Sphericity ($X^2 = 5875.53$; $p<0.001$) at 0.05 (Appendix 20).

The multivariate analysis resulted in the extraction of five factors after a re-ran and rotation (Figure 3.4, Appendices 20-23). The Cronbach's alpha coefficient was 0.932 for the five sub-scales computed from the factor loadings explaining 26.8%, 19.2%, 9.7%, 8.1% and 5.8% of the variance respectively. In total, these five factors explained 69.6% of the variance (Appendix 21). The five factors or dimensions were further categorised into five themes of adequate service delivery, provider attitudes, patient/client dignity, facility easy accessibility, and patient autonomy.

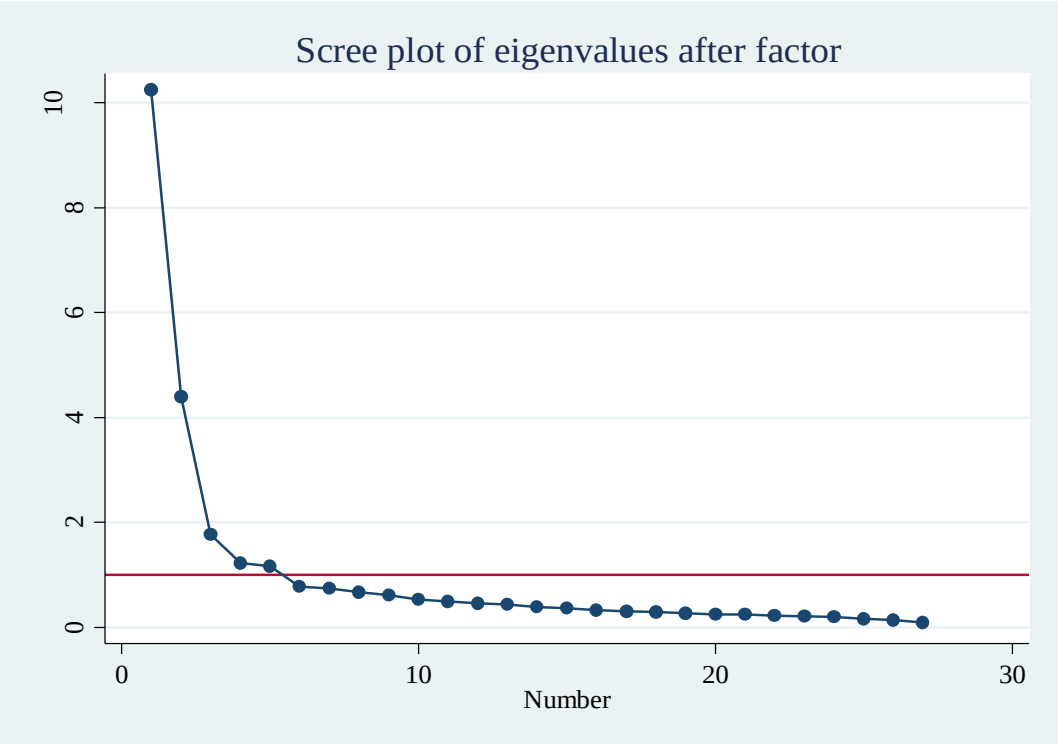


Figure 3. 5: Scree plot:The Perceived quality of care based on patient's satisfaction

To ensure validity, the design features that affected inference were strictly ensured through the proper training for the field team, pilot-testing of survey instruments, and incorporating findings and modifications back into data collection tools. This was done in addition to the carrying out of spot checks as part of quality control during fieldwork to ensure completeness, accuracy and consistency.

Generating the overall quality of care index, a factor score was predicted from the five-factor loadings of the perceived quality of care. The use of the factor score weights each of the items to how it is to the factor (Acock, 2010, 3rd ed). Further, a binary scale was employed for the "quality of care" construct indicated by "poor perception" (a value from -2.996504 to -0.0597194 coded as "0") and "good perception" (a value from 0.0204733 to 0.8522865 coded as "1") levels.

To understand the quality of care in the context of the Andersen Healthcare Services Utilisation Behaviour Model, the quality of care index was regressed against socio-demographic and socio-economic characteristics, lifestyle risk behaviours and health-related factors to identify the predictors of quality healthcare service using the Multiple Logistic Regression (MLR) models. MLR, a statistical technique was used given the dichotomous nature of the dependent variable (Acock, 2010, 3rd edition) and the need to control for all other covariates. Furthermore, to investigate the extent to which SPIs affect the quality of care among older persons, quality of care was used as a binary variable (good or poor perception) derived from the computation of quality of care index. In the framework of the Andersen Healthcare Services Utilization Behaviour model, predictive factors of quality of care (good perception of the quality of care) were further investigated in the context of SPIs.

3.3.4.2 Independent variables

3.3.4.2.1 Social protection variables

Social protection initiatives were the main predictor variable used for this study. The measures of social protection initiatives are based on an individual's social protection status derived from LEAP and/or NHIS. As a fundamental human right issue (Browne, 2015), social protection is crucial for older persons (UN, 1966). This is because, it helps older persons in financial risk management and safeguards them from poverty (WHO, 2015).

In this study, social protection status of older persons is measured and categorized into an individual participating in at least one or both SPIs or not. This has been classified as LEAP only, NHIS only, both on LEAP and NHIS, and none. This was further classified into beneficiary (LEAP only, NHIS only, both on LEAP and NHIS) or non-beneficiary (participating in none of the initiatives) of SPIs. From the study's conceptual framework, these are known as the enabling factors.

3.3.4.3 Control variables

A range of factors was controlled for in this study. These included household characteristics such as wealth index and food security. Individual demographic characteristics controlled for constituted age, sex, religious affiliation, marital status and location. Socio-economic characteristics controlled for comprised of education level attained, occupation and having received social support in cash or in-kind. Other factors considered were lifestyle risk factors such as smoking status and alcohol consumption. Variables that were also controlled for were living arrangements like household size and having a primary caregiver. Health-related characteristics such as self-rated health status, functional disability status, disease condition and illness/injury were controlled for in the study. Other health-related variables controlled for were the type of health service accessed and the place of seeking healthcare services. Table 3.3 presents the various types of variables, how each was measured, and utilized in the study.

Table 3.3: Variable description, measurement and form of utilisation and categorisation

VARIABLE	DESCRIPTION & MEASUREMENTS	FORM OF UTILISATION & CATEGORISATION
DEPENDENT VARIABLE		
Quality of Care (QoC) - Perceived	The final factor scores generated from 27 of the 32- items resulted in five components covering the elements of quality of care.	1.Catergoricial (by factor score) Poor perception level: -2.996504 to -0.0597194 coded as "0" Good perception level: 0.0204733 to 0.8522865 coded as "1"
INDEPENDENT VARIABLES		
Social protection initiatives		
Social Protection Status	Status of participants in participating in social protection initiatives (LEAP &/or NHIS, and none). Classifications of type of social protection initiatives by participants.	Categorical 1 Beneficiary Non-beneficiary Categorical 2 LEAP only NHIS only LEAP & NHIS None
Households control variables		
Household wealth index	The household wealth index score computed based on household living assets and possessions such as television, type of floor and water source.	Categorical Poor Middle Rich
Household food security	Household food security was measured as the availability and access to food by households of study participants within the last 30 days preceding the survey. Three questions were utilized based on availability, access and time reference (Appendix 3). Responses were further transformed into a binary scale utilising the Additive technique.	Categorical Food secured Not food secured
Individual control variables		
Demographic characteristics		
Age	Age of participants in completed years	Categorical 60-64 65-69 70-74 75-79 80-84 85+
Sex	Sex of participants	Categorical Male Female
Religious affiliation	Religious affiliation of participants	Categorical Catholic/Protestant Pentecostal/Charismatic Other Christian Non-Christians

Marital status	Marital status of participants	Categorical Married Widowed Divorced/Separated Never married
Location	Place of residence of participants	Categorical Rural Urban
Socioeconomic characteristics		
Education level attained	Completed level of education attained by participants	Categorical No education Primary Middle Secondary and above
Occupation	Type of work participants are engaged in	Categorical No occupation Agriculture Non-agriculture
Received social support	Having received any cash or in-kind from a relative or friend in the last 12 months before the survey.	Categorical Yes No
Lifestyle risk behaviours		
Smoking status	Assesses the smoking patterns and behaviours of participants in their lifetime.	Categorical Never smoked Ever smoked
Alcohol consumption status	Assesses the consumption of alcohol patterns and behaviours of participants in their lifetime.	Categorical Never consumed alcohol Ever consumed alcohol
Living arrangements		
Household size	The total number of persons in the participants' household.	Categorical Alone 2-3 members ≥4 members
Having a primary caregiver	Someone who lives/does not live with participants and provides care and/or support financially or non-financially.	Categorical No Caregiver Same household Separate household
Health-related characteristics		
Self-rated health status	Perceived health status of participants	Categorical Good Moderate Bad
Functional disability status	Computed using the WHODAS 2.0 with a 12-item which covers six disability domains in the 30 days prior to the assessment to measure the extent of disability of participants	Categorical Yes = 1 to 44 coded as "1" No = 0 as "0"
Disease condition	Assesses at least one specific health condition and symptoms covering both communicable and/or non-communicable diseases participants have been diagnosed or believe to have or have had.	Categorical No Yes

Injury/Illness	To examine recent history of illness/injury in the last one month prior to the survey among participants	Categorical Yes No
Type of health service accessed	This constitutes In-patient and out-patient care services. In-patients care service refers to participants' recent contact with the delivery care system by admission in the last 12 months preceding the data collection. Out-patient care service refers to participants' recent contact with the delivery care system by non-admission in the last four (4) weeks preceding data collection	Categorical In-patient care service Out-patient care service (OPD) Did not seek care
Place of seeking care	Assesses the place participants sought care.	Categorical Hospital Polyclinic/health/clinic/mission Pharmacy/drug store/Chemical store Other Did not seek care

3.3.4.4 Other measures and definitions

Promoters of quality healthcare

These are the reasons for which participants were satisfied or very satisfied with the quality of care received at the health facility. Promoters of quality healthcare are measured using reasons such as availability of drugs and equipment, qualification of health staff, cleanliness, good attitude of staff and short waiting time. The rest is an administrative process less complicated, health education, other reasons, got well and affordability.

Barriers to quality healthcare

These are reasons for which participants were dissatisfied or very dissatisfied with the quality of care received at the health facility. Barriers of quality healthcare are measured using reasons like drugs of low quality, unavailability of drugs, services of low quality, and inadequate training for health staff. The rest are long waiting time, not recovered and very costly.

Predisposing factors

The socio-demographic (age, sex, etc), socio-economic characteristics (education, occupation, etc), behavioural (lifestyle risk factors – alcohol consumption and smoking) factors and, living arrangements (household size and having a primary caregiver) that existed at the time of the survey and they describe the tendency of individuals to utilize services (Aday and Andersen, 1974).

Enabling factors

Factors that describe the means available to study participants to use services such as social assistance (LEAP) and/or social insurance (NHIS).

Need factors

Need factors are the most immediate cause of health service use. Self-rated health status, functional disability status, disease condition, and illness/injury are used to measure need factors.

Political factors

Political factors are statements with direct bearing from governance (political system) based on political administration's policies and programmes which may affect SPIs and access to quality healthcare linkage positively or negatively. These are measured using the introduction of NHIS and LEAP, and abolishing of the capitation model of the NHIS as positive effects. Change in political administration, and government policies and directives that affect SPIs-quality of care linkage, and perceived use of NHIS and LEAP as electoral baits as negative effects.

Economic factors

Economic factors are reasons with direct impact on the cost-effectiveness and financial position of institutions that may affect SPIs and access to quality healthcare linkage positively or negatively. These are measured using NHIS as main source of internally generated fund (IGF)

and reduction in abscondment incidence which increase health facility's income as positive effects while delay in the payment of NHIS claims and lack of motivation for LEAP volunteers as negative effects.

Technological factors

These are factors with direct bearing on the technical activities/training of programme planners and implementers, and service providers that may affect SPIs and access to quality healthcare linkage positively or negatively. Also, these cover resources, staff and professional content, and equipment. They are measured as positive (use of biometric registration, issuance of electronic and existence of equipment for peculiar disease) and negative (poor internet connectivity, limited infrastructure/health personnel to meet the demand of older persons, lack of basic/special equipment/trained health personnel for elderly care, lack of logistic for service provision and structural design of health facilities infrastructure/furnishings) effects.

Legal factors

These are factors that may receive direct bearing from the legal angle (legislative instruments and Acts/legal frameworks) that may affect SPIs and access to quality healthcare linkage positively or negatively. The definition of legal factors included accreditation for health facilities and referral system as positive effects while non-existence of a focused policy on the care for the elderly, variations in the definitions of older persons, and mandated service delivery per facility level of operation as negative effects.

Environmental/geographic factors

Environmental/geographic factors are defined as factors which are influenced by the environment, and the location from which program planners and implementers, and service providers carry out activities which may affect SPIs and access to quality healthcare linkage positively or negatively. The presence of CHPS compound at the community level was used to define positive effects while poor transportation network was sued to define negative effects.

Socio-cultural factors

They are defined as factors which are influenced by beliefs, norms, and values of services provided by institutions that may affect SPIs and access to quality healthcare linkage positively or negatively. These included respect for older persons and cooperate social responsibility as positive effects, and witchcraft accusation, breakdown of family support system and culture of health seeking behaviour as negative effects.

Communities

In this study, community is defined as a clearly distinct geographic territory with a number of people who regularly interrelate with each other as a group, usually share common values, beliefs, attitudes in addition to economic and social services (Hall, 2018).

Urban centres

Urban centres are settlements with a population of 5,000 people or more (GSS, 2013c).

Municipality

A municipality is a single compact settlement with a minimum population of 95,000 people (Institute of Local Government Studies (ILGS) and Friedrich Ebert Stiftung-Ghana, 2016). A metropolitan area or municipality may be considerably larger than an urban area and may contain some rural area (GSS, 2013c).

Zonal councils

Zonal councils are found in the "one-town" Municipal Assemblies with a population of 3,000 (ILGS and Friedrich Ebert Stiftung-Ghana, 2016).

3.3.5 Method of analysis

Some analytical techniques covering both quantitative and qualitative analyses were employed in answering the research questions and meeting the study's objectives. For the qualitative data analyses (FGDs and IDIs), thematic technique approach was used (Attride-Stirling, 2001) with the assistance of the Atlas-ti version 7.5.7. Firstly, from the recordings of the discussions and

interviews, transcripts were read through for data familiarisation after transcribed and translated into the English language. Secondly, to provide structure and conceptual clarity on the process of coding, codes were assigned to segments of records. Initial codes were deductively derived from literature and earlier studies on social protection initiatives (Pearson, Webb & Ashenafi, 2010; Arnold, Conway, & Greenslade, 2011) and access to quality healthcare (Donabedian, 1966; Donabedian, 1997; Donabedian, 1980; Sixma et al., 2000).

Unexpected themes also emerged from the transcripts and these were the inductive codes. To further explain the coverage and depth of the themes across transcripts, emerging themes were compared against each other. To investigate the linkage between SPIs and access to quality care among older persons, coding frames that describe the relationships between codes and frequency were generated. Additionally, the relationship between basic themes, organizing themes and the global themes were displayed using thematic networks.

Furthermore, I exported the quantitative data (survey) collected with the electronic device into STATA version 14.0 software for cleaning, recording and analysis. Data analyses were carried out using descriptive techniques such as percentages and proportions, and the multivariate statistical technique, which is a data reduction technique [Appendices 16-23]. Multiple logistic regression modelling was also employed to examine the predictors of SPIs, access to quality healthcare, and the extent of linkage between the two.

Variables used in the regression models were tested for multicollinearity. Multicollinearity occurs when two or more predictors are correlated (Daoud, 2017; Alin, 2010; Hair et al., 2010). These correlated predictors do provide redundant information about the response (Hair et al., 2010). Multicollinearity was measured by Tolerance and Variance Inflation Factors (VIF), and

it was not a problem in this study. Tolerance is how much the variability of a specific independent variable is not explained by other independent variables in the model, and it is by the formula, 1 - R^2 for each variable (Daoud, 2017). VIF on the other hand is the inverse of the Tolerance value (1 divided by Tolerance) (Daoud, 2017). In this study, Tolerance values for the various independent variables were between 0.453 and 0.917, which are more than 0.10; hence, the assumption underlying multicollinearity has not been violated (Hair et al., 2010). Also, the mean VIF value was 1.34 with a range between 1.09 and 2.21 which is well below the cut-off of 4.0 (Hair et al., 2010).

3.3.5.1 Objective 1: Explore the forms of social protection initiatives for older persons.

This objective was answered utilising both the quantitative and qualitative analyses. Firstly, participants' awareness of the various forms of social protection initiatives was examined using descriptive techniques. The various forms of SPIs older persons are beneficiaries or knew of were elicited from the survey responses. The second approach involved qualitative analysis of the FGD data on various forms of social protection programmes older persons were aware of. Transcripts from the qualitative data (focus group discussions) were read severally to extract the different forms of social protection programmes that older persons were engaged in or were aware of irrespective of the source of assistance. In this study, these were further grouped into different typologies covering the formal, informal, and semi-formal guided by the form of principles guiding the initiative, source of funding and the accountability-related issues (OSSREA, 2013).

The most preferred channel of information on SPI messages among study participants was also examined utilising frequencies and proportions. Study participants' perceptions of SPIs were further explored using the multivariable statistical technique. Also, a thematic analysis

approach was used to explore the perceptions of SPIs from the qualitative mixed methods (FGDs and IDIs).

3.3.5.2 Objective 2: Identify the predictors of participating in social protection initiatives for older persons.

This objective was accomplished using a two-stage analytical approach. Firstly, frequencies and proportions were used to examine the characteristics of the study participants. Multicollinearity was examined among variables that were found to be significantly associated with social protection status (category 1) and was further used in the multiple logistic regression analysis models.

For the second phase of the analysis, the significant effects of influential factors that were non-collinear on social protection initiatives (category 1) were determined utilising the multiple logistic regression model. The multiple logistic regression analysis was carried out because participating in SPIs is influenced by factors at different levels, namely, individual and at the household. Hence, older persons are more likely to be exposed to similar factors that may affect their participation in SPIs. To enrich the interpretation of data, the formula below was used to fit the model;

$\log(\pi/1-\pi) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \cdots \beta_m X_m$ ---------- (Sperandei, 2013)

Where π = indicates the probability of SPI participation

β_i= the regression coefficients associated with the reference group;

X_i= indicates the explanatory/control variables such as the predisposing, enabling and need factors of the study participants.

Using the thematic approach emerged sub-themes related to the characteristics of older persons participating in SPIs derived from transcripts of FGDs and IDIs were also added.

3.3.5.3 Objective 3: Examine the promoters and barriers to quality healthcare for older persons

Both quantitative and qualitative analytical methods were used to achieve this research objective. The classification of promoters and barriers to quality of care was assessed based on reasons cited by study participants on their overall satisfaction at their most recent contact with the healthcare system using descriptive techniques. Among the 75.7% (303/400) of the study participants who utilised healthcare services in the last four (4) weeks (OPD) and/or in the last 12 months (in-patient care) preceding the survey, a majority (270/303) of them reported to be satisfied with the overall healthcare services. About 6.3% (19/303) indicated a normal/average care received from the health system. About 5% (14/303) expressed their dissatisfaction with the overall quality of health service. Assigned reasons for being satisfied (promoters) or dissatisfied (barriers) were further classified in the context of the three dimensions of Donabedian's quality of care model. The thematic technique was also used to extract emerged themes from FGDs in line with the three dimensions of quality of care. Results are presented in themes supported with quotes.

3.3.5.4 Objective 4: Investigate the extent to which social protection initiatives affect access to quality of healthcare among older persons.

The two main analytical methods, that is, quantitative and qualitative, were used to achieve this objective. For the quantitative analysis, the multiple logistic regression models were utilised. In the first analytical method, two models were run to study the relationship between social protection initiatives (category 1) as an independent variable and quality of care (dependent variable). Model 1 studied the relationship between SPIs and perceived level of access to quality of care among the study participants. In Model 2, covariates were controlled for in the analysis of the relationship between the independent variable and perceived level of access to quality of care. In the second analytical method, thematic codes related to the extent to which

SPIs affect the quality of care were explored from the focus group discussions with some triangulation from the in-depth interviews.

3.3.5.5 Understand communities' perspectives on the linkage between social protection initiatives and access to quality of care among older persons.

This research objective was also achieved through the qualitative analysis method. A thematic approach was used for the analysis and results are presented in quotes and thematic networks.

3.3.5.6 Explore institutional-related factors that influence social protection initiatives and access to quality healthcare linkage among older persons.

Utilising the transcriptions from the in-depth interviews with institutions, thematic analysis was employed as a qualitative analytical method to achieve this objective. Results were presented in thematic networks with supporting quotations.

3.3.6 Ethics of Human Subjects Research

I sought ethical clearances from the Ethics Committee for Humanities (ECH) of the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana-Legon [Protocol Number: ECH 096/16-17] and the Ethics Review Committee (ERC) of the Ghana Health Service (GHS) [Protocol Number: GHS-ERC: 03/05/17]. Obtaining ethical clearance from ERC/GHS helped to conduct a section of the in-depth interviews at its health facilities. Permission was also sought from the Regional Health Directorate and the Ministry of Gender, Children and Social Protection/Department of Social Welfare in the Ashanti Region. Furthermore, permission was obtained from the Mampong Municipality, the Municipal Health Directorate, Department of Social Welfare and National Health Insurance Office. I also carried out community entry at the various LEAP-targeted communities covered under this research work through opinion leaders (current and former assembly members, and members of Community LEAP committee) before the commencement of the data collection. Participants

were given detailed information regarding this research. Participants were informed of the need to consent before participation. They were assured of the confidentiality of their participation in this study regarding their information. They were also informed of the non-invasiveness of this study, and that participation was voluntary. This information was thoroughly explained verbally in the language best understood by study participants. Each participant was then asked to sign or thump print consent form (Appendices 8-13) after the form had been read aloud to participants or was read by participants. Appendices 8-13 detail the study procedures, information regarding consenting and the consent statement, and the rights of study participants.

3.4 Limitations of the Study

Some limitations may have influenced the results of this study and it is necessary to point them out. Firstly, the household survey was cross-sectional in nature and causality of the outcome of interest could therefore not be established. This may be attributed to the challenge of time-sequence in the determination of factors associated with the perceived level of access to quality healthcare. Some characteristics like participating in SPIs as an enabling factor, need factors (functional disability, having disease condition, injury/illness, self-rated health status), and occupation as a socio-economic characteristic may have changed after seeking care. Therefore, these characteristics may not necessarily determine the perceived level of access to quality of care. The association between SPIs and these factors particularly need factors may have been different before or after accessing healthcare. Knowledge about the existing state of these characteristics before and after accessing healthcare would have helped in understanding the effect of these variables on the perceived level of access to quality of care. Again, the findings from the qualitative data cannot be generalized in the study area. However, the study findings provide a useful understanding of knowledge and insight of access to quality healthcare in the context of SPIs.

Another limitation is with the measurement of some of the variables. For instance, the measure for access to quality of care in this study was based on the self-response of participants and did not assess their views to changes in the structure and process elements of quality healthcare. This was based on perceptions, and are often subjective. Nevertheless, perceptions of quality of healthcare highlights service gaps (Blendon et al., 2008), and are usually linked to overall health outcomes (Cleary, 1999; P.D. Cleary and S. Edgman-Levitan, 1997).

Again, the study assessed older persons who utilised OPD and In-patient care but did not assess patient-doctor/nurse interactions by observation. This may not reflect the overall quality of care in this setting. There is a need for future studies to incorporate the effect of patient-health service provider interactions. This will help to understand the changes in structure and process elements of quality of care to determine the overall quality of care in this study area.

Further, the measures for SPIs may have contributed to the non-significant association between SPIs and perceived level of access to quality of care. The measurement was on whether an individual was a beneficiary or not a beneficiary. But, the limited sample size did not allow for the disaggregation per social protection status such as NHIS only, LEAP only, both NHIS and LEAP, and none. These may be improved measures of participating in social protection initiatives to detect its effect on the perceived level of access to quality of care.

The use of older persons in focus group discussions to measure communities' perspectives on SPIs and access to quality healthcare linkage does not necessarily reflect the views of the entire community. However, this provides relevant information from older persons' perspectives on the linkage between SPIs and access to quality healthcare.

CHAPTER FOUR

FORMS OF SOCIAL PROTECTION INITIATIVES AMONG OLDER PERSONS

4.1 Introduction

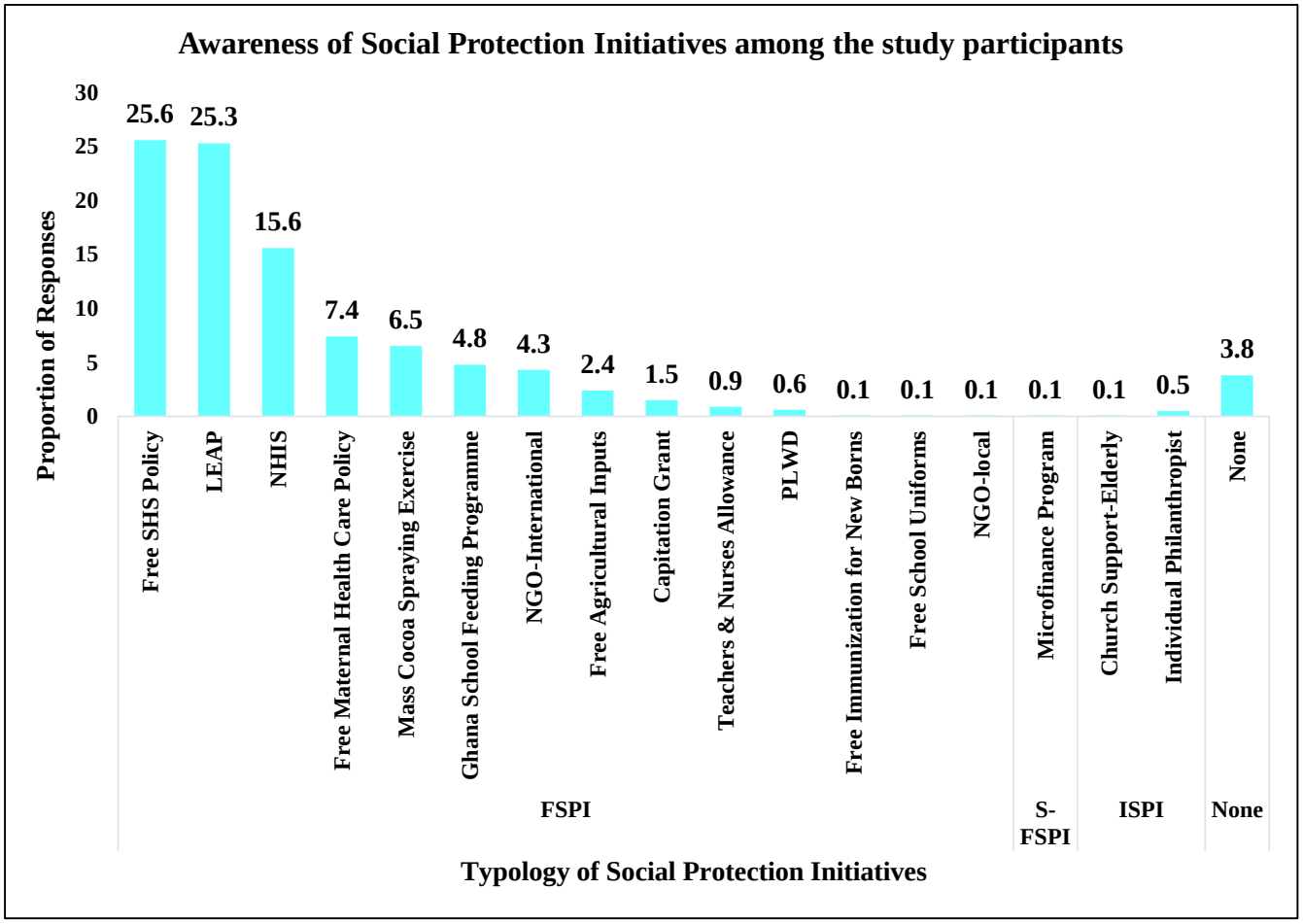
Social protection initiatives (SPIs) which encompass both contributory schemes (social insurance) and non-contributory taxed-fined schemes such as social assistance are crucial in promoting sustainable development, poverty reduction and decent economic activities among beneficiaries (International Labour Organisation (ILO), 2017). According to the 2017-2019 World Social Protection report, it is estimated that at least 45.0% of the world's population benefits from one social protection programme or the other (ILO, 2017). Nevertheless, only 29.0% receive the full range of benefits stemming from child and family to old-age pensions creating a gap of 71.0% (ILO, 2017). This has been attributed to the less investment attention social protection has received in most continents including Africa (ILO, 2017). Old-age pensions are the most widespread form of social protection for older persons (ILO, 2017).

This chapter explores the forms of social protection initiatives among older persons using both quantitative and qualitative methods. Furthermore, the perception levels of the two key SPIs of interest (LEAP and NHIS) are examined. Results from the analyses are presented utilising visuals including charts, graphs and tables. Supporting quotations from the qualitative analyses are also included. Where possible, sex and location variations are highlighted.

4.2 Awareness of the forms of Social Protection Initiatives

The awareness of social protection initiatives was based on self-reporting among the study participants and is presented in Figure 4:1. The results showed that about 96.0% of participants

were aware of the existence of at least one social protection initiative. Only four percent had no idea of the existence of any SPI in the study area.



FSPI Formal Social Protection Initiatives **SFSPI Semi-formal Social Protection Initiatives**
ISPI Informal Social Protection Initiatives

Source: Author's Field Survey (Ageing, Social Protection & Health Systems project), September 2017 – October 2017.

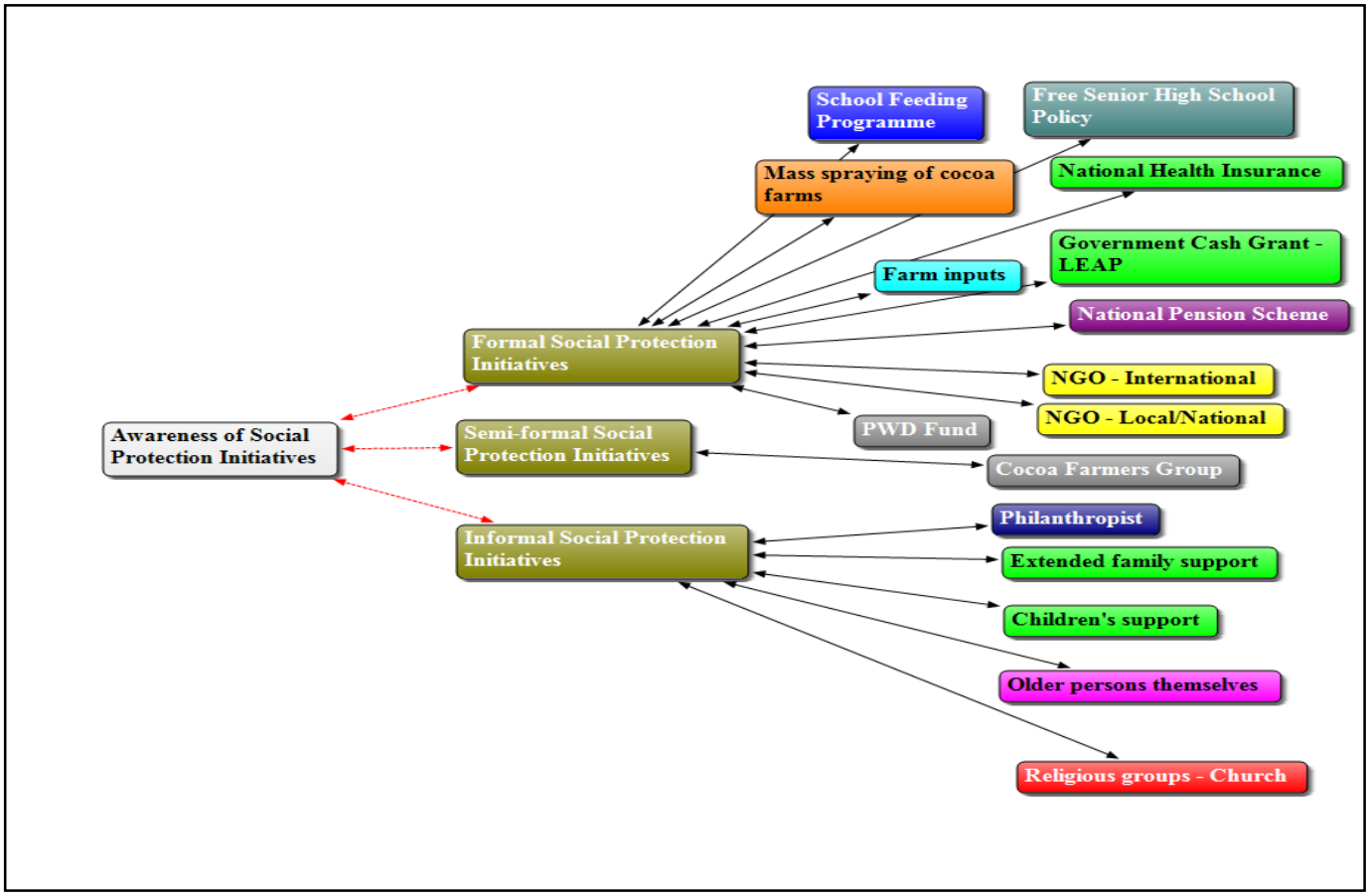
Figure 4. 1: Awareness of social protection initiatives among the study participants per proportion of responses.

Formal social protection initiatives (FSPIs) were the most commonly reported among participants. Free Senior High School Policy (25.6%), LEAP (25.3%) and NHIS (15.6%) were the top three mentioned FSPIs (Figure 4.1). Community microfinance program was the only SFSPI mentioned by participants. Church support for older persons and individual

philanthropists were the informal social protection initiatives stated and each had responses lower than one percent.

The three typologies of social protection initiatives awareness and their respective linkages were generated using the thematic network from the FGDs (Figure 4.2). The study found formal mechanisms as the most commonly known initiatives among both urban and rural participants respectively. While 10 components including LEAP and NHIS identified as formal mechanisms of SPIs, informal mechanisms were five. These included the extended family support (within or outside the family), child support (voluntary or based on reciprocity), a religious group especially the church, individual philanthropists, and older persons themselves (self-help group). Cocoa farmers group was the only mechanism as semi-formal SPI reported by study participants.

Irrespective of location and sex, four mechanisms of SPIs were consistently mentioned by participants. These were the LEAP, NHIS, and the supports from both extended family, and children (coded green – RM, RF, UM and UF). The mechanisms of social protection initiatives such as Non-Governmental Organisation (both local/national and international) were stated only among rural female (RF - Yellow colour coded) group. Persons With Disability (PWD) Fund and Cocoa Farmers Group were cited among only urban male (UM- Ash colour coded) group. Older persons themselves, like a self-help group as a social safety net was identified among the urban female (UF – Pink colour coded) FGD participants.



Source: Ageing, Social Protection & Health Systems project -Qualitative data, December 2017

Figure 4. 2: Thematic network for the typology for the awareness of social protection initiatives among the study participants.

Legend

RF	UM	RM & UM	RF, RM & UM	RF, RM & UM
UF	RM & UF	UM & UW	RM, UM & UF	RF, RM, UM & UF

Interestingly, the results showed that free senior high school policy had the highest responses among survey participants. However, this was identified in three of the FGDs except in the female urban group.

Generally, there was high awareness of the various mechanisms of SPIs among the study participants. Results from both the survey and FGD analyses showed that the general awareness of SPIs was more related to the formal social protection initiatives. This could be attributed to

the rise of the number of formal social protection mechanisms over other typologies of social protection especially the informal mechanisms. This corroborates findings from other studies (Devereux & Getu, 2013). Participants highlighted the supports that NGOs (local and international) give to their communities. International NGOs provide support for children's educational needs such as school enrolment and educational materials. Local NGOs organise health screening for community members, provide household items to the physically challenged in addition to the supply of educational materials to children of school-going age. This supports the fact that SPIs are not only provided by the state, but non-state actors such as international and local NGOs are involved to complement the efforts of the state institutions.

FGD participants also cited the eroding of extended family and children's supports as a mechanism of SPIs, especially for older persons. Participants narrated that factors responsible for this change are the migration of the younger generation into bigger towns and cities for livelihood and the lack of employment opportunities for decent livelihoods, especially in rural communities. Other reasons pointed out included family neglect of the elderly due to accusations of witchcraft, negative advice from religious leaders like pastors, economic hardship, and the loss of benefactors due to death. Older persons with no surviving child/children or childless and those who never gave support to their family members at their youthful stage in life (reciprocity) do also suffer due to the changing patterns in the family support system. Some participants had this to say about attributing witchcraft to growing old:

> *"Due to the belief in witchcraft, it has become difficult for even the children of your siblings to give you some support in your old age. It was not like that in the olden days…. But now, it has all changed due to the fear that some older persons have evil spirits to cast spell on other people who do them good"* – (Female Rural-FGD).

The issue of attributing old age to witchcraft was also reported. One urban IDI participant recommended the need for intensive public education. Attribution was made towards the backwardness of existing culture, ignorance and lack of knowledge. A participant had this to

say:

> *"Due to the backwardness of our culture, ignorance and the lack of knowledge, once you are growing old and have body changes, then that is for witchcraft. … . The need for education is very important"* - (Administrator, Hospital – Urban IDI participant).

Different interpretations were provided regarding LEAP. Most study participants referred to it in the local (Akan) language as "mmoborofoo sika" meaning "money for the poor or vulnerable", or "mmerewafo ne nkokorawafo sika" that is "money for the elderly". Others also referred to it as "ayarefo sika" meaning "money for the disabled". For the NHIS, the common name in the community was "insurance". Observations in the field showed how some of the study participants did not want to be connected with the cash grant programme due to the local name attached to it. It was seen as a stigma to being referred to as "poor" or "vulnerable" or "a terminally ill person" who needs such government assistance. On the contrary, other participants yearned for its expansion to cover all older persons due to old-age poverty. Participants attributed old age poverty to the result of an entire working life spent in the informal sector such as subsistence farming with no pension schemes.

Participants elaborated on challenges associated with SPIs. Study participants admitted that, although they were aware of the existence of SPIs, the depth of knowledge about the functions, overall operations, entitlements, and the selection process were limited. Study participants attributed these to the limited education and information on the process of becoming a beneficiary, transparency and knowledge about the programmes, as well as the selection criteria. Another issue mentioned was the extortion by some officers involved in the programmes. The knowledge gap about these initiatives may have contributed to the poor code of practices of some officers involved in the programme implementation.

4.3 Preferred channel of communicating messages on the SPIs of primary interest

Radio (48.3%), followed by information van (18.0%), and the community/information centre (16.9%) were the most preferred channel of communicating messages on SPIs among study participants who heard messages on LEAP and/or NHIS in the last three months preceding the study. Home visit (3.8%) was the least cited preferred source. Other sources included television, billboard, mobile phone text messages, community members, and from SPIs programme implementers (13.0%). The most preferred channel being radio could be attributed to the fact that most study participants live in households that own an electronic media gadget such as the radio. Another reason may also be due to the mistrust participants have for programme officers.

4.4 Perceptions of Social Protection Initiatives among the study participants

To measure the levels of perception of the study participants about the primary social protection initiatives of interest, a list of perception statements was used to elicit their responses.

4.4.1 Perceptions of LEAP

Table 4.1 depicts the descriptive statistics on participants' perceptions of LEAP. A total of eight statements/domains were used in measuring perception for LEAP in the survey. The calculated mean and standard deviations (SD) showed a lower SD indicating their closeness to the mean. Most study participants scored between 2.31 (bad) and 3.08 (fair). The least scored (2.31) domain was "*Mode of payment*" and the highest scored (3.08) was "*Awareness*".

Table 4. 1: Descriptive statistics on the perception of LEAP among the study participants

	Mean	(SD)	Minimum	Maximum
Attribute				
1. Awareness	3.08	(1.481)	1	5
2. Accessibility	2.59	(1.507)	1	5
3. Mode of payment	2.31	(1.517)	1	5
4. Usefulness	3.04	(1.543)	1	5
5. Significant change in living	3.00	(1.516)	1	5
6. Significant change in accessing healthcare	2.96	(1.489)	1	5
7. Healthcare utilisation change significantly	2.90	(1.507)	1	5
8. Significant change in access to quality healthcare for the elderly	2.93	(1.520)	1	5

Source: Author's Field Work, September 2017 – October 2017. Number of observations =400

The exploratory factor analysis was carried out with the eight domains (Table 4.1). The KMO sampling adequacy measurement generated a value of 0.91 and Bartlett's test of sphericity was also significant ($p<0.001$). This implies the sufficient correlation between variables for the level of perception measurement.

For the reliability of the scale in the measurement of the level of perception for LEAP, the Cronbach's alpha (α) indicated a value of 0.95. This was higher than the minimum alpha value level of 0.7 proposed (Nunally & Bernstein, 1978). This depicted a higher reliable scale for the perception of LEAP measurement. It also demonstrated the statements' contribution to the internal consistency of the scale. One factor was extracted with an eigenvalue greater than 1 (Figure 4.3). This accounted for the cumulative value of 73.6% for the total variance explained in the Varimax with Kaiser Normalisation rotation solution (Table 4.2).

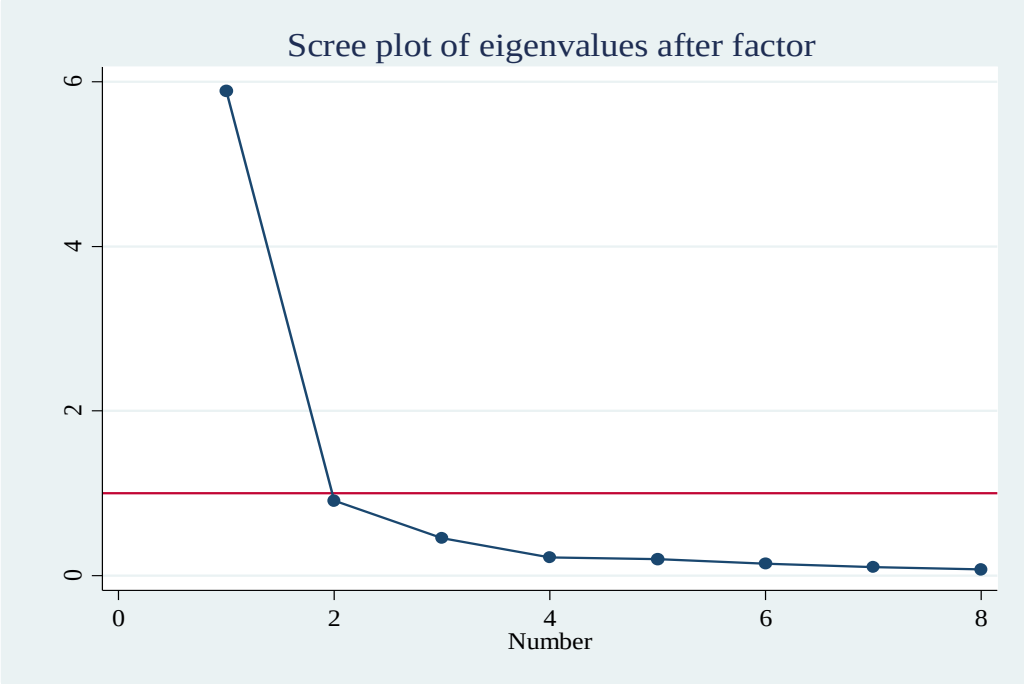


Figure 4.3: Scree plot: The Perception of LEAP

Given the high loadings (≥ 0.5) on the one factor for all the items, this was sub-scaled and re-labelled as "significant change in living and healthcare" (Table 4.2). Furthermore, an index of perception based on the factor score was generated (Figure 4.4). Whereas 11.0% had a good perception of the cash grant, 39.0% had poor perception. Half of the study participants had a moderate level of perception about the cash grant on making a significant change both in the lives and healthcare of recipients (Figure 4.4).

Table 4. 2: Perception dimensions and factor loadings (Number = 400) – LEAP

Factor/dimension	Variable	Factor loadings	Eigenvalues	% of values	Alpha (α)
Significant change in living and healthcare	Awareness of LEAP	0.7573	5.89	0.74	0.9474
	Accessibility to LEAP	0.7623			0.9466
	Mode of payment	0.7362			0.9488
	Usefulness of LEAP	0.9224			0.9349
	Significant change in living	0.9229			0.9351
	Significant change in accessing healthcare	0.9120			0.9363
	Healthcare utilisation change significantly	0.9232			0.9353
	Significant change in access to quality healthcare for the elderly	0.8972			0.9373
Overall (α)					0.9474

Source: Computed from author's survey data, September 2017 – October, 2017. Extracted Method: Factor Analysis Principal Component Factor Analysis (Exploratory Factor Analysis) Rotation Method: Varimax with Kaiser Normalisation. Variance Explained for the One Factor: 73.6%

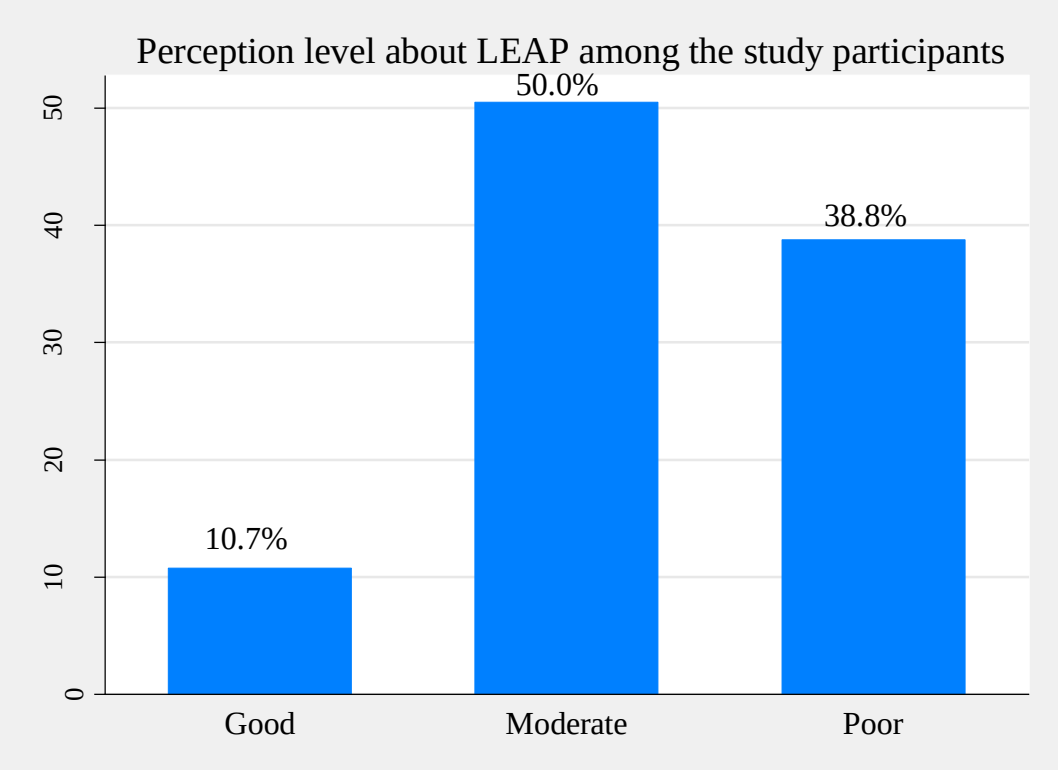


Figure 4.4: Level of perception about LEAP among the study participants

In the qualitative analysis, LEAP as an SPI bringing about a significant change in living and healthcare among recipients, participants explained that the cash grant serves as a source of income for food. Some FGD participants reported that the cash grant serves as financial support given as a "*token of emergency"* especially in situations when one is not economically active, usually like an "*emergency support fund"*. This assertion was also corroborated by the experts who participated in the in-depth interviews. Sharing experiences, one participant asserted:

> "*…As old as I am, I am a beneficiary of the cash grant …that is what I depend on since I am not engaged in any form of work"* – (Female Rural -FGD).

One expert mentioned categorically that:

> *"The cash grant has also brought a lot of relief especially for older persons who are not working. All that they depend on is LEAP. … . This tells that without the cash grant that old man or woman will find it difficult to survive"*- (Social worker, Urban IDI participant).

Others asserted that it assists recipients to enjoy other benefits such as health insurance. This provides financial access to healthcare. Supporting this assertion, an IDI participant narrated how the cash grant has paved way for some older persons to further enjoy complementary services such as the NHIS. He narrated:

> *"Participating in the cash grant program helps older persons to enrol unto NHIS. Some of them would not have found money to enrol unto the insurance scheme no matter what"* - (LEAP Community Committee member, Rural IDI participant).

Another key informant corroborated that:

> *"LEAP beneficiaries and their households are automatic NHIS enrolees. It is the entire household"* - (Social worker, Urban Male IDI participant).

On the contrary, some participants had different opinions about the cash grant programme. In an urban FGD among female participants, it was reported that the amount of money received was not enough for one to depend on. Participants asserted:

> *"…the cash grant is not enough. How can one depend on it?"* – (Female Urban-FGD).

Participants in a male FGD in a rural community suggested an increase in the cash grant and explained that:

"The GH¢ 60.00 that the government gives is not enough. It is not enough for two months. It is inadequate. It is not able to solve any problem. It should be increased"- (Male Rural-FGD).

4.4.2 Perceptions of NHIS

Table 4.3 illustrates the descriptive statistics on the perception levels of NHIS among survey participants. A total of nine statements/domains were used in the measurement (Tables 4.3). The calculated mean and standard deviations showed a lower SD indicating their closeness to the mean. Most study participants scored between 2.34 (bad) and 4.09 (good). The least scored (2.34) domain was "*Registration and Waiting Time*" and the highest scored (4.09) was "*Awareness*".

Table 4. 3: Descriptive statistics on participants' perception on NHIS

Attribute	Mean (SD)		Minimum	Maximum
NHIS				
1. Awareness	4.09	(1.140)	1	5
2. Accessibility	3.87	(1.323)	1	5
3. Usefulness	4.05	(1.231)	1	5
4. Significant change in Healthcare utilisation	4.01	(1.212)	1	5
5. Significant change in access to healthcare	4.01	(1.210)	1	5
6. Significant change in access to quality health care for the elderly	3.98	(1.230)	1	5
7. Cost of premium	3.20	(1.425)	1	5
8. Registration and waiting time	2.34	(1.463)	1	5
9. Code of Practice	3.04	(1.455)	1	5

Source: Author's Field Work, 2017. Number of observations =400

Using the data reduction technique, the exploratory factor analysis was carried out with the nine domains (Table 4.4). The KMO sampling adequacy measurement generated a value of 0.89 and Bartlett's test of sphericity was also significant ($p<0.001$). This indicates the sufficient correlation between variables for the level of perception measurement. This depicted a higher reliable scale. It also demonstrated the internal consistency of the contribution of the statements

as a scale. Two factors were extracted with an eigenvalue greater than 1 (Figure 4.5). This accounted for the cumulative value of 79.6% for the total variance explained in the Varimax with Kaiser Normalisation rotation solution.

Table 4. 4: Perception dimensions and factor loadings (Number = 400) – NHIS

Factor/dimension	Variable	Factor 1 loadings	Factor 2 loadings	Eigenvalues	% of values	Alpha (α)
Improvement in healthcare utilisation	Awareness of NHIS	0.7956		4.67	0.52	0.8878
	Accessibility to NHIS	0.8144				0.8846
	Usefulness of NHIS	0.8682				0.8812
	Significant change in healthcare utilisation	0.9187				0.8788
	Significant change in access to healthcare	0.9167				0.8804
	Significant change in access quality health care for the elderly	0.8999				0.8808
Features of service provision	Cost of premium		0.7818	2.20	0.24	0.8961
	Registration and waiting time		0.8032			0.9071
	Code of practice		0.8620			0.9063
Overall (α)						0.9005

Source: Computed from author's survey data, September 2017 – October 2017. Extracted Method: Factor Analysis Principal Component Factor Analysis (Exploratory Factor Analysis) Rotation Method: Varimax with Kaiser Normalisation. Variance Explained for the Two Factor: 59.0% (blanks represent abs(loading)<.5)

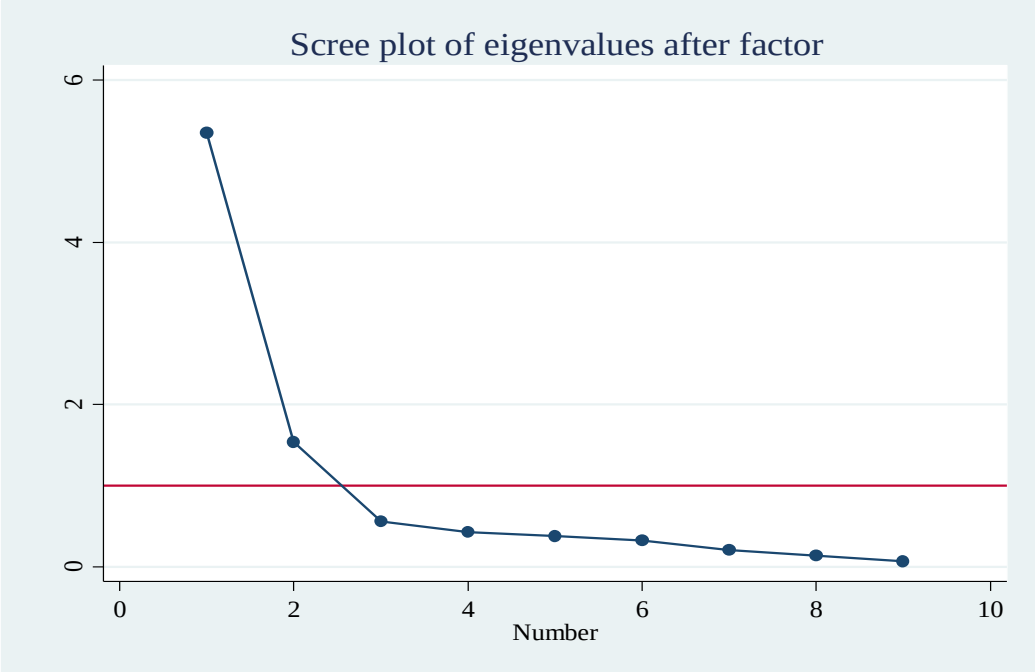


Figure 4. 5: Scree plot: The Perception of NHIS

Given the high loadings (≥ 0.5) on the two factors for all the items, they were sub-scaled and re-labelled (Table 4.4). The first and most significant factor accounts for 52.0% of the variance in the data. This indicates the importance of how having NHIS improves healthcare utilisation. Variables such as awareness, accessibility, usefulness, significant change in healthcare utilisation, significant change in access to healthcare and significant change in access to quality healthcare for the elderly were among the six factors that loaded unto it. For the second factor, it accounted for 24.5% of the variance. This shows the significant role that the features of service provision play concerning the cost of the premium, registration and waiting time and the code of practice loading three factors (Table 4.4).

An index was further generated using the scores of the two factors to test the overall effect of the features of service provision, and healthcare utilisation improvement influencing perceptions about NHIS (Figure 4.6). Only a few (9.5%) had good perceptions about the NHIS programme while many (58.5%) had moderate perceptions. About a third had poor perceptions about the programme (Figure 4.6).

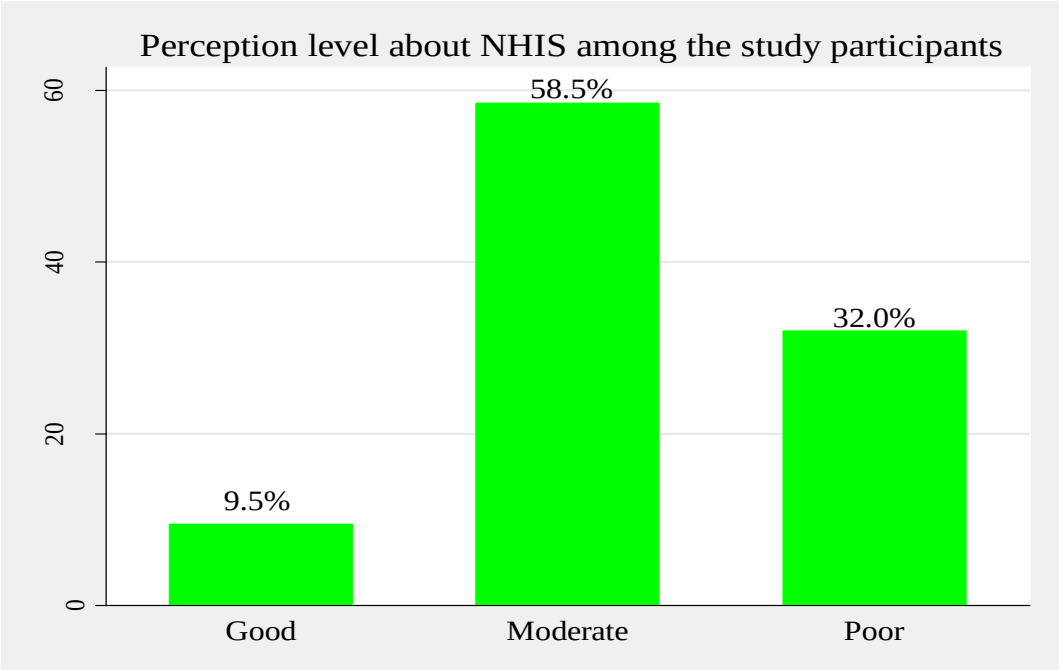


Figure 4.6: Level of perception about NHIS among study participants

Qualitative results on respondents' perceptions on NHIS as SPI in improving healthcare utilisation as established from the quantitative analysis, one key informant, and a community health worker in a rural facility revealed how the NHIS serves as a financial relief to both an elderly enrolee and the family/caregiver, especially where the former suffers from an NCD.

> *"It is a financial relief to both the elderly and the family or caregivers especially in the face of a severe condition like a stroke. If one has to be on admission, you will be offered a bed without paying for it. Without the insurance, the client will have to make a down payment before a bed is given"* - (Community Health Worker (CHW), CHPS Compound – Rural IDI participant).

On the features of service provision, participants in the FGDs and IDIs reported of unsatisfactory nature of the NHIS service particularly on code of practice. One cited issue was technological challenges such as poor internet connectivity which often results in extortions from clients. Female participants in one urban FGD narrated:

> *"Usually, you are told the network (internet) is not working. …Though, the challenge with the network (system down problem) is always cited as the reason, yet, the moment one offers extra money, the so-called network problem will cease"* - (Female Urban-FGD).

Conversely, some key informants had contrary views on the features of service provision of the NHIS especially on registration and waiting time. Participants stated that subscribers' service has improved over the years after the introduction of the biometric registration. Also, subscribers could access healthcare using their insurance card within one month, though, it used to be three months waiting period.

Participants' mixed reactions of LEAP and NHIS respectively may have accounted for the huge (more than half of the participants) moderate perceptions of both programmes. The reasons such as the provision of daily sustenance, financial access to care and improving healthcare utilisation could be attributed to participants' good perception about these initiatives. On the other hand, the poor perceptions of the initiatives could be due to the associated stigma of the name particularly LEAP, insufficiency of the cash grant to recipients, the knowledge gaps,

negative attitudes of programme officers, coupled with technological challenges. This may have implications on older person participation in these initiatives.

4.5 Discussion

This chapter aimed to explore and examine the different forms of social protection initiatives among study participants. Participants' perceptions about the key SPIs of interest were further examined. The study showed that generally, older persons are aware of the existence of SPIs in their communities. There was high awareness of the formal SPIs such as LEAP and NHIS, and informal mechanisms including extended family and children's support. This is also consistent with a quantitative study exploring the awareness coverage of old-age pension as an SPI in India to be 74.6% (Srivastava and Kandpal, 2014). Though LEAP and NHIS, the key SPIs of interest to this study were found to be among the top three, participants' highlighted on challenges as such knowledge gaps on LEAP and NHIS respectively. Participants attributed this to inadequate information and education managers of these SPIs have failed to furnish them with.

The weak traditional safety nets from the extended family and children for older persons as a result of witchcraft accusations, negative counselling from some religious leaders especially pastors, reciprocity of support and economic hardship were also reported. This often results in the mistreatment of older persons in the form of neglect. This may impede older persons' participation in SPIs. Studies in Ghana have also reported of witchcraft as part of ageing in Ghana (Crampton, 2013). There is evidence that elderly abuse or mistreatment of older persons due to witchcraft, neglect and economic hardship have been reported in other developing countries like Tanzania, South Africa, and Nigeria, (Agunbiade, 2019; Krug EG et al., 2002). Nevertheless, few countries have had legislations to ensure elderly abuse cases are mandatory reported (Krug EG et al., 2002).

The study also found the involvement of various actors including the government, families, religious organisations and NGOs in the provision of SPIs. This finding is also in support of what had been documented in other studies (Okello, 2015; Lloyd-Sherlock et al., 2012; Barrientos & Lloyd-Sherlock, 2002). Countries in Africa, Asia and Latin America over the years have had older citizens benefiting from social assistance. For instance, conditional cash transfer in South Africa has considerably improved the health of ageing adults (Behrman and Parker, 2013). Salinas-Rodríguez and Manrique-Espinoza (2013) reported an increased vaccination rate among older persons benefiting from a CCT in Mexico. In Ghana, formal social protection initiatives have been in existence since the mid-60s, and this is well documented (SSNIT, 2011). Duku et al., (2015) found higher NHIS enrolment for 70+ and 60–69 age groups among older persons compared to younger ages in Ghana as a result of the introduction of the Premium Exemption Policy.

Generally, formal SPIs were commonly known among study participants. This could be due to community awareness-raising about these initiatives through various media such as the radio and community mobilisation. This is in contrast to what was reported in a study in Philippine (Coalition of Services of the Elderly (COSE) and HelpAge International (HIA), 2016). A mixed-methods study in the Philippines found that the awareness of a social pension programme for older persons was created by word-of-mouth (person to person) dissemination of information. This resulted in low awareness (COSE and HIA, 2016). Other studies reported that the media such as the television is a highly effective instrument for obtaining information about SPIs like cash transfers, especially those with conditionalities attached (Ministry of Family & Social Policy, 2012). In this study, the most preferred channel of information on messages about SPIs among study participants was radio followed by the use of information van. This could be attributed to the fact that many of the study participants reside in households

that own radio that may serve as a source of information. Also, the choice of information van could be that most study participants residing in rural communities where it is one of the common sources of information dissemination.

The study further recognised the negative effects that low level of SPIs awareness could have on the program's transparency and accountability (COSE & HAI, 2016). The element of stigmatisation related to the cash grant, LEAP was also found in this current study due to the local name associated with the programme. A similar study by Roelen (2017) reported of SPI beneficiaries of social assistance like the cash grant being stigmatized due to poverty. On the other, Roelen et al., (2016) stated that the increased awareness of SPIs such as child support and foster child grants prevent stigmatisation in addition to averting the provision of misinformation to recipients.

The results from the survey showed that church support and individual philanthropists were the commonly known informal social protection initiatives for older persons. But, extended family and children's supports were also the commonly known informal SPIs among FGDs participants. It was shown that churches, mosques and other religious institutions and organisations provide social protection to older persons and their families through networks and interactions to improve their lives (WHO, 2014). The extended family and children's support as mechanisms of SPIs did not feature in the quantitative analysis. This may also be due to the continuous call for more formalised social protection policies and programmes over other typologies of SPIs (Devereux and Getu, 2013; Mokomane, 2013). Other attributable reasons included the weakened family support system, though, not completely dwindled, and the current socio-cultural dispensation influence from perceived religious beliefs such as witchcraft associated with ageing. Other reasons included the neglect of the elderly, and

reciprocity. The issue of elderly neglect corroborates other findings (Agunbiade, 2019; Krug EG et al., 2002). Also, this supports the findings reported in other studies that in all developing countries, there is the fast-eroding of support within the traditional family system for older persons (Kwankye, 2013; Apt, 2002).

There were mixed perceptions about SPIs among the study participants. A plausible justification can be linked to different purposes for the establishment of each initiative. However, both have the convergent goal of ensuring that LEAP recipients and NHIS enrolees would be able to access quality healthcare services. Study participants highlighted the strengths and benefits of these initiatives in addition to their associated limitations. Similarly, mixed findings of SPIs have been documented in other studies (Bastagli et al., 2016).

The varied perceptions about SPIs among study participants may influence their levels of use and participation in these initiatives. Besides, this may further influence the utilisation of healthcare services. Other studies have reported that people's perceptions direct their actions, thoughts and feelings dedicated to a particular process, situations and events (McMillan & Schumacher, 2001).

Though study participants had negative perceptions such as lack of transparency about the NHIS, they reported that the insured receives prompt attention than the uninsured at the point of seeking care particularly enrolees with NCDs. This illustrates to some extent the removal of financial barriers to accessing healthcare among older persons. The National Health Insurance Act, 2012 (852) emphasises the need to attain universal health insurance coverage for all citizenry in the country and to ensure that persons with plausible financial risk are protected including older persons (National Health Insurance Act, 2012). Older persons are prone to age-

related ill-health, mostly, non-communicable diseases. Participating in SPIs is crucial in reducing their risk adverse health outcomes (Duku et al., 2015). The need to address the concerns and challenges characterising these SPIs will promote older persons' participation along with improving the accountability of programme planners and implementers.

Communities' perceptions about the initiatives have the propensity of influencing the participation and use of the services associated with these SPIs. It also tends to influence how providers and implementers of the programme meet the expectations of potential and existing clients. The study has highlighted the setbacks of the programmes from the perspective of users in terms of awareness, knowledge and perception. The gradual eroding of informal SPIs especially from the extended family and children calls for the need to ensure that the formal mechanisms of social protection are effectively implemented and sustained to promote the well-being of older persons. Generally, the perceptions about SPIs were moderate. This could be attributed to the mixed reactions of the programmes by participants. There was also the poor perception of LEAP and could be due to the insufficient cash grant which may have had little or no impact in the lives of recipients. A similar finding has also been observed in social cash transfer in Zambia (Chiwele, 2010). Chiwele (2010) attributed it to the chronic under-funding of social protection programmes including cash transfers. Other poor perception issues were knowledge gaps and extortions, and this supports findings from other studies (Bastagli et al., 2016). On NHIS, issues raised included technological challenges due to internet connectivity. This confirms what other studies have cited. For instance, Gajate-Garrido and Owusua (2013) identified slow speed of internet connectivity, frequent breakdown and lack of experts at the district level on information and communications technology as challenges associated with District Mutual Health Insurance Schemes in Ghana. The analyses in this chapter have further

demonstrated the variations in SPIs among different participants by location and sex segmentation respectively.

4.6 Conclusion

The aim of the analysis in this chapter was to explore the forms of SPIs among participants in the study area. The results suggest that generally, there is a high awareness of SPIs among participants in the study area, particularly the key formal SPIs of interest, LEAP and NHIS. Exploring study participants' perceptions about the key SPIs of interest revealed moderate levels respectively. The study found that state and non-state actors are involved in the provision of SPIs for older persons. The results in this chapter also identified radio, an electronic media as the most preferred channel of information on messages about SPIs. This influence of older persons' awareness and perceptions on SPIs may affect their participation. The contributing factors of study participants participating in these initiatives are further examined in chapter five to understand the coverage gaps. This has implications for accessing quality healthcare.

CHAPTER FIVE

CHARACTERISTICS OF THE STUDY PARTICIPANTS AND THEIR RELATIONSHIP WITH SOCIAL PROTECTION INITIATIVES

5.1 Introduction

Social protection initiatives are introduced to protect individuals and households with specific characteristics in many developing countries (Cameron, 2014). The participation and access to these initiatives are therefore influenced by factors such as demographics like sex, age (Parmar et al, 2014), and socioeconomic featuring household poverty level (Gbedemah, Jones & Pereznieto, 2010), occupation (Gobah & Zhang, 2011), work status (Cameron, 2014) and social support (Parmar et al, 2014). Other characteristics such as lifestyle risks are also recognised as being influenced by a combined consumption and status effect through social inclusion as individuals participate in SPIs (Lundberg, 2010). As postulated in the conceptual model for this study, these characteristics are discussed as predisposing (demographic, socioeconomic, lifestyle risk factors and living arrangements) and need factors (health-related characteristics) to understand their association with participating in social protection initiatives (enabling factors) among the study participants.

The aim of the analysis in this chapter is to describe the characteristics of study participants and examine the predictive factors associated with participating in SPIs among older persons. The chapter further discusses the extent of participation in SPIs among the study participants. The predisposing factors (demographic, socioeconomic characteristics, lifestyle risk behaviours, and living arrangements), and need factors (health-related) of the study participants are investigated utilising descriptive analytical techniques. The characteristics of the study participants in the qualitative phase of this study (FGDs and IDIs) are discussed. Utilising the

multiple logistic regression models, the relationship between predisposing and need factors of participants, and the enabling factors (SPIs) are also investigated.

5.2 Predisposing factors

5.2.1 Demographic characteristics

The age range of participants was between 60 and 122 years, and the mean age was 73.7 years (SD±0.541) (Table 5.1). The proportion of the study participants reduces with increasing age. Twenty-two percent were in the age group 60-64 years. Whereas those in the age bracket, 65-69 years constituted 18.3% of the study participants, this was 16.7%, 16.3%, 13.0% and 14.0% for the age groups 70-74 years, 75-79 years, 80-84 years, and those aged 85 years and above respectively.

Similar to the national pattern, there were more female participants (59.3%) than males (40.7%). About 46.0% of the participants were orthodox Christians (Catholics and Protestants), 27.0% were other Christians and about 13.0% were non-Christians (such as Muslims, traditionalist/spiritualist and those who are not affiliated to any religion). Pentecost and charismatic formed about 14.0%. Attendance to religious services among study participants was 8 times a month, which is, averagely twice a week. By marital status, 37.5% were currently married, 44.0% were widowed and 18.5% were divorced/separated. Only one participant reported having never been married. The mean number of times to have been married was about twice (SD±0.066). Reflective of the national pattern among older persons by location, a higher proportion (56.5%) of study participants lived in rural areas while 43.5% resided in urban areas (Table 5.1).

Table 5. 1: Percentage distribution of the study participants by predisposing and need factors

Variable	Mean	Standard deviation
Age	73.7	0.541
Number of times been married	1.9	0.066
Attendance to religious services	8.4	21.048
Household size	3.0	0.120
Demographic characteristics		
	Percentage	**Number**
Age group		
60-64	21.7	87
65-69	18.3	73
70-74	16.7	67
75-79	16.3	65
80-84	13.0	52
85+	14.0	56
Sex		
Male	40.7	163
Female	59.3	237
Religious affiliation		
Catholic/Protestant	46.2	185
Pentecostal/charismatic	13.7	55
Other Christian	27.0	108
Non-Christians	13.0	52
Marital status		
Married	37.5	150
Widowed	43.8	175
Divorced/Separated	18.5	74
Never mar	0.25	1
Location		
Rural	56.5	226
Urban	43.5	174
Socioeconomic characteristics		
Highest level of education attained		
No education	34.5	138
Primary	16.7	67
Middle	39.7	159
Secondary and above	9.0	36
Occupation		
No occupation	41.5	166
Agriculture	42.7	171
Non-agriculture	15.8	63
Received social support (past 12 months in cash/kind)		
Yes	85.3	341
No	14.7	59
Household wealth index		
Poor	33.2	133
Middle	33.3	133
Rich	33.5	134

Source: Computed from author's survey data, September 2017 – October 2017

Table 5.1: continued (1)

Variable	Percentage	Number
Household food secured		
Food secured	66.5	266
Not food secured	33.5	134
Lifestyle risk factors		
Smoking status		
Ever smoked	17.2	69
Never smoker	82.8	331
Alcohol consumption status		
Ever drank	39.7	159
Never drank	60.3	241
Living arrangements		
Household size		
Alone	32.5	130
2-3 members	35.2	141
4 or more members	32.0	128
Unknown	0.25	1
Having a primary caregiver		
No	22.3	89
Same household	39.0	156
Separate household	38.7	155
Health-related characteristics		
Self-rated health status		
Good	37.0	148
Moderate	35.5	142
Bad	27.5	110
Functional disability		
Yes	87.5	350
No	12.5	50
Having disease condition		
No	15.7	63
Yes	84.3	337
Injury/Illness (in the last 4 weeks)		
Yes	46.5	186
No	53.5	214
Type of health service accessed		
Out patient care service accessed	83.3	333
In-patient care service accessed	12.0	48
Did not seek care	4.7	19
Place of accessing healthcare service		
Hospital	40.0	160
Polyclinic/clinic/health centre	21.8	87
Pharmacy/drug store/chemical shop	27.7	111
Other	5.8	23
Did not seek care	4.7	19

Source: Computed from author's survey data, September 2017 – October 2017

5.2.2 Socioeconomic characteristics

While about 34.5% had no formal education, almost 17.0% and 40.0% had attained primary and middle school levels of education respectively. Only a few (9.0%) had had educational attainment beyond the middle school level (Table 5.1). About 42.0% were not engaged in any economic activity. Similar proportions (43.0%) of participants were engaged in agriculture whereas about 16.0% were into non-agricultural activities such as trading, sales and service. A majority (85.3%) of the participants had received some social support either in-kind or in cash from a relative or family member in the past 12 months before the survey. The results showed virtually an equal distribution of study participants by household wealth index. About 67.0% of the study participants were in households with food security in the last 30 days before the survey compared to a third with food insecurity.

5.2.3 Lifestyle risk factors

The lifestyle risk factors of participants were measured using social behaviours such as smoking and alcohol consumption (Table 5.1). A majority (82.8%) of the participants reported to have never used or smoked tobacco products. Many (60.3%) of the study participants had never consumed alcohol (Table 5.1). This corroborates other studies in Ghana where very low alcohol consumption prevalence had been reported (Addo et al., 2018; Yawson et al., 2015).

5.2.4 Living arrangements

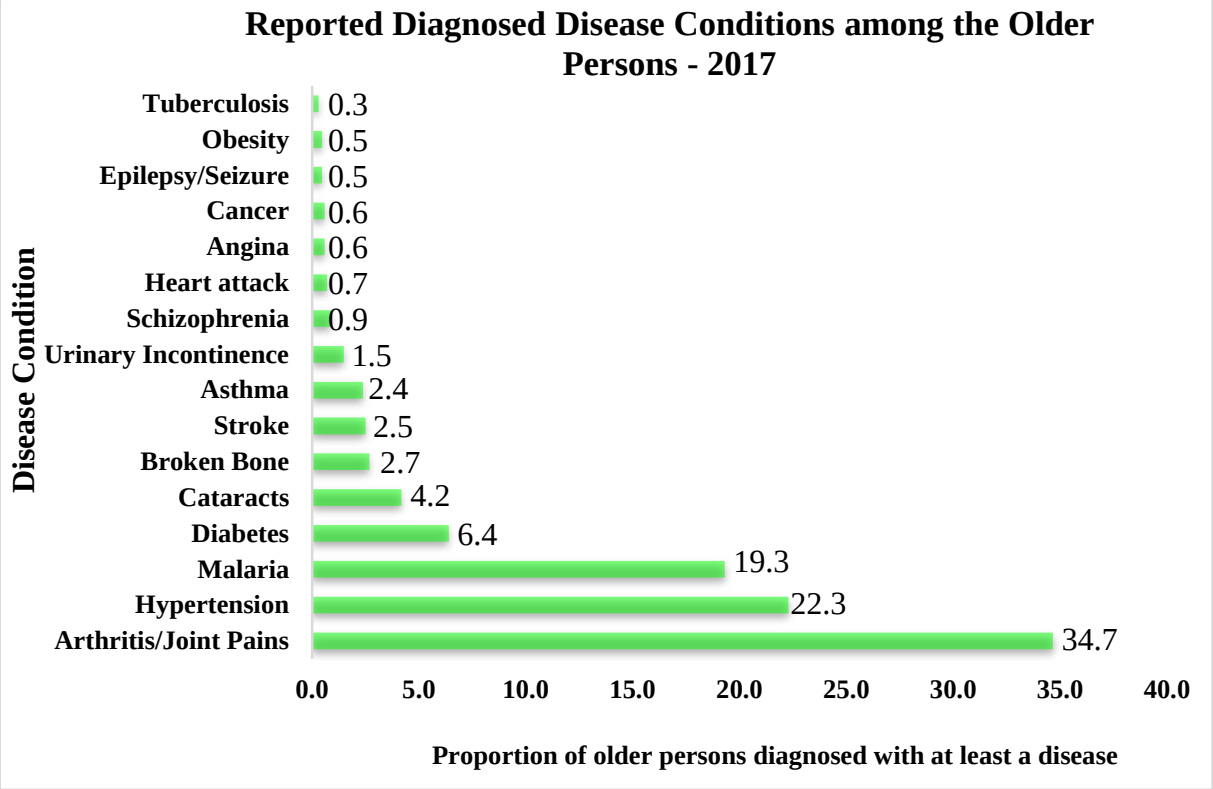
The living arrangements of the study participants were measured utilising the size of their households and the presence of a primary caregiver(s) who provides care or support financially and/or non-financially. The average household size among study participants was three. Thirty-two percent of the participants resided alone. Another one-third also lived in a household with two to three or four and more members respectively (Table 5.1). About 22.0% had no primary caregiver(s). About one-third, each resides with primary caregivers in the same and separate households respectively.

5.3 Need factors

5.3.1 Health-related characteristics

Nearly two-fifths of the participants reported that their health status was good (37.0%) and moderate (35.5%) respectively (Table 5.1). Participants who reported bad health status were about a third (27.5%). About 88.8% of the participants had some form of disability in performing tasks related to cognition, mobility, self-care, getting along with people, life activities, and participation in society. About 13.0% had no functional disability.

Eighty-four percent reported having ever experienced one specific disease or the other such as hypertension, asthma, arthritis/joint pain and malaria (Figure 5.1). Sixteen percent had no specific health condition or symptoms (Table 5.1). Figure 5.1 depicts the percentage distribution of reported health conditions and symptoms among the study participants. Arthritis/joint pains (34.7%) was the most commonly reported disease condition. The second highest reported disease condition was hypertension (22.3%), followed by malaria (19.3%), diabetes (6.4%) and then stroke (4.2%). The study results showed that 46.5% of participants suffered illness/injury in the last four weeks preceding the survey. However, more than half experienced no illness/injury in the last four weeks before the survey (Table 5.1). The study found that 40.0% of the participants accessed healthcare at the hospital level comprising of government, private or mission hospital. Non-hospital level such as the polyclinic, health centre, CHPS, pharmacy, drug store or chemical store was the most (49.5%) reported source where healthcare services were sought. About 5.8% utilised other sources such as community drug peddlers, herbal shops and traditional healer's home. About five percent of the participants indicated to have not utilised any health facility for out-patient or in-patient care services.



Source: Computed from author's survey data, September 2017 – October 2017.

Figure 5. 1: Percentage distribution of reported health conditions and symptoms among the study participants

5.4 Background characteristics of Focus Group Discussions study participants

Sixty participants were involved in the focus group discussions (Table 5.2). The age range was between 60 years to 120 years. The average age was 73.8 years (SD±2.177). While one in every five was between 70-74 years, about a third were 80 years and above. Thirteen percent were between the ages 60-64 years, and 18.3% were in the 65-69 year age group. The ages of a few (3.3%) of the participants were not known. Similar to the quantitative results, there were more (58.3%) females than males (41.7%). A majority (78.0%) were affiliated to the Christian religion. Fifteen percent belonged to the Islamic religion while traditional religion accounted for 3.3%. One in every 20 of the study participants was not affiliated with any religion. The religious affiliation of about 2.0% was not known. Contrary to the quantitative results by location, more (53.3%) participants were from urban settings than from rural areas (46.7%).

Table 5. 2: Descriptive statistics of the characteristics of focus group participants

Variable	Mean	Standard deviation
Age	73.8	2.177
	Percentage	**Number**
Age group		
60-64	13.3	8
65-69	18.3	11
70-74	20.0	12
75-79	13.4	8
≥ 80	31.7	19
Don't know	3.3	2
Sex		
Male	41.7	25
Female	58.3	35
Religious affiliation		
Christianity	78.0	45
Islam	15.0	9
Traditional	3.3	2
No religion	5.0	3
Don't know	1.7	1
Marital status		
Married	40.0	24
Widowed	33.3	20
Divorced	25.0	15
Don't know	1.7	1
Location		
Rural	46.7	28
Urban	53.3	32
Highest level of education attained		
No education	53.3	32
Primary	1.7	1
Middle	38.3	23
Secondary and above	5.0	3
Don't know	1.7	1
Occupation		
No occupation	33.3	20
Agriculture	61.7	37
Non-agriculture	3.3	2
Don't know	1.7	1

Source: Computed from author's focus group discussions data, December 2017. Number=60

Fifty-three percent of the study participants had not attained any level of education and 2.0% had completed primary education. Thirty-eight percent had completed middle school education. About 5.0% had secondary and above education, which was a little lower than the results of the survey. The educational attainment of 1.7% of participants was unknown. About 33.0% had no occupation and 62.0% were engaged in agriculture. This finding was higher than that from the survey. This is similar to the national pattern. Only 3.3% were engaged in non-agriculture jobs such as trading and sales, and the occupation of about 2.0% was unknown (Table 5.2).

5.5 Background characteristics of In-depth Interviews (IDIs) study participants

Thirteen participants were recruited for the in-depth interviews (Table 5.3). Detailed profiles of key informants/experts for the IDIs are provided in Appendix 24. The average age among key informants for the In-depth interviews was about 46 years (SD±4.407). The proportion of participants decreased by the older age group with those 60 years and above constitute about a quarter (15.3%). Most (61.5%) of the participants were males. A similar proportion (61.5%) worked in urban locations.

A majority (84.6%) of the IDI participants had a tertiary level of education. Only 15.4% reported having below the tertiary level of education. About 15.0% were into farming and enrolled as nurses or midwives respectively. Respectively, the same proportion (8.0%) had received training in the field of accounting, health administration, medics, pharmacy, social work and teaching. Fifteen percent of the study participants practice at the CHPS compound, private clinic or health centre respectively. About 8.0% were engaged at the maternity home/clinic, public hospital, health directorate, MoGCSP/DSW, LEAP Committee–urban as well as rural areas, and at the insurance office respectively. About 77.0% were engaged at government-owned/public institutions. Whereas 15.4% were owned by individuals (private), 7.7% were private missions (Table 5.3).

Table 5. 3: Descriptive statistics of the background characteristics of In-depth Interview participants (Key informants/experts)

Variable	Mean	Standard deviation
Age	45.8	4.407
	Percentage	**Number**
Age group		
< 40	30.8	4
40-49	30.8	4
50-59	23.1	3
≥ 60	15.3	2
Sex		
Male	61.5	5
Female	38.5	8
Location		
Rural	38.5	5
Urban	61.5	8
Highest level of education attained		
below tertiary education	15.4	2
Tertiary education	84.6	11
Occupation		
Farming	15.4	2
Accounting	7.7	1
Health Administrator	7.7	1
Community Health Worker	7.7	1
Enrolled Nurse	15.4	2
Medical Practitioner	7.7	1
Mid-wife	15.3	2
Pharmacist	7.7	1
Social Worker	7.7	1
Teaching	7.7	1
Institutional type		
CHPS Compound	15.4	2
Private Clinic	15.4	2
Maternity Home/Clinic	7.7	1
Health Centre	15.3	2
Public Hospital	7.7	1
Health Directorate	7.7	1
MoGCSP/DSW	7.7	1
LEAP Committee–urban area	7.7	1
LEAP Committee–rural area	7.7	1
Insurance Office	7.7	1
Institutional ownership		
Government/Public	76.9	10
Private (Individual)	15.4	2
Private (Mission)	7.7	1

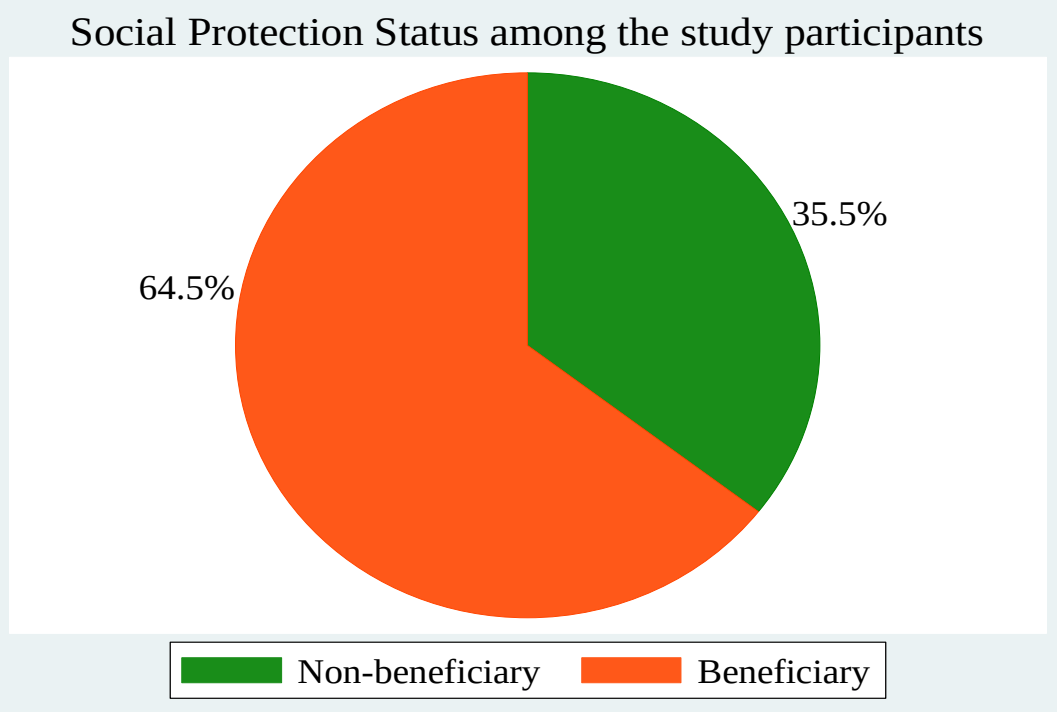
Source: Computed from author's in-depth interview data, December 2017 – January 2018. Number=13

5.6 Enabling factors

The enabling factors from the conceptual model (Chapter 2 - Figure 2.4) constitute the two initiatives of primary interest. Study participants' participation in SPIs were measured based on the verification of cards for both the LEAP and NHIS (survey and FGDs). The absence of physical verification of a card was substituted with self-report of participation.

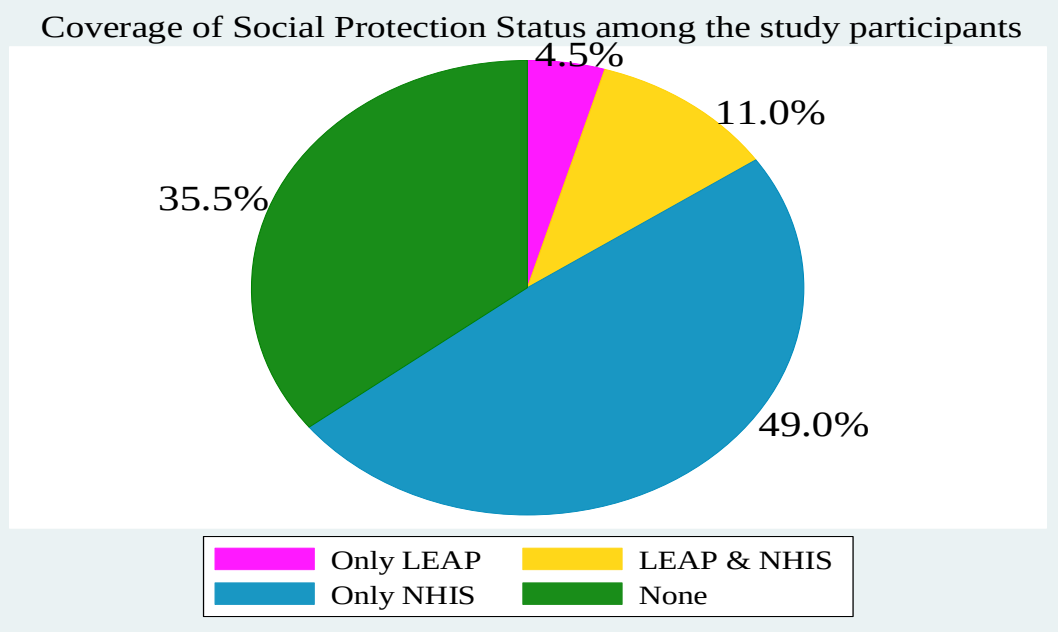
5.6.1 Coverage of social protection initiatives among the study participants

Overall, 64.5% of the study participants were SPI beneficiaries compared to 35.5% who were non-beneficiaries (Figure 5.2). This means that two in every three of the study participants were beneficiaries of SPIs. Figure 5.3 presents older persons' participation in SPIs by status type. Status type is categorised into four (4), namely, being on LEAP or NHIS only, being on both LEAP and NHIS and not on any of the two initiatives. Many (49.0%) of the participants were enrolees of the NHIS only while 4.5% were recipients of LEAP only.



Source: Author's Field Work, September 2017 – October 2017.

Figure 5.2: Participation in Social Protection Initiatives among the study participants.

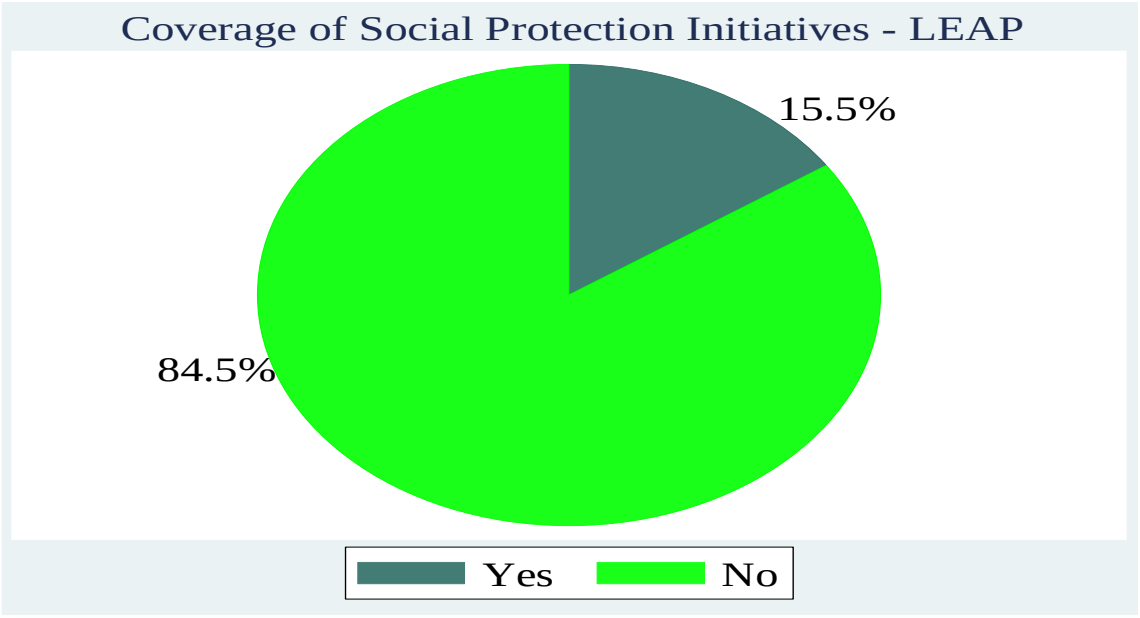


Source: Author's Field Work, September 2017 – October 2017.

Figure 5.3: Coverage of Social Protection Initiatives among the study participants by Status Type.

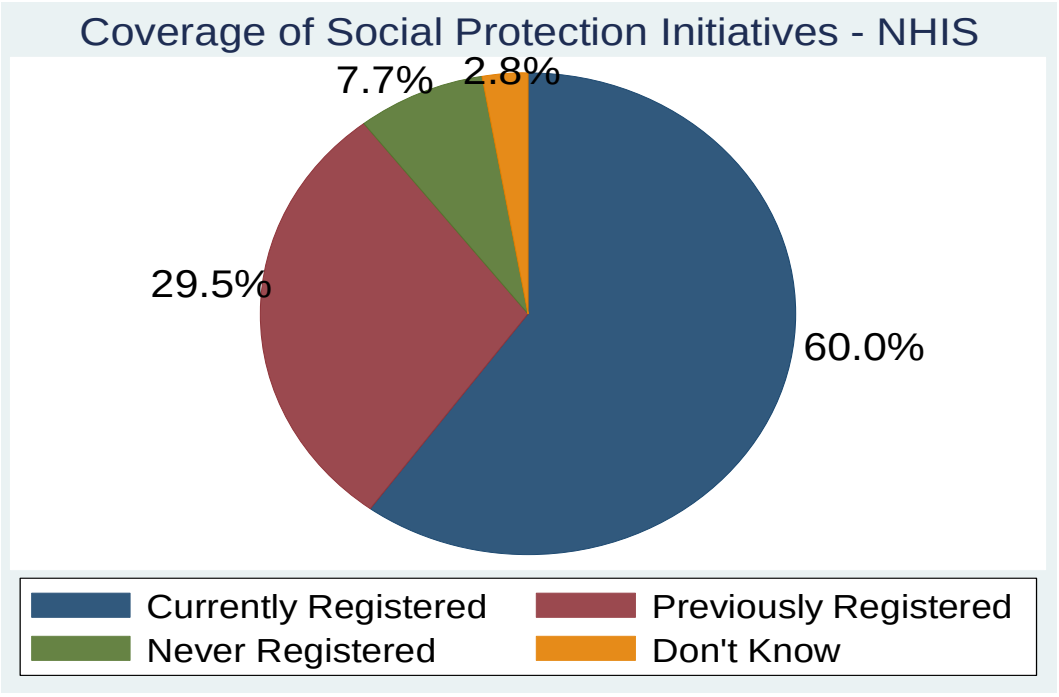
Figure 5.4 shows the coverage of LEAP among study participants. Generally, the coverage of LEAP was 15.5%, and 84.5% were non-recipients. This could be attributed to the eligibility criteria usually by heavy targeting nature of the programme (use of the Proxy Means Testing method) based on qualification threshold which often results in a very small proportion of potential beneficiaries (COSE & HAI, 2016).

Figure 5.5 presents the coverage of NHIS as a component of SPIs among the study participants. Sixty percent were current enrollees of the scheme while about a third of the participants were former enrollees of the scheme. This is 3.0% higher than the national figure of 57.0% (MoGCSP, 2015). One in every twelve (12) had never enrolled with the scheme. The enrolment status of one in every 33 was not known.



Source: Author's Field Work, September 2017 – October 2017.

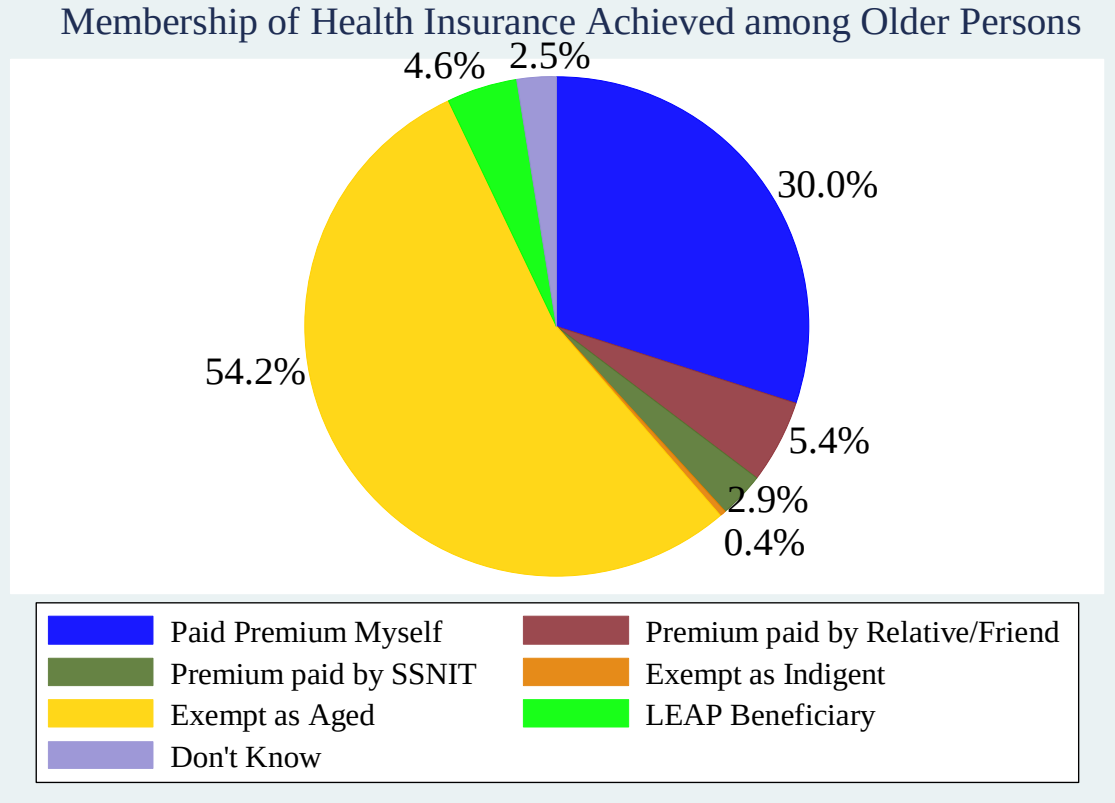
Figure 5.4: Coverage of Social Protection Initiatives - Livelihood Empowerment Against Programme (LEAP).



Source: Author's Field Work, September 2017 – October 2017.

Figure 5.5: Coverage of Social Protection Initiatives – National Health Insurance Scheme (NHIS)

Figure 5.6 illustrates the membership of NHIS among currently enrolled study participants. More than half were enrolees of the scheme by exemption from payment as a result of advanced age. About one in every three study participants paid the premium by themselves. About 5.0% of the study participants achieved the scheme's membership status as LEAP recipients, and by payment of the premium by relative/friend respectively. About 3.0% had enrolment premium paid by SSNIT as pensioners and less than one percent were by exempt as indigent (poor).

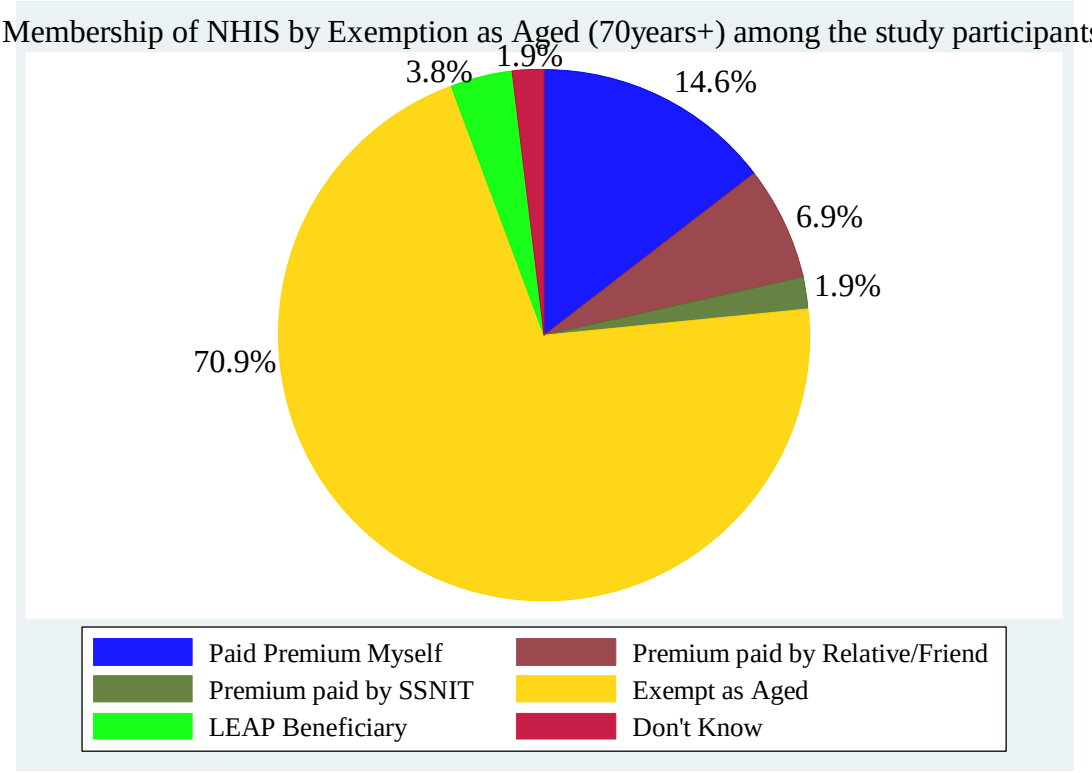


Source: Author's Field Work, September 2017 – October 2017.

Figure 5. 6: Membership of health insurance achieved among study participants

Figure 5.7 shows the extent of the premium exemption for the aged among the study participants who were enrolees of the scheme. The results indicated that about 71.0% of the study participants aged ≥70 years were members of the scheme by exempt as older persons. Two percent each were scheme members as SSNIT pensioners or recipients of LEAP

respectively. Fifteen percent were insurers by paying for the cost of premium themselves while about 7.0% had the scheme premium paid by relatives or friends.



Source: Author's Field Work, September 2017 – October 2017.

Figure 5.7: Membership of NHIS by premium exemption as Aged (70 years +) among the study participants

5.6.2 Coverage and status of social protection initiatives among the study participants in Focus Group Discussions

Similar to the pattern of NHIS coverage from the quantitative analysis, 60.0% of the FGD participants were insurers while 35.0% were formerly insured (Table 5.4). About 3.0% had never been enrolees of the scheme and the enrolment status of about 2.0% were not known. Twenty-two percent were recipients of LEAP, while 77.0% were non-recipients. The LEAP coverage status of 2.0% was not known. By coverage of social protection status, 8.0% were on LEAP only, 47.0% were NHIS enrolees only and 13.0% were both on LEAP and NHIS. Thirty percent were not on any of the SPIs. These findings were not particularly different from what

was observed in the quantitative results. Overall, 68.0% of the study participants were beneficiaries of SPIs. This was slightly higher than what pertained in the survey. Thirty percent were non-beneficiary of any of the initiatives. The participation status of 2.0% was unknown.

Table 5. 4: Coverage and status of social protection initiatives among the focus group participants

Categorical variables	Percentage	Number
NHIS coverage		
Currently registered	60.0	36
Previously registered	35.0	21
Never registered	3.3	2
Don't know	1.7	1
LEAP coverage		
Yes	21.7	20
No	76.6	37
Don't know	1.7	1
Coverage of social protection status		
LEAP only	8.3	5
NHIS only	46.7	28
LEAP & NHIS	13.3	8
None	30.0	18
Don't know	1.7	1
Social protection participation status		
Non-beneficiary	30.0	18
Beneficiary	68.3	41
Don't know	1.7	1

Source: Computed from author's focus group discussions data, December 2017. Number=60

5.7 Factors associated with social protection participation among the study participants

5.7.1 Demographic factors associated with participating in social protection initiatives

The likelihood of being a beneficiary of SPIs increased with age and this was statistically significant. This could be attributed to the use of age as one of the key demographic characteristics in SPI participation (Table 5.5). Participants aged 80 to 84 years were 3.6 times as likely those in 60-64 years to participate in SPIs. FGD participants also indicated that those ≥ 80 years are likely to be beneficiaries of the SPIs due to old-age poverty and illness.

Table 5.5: Results of a multiple logistic regression model showing the predictors of SPIs participation among the study participants

Category Predictor	Adjusted Odds Ratio [95% CI]	P-value	Standard error
Age group			
60-64 [RC]	1		
65-69	1.423 [0.594 – 3.411]	0.429	0.635
70-74	1.533 [0.602 – 3.907]	0.370	0.732
75-79	1.987 [0.755 – 5.230]	0.164	0.981
80-84	3.590 [1.116–11.540]	**0.032***	2.139
85+	0.777 [0.243 – 2.486]	0.671	0.461
Sex			
Female [RC]	1		
Male	0.590 [0.240 – 1.453]	0.252	0.271
Religious Affiliation			
Orthodox [RC]	1		
Pentecost/Charismatic	0.830 [0.350 – 1.971]	0.674	0.366
Other Christians	0.685 [0.337 – 1.394]	0.297	0.248
Non-Christian	0.518 [0.202 – 1.325]	0.170	0.248
Marital status			
Widowed [RC]	1		
Married	1.678 [0.676 – 4.162]	0.264	0.778
Divorced/Separated	0.971 [0.440 – 2.144]	0.942	0.392
Never married	(omitted)		
Location			
Rural [RC]	1		
Urban	0.670 [0.369 – 1.216]	0.188	0.204
Education level attained			
No education [RC]	1		
Primary	1.202 [0.471 – 3.061]	0.700	0.573
Middle	1.188 [0.524 – 2.691]	0.679	0.496
Secondary & above	0.580 [0.171 – 1.970]	0.383	0.362
Occupation			
No occupation [RC]	1		
Agriculture	0.559 [0.269 – 1.163]	0.120	0.209
Non-agriculture	1.947 [0.775 – 4.893]	0.156	0.915
Received social support (past 12 months in cash/kind)			
Yes [RC]	1		
No	1.108 [0.468 – 2.624]	0.815	0.487

Source: Computed from author's survey data, September 2017–October 2017. N = 378 ***P < 0.05** **P < 0.001
[RC] Reference Category

Table 5.5 continued (1)

Category Predictor	Adjusted Odds Ratio [95% CI]	P-value	Standard error
Household wealth index			
Poor [RC]	1		
Middle	0.605 [0.286 – 1.276]	0.187	0.230
Rich	0.938 [0.433 – 2.032]	0.870	0.370
Household food security			
Yes [RC]	1		
No	0.502 [0.262 – 0.961]	**0.037***	0.166
Smoking status			
Never smoked [RC]	1		
Ever smoked	2.040 [0.837 – 4.971]	0.117	0.927
Alcohol consumption status			
Never consumed [RC]	1		
Ever consumed	0.964 [0.501 – 1.853]	0.913	0.321
Household size			
Alone [RC]	1		
2-3 members	1.199 [0.562 – 2.556]	0.639	0.463
≥4 members	0.844 [0.393 – 1.811]	0.663	0.329
Having a primary caregiver			
Separate household [RC]	1		
No caregiver	0.674 [0.304 – 1.497]	0.333	0.274
Same household	1.701 [0.793 – 3.648]	0.172	0.662
Self-rated health status			
Good [RC]	1		
Moderate	1.236 [0.611 – 2.497]	0.555	0.443
Bad	1.821 [0.761 – 4.358]	0.178	0.811
Functional disability			
Yes [RC]	1		
No	0.501 [0.187 – 1.340]	0.168	0.251
Having disease condition			
Yes [RC]	1		
No	0.623 [0.262 – 1.485]	0.286	0.276
Injury/Illness (in the last 4 weeks)			
No [RC]	1		
Yes	0.812 [0.441 – 1.496]	0.505	0.253

Source: Computed from author's survey data, September 2017 – October 2017. N = 378 ***P < 0.05** **P <0.001
[RC]: Reference Category

Table 5.5 continued (2)

Category Predictor	Adjusted Odds Ratio [95% CI]	P-value	Standard error
Type of service			
Out-patient care [RC]	1		
In-patient care	3.317 [0.900 – 12.229]	0.072**	2.208
Place of accessing healthcare service			
Hospital [RC]	1		
Polyclinic/clinic/health centre	1.577 [0.690 – 3.605]	0.280	0.665
Pharmacy/drug store/chemical shop	0.126 [0.061 – 0.261]	**0.000***	0.047
Other	0.141 [0.044 – 0.450]	**0.001***	0.084
Did not seek care	[omitted]		

Source: Computed from author's survey data, September 2017 – October 2017. N = 398 ***P < 0.05** **P < 0.001
[RC]: Reference Category

The hypothesis that older persons 80-84 years are more likely to be beneficiaries of SPIs compared to those 60-64 years old was supported by this finding. This could be due to that both SPIs of interest use age as one of its demographic criteria in beneficiary selection. For instance, households with older persons ≥ 65 years without any form of support are eligible recipients of the cash grant after satisfying the score for the Proxy Means Test (LEAP Programme, Ghana-2020). For the NHIS, older persons ≥ 70 years are eligible enrolees, though, it comes with the payment of administrative cost (MoGCSP, 2015). The Premium Exempt Policy under the NHIS favours those ≥ 70 years compared to their counterparts 60-64. Finding from this study also revealed that more than half of the study participants are NHIS enrolees by exempt as aged with a few proportions as LEAP beneficiaries, SSNIT pensioner and an exempt as an indigent. This may account for the reason why age is a predictive factor in SPIs participation among study participants. This confirms findings from other studies (Wielen, Channon and Falkingham, 2018; Duku et al., 2015).

Other plausible beneficiaries of SPIs mentioned by FGD participants included the poor, the vulnerable, being a Ghanaian and having a disability. Also. IDI participants cited characteristics such as age, the sex, health condition and the poverty status of households to be associated with influencing older persons' participation in SPIs. In table 5.3, the sex of participants, religious affiliation, marital status, and location did not show a significant relationship with participating in SPIs among older persons.

5.7.2 Socioeconomic factors associated with participating in social protection initiatives

Participants' occupation was not statistically significant with participating in SPIs (Table 5.5). However, FGD participants mentioned working in an informal sector as a farmer has no pension scheme that may affect their participation in SPIs such as the NHIS. Relative to belonging to a household that is food secured, participants from households not food secured had 0.50 odds (Odds Ratio= 0.50, CI: [0.262 – 0.961], $p<0.05$) of not being beneficiaries of SPIs (Table 5.5). This could be due to that households food secured may have extra resources to enrol the aged unto as SPI such as the NHIS. The study found that about 30.0% and 5.4% were NHIS enrolees either by paying for premium him/herself and by a relative/friend respectively. Also, cash grant seeks to improve household consumption and this has been established in terms of consumption and food security in countries like Kenya, Lesotho, Malawi and Zambia (UNICEF-ESARO/Transfer Project, 2015). Nevertheless, variables like receiving social support from relatives or family in the past 12 months, and wealth index were not statistically significant with benefiting from SPIs.

5.7.3 Lifestyle risk factors associated with participating in social protection initiatives

The use of tobacco products and the consumption of alcoholic beverages did not show a statistically significant relationship with participating in SPIs among the study participants respectively (Table 5.5). This may be due to the small proportions of older persons engaged in lifestyle risk behaviours such as smoking and alcohol consumption respectively.

5.7.4 Living arrangements associated with participating in social protection initiatives

Household size and having a primary caregiver were not statistically significant with the participation in SPIs among the participants (Table 5.5). The selection for participating in SPIs does not factor in the number of persons in a household, rather, the number of persons that meet the criteria such as being poor, disability, and the presence of an older person with no productive capacity in LEAP as an SPI. For NHIS, participation depends on one's ability to pay for premium and administrative cost for those in the informal sector, being an exempt as an aged, indigent, LEAP beneficiary, and SSNIT contributor/pensioner for those in the formal sector.

5.7.5 Health-related characteristics associated with participating in social protection initiatives

Being a beneficiary of social protection initiatives was not statistically significant with self-rated health status, functional disability status, having a disease condition and having experienced injury/illness (Table 5.5). This is because the forms of disabilities that are often considered in social protection participation, especially in cash transfers, are usually visible.

Type of health service accessed participants accessed was found to be associated with participating in SPIs and this had a weak significance level (Table 5.5). Participants who utilized in-patient care services were 3.3 times as likely as out-patient counterparts to participate in SPIs. From the qualitative analysis, FGD participants narrated how benefiting from SPIs become crucial when one has to access in-patient care services. According to participants, benefiting from SPIs helps one to utilise in-patient care services. The place where healthcare service was sought was statistically significant with one's status as a beneficiary of SPIs. Participants who sought care at the pharmacy/drug store/chemical shop had 0.13 lower odds of participating in social protection initiatives compared to those who utilised healthcare

services at the hospital. The odds of participating in SPIs was 0.14 lower for seeking care from other sources such as drug peddlers and traditional healer's home relative to their counterparts who used services at the hospital (Table 5.5). This supports the hypothesis that compared to those who seek healthcare at the hospital level, older persons who seek healthcare at the pharmacy/drug store/chemical shop are less likely to be beneficiaries of SPIs. This could be attributed to the fact that most hospital facilities are likely to have the needed equipment that could provide older persons with the appropriate services. Furthermore, hospital-level facilities are more likely to have accreditation from NHIA to provide health services to NHIS subscribers relative to lower levels of health facilities such as the pharmacy, drug store or chemical shops.

5.8 Discussion

This chapter examined SPIs coverage and the characteristics (predisposing, and need factors) of the study participants, and the associated predictive factors. The study additionally highlights the low coverage of the cash grant programme among study participants. The existence of a coverage gap on the premium payment exemption policy among older persons aged ≥ 70 years was also presented.

Coverage for SPIs among study participants was 64.5% with a gap of 35.5%. The country's Social Protection Policy document also acknowledges the gaps in social protection delivery, both in social insurance (NHIS) and assistance (LEAP) (MoGCSP, 2015). According to the policy document, as of 2013, the insurance coverage gap among older persons in Ghana was 43.0% (MoGCSP, 2015). The document further acknowledged the inadequate coverage of LEAP among older persons in Ghana. In this study, the participation of older persons in NHIS as a social protection initiative was higher than in LEAP. From the study findings, 60.0% of the study participants were NHIS enrolees while about 15.0% were LEAP recipients. It is documented that contributory social health insurance programmes for civil servants are

common in 61.0% of African countries. Fifty percent of formal sector employees of these countries have social health insurance (SHI) programs (Cotlear & Rosemberg, 2018). This could be attributed to the long-time existence of the universal provision of social services in Ghana (Oduro, 2010). In Ghana, social insurance was initially restricted to formal sector workers (Oduro, 2010) until 2003 under the NHIS Act 650. This Act was further repealed for the new NHIS Act 2012 (Act 852) making it mandatory for all persons residing in Ghana in achieving universal health coverage (NHIA, 2012).

Overall, 54.0% of the study participants were enrolled as exempt by age under the Premium Exemption Policy. By the Premium Exemption Policy for free enrolment at age ≥70 years, 71.0% of study participants aged 70 years and above were insurers as exempt by age. In a cross-sectional study to understand the extent to which the premium exemption policy increases access to healthcare for older persons in Ghana, Duku et al., (2015) identified 62.8% for NHIS coverage among older persons age ≥70 years old. The authors further reported that older persons age ≥70 years were 2.7 times more likely to enrol in NHIS than the lower age group. Other studies have reported 56.9% coverage for older persons aged ≥70 years (ILO, 2014).

The protective nature of health insurance from catastrophic expenditure and poverty as a health policy for households has been well documented (Blanchet, Fink & Osei-Akoto, 2012; Asante & Aikins, 2008). A third of the study participants paid to enrol in the scheme while about 5.0% had their premiums paid by a relative or friend. Among those age ≥ 70 years, 21.5% were insurers either through self-payment or relative/friend paying for their premiums. This group is likely to fall into the informal category of the NHIS enrolment bearing the cost of premium insurance. This also supports the assertion that older persons still receive some support from the informal SPIs, especially from relatives and friends. Other studies have reported on the

ineffectiveness of the exemption policy in practice resulting in the inclusion of those who should have been excluded (Aikins et al., 2001). Duku et al., (2015) established in their study that, the awareness of NHIS as SPI particularly, about the exemption policy increased insurance coverage among older persons in Ghana as well as their healthcare service utilisation behaviour.

The study results showed that about 3.0% of the insured were SSNIT pensioners. This could also be that many of the participants are unemployed. Those employed are in the informal sector, particularly in the agricultural sector where access to income security is non-existent. According to a World Bank report (2007), the lower the coverage of formal old-age pension systems, the more likely it is for other forms of SPIs such as social insurance to be lower, and this could affect access to quality healthcare.

The coverage of the cash grant as SPI among the study participants was low and this could be attributed to the targeting nature of the programme. LEAP provides cash transfers for poor households using older persons and persons with disabilities as some of the eligibility criteria (MoGCSP, 2015). Other studies have pointed out the inherent flaws such as errors of inclusion and exclusion that the targeting nature of cash transfers may suffer from (Jimu and Msilimba, 2018; Kidd, Gelders, and Bailey-Athias, 2017; Devereux, 2016; Slater, 2011); for example including older persons who are not poor or excluding prime-age adults who are poor (Slater, 2011). Yet, Handa et al., (2013) in evaluating the LEAP programme cited that the grant programme does not only offer cash to recipients but provides health insurance through the NHIS for the extremely poor households across the country. This was also consistent with this current study where recipients of the cash grant reported to be entitled to free NHIS enrolment.

Cash transfers serve as additional incomes to the poor and the vulnerable (Arnold, Conway & Greenslade, 2011). This was also identified in the current study. Study participants see the cash grant as an emergency. To participants, it is referred to as an "*emergency token*" and a "*stop-gap*". Though, others refer to it as money for the poor. It may be emergency money for the poor. The main selection process for LEAP has to be through household using the proxy means test (Handa et al., 2013). The use of targeting methodology where a proxy means setting methodology is used usually results in a very small proportion of potential beneficiaries (COSE & HAI, 2016). Other studies have reported similar findings on the use of targeting methodology among older persons (Heslop, & Hofmann, 2014; Hofmann, Heslop, Clacherty & Kessy, 2008; Uprety, 2010). According to COSE & HAI report (2016), the process of target methodology measures household-level characteristics but not that of older persons such as the nature of remittances, levels of ill health and disability. Though universal SPIs have been argued to be costly (Freeland, 2013), other authors relay the benefits of universal SPIs over the use of means testing methodology as an efficient way of relieving the poor from income poverty (Cruz-Martinez, 2016).

Currently, Ghana as a country has no universal pension schemes covering the entire citizenry. According to Cotlear & Rosemberg (2018), non-contributory coverage programmes are common in most African countries with one-third having programmes for older persons. Countries such as Botswana and South Africa have statutory social pensions for all older populations (Case & Deaton, 1998). Other African countries like Swaziland and Lesotho run non-contributory social pension schemes providing cash transfers to their elderly citizens (Vincent & Cull, 2009). Industrialised economies also have social pensions paid to older persons 65 years and above who are low-income earners (Kalisch, Aman, and Buchele, 1998) as a way to combat old-age poverty. The need to address income poverty among older persons

will advance access to healthcare among the elderly since income poverty has a linkage with ill-health and causes (Pega et al., 2014).

Similar to the national pattern, there were more older persons aged 60-64 years relative to the other age groups (GSS, 2013). Compared to other older populations, there were more female study participants than males (GSS, 2013). This has been attributed to the higher life expectancy for the female population than the male population (Apt, 2007; GSS, 2013b). This is not only evident in sub-Saharan Africa but other regions in the world (Aboderin, 2008).

A majority (87.0%) of the study participants were affiliated to the Christian religion and this was not different from the national picture (GSS, 2013b). Religious bodies do serve as a source of social and spiritual capital especially for the elderly due to threatened witchcraft accusations (GSS, 2013b). Average frequent attendance to religious service was 8 times a month, that is, twice a week. Participants could find time to participate in social activities such as religious services due to their less participation in economic activities such as employment. This study also identified religious groups such as the church as one of the informal SPIs. Some form of social protection and, social capital and the network could be derived from marriage for older persons through spousal and relation support (GSS, 2013b). However, many of the people were widowed and this is typical among older persons (GSS, 2013b). The study also found more participants residing in rural communities than in urban centres. Similar findings have also been reported in other studies (GSS, 2013b; WHO, 2014). A clear minor difference among the older population by location (rural and urban) has also been reported (Pillay and Maharaj, 2013).

Many of the participants had a middle school level of education and one-third had never been to school. Close to 60.0% of the study participants were economically active and this was not different from what the 2010 PHC reported among older persons (≥60 years) (GSS, 2013b). Many of them were engaged in agriculture. The high proportion of economically inactive persons in the sample could also be attributed to the vulnerability of older persons to chronic diseases (Duku, van Dullemen & Fenenga, 2015).

A majority received financial or non-financial support from relatives or children. This implies that though, the traditional family system in providing support to the elderly has declined (Nantomah & Adoma, 2015; Kwankye, 2013), the existence of some care-providing structures has not completely dwindled out. It is also reported that in many developing countries, family support arrangements are still key in the well-being of a larger proportion of older persons (ILO, 2017). In this current study, informal SPIs as a non-state actor such as the family and children play a key role in providing financial support to older persons. There was very little difference in the distribution of the household wealth index among the study participants. There were more (67.0%) people from households with food security and this is in line with the SDG 2 that seeks to promote food security and improve nutrition through the elimination of hunger (ILO, 2017).

The lifestyle risk behaviours reported by study participants indicated a lower use of tobacco products and an average consumption of alcoholic beverages. The use of tobacco among older adult Ghanaians have also been reported to be relatively low compared to the middle and a higher income country respectively (GSS, GHS and ICF Macro, 2009). Yawson et al., (2013) reported the low use of tobacco among older adults in Ghana attributing this to the effectiveness of public health interventions. The authors also found the use of tobacco to be associated with

alcohol use. Older persons residing in Ashanti region, the location area of this study has also been found to have a lower prevalence of heavy drinking compared to other regions of Ghana (Yawson et al., 2015; WHO, 2014a). The low prevalence of drinking could be attributed to participants' involvement in religious services at least twice a week. The plausible positive effect of religious service attendance on alcohol consumption has also been reported in other studies (Addo et al., 2018; Lucchetti et al., 2014). Other studies have attributed this low prevalence to cultural and social factors such as religious belief, and economic development like the availability of alcohol policies and its effectiveness (Babor et al., 2010; WHO, 2007).

By living arrangements, quite a vast majority of the study participants live with at least one person. The average household size was 3. Though a substantial proportion also lives alone, earlier studies had found lower proportions (Mba, 2007; Nantomah & Adoma, 2015). This is unusual in the Ghanaian culture since older persons are more likely to live with the children or extended family members (GSS, 2013b). This could also be attributed to factors such as the migration of the younger generation for livelihood, family neglect and childlessness as reported from the qualitative results. Other studies have cited reasons such as a matter of choice or to avoid becoming dependent on the extended family members (Obiri Yeboah, 1991).

Many of the study participants also reported having no primary caregivers to provide care or support either financially or non-financially. This is not surprising since findings from this study pointed out that, quite a substantial number of participants live alone. A few had reported not to have received any social support in-kind or in-cash from relatives or children in the last 12 months. From the qualitative analysis, some study participants also lamented on the low level of care from the extended family or relatives that the present-day older person is confronted with.

The health-related characteristics of the study participants showed better self-health status and this has been reported in other studies. Assessing the social and health-related factors of self-reported health among older persons in Ghana, Fonta et al, (2017) found that 79.9% rated their health status as good. This study found arthritis as the commonly cited age-related ill-health. Other non-communicable diseases such as hypertension, diabetes and stroke were also mentioned by about a third (33.3%) of the study participants. It is well documented that NCDs continue to be the leading type of diseases that affect the aged (GSS, 2013b). This is also an indication of an increased risk of disability in many LMICs (Basu and King, 2013). Other studies have also reported of over 40.0% of older adults with at least one chronic disease (Sibai, Rizk, and Kronfol, 2014).

The results from this study revealed the expected relationship between age and being a recipient or an enrolee of SPIs especially NHIS enrolment among older ages (Jehu-Appiah et al., 2011). Both initiatives explored in this study have age as a criterion with a cut-off age at ≥ 65 for LEAP and ≥ 70 years for NHIS. This may explain why older ages (80-84 years) were 3.6 times more likely to participate in SPIs relative to those in early old age groups. This finding is also supported by results from the qualitative analysis, where FGD participants mentioned those 80 years and above to have higher chances of becoming beneficiaries of SPIs. Duku et al., (2015) found Ghanaian older persons ≥70 years to be about twice more likely to enrol in NHIS compared to the younger age group; attributing this finding to the exemption policy. Advanced ageing is associated with chronic illness such as hypertension, diabetes and stroke. This may result in disability which may further propel their inclusion in SPIs especially the LEAP programme. Older persons with disabilities may also need special consideration given the interaction between disability and inequalities (Browne, 2015).

Household food security played a key role in participating in SPIs among the study participants. In the provision of staple foods such as rice and other items, Handa et al., (2013) found LEAP to be crucial for beneficiary households in Ghana. Household food security was established as one of the immediate benefits of CCTs among Kenyans (National Gender and Equality Commission (NGEC), 2014).

Healthcare services were sought from non-hospital levels such as polyclinics, health centres, clinics, pharmacy, drug store and chemical shops. These are usually the most common level of seeking primary healthcare compared to that of hospitals. Additionally, a sizeable proportion of the study participants also sought care at the hospital level. Place of accessing healthcare services was found to be statistically significant in SPIs participation. This finding supports the hypothesis that older persons who seek care from the hospital level are more likely to be SPIs beneficiaries compared to those who seek care at non-hospital levels such as polyclinics, health centres, clinics, pharmacy, drug store and chemical shops. This could be due to the availability of the needed age-appropriate services for older persons mostly at the hospitals in addition to the NHIA accreditation these hospitals may have had. The use of other levels of providers such as drug peddlers and traditional healer's home reduced the odds of participating in SPIs. This could be that these health service providers are not listed as part of the credentialing facilities to ensure access to care for all subscribers of NHIS (NHIA, 2013). Handa et al., (2013) reported that LEAP recipients addressed healthcare needs from medical shops, traditional or herbal medicines while others used cash grant for transport to seek care. Being a cash grant recipient makes one an automatic enrolee of the NHIS (Abbey, Odonkor & Boateng, 2014) which beneficiaries had to register to access care with an insurance card.

The policy implications of older persons' participation in social protection initiatives are highlighted in the Ghana National Social Protection Policy, 2016 and the National Ageing Policy, 2011. Currently, the later document is a draft Ageing Bill to be finalized by the Attorney General's Department for submission to Cabinet (MoGCSP, 2018). Both documents acknowledge the poverty risk among older persons relative to the younger age groups. There is a need for appropriate policy response especially given that the majority of the study participants are engaged in the informal sector where access to formal income security protection is non-existent. The need to speed up the Ageing Bill amidst strengthening the implementation of the former policy geared towards older persons will promote the overall welfare of this sub-population. Strengthening through effective and efficient ways the enrolment and acceptability of the informal sector unto Pension Schemes using various innovative ways is essential for older persons.

5.9 Conclusion

In this chapter, the relationship between the characteristics of the study participants and SPIs participation were analysed to investigate which variables are the predictors of SPIs participation. The set of variables that were found to be the predictive factors of SPIs participation were demographic variables (age), socioeconomic variables (household food security) and health-related characteristics (place of accessing healthcare services). The next chapter discusses the extent to which the two theories (Andersen Healthcare Utilisation Behaviour and the Donabedian's Structure, Process and Outcome models) underpinning this study are examined in the context of access to quality healthcare, promoters, barriers and the predictive factors among the study participants.

CHAPTER SIX

ACCESS TO QUALITY HEALTHCARE: PROMOTERS, BARRIERS AND THE PREDICTIVE FACTORS.

6.1 Introduction

The element of quality healthcare, whether expected or perceived, in addition to the perspective from which it is examined, is complex and multidimensional (Donabeidan, 1980). Access to quality healthcare is seen as an individual gaining entry into the healthcare system and undergoing the treatment that increases one's likelihood of preferred health outcome that is in line with the modern professional knowledge (Aday & Andersen, 1974; Institute of Medicine, 1990). This is also determined by associated factors such as organisational (Campbell, Roland and Buetow, 2000, Murray and Frenk, 2000) including health policy (Peabody et al., 1999), community (Peabody et al., 1999), household and individual (Campbell, Roland and Buetow, 2000; Peabody et al., 1999) characteristics.

The analysis in this chapter examines the promoters and barriers to quality healthcare for older persons. The chapter discusses access to quality healthcare in the context of the Donabedian model that hinges on three main elements (structure, process and outcome). This chapter specifically examines the nature of quality of care based on what study participants perceived to have accessed using the combination of quantitative and qualitative techniques. The overall perceived quality of care as an index and its associated sub-scale dimensions are identified. Furthermore, in the context of the Andersen Healthcare Services Utilisation Behaviour Model, the predictors of the overall perceived level of access to quality healthcare among participants that utilised healthcare services are also studied.

6.2 Descriptive analysis – The Expected quality of care

Table 6.1 shows the descriptive statistics for the expected quality of care by mean score dimensions among the survey participants. Most items had scores between 3.26 and 3.74 points as well as standard deviations between 0.56 and 1.02. This reflects how crucial these items under each of the three grouped dimensions are to the study participants in the measurement of expected quality healthcare. "*Take patients seriously"* had the highest mean score of 3.76, followed by *"medicines free of charge"* (3.74). The least mean score was on "*patients have access to case notes/files/folders"* (3.26) and the second to the least mean score was recorded for "*good accessibility by telephone"* and *"general practitioner's phone switched through directly to the doctor on call"* (3.35) respectively.

Table 6.1: Descriptive statistics for expected quality of care among the study participants by mean score dimensions

[Score = not important - 1, fairly important – 2, important – 3, and extremely important – 4]

Item number	Statement	Obs	Mean (SD)	Min	Max
Process					
1	Take patients seriously	400	**3.76** (0.56)	1	4
2	Keep appointments punctually	400	3.70 (0.56)	1	4
3	Patients have access to case notes/files	400	**3.26** (1.02)	1	4
4	Patients receive information about combinations of medicines	400	3.60 (0.63)	1	4
5	Patients decides about treatment	400	3.44 (0.89)	1	4
6	Choice of another healthcare provider	400	3.36 (1.02)	1	4
7	Good understanding of the patient's problem	400	3.63 (0.61)	1	4
8	Work efficiently	400	3.73 (0.56)	1	4
Structure					
9	Access to hospital specialist within 2 weeks	400	3.56 (0.74)	1	4
10	Immediate home help after discharge from hospital	400	3.51 (0.87)	1	4
11	Good care co-ordination	400	3.66 (0.60)	1	4
12	Waiting time < 15 min	400	3.60 (0.70)	1	4
13	Good accessibility by telephone	400	**3.35** (0.96)	1	4
14	Medicines free of charge	400	**3.74** (0.57)	1	4
15	Reimbursement of cost within 2 months	400	3.55 (0.81)	1	4
16	Cost/benefits balance	400	3.53 (0.74)	1	4
Category-specific					
17	Friendly attitude towards the patient/client	400	3.69 (0.59)	1	4
18	Willingness to discuss matters that have not run satisfactorily	400	3.60 (0.65)	1	4
19	Always allow enough time for the patient/client	400	3.64 (0.62)	1	4
20	Arrangements on what to do in an emergency	400	3.60 (0.67)	1	4
21	Information leaflet with any medicines dispensed	400	3.54 (0.71)	1	4
22	Information about the risks involved in any treatment	400	3.56 (0.69)	1	4
23	Prescriptions delivered to the patients' home address	400	3.47 (0.84)	1	4

24	No objections if the patient brings someone with him/her to an appointment	400	3.50	(0.74)	1	4
25	Considerations about home help before being discharged	400	3.48	(0.82)	1	
26	Cover to be provided when my regular home help is ill or on holiday	400	3.41	(0.88)	1	4
27	Easy access for physically disabled or people in wheelchairs	400	3.66	(0.68)	1	4
28	Easy to get to by public transport	400	3.70	(0.57)	1	4
29	Easy to get to	400	3.63	(0.58)	2	4
30	General practitioner's phone switched through directly to the doctor on call	400	**3.35**	(0.92)	1	4
31	Home help for as many hours as the client needs	400	3.55	(0.74)	1	4
32	Possibility to determine how to allocate the budget for care services	400	3.48	(0.84)	1	4

Source: Computed from author's survey data, September 2017 – October 2017. Number = 400
Obs=Observations

6.3 Multivariate analysis – The Expected quality of care

The five factors from the multivariate analysis were efficiently analysed to measure what constituted expected quality of care among the study participants. Each factor/component was carefully labelled to reflect on the statements it encompassed (Table 6.2) as outlined from Table 6.1 above. These five combined main themes were (1) communication and respect [from factors 4, 18, 19, 20, 21, 22, 24, 29, and 30]; (2) adequate service delivery [from factors 3, 10, 23, 25, 26, 31, and 32]; (3) provider attitude [from factors 1, 2, 4, 5, 7, 8 and 9]; (4) cost [from factors 11, 12, 14, 15, and 16]; and (5) geographic accessibility [from factors 27 and 28].

The results showed lower values of uniqueness indicating the relevance of each item's contribution to the measurement of expected quality of care. These are mainly distributed among several different factors. The first and most significant factor accounts for 17.0% of the variance in the data and this indicated the importance of communication and respect dimension with nine variables loaded unto it. The second factor accounted for 14.2% of the variance and this indicated the importance of adequate service delivery with seven loaded variables. The third factor accounted for 13.9% of the variance and showed the importance of 'provider attitude' with seven variables.

Table 6.2: Expected quality of care dimensions (pattern matrix) and Factor loadings among the study participants

Factor/dimension	Statement	Factor Loadings	Eigen-values	% of variance	Cronbach's alpha (α)
1 Communication and respect	4 Patients receive information about combinations of medicines	0.540	5.439	17.0	0.962
	18 Willingness to discuss matters that have not run satisfactorily	0.587			
	19 Always allow enough time for the patient/client	0.563			
	20 Arrangements on what to do in an emergency	0.539			
	21 Information leaflet with any medicines dispensed	0.699			
	22 Information about the risks involved in any treatment	0.532			
	24 No objections if the patient brings someone with him/her to an appointment	0.682			
	29 Easy to get to	0.552			
	30 General practitioner's phone switched through directly to the doctor on call	0.782			
2 Adequate service delivery	3 Patients have access to case notes/files	0.509	4.535	14.2	0.961
	10 Immediate home help after discharge from hospital	0.645			
	23 Prescriptions delivered to the patient's home address	0.568			
	25 Considerations about home help before being discharged	0.722			
	26 Cover to be provided when my regular home help is ill or on holiday	0.739			
	31 Home help for as many hours as the client needs	0.634			
	32 Possibility to determine how to allocate the budget for care services	0.637			
3 Provider attitude	1 Take patients seriously	0.720	4.453	13.9	0.961
	2 Keep appointments punctually	0.730			
	4 Patients receive information about combinations of medicines	0.536			
	5 Patients decides about treatment	0.508			
	7 Good understanding of the patient's problems	0.562			
	8 Work efficiently	0.584			
	9 Access to hospital specialist within 2 weeks	0.601			
4 Cost	14 Medicines free of charge	0.719	4.225	13.2	0.962
	15 Reimbursement of costs within 2 months	0.639			
	16 Costs/benefits balance	0.529			
	11 Good care co-ordination	0.606			
	12 Waiting time < 15 min	0.543			
5 Geographic accessibility	27 Easy access for physically disabled or people in wheelchairs	0.652	2.329	7.3	0.962
	28 Easy to get to by public transport	0.710			
Consistency coefficient (α)					**0.962**

Source: Computed from author's survey data, September 2017 – October 2017. N = 400 Extracted Method: Factor Analysis Principal Component Factor Analysis (Exploratory Factor Analysis) Rotation Method: Varimax with Kaiser Normalisation. Variance Explained for the Five (5) Factors: 65.6%.

"Cost" as the fourth factor accounted for 13.2% with five variables. Finally, the fifth factor accounted for a variance of 7.3% was grouped under 'geographic accessibility' which identified the study participants' understanding of the role physical accessibility plays in the expected quality of care (Table 6.2).

The Cronbach's coefficient of overall acceptance reliability was 0.96. Each sub-scale measuring expected quality of care also had a high level of internal consistency (Table 6.2).

6.4 Descriptive analysis – The Perceived quality of care

The descriptive statistics for perceived quality of care among the study participants that utilised healthcare are displayed by mean score dimension in Table 6.3. On the score of 1 (very dissatisfied) to 5 (very satisfied), "*easy to get to by public transport"* had the highest mean score of 4.52. Three of the statements had the second highest mean score (4.44) each. These were "*take patients seriously"*, "*patients receive information about combinations of medicines"* and "*work efficiently"*. The least mean score was recorded on "*cover to be provided when my regular home help is ill or on holiday"* (2.32) and the second least mean core was "*considerations about home help before being discharged"* (2.72).

Table 6.3: Descriptive statistics for perceived quality of care by mean score dimensions among study participants that utilised health services

[Score =not satisfied - 1, satisfied –2, average/normal –3, dissatisfied – 4, and very dissatisfied – 5]

Item no.	Statement	Obs	Mean (SD)	Min	Max
Process					
1	Take patients seriously	303	**4.44** (0.87)	1	5
2	Keep appointments punctually	275	4.38 (0.85)	1	5
3	Patients have access to case notes/files	265	4.21 (0.97)	1	5
4	Patients receive information about combinations of medicines	303	**4.44** (0.89)	1	5
5	Patients decides about treatment	255	4.25 (0.96)	1	5
6	Choice of another healthcare provider	187	3.69 (1.43)	1	5
7	Good understanding of the patient's problem	303	4.43 (0.89)	1	5
8	Work efficiently	301	**4.44** (0.82)	2	5
Structure					
9	Access to hospital specialist within 2 weeks	202	3.79 (1.14)	1	5

10	Immediate home help after discharge from hospital	141	2.90	(1.82)	1	5
11	Good care co-ordination	296	4.30	(0.90)	1	5
12	Waiting time < 15 min	296	3.87	(1.12)	1	5
13	Good accessibility by telephone	138	3.31	(1.65)	1	5
14	Medicines free of charge	233	3.59	(1.20)	1	5
15	Reimbursement of cost within 2 months	126	3.21	(1.82)	1	5
16	Cost/benefits balance	282	3.78	(1.01)	1	5
Category-specific						
17	Friendly attitude towards the patient/client	301	4.42	(0.88)	1	5
18	Willingness to discuss matters that have not run Satisfactorily	264	4.20	(0.92)	2	5
19	Always allow enough time for the patient/client	296	4.35	(0.88)	1	5
20	Arrangements on what to do in an emergency	279	3.27	(1.54)	1	5
21	Information leaflet with any medicines dispensed	291	4.27	(0.91)	1	5
22	Information about the risks involved in any treatment	292	3.84	(1.35)	1	5
23	Prescriptions delivered to the patients' home address	150	2.82	(1.79)	1	5
24	No objections if the patient brings someone with him/her to an appointment	256	4.14	(1.07)	1	5
25	Considerations about home help before being discharged	138	**2.72**	(1.78)	1	5
26	Cover to be provided when my regular home help is ill or on holiday	193	**2.32**	(0.92)	1	5
27	Easy access for physically disabled or people in wheelchairs	290	4.32	(0.92)	1	5
28	Easy to get to by public transport	300	**4.52**	(0.74)	1	5
29	Easy to get to	300	4.48	(0.81)	1	5
30	General practitioner's phone switched through directly to the doctor on call	105	4.00	(1.24)	1	5
31	Home help for as many hours as the client needs	140	2.81	(1.84)	1	5
32	Possibility to determine how to allocate the budget for care services	207	3.09	(1.56)	1	5

Source: Computed from author's survey data, September 2017 – October 2017. N = 303
[some observations below N=303 due to the impossibility/non-applicability of some health facilities able to provide such services]

6.5 Multivariate analysis – The Perceived quality of care

The results showed lower values of uniqueness and this represented the relevance of each item's contribution to the measurement of perceived quality of care. Five factors were generated. These were also distributed primarily among several different factors. Adequate service delivery was the most significant factor for the perceived quality of care among participants (Table 6.4). This accounted for about 27.0% of the variance in the data and a total of 11 variables loaded unto it. The second factor accounted for 19.0% of the variance and this indicates the significance of provider attitudes with seven variables. Patient/client dignity was the third factor accounting for approximately 10.0% of the variance in perceived quality of care measurement with five variables (Table 6.4). The fourth factor, "facility easy accessibility"

accounted for 8.1% with three variables presenting the importance of easy to get to by public transport, easy to get to, and the information leaflet with any medicines dispensed. The fifth factor accounted for a variance of 5.3% and was grouped under "patient autonomy" as part of the quality of care experienced at the recent contact with the delivery care system among the survey participants.

Figure 6.1 depicts the overall perceived quality of care. The result showed that about 64.0% of the participants that utilized healthcare services had a good perception of the quality of care received. Thirty-six percent indicated the care received was of poor quality.

Table 6. 4: Perceived quality of care dimensions (pattern matrix) and Factor loadings among the study participants

Factor/dimension	Statement	Factor Loadings	Eigenvalues	% of variance	Cronbach's alpha (α)
1 Adequate service delivery	4 Immediate home help after discharge from hospital	0.834	7.233	26.8	0.926
	18 Good accessibility by telephone	0.833			
	19 Medicines free of charge	0.564			
	20 Reimbursement of costs within 2 months	0.861			
	21 Arrangements on what to do in an emergency	0.501			
	22 Prescriptions delivered to the patients' home address	0.852			
	24 Considerations about home help before being discharged	0.874			
	26 Cover to be provided when my regular home help is ill or on holiday	0.645			
	30 General practitioner's phone switched through directly to the doctor on call	0.808			
	31 Home help for as many hours as the client needs	0.827			
	32 Possibility to determine how to allocate the budget for care services	0.680			
2 Provider attitude	1 Take patients seriously	0.692	5.191	19.2	0.931
	4 Patients receive information about combinations of medicines	0.737			
	7 Good understanding of the patient's problem	0.770			
	8 Work efficiently	0.779			
	11 Good care co-ordination	0.715			
	17 Friendly attitude towards the patient/client	0.772			
	19 Always allow enough time for the patient/client	0.712			
3 Patient/client dignity	2 Keep appointments punctually	0.724	2.626	9.7	0.931
	5 Patients decides about treatment	0.547			
	18 Willingness to discuss matters that have not run satisfactorily	0.717			
	24 No objections if the patient brings someone with him/her to an appointment	0.579			
	32 Possibility to determine how to allocate the budget for care services	-0.541			
4 Facility easy accessibility	28 Easy to get to by public transport	0.847	2.175	8.1	0.932
	29 Easy to get to	0.745			
	21 Information leaflet with any medicines dispensed	0.507			
5 Patient autonomy	6 Choice of another healthcare provider	0.664	1.531	5.3	0.931
	26 Cover to be provided when my regular home help is ill or on holiday	0.584			
Consistency coefficient (α)					**0.917**

Source: Computed from author's survey data, September 2017 – October 2017. N = 303 Extracted Method: Factor Analysis Principal Component Factor Analysis (Exploratory Factor Analysis) Rotation Method: Varimax with Kaiser Normalisation. Variance Explained for the Five (5) Factors: 69.

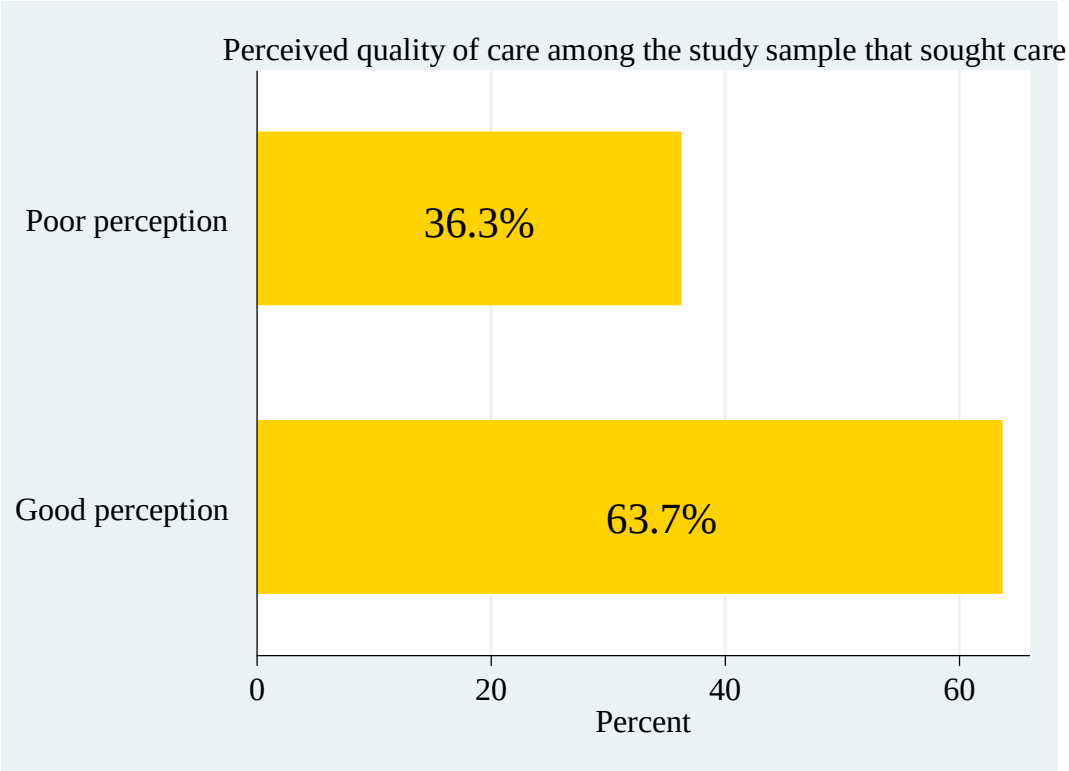


Figure 6.1: Perception about quality healthcare among the study participants that utilised health services.

6.6 Promoters and barriers to quality of care

The promoters and barriers to accessing quality healthcare among participants are discussed in the context of the Donabedian's quality of care framework.

6.6.1 Promoters of quality of care

Reasons related to the dimension of quality of care "Structure" contributed a total of 37.4%. This included the availability of drugs and equipment (24.1%), qualification of health staff (8.6%) and cleanliness (3.6%). From the qualitative results, participants on the availability of drugs and equipment explained that the required drugs needed were available at the facilities they sought care.

Those related to the "Process" dimension of quality of care model contributed a total of 57.7% of the promoters. These included a good attitude of the staff (41.0%), followed by short waiting time (13.7%), administrative process less complex (1.4%), received health education (0.7%), and other reasons (1.1%). On the good attitude of staff, FGD participants explained that health workers do have enough time for clients, treat the client nicely, and give information with the utmost respect.

The illustrative quote from an urban FGD was:

> *"…the patience the health worker will have for you without being cheeky when you even report that you have been ill for the last five weeks… The response will not be 'then how come you have not come to seek care all this while?"* – (Male Urban-FGD).

Reasons related to the "Outcome" dimension of quality of care constituted 5.8%, and this comprised of "got well" with 4.7% relating to participants recovery from illness, and 1.1% for "affordability". Getting well after use of the health facility and recovering from illness were some of the cited explanations given on "got well" outcome-related aspects of quality of care indicated among FGD participants. Female participants in an urban setting mentioned:

> *"Quality healthcare is when you become well after seeking care from the facility"* - (Female Urban-FGD).

Generally, for promoters of quality healthcare, the study participants were more concerned about the "process" dimension. This has to be with their interactions with the health service provider which meets their expectation. This could be due to the respect that older persons are expected to be given in the traditional system. Study participants are therefore particular about how they may be handled by health service providers to continue access health service for which will constitute quality healthcare.

6.6.2 Barriers to quality of care

Participants indicated their perceived barriers or reasons associated with their dissatisfaction in accessing quality healthcare. Factors associated with the "Structure" dimension of quality of care contributed 60.0%. Reasons indicated were participants' given drugs of low quality

(30.0%), unavailability of drugs (10.0%), inadequate training for health staff (10.0%), and services of low standard (10.0%). Given explanations on drugs of low quality, FGD participants indicated older persons are not given the required drugs due to health workers' perception that the illness is due to old-age. The quote below provides an example of how the issue of the low quality of drugs was cited among participants:

> *"And because we are older persons, the health workers assume that the illness is to old age and not any other disease. Due to that, we are given drugs that are not high quality"* - (Male Rural-FGD).

Barriers related to "Process" formed 10.0% and this was long waiting time (10.0%). Male FGD participants in rural communities suggested the need for preferential treatment for the elderly in health facilities to avoid long waiting time. Given that a substantial number of study participants suffer from NCDs, the long waiting periods at health facilities may create an uncomfortable situation for relaxation compared to be at home. Participants further added that facilities do not bother about older persons' complaints, and sometimes the use of the English language affect the Process aspect of quality care. Illustrating the barrier of long waiting time, participants pleaded for preferential treatments at health facilities. Participants in a rural focus group discussion mentioned:

> *"We plead that the government ensures older persons are given preferential treatment at the health facilities instead of joining the long queues to wait to be attended to. Sometimes the long waiting time aggravates the illness "*- (Male Rural-FGD).

Not recovered from illness presented at the health facility (20.0%) and healthcare being very costly (10.0%) were the cited "Outcome" dimension to the quality of care. This contributed 30.0% to the associated factors with perceived barriers to quality healthcare. Highlighting "not recovered from illness", FGD participants recounted how the non-recovery from illness result in hopping from one health facility to the other. A quote from a female FGD in the rural location stated:

"Sometimes, you are forced to hop from one health facility to the other for care with the same illness, and yet you never get better" - (Female Urban-FGD).

On barriers to quality healthcare, the key dimension for study participants was "structure" meaning that resource availability and acceptance of services are crucial in accessing quality healthcare. The lack of it and unacceptability may be seen as barriers to quality healthcare. This may affect older persons' access and utilisation of healthcare services.

6.7 Association between predictive factors and perceived level of access to quality healthcare

6.7.1 Demographic factors

The demographic predictors of accessing quality healthcare are presented in Table 6.5. The results of the multiple logistic regression analysis showed that age was statistically significant with having access to a good perceived level of quality healthcare (Table 6.5). Older persons in the age group 75-79 years had the odds of 0.27 (Odds Ratio=0.29, CI: [0.087 – 0.827], $p < 0.05$) times less likely to have a good perception about the quality of care accessed compared to those 60-64 years old. This could be attributed to services received that did not meet their expectation as a restful of the lack of age-appropriate services and resources. Other demographic characteristics such as sex, religious affiliation, marital status and location were not significant predictors of the perceived level of access to quality healthcare.

6.7.2 Socioeconomic factors

Household food security of participants was statistically significant with the perceived level of access to quality of care (Table 6.5). The results indicate that belonging to a household that experienced food security was associated with good perception about the quality healthcare accessed compared to a household with food insecurity. Participants from households with food insecurity were 0.16 less likely to have a good perceived level of access to quality of care compared to those from households with food security.

Table 6. 5: Results of a multiple logistic regression model showing the predictors of the perceived level of access to quality healthcare among the participants that sought care

Category Predictor	Adjusted Odds Ratio [95% CI]	P-value	Standard error
Demographic factors			
Age group			
60-64 [RC]	1		
65-69	1.006 [0.346 – 2.926]	0.991	0.658
70-74	1.974 [0.624 – 6.247]	0.247	1.160
75-79	0.269 [0.087 – 0.827]	**0.022***	0.154
80-84	0.757 [0.216 – 2.653]	0.663	0.484
85+	0.380 [0.096 – 1.515]	0.170	0.268
Sex			
Female [RC]	1		
Male	1.161 [0.383 – 2.523]	0.792	0.657
Religious Affiliation			
Catholic/Protestants [RC]	1		
Pentecost/Charismatic	1.366 [0.482 – 3.868]	0.557	0.725
Other Christians	0.893 [0.413 – 1.933]	0.774	0.352
Non-Christian	1.871 [0.592 – 5.909]	0.286	1.098
Marital status			
Widowed [RC]	1		
Married	0.889 [0.313 – 2.527]	0.826	0.474
Divorced/Separated	0.675 [0.272 – 1.677]	0.398	0.313
Never married	[omitted]		
Location			
Rural [RC]	1		
Urban	0.539 [0.266 – 1.090]	0.085**	0.194
Socioeconomic factors			
Education level attained			
No education [RC]	1		
Primary	1.032 [0.372 – 2.862]	0.952	0.537
Middle	1.168 [0.460 – 3.969]	0.744	0.556
Secondary & above	0.424 [0.092 – 1.943]	0.269	0.329
Occupation			
No occupation [RC]	1		
Agriculture	0.536 [0.238 – 1.209]	0.133	0.222
Non-agriculture	1.020 [0.365 – 2.850]	0.970	0.535

Source: Computed from author's survey data, September 2017 – October 2017. N = 298 ***P < 0.05** **P < 0.001
[RC] Reference Category

Table 6.5: continued (1)

Category Predictor	Adjusted Odds Ratio [95% CI]	P-value	Standard error
Received social support (past 12 months in cash/kind)			
Yes [RC]	1		
No	1.763 [0.581 – 5.350]	0.317	0.998
Household wealth index			
Poor [RC]	1		
Middle	1.483 [0.640 – 3.437]	0.358	0.636
Rich	1.496 [0.617 – 3.630]	0.373	0.676
Household food security			
Food secured [RC]	1		
Not food secured	0.162 [0.076 – 0.343]	**0.000***	0.062
Lifestyle risk factors			
Smoking status			
Never smoked [RC]	1		
Ever smoked	0.376 [0.125 – 1.133]	0.082**	0.212
Alcohol consumption status			
Never consumed [RC]	1		
Ever consumed	2.051 [0.920 – 4.575]	0.079**	0.839
Living arrangements			
Household size			
Alone [RC]	1		
2-3 members	0.377 [0.165 – 0.864]	**0.021***	0.159
≥4 members	0.468 [0.191 – 1.146]	0.097**	0.214
Having a primary caregiver			
Separate household [RC]	1		
No caregiver	0.369 [0.147 – 0.923]	**0.033***	0.173
Same household	4.634 [1.963–10.936]	**0.000***	2.030
Need factors/Health-related characteristics			
Self-rated health status			
Good [RC]	1		
Moderate	1.413 [0.582 – 3.430]	0.445	0.639
Bad	0.470 [0.179 – 1.233]	0.125	0.231

Source: Computed from author's survey data, September 2017 – October 2017. N = 298 ***P < 0.05** **P < 0.001
[RC] Reference Category

Table 6.5: continued (2)

Category	Adjusted Odds Ratio [95% CI]	P-value	Standard error
Predictor			
Functional disability			
Yes [RC]	1		
No	0.994 [0.258 – 3.822]	0.993	0.683
Disease condition			
Yes [RC]	1		
No	0.363 [0.112 – 1.180]	0.092**	0.218
Injury/Illness (in the last 4 weeks)			
No [RC]	1		
Yes	0.974 [0.489 – 1.938]	0.940	0.342
Type of service			
Outpatient care [RC]	1		
In-patient care	0.821 [0.329 – 2.049]	0.673	0.383
Place of accessing healthcare services			
Hospital level [RC]	1		
Polyclinic/clinic/health centre	0.591 [0.275 – 1.268]	0.177	0.230
Pharmacy/drug store/chem. shop	1.287 [0.481 – 3.445]	0.615	0.646
Other	0.594 [0.129 – 2.737]	0.504	0.463

Source: Computed from author's survey data, September 2017 – October, 2017. N = 298 ***P < 0.05** **P < 0.001
[RC]: Reference Category

This could be due to those participants from food secured households have the needed resources to ensure they access quality healthcare. This includes being able to pay for any extra items/services required at the place of seeking care as well as accessing healthcare at a facility which is more resourced. On the other hand, there was no statistically significant association between covariates such as education level attained, occupation, receiving social support (cash/in-kind) and household wealth index, and the perceived level of access to quality of care among study participants.

6.7.3 Lifestyle risk factors

The results illustrate a weak significant association between lifestyle risk factors and the level of the perceived level of access to quality healthcare (Table 6.5). Study participants who have ever used tobacco products had 0.38 lower odds of having good perception about the quality of care received relative to never smoked counterparts. By alcohol consumption status, participants who had ever consumed alcohol were 2.0 times as likely as those who have never consumed alcohol to have a good perceived level of quality healthcare accessed. The insignificance of the lifestyle variables in the model could be attributed to the limited sample sizes.

6.7.4 Living arrangements

The household size of the participants was statistically significant with the perceived level of access to quality of care (Table 6.5). Compared to participants living alone, those from households with 2-3 members were less likely to have a good perceived level of access to quality healthcare. This could be due to that though they live with other household members, they may not have the needed financial resources to access the appropriate health services. In cases where access to healthcare is made possible, being able to afford other essential treatment may not be possible. Similarly, the presence of a primary caregiver had a significant relationship with the perceived level of access to quality healthcare. Having a primary caregiver in the same household was associated with a good perception of quality healthcare accessed relative to having a primary caregiver living in a separate household by five folds. Contrariwise, having no primary caregiver was associated with a poor perceived level of access to quality of care received compared to primary caregiver residing in a separate household (Table 6.5). This is because primary caregivers in the same household are more likely to serve as accompanying persons during visits to seek access to healthcare. This helps older persons to receive the needed and appropriate information on diagnosis and treatment. Results from the

qualitative analysis confirmed that older persons who live alone and are with no primary caregiver do not receive good quality healthcare service. FGD Participants averred:

> *"An older person living on your own and not depending on anyone, the way sometimes health personnel could maltreat you at the health facility, this could even make your sickness worse and cause your recovery to slow down"* – (Male Rural-FGD).

6.7.5. Health-related characteristics

Contrary to the findings of Sung et al., (2013) which found health status to be positively associated with primary care quality, self-rated health status had no significant relationship with perceived quality of care (Table 6.5). Other health-related characteristics such as functional disability, having a disease condition, injury/illness, type of service accessed and place of accessing healthcare service had no statistically significant relationship with the perceived level of access to quality of care respectively. None of the health-related characteristics was found to be statistically significant in the model. This could be attributed to the challenge of different time-sequences used in the measurements of these variables and how they may be associated with the perceived level of access to quality healthcare.

6.8 Discussion

The chapter examined the features of quality of care in the context of Donabedian's model exploring both the expected and perceived quality of care among the study participants. Furthermore, the promoters and barriers to accessing the quality of care were analysed. Predictive factors associated with the perceived level of access to quality of care were additionally analysed guided by the Andersen Healthcare Services Utilisation Behaviour model.

This study showed that service quality factors (expected and perceived) are crucial to participants and these are further influenced by predictive factors. The study showed some interesting similarity and differences in the expected and perceived quality of care. Five

dimensions were generated for the expected quality of care. These included communication and respect, adequate service delivery, provider attitude, cost and geographic accessibility. For the perceived quality of care, the generated sub-scales were adequate service delivery, provider attitude, patient/client dignity, facility easy accessibility and patient autonomy. Confirming what this study found, other studies have also reported of communication, and dignity and respect as key components of perceived quality of care among study participants in three administrative regions of Ghana (Andoh-Adjei et al., 2018). Khamis and Njau (2014) have also suggested the need for health staff to improve their communication skills to enhance the quality of healthcare delivered.

About 64.0% of the study participants had a good perception of the quality of care accessed while 36.0% had poor perception. Similar findings have also been reported in other studies. In a health facility study in two administrative divisions of Bangladesh, Adhikary et al., (2018) pointed out that, 63.2% of the study participants reported to have been satisfied with the healthcare service they received. The need for health service providers to address the concerns of the perception of poor quality healthcare among users is crucial in order not to deter older persons from using the available services. This is because accessing quality healthcare also has a direct impact on the quality of life of users.

The main promoter of quality of care was a good attitude of staff while drugs that are of low quality was the main cited barrier. In rural Namibia, Van Rooy, Mufune and Amadhila, (2015) reported of positive provider attitude to access health services among older persons. Utilising a qualitative approach to explore the experiences of outpatient hospital service utilisation, access to medication was found to be a barrier for older persons in Asante Akyem North District

in Ashanti region (Bayuo, 2017). Roth et al., (2008) suggested the need for strategies to better measure and improve the quality of drugs use in older persons.

From the qualitative analysis, one interesting finding was language (English) as a barrier that may affect the "Process" dimension in the quality of care measurement. The language was a barrier to quality healthcare according to the FGD participants. They attributed the language barrier to the difficulty in understanding the process involved in accessing healthcare. Hence, study participants assume that health workers pay less attention to older persons as their clients. Confirming language difficulty as a barrier to quality healthcare in this study, Van Rooy, Mufune and Amadhila, (2015) found language difficulties as a barrier to health services use for older persons in rural Namibia. In their study, the authors indicated that older persons perceived the use of the English language by health providers as rude and unfriendly.

Though to the study participants, communication and respect at the point of interacting with the delivery care system were crucial, that was not offered. The effect of patient-provider communication on the perceived quality of care delivered has been well documented. Communication between the patient and the provider allows the users to access information related to their health condition and the associated treatment (Curry and Singlair, 2002).

The cost of care was one of the key themes to the expected quality of care among study participants. According to the report of the United Nations General Assembly (2015), a lot of older persons do not utilise preventive care and where there is utilisation, this is done at the expense of other basic needs which could be attributed to the cost of seeking care. In a study in a rural district in the Central region of Ghana, FGD participants cited the high cost of service is detrimental to the delivery of effective quality healthcare (Turkson, 2009).

Age was found to be associated with poor perception of quality healthcare among participants. This finding corroborates earlier studies showing that older clients perceived the quality of care received to be poor due to unavailability of services and age insensitivity of services especially in government/public facilities (Aboderin and Kizito, 2010). Travers et al., (2019) also found US older adults to be dissatisfied with the medical care quality received due to age-related barriers in access such as transportation. From a qualitative study in Greater Accra Region, Ghana's older persons are faced with quality of care issues (WHO, 2014). According to the report on ageing and health, these quality issues included the inability to afford medication and long waiting time to be attended to by health personnel (WHO, 2014). On the contrary, some studies have found positive perceptions of quality of care and age among patients (Abuosi et al., 2016; Robyn et al., 2013). Abuosi et al., (2016) attributed this to the linear relationships between age and perceived quality of care. This study, therefore, suggests the need for service providers and policymakers to be sensitive to the plight of older persons to promote quality health service for this sub-population.

It was also observed that with improvements in household food security, the perception of the quality of care of the participants was good. The 2014 WHO assessment report on ageing and health for Ghana indicated that many older persons are at risk of food insecurity (WHO, 2014a). Many of the study participants are engaged in agriculture and about a third are from poorest households. The recording of high incidences of food insecurity may affect household poverty and subsequently, the quality of care older persons may receive due to cost as well as accessing the needed healthcare from the appropriate health facilities.

Household size had an indirect relationship with a good perception of the quality of care. This could be attributed to the effect of household wealth and its composition on the well-being of

its members (WHO, 2014a). This could result in influencing financial access to appropriate health services. It was evident among FGD participants that older persons who live alone and had no primary caregiver are likely to be ill-treated by health workers. Other FGD participants added that, in most cases, health workers request older persons to come along with an accompanying person(s)/caregiver(s) when accessing healthcare. This may be crucial in ensuring that older persons receive the proper diagnosis and the appropriate treatment needed.

The presence of a primary caregiver in the same household having a positive influence on the quality of care accessed has also been reported in the US where these caregivers (informal carers) act as mediators to ensure older people access health services (European Commission, 2008). As was found in this study, the need for accompanying persons for older clients at the point of seeking care was also highlighted as a quality of care issue among older persons in Ghana (WHO, 2015). This may be relevant for accessing quality healthcare among older persons in an African country such as Ghana.

6.9 Conclusion

The focus of the analysis in this chapter was to examine the promoters and barriers to quality of care for older persons. The dimensions of quality of care (expected and perceived) were identified in addition to the overall perceived quality of care index. Finally, predictive factors associated with quality healthcare were examined. The results show four key findings. Firstly, good provider attitude was the main promoter of quality healthcare while drugs of poor quality were the leading barrier to quality of care. Secondly, the key dimensions of expected and perceived quality healthcare resulted in five factors each. Generally, the index showed the existence of good perception of the quality of care accessed. Factors such as age, household food security, household size and having a primary caregiver predicted good perception of access to quality healthcare. The next chapter presents the influence of SPIs participation on

access to quality healthcare among older persons. This is crucial in understanding the extent of access to quality healthcare in the context of SPIs especially for older persons in developing countries.

CHAPTER SEVEN

THE INFLUENCE OF SOCIAL PROTECTION INITIATIVES ON ACCESS TO QUALITY HEALTHCARE AMONG OLDER PERSONS

7.1 Introduction

The aim of the analysis in this chapter is to examine the influence of social protection initiatives (SPIs) on access to quality healthcare among older persons using multiple regression models. This was investigated at two different levels. The first level examined the effect of SPIs on the perceived level of access to quality healthcare (quality of care index). The second level examines the combined effects of the first level, controlling for the predisposing and need factors. The control variables that were used in the independent models for SPIs (Chapter 5) and perceived level of access to quality healthcare (Chapter 6) were utilised. Table 7.1 displays the SPIs participation, perceived quality of care and other variables used in the multiple logistic regression models.

7.2 The influence of participation in social protection initiatives (LEAP and/or NHIS) on the perceived level of access to quality healthcare (quality of care index) among older persons

Table 7.2 presents the results of the effects of participants' benefiting from SPIs on the perceived level of access to quality healthcare. The results from the multiple logistic regression models showed that participating in SPIs did not significantly predict the perceived level of access to quality healthcare. This was either independently (Model 1) or after controlling (Model 2) for all covariates (Table 7.2). The hypothesis that older persons who are beneficiaries of SPIs have a good perception of the quality of care accessed than their non-beneficiary counterparts was not supported by these findings. This implies that participating in social

programmes such as NHIS and LEAP does not guarantee access to quality healthcare. This is because there may be mediating and external factors from the individual, household, community and institutional levels which may influence the different dimensions of access to quality healthcare in the context of SPIs participation. Age, location, household food security, smoking status, alcohol consumption status, household size, having a primary caregiver, and disease condition were the factors that exhibited some levels of significance in the adjusted model (Model 2, Table 7.2).

Table 7.1: A matrix showing how the predictor variables are used in the multiple regression models

Level 1 Variable [Social protection initiatives participation]
Beneficiary of NHIS and/or LEAP
Non-beneficiary of NHIS and/or LEAP

Level 2 Variables [Level 1 & Covariates]
Covariates
Demographic
Age | Marital status | Religion
Sex | Location

Socioeconomic
Educational level attained | Occupation
Household wealth index | Receiving social support (in cash or in-kind in the last 12 months)
Household food security

Lifestyle risk
Smoking status
Alcohol consumption

Living conditions
Household size
Having a primary caregiver

Health-related
Functional disability | Disease condition | Injury/Illness (in the last 4 week)
Type of health service accessed | Place of accessing healthcare services

Outcome Variable [Overall perceived quality of care]
a. Overall perceived level of access to quality healthcare (quality of care index)

Table 7.2: Results of the influence of SPIs participation (LEAP and/or NHIS) on the perceived level of access to quality healthcare among the study participants through regression analysis.

	Access to the perceived level of quality of care	
	Overall perceived level of access to quality healthcare	
	Model 1 [Unadjusted]	***Model 2 [Adjusted]***
Level 1 Covariate (Enabling factor)		
Social protection initiatives participation		
Yes [RC]	1	
No	1.046[0.608 -1.798](0.289)	1.548[0.671-3.572](0.660)
Level 2 Covariates (Predisposing and need factors)		
Demographic factors		
Predictor		
Age group		
60-64 [RC]		1
65-69		1.029[0.353-2.998](0.561)
70-74		2.128[0.661-6.848](1.267)
75-79		0.265[0.086-0.818](0.152)*****
80-84		0.808[0.229-2.850](0.520)
85+		0.385[0.096-1.550](0.274)
Sex		
Female [RC]		1
Male		1.120[0.366-3.424](0.638)
Religious affiliation		
Catholic/Protestants [RC]		1
Pentecost/Charismatic		1.326[0.462-3.800](0.712)
Other Christian		0.863[0.398-1.871](0.341)
Non-Christian		1.757[0.548-5.636](1.045)
Marital status		
Widowed [RC]		1
Married		0.964[0.335-2.779](0.521)
Divorced/Separated		0.667[0.268-1.661](0.310)
Location		
Rural [RC]		1
Urban		0.525[0.259-1.066](0.190)**

Source: Computed from author's survey data, September 2017 – October, 2017. N = 303 ***P < 0.05** **P < 0.001
[RC] Reference Category ( ) Standard error

Table 7.2: continued (1)

	Access to the perceived level of quality of care
	Overall perceived level of access to quality healthcare
	Model 1 [Unadjusted] ***Model 2 [Adjusted]***
Socioeconomic factors	
Education level attained	
No education [RC]	1
Primary	1.055[0.380-2.931](0.550)
Middle	1.172[0.457-3.002](0.562)
Secondary & above	0.405[0.088-1.853](0.314)
Occupation	
No occupation [RC]	1
Agriculture	0.508[0.223-1.157](0.213)
Non-agriculture	1.059[0.377-2.976](0.558)
Received social support (past 12 months in cash/kind)	
Yes [RC]	1
No	1.838[0.602-5.611](1.046)
Household wealth index	
Poor [RC]	1
Middle	1.400[0.600-3.267](0.605)
Rich	1.473[0.606-3.580](0.667)
Household food security	
Food secured [RC]	1
Not food secured	0.153[0.071-0.329](0.060)*****
Lifestyle risk factors	
Smoking status	
Never smoked [RC]	1
Ever smoked	0.383[0.126-1.162](0.217)**
Alcohol consumption status	
Never consumed [RC]	1
Ever consumed	2.049[0.919-4.572](0.839)**
Living arrangements	
Household size	
Alone [RC]	1
2-3 members	0.378[0.164-0.870](0.161)*****
≥4 members	0.456[0.185-1.124](0.210)*

Source: Computed from author's survey data, September 2017 – October, 2017. N = 303 ***P < 0.05** **P < 0.001
[RC] Reference Category ( ) Standard error

Table 7.2: continued (2)

	Access to the perceived level of quality of care
	Overall perceived level of access to quality healthcare
	Model 1 [Unadjusted] ***Model 2 [Adjusted]***
Having a primary caregiver	
Separate household [RC]	1
No caregiver	0.365[0.146-0.914](0.171)*
Same household	4.676[1.980-11.041](2.050)*
Health-related factors (Need factors)	
Self-rated health status	
Poor [RC]	1
Moderate	1.426[0.587-3.464](0.646)
Bad	0.480[0.183-1.262](0.237)
Functional disability	
Yes [RC]	1
No	0.984[0.256-3.774](0.675)
Disease condition	
No [RC]	1
Yes	0.333[0.101-1.093](0.202)**
Injury/Illness	
No [RC]	1
Yes	0.967[0.485-1.928](0.340)
Type of service	
Outpatient care [RC]	1
In-patient care	0.838[0.334-2.106](0.394)
Place of seeking healthcare service	
Hospital [RC]	1
Polyclinic/clinic/health centre	0.582[0.270-1.254](0.228)
Pharmacy/drug store/chemical shop	1.078[0.382-3.045](0.571)
Other	0.477[0.098-2.328](0.386)

Source: Computed from author's survey data, September 2017 – October 2017. N = 303 ***P < 0.05** **P < 0.001
[RC] Reference Category ( ) Standard error

Participants in the age group 75-79 years were 0.26 less likely to have a good perception of the quality of care accessed relative to those 60-64 years. This was statistically significant. This could be as a result of the diagnosis and treatment received during healthcare utilisation which

may not have met their expectation as beneficiaries of SPIs. These could be related to the structure, process and outcome dimensions of quality healthcare. Participants in households with no food security were 0.15 times less likely to report of good perceived level of quality of care compared to those from households that food security. This was statistically significant. Older persons in households that are food secured may have the resources to afford the appropriate healthcare services in addition to participating in SPIs. Whereas the participation in SPIs guarantees access to and utilisation of health services, the resources may help in accessing vital and needed services which may promote quality healthcare.

Living in a 2 to 3 (Odds Ratio=0.38, CI: [0.164 – 0.870], $p<0.05$) or 4 or more (Odds Ratio=0.46, CI: [0.185 – 1.124], $p<0.05$) member household was associated with a poor perceived level of quality healthcare relative to living alone respectively. Plausible reasons could be that the utilisation of health service may not have met their expectation due to inadequate funds and limited information on diagnosis and treatment received at the health facilities. Having a primary caregiver in the same household increases one's odds of good perceived level of access to quality healthcare about five times (Odds Ratio=4.7, CI: [1.980 – 11.041], $p<0.05$) relative to those with a primary caregiver in separate households. This finding supports the hypothesis that older persons living with primary caregivers in the same household have a good perception of the quality of care accessed relative to their counterparts who reside in separate households with primary caregivers. This could also be due to the accompanying person factor during healthcare utilisation that may promote access to quality healthcare through receiving adequate information and proper diagnosis and treatment. However, having no caregiver was statistically significant with poor perception about the quality of care accessed (Odds Ratio=0.36, CI: [0.146 – 0.914], $p<0.05$) (Model 2, Table 7.2).

Results from the qualitative analysis further revealed that participating in SPIs does not necessarily promote access to quality healthcare. FGD participants stated that the affordability for health services is key in accessing quality healthcare. According to participants, access to quality of care is not dependent on one being an NHIS enrolee or a recipient of a cash grant. This means that participating in a social programme does not guarantee access to quality healthcare. Rather one's ability to pay for the needed services was key in accessing quality healthcare. Some FGD participants affirmed:

> *"If one has the money to pay for the services, then you will have quality healthcare. If not, with the NHIS only, you will be given paracetamol as your medication"* – (Female Urban-FGD).

Other participants emphatically pointed out that affordability is key in accessing quality healthcare:

> "*Unless you are ready to pay. Once you are ready to pay, you will receive quality healthcare"* – (Female Rural-FGD).

Besides the opinions of older persons, IDI participants also shared divergent views on the influence of SPIs participation on access to quality healthcare among older persons. Some participants indicated that being a beneficiary of SPI does not necessarily attract any special treatment at the point of seeking care relative to non-beneficiaries. One IDI participant had this to say:

> *"We do not have any special treatment. Whatever treatment done for the insured is also given to the uninsured"* - (Male, Nurse, Health Centre - Urban IDI).

A member of the community cash grant committee in an urban area supported this assertion that there is no discrimination by SPI status in the delivery of quality of care for older persons and said this:

> *"There is no discrimination in the quality of care one receives at the health facility"* – (Male, LEAP Community Committee Member - Urban IDI).

However, other participants had opposing views citing that the SPI status of older clients plays a crucial role in accessing quality healthcare. Some healthcare providers in rural locations indicated how beneficiaries of SPIs especially the NHIS receive prompt attention compared to non-beneficiary clients.

> *"There is a clear distinction between the insured and the uninsured when it comes to access and utilisation of the services among the elderly. This is also in addition to all the other costs that come with receiving quality healthcare services. For instance, the insured will be offered a bed as quickly as possible to save his life compared to the uninsured"* - (Female, Community Health Worker, CHPS Compound - Rural IDI).

Other participants, however, highlighted the relevance of participating in social protection initiatives and how it influences access to quality healthcare. Some FGD participants mentioned how being a recipient of the cash grant allows one to meet the demands for medical supplies such as adhesive bandage at the point of seeking care. Study participants cited how the cash grant promotes access to quality healthcare through the purchase of the needed medical supplies:

> "*The LEAP helps older persons because even at the health facility if you are asked provide some supplies such as an adhesive bandage, you will be able to buy it for treatment"* – (Male Urban FGD).

The cash grant also makes it possible to access other specific health services such as laboratory services. Study participants also voiced this out:

> *"Yes. The cash grant helps because sometimes at the health facility you are asked to do the laboratory test, you will need some money to pay for it"* – (Female Urban-FGD).

Some FGD participants had contrary opinions concerning the cash grant in ensuring quality healthcare. Some participants in a rural FGD cited the cash grant as a "one day gentleman's money", that is, monies that are spent at the spur of the moment. To participants, the amount of money one receives under the cash grant programme is not sufficient and may not help recipients to access quality healthcare. Participants had asserted:

> "*The money is too small. It cannot do anything meaningful. It is "one day gentleman" money*" – (Male Rural-FGD).

Despite the emerged issue of affordability, there were diverse views from the qualitative results related to influence of SPIs on access to quality healthcare among older persons. This may have contributed to the reason why the regression models did not support the hypothesis that SPIs influence access to quality healthcare. Other factors may account for that.

7.4 Discussion

The results from the analyses of the multiple regression models indicated that being an SPI beneficiary does not significantly influence the perception level of access to quality healthcare. The finding did not support the hypothesis that participants who benefit from SPIs have a good perception of the quality of care accessed relative to their non-beneficiary counterparts. This means that having a health insurance cover and/or being a recipient of a cash grant is not a guarantee that one would have access to quality healthcare service. Rather, the ability for users of the service to cover the full cost of treatment has the potential in ensuring access to quality healthcare. This could be attributed to the reason why the cost of care emerged as one of the established factors of expected quality of care among the study participants.

Contrary to the findings in this study, in 94 non-randomised control trial studies, most of the studies showed a positive relationship between an SPI such as health insurance and health outcomes or healthcare utilisation (Hadley et al., (2003). While Quimbo et al's., (2011) study showed that the type of disease and population play a key role on the extent of health benefits, other studies have also reported otherwise in different population age groups. For instance, in a nationally representative study in Ghana, beneficiaries of SPIs such as the NHIS were found to have poor perceptions about the quality healthcare received at their recent health facility visit compared to non-NHIS users (Duku et al., 2018). Again, in a hospital-based study in Accra, Baidoo et al., (2016) also reported of lower (poor) perception of service quality among patients with no insurance relative to their insured counterparts.

Other studies have established that the Capitation Payment Policy of the NHIS piloted and ran in the region of the study area may have influenced the perception of the quality of care among subscribers (Andoh-Adjei et al., 2018). Though, there are inconsistent findings on the impact of health insurance on quality healthcare (Robyn, Fink and Sauerborn, 2012; Atinga, 2011; Fenny et al., 2014), information on the extent to which cash transfers impact on the quality of services are limited (Ford, Rasanathan and Krech. 2012). But, in Kenya, older persons that participate in cash transfers were able to access medication or pay for transportation to health facilities (National Gender and Equality Commission (NGEC), 2014). This is also consistent with the findings of this study.

Age contributed to the effect of SPIs on the perceived level of access to quality healthcare among older persons. This was found to have marginal significance by location. Both initiatives (NHIS and LEAP) considered in this study have age as a key inclusion criterion. However, it was a predictor in reducing the odds of having a positive perception about the quality of care, particularly for the 75-79 age group. This study showed that the majority of the study participants utilised outpatient services. Duo et al's., (2015) study on utilising outpatient services among older adults was found to be significantly associated with age. The fairly lesser income among older persons and the association with lower capacity to afford health services may be a possible obstacle to accessing healthcare (Sun et al., 2009). This may affect the quality of care this sub-population receives. As pointed out by this study's FGD participants, one's ability to pay for services was crucial in accessing quality healthcare. There is the need to consider the variations in age among older persons in the provision of quality healthcare for this sub-population.

Household food security was a strong predictor on the linkage between SPIs and perceived level of access to quality healthcare. There is a plethora of evidence on the effect of household food (in)security on health outcomes which are also consistent with the findings from this study. Analysing data from 149 countries across the globe, Jones (2017) found that individual-level of food insecurity was associated with poorer mental health. In a developed country such as Canada, using data from a population-based cross-sectional survey, Gucciardi et al., (2009) asserted that household food insecurity was higher among participants with diabetes compared to those without. Pheley et al., (2002) also reported that respondents from food-insecure households had poorer functional status relative to participants in households with food security. Tackling food security as a predisposing factor for quality healthcare is therefore crucial in improving the quality of life of older persons.

Household size was a predictor of the influence of SPIs on the perceived level of access to quality healthcare. As was found in this study, household size was a predictor for a poor perceived level of access to quality healthcare but not for participating in social protection initiatives. This suggests that the problems with access to the perceived level of quality healthcare are driven by having 2-3 member household size. This could be attributed to the services received at the place of seeking care though older persons in 2-3 members are more likely to receive financial or social support in-kind or in cash from household members.

Having a primary caregiver in the same household was a strong predictor of the influence of SPIs on the good perception of quality healthcare among older persons. This supports the hypothesis that in the context of SPIs, older persons who live with their primary caregivers in the same household have good perceptions of the quality of care accessed compared to those with their caregivers in separate households. The presence of caregivers allows older persons

to enjoy their support and care including ensuring they access the needed healthcare services appropriately. In this current study, some health service providers emphasized the need for caregivers to accompany older clients to access and utilise healthcare services. This is to ensure that they receive needed treatment and diagnosis through proper communication. Given the dwindling family care model over time, regularizing and supporting this form of care is important especially among older persons who may also be carers. This is because informal caregiving which is common in most developing countries including Ghana is complementary to formal care (UN, 2003).

7.5 Conclusion

The results of the analysis in this chapter provide supporting evidence that access to quality healthcare in the study setting in not an outcome factor for SPIs participation. Factors that showed significant influence on access to quality healthcare were age, household food security, household size as well as having a primary caregiver.

This chapter has exhibited the interconnectedness between the Andersen's Healthcare Services Utilisation Behaviour and Donabedian's Structure, Process and Outcome models. It has further broadened our understanding of the influence of SPIs on the perceived level of access to quality healthcare among older persons. It has also shown empirical evidence of the plausible role that predisposing factors play in perceived level of access to quality healthcare in a typical setting in an African country.

CHAPTER EIGHT

COMMUNITY AND INSTITUTIONAL PERSPECTIVES ON SOCIAL PROTECTION INITIATIVES AND ACCESS TO QUALITY HEALTHCARE

8.1 Introduction

This chapter focuses on the linkage between social protection initiatives (SPIs) and access to quality healthcare from the perspectives of communities and institutions respectively. The perspectives of the communities were drawn from FGD participants' experiences segmented by location (rural and urban) and sex (male and female). Factors that affect this linkage from the perspectives of institutions were also elicited from IDI participants constituting program planners and implementers, and service providers.

8.2 Communities' perspectives on SPIs and access to quality of care linkage

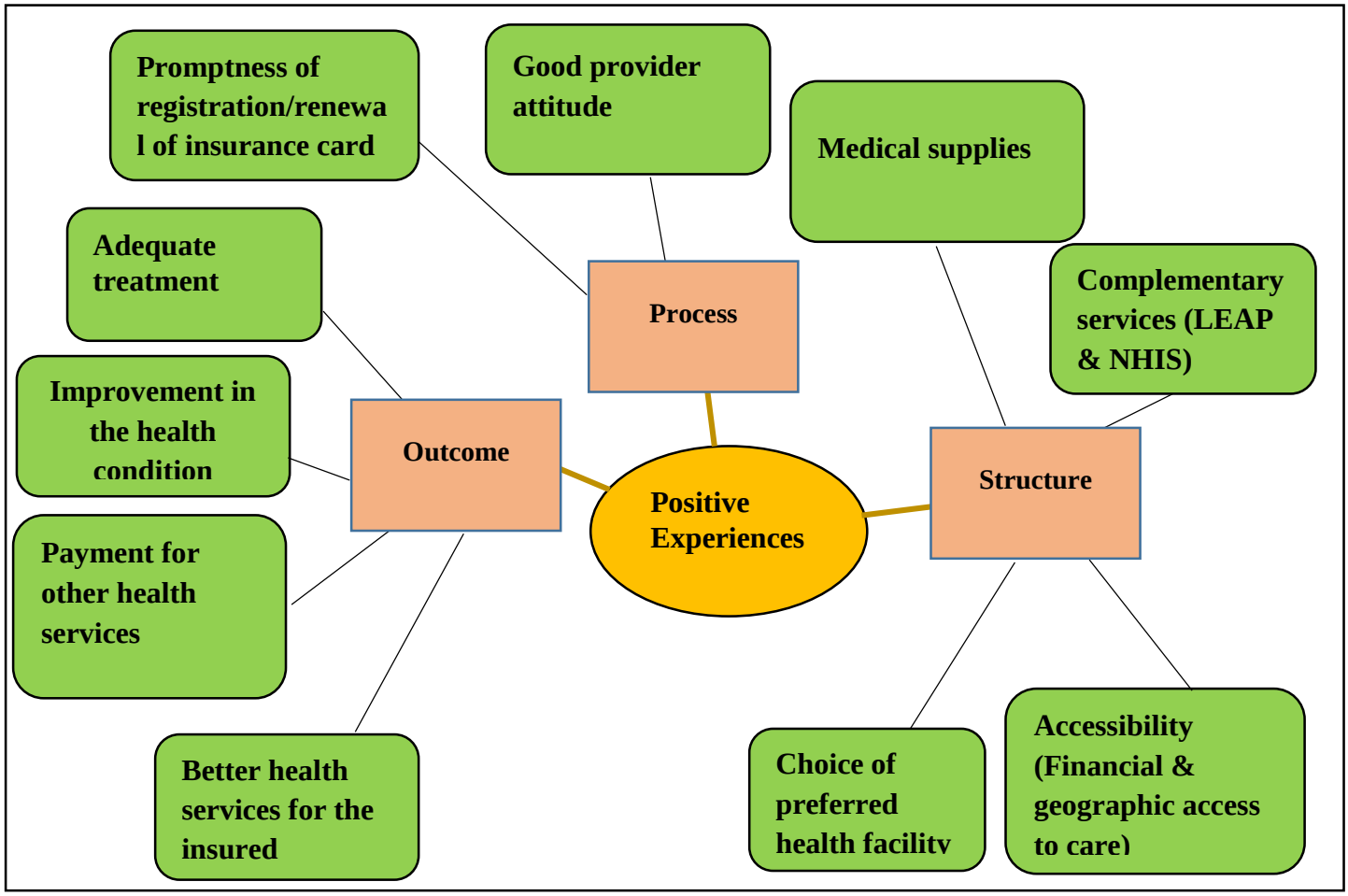
The experiences from the communities' perspectives are presented under two broad themes: Positive and negative experiences within the context of the linkage between SPIs and the access to quality healthcare among older persons. The two themes are discussed within the Donabedian's Structure, Process and Outcome model on the concept of quality of care.

8.2.1 Positive experiences

Participants were asked to share their experiences on the extent to which SPIs participation affect quality healthcare among older persons. Table 8.1 displays the content and spread of views of participants' positive perspectives on the linkage between SPIs and access to quality healthcare while Figure 8.1 shows the thematic networks.

Table 8. 1: Summary of focus group discussion participants' positive experiences of how SPIs affect access to quality healthcare among older persons

Content		Spread of views
Positive experiences		
	Structure	
1.	Accessibility (financial & geographic access to care)	Rural Female FGD Rural Male FGD Urban Male FGD
2.	Choice of preferred health facility	Urban Female FGD
3.	Other medical supplies	Urban Female FGD Urban Male FGD
4.	Receipt of Complementary service (LEAP & NHIS)	Rural Female FGD Urban Female FGD
	Process	
5.	Promptness of registration/renewal of insurance card	Rural Female FGD Urban Female FGD
6.	Good provider attitude	Urban Male FGD Rural Female FGD
	Outcome	
9.	Adequate treatment	Rural Female FGD Urban Female FGD
10.	Better health services for the insured	Rural Female FGD Rural Male FGD Urban Female FGD
11.	Improvement in the health condition	Urban Female FGD
12.	Payment for other health services (Laboratory tests)	Urban Female FGD Urban Male FGD



Source: Author's FGD Qualitative data, December 2017

Figure 8.1: Communities' perspective of positive experiences of social protection initiatives and access to quality healthcare.

8.2.1.1 Structure

The "structure" component of Donabedian's model refers to the physical and organizational characteristics where healthcare occurs (Haj, Lamrini and Rais, 2013; Campbell et al., 2000; Donabedian, 1980). From the results, four sub-themes emerged under the structure dimension of quality of care. Accessibility (financial and geographic to healthcare), choice of preferred health facility, meeting the demand for medical supplies, and receiving complementary services were the structure-related positive experiences cited among participants (Figure 8.1).

Accessibility (financial & geographic access to care)

Participants reported that the linkage between SPIs and access to quality healthcare provides them with both financial and geographic accessibility to healthcare. Being an SPI beneficiary helps one to access healthcare at any facility. For instance, the NHIS allows older persons to visit any health facility of their choice when unwell while the cash grant will help with the payment of transportation when necessary. This helps to strengthen the linkage between SPIs and access to quality healthcare for older persons.

Choice of preferred health facility

Participants also stated that the fact that older persons could access and utilise healthcare services from any health facility of their choice without restrictions (referring to the Capitation model under the NHIS) strengthens the linkage between SPIs and access to quality healthcare. Participants in an urban community emphasised:

> *"Yes. One could go and seek care anywhere of his/her choice with the NHIS card"* - (Female Urban-FGD).

Other medical supplies

Participants described that being a recipient of the cash grant programme promotes access to quality healthcare. This is because at the health facilities one will have to provide for his/her medical supplies such as gloves and an adhesive bandage. With the cash grant, older persons can purchase those items for treatment. This helps them to receive quality healthcare. In an urban FGD, participants had this to say:

> *"It will help because even at the health facility if you are asked to provide some supplies to treat you such as an adhesive bandage, you will be able to provide*" – (Male Urban-FGD)

Receipt of Complementary service (LEAP & NHIS)

Additionally, participants reported their positive experiences with the linkage between SPIs participation and access to quality healthcare. Participants professed that benefiting from the cash grant programme accords older persons the chance to enjoy other complementary services

like the NHIS. This helps them not only to access healthcare services but also some money for sustenance. This has been made possible due to that cash grant recipients and their household members are entitled to NHIS enrolment. Some participants mentioned:

> *"Recipients of the cash grant (LEAP) who did not have the NHIS card were asked to go and get one"* - (Female Urban-FGD).

8.2.1.2 Process

The Process component of Donabedian's model focuses on the factors of the encounter between the healthcare provider and the client (Haj, Lamrini and Rais, 2013; Campbell et al., 2000; Donabedian, 1980). The "Process" aspect of quality healthcare mentioned by study participants included the receipt of promptness to register/renew insurance and good provider attitude (Figure 8.1).

The receipt of promptness to register/renew insurance

FGD participants pointed out that there are mechanisms put in place to ensure that SPIs beneficiaries access healthcare services. This helps to strengthen the linkage between SPIs and access to quality healthcare. Beneficiaries, particularly, recipients of the cash grant programme are usually prompted to register/renew their NHIS cards. This is often done through an announcement and this serves as a reminder. This initiative helps beneficiaries of the SPIs.

Female rural participants commented:

> *"Even recently, it was announced that all those beneficiaries of the cash grant were supposed to go for free NHIS registration. It helps beneficiaries of SPIs to access healthcare services* – (Female Rural-FGD).

Good provider attitude

Good provider attitude was mentioned among urban female and rural male participants. Participants disclosed that health workers treat older persons with respect and patience. Others added that some health facilities have measures in place such as complaint desk with officers to ensure that clients including older persons could report on any unsatisfactory treatments. Due to that, it strengthens the linkage between SPIs and access to quality healthcare since once

older persons utilise healthcare, they could report of any unsatisfactory treatments they experience. Participants in a female rural FGD recounted:

> "*…Some health facilities have complaints desk with officers where you could channel all your concerns to if you think you were not treated well by health personnel or worker"* - (Female Rural-FGD).

8.2.1.3 Outcome

The outcome aspect of the model relates to the consequences of care on clients (Haj, Lamrini and Rais, 2013; Campbell et al., 2000; Donabedian, 1980). Adequate treatment, better health services to the insured, improvement in health condition, and payment for other health services were mentioned as outcome dimensions for positive experiences (Figure 8.1).

Adequate treatment

Participants pointed out that older persons' participation in SPIs makes them receive adequate treatment. This helps to strengthen the linkage between SPIs and access to quality healthcare. Of particular is the medication for which older persons do not hesitate to utilise healthcare services once their medication gets finished at home. Participants in an urban FGD stated:

> *"At the health facility, we are attended to well. Once, your medication gets finished you only go back for more". –* (Female Urban FGD).

Better health services to the insured

FGD participants reported that beneficiaries of SPIs especially enrollees of the NHIS receive better health services compared to the uninsured. The uninsured older persons are expected to pay for every service received. Hence, insured older persons have financial protection to utilise healthcare service thereby strengthening the linkage between SPIs and access to quality healthcare among older persons. This was reported in 7/8 FGDs except among urban male participants (Figure 8.1). Some participants in a rural FGD emphasized:

> *"…With no insurance, you are made to pay for every service you are given". –* (Female Rural-FGD).

Improvement in the health condition

Another positive experiences participants shared related to "outcome" dimension was that participating in SPIs has resulted in improvements in health conditions, especially, from NCDs such as hypertension and stroke. The medication given does not only improve their health condition but also help older persons to cope with daily activities such as being mobile. Hence, participants identified the connection between SPIs and access to quality healthcare as a channel for improving the health conditions of beneficiaries. One participant echoed her experience:

> *"I always go for the pressure medication every month. I have suffered from stroke before. The drugs I am given really helps me a lot to cope daily in my movement. Though, I am not able to walk fast enough"* – (Female Urban-FGD).

Payment for other health services

From the FGDs, there was a general consensus about the role that SPIs play in the payment for other services such as laboratory tests. Participants reported that cash grant recipients are able other services such as laboratory tests which are not covered under the NHIS. While SPIs beneficiaries utilise healthcare using the NHIS, the cash transfer helps them to afford the cost of care on other medical services. Some urban participants averred:

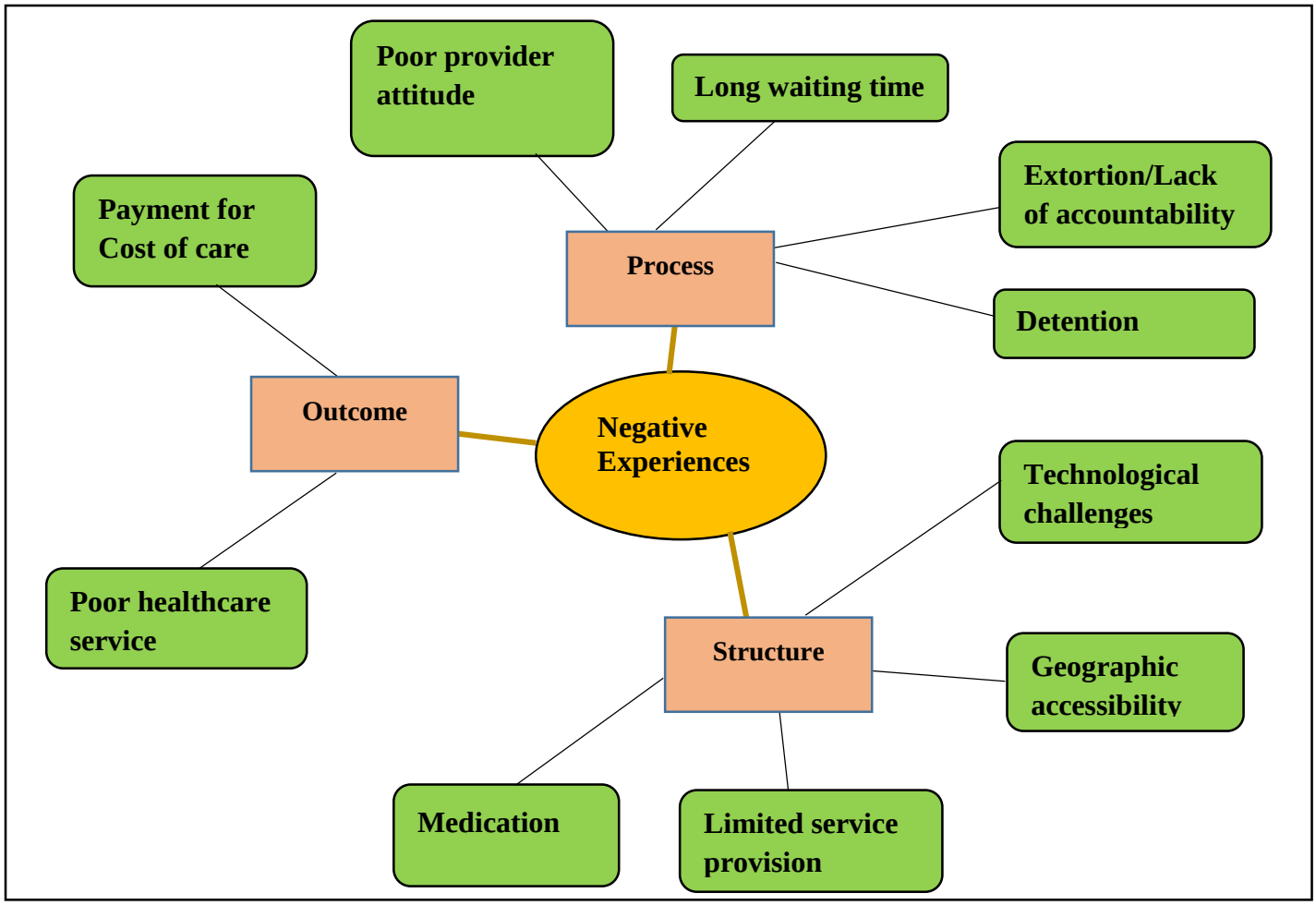
> "*…the cash grant helps. Sometimes at the health facility, you are asked to go to the laboratory and you will need some money to pay for it"* – (Female Urban-FGD).

8.2.2 Negative experiences

The negative experiences of the study participants on the effect of SPIs on access to quality healthcare are illustrated in a thematic network. Similar to the positive experience, the sub-themes are presented in the context of Donabedian's model. Table 8.2 displays the content and spread of views of participants' negative experiences on the linkage between social protection initiatives and access to quality health care while Figure 8.2 shows the thematic networks.

Table 8. 2: Summary of focus group discussion participants' negative experiences of how SPIs affect access to quality healthcare among older persons

Content		Spread of views
Negative experiences		
	Structure	
1.	Medication	Urban Female FGD Rural Male FGD Rural Female FGD
2.	Limited service provision	Urban Female FGD Urban Male FGD Rural Female FGD
3.	Technological challenges	Urban Male FGD Rural Male FGD Urban Female FGD
4.	Geographic inaccessibility	Urban Female FGD
	Process	
5.	Detention	Rural Male FGD
	Long waiting time	Urban Male FGD Rural Female FGD
6.	Extortion/Lack of accountability	Urban Male FGD Urban Female FGD
7.	Poor provider attitude	Urban Male FGD Urban Female FGD
	Outcome	
8.	Poor healthcare service	Rural Female FGD Urban Female FGD
9.	Payment for cost of care	Rural Female FGD Urban Female FGD Urban Male FGD Rural Male FGD



Source: Author's FGD Qualitative data, December 2017

Figure 8. 2: Communities' perspective of negative experiences of social protection initiatives and access to quality healthcare.

8.2.2.1 Structure

Medication, limited service provision, technological challenges and geographic inaccessibility were the structure-related negative experiences study participants mentioned (Figure 8.2).

Medication

Participants reported that the drugs offered at the health facility are usually inadequate. Sometimes, facilities ran out of stock of drugs. At times where drugs are supplies too, they are not appropriated for the kind of medical condition an older person presented at the facility. Realizing the importance of education on drug use, participants also mentioned limited health

education on the side-effects of medication given to them. This does not promote the linkage between SPIs and access to quality healthcare among older persons. Participants emphasized:

> *"We are not informed about the side effects of drugs. We are not given any detailed information related to taking the drug and its aftermath consequences"* – (Male Urban FGD).

Also, participants recounted that older persons are often issued with prescription forms to purchase drugs by themselves elsewhere. Participants attributed this to the frequent shortage of drugs at the facilities. In situations where drugs are available, they are offered the Paracetamol and B-complex. Participants indicated:

> *"Other times too, the prescription form is given to you to make the purchase yourself but if you have to receive any medication, you will have Paracetamol and B-complex"* - (Male Rural FGD)

> *"Sometimes the drugs prescribed and given is not even meant for the exact illness you came to the health facility to report on!"* - (Female Urban-FGD).

Limited service provision

Participants mentioned the issue of limited service provision, though, study participants recognized the need to utilize health services as beneficiaries of SPIs, in their view, and one does not receive the full benefit of the needed care. Participants added that payments are often made at the place of seeking care even when one is an SPI beneficiary. This does not strengthen the linkage between SPIs participation and access to quality healthcare. Participants said:

> "*We have insurance. But, we are asked to pay money when seeking care"* – (Female FGD-Rural).

One participant in an urban FGD reported on the limited number of drugs clients were given at the health facility:

> "*The use of the NHIS does not promote quality healthcare since the number of prescribed drugs are not enough"* – (Female Urban-FGD).

Technological challenges

Study participants reported of technological challenges that affect the linkage between SPIs participation and access to quality healthcare among older persons. Participants made mention of inefficient medical equipment and poor internet connectivity. As a result of the inefficient medical equipment particularly at the laboratory, older persons are asked to seek care from one facility to the other. The poor internet connectivity is another challenge to enrolment unto an SPI specifically the NHIS. FGD participants acknowledged:

> *"There is a laboratory but sometimes you are told the equipment is spoilt. Hence, you are made to go elsewhere to access the service"* – (Male Urban-FGD).

> *"The poor internet connection has been a major setback for us obtaining our NHIS cards on time"* – (Female Rural-FGD).

8.2.2.2 Process

As shown in Figure 8.2, the negative experiences related to "process" aspect cited by participants included detention, extortion/lack of accountability, long waiting time and poor provider attitude.

Detention

Participants recounted that older persons are sometimes detained at the health facility due to non-settlement of bills. The affects the SPIs and access to quality healthcare linkage. According to participants, detention arises due to the high cost of healthcare utilization, particularly for in-patient services. Participants in a rural FGD stated:

> *"Due to high cost of seeking care, when you are on admission and your family has not gotten the needed money to discharge you, you will be detained there until all the payments due them are settled"* – (Male Urban-FGD).

Extortion/lack of accountability

Study participants mentioned that monies are extorted from older persons at the point of utilising healthcare services. This has a negative influence on the linkage between SPIs and access to quality healthcare. They recounted of how officers refuse to issue receipts for services

they have paid for although such services are meant to have been free. This was common in urban localities. Participants stated:

> *"Sometimes when you are asked to do a laboratory test, by the time you realize, you are privately called aside and money extorted from you"* – (Male Urban-FGD).

> *"At my recent visit to the facility, the drug dispenser made me pay GH¢ 30.00 for the drugs... .Aside that he did not issue me with any receipt"* - (Male Urban-FGD).

Long waiting time

Participants bemoaned the issue of long waiting time during health service utilisation. Health workers spend much time sometimes searching for folders for older persons. This negatively affects the linkage between SPIs and access to quality healthcare among older persons. In a male group discussion in the urban location a participant mentioned:

> *"…Some time ago, I went and it took about four hours to search for my folder. … Meanwhile, I did not bring my folder home but it was kept by the facility"* – (Male Urban-FGD).

Poor provider attitude

Important factor participants reported to have a negative influence on the linkage between SPIs and access to quality healthcare was the poor attitude of service providers. Service providers generally perceived old age to be an illness. As a result, older persons are not offered needed care. Aside from the inappropriate treatment, the use of the English language as a medium of communication to older persons does not help in accessing quality healthcare. FGD Participants reiterated:

> *"And because we are older persons, the health workers assume that the illness is due to old age and not any other disease. Hence, we are given drugs that are not of high quality"* – (Male Rural-FGD).

> *"Sometimes, how some of the nurses treat us is appalling. They do not know how to address you as an older person."* – (Female Urban-FGD).

> *"Yes. You know these formal workers and their English. They only write on the form and you are given the same drug that you came complaining about"* – (Male Urban-FGD).

8.2.2.3 Outcome

The main identified "outcome" related to negative experiences among FGD participants were poor healthcare services and the payment for the cost of care.

Poor healthcare services

Participants reported of the poor quality of services that health workers render to older persons especially when you are an insured client. Older persons are often told that insurance does not cover some medication or the other especially drugs. This negatively affects the linkage between SPIs and access to quality healthcare among older persons. Participants in a rural FGD highlighted:

> *"With insurance, you will not receive any better healthcare. You are always told the insurance does not cover one drug or the other…. It is a problem"* – (Female Rural-FGD).

Payment for cost of care

Participants mentioned that older persons are made to do out-of-pocket payments in addition to paying for the cost of extra service. Although older persons are SPIs beneficiaries such as insurance. One is also required to make payment for other services such as imaging or scan. In situations where older persons receive drugs as an insured client, they are usually paracetamol and will have to make payments for other medication. Participants emphasised:

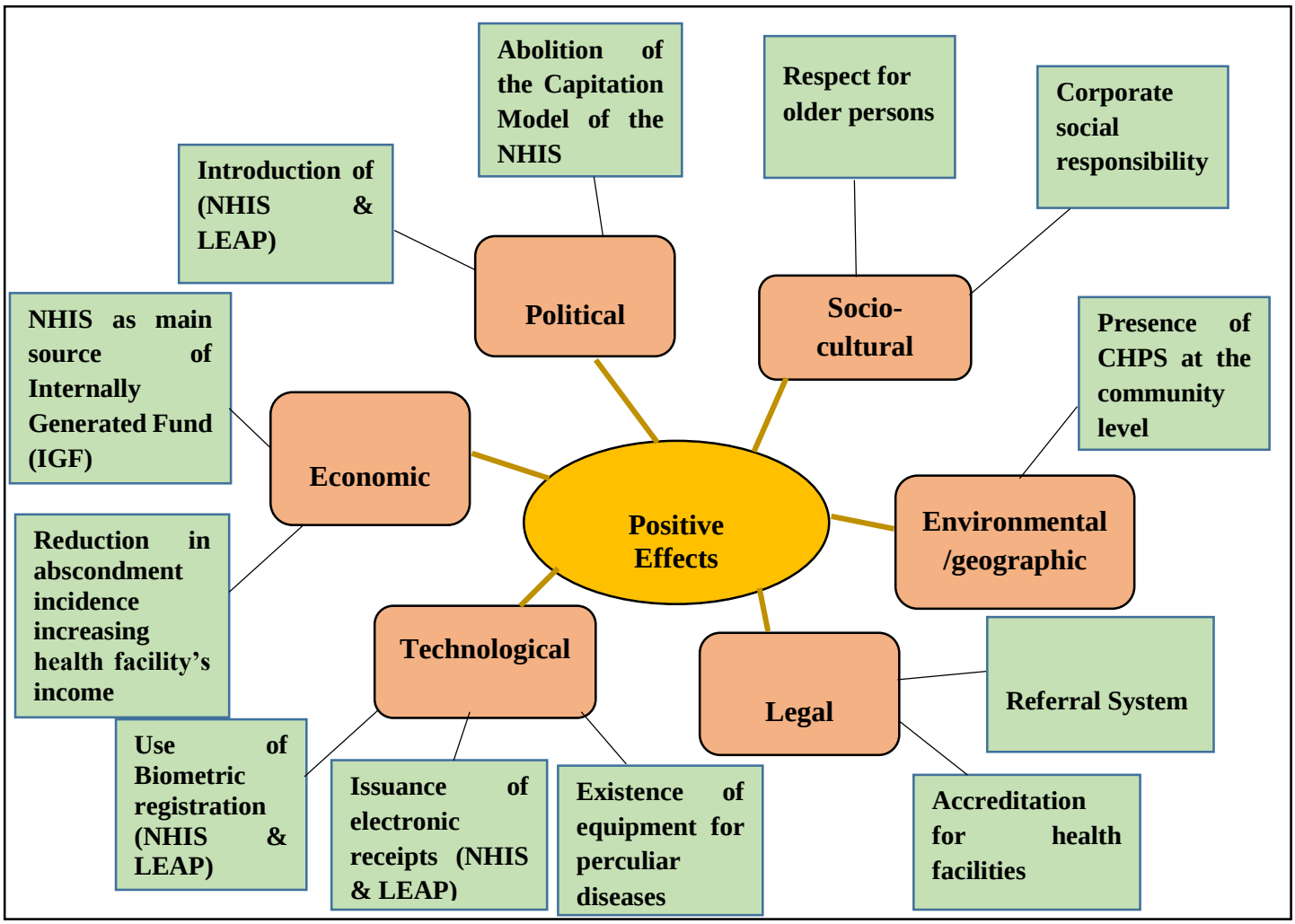
> *"For the laboratory service too, the same. You will have to pay because the insurance does not cover it. For imaging or scan too, you will be required to pay for the service"* – (Female Urban-FGD)

> *"…the medication that the insurance covered was paracetamol. Every other medication, you will have to pay with cash"* – (Female Rural FGD).

8.3 Institutional perspectives on SPIs and access to quality of care linkage

The institutional perspectives on the factors that affect the linkage between SPIs and access to quality healthcare are also presented under two broad categories: positive and negative effects Each effect is further presented in six sub-themes: 1) political factors; 2) economic factors; 3)

technological factors; 4) legal factors; 5) environmental/geographic factors, and 6) socio-cultural factors. Figures 8.3 and 8.4 respectively illustrate the factors that positively and negatively affect this linkage drawn from the perspectives of programme planners and implementers and service providers. A detailed coding framework is presented in Appendices 25 and 26.



Source: Author's IDI Qualitative data, January 2018

Figure 8.3: Positive effects associated with social protection initiatives and access to quality healthcare from the perspectives of institutions.

8.3.1 Positive effects

8.3.1.1 Political factors

Introduction of NHIS and LEAP

IDI participants reported that the introduction of social programmes such as the NHIS and LEAP by a political regime has had a positive effect of the linkage between SPIs and access to quality healthcare among older persons. These social programmes have given financial relief to older persons and their caregivers, especially those who suffer from NCDs like stroke. Also, these social programmes do not only grant them access to healthcare but also as a form of daily sustenance. In one rural IDI, a participant mentioned:

> "*NHIS has brought financial relief to both the elderly and the family or caregivers especially in the face of a severe condition like stroke…*" – (Female, Enrolled Nurse, CHPS Compound– Rural IDI).

> "*LEAP has also brought a lot of relief especially for older persons who are not working. … This is evidential that without the cash grant, that elderly person will find it difficult to survive"* – (Male, Social worker - Urban IDI).

Abolition of the Capitation Model of the NHIS

Participants reported that the abolishing of the Capitation model under the NHIS had a positive effect on the linkage between SPIs and access to quality healthcare among older persons. The abolition allows older persons to access health services at any facility of their choice. Participants highlighted that the Capitation model limited one's ability to receive healthcare as and when he/she wanted to.

> ***"****Capitation model was a challenge. …, it becomes difficult for people including older persons to access healthcare. We thank God that it has now been scrapped off"* – (Male, Social Worker, - Urban IDI).

8.3.1.2 Economic factors

NHIS as the main source of Internally Generated Fund (IGF)

IDI Participants also cited the financial and economic benefits that SPIs bring to service providers as internally generated funds (IGFs) especially the NHIS claims. Though some

service providers have other sources as IGFs, claims from the NHIS could not be overlooked. This forms a majority of the income that health facilities depend on to provide quality healthcare services. Participants further added that it has helped facilities to improve the quality of services to older persons. Hence, having a positive effect on the linkage between SPIs and access to quality healthcare. Participants narrated:

> *"Most health service providers we have interacted with will tell you that more than 80% of their IGFs come from the insurance. So, it tells you how sensitive health insurance is to them"* – (Male, Scheme Manager - Urban IDI).

> *"The facility does not have any IGF apart from the NHIS claims. That is it!"* - (Male, Health worker Health Centre - Urban IDI).

> *"…the facility depends on the NHIS claims to run although the facility generates Other IGFs"* - (Female, Midwife, Health Centre - Rural IDI).

Reduction in abscondment incidence increasing health facility's income

Participants reported that the introduction of these social programmes has reduced that number of clients including older persons who abscond after utilizing health services. The reduction in the incidence of this practice has helped to increase the income base of health service providers. A male Administrator in an urban hospital cited:

> *"NHIS as a form of SPI has also reduced the incidence of abscondment among clients since they come with the insurance. It has improved the revenue of the facility compared to before its inception"* – (Male, Administrator, Hospital – Urban IDI).

8.3.1.3 Technological factors

Use of Biometric registration (NHIS & LEAP)

Participants reported how the use of technology such as the biometric system for registering clients including older persons have had a positive effect on the linkage between SPIs and access to quality healthcare. The biometric system makes access to cash grant easier for recipients. Participants indicated that the NHIS biometric system makes it possible for subscribers to access healthcare within a month of registration or renewal compared to the waiting period of three months before its inception. Participant highlighted:

> *"The use of the biometric makes the payment for the cash grant very accessible to recipients"* – (LEAP Community Committee member, Urban IDI).

> *"…Previously, the waiting time for one to use the NHIS was three months…It has been reduced to one month since it was introduced in 2014…and to ensure accountability, electronic receipts are issued to NHIS subscribers."*– (Male, Scheme Manager – Urban IDI).

Issuance of electronic receipts (NHIS & LEAP)

IDI participants mentioned that the adoption of the use of technology in issuing receipts under these social programmes has improved accountability on the part of service providers. This has had a positive effect on the linkage between SPIs and access to quality healthcare among older persons.

Existence of equipment for peculiar diseases

IDI participants recounted that facilities did not use to have the equipment to provide quality healthcare to older clients. This affected the service utilization among older persons in these facilities. However, the introduction of equipment for diagnosing peculiar chronic diseases such as hypertension and diabetes has made it possible to render quality healthcare to older clients. Hence, strengthening the linkage between SPIs and access to quality healthcare.

A female health worker in a rural community pointed out:

> *"The facility did not have both glucometer and BP apparatus. They are now available"* – (Female, Community Health Worker, CHPS Compound - Rural IDI).

8.3.1.4 Legal factors

Accreditation for health facilities

Another issue as legal factor participants mentioned was the fact that the accreditation to health facilities to render healthcare to NHIS subscribers including insured older clients has made it possible for health service providers to render quality healthcare to older persons. According to participants, accredited facilities are expected to meet a minimum standard of services set for them. This ensures that service providers procure quality drugs. Also, providers are

monitored by a team from the NHIA to ensure clients including older persons receive quality healthcare.

> *"Health facilities have also improved on the quality of the services since we have accreditation from the NHIS … It has served as a check …. There is a monitoring team from the NHIA that comes to inspect on how services are rendered to patients"* – (Male, Administrator, Hospital – Urban IDI).

Referral System

Participants also made mention of the existence of the referral system that allows service users including older clients to access healthcare services from the primary level to the secondary and tertiary levels within the healthcare system. This ensures that older persons receive quality healthcare. Older clients are often referred to as bigger facilities for further treatment. A participant commented:

> *"If the blood pressure is still high, then a referral is given to the elderly to go to the urban centre, municipal Government hospital for further examination and medication"* – (Enrolled Nurse, CHPS Compound – Rural IDI).

8.3.1.5 Environmental/geographic factors

Presence of CHPS at the community level

IDI participants also mentioned that the presence of the CHPS system at the community level has made it possible for older persons to access quality healthcare. Older persons can access and utilise health services within their reach in order not to incur transportation cost. Study participants suggested the need to strengthen such a system.

8.3.1.6 Socio-cultural factors

Respect for older persons

Participants mentioned that the respect that service providers have had for older clients has strengthened the linkage between SPIs and access to quality healthcare for older persons. Participants stated that treating older persons with respect during service utilisation opens the door for them to share their grievances. Some facilities also assign health workers to attend to older clients to avoid long waiting times at the facilities. This improves the provision of the

needed and quality health services for these older clients. IDI participants added that service providers use verbal and non-verbal communications that are crucial in the provision of quality healthcare to older clients. However, illnesses like ear impairments have made verbal communication to some older clients a challenge in service provision. Service providers in some cases resort to shouting or speaking a bit louder in giving information to older clients. These are sometimes interpreted as disrespect or inhumane treatment to older persons. Participant revealed:

> *"Our facial expression and tonation also count in giving quality healthcare to older client. Some older clients have some ear impairment, so if you do not shout or speak a little bit louder, it is difficult for them to hear the information you are giving to them"* - (Enrolled Nurse, CHPS Zone – Rural IDI).

> *"There are times when depending on the facility, specific people are assigned to handle older persons so that, as soon as they get to the facility, their folders are pulled out…"* – (Pharmacist in charge of Health Services, Urban IDI).

Corporate social responsibility

Another socio-cultural factor cited was the corporate social responsibilities which most of the institutions undertake. Participants reported that some institutions liaise with other service providers to ensure that older persons become beneficiaries of SPIs to enjoy quality healthcare. Other institutions organise and mobilise older persons for NHIS registration and renewal to speed up the process of their enrolment. In additions, some heads of service providers at times intervene even at the point of service utilisation issue small notes to older clients to get enrolment unto the insurance scheme to avoid long waiting periods. Sometimes, between 37.0% and 40.0% of the cost of insurance enrolment is covered by some institutions. This has helped older persons to enrol unto NHIS to enjoy access to quality healthcare. These diverse corporate social responsibilities have positive effects on the linkage between social protection initiatives and access to quality healthcare among older persons. IDI participants averred:

> *"Hmmm…in case any of the LEAP recipients has their NHIS card expired, I give a call to inform the Welfare Director for the municipality about it"* – (Male, LEAP Community Committee Member - Urban IDI).

> *"Sometimes the facility assists older clients to get their NHIS cards. We mobilise them and do the registration or renewal for them. Other times too, a note is issued for some clients to get NHIS card …so they could utilise healthcare* - (Female, Medical Practitioner, Private Clinic – Urban IDI).

> *"The health facility organised health insurance registration for the elderly last year (that is, 2016) and this was subsided. This registration was GH¢ 8.00 and GH¢ 5.00 for renewal. They paid GH¢5.00 for registration and GH¢3.00 for the renewal"* - (Male, Head of Finance & Administration, Mission Clinic – Rural IDI).

8.3.2 Negative effects

Figure 8.4 displays the thematic network showing negative effects associated with the linkage between SPIs and access to quality healthcare from the perspectives of institutions.

8.3.2.1 Political factors

Change in political administration

IDI participants reported that the change in the country's political administration has negatively affected the linkage between SPIs and access to quality healthcare among older persons. The change in political administration sometimes halts social interventions including NHIS and LEAP. This is often in the case whereby the ruling government was not the initiator of the programme. This affects beneficiaries of the programme including older persons in access quality healthcare. One participant shared his experience:

> *"When the LEAP programme began in 2008, I was involved but the change in government halted the programme for the whole of the year 2009 since the then current government was not making payments to the recipients"* – (Male, LEAP Community Committee Member - Urban IDI).

Government policies and directives

IDI participants reported that government policies and directives have negative effects on the linkage between SPIs and access to quality healthcare among older persons. The direct of non-posting of new health personnel to health facilities especially in rural areas has affected the quality healthcare that could be rendered to service users including older persons. Another

related issue pointed out by participants was the non-decentralization of new recipients for social programmes such as the LEAP. Whereas health insurance as a social programme can enrol beneficiaries every time throughout the year irrespective of the municipality, the cash grant programme is not operated as such. The enrolment unto the cash grant programme depends on the government since it is not centralized. Hence, non-recipients older persons remain as such until it is announced that new enrolment is being made. This has negative effects on the SPIs and access to quality healthcare linkage among older persons given the old age is associated with illness and poverty. A male IDI participant recounted:

> *"The cash grant system is not programmed like that of the NHIS where clients are enrolled every day…. But if the government has not opened up that enrolment, no recipient could be added…. It is a policy problem…"* – (Male, Social worker - Urban IDI).

Perceived use of SPIs as electoral baits

IDI participants reported that SPIs are usually seen as bait to deny potential electorates their usufructuary rights and this makes participation in such programmes a challenge. One participant recounted how a section of the population refused to be enrolled even a social programme even after been persuaded as a result of its politicisation. An urban IDI participant recounted the experience in the field:

> *"During one of the recent cash grant enrolment, it was politicized when people were asked to present an ID card. Some recipients taught that it was a ploy to deny them of their voting rights. This affected the enrolment… . and yet, some people did not show up. … ."* – (Male, Social worker - Urban IDI).

8.3.2.2 Economic factors

Participants drew on three economic-related factors that negatively affect the linkage between SPIs and access to quality healthcare for older persons: out-of-pocket payment for prescribed drugs for clients, delay in payment of NHIS claims to the accredited health facilities and the lack of motivation for LEAP volunteers.

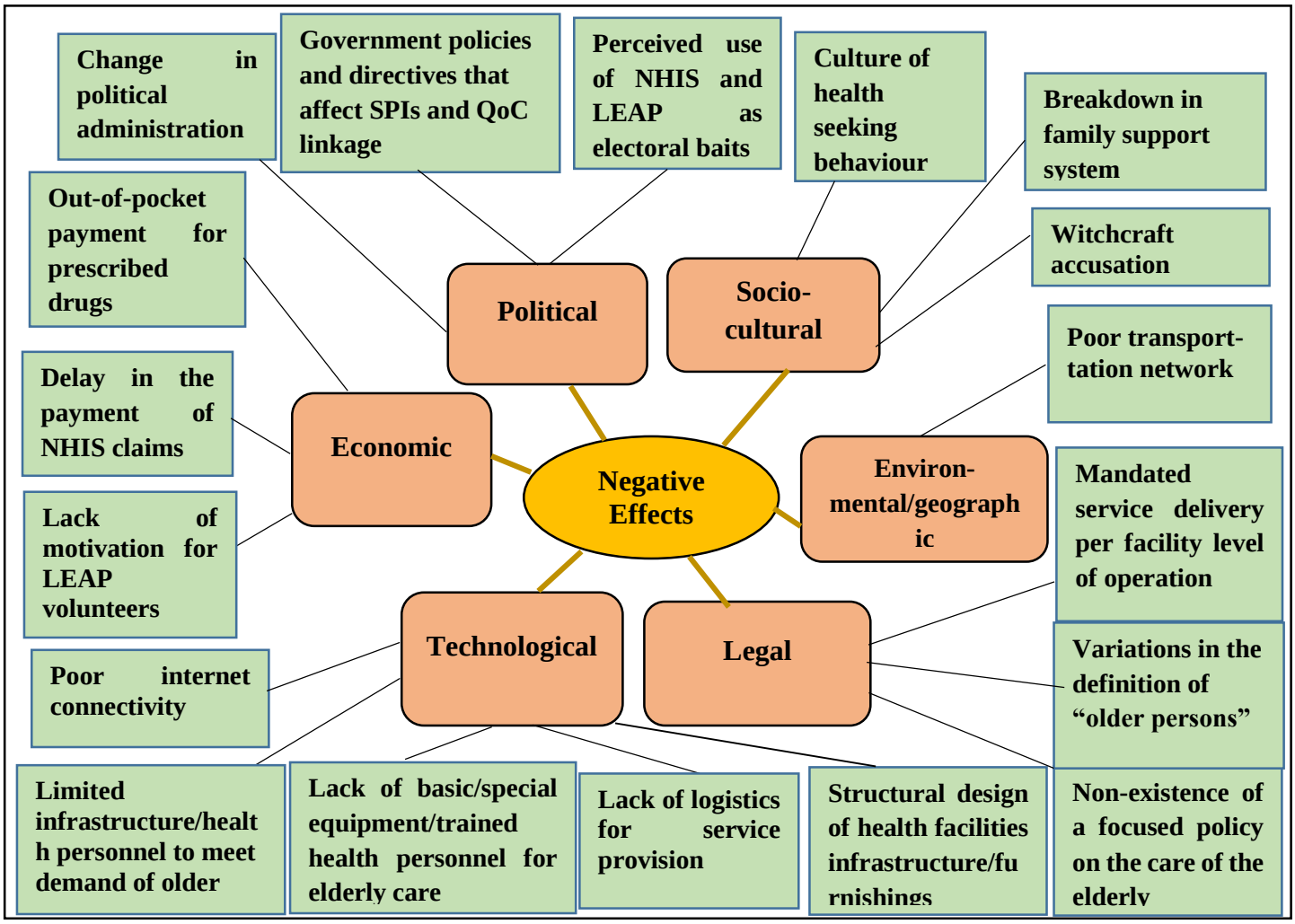


Figure 8.4: Negative effects associated with SPIs and access to quality healthcare linkage from the perspectives of institutions

Out-of-pocket payment for prescribed drugs for clients

IDI participants revealed that clients including older persons make out of pocket payment for drugs, though, they are NHIS subscribers. They are directed to purchase prescribed drugs outside the health facility. This affects the quality of care older persons are expected to access health facilities. A male service provider averred:

> *"It is not every drug that is covered under the NHIS. So clients are told, and where they could afford for such drugs, they top-up for it"* - (Male, Health Centre, Nurse - Urban IDI).

Delay in payment of NHIS claims

Participants also mentioned the delay in the payment of NHIS claims to accredited health facilities. Some participants acknowledged how the delay affects the quality of services rendered to clients including older persons. This also puts the facility into some form of a financial crisis. It compels health providers to issue prescription forms to clients or refer them to bigger facilities. A participant disclosed:

> *"The NHIS delay in payment of claims affects the quality of services the facility gives to older persons. ...the delay in the payment of claims makes it impossible for the facility to purchase the same drugs that have been given out to these older clients. ... . Sometimes the only option left is to issue a prescription form for the drugs to be bought"* - (Male, Nurse, Health Centre, - Urban IDI).

Providers of health services pointed out how the extent to which the delay in the payment of NHIIS claims may even collapse some facilities especially the private ones as a result of the frustration in owing their suppliers.

> *"The NHIS claims do not come regularly. The facility owes a lot of suppliers. The facility has a lot of costs to cover like staff payment, overhead cost, and another cost. I sometimes feel like folding up the facility"* - (Female, Midwife, Private Maternity Home/Clinic – Urban IDI).

Participants also acknowledged how the delay in the payment of NHIS claims promotes the taking of unapproved monies from clients who access health services. Another participant added this:

> *"...but once the providers also need funds to procure or buy medicines,....obviously in a way or the other, the delay may affect services...but even with that, I still disagree with service providers for taking monies from clients because the question I ask is 'if madam X came to you, you took illegal money from that person, then government reimburses you, will you call madam X to come back for her money?'* – (Male, Pharmacist in charge of Health Services, Urban IDI).

Lack of motivation for LEAP volunteers

The lack of motivation for volunteers involved in supporting LEAP at the community level was also cited as an economic factor that may negatively affect the linkage between SPIs and

access to quality healthcare. Volunteers recognize that their work is a non-paid job, yet, the needed resources to work efficiently are not provided. One participant stated:

> *"Sometimes too, recipients tell you they do not know the location of the Social Welfare office at the municipal capital. I will have to then accompany such a person to the place to get the card renewed.*
> ***Interviewer**: Who is responsible for the transportation cost of such an errand?*
> ***Respondent**: I pay for the transportation cost myself"* - (Male, LEAP Community Committee Member - Rural IDI).

Other participants bemoaned the poor conditions of service under which this voluntary job is undertaken.

> *"We need motorbikes for work. I am only given GH¢ 10.00 as transportation cost after every payment session. There is no motivation or payment for this work. It is a voluntary job. We bear the cost of airtime for calling recipients to gather for the payment session….No job description or rules about the work. No training or meeting for the work"* - (Male, LEAP Community Committee Member - Urban IDI).

8.3.2.3 Technological factors

Three technological factors emerged as negative effects that influence the linkage between SPIs and access to quality healthcare (Figure 8.4). These were poor internet connectivity, limited infrastructure and health personnel to meet the demand of older persons, poor structural design and furnishings of health facilities, and the lack of basic and special equipment/trained health personnel for elderly care.

Poor internet connectivity

Participants mentioned that poor internet connectivity in some rural locations as a barrier to SPIs and access to quality of care linkage. Though some efforts have been made to ensure that this sub-population could participate in SPIs in their communities, these efforts have proved futile. Older persons have no other option than to travel outside of their communities to access such services. One health service provider shared this experience:

> *"…We had tried a couple of times to get the NHIS officers to come and work here. It has proved futile due to poor internet connectivity in this community. Organizing registration/renewal exercise for subscribers in this community has not worked. …But the Assemblymember advised that we should be able to locate a point in the community where the telecommunication network is very good for the NHIS operations. But, the*

> *only option left for the elderly is to travel to the municipal capital to do the registration and renewal"* - (Enrolled Nurse, CHPS Zone – Rural IDI).

Another participant expressed the concern that it was not only the issue of poor internet connectivity but also how quick such a challenge is addressed, said this:

> *"…We are also working with machines. And so, once we have a little challenge with the machines and probably the authorities do not attend to it immediately,…it is going to affect the flow of work"* - (Male, Scheme Manager – IDI Urban).

Limited infrastructure and health personnel

IDI participants made mention of the limited infrastructure such as rooms for consulting, and health personnel to meet the demands of older persons. According to participants, the lack of space hinders the provision of the needed services to clients including older persons. And the inadequate health personnel has affected the routine duties such as home visits and this has further influenced negatively the quality healthcare provided for older persons in their various homes especially in rural communities. Though older persons may be insured, the limited infrastructure and health personnel do not allow him/her to receive the need attention from health personnel. These challenges have negative effects on the linkage between SPIs and access to quality healthcare among older persons.

> *"We have only one consulting room. The facility is being operated under capacity due to the limited space and infrastructure…we are not able to do home visits in the community due to the limited number of staff. … We do not have enough spaces for handling our clients…"* - (Male, Nurse, Health Centre - Urban IDI).

Lack of basic and special equipment, and trained health personnel

Lack of basic and special equipment and trained health personnel for elderly care were also important technological factors participants mentioned. Participants recounted that the lack of basic equipment like BP Apparatus to detect hypertension among older persons often force older clients to travel to urban areas to access health services. This causes older clients to spend resources in terms of time and money to access such health service elsewhere. Again, health personnel have not received any special training at all either by a workshop or through formal

education on the care for the aged. This affects how older clients are handled. As a result, services provided to older persons usually do not meet their expectation. Hence, this negatively affects on the linkage between SPIs and access to quality healthcare among older persons. Some participants asserted:

> *"The facility has limited space for the clients. We do not have the equipment for detecting hypertension too.*" - (Female, CHPS Compound, Enrolled Nurse - Rural IDI).

> *"We have not received any special training for caring for older persons since we completed school. Neither have we attended any workshop related to aged care"* - (Female, Community Health Worker, CHPS Compound – Rural IDI).

Poor structural design and furnishings of health facilities

IDI participants mentioned that the structural design of health facilities' infrastructure and furnishings impede services for older persons. The structure of some health facilities has been designed without recourse to the elderly and persons with disabilities. Furnishings such as chairs provided at health facilities are sometimes uncomfortable to use and are often not good for older persons. Besides some of these buildings are not old-age friendly and make it almost impossible for older persons to utilise essential health services. Some urban participants quoted:

> "*The structures of facilities are designed without considering the physically challenged and in that sense, the elderly too. It is assumed that everyone could walk to the facility by him or herself. Even the chairs that are provided in some of our health facilities that I have seen, they are too low. Such chairs are not good for older persons"* - (Female, Medical Practitioner, Private Clinic - Urban IDI).

> *"… . The design of some of the buildings is not old age-friendly* - (Female, Midwife, Private Maternity & Clinic - Urban IDI).

8.3.2.4 Legal factors

Three issues were raised as legal factors among IDI participants (Figure 8.3). These included the non-existence of a focused policy on the care of the elderly**,** variations in the definition of "older persons", and the mandated service delivery per facility level of operation.

The non-existence of a focused policy on the care of the elderly

Participants reported the lack of a focused policy on the care for the elderly. As a result, clients are treated based on the health condition(s) presented at the facility without consideration for your age. This has further worsened the plight of the older persons since such a policy would have directed on how and what to train health workers for aged care. One participant mentioned:

> *"…there is no focused training for the care of the aged. That one is a policy issue. … For now, there is no working document for that. All clients come with a condition so it is not age-specific. It is based on conditions"*- (Male, Administrator, Hospital – Urban IDI).

Variations in the definition of "older persons

Participants highlighted the variations and the inconsistencies in the age definitions of the elderly related to social programmes. This also affects the provision of services to older persons. The variation in the definition also creates gaps where older persons fall within these cracks in missing out on these social intervention programmes and it affects their access to quality healthcare. One participant explained:

> *"Per the Department of Social Welfare definition, the elderly is 65 years and above, and per the NHIS, it is 70 years. Per the Pension Act of Ghana, it is 60 years and above. We have a problem with the definition of the elderly"* - (Male, Social worker - Urban IDI).

The mandated service delivery

The mandated service delivery per facility level of operation was also cited among IDI participants. Health facilities are required to provide some specific services. This comes along with a particular type of drugs that could be prescribed for clients. And this also depends on the calibre of health staff available at the facility. This sometimes serves as a barrier to older persons utilising quality health services. As a result, any condition presented by a client that is above the services a facility provides, the client is referred to a higher level of seeking care and older persons are not excluded from this arrangement. This sometimes is detrimental to the

health of the elderly since it negatively affects the linkage between SPIs and access to quality healthcare among older persons. Participants explained:

> *"Here, we have our level of the prescription of drugs. The only thing that may prevent some older persons from coming to this facility is when they are either diabetic or hypertensive patients. This is because those drugs are not served here. Unless there is a Physician Assistant*" - (Female, Midwife, Health Centre - Rural IDI).

> *"It depends on the level of the facility. Facilities supply drugs to clients based on their level of drug prescription. Health conditions above the level of care of a facility must be referred to a high level of seeking care"* - (Female, Medical Practitioner, Private Clinic - Urban IDI).

8.3.2.5 Environmental/geographic factors

Participants also cited poor road networks as having negative effects on the linkage between SPIs and access to quality healthcare among older persons (Figure 8.4). Poor road networks affect health workers to accept postings to some parts of the country to provide health services to clients including older persons. Participants indicated that the poor road network has also affected clients during emergencies when older persons are to be referred to the municipality capital for care. Some end up losing their lives due to the longer time it takes for vehicles to plough in between communities and towns to access healthcare. At times too, drivers refuse to carry clients to the facility due to the poor nature of the roads. Participant alluded:

> *"Poor road, it is a major factor. …There are times when there are emergencies and these older persons are referred to the municipal capital but due to the poor nature of the road, the client gets there being worse off. …. This road issue is very important. It must be fixed*" - (Male, Nurse, Health Centre - Urban IDI).

> *"The poor nature of the road discourages drivers from transporting clients to the facility"*- (Female, Medical Practitioner, Private Clinic - Urban IDI).

8.3.2.6 Socio-cultural factors

Participants identified the culture of health-seeking behaviour, breakdown in family support system and witchcraft accusation as the socio-cultural factors that negatively affect the linkage between SPIs and access to quality healthcare (Figure 8.4).

The culture of health seeking behaviour

Participants mentioned that the culture of health seeking behaviour is gendered where older women are more likely to seek care compared to their male counterparts. As a results, most men including older men come to seek care at the time where it is difficult to save their lives. They added that this has also been worsened by the practice of self-medication particularly with traditional medicines with the worst part being that NCDs such diabetes and hypertension are seen as "spiritual illnesses". Hence, many older clients do not adhere to the treatment and medication given to them. This worsens their plight and negatively affects the linkage between SPIs and access to quality healthcare among older persons. Participants recounted:

> ***"****... I think generally, health-seeking behaviour among men is low. It is usually the women who will utilize health services. Men generally trivialize symptoms they experience such as headache. Most men seek late when they cannot bear the illness again. These community members believe in traditional medicine. So some choose to use such methods for treatment instead of the modern/orthodox medicine. ...By the time one comes to seek care, it is out of control"* - (Female, Community Health Worker, CHPS Compound – Rural IDI).

> *"The moment a client is diagnosed with diabetes or hypertension, it is assumed that that illness was spiritually acquired. The person heads on to the pastor for prayers. As a result, even the prescribed drugs given, are not adhered to"* - (Male, Nurse, Health Centre - Urban IDI).

Breakdown in family support system

The breakdown in the family support system was also pointed out as a set-back on the effect of SPIs on access to quality healthcare for older persons. Participants mentioned that the kind of family support system for older persons has changed in recent times. The traditional support system barely exists to give that support to the aged. Families have become more nuclear than extended. Hence, the care and support that older persons need are not met. This further affects the linkage between SPIs and access to quality healthcare among older persons. A participant stated:

> *"Older persons have family members around but you see today, things have changed. Now the family system has become like "each one for him/herself". ... that family*

support system is no more like before" - (Male, LEAP Community Committee Member - Rural IDI).

Witchcraft accusation

Witchcraft accusation also emerged as a socio-cultural factor that influences the linkage between SPIs and access to quality healthcare among older persons. Participants indicated that the changes in the biological growth associated with ageing and the ageing process especially during menopause cause some older persons to act outside the acceptable societal norm. This behaviour is tagged as witchcraft. In cases where pronouncements are made by religious leaders such as a pastor to accuse such older person as the cause of the predicaments of a family member, then this affects the care and support such older person is expected to receive. This has further implications on his/her access to quality healthcare. Participants commented:

> ***"****As a result of older persons' menopausal stage, their behaviour makes them be tagged as witches and wizards. Sometimes too, family members are told by pastors that a spell has been cast on them. If an older person in the household is tagged as the cause of the person's predicament, then, that is where the neglect begins"* - (Female, Community Health Worker, CHPS Compound – Rural IDI).

> *"Some people also think that when one becomes old, he/she is a witch/wizard. The moment wrinkles are seen on the face, you are labelled you are turning into a wizard/witch. Once they have that mindset for you, there will be little support for you for your medication. This could be a hindrance to accessing quality healthcare"* - (Male, Administrator, Hospital – Urban IDI).

8.4 Discussion

This chapter explored community and institutional perspectives on the link between social protection initiatives and access to quality healthcare among older persons respectively. Older persons' experiences were drawn from FGD discussants while that of the institutions were IDIs with program planners and implementers and service providers. The themes respectively were organized around Donabedian's model of quality of care, and other factors covering political, legal, economic, technological, environmental/geographic and socio-cultural aspects.

The chapter has demonstrated that the extent to which SPIs affect access to quality healthcare among older persons are not only influenced by the model of quality of care but are also affected by other factors such as political, legal, economic, technological, environmental/geographic and socio-cultural. This is consistent with what the literature suggests that political, economic, social and technological factors have effects on the implementation of SPIs such as the NHIS (Addei Mensah, 2016; NHIA, 2011) and cash grant (Hickey et al., 2018; Bloom, David and McKinnon, 2010). This chapter's discussion focuses on two key findings: 1) community's perspectives (structure, process and outcome aspect of quality of care; and 2) institutional perspectives regarding political, economic, technological, legal, environmental/geographic and socio-cultural factors.

8.4.1 Communities' perspectives

The structure dimension of quality of care that the study found included accessibility, service provision, medication and technology in line with what the literature suggests (Abuosi et a., 2016; Peabody et al., 2006; Sharma and Narang, 2011). The existence of these components promotes access to quality healthcare in the context of SPIs participation. The most commonly structure-related positive experience among FGD study participants was accessibility (financial and geographic). This was cited among rural female and male discussion groups, and urban male groups. This was also confirmed by programme planners and implementers, and service providers that SPIs have ensured financial accessibility to quality healthcare among older persons. The NHIS Subscriber Handbook makes it clear that "*The NHIS is a social intervention program introduced by government to provide financial access to quality healthcare for residents of Ghana*" – (Page 2). The Department of Social Welfare in collaboration with UNICEF document on "The LEAP Programme" "*also seeks to help assist poorest families with basic needs and this includes health"* (UNICEF & DSW, n.d. page 1). These include older persons in poorest households, and are residents in Ghana.

This qualitative result on accessibility that influences the link between SPIs and access to quality healthcare is also consistent with a recent quantitative study which explored the use of outpatient services among older persons in Indonesia. Madyaningrum et al., (2018) found that insurance as SPI was associated with the higher use of OPD services among the elderly due to the removal of financial barriers to care. On the other hand, Scheil-Adlung and Bonan (2013) identified gaps in financial protection of SPIs which often results in co-payments among the elderly. In a developing country like Kenya, older persons participating in cash transfer as SPIs accessed medication or paid for transportation to health facilities (NGEC, 2014). This was also cited by participants in this study where SPIs promote financial and geographic access to healthcare as well as paying for medical supplies.

Process, which is the real delivery and receipt of care, was also found in the study. Participants cited provider attitude, communication, waiting period and extortions/lack of accountability may influence the link between SPIs participation and access to quality healthcare among older persons. Provider attitude which featured in the FGDs and the survey is an inter-personal and interaction between service providers and clients (Donabedian, 1988) and has also been reported in other studies. This finds support in the literature (Juma and Manongi, 2009). Nonetheless, there is evidence of some of the quality concerns in the form of verbal abuse among patients by providers of healthcare services reported in Ghana's hospital (Abuosi et al., 2016). The new Patient's Charter of the Ghana Health Service makes it clear the need to respect the rights and responsibilities of clients. Also, clients are to be protected from discrimination based on age or type of illness or disability, and this includes the older person (GHS, 2016). There is the need to ensure the re-enforcement among health personnel as well as promoting its awareness and education among the Ghanaian population especially older persons. This is

because; there is evidence that the existence and knowledge on some of the contents of this policy document is known among health workers, but not among patients (Yarney et al., 2016).

On waiting period, previous studies have found waiting time to be less satisfactory among beneficiaries of SPIs such as the NHIS (Atinga, 2012; Dalinjong and Laar, 2012; Jehu-Appiah, Aryeetey, Agyepong, Spaan, Baltussen, 2012; Bruce, Narh-Bana, and Agyepong, 2008). Findings from other developing countries like South Africa and Liberia showed that patients were ready to tolerate long waiting time; poor staff attitudes and disrespectfulness, as long as they receive the expected good quality care such as medicine and a thorough examination (Honda at al., 2015; Kruk et al., 2011). In this study, some participants mentioned waiting for close to 4 hours for health personnel to retrieve folder before receiving care. This confirms the long waiting period at the point of seeking care and this has implications for quality healthcare. However, how long participants spent being attended to at the consulting room is unknown.

Previous studies have shown that unofficial/informal fees are collected from clients by some health care providers (Abuosi et al., 2016). This confirms the issue of extortion/lack of accountability reported by participants in this study.

The outcome dimension of quality of care which is the consequences of care (Campbell et al., 2000) found in this study included the cost of paying for services, receipt of adequate treatment, better health services, improve health condition and poor healthcare. Cost of care was seen as one of the negative experiences cited among FGD participants. This often results in out-of-pocket-payment and extortions for services. In the quantitative analysis, the issue of cost was identified as one of the five dimensions in the expected quality of care among study participants. Other studies have also identified "cost" to be one of the major factors associated

with lack of accessing healthcare (Bayuo, 2017; Schneider, Zaslavsky and Epstein, 2002; Escarce, Epstein, Colby and Schwartz, 1993).

8.4.2 Institutional perspectives

Participants mentioned different forms through which political factors influence SPIs and access to quality healthcare linkage for older persons. These included change in political administration, perceived use of SPIs as electoral baits, and the abolition of the Capitation Model under the NHIS. The findings indicate that participants acknowledge the role that politics play in promoting quality healthcare in the context of SPIs participation. Again, it suggests that given the political will, SPIs such as cash transfers and insurance could result in quality healthcare for older persons. Other studies have reported that politics strongly influence decisions about SPIs such as cash grant programmes and insurance in developing countries like Kenya, Malawi, Pakistan, Senegal and Sierra Leone including Ghana (Addei Mensah, 2016; NHIA, 2011; Farrington et al., 2006-2007). In sharp contrast, other studies did not find electoral politics as a major driver of SPIs such as social assistance especially in highly dominant party regimes in countries like Ethiopia and Rwanda (Hickey et al., 2018).

This study found economic factors such as NHIS as the main source of IGFs for health facilities and the delay in NHIS claims payments which have a direct impact on the cost-effectiveness and financial position of institutions that may affect SPIs and access to quality healthcare linkage. Financial relief enjoyed by older persons as beneficiaries of SPIs like the NHIS extends to service providers such as accredited NHIS health facilities. Claims made based on services provided to insured older persons serve as sources of internally generated funds allow facilities to constantly provide quality healthcare services. This reduces the rate of abscondment among clients. Nevertheless, the delaying in the payment of NHIS claims was also highlighted and has also been reported in other studies (Daliniong and Laar, 2012; Twum-

Barima, 2012). Consistent with these findings, Baidoo (2009) reported that the delay of NHIS claims payment to hospitals often times leads to the refusal of medical treatment for insured patients affecting the quality of care. The author reiterated that health care facilities depend on these claims as financial support to purchase drugs, medical technologies or hire health personnel. From participants in this current study, it was revealed that, due to the cost of care, older clients are sometimes deterred from seeking care. In circumstances where care is sought, as a result of out-of-pocket payments for prescribed drugs, older clients end up not becoming completely well. Confirming this finding, Fitzpatrick et al, (2004) found cost in the form of medical bills as one of the most common barriers to seeing a physician.

The findings from this study showed that technological factors such as medical equipment, trained personnel and internet connectivity play key roles in the linkage between SPIs and access to quality healthcare for older persons. These findings corroborate prior research showing that lack of doctors and other basic supplies and equipment to work was the major quality of care concern that affected patients irrespective of SPI (NHIS) status (Abuosi et al., 2016).

The results from this study identified legal factors such as accreditation for health facilities that affect SPIs and access to quality healthcare linkage for older persons. Mate et al., (2014) reported that accreditation to health institutions is one of the strategies being used in other developing countries like India, Indonesia, Kenya, Malaysia, Mali, Nigeria, the Philippines, and Vietnam to improve quality of care. Analysis from this study also confirmed the assertion that accreditation to health facilities ensures that quality healthcare is rendered to clients including older persons.

Previous studies found age-related barriers such as transportation to be associated with dissatisfaction with medical care quality (Travers et al 2019). This study confirmed that environmental/geographic factors such as transportation network influence SPIs and access to quality healthcare for older persons.

This study found respect for older persons, culture of health seeking behavior, breakdown in family support system and witchcraft accusation as some of the socio-cultural factors associated with SPIs and access to quality healthcare for older persons. This is consistent with a recent study that combined survey and ethnographic methods to evaluate CCT programmes in Nicaragua and Turkey (Adato, 2008). The author found socio-cultural factors influencing health service utilisation (Adato, 2008).

8.5 Conclusion

In this chapter, the linkage between SPIs participation and access to quality healthcare was explored from the perspectives of the communities and institutions respectively. Communities' experiences in the context of the Donabedian's model identified structure (accessibility, medical supplies, service provision, etc), process (provider attitude, waiting time, etc), and outcome (cost, improvement in health condition, etc) dimensions to influence SPIs and access to quality healthcare linkage for older persons. Institutional-related factors such as political, economic, technological, legal, environmental/geographic, and socio-cultural were also found to be associated with this linkage.

This study findings highlight the fact that the influence of SPIs on access to quality of care is multidimensional, and future studies on quality of care in the context of SPIs participation among older persons need to focus not only on the individual and household characteristics but also the community and institutional-related factors.

CHAPTER NINE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

9.1 Introduction

This study sought to investigate the extent to which social protection initiatives (SPIs) influence access to quality healthcare among older persons (age ≥ 60 years) in the Mampong Municipality in the Ashanti Region of Ghana. Understanding the extent to which SPIs influence access to quality of care is crucial in improving the quality of life for older persons. Due to inadequate research in this area, currently, there is a paucity of data on the linkage between SPIs and access to quality healthcare. The limited attention received in many developing countries in understanding this linkage is attributed to the lower prioritization of research on older persons. Such data are desirable to develop effective and efficient policy guidelines and programmes for older persons. This will promote age-friendly services for older persons. It will also ensure their full participation in SPIs, and in aligning health systems to older populations.

Globally, while some studies have been done on older persons, what is missing in the literature is older persons' participating in SPIs and how it is linked to their conceptualization of quality of care from different perspectives. This involved utilizing study populations such as older persons themselves, program planners and implementers and service providers. There is evidence that information on SPIs and access to quality healthcare linkage is vital in highlighting what constitutes quality of care among older persons in SPIs participation.

Theoretically, this study has made contributions to the literature by demonstrating methodological descriptions and illustrations of SPIs and access to quality of care from the perspectives of older persons, programme planners and implementers and service providers. Again, the study has clearly shown that the linkage between SPIs and access to quality of care can be broadened through the advancement of research in developing countries especially in Africa by considering the perspectives of myriad stakeholders such as older persons and programme planners and implementers and service providers.

This study utilized a cross-sectional technique and employed a triangulation mixed-method research design. Quantitative and qualitative data collection and analyses, and a community scorecard were used to examine the linkage between SPIs and access to quality healthcare. The study drew on the concepts of Sixma et al., (2000) with some modifications made for both culture and language in measuring the quality of care. The study also tested for the feasibility, reliability and validity of the instruments.

The study drew on the models of the Andersen Healthcare Services Utilization Behaviour on access to care, and the Donabedian's Structure, Process and Outcome for quality of care in explaining its concepts and findings. In this chapter, the summary of findings, implications of the study findings, the contribution of the study to the theoretical and empirical literature, and the policy recommendations with recommendations for further research are presented below.

9.2 Summary of empirical findings

In general, the main finding of the study was that participating in SPIs does not promote access to quality healthcare among older persons. This was established from the different methodologies employed in this study. This is because there are several mediating variables both internally and externally which may account for this non-existence relationship. These

factors are linked to an individual (age) and household (household food security, household size and having a primary caregiver) characteristics, and community (positive and negative experiences) and institutional level (political, economic, technological, legal, environmental/geographic and socio-cultural) factors. Summaries of findings from each of the objectives of the study have been provided below:

9.2.1 Forms of social protection initiatives among older persons

The awareness of the various mechanisms and typologies of SPIs was high (96.2%) among the study participants. Study participants were generally aware of formal social protection initiatives than the informal or semi-formal social protection initiatives respectively. From the reviewed studies in Chapter Two, Devereux & Getu, (2013) attributed this phenomenon to the rise of the number of formal social protection mechanisms over other typologies of social protection especially the informal mechanisms such as the extended family and children's supports. The dwindling of the extended family and children's support, family neglect as a result of witchcraft accusations and economic hardship were cited reasons. Similar studies in countries like Ethiopia, India, Nigeria, and also in different regions in Ghana have also reported of neglect of older persons in some cases due to witchcraft, particularly women by their significant others, which result in elderly abuse (Agunbiade, 2019; Eboiyehi, 2017; Chane and Adamek, 2015; WHO. 2014; Chokkanathan and Lee, 2005).

The perception dimensions generated from the combined scores identified SPIs as bringing about significant change in living and healthcare among older persons. Participating in LEAP was seen as a source of daily sustenance, support for livelihood especially in agriculture, access to care through complementary services as well as supporting the educational needs of other household members. Other studies as revealed in the literature have also established access to basic healthcare as an immediate benefit of (conditional) cash transfers in other African

countries (NGEC, 2014). Cited challenges associated with LEAP as a form of SPI were related to how meagre the cash grant is, and the delay in the payment. There are some empirical studies in Ghana that have reported challenges associated with LEAP as an SPI. In Ghana, a study in two district of Upper West region found about 21.0% of beneficiaries to be dissatisfied with the LEAP programme due to delays in the payment, particularly, the bi-monthly payment (Fuseini, 2018). Affirming Fuseini's findings, Abbey, Odonkor, and Boateng, (2014) reported that 15.0% of beneficiaries indicated delays in the transfer as a concern in their study in two (Greater Accra and Ashanti) regions of Ghana. Similarly, payments under the LEAP programme have been reported to be insufficient among beneficiaries in the Wa Municipality (Agbenyo et al., 2017). Delays in the payments of cash transfers have also been documented in other developing countries like Palestine and Zambia (Hamad and Pavanello, 2012; Jones and Shaheen, 2012; Chiwele, 2010). The delays in the payment of the grant oftentimes affect its purchasing power due to the rise in the cost of living (Agbenyo, 2017).

Improvement in healthcare utilisation and the features of service provision were the generated dimensions from the combined scores of perception about NHIS as a form of SPI. The increase in service utilisation and the provision of financial relief to access healthcare were cited reasons related to good perceptions about the programme. Financial risk protection is a predictor of positive perception of NHIS services enjoyed among respondents in the Greater Accra region of Ghana (Boateng and Yawason, 2019). Other empirical studies in Ghana have reported on the financial protection the insured enjoys when healthcare services are utilized from NHIS accredited health facilities relative to the uninsured (Okoroh, Ottie-Boakye, et al., 2020; Aryeetey et al., 2016; Kusi et al., 2015). Reasons stated for the poor perception of NHIS services in this study included the shortage of drugs at health facilities, delay in payment of NHIS claims, poor internet connectivity, and out-of-pocket payments for other health services

such as laboratory test and imaging (scan). Similar studies in Ghana have found the non-availability of essential medicines, though, this has improved compared to the period before the introduction of NHIS (Aryeetey et al., 2016). Other studies have also reported on the intermittent supply of medicines to facilities resulting in patients making supplementary payments (Ashigbie, Azameti and Wirtz, 2016; Atinga R et al., 2012). The delays in the payment of NHIS claims have also been reported in similar studies (Aryeetey et al., 2016; Duku et al., 2018). These delays have been attributed to reasons such as errors in claims processing and the absence of clarity on claims reporting procedures (Aryeetey et al., 2016).

9.2.2 Predictive factors associated with participating in social protection initiatives among older persons

The overall participation of SPIs among older persons was 64.5%. Ghana's National Social Protection Policy identified gaps in SPI coverages among older persons. NHIS coverage gap was 43.0% while the coverage of LEAP was pointed out to be low among older persons (MoGCSP, 2015). Similar studies have reported of 62.8% for NHIS coverage among older persons (≥70 years) in Ghana (Duku et al., 2015). Previous studies reported higher NHIS coverage (75.9%) for those 70 years and older in Ghana (Durairaj, D'Almeida and Kirigia, 2010). Some studies have attributed NHIS coverage gap to be factors related to both the services of the NHIS and healthcare delivery facilities (Duku et al., 2015; Aryeetey et al., 2013; Jehu-Appiah et al., 2011).

The main predictors of participating in SPIs were age, household food security and place of accessing healthcare services. The results from Chapter Five demonstrated that predictive factors in participating in SPIs are multidimensional, and this is supported by evidence from other studies as revealed in the literature (Lloyd-Sherlock et al., 2012; Food and Agriculture Organisation of the United Nations, 2016; NGEC, 2014; Holmes and Jones, 2010; World Bank,

2007). The hypothesis that older persons 80-84 years are more likely to be beneficiaries of SPIs compared to those 60-64 years old was supported by findings from this study. Similar studies have corroborated this finding (Wielen, Channon and Falkingham, 2018; Duku et al., 2015). Also, the study finding supported the hypothesis that older persons who seek care from the hospital level are more likely to be SPIs beneficiaries compared to those who seek care at non-hospital levels such as pharmacy/drug store/chemical shop. This could be attributed to the fact that non-hospital level service providers are more likely not to be listed as part of the credentialing facilities to ensure access to care for all subscribers of NHIS (NHIA, 2013).

9.2.3 Promoters, barriers and predictors of access to quality healthcare among older persons

The study identified cost as crucial in accessing quality healthcare. This was prominent for the expected quality of care but missing for the perceived quality of care among the study participants. The issue of cost in meeting quality healthcare and appropriate healthcare services among older persons in Africa have been well documented (Parmar et al., 2014). Other studies as revealed in the literature have also confirmed the extent to which cost influences access and utilisation of healthcare services among older persons (Skinner, Fisher & Wennberg, 2001; Averill, 2002; McIntyre, 2004; Fitzpatrick et al, 2004; Turkson, 2009; Marengoni et al., 2011; Saeed et al., 2012; United Nations General Assembly, 2015; Bayuo, 2017).

In the context of Donabedian's model, the study demonstrated the promoters and barriers to quality healthcare. The good attitude of staff was found to be the main promoter while drugs of low quality were the main barrier to quality healthcare. About 64.0% of the study participants had a good perception of the quality of care accessed. This shows a gap of 36.0% in access to quality healthcare. The main predictors of good perceived quality of care accessed among older persons were age, household food security and household size. Other studies have

shown the multidimensionality of accessing quality healthcare (Kajonius and Kazemi, 2015; Maxwell, 1984; Donabeidan, 1980; Weisgrau, 1995; Peabody et al., 1999; WHO, 2000; WHO, 2014a).

9.2.4 The influence of social protection initiatives on access to quality healthcare among older persons

The influence of SPIs on access to quality healthcare was examined using multiple logistic regression modelling. The findings from the regression models showed that access to quality healthcare among the study participants (older persons) is not an outcome of enabling factors such as SPIs, but rather from the individual (predisposing factors such as age) and household (predisposing factors such as household food security, household size, and primary caregiver) factors. This could be attributed to the differences in services received at the point of healthcare utilization. Duku et al., (2018) found being currently insured to be associated with a significantly lower perception of quality healthcare in two regions of Ghana. Dei and Miguel (2018) found that possessing health insurance as an enabling factor was found to be associated with both inpatient and outpatient services utilization among older Ghanaians. Contrariwise, in Burkina Faso, Robyn et al., (2013) found that the insured and uninsured rated high the delivery of quality healthcare. Nevertheless, empirical studies have reported the influence of enabling factors such as income on healthcare use among older persons, although, this current study did not account for participants' income. Yam et al., (2009) established that monthly household income per capita as an enabling factor in Anderson's behavioural framework was significantly related to the utilization of healthcare services among older persons in Hong Kong. The researchers found that lower-income elderly relative to the more affluent had lower total utilization of healthcare services though they had greater healthcare needs (Yam et al., 2009). Other studies have reported otherwise. Results from a longitudinal study in German among older persons found no enabling (income and perceived access to primary healthcare services)

and predisposing factors to be predictive for healthcare use (Hajek, Bock and König, 2017). In Uganda, Wandera, Kwagala and Ntozi (2015) found otherwise. Household wealth status and earning wages, in particular, were the most important enabling factors that determined access to healthcare among older persons. Social protection initiatives did not significantly influence access to quality healthcare among the study participants. In the context of SPIs participation, the study established the hypothesis that older persons living with primary caregivers in the same household have a good perception about the quality of care accessed relative to their counterparts who reside in separate households with primary caregivers. Though there are limited studies on (informal) caregiving for older persons in the context of SPIs participation and access to quality healthcare, informal caregiving is complementary to formal care (UN, 2003).

9.2.5 Communities' and institutional perspectives on the influence of social protection initiatives on access to quality healthcare among older persons

The study showed that external factors from both the community and institutional perspectives influence the linkage between SPIs and access to quality healthcare among older persons. Study participants (older persons in FGDs) identified positive and negative experiences that affect the linkage between SPIs participation and access to quality healthcare. Also, from the institutional perspective (programme planners and implementers, and service providers in IDIs), political, economic, technological, legal, environmental/geographic and socio-cultural factors influence this linkage among older persons. This establishes that the need to bridge the gap in access to quality healthcare in the context of SPIs especially among older persons is multidimensional. Related studies have confirmed these findings in both developed and developing countries among different segments of the population (Hickey et al., 2018; Addei Mensah, 2016; Fenny et al., 2014; Blomqvist and Winblad, 2011; NHIA, 2011; Bloom, David

and McKinnon, 2010; Sharma and Narang, 2011; Turkson, 2009; Ibiwoye and Adeleke, 2008; Hirose et al., 2003).

9.2.6 Implications of study findings

The main aim of this study was to investigate the extent to which social protection initiatives influence access to quality healthcare among older persons in the Mampong Municipality in the Ashanti region. This study did so by using purposively collected primary data utilizing both quantitative and qualitative research methodologies to collect data from different levels (individual, household, community and institutional).

Accordingly, the major contribution of the current study is that it provides the desired empirical data on the awareness, perceptions, and participation of SPIs, barriers and promoters to quality healthcare, and the extent of SPIs and access to quality healthcare linkage among older persons. This information is important given that older persons are often excluded from health surveys resulting in a paucity of data (Ford, Rasanathan and Krech, 2012). Exploring the awareness, perceptions, and participation of SPIs will allow policy-makers, service providers, and programme planners and implementers to design innovative ways such as based on older persons' knowledge about these SPIs, and the existence of coverage gap. For instance, the high level of awareness coupled with moderate perceptions of SPIs did not translate into universal participation especially for insurance as an SPI. Coverage gap in SPIs participation identified has inverse implications for the well-being of older persons in Ghana, especially those who fall prey to the breakdown of the traditional family system in caring for the aged. However, the positive influence of SPIs participation on access to healthcare and welfare of beneficiary older persons was also underscored in this study. This implies that the call to strengthen social protection schemes for older persons in developing countries including Ghana is appropriate.

The study also emphasized on the common agreement in studies focused on an African context that age (Wielen, Channon and Falkingham, 2018; Jehu-Appiah, 2011; Popay et al., 2008), household food security (Handa et al., 2013; NGEC, 2014) and place of accessing health services (Macha et al., 2012) are associated with SPIs participation. There is need for cutting-edge policies and programmes including harmonization of the different definitions of older persons across the various initiatives (highlights the limitations in the chronological age and time definition of ageing), strengthened collaboration among provider institutions, and community engagements. This will not only narrow SPIs coverage gaps, but will promote food security, and the quality of life of older persons.

Another important implication of this study derived from findings on the uniqueness of the knowledge that among older persons, accessing quality healthcare is not associated with SPIs participation. The finding points to the fact that this linkage is influenced by the individual (age), household (household food security, household size), community and institutional factors.

Accordingly, the research suggests the need for collaborative efforts to develop age-appropriate healthcare and mechanisms with the focus on key access to the expected and perceived quality healthcare dimensions (that is, communication and respect, adequate service delivery, provider attitude, cost, geographic accessibility, patient/client dignity, and patient autonomy). This will bridge the gap in access to quality healthcare among older persons in Africa, particularly in Ghana. This is because access to quality healthcare has implications on overall health outcomes (Cleary, 1999; P.D. Cleary and S. Edgman-Levitan, 1997) and well-being.

These dimensions on quality healthcare accessibility are corroborated in studies in other African countries (Andoh-Adjei et al., 2018; UN, 2015; Khamis and Njau, 2014; Turkson, 2009; Curry and Singlair, 2002). This will not only strengthen mechanisms to promote quality healthcare for older persons in developing countries but will minimize the associated barriers in the context of SPIs participation.

9.2.7 Contribution of the Study

This study's contribution to knowledge is categorized into theoretical and empirical contribution.

9.2.7.1 Theoretical Contribution

The study provides a conceptual definition of quality of care in the context of access to quality healthcare among older persons in an African country like Ghana. The measurement of quality of care was guided by the modification of the QUOTE-Elderly instrument generated based on the concept of Zastowny et al., (1983) which circumvent the problems associated with traditional instruments. It is unique in the sense that it also draws on the dimensions of quality healthcare which is widely accepted, that is, Donabedian's framework and the Institute of Medicine (2001) (Sixma et al., 2000). These dimensions such as communication and respect, cost, adequate service delivery, provider attitude, patient/client dignity, geographic/facility easy accessibility, and patient autonomy are pertinent to an African country context especially among vulnerable populations like older persons. These are a promising way to measure selected aspects of quality of care especially among older persons in an African country like Ghana.

The provision of formal SPIs particularly, social assistance and insurance seek to improve access to quality healthcare in Ghana (NHIA, 2009; UNICEF & DSW, n.d.). The development of the quality of care scale proved reliable through various tests utilised in the study, and

therefore could be adopted or adapted as a useful tool in strengthening quality healthcare assessment in developing countries. This will help to promote healthcare for all specifically among older persons in the context of achieving universal health coverage.

Another theoretical contribution of this study is the development of a hybrid version of quality of care scale appropriate to the conceptual definition of access to quality healthcare. Though the original instrument (QUOTE-Elderly instrument) did not include aspects related to "outcome" in quality of care measurement, this study used a unique scale that explored the perceived level of access to quality healthcare drawing on the existing theories and incorporated the "outcome" dimension. The original instrument used 32-items, however, this study utilized 27-items after different tests were run. Based on recent contact with the delivery care system, the extent to which SPIs influence older persons' perception of the quality of care was investigated within the framework of Peabody et al., (1999). This is the first of its kind, to the best of the author's knowledge.

This study drew on the quality of care framework developed by Peabody et al., (1999) as a predominant concept within which the concepts of access and quality of care models are incorporated. The findings pointed out that participating in SPIs did not influence access to quality healthcare. However, access to quality healthcare that hinged on the structure and process dimensions (Donabedian, 1966) was rather predicted by predisposing factors (age, household food security, household size and having a primary caregiver) as stipulated in the Andersen's Healthcare Service Utilisation Behaviour model (Aday & Andersen, 1974). External factors such as political, economic, technological, legal, environmental/geographic and socio-cultural were also identified to have effects on this linkage. The Andersen Healthcare Services Utilisation Behaviour and Donabedian's Structure, Process and Outcome models have

been used among health service researchers to explain access to medical care (Babitsch, Gohl & von Lengerke, 2012; Andersen, 2008; Aday & Andersen, 1974; Donabebian, 1966), discover what promotes or impedes health service utilisation ((Babitsch, Gohl & von Lengerke, 2012; Andersen, 2008; Andersen & Newman, 1974), and to help assess the quality of care provided to patients/clients (Ameh et al., 2017; Abuosi et al., 2016; Robyn et al., 2013; Kunkel, Rosenqvist and Westerling, 2007). These theories are still relevant in the context of an African country such as Ghana in addition to the author's additional discoveries, particularly among older persons.

In providing accounts on study participants accessing quality healthcare in the context of SPIs, the study drew on the aspect of the utilisation of health services explained by Aday and Andersen, (1974). The study's findings confirmed this aspect of access to care focusing on the characteristics of the population at risk referred to as study participants (older persons). The study showed that accessing healthcare was not centred on enabling factors (SPIs in this current study) as suggested in the theory of Andersen's Healthcare Services Utilization Behaviour. With regards to quality healthcare in the context of SPIs particularly on the dimensions of expected quality of care, this study drew on the Donabedian's Structure, Process and Outcome model confirming the three elements of the theory. However, the dimensions of perceived quality of care confirmed both structure and process aspects of the model. This implies that for service users primarily older persons to have access to quality healthcare, there is need to look beyond the provision of social programmes and draw in efforts from different standpoints such as institution, community, household and the individual.

The Peabody et al., (1999) quality of care framework adopted for this study highlighted four external factors (political, institutional, cultural and social factors). However, four (4)

dimensions, namely, economic, technological, legal and environmental/geographic were entirely developed by the author. This development was motivated by the fact that these factors that act as external forces also have the propensity to influence the linkage between SPIs and access to quality healthcare. Recognizing and addressing these factors in addition to those demonstrated in the framework of the above-mentioned theories will provide potential solutions to improve quality of care in the context of SPIs for older persons.

9.2.7.2 Contribution to the empirical literature

The investigation of the influence of SPIs especially formal SPIs on quality healthcare based on the dimensions and indicators of perceived quality of care used among older persons in cash grant-targeted communities in this study is the first of its kind, to the best of the author's knowledge. This has made it possible to explore and identify gaps in older persons' awareness, participation, and perceptions of SPIs.

Often, older persons are excluded from health surveys. This study makes a valuable contribution to the evaluation of SPIs on the quality of health service delivery for older people in an African country like Ghana. The use of purposively collected primary data which addresses the limitations in nationally collected datasets provides visibility for older persons in social protection programmes and health service delivery. Although the study area was limited to one municipality, the use of both quantitative and qualitative research methodologies provides current insightful information on older persons' experiences (awareness, participation and perceptions), and the associated gaps in SPIs coverage and access to quality healthcare respectively. Future studies will be needed to minimize these gaps through the design and re-alignment of age-related policies and programmes, particularly in cash grant-targeted communities.

Given the modified quality of care scale from older persons' perspective, the findings that some demographic, socioeconomic and living arrangements indicators such as age, household food security, household size, and primary caregiver as well as external forces like political, economic, socio-cultural, legal, technological, and environmental/geographic factors influence access to quality healthcare in the context of SPIs is a significant contribution.

Findings from the qualitative research highlighted on other quality of care and SPIs linkage challenges from the perspectives of the community and service providers, programme planners and implementers which could be relevant in understanding what promotes age-friendly services for older populations. These challenges included those that influence the various dimensions (structure, process and outcome) of quality healthcare as well as those that have direct effects on institutions including service providers.

9.3 Recommendations

9.3.1 Policy recommendations

The need to strengthen the provision of quality healthcare for the entire population specifically older persons is essential to overall user satisfaction with healthcare. Although Ghana's social programmes are also meant to bridge the gap of health inequity, this study highlights coverage gaps, poor perceptions of users' experiences in access to quality healthcare, individual, household, the community in addition to external factors. In cognizance of the fact that pro-poor policies which are health-related (LEAP and NHIS) are meant to promote access to quality healthcare, the study findings seemingly reveal potential gaps in linking SPIs participation and access to quality healthcare. The following recommendations are made.

Findings from this study showed that there are no existing policy documents solely on the care for older persons, in addition to explicit information about the care for older persons within the

health systems in Ghana. Though the National Ageing Policy acknowledges old age and health challenges, it does not address the issue of caring for older persons aligned to the healthcare system. This study recommends that the country's Ministry of Health (MoH) develops a national health policy on caring for the aged. The need to develop and implement the National Health Policy for the Care of the Aged has also been overtly stated as part of the identified research needs strategies in the Ghana National Health Research Agenda 2015-2019 (GHS, 2015-2019). Study participants also identified the lack of a policy document for the care of older persons as one of the key challenges to the linkage between SPIs and access to quality healthcare among older persons. Most existing health policies, protocols, guidelines and frameworks explicitly address the needs of under-five children, pregnant and lactating mothers and other younger population groups but fail to address the needs of older persons. This has further influenced how the health systems are aligned to the disadvantage of older persons. For instance, the health systems have established age-related services such as Ante Natal Care (ANC) for pregnant women, Baby-Friendly Health Facilities and Post-Natal Care (PNC) for newborns and lactating mothers. Others include Child Welfare Clinic (CWC) for under-five children and Adolescent Friendly Corners for adolescents and young people in almost all public health facilities. But, there is limited evidence of how the healthcare system is aligned to older populations such as the provision of geriatric services and the establishment of an 'Aged Day Care' to provide age-friendly services for older persons. The initiation and implementation of policies and interventions with the provision of comprehensive quality healthcare for older persons by the MoH and its agencies, it would promote the understanding of overall healthcare for older persons to improve the quality of care they receive, particularly in the context of SPIs participation. Complementing the efforts of MoH will include the building and maintenance of strong collaborations with institutions involved in the provision of social programmes.

The study showed gaps in SPIs coverage and only three percent were SSNIT pensioners. There is therefore the need for Government to consider old-age pension schemes (non-contributory and universal) as a key strategy to improve their income security and enhance the social welfare for older persons. Harnessing the best practices from other developing countries in Latin America and southern Africa with such interventions for older persons will guarantee their effectiveness and efficiency. Incorporating age-sensitivity into cost of care as a component of old-age pension schemes (non-contributory and universal) will promote affordability and further reduce old age poverty.

Further, this study showed that participating in SPIs did not necessarily influence access to quality healthcare among older persons. Of particular significance is the influence of individual (predisposing and need factors) and household factors as were found in this current study, and in other contexts in the developing world. A myriad of external factors (political, economic, technological, legal, socio-cultural, and environmental) outside the scope of the individual and household also influenced access to quality healthcare. This calls for a coordinated attempt to ensure access to quality healthcare for older populations in settings such as the current study in Africa. There is the need to strengthen existing frameworks, protocols and guidelines governing the provision of healthcare services through enforcement as stipulated in documents like The Patient Charter, the Code of Ethics, and the Quality and Patient Safety book in health service provision. This cannot be achieved without the involvements of other actors such as individuals, households and the community through education and sensitization employing both the traditional and modern media on the rights and responsibilities of service users, especially older persons.

The need for the National Health Insurance Authority and Ministry of Gender, Children and Social Protection/Department of Social Welfare (MoGCSP/DSW) to re-strategize and strengthen monitoring and evaluation of services for clients including older persons are also relevant. This will ensure that the full benefits of programmes are reaped by older clients along with a well-defined health system addressing ageing issues.

The study showed that about a third of older persons had a poor perception of the quality of care received. Limited training for the care for older persons among health service providers with the associated resource (human and logistics) challenges was also established. This was evident across the various levels of health-seeking facilities. There is a need for government to re-equip health facilities in the country. This should be done across the different levels of seeking care to promote and improve access to quality healthcare for older persons in achieving universal health coverage. There is also the need for geriatric services and facilities, special care and specialists (doctors and nurses), nurses for older persons and other specialists such as social workers solely for aged care. This could be done by the conscious integration of basic geriatric services for older persons as part of the mainstream delivery care system at the different levels of seeking care. There is the need to also incorporate and promote specialization in the training of health personnel in geriatric and gerontology to promote the study of ageing and old age, the ageing process and associated needed healthcare services.

Comparable to existing literature, SPIs participation promote access and utilisation of healthcare services. But, this did not influence access to quality of care among older persons. In essence, access to quality healthcare should not be limited to SPIs participating at the microsystem such as intrapersonal, family and community levels. It should rather be viewed from the macro-system such as the health system, societal, and at the national policy level. The

need for inter-sectoral collaboration and partnership is very important in improving the quality of care for older persons. Although the country's constitution acknowledges the rights of older persons, amending it where appropriate to establish a legal requirement for immediate relatives particularly children to be responsible for their aged relations as stipulated in the African Union Policy Framework and Plan of Action on Ageing (AU Plan).

The need to use existing systems such as the Home Visits and Community Outreaches to give the needed care to older persons is crucial in promoting their wellbeing. Giving equal priority to Aged care as part of home visits will help in early detection of complications related to NCDs or the insurgence of NCDs. Besides, there is a need to incorporate psychosocial factors into healthcare services provided for older persons.

The study further observed that informal SPIs complement formal SPIs. Some older persons depend on the assistance of non-state actors such as the family system and religious organisations like the church. Again, the presence of these non-state actors makes it possible for older persons to access quality healthcare. In the effort to improve the overall quality of life for older persons, there is a need for policymakers and practitioners to strengthen the relationship between formal SPIs and informal SPIs. This will be boosted through community engagements, incorporating local leadership in the care for older persons devoid of political interference, intensification of education and sensitization on old age, the ageing process and the associated challenges. This will serve as agents of change and development in altering negative attitudes, reduce victimization and discrimination towards older persons. This will also revive the appreciation for old age, ageing, embrace the ageing process, the acceptance, and preparation towards ageing. Strategies like the intensification of community and institutional education on age-related policies such as the National Ageing Policy and the

National Social Protection Policy are vital in enhancing the welfare of older persons. Also, using the radio and information van as channels of communication for education and sensitization on ageing would demystify the negative perceptions about old age and ageing. The passing of the National Ageing Policy in its current state into a bill by the Parliament of Ghana is also fundamental to access to quality of care provision for older persons.

This study recommended the need to pay attention to socio-demographic, socioeconomic, lifestyle behaviours, living arrangements, and external factors to promote age-friendly services for older persons. This will ensure complete economic and social participation of older persons in society. Also, implementing a non-contributory universal old-age pension scheme with the component of the programme to cater for the cost of healthcare will support dignified ageing among older persons.

Also, the use of the Scorecard methodology in this study has proven to have given efficient and useful expectations and feedbacks from the study participant about the performances of health service providers in the provision of quality of care. Integrating this methodology into similar studies for older persons will help in documenting their experiences in the provision of services for further improvements.

Additionally, participants suggested ways to improve SPIs coverage among older persons. The need for harmonization of the definition of "older persons" by age across the different interventions is necessary to prevent older persons from falling through the cracks of non-participation in SPIs. Participants called for alternative ways of renewing and registering NHIS subscription using old age-friendly technologies.

Again, participants appealed for the re-enforcement of a standard guideline for age-friendly structural design and furnishing of health facilities to ensure older persons' physical access to quality healthcare. This current study found that many older persons have one form of functional disability or the other. Looking at the structural design and furnishing of health facilities is one of the surest ways of promoting and providing quality healthcare for this sub-population.

Study participants also emphasized the need to consider modifying the features of SPIs especially, the NHIS, such as the elimination of the registration fee/administrative cost associated with enrolment. This registration fee/administrative cost sometimes serve as a barrier to participating in SPIs.

On the issue of drugs and medication, participants recommended the need to factor in the country's progressively ageing population and its associated ill-health unto the drug list under the NHIS programme. This is very crucial in promoting quality of care among older persons.

Reinforcing the fact that urban facilities are better than those located in rural locations, an IDI participant recommended the need to equip rural facilities especially at the lower levels of seeking primary care with the needed working tools as well as the human resource to provide quality healthcare to older persons.

9.3.2 Recommendations for future studies

Based on the findings from this study, the following recommendations are made for future studies. Firstly, since the coverage gap existed in SPIs even in LEAP-targeted communities where this study was carried out, this may indicate that the coverage gap among older persons will be even wider in the entire Mampong municipality. Based on this, there is a need for future

studies to be replicated using varied methods and larger sample size in the municipality among older persons. This will help provide an overview of the extent of the existence of the coverage gap in SPIs and the associated nuances to design and re-align policies and programmes to minimize this gap.

Secondly, older persons' participation in SPIs did not necessarily influence access to quality healthcare, and the number of beneficiaries of SPIs in a household was not considered in the study. As a result, there is a need for future studies to explore the extent to which the number of SPIs beneficiaries in a household with older persons affects their access to quality healthcare. This will help to assess the holistic impact and set a clearer picture of SPIs on the quality of care accessed among older persons which will inform and re-shape future policies.

Thirdly, to fully understand the opinions of older persons' participation and access to quality healthcare linkage, future studies need to focus on using a phenomenological approach to explore the lived experiences and highlight the impact at the individual level. This is because, it emphasizes the sense of meaning and wellbeing of older persons in formulating policies and programmes in the linkage between SPIs and access to quality of care compared to the use of cross-sectional household survey, FGDs and experts' interviews/key informants (IDIs) utilised in this study.

Fourthly, only about two-thirds of older persons had a good perception of the quality of care accessed. Responses may be influenced by recall biases due to the study design being cross-sectional in nature where questions were elicited retrospectively. Future studies may need to examine the quality of care among older person using an observational study methodology. This will aid in understanding the context of adequate monitoring of diagnosis and treatment

that is in line with modern professional knowledge. It will also provide an evidence-based of how policies affect the elements (structure, process and outcome) of quality healthcare among older persons in Ghana. Another plausible method could be the use of randomised control trials where geriatric services and facilities are compared with the current healthcare system. This will help in our understanding of the extent of the impact on the quality of care and the well-being of older persons.

Also, most of the older persons in LEAP-targeted communities of the Mampong municipality had some form of functional disability compounded with the challenge of geographic/physical accessibility to health facilities. Future studies should look at exploring the perceptions and attitudes of universal community established long-term care system as a guarantee to equal access to quality healthcare among older persons. To achieve this, there may be a need for healthcare specialists (doctors and nurses) in addition to social workers at the community level.

Lastly, future studies will need to explore the knowledge, attitudes, behaviours and perceptions of health service providers towards old age, the ageing process and how these impact on the quality of care provided for older persons. This is crucial since the provider attitude has implications for quality healthcare. This is well documented as was found in this current study and other contexts such as in other developing countries.

9.4 Conclusion

This study showed that there exist coverage gaps in social protection initiatives and access to quality of care among older persons. It is clear from the study that participating in SPIs does not influence the perceived level of access to quality of care. This indicates that participating in SPIs promotes access and utilisation of health services but not the quality of it. However, the linkage between social protection initiatives and access to quality healthcare is influenced

by factors from different levels (individual, household, community and institution). Addressing access to quality of care among older persons requires a multidimensional approach in addition to strengthening the associated promoters to quality health services.

This study also brought out the needed information relevant to the field of Demography and Population Studies. Fertility, Mortality and Migration are the three main components of population change addressed in Demography and Population Studies. But, the demographic phenomenon of decreasing fertility and mortality contributes to the large growth in population ageing (Lesthaeghe, 2000).

This study also provided information that is unique in the context of quality healthcare for older persons which is useful for health service managers and professionals in service provision. This is also important to older persons demanding quality healthcare services. This could contribute to model healthcare for older persons in Ghana, especially in the study setting.

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APPENDICES

Appendix 1: Listing Form for Housing Structures

Ageing, Social Protection and Health Systems Project, April 2017

							EA Code:					
1. Enumerator's Name:					Date: (DD/MM/YYYY):							
2. Locality Name:			3. Base//Suburb Name:			5.Street Name (if available)						
6. House No.	**7. Dwelling ID**	**8. Details Description of the location. e.g. sub-suburb, landmarks etc** Example Madina-Rawlinig Circle, street adjacent policlinic when moving towards Atomic junction	**9. Detail description of getting to the structure** Example Turn left on the main road from Rawlings Circle towards atomic junction, take first right turn; Structure is on the left opposite an Electricity Transformer	**10. Type of dwelling See Codes behind this sheet**	**11 Storey building?** Yes ..1 No....2>>13	**12. If yes, how many storeys**	**13. Painted?** Yes ..1 No....2>>16	**14. Main colour?**	**15. Gated?** Yes ..1 No....2>>17	**16. Main colour of gate?**	**17. Accessibility**

Types of dwelling

Separate house …… ..1
Semi-detached house 2
Flat/Apartment …… 3
Compound house …… .4
Tent .....…… ……...5
Container/Kiosk ……..... 6
Uncompleted building …… 7
Other, please specify……8

Accessibility Codes

Easily Accessible……1
Accessible……2
Not easily accessible……3

Appendix 2: Individual Survey Questionnaire

Project Title

Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana: Evidence from Mampong Municipality

Portions of questions adapted from the Urban Health and Poverty Project-RIPS, UG and WHO, (2006)

HH1 *REGION:* REGION 1 ……*ASHANTI* **LOCALITY NAME:……** **E.A. BASE:……..**	**HH3 Community:** **COMMUNITY NAME:** _____ **COMMUNITY CODE:**_____ **NAME OF RESPONDENT(60+ YEARS):…….**
HH2. *AREA:* Urban 1 Rural 2	**HH4**. *Structure number:* ___ ___ __ **HH5**. *Household number:* ___ ___
HH6a. *Interviewer's name and number:* NAME _____ ___ ___ ___	**HH6b**. *Supervisor's name and number:* NAME _____ ___ ___ ___
HH7a. *Day / Month / Year of interview:* ___ ___ /___ ___ / 2 0 1 7	**HH7b:** *GPS Coordinates:* **Lat**___ ___ /___ ___ / **Lon**___ ___ /___ ___ /

Check that the respondent is a knowledgeable member of the household and at least 60 years old before proceeding. You must not interview any person below age 60 years.	**HH8**. *Record the time.* HOURS : MINUTES ☐☐ : ☐☐

HH12. Hello, my name is (*your name*). We are from the Regional Institute for Population Studies, University of Ghana, Legon. We are conducting a survey to understand the effect of social intervention programmes such the National Health Insurance Scheme and the Livelihood Empowerment Against Poverty (LEAP) on access to quality of care elderly persons receive at health facilities in Ghana. The study will also explore how factors such as social, economic, cultural, etc affect the elderly's quality of health care covering the individual, household, community and institutional levels. I would like to talk to you about these subjects. This interview may take averagely about one hour. All the information we obtain will strictly be kept confidential and anonymous. If you do not wish to answer a question or stop the interview, please let me know. May I start now?

YES, CONSENT GIVEN..... 1 *NO, CONSENT IS NOT GIVEN..... 2*	1 ⇨*START INTERVIEW* 2 ⇨*HH9*

HH9. *Result of Household Questionnaire interview: Discuss any result not completed with Supervisor.*	COMPLETED…….01 REFUSED……..02 CALL BACK……..03 DWELLING NOT FOUND…….04 RESPONDENT INCAPACITATED…….05 OTHER (*specify*)_____96

HH10.	NAME OF RESPONDENT:_____ LINE NO. OF ELDERLY RESPONDENT IN HOUSEHOLD ☐☐

Now, I would like to ask you some background information about yourself.

SECTION 1 – RESPONDENT'S BACKGROUND

QNO.	QUESTION
100.	Sex of respondent 1=FEMALE 2=MALE
101.	In what month and year were you born? **(CODE 98 FOR MONTH AND/ 9998 FOR YEAR IF DON'T KNOW MONTH AND/YEAR)**
102.	How old were you on your last birthday? **COMPARE AND CORRECT 101 AND/OR 102 IF INCONSISTENT**
103.	Have you ever attended school? 1=YES 2=NO
104.	What is the highest level of education you have attained/completed? None……..00 Kindergarten..01 Primary……..02 JSS/JHS…….03 Middle……...04 SSS/SHS…...05 Secondary….06 Voc/Tech/Comm…..07 Teacher Train/Agric/Nurs/Cert…..08 Post Sec. Dip(HND, Teacher Training, Nursing, University Dip)……09 Bachelor degree……10 Post graduate……..…..11 Other(specify)……....12
105.	Can you **read** a phrase/sentence in English or French? Yes, English...1 Yes, French…2 Yes, both……3 No.....4
106.	In what Ghanaian language can you **write** a sentence? None.....1 Twi/Fanti.....2 Ewe.....3 Ga-Dangme.....4 Dagbani.....5 Frafra/Grusi.....6 Nzema.....7 Wali/Dagari.....8 Other (specify)……..9
107.	Can you **write** a sentence in English/French? Yes English..1 Yes French..2 Yes both…..3 No…....…4
108.	In what Ghanaian language can you **read** a sentence? None.....1 Twi/Fanti.....2 Ewe.....3 Ga-Dangme.....4 Dagbani.....5 Frafra/Grusi.....6 Nzema.....7 Wali/Dagari.....8 Other (specify)……..9
109.	What is your current marital status? 01 NEVER MARRIED/SINGLE 02 CURRENTLY MARRIED 03 COHABITING/LIVING TOGETHER 04 SEPRATED 05 DIVORCED 06 WIDOWED
110.	For how many years have you been separated, divorced or widowed? *if less than 1 year, enter "00" , enter "88" if still in a union*
111.	For how many years have you been married or living together *if less than 1 year, enter "00", enter "88" if no more in a union*
112.	Number of times been married _____ _____
113.	What is your religion/religious affiliation? 01=NO RELIGION 02=CATHOLIC 03=PROTESTANT(Presby,methLutheran) 04=PENTECOSTAL/CHARISMATIC 05=OTHER CHRISTIAN 06=ISLAM 07=TRADITIONAL/SPIRITUALIST 96=OTHER (SPECIFY)
114.	How important is religion to you? 1=VERY IMPORTANT 2= IMPORTANT 3= INDIFFERENT 4=NOT IMPORTANT 5=NOT IMPORTANT AT ALL 6=NO RELIGION

115. In the past one (1) month, how often did you attend religious services? **(CODE 999 IF DON'T KNOW)**

116. What is your ethnic group? 01=AKAN 02=GA-DANGME 03=EWE 04=GUAN 05=GRUMA
06=MOLE-DAGBANI 07=GRUSSI 08=MANDE 96=OTHER (SPECIFY)….....

117. Who are you living with?1= ALONE 2=PARENT(S) 3= SPOUSE/PARTNER 4= CHILD(REN)
5=SPOUSE/PARTNER AND CHN 6=FRIEND 7=SPOUSE/PARTNER &/ CHILD(REN) & OTHERS
8=SIBLINGS 9=GRANDPARENT(S) 10=OTHER (SPECIFY).....

118. Number of children alive ____ _____

119. Number of children dead ____ _____

120. Do you live with your primary caregiver? 0. No primary caregiver 1. Yes, same Household 2.Lives in different household but same House 3.Lives in different house but same community 4. Resides in different community/town/city but same district 5. Resides in different district but same region 6. Resides Abroad 7.Other (specify) _____

SECTION 2 – WORK HISTORY AND BENEFITS

117. Have you done any work in the last 12 months? 1=YES 2=NO

118. During the last 12 months, how many months did you work?

119. How long did you do/have you been doing this particular work in the last 12 months?
IF MULTIPLE JOBS ASK ABOUT THE MAIN JOB

120. In the Last 7 days, did you engage in any activity for pay(cash or kind) or profit or family gain for at least one hour? **(THIS INCLUDES HELPING IN THE FAMILY BUSINESS/FARM, TRADING,STREET VENDING, ETC).**
1 Yes 2 No

121. Do/Did you do this work for a member of your family, for someone else or are you self-employed?
1=FOR FAMILY MEMBER 2=FOR SOMEONE ELSE (govt &private) 3=SELF-EMPLOYED

122. How many paid employees do you have? **IF NOT APPLICABLE CODE 88**

123. Do you usually work at home or away from home? 1=HOME 2=AWAY

124. How many work days were you away from work in the past month due to your own illness or injury, or that of other family members? **NOT WORKED IN PAST MONTH, CODE 88**

125. Do you usually work throughout the year, or do you work seasonally, or only once in a while?
1=THROUGHOUT THE YEAR 2=SEASONALLY/PART OF THE YEAR 3=ONCE IN A WHILE

126. Does/Did your employment require you to work at night? 1=ALWAYS 2=SOMETIMES 3=NEVER
4=NOT WORKING

127. What **has been**/is your occupation, that is, what kind of work **have you**/do you mainly **did**/do? 01=NO OCCUPATION 02=PROFESSIONAL/TECHNICAL 03=MANAGERIAL 04=CLERICAL 05=SALES/TRADING 06=AGRICULTURE- SELF EMPLOYED 07=AGRICULTURE 08=HOUSEHOLD AND DOMESTIC

09=SERVICE 10=SKILLED MANUAL 11=UNSKILLED MANUAL 12=OTHER (SPECIFY)..... 99=DON'T KNOW 88 NA

128. Do you think the work you **did**/are doing now/did fit your skill/qualification? 1=YES 2=NO

3=REQUIRE NO SKILLS

129. Are/were you paid or do you earn cash or in kind for this work or are you not paid at all?

1=CASH ONLY 2=CASH AND KIND 3=IN KIND ONLY 4=NOT PAID

130. How much **did**/do you earn for this work per month? **RECORD AMOUNT (GH₵)** →

131. In this main job, do/did you receive any of the following benefits in addition to your payment in cash or in kind?

	Yes	No		Yes	No
a. Retirement or pension	1	2	d. Cash bonuses	1	2
b. Medical services/health care	1	2	e. No benefits	1	2
c. Food or provisions	1	2	f. Other(specify)	1	2

132. Who mainly decides how the money you earn will be used? 1=SELF 2=SPOUSE/PARTNER

3=SELF AND PARTNER JOINTLY 4=SOMEONE ELSE 5=JOINTLY WITH SOMEONE ELSE 6=PARENT(S)

7=CARE TAKER 8=CHILDREN

133. On average, how much of your household's expenditures **did**/do your earnings pay for: 1=ALMOST NONE 2=LESS THAN HALF 3=ABOUT HALF 4=MORE THAN HALF 5=ALL

SECTION 3 - HEALTH STATE DESCRIPTION

134. In general, how would you rate your health today? 1 Very good 2 Good 3 Moderate 4 Bad 5 Very bad

135. Overall in the last 30 days, how much difficulty did you have with work or household activities?

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme/cannot do

136. Have you been taking any medication regularly for the past six months or more prescribed by a doctor/nurse for any long term illness? 1 Yes 2 No

SECTION 4 – RISK FACTORS AND PREVENTIVE HEALTH BEHAVIOURS

137. Have you ever smoked tobacco or used smokeless tobacco? 1 Yes 2 No 99 DK

137a. What products have you smoked/used mostly? 01 Manufactured cigarettes 02 Hand-rolled cigarettes (taa) 03 Snuff (for nasal use) 04 Chewing tobacco(bonto) 05 Pipes full of tobacco (abua) 06 Cigars

07 Other(specify) 99 Don't know 88 NA

138. When was the recent tobacco smoked/used? *Probe – 30 days, 1 week, 12 months, etc*

139. What products have you smoked/used in the last 7 days? 01 Manufactured cigarettes 02 Hand-rolled cigarettes (taa) 03 Snuff (for nasal use) 04 Chewing tobacco(bonto) 05 Pipes full of tobacco (abua) 06 Cigars 07 Other(specify)

99 Don't know 88 NA

140. Have you ever consumed a drink that contains alcohol (such as beer, wine, spirits, etc.)? 1 YES 2 NO, NEVER

140a What kind of alcohol did/do you drink most frequently? 01 Industrial beer 02 Industrial spirits

03 Other industrial alcohol 04 Locally brewed alcohol (eg: Pito) 05 Palm wine

06 Locally-distilled alcohol(eg: akpeteshie) 07 Refused to answer 08 Other (specify) 88 NA 99 Don't know

141. When was the last time you consumed a drink that contains alcohol?

Probe – 30 days, 1 week, 12 months, etc

142. What kind of alcohol did you drink **most** frequently in the last 7 days? 01 Industrial beer 02 Industrial spirits 03 Other industrial alcohol 04 Locally brewed alcohol (eg: Pito) 05 Palm wine 06 Locally-distilled alcohol(eg: akpeteshie) 07 Refused to answer 08 Other (specify) 88 NA 99 Don't know

SECTION 5 - HEALTH SEEKING BEHAVIOUR AND BEHAVIOUR CHANGES

143. Is there a place that you **usually** go when you are **unwell/sick**? 1 Yes 2 There is more than one place 3 There is no place 99 Don't know

144. What kind of place do you go to **most often**? [**REFER TO CODES**]

145. Is there a place that you **usually** go when you need **advice about your health**? 1 Yes 2 There is more than one place 3 There is no place 99 Don't know

146. What kind of place do you go to **most often** when you **need advice about your health**? [**REFER TO CODES**]

CODES FOR SECTION 5 & QUESTION 171

Public Health Sector: Teaching Hospital……01 Regional Hospital……02 District Hospital....03 Other Public Hospital…..04 Polyclinic…05 Health Centre…..06 CHPS….07 MCH Clinic…..08 Maternity Home…….09 Other(specify)……10

Private Health Sector: Hospital…11 Clinic……12 Maternity Home….. 13 Chemical Store……14 Medical Practitioner Home…...15 Patient's Home……16 Mission Hospital/Clinic….17 Pharmacy…...18 Other(specify)…..…19

Medical Alternative: Homeopathy……...20 Traditional Healer's Home…21 Other(specify)……..….22

SECTION 6 – WHODAS SCORE

147. 0 = NO DIFFICULUTY 1 = MILD DIFFICULTY 2 = MODERATE DIFFICULT
3 = MODERATE DIFFICULTY 4 = EXTREME DIFFICULTY OR CANNOT DO

S1.	Standing for long periods such as 30 minutes?	
S2.	Taking care of your household responsibilities?	
S3.	Learning a new task, for example, learning to get to a new place	
S4.	How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities in the same way as anyone else can?	
S5.	How much have you been emotionally affected by your health problems?	
S6.	Concentrating on doing something for ten minutes?	
S7.	Walking a long distance such as a kilometre (or equivalent)?	
S8.	Washing your whole body?	
S9.	Getting dressed?	
S10.	Dealing with people you do not know?	
S11.	Maintaining a friendship?	
S12.	Your day-to-day work?	
H1.	Overall, in the past 30 days, how many days were these difficulties present?	
H2.	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	
H3.	In the past 30 days, not counting the days that you were totally unable, for how mnay days did you cut back or reduce your usual activities or work because of any health condition?	

SECTION 7 - SPECIFIC HEALTH CONDITIONS AND SYMPTOMS

A. DID/DO YOU HAVE (CONDITION) ?
B. WHO TOLD YOU THAT YOU HAD/HAVE THIS CONDITION?
C. WHAT TREATMENT DID YOU HAVE FOR THIS CONDITION?
D. DID YOU HAVE ANY LABORATORY EXAMINATIONS FOR THIS CONDITION?
E. DID YOU HAVE ANY OTHER TESTS FOR THIS CONDITION?
F. DO YOU STILL HAVE THIS CONDITION?
G. WERE YOU RESTRICTED IN YOUR USUAL ACTIVITIES BECAUSE OF THIS CONDITION?

148.	CONDITION	a.DIAG-NOSIS 1=YES 2=NO 9=DK	b.WHO DIAGNOSED? 1=DOCTOR 2=NURSE 3=MIDWIFE 4=PHARMACIST 5=PRIEST 6=HERBALIST 7=NO ONE	c.TREAT-MENT	d.LAB EXAMS 1=YES 2=NO	e.OTHER TEST	f.DO YOU STILL HAVE IT? 1=YES 2=NO	g.RESTRIC-TION 1 =YES 2=NO
	HYPERTENSION							
	DIABETES							
	HEART ATTACK/SHOCK							
	STROKE							
	CHRONIC LUNG CONDITION, NOT ASTHMA							
	ASTHMA							
	DEPRESSION/ANXIETY							
	CANCER(SPECIFY)							
	MALARIA							
	TUBERCULOSIS							
	OBESITY							
	URINARY INCONTINENCE							
	BROKEN BONE							
	ARTHRITIS/JOINT PAIN							
	SCHIZOPHRENIA							
	EPILEPSY/SEIZURE OR FIT							
	CATARACTS							
	ANGINA							

HEALTH – DISABILITY STATUS

149. WHAT TYPE OF DISABILITY DO YOU HAVE THAT LIMITS YOUR FULL PARTICIPATION IN LIFE ACTIVITIES (SUCH AS MOBILITY, WORK, SOCIAL LIFE)?

NONE…… 0 SIGHT……..1 HEARING……2
SPEECH……3 PHYSICAL……...4 INTELLECT……...……..5
EMOTIONAL……6 OTHER(SPECIFY)…...7

SECTION 8 - HEALTH : SOCIAL INSURANCE PARTICIPATION, ACCESS AND UTILISATION OF HEALTH SERVICES

150. What is your health insurance status? 01 Currently registered 02 Previously registered 03 Never registered

151. How was your membership of the health insurance achieved? 01 Paid premium myself 02 Premium paid by a relative/friend 3 Premium paid by employers 04 Premium paid by SSNIT 05 Exempt as indigent 06 Exempt as aged 07 LEAP Beneficiary Other(specify) 99 Don't know

152. Do you hold a vaild health insurance scheme (HIS) card? 01 Yes, card seen 02 Yes, can not seen 03 No, never registered

If currently registered, what insurance category do you belong to? 01 Formal SSNIT 02 Informal 03 Exempt(poor) 04 Exempt(elderly65+) 05 Exempt(pregnant women) 06 Exempt (children) 07 Exempt(LEAP) 08 Private HI other private/public 99 Don't know 88 NA 09 Other (specify)

153. Do you have a valid insurance card? 01 Yes seen-valid 02 Yes seen, not valid 03 Yes not seen 04 No, never registered 05 No, previously registered 06 99 888 NA

155. Have you used the card within the last 12 months? 1 Yes 2 No 88 NA

156. Would you renew membership if it expires? 1 Yes 2 No 88 NA

157. If YES, why? /01 Always sick, requires care 02 Premium payment okay 03 Benefited from HI 04 Good attitude of HI staff 05 Easy accessing health care 06 Drug available 07 Good quality of care 08 Good waiting times 09 Other(specify) 99 Don't know 88 NA

158. If NO, why? 01 No money 02 Prefer cash payment 03 Doesn't fall sick 04 Didn't benefit from HI 05 Poor attitude of HI staff 06 Good benefit package 07 Insurance agents not trustworthy/reliable 08 Long waiting period 09 Long waiting times

159. During the last 4 weeks, have you suffered from either an illness or injury? Neither…....1 Illness….2 Injury…3 Both…....4

160. During the last 4 weeks have you consulted a health practitioner, visited a health facility or consulted a traditional healer or purchased drugs? Yes…..1 No……2

161. If NO, why did you not seek healthcare at a health facility or purchase drugs? (*only one option to choose*)
01 Did self-treatment 02 No money 03 Doesn't fall sick 04 Didn't benefit from HI 05 Poor attitude of HI staff 06 Good benefit package 07 Insurance agents not trustworthy/reliable 08 Long waiting period 09 Long waiting times 10 Difficult accessing health care 11 Drugs not available 12 Poor quality of care 13 Bad attitude of health staff Don't know 14 Other(specify) 88 NA

162. If previously a member of a health insurance, why has NAME not renewed the card? 01 Not aware card expired 02 No money 03 Did not use health services previous year (s) 04 Benefit package inadequate 05 Insurance agents nto trustworthy/reliable 06 Process of renewal too complex 07 Long waiting period for card 08 Expenditure on HI too expensive 09 Poor quality of care 10 Difficult in accessing health services 11 Not satisfied with the attitude of provider (s) 12 Process of getting care too complicated 13 Waiting time too long 14 Other(specify) 99 Don't know 88 NA

163. If NEVER been a member of a Health Insurance, why have you never registered with the insurance scheme (Main reason)?
01 Healthy, don't need 02 Prefer traditional treatment 03 No information about HI 04 Premium too expensive 05 No money 06 Benefit package inadequate 07 Insurance agents nto trustworthy/reliable 08 Waiting period too long 09 Poor quality of care 10 Difficult in accessing health services 11 Poor attitude of provider (s)

12 Long waiting time 14 Other(specify) 99 Don't know 88 NA

164. Would you like to be a member in the future? 1 Yes 2 No 99 Don't know 88 NA

165. If Yes, why? 01 If money becomes available 02 Health failing, would require care 03 Premium payme okay 04 Good attitude of HI staff 05 Good benefit package 06 Easy accessing healthcare 07 Drug availability 08 Good waiting times 09 Health staff welcoming 10 Other (specify) 99 Don't know 88 NA

166. If NO, why? 01 No money to renew/register 02 Prefer cash payment 03 Didn't benefit from HI 04 Limited benefit from HI 05 Limited benefit package 06 Good benefit package 07 Difficult accesing healthcare 08 Drugs not available 09 Bad attitude of health staff 10 Poor quality of care 11 Other(specify) 99 Don't know 88 NA

167. When was your most recent visit to a health facility or use of health service or purchase drugs?

01 > 1 months <= 2 months 02 2-3 months 03 3-6 months 04. Over 6 months 05 Don't know

168. On the most recent visit whom did you consult? 01 Doctor 02 Denist 03 Nurse 04 Medical Assistant 05 Midwife 06 Pharmacist 07 Drug/chemical seller 08 Traditional Healer 09 Trained TBA 10 Untrained TBA 11 Spiritualist 12 Other(specify)

169. What was the main reason for the most recent visit?

Illness ……..1 Injury…….2 Follow-up……..3 Check up……4 Vaccination…….5 Other(specific)……..9

170. Where did the the consultation take place? (codes above – Section 5)

171. Why did you use this provider? (**Main reason only**) 01 Closet health facility 02 Told to go there by Doctor/Nurse 03 Open at convenient time 04 Did not have to pay/lower payment 05 Know that care available there will help me get better 06 I will be treated respectfully 07 Always go there/continuity of care 08 Medicines generally available 09 Facility is covered by NAME's HI 10 Due to the quality of care 11 Other(specify)

172. What was the mode of payment at the health facility? 1 Cash 2 Health insurance card 3 Health insurance card & Cash 4 In-kind 5 Don't have to pay because health worker is relative or friend 6 Others(specify) 99 Don't know

173. How much (Ghana Cedis) did you pay for:

Registration _____ Consultation _____ Diagnosis/laboratory/X-ray_____

Drugs/treatment_____ Transportation(in & out)_____ Other cost(non-medical)_____

Overall coast for treatment (if cannot give the breakdown)_____

174. What was the **main source** of cash? 01 Cash/Savings 02 Sold Assets 03 Business capital 04 Borrowed 05 Gift 06 Reduce daily 07 Other (specify) 99 Don't know 88 NA

175. How satisfied were you with the quality of care? 01 Very satisfied 02 Satisfied 03 Average/normal 04 Dissatisfied 05 Very dissatisfied 99 Don't know 88 NA

176. If dissatisfied or very dissatisfied, what was the **main problem**? 01 Waiting tiem 02 Attitude of staff 03 Cleanliness 04 Health facility too far 05 Qualification of health staff 06 Availability of drugs and equipment 07 Administrative too complelx/time consuming 08 Other(specify) 99 Don't know 88 NA

177. Have you ever been admitted to hospital in the last one year? 1 Yes 2 No

178. If YES, How many times in the last on year (12 months) were you admitted?

179. If YES, were you admitted within the last four weeks? 1 Yes 2 No

180. Where did NAME go or what action did NAM take? (***only one option to choose***) 01 Traditonal healer 02 Pharmacy/LCS 03 Private clinic 04 Community health centre/CHPS 05 Public Health Centres/Polyclinics 06 District Hospitals 07 Regional hospital 08 Teaching hospital 09 Other(specify) 88 NA

181. Why did you use this provider? (**Main reason only**) 01 Closet health facility 02 Told to go there by Doctor/Nurse 03 Open at convenient time 04 Did not have to pay/lower payment 05 Know that care available there will help me get better 06 I will be treated respectfully 07 Always go there/continuity of care 08 Medicines generally available 09 Facility is covered by NAME's HI 10 Due to the quality of care 11 Other(specify)

182. Did you use a viald insurance card? 01 Yes 02 No 99 Don't know 88 NA

183. If valid card but did not use, what is the reason why you did not use card? 01 Illness not covered 02 Facility not covered 03 Pharmacy not covered 04 Drugs not covered/poor quality drugs 05 Didn't have a prescription 06 Not referred to facility 07 Process complicated if use card 08 Attitude of staff is poor if use card 09 Drugs not available if use card 10 Other(specify) 99 Don't know 88 NA

184. What was the **mode of payment** at the health facility? 1 Cash 2 Health insurance card 3 Health insurance card & Cash 4 In-kind 5 Don't have to pay because health worker is relative or friend 6 Others(specify) 99 Don't know

185. How much (Ghana Cedis) did you pay for:

Medical cost (Registration/Consultation/Diagnosis/laboratory/X-ray/Treatment)_____

Transportation(in & out)_____ Other cost(non-medical)_____

186. What was the **main source** of cash? 01 Cash/Savings 02 Sold Assets 03 Business capital 04 Borrowed 05 Gift 06 Reduce daily 07 Other (specify) 99 Don't know 88 NA

187. How satisfied were you with the quality of care? 01 Very satisfied 02 Satisfied 03 Average/normal 04 Dissatisfied 05 Very dissatisfied 99 Don't know 88 NA

188. If dissatisfied or very dissatisfied, what was the **main problem**? 01 Waiting tiem 02 Attitude of staff 03 Cleanliness 04 Health facility too far 05 Qualification of health staff 06 Availability of drugs and equipment 07 Administrative too complelx/time consuming 08 Other(specify) 99 Don't know 88 NA

AWARENESS OF, AND PARTICIPATION IN SOCIAL INTERVENTIONS

189. What are the various social interventison that you are aware of?_____

190. Which ones do directly benefit odler persons (60 years and above)?_____

191. Are you a direct beneficiary of any social intervention programmes? 1 Yes 2 No

192. Whicn one (s) are you a beneficiary? _____ *(check if person has valid card, household is part of LEAP)*

193. Have you heard about LEAP? 1 Yes 2 No

194. Are you a LEAP beneficiary? 1 Yes 2 No

195. If YES, what are the conditionalities attached to this programme?_____

196. What are the entitlement as a beneficiary? Household not beneficiary…….0 Shelter…….1 Food……2 Soap……3 Water……..4 Clothing ……5 School fees……6 School supplies…….7 Farm inputs……..8 Skills/training…….9 Medical services……..10 Other(specify)……11 Don't know……99 NA …….88

197. If "NO", do you wish you should have been a beneficiary? 1 Yes 2 No 99 Don't know 88 NA

198. If "Yes", what is/are your reason(s)?_____

199. If "No", what is/are your reason(s)?_____

200. Paricipating in LEAP makes one lazy and dependent. 01 Strongly disagree 02 Dissagree 03 Agree 04 Strongly agree

201. Elderly participation in **NHIS** promotes access to quality care 01 Strongly disagree 02 Dissagree 03 Neither agree/disagree 04 Agree 05 Strongly agree

202. Elderly participation in **LEAP** promotes access to quality care 01 Strongly disagree 02 Dissagree 03 Neither agree/disagree 04 Agree 05 Strongly agree

SECTION 9 – MEASUREMENT OF QUALITY OF CARE FROM THE PERSPECTIVE OF OLDER PERSONS			
Quality of Care Indicator [From your perspective, how important will each indicator to seek care from your service provider] 1=Not important 2=Fairly important 3=Important 4= important extremely **[Ask about level of satisfaction for 2]**			
204.	**PROCESS**	**1. NOT GONE TO SEEK CARE**	**2. AFTER SEEKING CARE**
	Take patients seriously		
	Keep appointments punctually		
	Patients have access to case notes/tiles/folders		
	Patients received information about combinations of medicines		
	Patient decides about treatment		
	Choice of another health care provider		
	Good understanding of the patient's problems		
	Work efficiently		
	STRUCTURE		
	Access to hospital specialist within 2 weeks		
	Immediate home help after discharge from hospital		
	Good care co-ordination		
	Medicines free of charge		
	Reimbursement of costs within 2 months		
	Costs/benefits balance		
	OTHER CATEGORY SPECIFIC		
	Friendly attitude towards the patient/client		
	Willingness to discuss matters that have not run satisfactorily		
	Always allow enough time for the patient/client		
	Arrangements on what to do in an emergency		
	Information leaflet with any medicines dispensed		
	Prescriptions delivered to the patient's home address		
	No objections if the patient brings someone with him/her to an appointment		
	Considerations about home help before being discharged		
	Cover to be provided when my regular home help is ill or on holiday		
	Easy access for physically disabled or people in wheelchairs		
	Easy to get by public transport		
	Easy to get to		
	General practitioner's phone switched through directly to the doctor on call		
	Home help for as many hours as the client needs		
	Possibility to determine how to allocate the budget for care services		

SECTION 10 – SOCIAL NETWORKS & INTERGRATION

205. Have you ever been a member of an association/club [formal or informal]? 01 Yes 02 No

206. Are you currently a member of an association/club [formal or informal]? 01 Yes 02 No

207. How many associations/clubs are you currently a member? _____ _____

208.

	Name of Association/Club	Purpose/Aim	Years of being member	Benefits entitled
1.				
2.				
3.				
4.				
5.				
6.				

209. How close are you to your family and friends? 01 Very close 02 Close 03 Not close 04 Not very close

210. In the last 12 months, have you received any financial or in-kind support from your family (children, siblings or parents), relatives (other kin) and friends who do not live with you? 01 Yes 02 No 99 Don't know 88 NA

201. What type of assistance did you receive? 01 Money only_____ 02 Kind only 03 Both money & kind_____

212. During the past year, did you provide help to a relative or friend (adult or child), because this person has a long-term physical, or mental illness, or disability, or is getting old and weak? 01 Yes, physical illness 02 Yes, mental illness 03 Yes, disability 04 Yes, getting old and weak 05 No 06 Don't remember

SECTION 11 - OTHER AGEING-RELATED ISSUES

213. Awareness of Ghana's Ageing Policy 01 Yes 02 No 03 Don't know/refused to answer

214. If "Yes", can you state one main issue that this policy addresses in relation to older persons in Ghana? _____

215. Awareness of Ghana's Social Protection Policy 01 Yes 02 No 03 Don't know/refused to answer

216. There is little talk on the ageing-related issues in Ghana 01 Strongly agree 02 Agree 03 Disagree 04 Strongly disagree

217. Ghana's healthcare system is ageing friendly 01 Strongly agree 02 Agree 03 Disagree 04 Strongly disagree

218. The Capitation model has improved the quality of health care that elderly persons receive 01 Strongly agree 02 Agree 03 Disagree 04 Strongly disagree

Appendix 3: Household Survey Questionnaire

Project Title

Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana: Evidence from Mampong Municipality

Portions of questions adapted from the Urban Health and Poverty Project-RIPS, UG, Coates, Swindale and Bilinsky, (2007) and Abebrese, (2011).

HOUSEHOLD INFORMATION	HH
HH1 *REGION:* REGION 1 ……..*ASHANTI* **LOCALITY NAME:……** **E.A. BASE:……..** **NAME OF HOUSEHOLD HEAD:……..**	**HH3 Community:** COM 1..... 1 COM 2..... 2 COM 3..... 3 COM 4..... 4
HH2. *AREA:* Urban 1 Rural 2	**HH4**. *Structure number:* ___ ___ __ **HH5**. *Household number:* ___ ___
HH6a. *Interviewer's name and number:* NAME _____ ___ ___ ___	**HH6b**. *Supervisor's name and number:* NAME _____ ___ ___ ___
HH7a. *Day / Month / Year of interview:* ___ ___ /___ ___ / 2 0 1 7	**HH7b:** *GPS Coordinates:* **Lat**___ ___ /___ ___ / **Lon**___ ___ /___ ___ /

Check that the respondent is a knowledgeable member of the household and at least 60 years old before proceeding. You must not interview any person below age 60 years.	**HH8**. *Record the time.* HOURS : MINUTES ☐☐ : ☐☐

HH12. Hello, my name is (***your name***). We are from the Regional Institute for Population Studies, University of Ghana, Legon. We are conducting a survey to understand the effect of social protection initiatives on access to quality of health care among elderly persons in Ghana. The study will also explore how factors such as social, economic, cultural, etc affect the elderly's quality of health care covering the individual, household, community and institutional levels. I would like to talk to you about these subjects. This interview may take about Twenty-five(25) minutes. All the information we obtain will strictly be kept confidential and anonymous. If you do not wish to answer a question or stop the interview, please let me know. May I start now?

YES, CONSENT GIVEN .....1 *NO, CONSENT IS NOT GIVEN 2*	1 ⇨*LIST OF HOUSEHOLD MEMBERS* 2 ⇨*HH9*

HH9. *Result of Household Questionnaire interview:* *Discuss any result not completed with Supervisor.*	COMPLETED ..... 01 REFUSED ..... 02 CALL BACK ..... 03 REFUSED ..... 04 DWELLING NOT FOUND ..... 05 RESPONDENT INCAPACITATED ..... 06 OTHER (*specify*)_____ 96

HH10.	TOTAL PERSONS IN HOUSEHOLD ☐☐ LINE NUMBER OF HOUSEHOLD RESPONDENT ☐☐ LINE NO. OF ELDERLY RESPONDENT ☐☐

LIST OF HOUSEHOLD MEMBERS **HL**

First complete HL2 for all members of the household. Then proceed with HL3 and HL4 vertically. Once HL2-HL4 are complete for all members, make sure to probe for additional members: Those that are not currently at home, any infants or small children and any others who may not be family (such as servants, friends) but who usually live in the household.

Then, ask questions HL5-HL20 for each member one at a time. If additional questionnaires are used, indicate by ticking this box:..... ☐

HL1. *Line Number*	**HL2**. First, please tell me the name of each person who usually lives here, starting with the head of the household. *Probe for additional household members.*	**HL3**. What is the relationship of (***name***) to the head of household?	**HL4**. Is (***name***) male or female? **1 MALE** **2 FEMALE**	**HL5**. What is (***name***)'s date of birth?		**HL6**. How old is (***name***)? *Record in completed years.*	**HL7. Years** lived in current **household** **Lifetime=00**	**HL8. Marital Status**
				98 DK	9998 DK			
LINE	NAME	RELATION*	M F	MONTH	YEAR	AGE		
01		0 1	1 2	__ __	__ __ __ __	__ __		
02		__ __	1 2	__ __	__ __ __ __	__ __		
03		__ __	1 2	__ __	__ __ __ __	__ __		
04		__ __	1 2	__ __	__ __ __ __	__ __		
05		__ __	1 2	__ __	__ __ __ __	__ __		
06		__ __	1 2	__ __	__ __ __ __	__ __		
07		__ __	1 2	__ __	__ __ __ __	__ __		
08		__ __	1 2	__ __	__ __ __ __	__ __		
09		__ __	1 2	__ __	__ __ __ __	__ __		
10		__ __	1 2	__ __	__ __ __ __	__ __		
11		__ __	1 2	__ __	__ __ __ __	__ __		
12		__ __	1 2	__ __	__ __ __ __	__ __		
13		__ __	1 2	__ __	__ __ __ __	__ __		
14		__ __	1 2	__ __	__ __ __ __	__ __		
15		__ __	1 2	__ __	__ __ __ __	__ __		
16		__ __	1 2	__ __	__ __ __ __	__ __		

* *Codes for **HL3**: Relationship to head of household:*			**CODES FOR HL8.(MARITAL STATUS)**	
01 HEAD	05 GRANDCHILD	09 ADOPTED/FOSTER/STEP CHILD	01 CURRENTLY MARRIED	05 SEPARATED
02 SPOUSE / PARTNER	06 PARENT	96 OTHER (NOT RELATED)	02 LIVING WITH A MAN/WOMAN	06 NEVER MARRIED
03 SON / DAUGHTER	07 PARENT-IN-LAW	98 DON'T KNOW	03 WIDOWED	07 UNDER 12 YEARS
04 SON / DAUGHTER-IN-LAW	08 CO-WIFE		04 DIVORCED	
	09 OTHER RELATIVE			

ED1. *Line number*	**ED2**. *Name and age.* *Copy names and ages of all members of the household from HL2 and HL6 to below and to next page of the module.*	**ED3**. *Age 3 or above?* 1 YES 2 NO ✩ *Next Line*	**ED4**. Has (***name***) ever attended school or any Early Childhood Education programme? 1 YES 2 NO ✩ *Next Line*	**ED5**. Highest level of education (**name**) attended/attending? 00 NONE 01 KINDERGATEN 02 PRIMARY 03 JSS/JHS 04 MIDDLE 05 SSS/SHS 06 SECONDARY 07 VOC/TECH/ COMMERCIAL 08 POST MIDDLE/SEC CERT 09 POST SECONDARY DIPLOMA 10 BACHELOR DEGREE 11 POST GRADUATE 12 OTHER (SPECIFY) 99 DON'T KNOW	**ED6**. Highest GRADE (**name**) completed for those in **ED5**? None…...00 Pre-school…..01 P1.....11 P2…….....12 P3.....13 P4…….....14 P5.....15 P6….....16 JSS1/JHS1..17 JSS2/JHS2.....18 JSS3/JHS3..19 M1….....20 M2..... ..21 M3.....22 M4.....23 SSS1/SHS1.....24 SSS2/SHS2….25 SSS3/SHS3…26 SHS4.....27 S1…….....28 S2.....29 S3….....30 S4... .....31 S5.....32 L6... .....33 U6.. ….....34 Voc/Tech/Computer/Comm/ Agric.....41 Teacher Training.....42 Nursing Training.....43	**ED7.Why "NO" in ED4 ?** Too young …….01 Disabled/ illness…02 No school / school too far..03 Cannot afford schooling....04 Family did not allow schooling….....05 Not interested in school.....06 Education not considered valuable……...07 School not safe…...08 To learn a job…. ..09 To work for pay ....10 To work as unpaid worker in family business/farm…11 Help at home with household chores….12 Other…....13	**RE1.**Religious Affiliation 01 No Religion 02 Catholic 03 Protestant (Anglican, Lutheran, Presbyterian, Methodist, etc) 04 Pentecostal/ Charismatic 05 Other Christian 06 Islam 07 Ahmadi 08 Traditionalist 09 Other (Specify)	**ET1.** Ethnicity 01 Asante 02 Akwapim 03 Fante 04 Other Akan 05 Ga/Adangbe 06 Ewe 07Guan 08 Mole-Dagbani 09 Grussi 10 Gruma 11 Hausa 12 Other (specify)

							Polytechnic.....51 University.....52 Other Tertiary.....53 Other (specify)....61	(specify)		
LINE	NAME	AGE	YES	NO	YES	NO	EDUCATION	GRADE	NOSCHOOL	RELIG	ETHNIC
01		___ ___	1	2	1	2					
02		___ ___	1	2	1	2					
03		___ ___	1	2	1	2					
04		___ ___	1	2	1	2					
05		___ ___	1	2	1	2					
06		___ ___	1	2	1	2					
07		___ ___	1	2	1	2					
08		___ ___	1	2	1	2					
09		___ ___	1	2	1	2					
10		___ ___	1	2	1	2					
11		___ ___	1	2	1	2					
12		___ ___	1	2	1	2					
13		___ ___	1	2	1	2					
14		___ ___	1	2	1	2					
15		___ ___	1	2	1	2					
16		___ ___	1	2	1	2					

		Economic Activity In the Last 7 days prior to Survey(*FOR ONLY HOUSEHOLD MEMBERS 5 YEARS AND ABOVE*)							
EA1. *Line number*	**NA1.** Nationality 01 Ghanaian by birth 02 Dual Nationality 03 Ghanaian by naturalisation 04 Nigerian 05 Liberian 06 Sierra Leonean 07 Gambian 08 Togolese 09 Burkinabe 10 Ivorian 11 Other ECOWAS National 12 African, other than ECOWAS 13 Other(specify)	**EA2**. **In the Last 7 days, did [NAME]** **engage in any activity for pay (cash or kind) or profit or family gain for at least one hour?** **(THIS INCLUDES HELPING IN THE FAMILY BUSINESS/ FARM, TRADING, STREET VENDING, ETC)** 01 YES 02 NO ✩ *Next Line*	**EA3.** **How was [NAME] mainly engaged?** 01 Did not work but had job to go back to (**GO TO EA5**) 02 Worked before, seeking work and available for work (**GO TO EA5**) 03 Seeking work for the first time and available for work (**GO TO HH1A**) 04 Did voluntary work without pay (**GO TO EA5**) 05 Did not work and not seeking 06 Other(specify)	**EA4**. **Why did [NAME] not seek work?** **GO TO HH1A.** 01 Did home duties (household chores/ full time homemaker) 02 In full time education /student 03 Pensioner/Retired 04 Disabled/too sick to work 05 Too old/too young 06 Other(specify)	**EA5**. **OCCUPATION** **IF YES IN EA2;** **ASK:** What kind of work did [NAME] mainly do? **IF EA3 = 1, ASK:** What kind of work did [NAME] do before the break period? **IF EA3 = 2 OR 4, ASK:** What kind of work did [NAME] do previously?	**EA6**. **EMPLOYMENT STATUS** **What was [NAME]'s employment status in that establishment/ industry?** 01 Employee 02 Self employed without employees 03 Self employed with employees 04 Casual worker 05 Contributing family worker 06 Apprentice 07 Domestic employee (house-help) 8 Other(specify)	**EA7.** **EMPLOYMENT SECTOR** **In what sector was [NAME] mainly working?** 01 Public (Government) 2 Private Formal 3 Private Informal 4 Semi-Public/Para-statal 5 NGO (Local and International) 6 International Organisation	**EA8. MONTHLY EARNINGS** **How much has [NAME] earned in the LAST ONE MONTH? (GH¢)** **Don't know=99**	

LINE	NATIONALITY	EACTIVITY	ENGAGED	NOSEEK	OCCUP	EMPSTATUS	EMPSEC	CEDIS	PESEWAS
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									
15									
16									

UHC1. *Line number*	**UHC2**. *Name and age.* *Copy names and ages of <u>all</u> members of the household from HL2 and HL6 to below <u>and</u> to next page of the module.*		**UHC3**. Health Insurance Status 01 Currently registered 02 Previously registered (**GO TO UHC11**) 03 Never Registered (**GO TO UHC12**) 99 Don't know	**UHC4**. Insurance Category does [name] belong to if **UHC3[01]** 01 Formal SSNIT 02 Informal 03 Exempt (poor) 04 Exempt (elderly) 05 Exempt (pregnant women) 06 Exempt (children) 07 Exempt(LEAP) 07 Private HI 08 Both private/public 99 Don't know 88 NA 98 Other (specify)	**UHC5.** Does [NAME] have a Valid Insurance Card? 01 Yes seen-valid 02 Yes seen- not valid (**GO TO**) 03 Yes, not seen 04 No (GO TO) 99 Don't know 88 NA	**UHC6**. Has [NAME] used the card within the last 12 months? 01 Yes 02 No 99 Don't Know	**UHC7.** Does [NAME] pay premium and/or processing fee to become a member? 01 Processing only 02 Premium and processing 03 Exempted (>>11) 88 N/A	**UHC8.** Would [NAME] renew membership if it expires? 01 Yes 02 No 99 Don't know	**UHC9.** If Yes in **UHC8**, Why? 01 Always sick, requires Care 02 Premium payment ok 03 Benefitted from HI 04 Good attitude from HI staff 05 Good benefit package 06 Easy accessing health care 07 Drugs available 08 Health staff welcoming 09 Good quality of care 10 Good waiting times 11 Other(specify) 99 Don't know 88 NA

LINE	NAME	AGE	INSURE	CATEGORY	VALCARD	USECARD	MEMBER	RENEW	WHYRENEW
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									
15									
16									

HOUSEHOLD LEVEL IN UNIVERSAL HEALTH COVERAGE, DISABILTIY AND OTHER SOCIAL PROTECT PROGRAMS PARTICIPATION - 1

UHC1. *Line number*	**UHC10**. If NO in **UHC8**, Why? 01 No money to renew 02 Prefer cash payment 03 Don't fall sick 04 Didn't benefit from HI 05 Poor attitude of HI staff 06 Good benefit package 07 Insurance agents not trustworthy/reliable 08 Long waiting period 09 Bad attitude of health Staff 10 Poor quality of care 11 Other(specify) 99 Don't know 88 NA	**UHC11. If previously a member of a Health insurance, why has [NAME] not renewed the card? (main reason).** Premium is too high.....01 Do not have confidence in operators of the schemes....02 Covered by other alternatives..... .03 Was not getting benefits.....04 Registered, but not fully paid……05 Registered/Renewed, card not received……..…...06 Registered, in waiting period…07 Registered not renewed…….08 Lost insurance card.…….…09 No money……..10 Other (specify).....96 Do not know…..99 NA….88	**UHC12. If (NAME) is registered or covered, what type of health insurance scheme is he/she registered with?** National/District Health Insurance (NHIS)…….....1 Private Health Insurance....2 Both……3Other(specify)……4 Do not know……99 NA……88	**UHC13. How was (NAME's) membership of the health insurance achieved**? Paid premium myself.....1 Premium paid by a relative or friend.....2 Premium paid by employers.....3 Premium paid by SSNIT….4 Exempt as indigent…….....5 Exempt as under 18…….6 Exempt as aged……7 Exempt as LEAP beneficiary ……..8 Free Maternal Service……..9 Other (specify)……10 NA……88	**DS1. What type of disability does (NAME) have that limits her/his full participation in life activities(such as mobility, work, social life, etc)?** None……0 Sight.....1 Hearing.....2 Speech.....3 Physical.....4 Intellect.....5 Emotional.....6 Other(specify).....7 Do not know…….99	**SP1**. **What social protection programmes does [NAME] participate in or directly benefit from?** 00 None 01 Ghana School Feeding Programme 02 LEAP 03 NHIS 04 Free Uniforms 05 Capitation Grant 06 NYEP 07 Integrated Agricultural Support Programme 07 NGO 08 Other(specify) 99 Do not know
LINE	NOTREG	NORENEWED	SCHEME_TY	MEMBERSHIP	DISABILITY	SPP
01						
02						
03						
04						
05						
06						
07						
08						
09						
10						
11						
12						
13						
14						

SOCIAL PROTECTION PROGRAMS PARTICIPATION AND SOCIAL NETWORKS

UHC1. *Line number*	**SP2. Which target groups does [NAME] fall/belong to?** 00 None 01 Subsistence farmers & fishermen 02 Extremely poor 65+ 03 Persons with disabilities without productive capacity 04 Elderly(65+) 05 Caregivers of OVC(able to work) 06 Lactating mothers with HIV/AIDS(able to work) 07 Other (specify)	**SP3. What are the Complementary services enjoyed by [NAME]?** ***Multiple responses*** 00 None 01 NHIS Indigent Card 02 Microfinance & income-generating activity support 03 MOFA skills training 04 MOFA extension services 05 Ministry of Fisheries Alternative Livelihoods Project 06 Free Bus Ride 07 Erban Card 08 Micronutrients 09 Caregivers NHIS Indigent Card 10 Skills training for caregivers 11 School Feeding Programme 12 Skills training 13 Subsidised fees for PMTCT/ART 13 Food supplements/supplementary feed 14 Agric input support 15 Women's Dev. Fund(MOWAC) 16 GAC support to PLWHA Associations 17 Other(specify) 99 NA	**SN4. Which networks or groups (formal, informal, association & networks) do you/household member(s) TYPICALLY rely on to resolve issues of everyday life?** 00 None 01 Church groups 02 Clubs 03 Settlers groups 04 Welfare groups 05 Women's/Men's fellowship 06 Traditional council 07 Associations 08 Committees 09 Co-operative farmers associations 10 Other(specify)	**SN5. What benefit(s) does (NAME) USUALLY derive from being a member of the network(s) or group(s)?** 01 Pays school fees 02 Pay for health service 03 Obtain accommodation 04 Food 05 Caregiving 06 Homework/Assignment/Extra classes 07 Financial Assistance 08 Spiritual support 09 Emotional support 10 Funeral donation 11 Child Support 12 Other(specify)

LINE	TARGET_GRP	A	B	C	D	E	NETWORK	BENEFITS_NET
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								

DWELLING CHARACTERISTICS AND HOUSEHOLD POSSESSIONS DCHP		
DC1. How many rooms do members of this household usually use for sleeping?	NUMBER OF ROOMS..... __ __	
DC2. *Main material of the dwelling floor.* *Record observation.* *If observation is not possible, ask the respondent to determine the material of the dwelling floor.*	**NATURAL FLOOR** EARTH / SAND..... 11 DUNG ..... 12 **RUDIMENTARY FLOOR** WOOD PLANKS ..... 21 PALM / BAMBOO ..... 22 **FINISHED FLOOR** PARQUET OR POLISHED WOOD..... 31 VINYL OR ASPHALT STRIPS ..... 32 CERAMIC TILES ..... 33 CEMENT ..... 34 CARPET..... 35 OTHER (*specify*) _____ 96	
DC3. *Main material of the roof.* *Record observation.*	**NATURAL ROOFING** NO ROOF ..... 11 THATCH / PALM LEAF..... 12 SOD..... 13 **RUDIMENTARY ROOFING** RUSTIC MAT ..... 21 PALM / BAMBOO ..... 22 WOOD PLANKS ..... 23 CARDBOARD..... 24 **FINISHED ROOFING** METAL / TIN ..... 31 WOOD ..... 32 CALAMINE / CEMENT FIBRE ..... 33 CERAMIC TILES..... 34 CEMENT ..... 35 ROOFING SHINGLES ..... 36 SLATE/ASBESTOS……37 OTHER (*specify*).....96	

DC4. *Main material of the exterior walls.* *Record observation.*	**NATURAL WALLS** NO WALLS ..... 11 CANE / PALM / TRUNKS ..... 12 DIRT..... 13 **RUDIMENTARY WALLS** BAMBOO WITH MUD..... 21 STONE WITH MUD ..... 22 UNCOVERED ADOBE..... 23 PLYWOOD ..... 24 CARDBOARD ..... 25 REUSED WOOD ..... 26 **FINISHED WALLS** CEMENT ..... 31 STONE WITH LIME / CEMENT..... 32 BRICKS ..... 33 CEMENT BLOCKS..... 34 COVERED ADOBE ..... 35 WOOD PLANKS / SHINGLES..... 36 OTHER (*specify*).....96	
DC5. Type of Dwelling	01 SEPARATE HOUSE 02 SEMI-DETACHED 03 COMPOUND ROOMS 04 FLAT 05 HUT 06 TENT 07 KIOSK/CONTAINER 08 PART OF BUSINESS 09 OTHER(SPECIFY)	
DC6. Main Source of Lighting	01 INTERCONNECTED GRID (ELECTRICITY) 02 GENERATOR 03 KEROSINE LAMP 04 GAS LAMP 05 SOLAR 06 DISCONNECTED IN THE LAST 6 MONTHS 06 NONE 07 OTHER(SPECIFY)	

DC7. Does your household have: [A] A fixed telephone line? [B] A radio? [C] A television? [D] A refrigerator? [E] A watch/wall clock [F] A fan? [G] A bicycle? [H] A motorcycle or scooter or motor-king? [I] An animal-drawn cart? [J] A car, truck or van? [K] A boat/canoe? [L] A mobile telephone? [M] A electric/box iron? [N] A sewing machine? [O] A computer or tablet? [P] Access to internet at home? [Q] A piece of land?	YES NO FIXED TELEPHONE LINE ..... 1 2 RADIO ..... 1 2 TELEVISION..... 1 2 REFRIGERATOR..... 1 2 WATCH/WALL CLOCK .....1 2 FAN……1 2 BICYCLE.....1 2 MOTORCYCLE / SCOOTER OR MOTOR-KING ……..1 2 ANIMAL-DRAWN CART.....1 2 CAR / TRUCK / VAN .....1 2 BOAT/CANOE .....1 2 MOBILE TELEPHONE…..……...1 2 ELECTRIC/BOX IRON……1 2 SEWING MACHINE.....1 2 COMPUTER/TABLET……1 2 ACCESS TO NET……....1 2 LAND……...1 2	
DC8. Tenure/Holding arrangement of household Dwelling.	OWN ..... 1 RENT ..... 2 RENT-FREE……..3 PERCHING……4 SQUATTING……5 CARETAKER……6 OTHER (*specify)* _____ 7	
DC9. Does any member of this household own any land that can be used for agriculture?	YES ..... 1 NO 2	2 ⇨*DC11*
DC10. How many **units** of agricultural land do members of this household own?	PLOTS…….__ ___ POLES…….……___ ___ ACRES…….….___ ___ HECTARES ..... ___ ___ DK 98	
DC11. Does this household own any livestock, herds, other farm animals, or poultry?	YES ..... 1 NO 2	2 ⇨*DC13*

DC12. How many of the following animals does this household have? [A] Milk cows or bulls? [B] Other cattle? [C] Horses, donkeys or mules? [D] Goats? [E] Sheep? [F] Chickens? [G] Pigs? [H] Other(specify) *If none, record '00'. If 95 or more, record '95'.* *If unknown, record '98'.*	MILK COWS OR BULLS .....___ ___ OTHER CATTLE .....___ ___ HORSES, DONKEYS OR MULES.....___ ___ GOATS .....___ ___ SHEEP.....___ ___ CHICKENS.....___ ___ PIGS .....___ ___ OTHER .....___ ___	
HOUSEHOLD ENERGY USE		
EU1. Type of cook stove household <u>mainly</u> uses for <u>cooking</u>?	ELECTRIC STOVE .....01 SOLAR COOKER .....02 LIQUEFIED PETROLEUM GAS (LPG)/ COOKING GAS STOVE.....03 PIPED NATURAL GAS STOVE.....04 BIOGAS STOVE .....05 LIQUID FUEL STOVE .....06 MANUFACTURED SOLID FUEL STOVE .....07 TRADITIONAL SOLID FUEL STOVE .....08 THREE STONE STOVE / OPEN FIRE .....09 OTHER (*specify*) _____96 NO FOOD COOKED IN HOUSEHOLD.....97	01 ⇨*EU3* 02 ⇨*EU3* 03 ⇨*EU3* 04 ⇨*EU3* 05 ⇨*EU3* 06 ⇨*EU2* 09 ⇨*EU2* 96 ⇨*EU2* 97 ⇨*EU4*
EU2. Type of fuel or energy source household uses for this cook stove? *If more than one, circle the main energy source for this cook stove*	ALCOHOL / ETHANOL .....01 GASOLINE / DIESEL .....02 KEROSENE / PARAFFIN.....03 COAL / LIGNITE .....04 CHARCOAL.....05 WOOD .....06 CROP RESIDUE / GRASS / STRAW / SHRUBS .....07 ANIMAL DUNG / WASTE.....08 PROCESSED BIOMASS (PELLETS) OR WOODCHIPS .....09 GARBAGE / PLASTIC .....10 SAWDUST .....11 **OTHER (*specify*) 96**	

EU3. Type of cooking space *If in main house, probe to determine if cooking is done in a separate room.* *If outdoors, probe to determine if cooking is done on veranda, covered porch, or open air.*	IN MAIN HOUSE NO SEPARATE ROOM .....1 IN A SEPARATE ROOM .....2 IN A SEPARATE BUILDING .....3 OUTDOORS OPEN AIR.....4 ON VERANDA OR COVERED PORCH .....5 OTHER (*specify*) _____6	
EU4. At night, what does your household <u>mainly</u> use to <u>light</u> the household?	ELECTRICITY .....01 SOLAR LANTERN .....02 RECHARGEABLE FLASHLIGHT, TORCH OR LANTERN .....03 BATTERY POWERED FLASHLIGHT, TORCH OR LANTERN .....04 BIOGAS LAMP.....05 GASOLINE LAMP.....06 KEROSENE OR PARAFFIN LAMP .....07 CHARCOAL.....08 WOOD .....09 CROP RESIDUE / GRASS / STRAW / SHRUBS .....10 ANIMAL DUNG / WASTE.....11 OIL LAMP .....12 CANDLE.....13 OTHER (*specify*) _____96 NO LIGHTING IN HOUSEHOLD.....97	

WATER AND SANITATION		WS
WS1. Main source of drinking water used by members of your household? *If unclear, probe to identify the place from which members of this household most often collect drinking water (collection point).*	**PIPED WATER** PIPED INTO DWELLING ..... 11 PIPED TO YARD / PLOT ..... 12 PIPED TO NEIGHBOUR ..... 13 PUBLIC TAP / STANDPIPE..... 14 TUBE WELL / BOREHOLE ..... 21 **DUG WELL** PROTECTED WELL..... 31 UNPROTECTED WELL ..... 32 **SPRING** PROTECTED SPRING..... 41 UNPROTECTED SPRING ..... 42 RAINWATER..... 51 TANKER-TRUCK..... 61 CART WITH SMALL TANK ..... 71 WATER KIOSK ..... 72 SURFACE WATER (RIVER, DAM, LAKE, POND, STREAM, CANAL, IRRIGATION CHANNEL)..... 81 **PACKAGED WATER** BOTTLED WATER..... 91 SACHET WATER ..... 92 OTHER (*specify*) _____ 96	11⇨*WS7* 12⇨*WS7* 13⇨*WS3* 14⇨*WS3* 21⇨*WS3* 31⇨*WS3* 32⇨*WS3* 41⇨*WS3* 42⇨*WS3* 51⇨*WS3* 61⇨*WS4* 71⇨*WS4* 72⇨*WS4* 81⇨*WS3* 96⇨*WS3*

WS2. What is the <u>main</u> source of water used by members of your household for other purposes such as cooking and handwashing? *If unclear, probe to identify the place from which members of this household most often collect water for other purposes.*	**PIPED WATER** PIPED INTO DWELLING ..... 11 PIPED TO YARD / PLOT ..... 12 PIPED TO NEIGHBOUR ..... 13 PUBLIC TAP / STANDPIPE..... 14 TUBE WELL / BOREHOLE ..... 21 **DUG WELL** PROTECTED WELL..... 31 UNPROTECTED WELL ..... 32 **SPRING** PROTECTED SPRING..... 41 UNPROTECTED SPRING ..... 42 RAINWATER..... 51 TANKER-TRUCK..... 61 CART WITH SMALL TANK ..... 71 WATER KIOSK ..... 72 SURFACE WATER (RIVER, DAM, LAKE, POND, STREAM, CANAL, IRRIGATION CHANNEL)..... 81 OTHER (*specify*) _____ 96	11 ⇨*WS7* 12 ⇨*WS7* 61 ⇨*WS4* 71 ⇨*WS4* 72 ⇨*WS4*
WS3. Where is that water source located?	IN OWN DWELLING ..... 1 IN OWN YARD / PLOT..... 2 ELSEWHERE 3	1 ⇨*WS7* 2 ⇨*WS7*
WS4. Who usually goes to this source to collect the water for your household? *Record the name of the person and copy the line number of this person from the LIST OF HOUSEHOLD MEMBERS Module.*	ADULT WOMAN……1 ADULT MAN……..2 FEMALE CHILD……3 MALE CHILD……..4 DO NOT KNOW……99 NAME _____ LINE NUMBER..... __ __	

WS5. What kind of toilet facility do members of your household usually use? *If 'Flush' or 'Pour flush', probe:* Where does it flush to? *If not possible to determine, ask permission to observe the facility.*	**FLUSH / POUR FLUSH** FLUSH TO PIPED SEWER SYSTEM ..... 11 FLUSH TO SEPTIC TANK ..... 12 FLUSH TO PIT LATRINE ..... 13 FLUSH TO OPEN DRAIN ..... 14 FLUSH TO DK WHERE ..... 18 **PIT LATRINE** VENTILATED IMPROVED PIT LATRINE ..... 21 PIT LATRINE WITH SLAB ..... 22 PIT LATRINE WITHOUT SLAB / OPEN PIT ..... 23 COMPOSTING TOILET ..... 31 BUCKET ..... 41 HANGING TOILET / HANGING LATRINE ..... 51 NO FACILITY / BUSH / FIELD ..... 95 OTHER (*specify*) _____ 96	11 ⇨*WS14* 14 ⇨*WS14* 18 ⇨*WS14* 41 ⇨*WS14* 51 ⇨*WS14* 95 ⇨*End* 96 ⇨*WS14*
WS6. Where is this toilet facility located?	IN OWN DWELLING ..... 1 IN OWN YARD / PLOT ..... 2 ELSEWHERE 3	
WS7. Do you share this facility with others who are not members of your household?	YES ..... 1 NO 2	2 ⇨*End*
WS8. Do you share this facility only with members of other households that you know, or is the facility open to the use of the general public?	Yes, with other household(s) in same house……..1 Yes, with other household(s) in different house…..2 Yes, with other household(s) and located in different house……3 No……..4	2 ⇨*End*
WS9. How many households in total use this toilet facility, including your own household?	NUMBER OF HOUSEHOLDS (IF LESS THAN 10) ..... 0 __ TEN OR MORE HOUSEHOLDS ..... 10 DK 98	

WS9. Type of bathing facility for household	OWN BATHROOM.....1 SHARED.....2 MOBILE OBJECT OBSERVED PRIVATE OPEN CUBICLE.....3 SHARED CUBICLE.....4 OTHER HOUSE .....5 OPEN SPACE……6 RIVER……7 POND……..8 OTHER(*specify*) _____ 9	
WS10. Household disposal of solid waste (rubbish)	COLLECTED.....1 BURNT……...2 PUBLIC DUMP……..3 DUPED ELSEWHERE……..4 BURIED……5 OTHER*(specify)*.....6	
FOOD SECURITY [AVAILABILITY AND ACCESS]		
FS1. Household has sufficient quantities of necessary types of food.	STRONGLY AGREE……..1 AGREE……..2 NEITHER AGREE NOR DISAGREE…….3 DISAGREE……4 STRONGLY DISAGREE.....5 DO NOT KNOW……9	
FS2. Household's incomes are adequate to purchase or barter for appropriate foods in sufficient amount.	STRONGLY AGREE……..1 AGREE……..2 NEITHER AGREE NOR DISAGREE…….3 DISAGREE……4 STRONGLY DISAGREE.....5 DO NOT KNOW……9	
FS3. Was there a day in the previous 30 days when you or any member of the household did not have enough food to eat.	NO……0 Between 1-5 days ……..1 Between 6-10 days…….2 More than 10 days…….3	

HOUSEHOLD FINANCIAL INFORMATION		
HC19. Does any member of this household have a bank account?	YES .....1 NO 2	
HC20. How frequently does your household/member put aside money for savings?	EACH WEEK……...1 EACH MONTH……2 2-3 TIMES PER YEAR……3 ONCE PER YEAR……...4 RARELY……..5 NEVER……6	
HC21. Has your household/member **EVER taken a LOAN** from a bank/financial institution?	YES……....1 NO……..2	**(GO TO HC23)**
HC22. When was the **MOST RECENT LOAN** taken?	A WEEK OR LESS AGO……1 A MONTH BUT > A WEEK AGO....……....2 A YEAR BUT > A MONTH AGO…….....3 1-5 YEARS AGO……....4 OVER 5 YEARS AGO……...5	

HC23. Where was the **MOST RECENT LOAN** taken from?	MICROFINANCE…….....1 RURAL BANK…….....2 SAVINGS & LOAN…….....3 COMMERCIAL BANK……..4 INVESTMENT BANK…….....5 OTHER(SPECIFY)……..6	
HC24. How was the **MOST RECENT LOAN** utilized?	ANIMAL RAISING……1 FARMING/AGRICULTURAL TOOLS/PRODUCTION……2 BUSINESS/TRADING…….....3 BUILDING HOUSE…….....4 HH EQUIPMENT/CAR/MOTORBIKE……..5 SOCIALACTIVITIES/MARRIAGE/FUNERAL/ CEREMONIES……6 BASIC NEEDS FOR LIVING-FOOD……7 HELPING RELATIVES…….....8 MEDICAL TREATMENT…….……9 OTHER(SPECIFY)……10	
HC25. Loan Size (**MOST RECENT**) GHANA CEDIS	**GHANA CEDIS**___ ___ **PESEWAS** ___ ___	
HC26. Household participates in LEAP intervention (receives grant).	YES……1 NO……0	
HC27. When was the **LAST(recent)** time your Household received benefits(grant) under the LEAP?	DAYS ___ ___WEEK __ ___ MONTH___ ____ YEAR___ ___	
HC28. How was the grant(cash) paid the **LAST(recent)** time you/household received it?	HOUSEHOLD **NOT** BENEFICIARY……0 FACE-TO-FACE……. 1 MOBILE MONEY……2 BANK ACCOUNT……3 OTHER(SPECIFY)……...4	
HC29. How much did your Household **receive** for the **RECENT** grant?	**GHANA CEDIS**___ ___ **PESEWAS** ___ ___	
HC30. What did your Household use the **LAST (recent)** grant/payment for?	HOUSEHOLD NOT BENEFICIARY …..0 SHELTER……..1 FOOD…….....2 SOAP…….....3 WATER…….....4 CLOTHING……5 SCHOOL FEES……..6 SCHOOL SUPPLIES……7 MEDICAL SUPPORT…….....8 OTHER(SPECIFY)……9	

HC30. How would/you or your Household rate the following ATTRIBUTES of the **LEAP/CASH TRANSFER?**	**ATTRIBUTE** 01 AWARENESS 1 2 3 4 5 02 ACCESSIBILITY 1 2 3 4 5 03 PERCEPTIONS OF PAYMENT MODE 1 2 3 4 5 04 USEFULNESS OF GRANT 1 2 3 4 5 05 SIGNIFICANT CHANGE IN LIVING 1 2 3 4 5 06 SIGNIFICANT CHANGE IN ACCESS TO QUALITY OF HEALTH CARE ESPECIALLY FOR THOSE 60 YEARS AND ABOVE 1 2 3 4 5	**1=VERY BAD** **2=BAD** **3=FAIR** **4=GOOD** **5=VERY GOOD**
HC31. How would/you or your Household rate the following ATTRIBUTES of the **NATIONAL HEALTH INSURANCE SCHEME?**	ATTRIBUTE 01 AWARENESS 1 2 3 4 5 02 ACCESSIBILITY 1 2 3 4 5 03 USEFULNESS OF NHIS 1 2 3 4 5 04 SIGNIFICANT CHANGE IN ACCESS TO HEALTH CARE 1 2 3 4 5 05 SIGNIFICANT CHANGE IN HEALTHCARE UTILIZATION 1 2 3 4 5 06 SIGNIFICANT CHANGE IN ACCESS TO QUALITY OF CARE 1 2 3 4 5 07 HEALTH CARE ESPECIALLY FOR THOSE 60 YEARS AND ABOVE 1 2 3 4 5 08 COST OF PREMIUM 1 2 3 4 5 09 REGISTRATION & WAITING TIME 1 2 3 4 5 10 CODE OF PRACTICE 1 2 3 4 5	**1=VERY BAD** **2=BAD** **3=FAIR** **4=GOOD** **5=VERY GOOD**
SOCIAL PROTECTION PROGRAMMES MESSAGES AND SOURCES		
MS1. Have you/household heard of any SOCIAL PROTECTION PROGRAMMES' messages in the last three months?	00 NO MESSAGE 01 YES, LEAP ONLY 02 YES, NHIS ONLY 03 YES, BOTH NHIS & LEAP 04 YES, OTHER(SPECIFY)	

MS2. which messages can you recall?	**NHIS** THE NEED TO HAVE NHIS CARD……1 PLACE TO PROCESS NHIS CARD……..2 RENEWAL OF NHIS CARD……..3 LOCATION TO RENEW NHIS CARD…… ……..4 LOCATION TO ACCESS CARE WITH CARD…...5 RECRUITMENT OF HH FOR NHIS……6 **LEAP PROGRAMME** LOCATION FOR HH RECRUITMENT PROCESS FOR LEAP……..…… 7 ANNOUNCEMENT ON LEAP GRANT PAYMENT…….....8 TIME FOR LEAP GRANT PAYMENT…….....9 MODE OF PAYMENT FOR LEAP……...10 LEAP PAYMENT PROCESS……11 AMOUNT OF PAYMENT DUE BENEFICIARY HOUSEHOLD……..12 INFORMATION ON BENEFICIARY NOT GIVING OUT HONOURARIUMS TO SOME OFFICIALS/COMMITTEE MEM- BERS……13 OTHER (*specify*)_____ 14 DK 99	
MS3. Where did you hear this/these message(s?) *Probe:* Anything else? **RECORD ALL METHODS MENTIONED**	**NHIS** GOVERNMENT'S HEALTH WORKERS ..... A COMMUNITY HEALTH VOLUNTEERS ..... B CLINIC/HOSPITAL..... C NGO STAFF..... D TRADITIONAL LEADERS .....E POSTER/FLYER/LEAFLETS .....F RADIO ..... G TV..... H COMMUNITY EVENTS.....I CHURCH/MOSQUE..... J OTHER (*specify*) _____ X DK .....Z **LEAP PROGRAMME** GOVERNMENT'S HEALTH WORKERS ..... A COMMUNITY HEALTH VOLUNTEERS ..... B CLINIC/HOSPITAL..... C NGO STAFF..... D TRADITIONAL LEADERS .....E POSTER/FLYER/LEAFLETS .....F RADIO ..... G TV..... H COMMUNITY EVENTS.....I CHURCH/MOSQUE..... J OTHER (*specify*) _____ X DK .....Z OTHER……1 OTHER……2	

MS4. In which channel of communication or mechanisms do you prefer most to get information on SOCIAL PROTECTION INTERVENTIONS SUCH AS LEAP and NHIS or any information that you want to hear or learn? *Probe:* Anything else? **RECORD ALL METHODS MENTIONED**	**NHIS** RADIO ..... A SMS/MOBILE PHONE..... B TV..... C HOUSE VISIT..... D POSTERS/FLYERS/LEAFLETS.....E BILLBOARD .....F DRAMA PRESENTATION..... G PUBLIC ADDRESS SYSTEM ..... H VIDEO SHOWING.....I THROUGH CHURCH/MOSQUE ..... J OTHER (*specify*) _____ X DK .....Z **LEAP PROGRAMME** RADIO ..... A SMS/MOBILE PHONE..... B TV..... C HOUSE VISIT..... D POSTERS/FLYERS/LEAFLETS.....E BILLBOARD .....F DRAMA PRESENTATION..... G PUBLIC ADDRESS SYSTEM ..... H VIDEO SHOWING.....I THROUGH CHURCH/MOSQUE ..... J OTHER (*specify*) _____ X DK .....Z OTHER……1 OTHER……2	

Appendix 4: Focus group discussion guide for older persons (60years & above)
Qualitative Study Tools

Topic: **Social Protection Initiatives and Access to Quality Health Care among Elderly Population in Ghana – Evidence from Mampong Municipality**

Date _____

Community_____

Type of Location_____

Sex of Participants _____

Number of Participants _____

Time: from_____ **to**_____

Facilitator _____

Note taker _____

Focus Group Discussion Questions
Opening questions
1.) What do you know about social protection initiatives (probe for informal, formal, semi-formal, etc)? Why are they important?
2.) Have you heard anything about social protection initiatives within your communities?
3.) Who are those elderly persons benefiting from these social protection
4.) Which ones are the elderly beneficiaries? What kinds of benefits are they entitled to? initiatives(demographic, social, economic,etc).
5.) What criteria are/were used in the selection of beneficiaries?
6.) What challenges are involved in participating in such initiatives?
Promoters and Barriers to quality health care questions
5.) What do you consider to be quality health care?
6.) Why do you think some elderly persons will not seek care?
7.)What is your opinion about the effectiveness of the procedure involve in providing quality health care for the elderly?
8.) Can you tell us about some cultural practices or religious beliefs (if any) related to quality health care for the elderly?
9.) What have your experiences with health care delivery services by providers been? [probe for positive/negative experiences with health workers, wait time, quality of health facility, place of choice of seeking care and why?, what took one to a health facility, mode of payment, ageism, etc]
10.) What influences your decision on whether or not to seek care?
11.) What services did you receive when you went to seek care? [probe for process, structure, etc of the health system, etc].
12.) Were you satisfied with your visit? Is there anything you wished they had done for you or not done?
13.) Did you have any questions or concerns about your own health? Were these addressed during the visit?
14.) What types of ageing-related counselling or information were you provided during your visit? What caregiving information were you provided about ageing, and diseases and

proper health seeking behaviour?

15.) Is there any other place besides a health facility you would go if you wanted to talk to a health practitioner?

16. What do you perceive to be the relationship between health personnel and the elderly in this community?

16.) Is there anything that can be done to promote and improve the delivery of health service to the elderly[probe for community action, health sector action and the current health reform (capitation model)].

The Link between social protection initiatives and access to quality health care

17.) What challenges do you face in participating in social protection programmes?

18.) What is the link between participating in social protection initiatives and the access to quality health care? [probe for NHIS, LEAP stressing more on the elderly's experiences in relation to community knowledge, opinions, perceptions and challenges].

19. What do you perceive to be the actual knowledge, perception, practice, etc in our health facilities from the community's perspective.

Other ageing-related issues

20.) Awareness of existing policies (National Ageing and the Social Protection Policy Documents) [probe for content knowledge of documents]

21.) The focus of ageing discussions within community/country [probe for ageism, barriers, promoters, way forward, participation in community activities, current role of the elderly, pension issues, income generating activities, community participation, etc]
etc].

Closing

Is there anything that you feel was not covered in this interview that you'd like to address?
Do you have any questions for me?
Thank study participants again for their participation in the interview and discuss how their answers are important and will be useful in understanding the link between ageing, social protection initiatives and access to quality health care.

Appendix 5: In-Depth Interview (IDI) guide for Health Personnel

Topic: **Social Protection Initiatives and Access to Quality Health Care among Elderly Population in Ghana – Evidence from Mampong Municipality**

Date_____ **Facility type** _____

Facility Ownership_____ **Community**_____

Type of Location_____ **Sex of Participant** _____

Occupation_____ **Position of Participant** _____

Time: from_____ **to**_____

Facilitator _____

In-depth Interview Questions

Opening question

1. What services do you offer?
2. Who are your usual clients?
3. What are the existing frameworks for health service delivery in this facility? (probe for adopted/adapted/ or developed one different from the GHS)
4. What services do you provide for the elderly? (probe for process, structure, etc of the health system, etc)
5. What categories of elderly persons do you attend to?
6. What are the existing frameworks/practical guidelines for caring for the elderly? (probe for aged corner)
7. How is it supposed to be done?
8. Is your facility's own different from other levels of seeking care?
9. Are there any specific days or times dedicated to attend to the elderly seeking care/home care? (probe for home visits)
10. What training has personnel in this facility received in caring for the elderly?
11. How many personnel are here?
12. How many have received such training?
13. When was the last time such a training was received or organized for any of the personnel?

Social Protection and Health Seeking Behaviour

14. What do you know about social protection initiatives? Why are they important?
15. What are the various social protection initiatives within your area of operations/catchment area?
16. Which ones do the elderly benefit from? What kinds of benefits are they entitled to?
17. Which benefits are directly obtained from your outfit as services among the elderly?
18. Who are those elderly persons benefiting from these social protection initiatives (demographic, social, economic, etc).
19. What challenges are involved in participating in such initiatives?
20. What criteria are/were used in the selection of beneficiaries?

Promoters and Barriers to quality health care questions

21. What do you consider to be quality health care especially for the elderly?
22. Why do you think some elderly persons will not seek care?

23. What is your opinion about the effectiveness of the procedure involved in providing quality health care for the elderly?
24. Can you tell us about some cultural practices or religious beliefs (if any) related to quality health care for the elderly?
25. What have been your experiences in providing health care for the elderly? [probe for positive and negative experiences, ageism, etc].
26. What influences your decision to attend to an elder person or not?
27. What are the challenges you face in providing health care for this elderly population?
28. What do have to say about the satisfaction you derived from providing care for an elderly person? Is there anything you wished could be done for you or not done?
29. Do you usually have any questions or concerns about the health and health care of this age group? How have these been addressed by your facility?
30. If you are to choose between delivering health service to an elderly person and a younger one, whom would you choose and why?
31. What types of ageing-related counselling or information do you provided during their visit? What caregiving information do you provide about ageing, and diseases and health seeking behaviour?

31.Is there any other place aside your facility the elderly would go if you wanted to talk to a health practitioner?

32. Is there anything that can be done to promote and improve the delivery of health service to the elderly[probe for community action, health sector action and the current health reform (capitation model)].

The Link between social protection initiatives and access to quality health care

33. What are the experiences with using social protection programmes to access health care in this community? (probe NHIS, LEAP stressing more on the elderly's experiences in relation to community knowledge, opinions, perceptions and challenges).
34. How does the social protection status of an elderly affect the services he/she receives? (Probe for access, utilization, quality, acceptability, availability, the capitation model, etc)
35. What do you perceive to be the knowledge, perception, practice, etc in our health facilities from the community's perspective in the provision of quality health care for the elderly?

Other ageing-related issues

36. Awareness of existing policies (National Ageing and the Social Protection Policy Documents) [probe for content knowledge of documents].

Closing

Is there anything that you feel was not covered in this interview that you'd like to address?

Do you have any questions for me?

Thank study participant again for his/her participation in the interview and discuss how his/her answers are important and will be useful in understanding the link between ageing, social protection initiatives and access to quality health care.

Appendix 6: In-Depth Interview (IDI) guide for the NHIS Representative

Topic: **Social Protection Initiatives and Access to Quality Health Care among Elderly Population in Ghana – Evidence from Mampong Municipality**

Date_____

Community_____

Type of Location_____ **Sex of Participant** _____

Occupation_____ **Position of Participant** _____

Time: from_____ **to**_____

Facilitator _____

In-depth Interview Questions

Opening question

1. What services do you offer?
2. Who are your usual clients?
3. What are the existing frameworks to become a beneficiary?
4. What services do you provide for the elderly?
5. What is your opinion about the effectiveness of the procedure involved in providing services for the elderly?
6. What categories of elderly persons do you attend to?
7. What are the existing frameworks/practical guidelines related to your service provision for the elderly? (probe for the disabled, condition, etc)
8. How different is your institution's own from other types of health insurance schemes?
9. What trainings have personnel in your institution received in dealing with the elderly?
10. When was the last time such a training was received or organized for any of the personnel?

Social Protection and Health Seeking Behaviour

11. What do you know about social protection initiatives? Why are they important?
12. What are the various social protection initiatives available to your client within your area of operations/catchment area?
13. Which one(s) do you provide for?
14. Which ones do the elderly benefit from? What kinds of benefits are they entitled to?
15. Which benefits are directly obtained from your outfit as services for the elderly?
16. Who are those elderly persons benefiting from these social protection initiatives (demographic, social, economic, etc).
17. What linkage exists between the services you provide for the elderly and health seeking behaviour?

Promoters and Barriers to quality health care questions

18. What do you consider to be quality health care especially for the elderly?
19. Why do you think some elderly persons will not seek care?
20. How is the service you provide
21. Can you tell us about the cultural practices or religious beliefs (if any) related to quality health care for the elderly?
22. What has been your experiences in providing services to the elderly? [probe for positive and negative experiences, ageism, etc].

23. What influences your decision to attend to an elderly person or not?
24. What are the challenges you face in providing services for this elderly population?
25. What do you have to say about the satisfaction you derived from providing a service for an elderly person? Is there anything you wished could be done for you or not done?
26. Do you usually have any questions or concerns about the health and health care of this age group? How have these been addressed by your organization?
27. If you are to choose between delivering a service to an elderly person and a younger one, whom would you choose and why?
28. What types of ageing-related counselling or information do you provide for the elderly? What caregiving information do you provide about ageing, and diseases and health-seeking behaviour?
29. Is there any other place aside your institution the elderly would go if you wanted to have access to a social protection programme?
30. Is there anything that can be done to promote and improve elderly participation in your service provision[probe for community action, health sector action and the current health reform (capitation model)].

The Link between social protection initiatives and access to quality health care

31. What is the link between participating in social protection initiatives and access to quality health care? [probe for NHIS, LEAP stressing more on the elderly's experiences in relation to community knowledge, opinions, perceptions and challenges].
32. How has the social protection you provide affected the health services the elderly person receives? (Probe for access, utilization, quality, acceptability, availability, the capitation model, etc)
33. What do you perceive to be the knowledge, perception, practice, etc of your services from the community's perspective in the provision of quality health care for the elderly?

Other ageing-related issues

34. Awareness of existing policies (National Ageing and the Social Protection Policy Documents) [probe for content knowledge of documents].

Closing

Is there anything that you feel was not covered in this interview that you'd like to address? Do you have any questions for me?

Thank study participant again for his/her participation in the interview and discuss how his/her answers are important and will be useful in understanding the link between ageing, social protection initiatives and access to quality health care.

Appendix 7: In-Depth Interview guide for MoGCSP/DSW Representative

Topic: **Social Protection Initiatives and Access to Quality Health Care among Elderly Population in Ghana – Evidence from Mampong Municipality**

Date_____

Community_____

Type of Location_____ **Sex of Participant** _____

Occupation_____ **Position of Participant** _____

Time: from_____ **to**_____

Facilitator _____

In-depth Interview Questions

Opening question

1. What services do you offer?
2. Who are your usual clients?
3. What are the existing frameworks to become a beneficiary?
4. What services do you provide for the elderly?
5. What is your opinion about the effectiveness of the procedure involved in providing services for the elderly?
6. What categories of elderly persons do you attend to?
7. What are the existing frameworks/practical guidelines related to your service provision for the elderly? (probe for the disabled, condition, etc)
8. How different is your institution's own from other types of social welfare/protection initiatives?
9. What trainings have personnel in your institution received in dealing with the elderly?
10. When was the last time such training was received or organized for any of the personnel?

Social Protection and Health Seeking Behaviour

11. What do you know about social protection initiatives? Why are they important?
12. What are the various social protection initiatives available to your client within your area of operations/catchment area?
13. Which one(s) do you provide?
14. Which ones do the elderly benefit from? What kinds of benefits are they entitled to?
15. Which benefits are directly obtained from your outfit as services for the elderly?
16. Who are those elderly persons benefiting from these social protection initiatives (demographic, social, economic, etc).
17. What linkage exists between the services you provide for the elderly and health-seeking behaviour?
18. What are the challenges involved in the provision of the services to the elderly?

Promoters and Barriers to quality health care questions

19. What do you consider to be quality health care especially for the elderly?
20. Why do you think some elderly persons will not seek care?
21. Can you tell us about the cultural practices or religious beliefs (if any) related to quality health care for the elderly?
22. What have been your experiences in providing services to the elderly? (probe for

positive and negative experiences, ageism, etc).

23. What influences your decision to attend to an elder person or not?
24. What are the challenges the elderly face in accessing your services?
25. What do you have to say about the satisfaction you derived from providing a service for an elderly person? Is there anything you wished could be done for you or not done?
26. Do you usually have any questions or concerns about the health and health care of this age group? How have these been addressed by your organization?
27. If you are to choose between delivering a service to an elderly person and a younger one, whom would you choose and why?
28. What types of ageing-related counselling or information do you provide for the elderly? What caregiving information do you provide about ageing, and diseases and Health-seeking behaviour?
29. Is there any other place aside your institution the elderly would go if you wanted to have access to a social protection programme?
30. Is there anything that can be done to promote and improve elderly participation in your service provision[probe for community action, health sector action and the current health reform (capitation model)].

The Link between social protection initiatives and access to quality health care

31. What is the link between participating in social protection initiatives and access to quality health care? [probe for NHIS, LEAP stressing more on the elderly's experiences with community knowledge, opinions, perceptions and challenges].
32. How has the social protection you provide affected the health services elderly persons receives? (Probe for access, utilization, quality, acceptability, availability, the capitation model, etc)
33. What do you perceive to be the knowledge, perception, practice, etc of your services from the community's perspective in providing for the elderly?

Other ageing-related issues

34. Awareness of existing policies (National Ageing and the Social Protection Policy Documents) [probe for content knowledge of documents].

Closing

Is there anything that you feel was not covered in this interview that you'd like to address?

Do you have any questions for me?

Thank study participant again for his/her participation in the interview and discuss how his/her answers are important and will be useful in understanding the link between ageing, social protection initiatives and access to quality health care.

Appendix 8: Consent form for Individual Older Persons for Household Survey

PARTICIPANTS' INFORMATION SHEET AND INFORMED CONSENT FORM FOR OLDER PERSONS FOR HOUSEHOLD SURVEY

INFORMATION SHEET

Title of Study:	"Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana – Evidence from Mampong Municipality"
Principal Investigator:	Doris Ottie-Boakye

Participation Duration: 60-70 minutes

Introduction

My name is Doris Ottie-Boakye and I am a PhD Candidate at the Regional Institute for Population Studies, University of Ghana-Legon. I am conducting this research for academic purposes to investigate the link between social protection initiatives and access to quality health care among elderly persons in Ghana. You are invited to participate in the study on how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard(from their viewpoint) of the elderly. The discussion will take about one hour and your name will not be identified in any report. The decision to participate is completely voluntary.

General Information about Research

The study is to understand how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard(from their viewpoint) of the elderly among older persons in Ghana. The study will especially allow us to understand the various forms of social intervention programmes among older persons as well as their characteristics. Also, household, community and institutional level factors associated with such social programmes and the health care that meets older persons' standards from their angles will be investigated. This will assist us in understanding the extent to which these initiatives influence the quality health care among elderly persons and make the appropriate recommendations. Participating in this study is completely voluntary.

Benefits and Risks of Study

There will be no direct benefits to you as a study participant. Nevertheless, the information gathered from this study will be used to assist researchers and policymakers in improving the participation of elderly persons in social protection interventions as well as receiving quality health care. Study results will be made available at the Regional Institute for Population Studies, University of Ghana, Legon and in peer-review journals from January 2018 for others to learn the best practices from it.

There are no direct or indirect risks associated with this study. You may However, elderly persons might benefit indirectly from policies that could be adopted as a result of this study. There are no physical, social or psychological risks anticipated for this study.

Confidentiality

Participation in this study is completely anonymous. All responses will be treated with the confidentiality it deserves and would be used for only academic purposes for this study. Your name or any identifiable information will not be included in the research publication and final analysis.

Questionnaires from this study would be stored in a safe place after processing, and would not be made accessible to unauthorized persons.

Payment/Compensation

There are no financial compensation packages attached to your participation in this study either in kind or in cash.

Withdrawal from Study
Participation in this study is voluntary and you can opt-out of the study at any point in time you feel and will not suffer any penalties. You will not be adversely affected nor any health or social services that you are entitled to you declines to participate or later stops participating.

Your rights as a Research Participant
Participation in this study is completely voluntary. You have the right to choose not to participate at all or to leave in the course of the interview at any time. If you decide not to participate or leave the study after answering a few questions, there will be no penalty, risk or negative consequences. If you decide to participate in the study and then choose to leave, the answers obtained from you will not be included in the data analysis or final report of the study.

Questions or Concerns
If you have any questions regarding the study or this consent form, please contact the Principal Student Investigator, Ms Doris Ottie-Boakye on +233 244 841 873.

Contact for Additional Information
In case you have further questions or concerns about this study, you can contact Dr Ayagah Bawah on Tel: +233 244 714 164 at the Regional Institute for Population Studies, University of Ghana-Legon. You may also contact the Administrator, Ethics Committee for Humanities, ISSER, University of Ghana-Legon on Tel: +233 303 933 866 or the Email address: ech@isser.edu.gh/ech@ug.edu.gh or Madam Hannah Frimpong,
GHS-ERC Administrator on 233 (0) 243235225 or 0507041223 or the Email address: Hannah.Frimpong@ghsmail.org.

INFORMED CONSENT
Consent of Participation
I have had the opportunity to read this consent form or have had it read to me. I understand all of the information in this consent form. I had the opportunity to ask questions and I have gotten answers for all of my questions. I voluntarily agree to take part in this study and understand that I have the right to withdraw at any time.

_____ _____

Name of Participant Date

_____ _____

Signature of Participant Name of Witness

For person who cannot sign:

Thumbprint: Date

Statement of Principal Investigator/Research Assistant/Interviewer obtaining Informed Consent
I have fully explained the purpose and procedures of this study, as well as the possible risks and benefits. I have explained that participation is completely voluntary and that the participant may leave this study at any time. I have asked if the participant has any questions and have answered them fully and accurately to the best of my ability.

_____ _____

Name of Person Obtaining Informed Consent Date:

Appendix 9: Consent form for Older Persons for Household Questionnaire

PARTICIPANTS' INFORMATION SHEET AND INFORMED CONSENT FORM FOR OLDER PERSONS FOR HOUSEHOLD SURVEY (HOUSEHOLD QUESTIONNAIRE)

INFORMATION SHEET

Title of Study:	"Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana – Evidence from Mampong Municipality"
Principal Investigator:	Doris Ottie-Boakye

Participation Duration: 50-60 minutes

Introduction

My name is Doris Ottie-Boakye and I am a PhD Candidate at the Regional Institute for Population Studies, University of Ghana-Legon. I am conducting this research for academic purposes to investigate the link between social protection initiatives and access to quality health care among older persons in Ghana. I will like to talk to you and your household about your experience with or without being a beneficiary of any social protection initiatives and or had sought care. The decision to participate is completely voluntary. If you wish to participate in this study, please sign and date this consent form at the bottom.

General Information about Research

The study is to understand the link between social protection initiatives and access to quality health care among older persons in Ghana. The study will especially allow us to understand the various forms of social protection initiatives among older persons as well as their characteristics. Also, household, community and institutional level factors associated with social protection and quality health care for the elderly will also be investigated. Participating in this study is completely voluntary.

Study participants will be interviewed using standard questioning and answer procedure. In this study, no experimental or intrusive methods will be adopted.

Benefits and Risks of Study

There will be no direct benefits to you/your household as a study participant. Nevertheless, the information gathered from this study will be used to assist researchers and policymakers in improving the participation of elderly persons in social protection interventions as well as receiving quality health care. Study results will be made available at the Regional Institute for Population Studies, University of Ghana, Legon and in peer-review journals from January 2018 for others to learn the best practices from it.

There are no direct or indirect risks associated with this study. You may However, elderly persons might benefit indirectly from policies that could be adopted as a result of this study. There are no physical, social or psychological risks anticipated for this study.

Confidentiality

Participation in this study is completely anonymous. All responses will be treated with the confidentiality it deserves and would be used for only academic purposes for this study. Your name or any identifiable information will not be included in the research publication and final analysis.

Questionnaires from this study would be stored in a safe place after processing, and would not be made accessible to unauthorized persons.

Payment/Compensation

There are no financial compensation packages attached to your participation in this study either in kind or in cash.

Withdrawal from Study
Participation in this study is voluntary and you can opt-out of the study at any point in time you feel and will not suffer any penalties. You will not be adversely affected nor any health or social services that you are entitled to decline to participate or later stop participating.

Your rights as a Research Participant
Participation in this study is completely voluntary. You have the right to choose not to participate at all or to leave in the course of the interview at any time. If you decide not to participate or leave the study after answering a few questions, there will be no penalty, risk or negative consequences. If you decide to participate in the study and then choose to leave, the answers obtained from you will not be included in the data analysis or final report of the study.

Questions or Concerns
If you have any questions regarding the study or this consent form, please contact the Principal Student Investigator, Ms Doris Ottie-Boakye on +233 244 841 873.

Contact for Additional Information
In case you have further questions or concerns about this study, you can contact Dr Ayagah Bawah on Tel: +233 244 714 164 at the Regional Institute for Population Studies, University of Ghana-Legon. You may also contact the Administrator, Ethics Committee for Humanities, ISSER, University of Ghana-Legon on Tel: +233 303 933 866 or the Email address: ech@isser.edu.gh/ech@ug.edu.gh or Madam Hannah Frimpong, GHS-ERC Administrator on 233 (0) 243235225 or 0507041223 or the Email address: Hannah.Frimpong@ghsmail.org.

INFORMED CONSENT

Consent of Participation
I have had the opportunity to read this consent form or have had it read to me. I understand all of the information in this consent form. I had the opportunity to ask questions and I have gotten answers for all of my questions. I voluntarily agree to take part in this study and understand that I have the right to withdraw at any time.

_____ _____
Name of Participant Date

_____
Signature of Participant

_____
Name of Witness

For person who cannot sign:

_____
Signature of Witness

Thumbprint:

_____
Date

Statement of Principal Investigator/Research Assistant/Interviewer obtaining Informed Consent
I have fully explained the purpose and procedures of this study, as well as the possible risks and benefits. I have explained that participation is completely voluntary and that the participant may leave this study at any time. I have asked if the participant has any questions and have answered them fully and accurately to the best of my ability.

_____ _____
Name of Person Obtaining Informed Consent Date:

Appendix 10: Consent form for Older Persons for Focus Group Discussion

PARTICIPANTS' INFORMATION SHEET AND INFORMED CONSENT FORM FOR OLDER PERSONS FOR FOCUS GROUP DISCUSSION

INFORMATION SHEET

Title of Study:	"Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana – Evidence from Mampong Municipality"
Principal Investigator:	Doris Ottie-Boakye

Participation Duration: 55-60 minutes

Introduction

I will like to thank you for agreeing to participate in this study. My name is Doris Ottie-Boakye and I am a PhD Candidate at the Regional Institute for Population Studies, University of Ghana-Legon. I am conducting this research for academic purposes to investigate on how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard(from their viewpoint) of the elderly. I will like to talk to you about your experience with or without being a beneficiary of any social protection initiatives and or had sought care. The discussion will take about one hour and your name will not be identified in any report. The decision to participate is completely voluntary.

General Information about Research

The study is to understand how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard(from their viewpoint) of the elderly among older persons in Ghana. The study will especially allow us to understand the various forms of social intervention programmes among older persons as well as their characteristics. Also household, community and institutional level factors associated with such social programmes and the health care that meets older persons' standards from their angles will be investigated. This will assist us in understanding the extent to which these initiatives influence the quality health care among elderly persons and make the appropriate recommendations. Participating in this study is completely voluntary.

Benefits and Risks of Study

There will be no direct benefits to you as a study participant. Nevertheless, the information gathered from this study will be used to assist researchers and policymakers in improving the participation of elderly persons in social protection interventions as well as receiving quality health care. Study results will be made available at the Regional Institute for Population Studies, University of Ghana, Legon and in peer-review journals from January 2018 for others to learn the best practices from it.

There are no direct or indirect risks associated with this study. However, elderly persons might benefit indirectly from policies that could be adopted as a result of this study. There are no physical, social or psychological risks anticipated for this study.

Confidentiality

Participation in this study is completely anonymous. All responses will be treated with the confidentiality it deserves and would be used for only academic purposes for this study. Your name or any identifiable information will not be included in the research publication and final analysis.

These group discussions will be recorded using field notes and a recording device, transcribed, and then permanently deleted after publications.

Information gathered during these group discussions will be stored in a safe place after transcription and would not be made accessible to unauthorized persons. We also urge other members of this group to respect each other's confidentiality.

Payment/Compensation

There are no financial compensation packages attached to your participation in this study either in kind or in cash.

Withdrawal from Study

Participation in this study is voluntary and you can opt-out of the focus group discussion at any point in time you feel and will not suffer any penalties. You will not be adversely affected nor any health or social services that you are entitled to you declines to participate or later stops participating.

Your rights as a Research Participant

Participation in this study is completely voluntary. You have the right to choose not to participate at all or to leave in the course of the focus group discussion at any time. If you decide not to participate or leave the group discussion after answering a few questions, there will be no penalty, risk or negative consequences and your benefits will remain the same.

Questions or Concerns

If you have any questions regarding the study or this consent form, please contact the Principal Student Investigator, Ms. Doris Ottie-Boakye on +233 244 841 873.

Contact for Additional Information

In case you have further questions or concerns about this study, you can contact Dr. Ayagah Bawah on Tel: +233 244 714 164 at the Regional Institute for Population Studies, University of Ghana-Legon. You may also contact the Administrator, Ethics Committee for Humanities, ISSER, University of Ghana-Legon on Tel: +233 303 933 866 or the Email address: ech@isser.edu.gh/ech@ug.edu.gh or Madam Hannah Frimpong, GHS-ERC Administrator on 233 (0) 243235225 or 0507041223 or the Email address: Hannah.Frimpong@ghsmail.org.

INFORMED CONSENT

Consent of Participation

I have had the opportunity to read this consent form or have had it read to me. I understand all of the information in this consent form. I had the opportunity to ask questions and I have gotten answers for all of my questions. I voluntarily agree to take part in this study and understand that I have the right to withdraw at any time. I will also respect the confidentiality of each member of the group.
I understand that I will be audio-recorded and transcribed as a part of this study.

Please indicate whether you agree to be audio recorded as a part of this study.

☐ **Yes**

☐ **No**

_____ _____

Name of Participant Date

_____

Signature of Participant

For person who cannot sign:

Thumbprint:

_____

Name of Witness

_____

Signature of Witness

_____

Date

Consent for Audio Recording

I agree to the audio recording of the interview to facilitate data collection. I do understand that due to the likelihood of risks to confidentiality of audio data (albeit minimal), transcripts from audio files would be anonymized for both me and/or my institution. In the event that I do mention my institution's name or mine, they will be deleted during transcription.No tape will be linked to this consent document and anonymized paper transcripts or reports of the recordings would be used.

_____ _____

Signature Date

Statement of Principal Investigator/Research Assistant/Interviewer obtaining Informed Consent
I have fully explained the purpose and procedures of this study, as well as the possible risks and benefits. I have explained that participation is completely voluntary and that the participant may leave this study at any time. I have asked if the participant has any questions and have answered them fully and accurately to the best of my ability.

_____ _____

Name of Person Obtaining Informed Consent Date:

Appendix 11: Consent form for Health Personnel for In-Depth Interview

PARTICIPANTS' INFORMATION SHEET AND INFORMED CONSENT FORM FOR HEALTH PERSONNEL

INFORMATION SHEET

Title of Study:	"Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana – Evidence from Mampong Municipality"
Principal Investigator:	Doris Ottie-Boakye

Participation Duration: 60 minutes

Introduction

My name is Doris Ottie-Boakye and I am a PhD Candidate at the Regional Institute for Population Studies, University of Ghana-Legon. I am conducting this research for academic purposes to investigate the link between social protection initiatives and access to quality health care among elderly persons in Ghana. I will like to talk to you about your institution's roles and experience in delivering services especially to the elderly; and how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard of the elderly. The discussion will take about one hour and will be recorded on a machine and later transcribed and analyzed. However, your name will not be identified in any report. The decision to participate is completely voluntary. If you wish to participate in this study, please sign and date this consent form at the bottom.

General Information about Research

The study is to understand how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard of the elderly among older persons in Ghana. The study will especially allow us to understand the various forms of social intervention programmes among older persons as well as their characteristics. Also household, community and institutional level factors associated with such social programmes and the health care that meets older persons' standards from their angles will also be investigated. This will assist us in understanding the extent to which these initiatives influence the quality health care among elderly persons and make the appropriate recommendations. Participating in this study is completely voluntary.

Benefits and Risks of Study

There will be no direct benefits to you as a study participant. Nevertheless, the information gathered from this study will be used to assist researchers and policymakers in improving the participation of elderly persons in social protection interventions as well as receiving quality health care. Study results will be made available at the Regional Institute for Population Studies, University of Ghana, Legon and in peer review journals from January 2018 for others to learn the best practices from it.

There are no direct or indirect ricks associated with this study. You may, however, might benefit indirectly from policies that could be adopted as a result of this study. There are no physical, social or psychological risks anticipated for this study.

Confidentiality

Participation in this study is completely anonymous. All responses will be treated with the confidentiality it deserves, and would be used for only academic purposes for this study. Your name or any identifiable information will not be included in the research publication and final analysis.

This interview will be recorded using field notes and a recording device, transcribed, and then permanently deleted after publications.

Information gathered during this interview will be stored in a safe place after transcription and would not be made accessible to unauthorized persons.

Payment/Compensation

There are no financial compensation packages attached to your participation in this study.

Withdrawal from Study

Participation in this study is voluntary and you can opt-out of the study at any point in time you feel and will not suffer any penalties. You will not be adversely affected nor any support that your outfit is entitled to if you decline to participate or later stop participating.

Your rights as a Research Participant

Participation in this study is completely voluntary. You have the right to choose not to participate at all or to leave in the course of the interview at any time. If you decide not to participate or leave the study after answering a few questions, there will be no penalty, risk or negative consequences. If you decide to participate in the study and then choose to leave, the answers obtained from you will not be included in the data analysis or final report of the study.

Questions or Concerns

If you have any questions regarding the study or this consent form, please contact the Principal Student Investigator, Ms. Doris Ottie-Boakye on +233 244 841 873.

Contact for Additional Information

In case you have further questions or concerns about this study, you can contact Dr. Ayagah Bawah on Tel: +233 244 714 164 at the Regional Institute for Population Studies, University of Ghana-Legon.

You may also contact the Administrator, Ethics Committee for Humanities, ISSER, University of Ghana-Legon on Tel: +233 303 933 866 or the Email address: ech@isser.edu.gh/ech@ug.edu.gh or Madam Hannah Frimpong, GHS-ERC Administrator on 233 (0) 243235225 or 0507041223 or the Email address: Hannah.Frimpong@ghsmail.org.

INFORMED CONSENT

Consent of Participation

I have had the opportunity to read this consent form or have had it read to me. I understand all of the information in this consent form. I had the opportunity to ask questions and I have gotten answers for all of my questions. I voluntarily agree to take part in this study and understand that I have the right to withdraw at any time.

I understand that I will be audio recorded and transcribed as a part of this study.

Please indicate whether you agree to be audio recorded as a part of this study.

☐ **Yes**

☐ **No**

_____ _____

Name of Participant Date

_____ _____

Signature of Participant Name of Witness

For person who cannot sign:
Thumbprint:

_____

Signature of Witness

_____

Date

Consent for Audio Recording

I agree to the audio recording of the interview to facilitate data collection. I do understand that due to the likelihood of risks to confidentiality of audio data (albeit minimal), transcripts from audio files would be anonymized for both me and/or my institution. In the event that I do mention my institution's name or mine, they will be deleted during transcription.No tape will be linked to this consent document and anonymized paper transcripts or reports of the recordings would be used.

_____ _____

Signature Date

Statement of Principal Investigator/Research Assistant/Interviewer obtaining Informed Consent

I have fully explained the purpose and procedures of this study, as well as the possible risks and benefits. I have explained that participation is completely voluntary and that the participant may leave this study at any time. I have asked if the participant has any questions and have answered them fully and accurately to the best of my ability.

_____ _____

Name of Person Obtaining Informed Consent Date:

Appendix 12: Consent form for NHIS Representative for In-Depth Interview

PARTICIPANTS' INFORMATION SHEET AND INFORMED CONSENT FORM -REPRESENTATIVE, NATIONAL HEALTH INSURANCE SCHEME

INFORMATION SHEET

Title of Study:	"Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana – Evidence from Mampong Municipality"
Principal Investigator:	Doris Ottie-Boakye

Participation Duration: 50-55 minutes

Introduction

My name is Doris Ottie-Boakye and I am a PhD Candidate at the Regional Institute for Population Studies, University of Ghana-Legon. I am conducting this research for academic purposes to investigate the link between social protection initiatives and access to quality health care among elderly persons in Ghana. I will like to talk to you about your institution's roles and experience in delivering services especially to the elderly; and how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard of the elderly. The discussion will take about one hour and will be recorded on a machine and later transcribed and analyzed. However, your name will not be identified in any report. The decision to participate is completely voluntary. If you wish to participate in this study, please sign and date this consent form at the bottom.

General Information about Research

The study is to understand how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard of the elderly among older persons in Ghana. The study will especially allow us to understand the various forms of social intervention programmes among older persons as well as their characteristics. Also household, community and institutional level factors associated with such social programmes and the health care that meets older persons' standards from their angles will also be investigated. This will assist us in understanding the extent to which these initiatives influence the quality health care among elderly persons and make the appropriate recommendations. Participating in this study is completely voluntary.

Benefits and Risks of Study

There will be no direct benefits to you as a study participant. Nevertheless, the information gathered from this study will be used to assist researchers and policymakers in improving the participation of elderly persons in social protection interventions as well as delivering and receiving quality health care. Study results will be made available at the Regional Institute for Population Studies, University of Ghana, Legon and in peer-review journals from January 2018 for others to learn the best practices from it.

There are no direct or indirect risks associated with this study. You may, however, might benefit indirectly from policies that could be adopted as a result of this study. There are no physical, social or psychological risks anticipated for this study.

Confidentiality

Participation in this study is completely anonymous. All responses will be treated with the confidentiality it deserves and would be used for only academic purposes for this study. You name or any identifiable information will not be included in the research publication and final analysis.

This interview will be recorded using field notes and a recording device, transcribed, and then permanently deleted after publications.

Information gathered during this interview will be stored in a safe place after transcription and would not be made accessible to unauthorized persons.

Payment/Compensation
There are no financial compensation packages attached to your participation in this study either in kind or in cash.

Withdrawal from Study
Participation in this study is voluntary and you can opt-out of the study at any point in time you feel and will not suffer any penalties. You will not be adversely affected neither will the support your outfit is entitled to will be redrawn if you decline to participate or later stop participating.

Your rights as a Research Participant
Participation in this study is completely voluntary. You have the right to choose not to participate at all or to leave in the course of the interview at any time. If you decide not to participate or leave the study after answering a few questions, there will be no penalty, risk or negative consequences. If you decide to participate in the study and then choose to leave, the answers obtained from you will not be included in the data analysis or final report of the study.

Questions or Concerns
If you have any questions regarding the study or this consent form, please contact the Principal Student Investigator, Ms. Doris Ottie-Boakye on +233 244 841 873.

Contact for Additional Information
In case you have further questions or concerns about this study, you can contact Dr. Ayagah Bawah on Tel: +233 244 714 164 at the Regional Institute for Population Studies, University of Ghana-Legon.

You may also contact the Administrator, Ethics Committee for Humanities, ISSER, University of Ghana-Legon on Tel: +233 303 933 866 or the Email address: ech@isser.edu.gh/ech@ug.edu.gh or Madam Hannah Frimpong, GHS-ERC Administrator on 233 (0) 243235225 or 0507041223 or the Email address: Hannah.Frimpong@ghsmail.org.

INFORMED CONSENT

Consent of Participation
I have had the opportunity to read this consent form or have had it read to me. I understand all of the information in this consent form. I had the opportunity to ask questions and I have gotten answers for all of my questions. I voluntarily agree to take part in this study and understand that I have the right to withdraw at any time.
I understand that I will be audio recorded and transcribed as a part of this study.
Please indicate whether you agree to be audio recorded as a part of this study.
☐ **Yes**
☐ **No**

_____ _____
Name of Participant Date

_____ _____
Signature of Participant Name of Witness

For person who cannot sign:
Thumbprint:

_____
Signature of Witness

_____
Date

Consent for Audio Recording
I agree to the audio recording of the interview to facilitate data collection. I do understand that due to the likelihood of risks to confidentiality of audio data (albeit minimal), transcripts from audio files would be anonymized for both me and/or my institution. In the event that I do mention my instituttion's name or mine, they will be deleted during transcription.No tape will be linked to this consent document and anonymized paper transcripts or reports of the recordings would be used.

_____ _____
Signature Date

Statement of Principal Investigator/Research Assistant/Interviewer obtaining Informed Consent
I have fully explained the purpose and procedures of this study, as well as the possible risks and benefits. I have explained that participation is completely voluntary and that the participant may leave this study at any time. I have asked if the participant has any questions and have answered them fully and accurately to the best of my ability.

_____ _____

Name of Person Obtaining Informed Consent Date:

Appendix 13: Consent form for MoGCSP/DSW Representative for In-Depth Interview

INFORMATION SHEET AND INFORMED CONSENT FORM FOR REPRESENTATIVE, DEPARTMENT OF SOCIAL WELFARE

INFORMATION SHEET

Title of Study:	"Social Protection Initiatives and Access to Quality Healthcare among Older Persons in Ghana – Evidence from Mampong"
Principal Investigator:	Doris Ottie-Boakye

Participation Duration: 60 minutes

Introduction

My name is Doris Ottie-Boakye and I am a PhD Candidate at the Regional Institute for Population Studies, University of Ghana-Legon. I am conducting this research for academic purposes to investigate the link between social protection initiatives and access to quality health care among elderly persons in Ghana. I will like to talk to you about your institution's roles and experience in delivering services especially to the elderly; and how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard of the elderly. The discussion will take about one hour and will be recorded on a machine and later transcribed and analyzed. However, your name will not be identified in any report. The decision to participate is completely voluntary. If you wish to participate in this study, please sign and date this consent form at the bottom.

General Information about Research

The study is to understand how social intervention programmes such as the Livelihood Empowerment Against Poverty (LEAP) and the National Health Insurance Scheme promote access to care at health facilities that meet the standard of the elderly among older persons in Ghana. The study will specially allow us to understand the various forms of social intervention programmes among older persons as well as their characteristics. Also household, community and institutional level factors associated with such social programmes and the health care that meets older persons' standards from their angles will also be investigated. This will assist us in understanding the extent to which these initiatives influence the quality health care among elderly persons and make the appropriate recommendations. Participating in this study is completely voluntary.

Benefits and Risks of Study

There will be no direct benefits to you as a study participant. Nevertheless, the information gathered from this study will be used to assist researchers and policymakers in improving the participation of elderly persons in social protection interventions as well as delivering and receiving quality health care. Study results will be made available at the Regional Institute for Population Studies, University of Ghana, Legon and in peer review journals from January 2018 for others to learn the best practices from it.

There are no direct or indirect ricks associated with this study. You may, however, might benefit indirectly from policies that could be adopted as a result of this study. There are no physical, social or psychological risks anticipated for this study.

Confidentiality

Participation in this study is completely anonymous. All responses will be treated with the confidentiality it deserves, and would be used for only academic purposes for this study. You name or any identifiable information will not be included in the research publication and final analysis.

This interview will be recorded using field notes and a recording device, transcribed, and then permanently deleted after publications.

Information gathered during this interview will be stored in a safe place after transcription and would not be made accessible to unauthorized persons.

Payment/Compensation
There are no financial compensation packages attached to your participation in this study either in kind or in cash.

Withdrawal from Study
Participation in this study is voluntary and you can opt-out of the study at any point in time you feel and will not suffer any penalties. You will not be adversely affected neither will the support your outfit is entitled to will be redrawn if you decline to participate or later stop participating.

Your rights as a Research Participant
Participation in this study is completely voluntary. You have the right to choose not to participate at all or to leave in the course of the interview at any time. If you decide not to participate or leave the study after answering a few questions, there will be no penalty, risk or negative consequences. If you decide to participate in the study and then choose to leave, the answers obtained from you will not be included in the data analysis or final report of the study.

Questions or Concerns
If you have any questions regarding the study or this consent form, please contact the Principal Student Investigator, Ms. Doris Ottie-Boakye on +233 244 841 873.

Contact for Additional Information
In case you have further questions or concerns about this study, you can contact Dr. Ayagah Bawah on Tel: +233 244 714 164 at the Regional Institute for Population Studies, University of Ghana-Legon.

You may also contact the Administrator, Ethics Committee for Humanities, ISSER, University of Ghana-Legon on Tel: +233 303 933 866 or the Email address: ech@isser.edu.gh/ech@ug.edu.gh or Madam Hannah Frimpong, GHS-ERC Administrator on 233 (0) 243235225 or 0507041223 or the Email address: Hannah.Frimpong@ghsmail.org.

INFORMED CONSENT

Consent of Participation
I have had the opportunity to read this consent form or have had it read to me. I understand all of the information in this consent form. I had the opportunity to ask questions and I have gotten answers for all of my questions. I voluntarily agree to take part in this study and understand that I have the right to withdraw at any time.

_____ Date

_____

Name of Participant

_____ _____

Signature of Participant Name of Witness

For person who cannot sign: Signature of Witness

Thumbprint:

_____

Date

Consent for Audio Recording
I agree to the audio recording of the interview to facilitate data collection. I do understand that due to the likelihood of risks to confidentiality of audio data (albeit minimal), transcripts from audio files would be anonymized for both me and/or my institution. In the event that I do mention my instit uttion's name or mine, they will be deleted during transcription.No tape will be linked to this consent document and anonymized paper transcripts or reports of the recordings would be used.

_____ _____

Signature Date

Statement of Principal Investigator/Research Assistant/Interviewer obtaining Informed Consent
I have fully explained the purpose and procedures of this study, as well as the possible risks and benefits. I have explained that participation is completely voluntary and that the participant may leave this study at any time. I have asked if the participant has any questions and have answered them fully and accurately to the best of my ability.

_____ _____

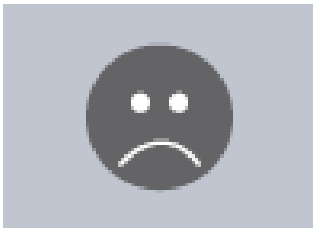
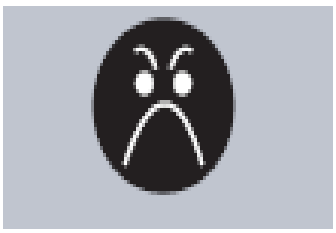
Name of Person Obtaining Informed Consent Date:

Appendix 14: Scorecard for Facial Expression for Measuring the Quality of healthcare from the perspective of Older Persons

CRITERIA	EXPRESSION	SCORE
Not Important		1
Fairly Important		2
Important		3
Very Important		4

Source: Adapted from CARE Malawi. "The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services." Cooperative for Assistance and Relief Everywhere, Inc. (CARE), 2013.

Appendix 15: Scorecard for Faical Expression for Scoring WHO Disability Assessment

CRITERIA	EXPRESSION	SCORE
No Difficulty		0
Mild Difficulty		1
Moderate Difficulty		2
Severe Difficulty		3
Extreme Difficulty or Cannot Do		4

Source: Modified from CARE Malawi. "The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services." Cooperative for Assistance and Relief Everywhere, Inc. (CARE), 2013.

Appendix 16: KMO and Barlett's Test for expected quality of care

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.9542
Bartlett's Test of Sphericity	Approx. Chi-Square	9136.59
	Df	150
	Sig.	<0.001

Source: Author's Field Work, September 2017 – October 2017. **N=400

Appendix 17: Factor analysis (rotated) on expected quality of care

Factor analysis/correlation — Number of observations =400

Method: principal-component factors — Retained factors = 5

Rotation: orthogonal varimax (Kaiser off) — Number of parameters = 150

Factor	Variance	Difference	Proportion	Cumulative
Factor1	5.439	0.904	0.170	0.170
Factor2	4.535	0.082	0.142	0.312
Factor3	4.453	0.228	0.139	0.451
Factor4	4.225	1.895	0.132	0.583
Factor5	2.329	.	0.073	0.656

LR test: independent vs. saturated: chi2 (496) = 9136.59 Prob>chi2 = 0.000

Appendix 18: Rotated Factor loadings (pattern matrix) and unique variances on the expected quality of care

Item No.	Variable	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Uniqueness
Process							
1	Take patients seriously	0.249	0.153	**0.720**	0.050	0.311	0.297
2	Keep appointments punctually	0.223	0.137	**0.730**	0.201	0.285	0.277
3	Patients have access to case notes/files	0.197	**0.509**	0.470	0.083	-0.053	0.471
4	Patients receive information about combinations of medicines	**0.540**	0.210	**0.536**	0.191	-0.002	0.341
5	Patients decides about treatment	0.481	0.355	**0.508**	0.223	-0.037	0.333
6	Choice of another health care provider	0.032	0.300	0.470	0.441	0.025	0.493
7	Good understanding of the patient's problem	0.367	0.273	**0.562**	0.365	0.153	0.318
8	Work efficiently	0.055	0.237	**0.584**	0.463	0.251	0.318
Structure							
9	Access to hospital specialist within 2 weeks	0.414	0.221	**0.601**	0.258	-0.032	0.350
10	Immediate home help after discharge from hospital	0.028	**0.645**	0.392	0.337	0.070	0.312
11	Good care co-ordination	0.263	0.227	0.449	**0.543**	0.123	0.368
12	Waiting time < 15 min	0.371	0.207	0.349	**0.606**	0.015	0.330
13	Good accessibility by telephone	0.445	0.469	0.217	0.379	-0.111	0.379
14	Medicines free of charge	0.185	0.106	0.161	**0.719**	0.237	0.356
15	Reimbursement of cost within 2 months	0.245	0.349	0.079	**0.639**	0.123	0.389
16	Cost/benefits balance	0.427	0.328	0.253	**0.529**	0.086	0.358
Category-specific							
17	Friendly attitude towards the patient/client	0.444	-0.006	0.246	**0.536**	0.306	0.361
18	Willingness to discuss matters that have not run satisfactorily	**0.587**	0.185	0.270	0.325	0.284	0.361
19	Always allow enough time for the patient/client	**0.563**	0.197	0.173	0.429	0.317	0.329
20	Arrangements on what to do in an emergency	**0.539**	0.259	0.255	0.433	0.244	0.330
21	Information leaflet with any medicines dispensed	**0.699**	0.153	0.289	0.305	0.072	0.305
22	Information about the risks involved in any treatment	**0.532**	0.215	0.325	0.219	0.296	0.429
23	Prescriptions delivered to the patients' home address	0.107	**0.568**	0.194	0.397	0.262	0.402
24	No objections if the patient brings someone with him/her to an appointment	**0.682**	0.300	0.090	0.267	0.189	0.330
25	Considerations about home help before being discharged	0.317	**0.722**	0.105	0.202	0.148	0.305
26	Cover to be provided when my regular home help is ill or on holiday	0.327	**0.739**	0.127	0.139	0.251	0.248
27	Easy access for physically disabled or people in wheelchairs	0.157	0.198	0.138	0.356	**0.652**	0.365
28	Easy to get to by public transport	0.222	0.346	0.221	0.128	**0.710**	0.262
29	Easy to get to	**0.552**	0.319	0.302	0.068	0.446	0.298
30	General practitioner's phone switched through directly to the doctor on call	**0.782**	0.254	0.153	0.036	0.125	0.283
31	Home help for as many hours as the client needs	0.224	**0.634**	0.231	0.072	0.365	0.356

32	Possibility to determine how to allocate the budget for care services	0.356	**0.637**	0.219	0.092	0.220	0.362

Source: Computed from author's survey data, September 2017 – October, 2017. Number = 400

Appendix 19: Factor rotation matrix for expected quality of care

	Factor1	Factor2	Factor3	Factor4	Factor5
Factor1	0.533	0.464	0.468	0.451	0.280
Factor2	-0.177	0.790	-0.302	-0.441	0.241
Factor3	-0.784	0.212	0.491	0.284	-0.138
Factor4	-0.233	-0.073	-0.555	0.616	0.502
Factor5	-0.127	-0.330	0.375	-0.377	0.769

Appendix 20: KMO and Barlett's Test for perceived quality of care

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.917
Bartlett's Test of Sphericity	Approx. Chi-Square	5875.53
	Df	125
	Sig.	<0.001

Source: Author's Field Work, September 2017 – October 2017. Number of observations=303

Appendix 21: Factor analysis (rotated) for perceived quality of care

Factor analysis/correlation — Number of observations =303

Method: principal-component factors — Retained factors = 5

Rotation: orthogonal varimax (Kaiser off) — Number of parameters = 125

Factor	Variance	Difference	Proportion	Cumulative
Factor1	7.233	2.041	0.268	0.268
Factor2	5.191	2.565	0.192	0.460
Factor3	2.626	0.451	0.097	0.557
Factor4	2.175	0.596	0.081	0.638
Factor5	1.579	.	0.058	0.696

LR test: independent vs. saturated: chi2 (351) = 5875.53 Prob>chi2 = 0.000

Appendix 22: Rotated Factor loadings (pattern matrix) and unique variances for the perceived quality of care

Item Number.	Variable	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Uniqueness
Process							
1	Take patients seriously	0.126	**0.692**	0.212	0.102	0.268	0.377
2	Keep appointments punctually	0.159	0.258	**0.724**	0.183	0.311	0.254
3	Patients receive information about combinations of medicines	0.065	**0.737**	0.252	0.321	-0.042	0.285
4	Patients decides about treatment	0.221	0.370	**0.547**	0.199	-0.113	0.463
5	Choice of another health care provider	0.496	0.022	0.299	-0.068	**0.664**	0.218
6	Good understanding of the patient's problem	0.097	**0.770**	0.171	0.201	0.058	0.324
7	Work efficiently	0.107	**0.779**	0.176	0.141	0.127	0.315
Structure							
8	Immediate home help after discharge from hospital	**0.834**	0.020	0.106	0.179	0.144	0.240
9	Good care co-ordination	0.216	**0.715**	0.047	0.010	-0.026	0.429
10	Good accessibility by telephone	**0.833**	0.122	0.060	-0.098	0.109	0.267
11	Medicines free of charge	**0.564**	0.337	0.301	-0.034	-0.301	0.385
12	Reimbursement of cost within 2 months	**0.861**	0.205	0.097	0.009	0.060	0.203
13	Cost/benefits balance	0.385	0.449	-0.174	0.030	0.450	0.416
Category-specific							
14	Friendly attitude towards the patient/client	0.133	**0.772**	0.077	0.245	-0.022	0.320
15	Willingness to discuss matters that have not run satisfactorily	0.241	0.350	**0.717**	0.185	0.105	0.260
16	Always allow enough time for the patient/client	0.194	**0.712**	0.058	0.160	-0.147	0.404
17	Arrangements on what to do in an emergency	**0.501**	0.307	-0.081	-0.069	0.406	0.479
18	Information leaflet with any medicines dispensed	0.184	0.476	0.301	**0.507**	-0.090	0.384
19	Prescriptions delivered to the patients' home address	**0.852**	0.133	0.195	0.003	0.042	0.217
20	No objections if the patient brings someone with him/her to an appointment	0.344	0.188	**0.579**	0.272	-0.145	0.416
21	Considerations about home help before being discharged	**0.874**	0.062	0.134	0.165	0.131	0.170
22	Cover to be provided when my regular home help is ill or on holiday	**0.645**	-0.077	0.109	0.213	**0.584**	0.180
23	Easy to get to by public transport	0.078	0.290	0.096	**0.847**	0.053	0.180
24	Easy to get to	0.028	0.352	0.182	**0.745**	0.016	0.287
25	General practitioner's phone switched through directly to the doctor on call	**0.808**	0.152	0.193	-0.136	0.097	0.259
26	Home help for as many hours as the client needs	**0.827**	0.148	-0.040	0.187	0.068	0.252
27	Possibility to determine how to allocate the budget for care services	**0.680**	0.143	**-0.541**	0.127	0.014	0.207

Source: Computed from author's survey data, September 2017 – October, 2017. N = 303 Bolden figure (≥0.5)

Appendix 23: Factor rotation matrix for perceived quality of care

	Factor1	Factor2	Factor3	Factor4	Factor5
Factor1	0.721	0.549	0.291	0.257	0.166
Factor2	-0.643	0.598	0.267	0.349	-0.191
Factor3	0.049	0.465	-0.875	-0.085	-0.087
Factor4	0.236	0.246	-0.083	-0.478	0.805
Factor5	-0.091	-0.254	-0.266	0.759	0.529

Appendix 24: Detailed profiles of key informants/experts (Programme planners and implementers, and service providers)

Identifier	Location	Age	Sex	Education Completed	Occupation	Institutional Type	Position
R1	Urban	40	M	Tertiary	Social Worker	MoGCSP/DWs	Director
R2	Urban	50	F	Tertiary	Medical Practitioner	Private Clinic	In-Charge of Health Facility
R3	Rural	29	F	Tertiary	Midwife	Health Centre	In-Charge of Health Facility
R4	Rural	28	F	Tertiary	Enrolled Nurse	CHPS Compound	In-Charge of Health Facility
R5	Rural	59	M	Tertiary	Accountant	Private Mission Clinic	Head of Finance & Administration
R6	Urban	58	M	Tertiary	Pharmacist	Health Directorate	Director of Health Services
R7	Urban	45	M	Tertiary	Teaching	NHIS	Scheme Manager
R8	Rural	27	F	Tertiary	Community Health Worker	CHPS Compound	In-Charge of Health Facility
R9	Urban	74	M	Non-tertiary	Kente Weaver/Farmer	LEAP Committee-Urban	LEAP Committee Member
R10	Urban	27	M	Tertiary	Nurse	Health Centre	2nd In-Charge of Health Facility
R11	Urban	69	F	Tertiary	Midwife	Private-Maternity	Midwife
R12	Urban	42	M	Tertiary	Administrator Health Services	Government Hospital	Head of Health Services Administration
R13	Rural	47	M	Non-tertiary	Farmer	LEAP Committee-Rural	LEAP Committee Member

Appendix 25: Basic themes, and codes for the linkage between SPIs and access to quality healthcare from the perspectives of key informants [Programme planners and implementers, and service providers]

Themes and codes	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	N
Positive effects														
Political factors														
Introduction of NHIS & LEAP	*		*	*			*	*	*				*	7
Abolishing of the Capitation model under the NHIS	*	*						*					*	4
Economic factors														
NHIS claims as main source of IGF for health facilities			*				*			*		*		4
Reduction in the incidence of abscondment among clients												*		1
Technological factors														
Use of electronic devices to capture biodata of beneficiaries (LEAP & NHIS)	*						*		*					3
Issuance of electronic receipts(LEAP & NHIS)	*						*							2
Existence of equipment for peculiar disease				*										1
Legal factors														
Accreditation for health facilities			*	*				*						3
Referral system		*	*				*				*			4
Environmental/Geographic factors														
Presence of CHPS at the community level				*								*		2
Socio-cultural factors														
Respect for older persons		*		*	*	*	*	*		*	*	*		9
Corporate social responsibility		*		*	*			*					*	5
Negative effects														
Political factors														
Change in political administration							*		*	*				2
Government policies and directives										*				1
Perceived use of NHIS and LEAP as electoral baits	*													1
Economic factors														
Out-of-pocket payment for prescribed drugs	*			*	*		*	*	*	*	*	*		9
Delay in the payment of NHIS claims			*		*		*			*	*			5
Lack of motivation for LEAP volunteers									*				*	2

Technological factors														
Poor internet connectivity	*			*			*							3
Limited infrastructure/health personnel to meet demand of older persons		*	*	*	*	*		*		*	*			8
Lack of basic/special equipment/trained health personnel for elderly care		*	*	*	*	*		*		*	*	*		9
Lack of logistics for service provision	*	*	*	*	*			*	*	*			*	9
Structural design of health facilities' infrastructure/furnishings		*	*			*				*	*			5
Legal factors														
Non-existence of a focused policy on the care of the elderly												*		1
Variations in the definition of "older persons"	*													1
Mandated service delivery per facility level of operation		*	*											2
Environmental/Geographic factors														
Poor transportation networks			*							*		*		3
Socio-cultural factors														
Witchcraft accusations				*								*	*	3
Breakdown in family support system		*	*	*				*		*			*	6
Culture of health seeking behaviour		*		*	*		*	*		*	*	*		8

Appendix 26: Global themes, organizing themes and basic themes for the linkage between social protection initiatives and access to quality healthcare among older persons from the institutional perspectives.

Global Themes	Organising Themes	Basic Themes	No. of responses	Descriptions	Sample quotes
Positive effects	**Political factors**	Introduction of NHIS and LEAP	7	Factors that have positive direct bearing from governance (political system) based on political administration's policies and programmes that may affect SPIs and access to quality healthcare linkage.	"*NHIS has brought financial relief to both the elderly and the family or caregivers especially in the face of a severe condition like stroke…*" – (Female, Enrolled Nurse, CHPS Compound– Rural IDI). ***"****Capitation model was a challenge. …, it becomes difficult for people including older persons to access healthcare. We thank God that it has now been scrapped off"* – (Male, Social Worker, - Urban IDI).
		Abolishing of the capitation model under the NHIS	4		
	Economic factors	NHIS claims as main source of IGF for health facilities	4	Factors that have positive direct impact on the cost-effectiveness and financial position of institutions that may affect SPIs and access to quality healthcare linkage.	*"Most health service providers we have interacted with, will tell you that more than 80% of their IGFs come from the insurance. So, it tells you how sensitive the health insurance is to them"* – (Male, Scheme Manager - Urban IDI). *"NHIS as a form of SPI has also reduced the incidence of abscondment among clients since they come with the insurance. It has improved the revenue of the facility compared to before its inception"* – (Male, Administrator, Hospital – Urban IDI).
		Reduction in the incidence of abscondment among clients	1		
	Technological factors	Use of electronic devices to capture biodata of beneficiaries (LEAP & NHIS)	3	Factors that have positive direct bearing on the technical activities/training of program planners and implementers, and service providers that may affect SPIs and	*"…Previously, the waiting time for one to use the NHIS was three months…It has been reduced to one month since it was introduced in 2014…and to ensure accountability, electronic receipts are issued to NHIS subscribers."– (Male, Scheme Manager – Urban IDI).*
		Issuance of electronic receipts (NHIS & LEAP)	2		
		Existence of equipment for peculiar disease	1		

				access to quality healthcare linkage.	*"The facility did not to have both glucometer and BP apparatus. They are now available"* – (Female, Community Health Worker, CHPS Compound - Rural IDI).
	Legal factors	Accreditation for health facilities	3	Factors that may receive positive direct bearing from the legal angle (legislative instruments and Acts/legal frameworks) that may affect SPIs and access to quality healthcare linkage.	*"Health facilities have also improved on the quality of the services since we have accreditation from the NHIS ... It has served as a check .... There is a monitoring team from the NHIA that comes to inspect on how services are rendered to patients"* – (Male, Administrator, Hospital – Urban IDI). *"If the blood pressure is still high, then a referral is given to the elderly to go to the urban centre, municipal Government hospital for further examination and medication"* – (Enrolled Nurse, CHPS Compound – Rural IDI).
		Referral system	4		
	Environmental/geographic factors	Presence of CHPS at the community level	2	Factors that are positively influenced by the environment and the location from which program planners and implementers, and service providers carry out activities which may affect SPIs and access to quality healthcare linkage.	*"Strengthening the CHPS system is very important. Older persons do not need to travel to access care and incurring transportation cost"* – (Male, Administrator, Hospital – Urban IDI).
	Socio-cultural factors	Respect for older persons	9	Factors that are positively influenced by the beliefs, norms, and values of services provided by institutions that may affect SPIs and access to quality healthcare linkage.	*"And even if we don't have enough machines to work with, per our culture, we need to respect the elderly so we give them priority"* - (Male, Scheme Manager – Urban IDI). *"The health facility organised health insurance registration for the elderly last year (that is, 2016) and this was subsided. This registration was GH¢ 8.00 and GH¢ 5.00 for renewal. They paid GH¢5.00 for registration and GH¢3.00 for the renewal"* - (Male, Head
		Corporate social responsibility	5		

					of Finance & Administration, Mission Clinic – Rural IDI).
Negative effects	**Political factors**	Change in political administration	2	Factors that have negative direct bearing from governance (political system) based on political administration's policies and programmes that may affect SPIs and access to quality healthcare linkage.	*"When the LEAP programme began in 2008, I was involved but the change in government halted the programme for the whole of the year 2009 since the then current government was not making payments to the recipients"* – (Male, LEAP Community Committee Member - Urban IDI). *"During one of the recent cash grant enrolment, it was politicized when people were asked to present an ID card. Some recipients taught that it was a ploy to deny them of their voting rights. This affected the enrolment… .and yet, some people did not show up. … ."* – (Male, Social worker - Urban IDI).
		Government policies and directives that affect SPIs and quality of care linkage	2		
		Perceived use of NHIS & LEAP as electoral baits	1		
	Economic factors	Out-of-pocket payment for prescribed drugs	9	Factors that have negative direct impact on the cost-effectiveness and financial position of institutions that may affect SPIs and access to quality healthcare linkage.	*"It is not every drug that is covered under the NHIS. So clients are told, and where they could afford for such drugs, they top up for it"* - (Male, Health Centre, Nurse - Urban IDI). *"The NHIS delay in payment of claims affects the quality of services the facility gives to older persons. …the delay in the payment of claims makes it impossible for the facility to purchase the same drugs that have been given out to these older clients. … . Sometimes the only option left is to issue a prescription form for the drugs to be bought"* - (Male, Nurse, Health Centre, - Urban IDI). *"Sometimes too, recipients tell you they do not know the location of the Social Welfare office at the municipal capital. I will have to then accompany such a person to the place to get the card renewed.* ***Interviewer**: Who is responsible for the transportation cost of such an errand?* ***Respondent**: I pay for the transportation cost myself"* - (Male, LEAP Community Committee Member - Rural IDI).
		Delay in the payment of NHIS claims	5		
		Lack of motivation for LEAP volunteers	2		

	Technological factors	Poor internet connectivity	3	Factors that have negative direct bearing on the technical activities/training of program planners and implementers, and service providers that may affect SPIs and access to quality healthcare linkage.	*"…We had tried a couple of times to get the NHIS officers to come and work here. It has proved futile due to poor internet connectivity in this community. Organising registration/renewal exercise for subscribers in this community has not worked. …But the Assembly member advised that we should be able to locate a point in the community where the telecommunication network is very good for the NHIS operations. But, the only option left for the elderly is to travel to the municipal capital to do the registration and renewal"* - (Enrolled Nurse, CHPS Zone – Rural IDI). *"We are not able to do home visits in the community due to the limited number of staff. … We do not have enough spaces for handling our clients…"* - (Male, Nurse, Health Centre - Urban IDI). *"… . The design of some of the buildings is not old age-friendly* - (Female, Midwife, Private Maternity & Clinic - Urban IDI).
		Limited infrastructure/health personnel to meet demand of older persons	8		
		Lack of basic/special equipment/trained health personnel for elderly care	9		
		Lack of logistics for service provision	9		
		Structural design of health facilities' infrastructure/furnishings	5		
	Legal factors	Non-existence of a focused policy on the care of the elderly	1	Factors that may receive negative direct bearing from the legal angle (legislative instruments and Acts/legal frameworks) that may affect SPIs and access to quality healthcare linkage.	*"…there is no focused training for the care of the aged. That one is a policy issue. … For now, there is no working document for that. All clients come with a condition so it is not age specific. It is based on conditions"*- (Male, Administrator, Hospital – Urban IDI). *"Per the Department of Social Welfare definition, the elderly is 65 years and above, and per the NHIS, it is 70 years. Per the Pension Act of Ghana, it is 60 years and above. We have a problem with the definition of the elderly"* - (Male, Social worker - Urban IDI). *"It depends on the level of the facility. Facilities supply drugs to clients based on their level of drug prescription. Condition above the level of care of the facility must be referred"* - (Female, Medical Practitioner, Private Clinic - Urban IDI).
		Variations in the definition of "older persons"	1		
		Mandated service delivery per facility level of operation	2		

	Environmental/geographic factors	Poor transportation networks	3	Factors that are negatively influenced by the environment and the location from which program planners and implementers, and service providers carry out activities which may affect SPIs and access to quality healthcare linkage.	*"The poor nature of the road discourages drivers from transporting clients to the facility"*- (Female, Medical Practitioner, Private Clinic - Urban IDI).
	Socio-cultural factors	Witchcraft accusations	3	Factors that are negatively influenced by the beliefs, norms, and values of services provided by institutions that may affect SPIs and access to quality healthcare linkage.	*"Some people also think that when one becomes old, he/she is a witch/wizard. The moment wrinkles are seen on the face, you are labelled you are turning into a wizard/witch. Once they have that mind set for you, there will be little support for you for your medication. This could be a hindrance to accessing quality healthcare"* - (Male, Administrator, Hospital – Urban IDI). *"Older persons have family members around but you see today, things have changed. Now the family system has become like "each one for him/herself". ... that family support system is no more like before"* - (Male, LEAP Community Committee Member - Rural IDI). *"The moment a client is diagnosed with diabetes or hypertension, it is assumed that that illness was spiritually acquired. The person heads on to the pastor for prayers. As a result, even the prescribed drugs that are given, are not adhered to"* - (Male, Nurse, Health Centre - Urban IDI).
		Breakdown in family support system	6		
		Culture of health seeking behaviour	8		